Narrative Reconstruction: An Integrative Intervention Module for Intrusive Symptoms in PTSD Patients

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Narrative Reconstruction: An Integrative Intervention Module for Intrusive Symptoms in PTSD Patients

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The high rates of posttraumatic stress disorder (PTSD) patients who are not helped by current effective psychotherapy methods call for the development of additional new treatment methods (Hoge, 2011; Schnyder, 2005). Memory disturbances related to the lack of integration of the traumatic memory within the autobiographical knowledge base are seen as a major factor contributing to intrusion symptoms in PTSD (Brewin, 2011). This work proposes Narrative Reconstruction (NR) as a novel module for the treatment of intrusive symptoms and memory disturbances in PTSD patients. NR is a brief and focused intervention (up to 12 sessions) combining elements of cognitive–behavioral treatment (CBT) such as exposure and cognitive restructuring, albeit in a unique way, alongside psychodynamic elements. The goal of NR is to create a cohesive and chronological narrative of the trauma while simultaneously addressing the personal significance of the trauma and integrating it in the patient’s autobiographical memories. Theoretical background, treatment description, and potential therapeutic advantages are discussed. In addition, preliminary results of six PTSD patients are reported. Treatment outcome showed significant reduction in PTSD and depressive symptoms demonstrating that NR may be an effective module in the treatment of PTSD patients and encourages further study of this intervention.

Keywords: Narrative Reconstruction, PTSD, intrusion symptoms, traumatic memory, treatment outcome

Evidence-based, highly effective psychotherapy interventions for posttraumatic stress disorder (PTSD) are available today (Foa, Keane, Friedman, & Cohen, 2009; Livanie, 2001). Yet, rates of PTSD and of serious impairment in quality of life following the wars in Iraq and Afghanistan (Schnurr, Lunney, Bovin, & Marx, 2009; Thomas et al., 2010; Wells et al., 2011) or after terror attacks on civilian populations (DiGrande, Neria, Brackbill, Pulliam, & Galea, 2011) are not different from those found prior to the development of these new interventions (Gradus, 2011). This paradox has been explained to be the result of limited dissemination of effective treatments and of the limited tendency to seek care by mental casualties. In addition, researchers indicated differences between the academic research settings in which the efficacy of treatments was tested and the complicated “real world” clinical situation. These differences include: (a) comorbidity—the prevalence of comorbidity of depression and other mental disorders is up to 80%, making the rates of recovery in the help-seeking population much lower (Foa et al., 2009; Schnyder, 2005); (b) dropouts—whereas Hembree et al. (2003) in a meta-analysis of dropout rates in RCTs for exposure-based treatments for PTSD found an average dropout rate of 20%, only 28% completed treatment in a clinical “real world” setting (Zayfert et al., 2005); (c) end-state functioning—a significant number of those treated with efficient treatments continue to suffer from significant debilitating symptoms after completion of manual guided treatments (Schnyder, Muller, Maercker, & Wittmann, 2011; Zayfert et al., 2005).

Additionally, we propose that current psychotherapies for PTSD concentrate on extinction of conditioned fear responses and on correcting impaired cognitive networks that cause uncontrolled anxiety and fear in innocuous situations, although other emotions commonly associated with trauma—such as guilt, shame and anger (Brewin, 2011)—are not directly addressed by current evidence-based interventions. Although fear extinction is a primary goal of current psychotherapies, in the DSM–IV Posttraumatic Stress Disorder Field Trial, a factor containing guilt, embarrassment, and violated trust accounted for more variance than any other factor when the investigators compared participants with and without lifetime PTSD (Kilpatrick et al., 1998 as cited in Rubin, Berntsen, & Bohm, 2008). Moreover, many patients suffering from PTSD describe the traumatic event as a turning point in their lives which results in a radical shift in self-perception. The statement “I am a different person now from the person who existed before the trauma” (Conway, Singer, & Tagini, 2004, p. 517) is a theme expressed recurrently by posttraumatic patients, demonstrating the lack of integration of the trauma into their self-concept and personal biography (Brewin, 2011; Conway et al., 2004). This theme is not addressed by most current interventions. The core components used in the vast majority of evidence-based interventions have involved combinations of exposure (particularly imaginal and in vivo), cognitive restructuring, relaxation/stress modulation techniques, and psycho education (Veteran Affairs/Department of Defense Clinical Practice Guideline for the Management of Posttraumatic Stress, Va/DoD, 2010); Brief Eclectic Psychotherapy (BEP), psychodynamic psychotherapy, Imagery Rehearsal Therapy (IRT), and Narrative Exposure Therapy (NET) tackle the aforementioned...
themes to a certain level. These other interventions are supported by some controlled studies and are included in the recommended psychotherapies for PTSD by the Va/DoD guidelines.

