

PROFESSIONAL ISSUES

A Post Traumatic Stress Disorder Ethical Update

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Post traumatic stress disorder (PTSD) is a complex condition with a variety of potential causes and symptoms, and it requires multifaceted treatment. Practitioners are cautioned to take great care in the informed consent process to ensure that clients know their treatment options, the level of support, and pros and cons of each option before giving consent. Practitioners need to be familiar with both the clinical and research data when developing a rationale and treatment approach that is individualized for the specific client. Moreover, practitioners should be competent in diagnosing a wide variety of conditions that are comorbid with PTSD and should ensure that they can legally make such a diagnosis and provide treatment for the specific conditions from which the client suffers. In addition, it is strongly recommended, if not legally required, that practitioners have an appropriate background in a mental health discipline so they are competent to help a client work through the traumas, symptoms, and side effects experienced by the client before undertaking the treatment of those suffering from PTSD.

Introduction

Post traumatic stress disorder (PTSD) is classified as an anxiety disorder that can develop after a traumatic event. People tend to believe that the world is safe, benevolent, predictable, and meaningful (Calhoun & Tedeschi, 1999). In reality, the world can be very stressful and unpredictable, and difficult events are everyday occurrences (Calhoun & Tedeschi, 1999). Sudden, unexpected events are more likely to be traumatic than are those that occur gradually or are expected (Calhoun & Tedeschi, 1999). The perception that one has lost or is not in control may make things seem worse. A significant traumatic event can be defined as one that disrupts the foundational beliefs of an individual that he or she is in control and that life is predictable.

According to MedlinePlus (2008), if you: (a) feel like an event is repeating itself, (b) have trouble sleeping or have nightmares, (c) do not feel close to other people, (d) become angry easily, and/or (e) feel guilty because others perished but you lived, then you may well be suffering from PTSD.

A wide variety of events can cause PTSD, including but not limited to natural disasters, abuse, rape, vehicle accidents, robbery, being in a concentration camp, war, or working in a profession where exposure to trauma is frequent (e.g., policeman, emergency rescue worker). In addition, health care practitioners are subject to “vicarious traumatization,” depending on the severity and duration of exposure (e.g., percentage of client caseload who suffer from severe trauma), as well as personal vulnerabilities (e.g., a beginning clinician is at greater risk than an experienced one; the coping skills of the clinician and the stability of their personality are also relevant factors). Practitioners who treat a large number of individuals who have experienced severe traumatic events (e.g., those suffering from PTSD) should take precautions to ensure that they do not suffer vicariously from the condition, including getting treatment for themselves if needed. It is interesting that a large number of individuals suffering from PTSD seem to suffer without ever being identified as having PTSD; for example, 20% of those who have spent time in an intensive-care unit show evidence of PTSD (Spiesel, 2008). Parents of children born with a severe developmental disability such as autism also often suffer from PTSD (Berkell Zager, 2005). These underserved populations could provide a large new client base for the health care practitioner skilled in treating the condition.

Common treatments for PTSD include psychotherapies (talk therapies), especially cognitive-behavior therapy, various forms of relaxation, systematic desensitization, eye movement desensitization and reprocessing (EMDR), various medications (especially those used to treat anxiety and depression), and increasingly, various forms of biofeedback (MedlinePlus, 2008). Within this mix of causes, symptoms, and treatments reside a number of ethical issues that must be addressed by the health care practitioner. Some of those issues will be addressed in this article.

Rationale

What is the rationale or basis for proposing to use biofeedback or other applied psychophysiological treat-

ment interventions with those suffering from PTSD? There seem to be several. First, from a physiological perspective, the amygdala in the brain, which regulates fear, seems to be working overtime in those suffering from PTSD (MedlinePlus, 2008). Demos (2005) stated that patients suffering from PTSD may well benefit from neurofeedback training in the occipital lobes, because there seems to be a unique connection between the visual cortex and the amygdala. In essence, an increase in blood flow in the amygdala is correlated with an increase in blood flow in the visual cortex, thus indicating a relationship between the two brain regions (Davidson & Irwin, 1999). Neurofeedback training in the area of the visual cortex seems to be successful in alleviating the anxiety and depression associated with PTSD (Demos, 2005). Second, those suffering from PTSD seem to have abnormal levels of the hormones that respond to stress, and these high hormone levels may cause strong memories to occur during traumatic events and these memories may result in flashbacks and a reliving of the traumatic event when stimuli associated with the event are encountered (MedlinePlus, 2008). White (1999) reported that both the sympathetic and parasympathetic nervous systems of persons suffering from PTSD show heightened arousal. Biofeedback of various forms often has been used to help individuals learn to relax and thus overcome some of the negative effects of stress, such as those associated with heightened levels of stress hormones and overarousal of the nervous system, by helping the individual learn to reacquire a state of physiological homeostasis. In fact, relaxation training is one of the very few uses of biofeedback approved by the Food and Drug Administration. Peniston and Kulkosky (1989) used a combination of six sessions of skin temperature biofeedback, guided imagery, and an alpha-theta crossover form of electroencephalographic (EEG) biofeedback to achieve positive treatment outcomes with military veterans suffering from PTSD. That protocol also has been used successfully by others to achieve successful treatment outcomes with those suffering from PTSD (White, 1999). Suffice it to say that a practitioner can find a rationale for using a biofeedback approach in providing treatment for those suffering from PTSD. Before doing so however, a practitioner should carefully review the clinical and research literature supporting the use of the proposed biofeedback treatment as well as that supporting other treatments such as medications, cognitive-behavior therapy, and EMDR. Such information then can be shared with the client during the informed consent process to ensure that he or she can make an informed decision about which treatment options are acceptable to him or her.

