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C-PTSD TREATMENT SUMMARY FOR RICH MULLINAX

Submitted: **May 8, 2012**
Completed By: **Rich Mullinax**
Treatment Provider: **UGA Psychology Clinic,** [redacted]

Following is a summary of the Cognitive Behavioral Therapy that I received for C-PTSD from the University of Georgia Psychology Clinic beginning Oct 2010 and ending May 2012.

PRELUDE

Prior to October 2010, (and to this day), I was under the outpatient care of a psychiatrist. For more than 4 years prior to October 2010, I was experiencing the following symptoms of PTSD as a result of my 6-year involvement in the cult Straight Inc. from 1983 – 1989 (http://en.wikipedia.org/wiki/Straight,_Incorporated):

1. Intrusive memories of the traumatic events
2. Frequent nightmares of the multiple traumatic events
3. Sleepless nights due to fear of sleep and dreaming of the traumatic events
4. Difficulty sleeping in general
5. Irritability
6. Overreacting (lashing out at others) in interpersonal interactions
7. Exaggerated startle response to sudden noises or movements
8. A constant fear and dread for the safety of all children, especially my children

9. An inability to concentrate (especially reading books)
10. A feeling of hopelessness
11. A loss of interest in activities that used to stimulate me
12. Avoiding and fearing activities that remind me of the trauma in anyway
13. Avoiding interaction with other people for fear of loosing control
14. Generalized Anxiety Disorder symptoms
15. Depression symptoms
16. Panic attacks
17. Gastrointestinal distress

- As a result of these symptoms, I sought PTSD therapy from a qualified clinician.
- My spouse, who has been supportive of this entire treatment process, encouraged my participation in therapy and has demonstrated unwavering support.

SEEKING TREATMENT

In October 2010 I was unemployed and uninsured, so I had limited options available to me for therapy. However, I continued to seek a solution and became willing to make compromises to get the therapy I needed.

INITIATING TREATMENT

- In October 2010 I learned of the UGA Psychology Clinic and scheduled an initial interview.
- After an initial interview with staff at the Clinic, I was offered an opportunity to receive treatment at the clinic on a sliding scale that I could afford, under the following conditions:

    - I agree to have my sessions observed for the purposes of teaching & research
    - I agree to have my sessions filmed for the purposes of teaching & research

- At no time during my treatment did I find this arrangement distracting or inconvenient. In fact, it was as if I was never being observed.

IN-DEPTH ASSESSMENT

For several weeks during November and December of 2010, I underwent an extensive assessment which included answering numerous questions about my family history, my trauma history, my daily activities and the symptoms I was experiencing. I undertook this assessment process with complete transparency.

DIAGNOSIS

It was confirmed to me by the staff at the UGA Psychology Clinic that I have been experiencing Post Traumatic Stress Disorder. Specific mention was made of *Complex* Post Traumatic Stress Disorder; an unofficial variation of the diagnosis that can occur when trauma takes place on an ongoing basis rather than a 1-time event.

INTRODUCTION TO TREATMENT PLAN - TREATMENT BEGINS

In December 2010 my treatment officially began by reviewing my diagnosis in detail and proposing a treatment plan, including a candid discussion about the commitment required from me to accomplish our treatment goals.

I was presented with a 2-part treatment plan that has proven to be effective in treating the symptoms of PTSD in other clients; Part 1 is Prolonged Exposure Therapy and Part 2 is Cognitive Processing Therapy.

PART 1 - PROLONGED EXPOSURE THERAPY

In P.E.T. I began by looking directly at my symptoms and the fears that were causing those symptoms. I wasted no time. This is not for the feint of heart.

AVOIDANCE – One of my most troublesome symptoms had been avoidance. I made every effort to avoid addressing and dealing with the stressors in my life. I began to examine and address the activities and thought processes that I had been avoiding in an effort to run away from facing the pain of the trauma that caused my P.T.S.D. I began to address avoidance in 3 ways:

1. In Vivo Exposures – To address the avoidances of everyday activities, (the things I used to enjoy or things I wanted and needed to do in my everyday life), I began to list these avoidances and rank them by the level of fear or stress I felt prior to the activity; a.k.a. their S.U.D.s level (Subjective Units of Distress). In other words, on a scale of 1 – 100, how anxious was I feeling going in to the activity?

Each week, my therapist and I would agree upon a few *In Vivo Exposures* that I felt I was ready to tackle. My *In Vivo Exposures* took place during my time between sessions and I discussed them with my therapist during my sessions. I started small. I was never asked to take on an *In Vivo Exposure* that I didn't feel I was ready to tackle. As I repeated the same *In Vivo Exposures* several times, the S.U.D.s levels for those activities began to drop in nearly every instance.