Following conclusions that additional new treatments are needed (Schnyder, 2005; Hoge, 2011) we propose a novel intervention for the treatment of intrusive memories in PTSD, Narrative Reconstruction (NR). This technique is directed to deal with the personal significance of the trauma and to its integration into the patient’s individual biography through the reconstruction of the trauma narrative. NR incorporates central elements of exposure-based therapies, albeit in a more natural manner, thus, aimed to enhance engagement in therapy and to reduce dropout rates. In NR, therapist and patient work together to deliberately reconstruct the traumatic memory into a structured, coherent, and well-organized narrative of the trauma. The trauma memory is integrated and related to the particular biography of the patient and an effort is made to capture the specific personal significance of the trauma, thus, enhancing and enabling integration of the traumatic memory. In the following, we focus on the rationale and technique of NR, and we present preliminary results of an open trial testing its efficacy.

**Trauma Narratives: Coherence, Organization, and Treatment Outcome**

There is considerable evidence that PTSD patients have difficulties in deliberately bringing to mind coherent, organized, and well-integrated memories of the traumatic event and that their description of the event remains fragmented and disorganized (Brewin, 2011). Disorganization of trauma memories has been operationalized by a lack of narrative coherence upon the intentional recall of the trauma. Indicators for narrative incoherence in PTSD are confused temporal order, the inability to recall important details of the trauma, repetitions, unfinished thoughts, and speech fillers (Foa, Molnar, & Cashman, 1995; Halligan, Michael, Clark, & Ehlers, 2003). Moreover, the relative absence of organized thoughts, as expressed through statements “indicating realization, decision making, or planning” (Foa et al., 1995, p. 682), has been suggested to represent an indicator for memory disorganization (Halligan et al., 2003). Evidence for disorganization of trauma memories comes from studies showing that trauma narratives of trauma survivors without the disorder (Halligan et al., 2003; Harvey & Bryant, 1999; Jelinek, Randjbar, Seifert, Kellner, & Moritz, 2009; Jones, Harvey, & Brewin, 2007). Disorganization of the trauma narrative has been shown to predict subsequent PTSD symptoms in people exposed to traumatic events (Amir, Stafford, Freshman, & Foa, 1998; Buck, Kindt, van den Hout, Steens, & Linders, 2007; Ehring, Ehlers, & Guitsman, 2008; Halligan et al., 2003; Jones et al., 2007; Murray, Ehlers, & Mayou, 2002; Ozer, Best, Lipsey, & Weiss, 2003; for review, see Brewin, 2011), and research examining changes in the trauma narrative pre- to post-treatment have shown a correlation between improved narrative organization and symptomatic reduction (Foa et al., 1995; van Minnen, Wessel, Dijkstra, & Roelofs, 2002).

Based on the above mentioned findings we hypothesize that a deliberate effort to reconstruct a coherent and cohesive narrative of the trauma will have positive effect on PTSD symptoms in general and on the level of intrusion symptoms in particular.

**Cognitive and Neuroscience Findings About the Differences Between Traumatic Memories and Other Autobiographical Memories**

