Case report

DOI: https://doi.org/10.4038/sljpsyc.v15i1.8525

Case report of the use of Narrative Exposure Therapy (NET) in the management of Posttraumatic Stress Disorder (PTSD) and comorbid disorders

A L D M Aththanayaka, D M C Sannasuriya, S C Pandithakoralage

SL J Psychiatry 2024; 15(1): 49-50

Keywords: post traumatic stress disorder, narrative exposure therapy

Childhood trauma is identified as a shared risk factor, playing a crucial role in the development of comorbid psychiatric disorders like anxiety and depression. This case study explores the effectiveness of Narrative Exposure Therapy (NET) in individuals with complex trauma histories.

Here we discuss the case of a 32-year-old male, presented with Social Anxiety Disorder (SAD), Major Depressive Disorder (MDD), and symptoms of Post-Traumatic Stress Disorder (PTSD). Childhood traumas and family conflicts, contributed to negative self-beliefs and distrust, impacting his mental health. NET, a structured therapeutic approach, was employed to address PTSD symptoms.

Posttraumatic Stress Disorder (PTSD) frequently coexists with various psychiatric disorders. Childhood trauma is identified as shared risk factor, playing a crucial role in the development of comorbid psychiatric disorders like anxiety and depression (Brady, 1997; Brady et al 2000). Recognizing and addressing these shared risk factors can contribute to a more comprehensive understanding and treatment approach for individuals dealing with the complex interplay of PTSD and other psychiatric conditions.

Narrative Exposure Therapy (NET) stands as an effective treatment for trauma-spectrum disorders in individuals who have endured multiple and complex traumas (Elbert and Schauer, 2002). Emotional memories form a network comprising sensory, cognitive, emotional, and physiological elements. The experience of multiple traumas is conceptualized as the expansion of fear networks, allowing triggers from any of these traumatic events to activate the overall fear network. Elbert and Schauer's model (2002) differentiates between two types of memories: cold memories: context and facts; hot memories: involving sensory information, cognitions, emotions, and physiological feelings.

According to the NET model, individuals with PTSD involuntarily retrieve "hot memories" without connections to the "cold memories" due to neurobiological processes during traumatic events. In the process of narrative exposure, fear networks associated with traumatic events, previously disjointed, are activated and linked with the cold memory to contextualize these events. The ultimate goal is to allow the individual to see the event in the context of their ongoing life rather than as an event being re-experienced in the present. Additionally, exposure to the traumatic memory inhibits the fear response.

Case report

A 32-year-old, single, skilled labourer from Piliyandala, presented with tremulousness of hands, palpitations, and feeling tense in social situations since the age of 16. He felt anxious on anticipation of facing situations in which he perceived he would be scrutinized and avoided them if possible. He found it difficult to continue with work as he had difficulty communicating with other colleagues due to fear of negative evaluation. He lost his job about two months prior to presentation as a result of the financial crisis in the country. This has led to pervasive sadness, helpless, hopeless and these symptoms had gradually worsened.

Other than this he had faced numerous traumatic events since childhood, stemming from family conflicts and enduring long-term sexual and physical abuse during early adolescence which has contributed to the development of negative self-beliefs and distrust towards others. He frequently experienced intrusive memories of these traumatic events, choosing not to disclose them to anyone. He also actively avoided places associated with these distressing memories. Additionally, he presented symptoms of SAD and MDD. The first episode of MDD occurred after he could not get the expected results from A/L exams, while current depression episode triggered by the sudden job loss during the COVID-19 pandemic. The symptoms of PTSD served as maintaining factors for the coexisting

conditions. There was no family history or psychoactive substance use in past. No other medical comorbidities. He received a diagnosis of MDD, SAD and PTSD. Pharmacological treatment was started with sertraline 25 mg (SSRI) daily dose and gradually increased it up to 100 mg daily dose. Short course of benzodiazepine added for 2 weeks duration, and he was managed as an out-patient. Psychotherapy sessions began two weeks after initiating medication. The initial focus of psychotherapy addressed his PTSD symptoms, as he expressed significant discomfort related to his traumatic memories.

NET was employed to address PTSD symptoms and the therapy conducted in four stages. In the first stage the steps followed were; diagnostic interview and psycho-education, discussion of the brain model, explanation of the fear network, and outline of the therapy plan, highlighting the problems associated with avoidance, and obtaining informed consent. In the second stage patient was given to draw the lifeline and in the third stage narrative exposure to flowers and stones was conducted; the focus was on addressing the stones (violent experiences occurred between parents, sexual abuse and physical abuse) caused PTSD symptoms. Consequently, client was given to narrate the traumatic event. In the final stage, client was given the opportunity to re-read the narrative to promote engagement in exposure to traumatic memories, and discussed about the patient's hopes on future. Finally, flowers were placed on lifeline to symbolize the wishes for the future. Also, the Cognitive Behavioral Therapy (CBT) sessions for MDD and SAD was conducted following the completion of NET.

Discussion

The integration of psychotherapy alongside medication demonstrated notable improvements in our patient's condition. Although, the Trauma-Focused Cognitive Behavior Therapy (TF-CBT) has the largest evidence-base for PTSD; we used NET for our patient since literature shows that these trials are not necessarily conducted on those who have experienced multiple traumatic events (Smith et al., 2019). However in NET when compared to TF-CBT all the significant events are explored in detail and in chronological order by taking the "lifeline" approach. NET proved to be more effective for our patient as he had experienced multiple traumas and it addressed both traumatic and positive events were identified and discussed within the context during therapy sessions. Discussing positive life events played a crucial role in helping the patient overcome negative thoughts and to adopt a more realistic thinking pattern. Moreover, In NET, a significant portion of the therapy involved a detailed exploration and exposure to traumatic experiences, facilitated in a more directive manner by the therapist. This approach allowed for close attention to emotional, physiological, and behavioural responses, providing a deeper understanding of the context of trauma occurred. Also, it was effective for our patient to express his emotions since he had avoided discussing his traumatic experiences.

Conclusion

This case emphasizes the challenges patients face in contending with underlying traumatic memories and the importance of addressing these issues concurrently with treating the core conditions. Additionally, it highlights the significance of integrating psychotherapeutic methods with medication, such as NET, in effectively managing cases characterized by complex mental health challenges.

A L D M Aththanayaka, National Institute of Mental Health, Angoda, Sri Lanka

D M C Sannasuriya, National Institute of Mental Health, Angoda, Sri Lanka

S C Pandithakoralage, University of Colombo, Sri Lanka

Corresponding author: A L D M Aththanayaka

E-mail: mihidevika@gmail.com

References

1. Brady KT. Posttraumatic stress disorder and comorbidity: recognizing the many faces of PTSD. Journal of Clinical Psychiatry. 1997; 58(9): 12-5.
2. Brady KT, Killeen TK, Brewerton T, Lucerini S. Comorbidity of psychiatric disorders and posttraumatic stress disorder. Journal of clinical psychiatry. 2000; 61: 22-32.
3. Neuner F, Schauer M, Roth WT, Elbert T. A narrative exposure treatment as intervention in a refugee camp: a case report. Behavioural and Cognitive Psychotherapy. 2002; 30 (2): 205-9.
4. Smith P, Dalgleish T, Meiser-Stedman R. Practitioner Review: Posttraumatic stress disorder and its treatment in children and adolescents. Journal of Child Psychology and Psychiatry 2019; 60(5): 500-15.