POST TRAUMATIC STRESS DISORDERS PART II: TREATMENT GUIDELINES FOR PHYSICIANS

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1. Situation: your patient's history reveals either a single incident trauma (e.g. motor vehicle accident) or a series of chronic stressors from which there was no perceived escape or relief, or little opportunity to work through emotionally.

2. Set at least 10 minutes aside to explore with your patient whether they would like to discuss what happened. Find out what resources were available to the patient at the time of trauma: could they talk about it, did anyone listen and support them in processing the emotions and the cognitions involved, especially issues of meaning. Did adequate Critical Incident Stress Debriefing occur? What are the remaining issues unresolved?

3. What current triggers re-evoke the upset feelings or their avoidance related to the trauma? How do they currently cope with these situations? For how long and for what functions are they impaired?

4. Would they like to be referred to a health care professional trained in methods of recovery from trauma? Prepare expectations of support, understanding, relief from anxiety and depression, other psychophysiological benefits such as improved sleep, energy, enjoyment, immunity levels, and overall health.

5. Refer to a professional with expertise in CISD, PTSD, and at least some training in one or more models of trauma recovery, such as cognitive behavior therapy, desensitization, hypnosis, EMDR.

6. Systematic Desensitization (SD) (Wolpe & Lazarus, 1958). Principle of reciprocal inhibition of the sympathetic nervous system by the parasympathetic. Relaxed state secured.

Hierarchy of static or dynamic scenes presented for about 10 or 15 seconds, then scenes switched off and relaxation continues. If client blocked at a scene, go back to earlier scenes or fragment stimulus elements of the scene and recombine later.

7. Eye Movement Desensitization and Reprocessing (EMDR) (Shapiro 1989). All desensitization is done with eyes open, therapist nearby, and a distracting and fragmenting eye-movement task in the foreground. Excellent results in PTSD, very good results in other anxiety-related disorders.

8. If patient refuses referral, consider others in church or friendship circle who might be available as volunteer to help your patient talk about the trauma with support.

9. If you decide to treat the patient, provide sufficient time for working through to occur, get training in this process yourself, and prepare your own "cuddle group" or support structure to ward against Secondary Traumatic Stress Syndrome and other forms of professional burnout.

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