Concurrently with the disorganized and fragmented voluntary memories of the trauma expressed in the trauma narrative, PTSD patients suffer from intrusive involuntary memories with prominent sensory/perceptual features which are highly emotional and involve an intense reliving of the event in the present (Michael, Ehlers, Halligan, & Clark, 2005; van Der Kolk & Fisler, 1995). This has been accounted for by dual representation theories of PTSD. Brewin, Gregory, Lipton, and Burgess (2010) proposed that there are distinct neural bases for abstract, flexible, contextualized representations (C-reps) and for inflexible, sensory-bound representations (S-reps). Traumatic involuntary memories are mainly encoded as S-reps with impaired contextualization and impaired integration with C-reps and thus, reexperienced as uncontrolled intrusions. Similarly, Ehlers and Clark’s cognitive model (Ehlers & Clark, 2000; Ehlers, Hackmann, & Michael, 2004) proposed two distinct systems for data-driven (predominantly sensory) processing and conceptually driven (meaning-based) processing. Lack of integration of sensory focused memories into conceptual, verbal autobiographical memory is responsible for the erroneous evaluations of neutral events as currently being dangerous and frightening. Conway (2005, 2009) proposed that intrusive memories of PTSD patients consisted of episodic elements (EE), parts of single episodic memories (SEM), which are not integrated into the self memory system (SMS) that provides an account for the organization of autobiographical knowledge.

These theories provide an explanation for the differences between the incoherent and disorganized voluntary memory of the trauma and the involuntary, sensory-bound reexperiencing of hot spots or flashbacks. These theories also account for the efficacy of exposure-based treatments for PTSD which ask patients to provide a detailed oral or written narrative of the traumatic event and, thus, enhancing its contextualization and integration into the C-reps (Brewin, Gregory, Lipton, & Burgess 2010), conceptually driven processes (Ehlers & Clark, 2000), or the self memory system (Conway, 2005).

Evidence from neuroscience converges with the aforementioned theories. In his revised dual representation model Brewin et al. (2010) specified the neural pathways involved in his model. C-Reps (i.e., contextualized memories) were identified with projections of sensory information to the inferior temporal cortex, with its connections to MTL structures such as the hippocampus and parahippocampus. S-Reps, responsible for intrusive memories, were identified with projections to the superior parietal areas and with their connections to the amygdala and insula. Furthermore, findings of elevated responsiveness of the amygdala and reduced mPFC functioning in PTSD patients while processing trauma memories (Hopper, Frewen, van Der Kolk, & Lanius, 2007; for review, see Francati, Vermetten, & Bremner, 2007) and reduced hippocampal volume in PTSD patients (Karl, 2006) are in line with these theories, demonstrating reduced top-down regulation of fear responses in PTSD. This notion is supported by accumulating evidence that high levels of stress have deleterious effects on hippocampal functioning while simultaneously potentiating amygdala functioning (Elzinga & Bremner, 2002; Metcalfe &
Narration of the traumatic experience has the potential to integrate sensory and perceptually fragmented memories into the wider context of autobiographical memory, thus, enhancing the patient’s ability to regulate previously involuntary memories (Brewin et al., 2010). In NR, we propose that the deliberate effort to reconstruct an organized and coherent narrative of the trauma while placing it into personal autobiographical context may facilitate the association of S-reps with more elaborated C-reps and enhance patient’s control over his or her traumatic memories. Indeed Narrative Exposure Therapy (NET), a short term intervention for PTSD centered upon narration of trauma, has been shown to enhance cortical top-down regulation of the responses of PTSD patients to aversive stimuli (Adenauer et al., 2011). This finding supports our notion that reconstruction of the traumatic narrative may promote cortical regulation and control of the retrieval of traumatic memories.

The Role of Self and Personal Significance in PTSD

Discrepancies between the traumatic event and assumptions or beliefs about oneself and about the world have been considered to add to the difficulties in integration of the traumatic memory into general autobiographical memory (Horowitz, 1976; Janoff-Bulman, 1992). Brewin et al. (2010) concluded that most of PTSD patients express not only fear responses to reminders of the trauma but also other intense emotions such as shame, guilt, and anger related to unresolved discrepancies with prior personal expectations and wishes. Brewin (2011) noted that in healthy individuals, traumatic events are often forgotten if they are not personally significant or consequential. By contrast, in PTSD, the trauma is usually strongly associated with the person’s sense of identity. Many PTSD patients comment that they are a different person now from the person who existed before the trauma, indicating the effect of trauma on their self-perception and the impaired integration of the trauma into their autobiography (Conway et al., 2004). Conway (Conway, 2005, 2009; Conway et al., 2000) formulated the Self-Memory System (SMS) as a conceptual framework that emphasizes the interconnectedness of self and memory and provides an account for the organization of autobiographical knowledge. Within this framework, the self is conceived as a complex set of active goals and associated self-images, collectively referred to as the working self which may constrain the integration of single episodic memories (SEMs) into the SMS. When these SEMs present a threat to current plans and goals of the self they are not integrated into the SMS and, thus, produce uncontrolled memories in the form of flashbacks.