Sometimes it was 2 steps forward and 1 step back, but **every** *In Vivo Exposure* eventually dropped in S.U.D.s levels.

Eventually, some activities that were initially very distressing disappeared from the list entirely. Other *In Vivos* went from a pre-activity S.U.D.s of 80 to a post-activity S.U.D.s of 20 within just 2 – 3 weeks. I added new activities to the list as I was able. By the spring of 2011, I began to see concrete improvement in my ability to function within my family and immediate surroundings. Seeing this improvement so quickly in my treatment was encouraging and made me confident that I could be successful in the rest of my therapy.

Additionally, with the guidance of my therapist, we exposed me to some tangible items that reminded me of the trauma itself; photographs of the exact chairs we sat in for 12 hours a day, 7 days a week; remembering & listening to the cult's songs that I was once forced to sing.

2. Imaginal Exposures – In order to understand my traumatic experiences in a more rational light, or for that matter, to even recognize that I had been looking at my traumatic experiences in a completely irrational light, I began *Imaginal Exposures.* This was an activity that I completed IN our treatment sessions under the supervision of my therapist.

We allowed more than the usual 60-minute sessions for *Imaginal Exposures* as they could be exhausting. The activity consisted of me selecting one of my traumatic events and describing it out loud. I spoke as if the event were going on right then and there. I remember wanting to describe the event as if I were watching from above the room. It was hard to resist describing the event as if it had happened to someone else. I described smells, clothes, facial expressions, even the colors of cars. I found myself remembering details that I had completely forgotten for 25+ years; details like who was wearing what shirt and the names of people long since forgotten. I also described the way I felt in detail; feelings like shame, fear and humiliation.

Once I had gone through some of these *Imaginal Exposures* more than a few times, I found that these feelings were less intense. Speaking through the trauma in a safe environment had an effect on the way I thought about the trauma. By the time a few weeks had passed after these *Imaginal Exposures*, these particular traumas eventually stopped creeping into my head or dreams. I'm not sure I even recognized that at the time. I may be just recognizing that now. I still find that other traumas can find their way into my thoughts and dreams, but it is much less frequent.

I remember that on the days I did *Imaginal Exposures*, I felt wiped out and was often too exhausted to do much more for the rest of the day. Because my traumas were hundreds of varied events that took place over 6 years, we decided to select a sampling of events; one was something that happened when I was a runaway on the streets, another from my time as a

victim in the cult and a third took place when I was a staff participant in the cult. There were other *Imaginal Exposures*, as well.

I recorded every session we had. Throughout our treatment, I listened to my weekly sessions 2 or 3 times per week, but during the *Imaginal Exposure* sessions, I usually listened every day.

3. BREATHING and RELAXATION – There was one more component that went along with both my *In Vivo Exposures* and *Imaginal Exposures*; breathing and relaxation techniques. In session, I learned several breathing and relaxation techniques that helped me get through both forms of exposures. For example; in some of my *In Vivo Exposures*, I found myself panicking at social functions that I had avoided in the past. But in therapy, I learned several breathing exercises that I could use to calm down if I found my S.U.D.s level climbing too high. On more than 1 occasion, I found a quiet place (such as my car) to go outside and practice my breathing and relaxation techniques. I also used ... (this may not be the correct term) ... "guided imagery" to relax. I recorded a written scenario that I found relaxing ("Cabin in the Woods") and by simply listening to that short recording, my heart rate would go down and I was reminded that I was in a safe environment. I keep a recording of this with me on my iPod and on a CD (for the car). There were also a variety of muscle relaxation techniques that helped me during *In Vivo* and *Imaginal Exposures.*

IRRATIONAL COGNITIONS – I'm not sure I have this term correct, but ... during the *Prolonged Exposure Therapy,* I learned that I had a false set of beliefs about the circumstances at hand. The lowering of my S.U.D.s levels over time proved that my pre-conceived notions and my worst fears relating to each thought (*Imaginal Exposure*) or predicted outcome (*In Vivo Exposure*) was **not** accurate. Upon looking at the evidence, (lower S.U.D.s levels for *In Vivo Exposures* and not dying when I experienced an *Imaginal Exposure*), I was able to restate the facts out loud and came to believe the truth. I found the evidence impossible to argue with.

I also became more acclimated to the events of the traumas and have found them creeping into my head less and less, including my nightmares. Because I experienced multiple traumas, it's possible that in the future I may remember new incidents or thoughts that are unwanted or disturbing. I may also face new *In Vivo Exposures* along the way. But because I can revisit these exercises & tools, this does NOT scare me.

In addition to the above curriculum, during the 1st half of treatment I learned skills such as sleep hygiene, regular walking and other basic lifestyle changes that assisted in accomplishing the therapy tasks at hand.

