MODULE 6

COMPLEX POST-TRAUMATIC STRESS

Case 1

PART 1

Chelsea is a 38-year-old cis gendered woman with a history of depression, TBI, and associated PTSD. Other diagnoses include rheumatoid arthritis and hypothyroidism. Additionally, she has a history of childhood trauma in the form of emotional neglect and abuse from her mother and physical abuse from her stepfather. Although her father is now a supportive, loving person in her life, after her parents' divorce at age 4 his presence in her life was unpredictable. She is the oldest of 4 children and was parentified. She states that her mother never wanted children and openly expressed resentment toward her as a young child, becoming annoyed and angry whenever Chelsea needed help or was upset. She has never felt warmth from her mother and has always tried to win her approval and love. Now as an adult she has deep feelings of unworthiness, not being allowed to ask for help, not allowed to express her emotions, sadness, and anger in particular.

She first married at 19 "to get out of my parents' house" and had two children, divorcing shortly after the birth of her second child due to infidelity. She remarried 6 months later, "even though I didn't really want to, I didn't know what else to do". However, this relationship is strained, she speaks very little of her marriage during intake. She is a member of the predominant local religion, which she tried to leave in her early 20s, but remained active due to threats that her mother would disown her.

She is a mother of four, not working since her TBI 1 year ago. Although not the breadwinner, she previously ran a successful online shop selling her art. She came to our clinic seeking ketamine therapy after talking to a friend who had success with the treatment, she feels she is "at the end of her rope" and is worried nothing will help her.

Her primary complaint on initial evaluation was PTSD from her cycling accident. When asked about history of childhood trauma, she appears to dissociate and answered only "yes" and then excused herself from the interview which was continued on a later date. She reports nearly daily, intrusive thoughts of suicide, she is guarded when asked more detailed risk assessment questions, stating that it is difficult to trust health professionals with these details as she had a traumatic hospitalization when she expressed suicidal ideation within the context of postpartum depression after the birth of her second child 16 years ago. After some reassurance about the parameters of mandatory reporting, she shares that she has thoughts of suicide and has thought of methods. These feelings are very distressing and intense, she has had a plan, but has never taken further preparatory action, though if things continue as they have or get worse, she feels she might.

She reports depression throughout her 20s and 30s, on two different occasions was treated with SSRIs, both times she experienced severely worsened suicidality (one trial coincided with the above-mentioned hospitalization) and since has been adamant about not taking an antidepressant. She is not currently on any antidepressant. She does have .5 mg Xanax prescribed PRN, using it 1-2 times per week. The severity of her depressive symptoms increased greatly following a cycling accident two years ago where she was struck by a vehicle. She was hospitalized for several weeks with serious injuries including a head injury. Her TBI symptoms, depressive symptoms, and suicidality are inextricably linked. Her chronic TBI symptoms include a constant headache, becoming easily overstimulated, changes in auditory language processing (ex. unable to

follow conversation if any background noise or music), quick to irritation, easily overwhelmed by daily tasks that she used to manage with ease (ex. running her online crafting shop, picking kids up from school, helping with homework). She describes feeling like a failure as a mother being unable to go to sporting events or school plays because public places quickly overwhelm her, causing panic, becoming hypervigilant, and experiencing flashbacks. This increases the severity of her constant headache and other TBI symptoms. By the end of a "normal" day, she has to retreat to a dark, quiet room. She describes having strong, intrusive feelings of "wanting to leave [die]"; Suicidality is only present when PTSD or TBI symptoms are flaring, this is not constant but does happen daily and most often in the context of overstimulation, hearing sirens, or conflict in her marriage.

For the past year she has seen a therapist 4 times a week (made possible from the auto insurance settlement), she cites a near daily need to have contact with this therapist to tether her to this life.

Her hospitalization and continued medical care resulted in significant medical trauma. She expressed concern that she would be unable to use IV or IM routes of administration due to a needle phobia she developed during her hospitalization 2 years prior and has observable symptoms of panic as this is discussed.

Discussion

1. What risks and protective factors are relevant for the case conceptualization?

2. What could be identified as goals of treatment? How might you help this client set an intention for a medicine session?

3. What challenges might you anticipate given the complexities of this case?

4. Given these challenges, what would be your initial treatment plan?

5. How would you approach discussing the intersection of symptoms with a client who has this constellation of diagnoses in the context of expectation management?

PART 2

The first session, in which she had a 100 mg ketamine lozenge followed by a 20 mg IM dose. She experienced a rush of fear as the IM dose was peaking, asking on a loop “am I ok?” She was given reassurance, but didn’t seem to accept that, continuing to ask. I turned the question back to her “do you think you’re ok?” she paused to evaluate, “I don’t know.” The session flowed on, and anxiety eased, she was in constant motion, dancing with her arms in the beanbag, giggling, and talking in a very child-like manner. She reported that during the session she had alleviation of her headache for the first time in two years. As the effects of the medicine wore off the headache returned, but she had a lightness in her voice and affect not previously observed. She had significant nausea following the session and vomited upon returning home.