Clinicians (Herman, 1992) and researchers (Pillemer, 1998) have proposed that traumatic events can form turning points in people’s construction of their own identity. Berntsen and Rubin (2007) showed that symptoms of PTSD are generally higher when individuals assign a trauma a central role in their life story and it becomes a cognitive reference point for the organization of autobiographical knowledge.

Bromberg (2003), from a psychoanalytic perspective, elaborated upon the nature of the threat to the self that traumatic experiences pose:

When trauma makes its presence felt, what is affected is not simply mental contents but the cohesiveness of mental structure—the very experience of selfhood; the effect evoked is not simply unpleasant but a disorganizing hyperarousal that threatens to overwhelm the mind’s ability to think, reflect, and process the experience cognitively (p. 567).

Bromberg (2003, 2009) views dissociation as fundamentally not a defense but as an adaptive process of disconnecting the mind from its capacity to perceive what is too much for selfhood to bear. We may conclude that tackling the significance of the trauma to the survivor’s self and to its perceptions of the world should be a central part in efficient treatments for PTSD.

Narration in the Treatment of PTSD

Fundamentally, all psychotherapies with an A-level recommendation for PTSD (i.e., good evidence showing that benefits outweigh harm, based upon criteria set forth by U.S. Preventive Services Task Force criteria) involve five core components: (a) narration, (b) cognitive restructuring, (c) in vivo exposure, (d) stress inoculation (e.g., relaxation) skills, and (e) psychoeducation (Benish, Imel, & Wampold, 2008). Hoge (2011), commenting on the limited effectiveness of current interventions in treating veterans of the wars in Iraq and Afghanistan, suggested that narration of the trauma is the most promising therapy module. Pennebaker and colleagues’ studies during the 1980s and 1990s found long-term benefits on health and immune function following both verbal and written disclosure of traumatic events (Harber & Pennebaker, 1992; Pennebaker & Beall, 1986; Pennebaker, Kiecolt-Galser, & Glaser, 1988). Examining the benefits of expressive writing, Pennebaker (1993) concluded from these results that the act of making sense of an event, of gaining insight about a trauma, and of organizing and integrating an upsetting experience into one’s self-schema is the mechanism by which expressive writing is therapeutic. Narration has been incorporated in various ways in the clinical setting: written, oral past tense, “imaginal” present tense, or combined with eye movements. A short intervention, NET, encompassing narration of the trauma as the main intervention, has shown effectiveness in reducing PTSD symptoms in adults, adolescents, and children with different traumatic experiences (Adenauer et al., 2011; Hensel-Dittmann et al., 2011; Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004). We may conclude that there is encouraging evidence for the incorporation of narration of the traumatic event in treatments of PTSD.

Narrative Reconstruction (NR)

NR comprises the following essential elements: (a) exposure to the traumatic memory, albeit in a more natural way than in usual prolonged exposure (PE), thus, enhancing patients’ readiness to stay in treatment; (b) systematic reconstruction and organization of the traumatic memory into a comprehensive written narrative; (c) integration of the traumatic memory into autobiographical memory; and (d) psychodynamic elements in which the personal meaning of the traumatic event for the patient in relation to his or her personal his or her story are revealed and worked through.

NR concentrates on the intrusion cluster of symptoms as they are defined as the center of the criteria defining PTSD (Brewin, Lanius, Novac, Schyner, & Galea, 2009). Focusing the interven-
tion on a single symptom cluster may enable to evaluate its contribution to recovery apart from additional components in treatment “packages” such as in vivo exposure and stress inoculation techniques. In clinical use of NR, additional cognitive and behavioral elements may be added prior to or following this intervention. The suggested module may be used as part of a therapy program which includes psychoeducation and relaxation training preceding the module, further CBT after the intervention for the treatment of avoidance behavior and depression, and/or rehabilitative therapy to minimize regression.