OTHER TOOLS FOR DEALING WITH AVOIDANCE, RELATIONSHIPS & LIFE

Throughout the *Prolonged Exposure Therapy* portion of treatment, I was continually learning and practicing new tools to help me as my daily activities and interactions with others increased (as a result of my lowered S.U.D.s in my *In Vivo Exposures*). These tools include assertiveness training, healthier communication and the **D.E.A.R. M.A.N.** tool. When expressing myself to others, I've learned to ***Define*** the facts, ***Express*** my feelings, ***Assert*** my wants, ***Reinforce*** the other party with encouragement, remain ***Mindful*** of my objectives, ***Appear*** confident (by maintaining eye contact and other body language) and to be prepared to ***Negotiate*** alternatives.

Part 2 – COGNITIVE PROCESSING THERAPY:

In part 2 of my treatment, I learned that I had been using defense mechanisms in order to get my mind around the traumas I experienced.

1. I ASSIMILATED the traumatic events into the way of thinking I was already comfortable with, (or the way of thinking I wasn't willing to let go of). For example:

   "What I experienced was bad, but I brought it ALL on myself because I am an alcoholic. And while it was drastic, it was necessary for me to experience this in order to recover from alcoholism."

2. On other occasions I ACCOMMODATED the trauma by denying the reality of what I experienced. I told myself (and others) that it "wasn't all that bad". For example:

   "I'm WAY overreacting to these events. In fact, OTHER people are way overreacting to the same events and they just need to get over it and move on!"

   Having heard the above statement for years from others who experienced the same trauma didn't help.

In this part of therapy, I began to understand how the traumas could either reinforce negative beliefs that I had prior to the traumas about myself in the areas of safety, trust, power / control, esteem and intimacy, ... or ... the traumas may have shattered my views about myself prior to the trauma regarding safety, trust, power / control, esteem and intimacy.

STUCK POINTS - Part 2's overall mission was to identify and reshape my Stuck Points regarding several beliefs I had about the trauma. About Stuck Points:

1. Stuck Points are disruptive to the recovery process

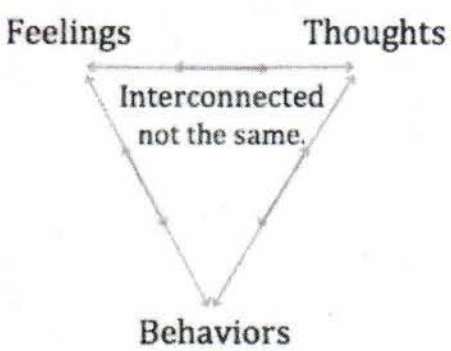
2. Stuck Points create strong negative (& untrue) beliefs and can create multiple beliefs that contradict each other
3. Stuck Points (& the false beliefs they create) cause unhealthy behavior & negative emotions
4. Stuck Points are the beliefs about my trauma that lead to PTSD symptoms
5. Stuck Points are created when there are conflicting beliefs (regarding safety, trust, power / control, esteem and intimacy) before and after the trauma. The trauma shatters the belief system, regardless of what the belief was to begin with. If the original belief was negative, the trauma reinforced that. If the original belief was healthy, the trauma shattered that.
6. Learning to CHANGE these beliefs resulted in a reduction in PTSD symptoms!

Throughout the remainder of therapy, I continued to examine my beliefs both before and after the trauma regarding the areas of safety, trust, power / control, esteem and intimacy. I learned a set of questions that force me to challenge each belief in a logical manner. When *I* answer these questions, it becomes possible to have an entirely NEW belief about trauma and about me. (These are my "Challenging Beliefs Worksheets".) When I compared my original impact statements with my current impact statements, there was a world of difference.

When I began the Stuck Points portion of therapy, it was at this point that I started to internalized that what I HAVE believed has been WRONG, and ... more importantly, I became capable of both recognizing AND changing those wrong beliefs using a set of tools available to me.

My goal is to change my final belief, or impact statement; to create a "realistic belief".

To begin to change my beliefs, I start by recognizing the relationships between Thoughts, Feelings and Actions:



Yes, these are interconnected, BUT ... they are NOT the same things. They are very different. So how many of my beliefs are wrong? I'm learning that MANY are wrong, and this is a GOOD thing because I've already proven that I CAN change my beliefs.

Concerning my thoughts, I am only consciously aware of a FRACTION of my thoughts. Concerning my feelings, well, they LOVE themselves! Feelings LOVE to continue to advance in the direction they are already headed in, good or bad! (Sounds like a good facebook status ...)