Diagnosis

It is important for practitioners to make sure that they know the correct way(s) to interview and to diagnose not just PTSD, but also the many comorbid conditions often associated with it (e.g., bipolar disorder, depression, other anxiety disorders, and substance abuse). In addition, it is important for practitioners to operate within the scope of practice for their profession and to be in compliance with any licensing laws that apply to their professional activities (Striefel, 2004).

In addition, other conditions can easily mimic PTSD, or vice versa, due to an overlap in symptoms: For example, PTSD and attention-deficit/hyperactivity disorder have overlapping symptoms (Demos, 2005). In making a diagnosis, a practitioner needs to be sure he or she is competent in the skills needed to do so and that he or she is legally allowed to make such a diagnosis based on state licensing laws, scope of practice, and other relevant rules and regulations (Striefel, 2004). If not legally allowed or if not competent to make a correct diagnosis, the practitioner should refer the patient to someone who is. Demos (2005) and Striefel (in press) have both stressed the importance of practitioners who treat certain complex conditions, such as PTSD, having a background in a mental health discipline.

Informed Consent

To date, no publication that has reviewed treatments for PTSD has concluded that any form of biofeedback is a validated treatment or a treatment of choice for PTSD. Yucha and Montgomery (2008) gave biofeedback a rating of only 2 (possibly efficacious) out of a possible score of 5 (efficacious and specific), due to the scarcity of published studies attesting to the efficacy of biofeedback in treating PTSD. This lack of research data does not mean that a practitioner cannot use biofeedback as a component in the treatment of PTSD, but rather that extra precautions and documentation should occur during the informed consent process to ensure that the client knows what his or her options are, the resources that exist in support of each of those options, and the pros and cons of each; that he or she gives consent; and that the consent is well documented. Most practitioners know that in clinical practice a variety of treatments are used for which sufficient research data does not yet exist, but where clinical data shows promise and where a logical argument can be made for using the specific treatment. Specific attention needs to be paid during the informed consent process to clearly explain why a practitioner is recommending a treatment such as an alpha-theta protocol when some well-supported, evidence-based treatment option already exists. For example, what rationale

would you use to recommend some form of neurofeedback treatment rather than EMDR?

Demos (2005) argued that alpha-theta training is often more efficient than any of the talk therapies for treating PTSD because trauma can severely compromise a person's cognitive processing skills, thus making talk therapies more difficult and less effective. He stated that recall of the traumatic event may well activate the limbic system and freeze up the left frontal lobe (e.g., Broca's area, which is responsible for speech). Speech is the key component in talk therapies. One can see how a lack of cognitive-processing skills and difficulty with speech might interfere with a treatment that relies on these skills. Demos also discusses several other multifaceted and useful EEG treatment protocols for dealing with PTSD when correctly applied with the right patient based on his or her individual symptoms and physiological parameters. Diaphragmatic breathing, teaching of basic coping skills, stabilization training along the central-motor strip, alpha-theta training, alpha enhancement or suppression, and beta asymmetry training all have produced positive outcomes with those suffering from PTSD when provided in an individualized manner, with the clinician making clear that "One size does not fit all" (Demos, 2005, p. 199). Just as one size does not fit all, one form of training alone is seldom sufficient for producing successful treatment outcomes. Are you competent in a multitude of treatments that might be combined to provide effective and efficient treatment for clients suffering from PTSD? If you are not, you should not be providing treatments for those suffering from such a disorder unless you are being closely supervised by someone who is skilled and competent in this area. Those providing treatment for less complex conditions may well not be competent to treat PTSD. Do you have the therapeutic skills needed for dealing with "traumatic recovery" (Demos, 2005)? Treatment of PTSD is not likely to be successful unless the trauma is worked through, for example, combining alpha-theta training and cognitive-behavior therapy (Demos, 2005). You should have highly honed therapeutic skills if you plan to treat those suffering from PTSD. Clients have a right to know during the ongoing informed consent process what your background, skills, and competence are in reference to any conditions or treatments that you propose to treat or apply, respectively. This includes knowing what kind of outcomes your patients have achieved after being in treatment with you.

A wide variety of potential side effects coexist with the treatment of PTSD. Practitioners are ethically obligated to help clients understand in advance what these likely side effects are (Striefel, 2007a, 2007b), especially because the

perception of loss of control and the nonpredictability of events contributed to the traumatization that occurred with the original event. Clearly, flashbacks, anxiety, depression, sleep difficulties, and so on are likely to occur during and between treatment sessions. Uptraining of theta is likely to produce flashbacks (Demos, 2005). So, if you plan to do such training, you need to prepare the client for flashbacks, obtain informed consent, and be prepared to help the client deal with any and all side effects that are likely to occur. Are you prepared to do this? How can you prepare the client for any likely side effects and how could you minimize their negative impact on the client? See Striefel (2007a, 2007b) for a very detailed discussion of the issues surrounding side effects.

Conclusion

At the end of treatment for PTSD, a client needs to have re-created a world view that incorporates what happened (the trauma) with how he or she can choose to feel and live; he or she needs to understand why the traumatic event produced the impacts that it did; and the events that were associated with the trauma should no longer produce any physical or mental responses that incapacitate or disrupt the life of the client (Calhoun & Tedeschi, 1999).

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