NR Treatment: A Short Description

The basic structure of NR revolves around the systematic reconstruction of the trauma memory along a chronological time line (the shortened treatment protocol is available upon request). The patient is asked to describe what he or she was doing, seeing, hearing, and feeling. The patient is asked also to tell about his or her thoughts and emotions moment by moment as his or her story unfolds. Within each session the therapist types and records the trauma narrative as the patient expresses it. The setting differs from common exposure therapies in that the therapist and the patient sit in front of a computer while the patient is describing his or her experience during the trauma and the therapist is typing the narrative on the computer. This special setting creates an atmosphere of controlled exposure to the traumatic memory. The fact that the therapist types the story dictates a slow and controlled pace for the progression of the story, thus, restricting possible intense emotional responses that may overwhelm the patient. Every session begins by reading the narrative to the point that was reached in the previous session, and additional information about the traumatic event that arises in future sessions is incorporated into the appropriate place in the trauma narrative. Work on the narrative begins with the day of going out to the place of the event (before the actual beginning of the trauma). At this stage, the emotional responses are still moderate; consequently, it is an opportune time to clarify the working method in detail and to initiate the patient into the setting. The narrative proceeds along a chronological time line. During the narrative reconstruction, there may be moments or longer periods of time in which the memory is impaired and lacking information. These gaps are recorded and an effort is made to go back to those gaps during future sessions or when the patient recalls the missing information. The narrative continues until the point in the event when the person regained composure and a sense of control.

The therapist may ask questions, clarify facts, and also ask for past memories related to the facts described by the patient. The therapist may also reframe the patient’s behaviors or relate them to past experiences in his or her life to deal with guilt or with what seems like exaggerated emotional responses to details of the trauma. As part of the process, the therapist and the patient work together to uncover the particular meaning and the personal significance of the trauma for the patient. In most cases, perception of the occurrences during the trauma and their successive emotional responses gain new meaning through the process and dissociated facts and feelings are revealed. The collaborative, step-by-step progression also enables the identification and working through of “hot spots” with high levels of anxiety, as well as moments of personal significance, which may be related to other emotions—such as shame, guilt, anger—triggered by the trauma. In the last session the patient is handed a printed copy of his or her narrative, therapist and patient review the full narrative once more, and the session concludes with a review of the changes in the patient’s emotional state attained through the therapy.

An Open Trial of NR for PTSD

In the following section, we report preliminary results of an open trial of NR with a variety of posttraumatic patients to evaluate its applicability and efficiency in the treatment of intrusion symptoms. Following the reduction in intrusion we also expected to see improvements in other symptom clusters such as avoidance or heightened arousal. We also anticipated improvement in depression symptoms as the result of the improvement in intrusive symptoms.

Method

Participants

The study was approved by the institutional review board of Bar Ilan University and by the Helsinki Ethics Committee of Mayanei Ha’Yeshua Medical Center (No. 31.11.). All participants read and signed informed consent forms. Six patients (four women, two men) who had been referred by their psychiatrists for the treatment of PTSD were recruited for the pilot study. All patients met the DSM–IV–TR criteria for PTSD as ascertained by the Clinician Administered PTSD Scale (CAPS). A cutoff score of 45 on the CAPS was used to establish a PTSD diagnosis. Weathers, Ruscio, and Keane (1995) in a review of the scoring rules for the CAPS determined that the total severity of 45 has optimal sensitivity and is valuable for screening. Age of the patients ranged between 26 and 62 (M = 41; SD = 13.3). Time since the trauma varied considerably between 4 months and 10 years (M = 3.47, SD = 3.3). Exclusion criteria were brain injury, psychosis, severe depression with suicidal ideation posing imminent danger, and drug or alcohol abuse. Three patients were motor vehicle accident (MVA) victims, two were victims of sexual assault, and one patient was in a train crash. Four of the six patients had comorbid conditions (three patients with major depressive disorder [MDD], one patient with generalized anxiety disorder [GAD]). Four patients were actively taking psychotropic medications and four had previously been in treatment for the trauma. No change in the medication regimen was made during treatment and follow-up period.

Measures

All participants were evaluated before the initiation of treatment and after the completion of treatment by M.A.-level clinical psychologists blind to treatment condition. The following clinician administered and self-report measures had been used.