While considering the ins and outs of Stuck Points, and the triangle of Thoughts, Feelings and Actions, I began some exercises to discover what some of my Stuck Points are and to see how I can break out of the cycle that had me perpetually headed in the wrong directions.

I used an **ABC** worksheet that forced me to examine the **A**ctivating Event (of a belief), the **B**elief itself (what I've told myself) and the resulting **C**onsequence. I then tested the assumptions in **A, B** & **C** against logic; "Are my thoughts based on reality?" (Usually, "No".) I then have an opportunity to re-state the thoughts based on reality and this can change my Belief. This is working for me now, in the REAL world.

I also wrote some *Trauma Accounts*. After writing them initially, I considered what sort of hindsight bias existed in my recounting of the events. Then I re-wrote them under a new set of assumptions (or should I say based on the facts) that challenged my initial beliefs. The result was a re-examination (and change) of my beliefs about the events.

Throughout this process, I've continued to learn skills that aide me in assertiveness, (beyond **D.E.A.R. M.A.N.**), specifically a set of assertiveness guidelines. When communicating what I want or need, if I am too passive, I am disrespecting myself and not getting what I need to be effective. This can also be disrespectful to the person I am communicating with. If I am overly assertive, I am disrespecting the other party by backing them in to a corner. I've been listening to others communicate assertively and have practicing asking assertive questions in an appropriate way.

RADICAL ACCEPTANCE – Some of this may be out of sequence, but there is a philosophy that I have picked up in therapy that has recently become easier to internalize: *RADICAL ACCEPTANCE* and "However I feel right now is OK. I feel how I feel. There is not always a need to panic, freak out or take drastic changes to change my feelings."

THE WORK

I was told early on that in order to be successful in treating C-PTSD, I would need to be willing to work hard, both inside and outside the therapy room. There were many weeks that included 2 sessions; a 90-minute session on Mondays and 60-minute sessions on Thursdays. Additionally, there was much work to be done at home between sessions. In fact, I would argue that the real work took place between sessions; not during the sessions.

RESULTS

I am thrilled with my results so far. I say "so far" because I realize that the work has really just begun. It's as if I have been through basic training and I am now ready to go out into battle. I have no regrets. I knew what I was signing up for and it has been worth all the work. After completing treatment, I can report the following reduction in PTSD symptoms (as of May 8, 2012):

1. Intrusive memories of the traumatic events – reduced by 65%
2. Frequent nightmares of the multiple traumatic events – reduced by 60%
3. Sleeplessness due to fear of dreaming of the traumatic events – reduced by 85%
4. Difficulty sleeping in general – reduced by 65%
5. Irritability – reduced by 65%
6. Overreacting (lashing out) in interpersonal interactions - reduced by 80%
7. Exaggerated startle response to sudden noises or movements - reduced by 55%
8. Constant fear for the safety of children, especially my children - reduced by 60%
9. Inability to concentrate (especially reading books) – reduced by 55%
10. A feeling of hopelessness – reduced by 95%
11. A loss of interest in activities that used to stimulate me – reduced by 70%
12. Avoiding & fearing activities that remind me of the trauma – reduced by 60%
13. Avoiding interaction with others for fear of loosing control – reduced by 75%
14. Generalized Anxiety Disorder symptoms - reduced by 60%
15. Depression symptoms - reduced by 60%
16. Panic attacks - reduced by 50%
17. Gastrointestinal distress - reduced by 5%

TREATMENT PLAN GOING FORWARD

The work I've completed with the University of Georgia's Psychology Clinic is merely the groundwork I need to continue to treat my C-PTSD treatment. During my time in therapy, I came to rely on 2 friends (who are unrelated to the trauma I was involved in) as people I can discuss these issues with from time to time. I intend to deepen those relationships going forward and look forward to continued recovery from PTSD.

One symptom that still needs to be addressed is physical; the gastrointestinal complications I have experienced in recent years. In fact, were it not for these symptoms, I would have completed my PTSD therapy at UGA sooner. In anticipation of this being my next step in recovery, I have sought out a new M.D. who is thoroughly versed in C-PTSD, the physical symptoms of C-PTSD and is experienced in treating these gastrointestinal symptoms with a gastroenterologist. In anticipation of this as my next step, I began treatment with my new physician in May of 2012. My M.D. has already diagnosed my gastrointestinal distress as being a direct result of my C-PTSD and has begun working closely with a gastroenterologist on my treatment plan. Tests have already begun and I expect to have a treatment plan by May 28, 2012.

Once my gastrointestinal symptoms have subsided, vocational rehabilitation will become my primary concern.

I want to take this opportunity to thank The University of Georgia Psychology Clinic for all their hard work, especially [redacted]. It is my hope that others suffering from PTSD will find the help they need and find the willingness to follow through.

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