The next week she reports that she surprisingly felt ok with the thought of receiving an injection, still anxious but not the same panic as before. She is able to discuss this calmly. She decides to forgo the oral “on ramp”.

She reports that for 2 days following the previous session she did not have any suicidal thoughts; the first time she has gone more than a day without these types of thoughts. She remarks on how different the environment of her brain felt in those two days, although she still had all her TBI symptoms, she noticed she was able to do more tasks, handle more small stresses before being overwhelmed and needing to retreat into her room.

Discussion

1. What supportive activities can you suggest to aid in prolonging the benefits of a session?

2. During the come-up phase of every session she has feelings of being unsafe, asking for reassurance again and again (“Am I ok?”), How might you guide her through this period of her session?

How could you help her prepare for this given the predictability of these feelings arising?

During the peak of her 4th session, she was talking about a positive memory, happily dancing in her beanbag when the sound of an ambulance was heard in the distance. Immediately she froze, and began to hyperventilate, cry, wail as the sound became louder, passing right in front of the building.

As the acute panic subsides, she says “I hate my body. I hate my brain! I hate that it does this!! Why why why??!”

Each session brings relief to her otherwise constant headache, a headache that has been evaluated by multiple neurologists, with multiple oral medications and injections trialed, none of which provided relief. The headache returns as she is coming out of the medicine, about 70 minutes after IM administration.

At the end of her 5th session, she states “My headache is coming back. My neck is getting tight, everything is getting tight again.”

Discussion

3. How would you support this client through this?

4. How could this be used as an opportunity to work with this trigger?

5. What therapeutic tools could you use to navigate the self-narrative surrounding PTSD symptoms?

6. Do you have thoughts on the nature of her headaches?

PART 3

Before starting the 6th session, she reports “I had one really great day this week. I took my kids trick or treating, and it was just so much fun, it felt so carefree.”

During the peak of that session, she states while crying “It’s like this every day! It is CONSTANT” referring to her fear, pain, depression.

Questions

1. Given what she told you before the session, how might you approach the belief/narrative that her symptoms are constant?

2. What suggestions could you give for integration?

At this point in her treatment, her progress is somewhat slow and seems to plateau, she reliably has 5-6 days after a treatment without suicidal thoughts and her window of tolerance has improved, and she has been able to reduce her dependance on her outside therapist, reducing 4x weekly sessions to twice a week. She has more function and engagement in her life, but after day 7 or 8, the window is much smaller and she experiences intense, intrusive suicidal thoughts and withdraws from her life, “shutting down”.

After two months of ketamine session every 1-2 weeks, she finally opens up about her marriage, what she describes is a financially abusive, emotionally abusive situation, stating “he just destroys all the progress I make here”, stating that he has been belittling, controlling, isolating, mean to her children (his stepchildren). She feels she is always on eggshells and feels he is often gaslighting her which has become worse since the TBI/PTSD and not being able to trust what her body and brain is telling her.

During this session she becomes very angry, screaming with a roar, yelling at the very top of her lungs “YOU AREN’T ALLOWED TO TREAT ME LIKE THIS!! YOU’VE TRAPPED ME! I’M TRAPPED! I NEED TO GET FREE!”

As she comes out of the medicine she says “I haven’t felt angry like that before. When I was little, I wasn’t allowed to be angry.”

Discussion

How would you discuss anger with her? What questions could you ask to further explore this?

At the next session she reports “we were sitting watching a movie and he said something really rude to me, just to belittle me, just to make me feel bad about myself. I told him he’s not allowed to treat me like that. He didn’t apologize; he wasn’t sorry, he did it on purpose. So, I told him to leave. To get out. And he left. My inner healer protected me, I’m so glad I found her. I’m setting myself free.”

Interestingly, at *all* prior sessions she had intense nausea come on at the end of the session which lingered for the rest of the day. However, after this session, she had no nausea and her headache did not immediately return.

Discussion

What are your thoughts on nausea in this client? How would you/do you approach discussing the potential of nausea/vomiting in PAT with any client?

This client is now divorced and has officially left her religion and is continuing to heal from religious trauma. She is supporting herself and her children with her art (and insurance settlement from her accident), and recently returned from a road trip with her kids “to see Taylor Swift and to be embraced by the ocean, who is my true mother”. She has not had suicidal thoughts for months, she has less than one headache day per week. She is engaged in several new hobbies which connect her to others. Though she continues to have hard days where TBI/PTSD symptoms and depression impair her function, she maintains her hope, knowing that these days will pass. She is maintained on a daily antidepressant (Auvelity) and ketamine assisted therapy every 4-6 weeks.