Clinician administered PTSD scale (CAPS, Blake et al., 1995). A comprehensive structured interview which comprises 30 items, including 17 items that assess DSM–IV PTSD symptoms. Other items assess related issues including trauma-related guilt and dissociation. The CAPS is the most widely used structured inter-
view for PTSD assessment and its translation to Hebrew was extensively used in previous studies in Israel.

Beck Depression Inventory—Revised (BDI, Beck & Steer, 1993). The BDI is a 21-item self-report questionnaire tapping cognitive, behavioral, and affective facets of depression with high reliability and validity. The Hebrew version of the BDI has been extensively used in studies in Israel and has shown good to excellent internal reliability (Levav, 2009, p. 66).

Procedure

Upon referral, a telephone screening was conducted and the possibility of participating in the study was discussed. Consenting participants deemed eligible for the study were scheduled for an initial assessment conducted by M.A.-level clinicians who underwent assessment training. Assessment included the Structural Clinical Interview for DSM–IV (SCID, First, Spitzer, Gibbon, & Williams, 1995) and the Clinician Administered PTSD scale (CAPS, 1998). Candidates who fulfilled the DSM–IV–TR diagnostic criteria for PTSD and the inclusion criteria for the study were assigned to receive NR treatment and went on for further evaluation with self-report tools and then assigned to a doctoral level therapist for treatment. Treatment began within 2 weeks from intake. Self-report and clinician-based diagnostic measures were administered again after treatment and at follow-up. Evaluators conducted their parts blind to the participants’ condition.

Treatment was provided by three Ph.D.-level clinical psychology residents. Throughout the treatment, first author T.P. conducted weekly individual supervision meetings with the clinicians. NR consisted of 12 weekly sessions of 60 minutes. Adherence to treatment protocol was monitored during weekly supervision meetings and a sample of meeting were recorded and videotaped to ascertain fidelity to the therapy manual. All assessment and treatment took place at the Community Counseling Service at the Psychology Department of Bar Ilan University.

Data Analysis

A series of repeated-measure analyses of variance (ANOVA) and planned contrasts was conducted to examine the efficacy of treatment on severity of total posttraumatic distress (CAPS), cluster symptoms of intrusion (Cluster B), avoidance (Cluster C), and hyperarousal (Cluster D), and severity of depression (BDI). Planned contrasts compared pre- (T1) versus post- (T2) and pre- (T1) versus follow-up (T3). Treatment effect sizes for changes in PTSD symptom scores between pretreatment and follow-up were calculated using Cohen’s d statistic (Cohen, 1988), following the formula used by Bradley, Greene, Russ, Dutra, and Westen’s (2005) meta-analysis of psychotherapy for PTSD: $d = \frac{M_{\text{initial}} - M_{\text{post}}}{\text{SD}_{\text{pooled}} \sqrt{2}}$ where $\text{SD}_{\text{pooled}} = \sqrt{(\text{SD}^2_{\text{initial}} + \text{SD}^2_{\text{post}})/2}$.

**Results**

At pretreatment assessment, all six patients met criteria for a PTSD diagnosis (total CAPS score: $M = 62.5$ and $SD = 21.8$). All patients completed a full round of treatment. Consistent with our hypothesis, the ANOVA with repeated measures for PTSD symptoms yielded a significant effect of time for the CAPS-total score, $F(1, 7) = 17.125, p < .01$ as well as for intrusion, $F(2, 10) = 13.827, p < .001$, avoidance, $F(2, 8) = 6.223, p < .05$, and hyper arousal, $F(1, 7) = 17.592, p < .001$ subscales. As shown in Table 1, planned contrasts were significant for the CAPS total, the intrusion cluster, and the hyper-arousal cluster at posttreatment, and for all PTSD symptom measures at the 3 months follow-up, indicating a significant reduction in PTSD symptoms after treatment which was maintained at follow-up. The ANOVA with repeated measures for depression (BDI) yielded an effect of time that was slightly above significance level, $F(2, 10) = 3.895, p = .056$ and the planned contrasts were significant at follow-up as shown in Table 1, indicating a reduction in depression following NR. The effect sizes for PTSD symptoms and depression were large, ranging from 0.99 to 1.66 and symptom levels remained low at the 3 month follow-up (see Table 1).

To facilitate clinical interpretation of the results, we applied three additional levels of improvement regarding PTSD, as defined by Schnyder, Muller, Maercker, and Wittmann (2011): treatment response (decline in CAPS total score of at least 22 points, i.e., 1 SD of pretreatment mean score); loss of diagnosis (no longer meeting symptom criteria and CAPS total score < 45); and complete remission (CAPS total score < 20). Of the six patients in the pilot study, two were fully remitted, three lost their diagnosis, and one was classified as a treatment responder, although still maintaining a PTSD diagnosis.

Of particular significance was the reduction in severity of PTSD symptoms among two patients that started treatment within half a year from the trauma (4 months and 6 months). For the entire sample, the percentage reduction between pre- and posttreatment

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pretreatment Mean ($SD$)</th>
<th>Posttreatment Mean ($SD$)</th>
<th>3 mo follow-up Mean ($SD$)</th>
<th>Cohen’s $d$</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAPS-Total</td>
<td>62.5 (23.91)</td>
<td>33.5 (18.86)$^*$</td>
<td>26 (20.01)$^{**}$</td>
<td>1.66</td>
</tr>
<tr>
<td>CAPS-Intrusion</td>
<td>16.5 (9.52)</td>
<td>7.17 (8.18)$^{**}$</td>
<td>6.83 (6.43)$^{**}$</td>
<td>1.19</td>
</tr>
<tr>
<td>CAPS-Avoidance</td>
<td>26.17 (9.26)</td>
<td>14.5 (9.05)$^*$</td>
<td>11.5 (6.95)$^{**}$</td>
<td>1.8</td>
</tr>
<tr>
<td>CAPS Hyperarousal</td>
<td>19.83 (8.64)</td>
<td>11.83 (5.71)$^*$</td>
<td>7.83 (7.49)$^{**}$</td>
<td>1.49</td>
</tr>
<tr>
<td>BDI</td>
<td>22.33 (8.8)</td>
<td>12.17 (8.59)</td>
<td>12.67 (10.78)$^{**}$</td>
<td>0.99</td>
</tr>
</tbody>
</table>

*Note.* Asterisks indicate results of planned contrasts: $^*$ $p < .05$. $^{**}p < .01$. $^{***}p < .001$. The Clinician Administered PTSD Scale (CAPS) is from Blake et al. (1995). The Beck Depression Inventory (BDI) is from Beck and Steer (1993). All contrasts between pretreatment and posttreatment were significant at $p < .01$. Effect sizes compared pretreatment and 3 month follow-up. Asterisks represent $p$-value of planned comparisons.
for PTSD symptoms was 46.4% and for depression symptoms was 45.5%. Among the two patients that sought treatment within a half-year from the trauma, the percentages were even higher: 64% for PTSD symptoms and 70% for depression.

Discussion

In this work, we propose Narrative Reconstruction (NR) as a novel module for the treatment of intrusive symptoms for post-traumatic patients. The results of a pilot study with six chronic PTSD patients resulting from a variety of traumatic events are encouraging. NR for PTSD was found to be very acceptable by the patients. Dropout rate was zero and all of the patients in the pilot study completed a full round of treatment. NR was highly effective in reducing PTSD symptoms and treatment gains were maintained during follow-up. The effect size for pretreatment to follow-up changes of PTSD symptoms (CAPS-total) of 1.66 was slightly higher than that reported in the meta-analysis of psychotherapy for PTSD (1.43) by Bradley et al. (2005). Most of our sample (four out of six) were chronic patients with comorbid disorders who were referred for treatment after having been previously treated with psychotherapy for PTSD. This demonstrates the potential of even higher effects of NR for patients who receive treatment earlier after the trauma and are experiencing psychotherapy for the first time. Indeed we found higher effects for the two patients who were referred to the treatment 4–6 months after the trauma and had not received psychotherapy for their disorder prior to NR.

NR incorporates the repeated exposure to traumatic memory similar to PE, yet there are fundamental differences. In exposure-based treatments such as PE, hotspots are given special attention (Foa & Rothbaum, 1998) although intrusive images that characterize PTSD don’t necessarily correspond to hotspots. Ehlers et al. (2002) observed that only 17% of intrusive images corresponded to the worst period of the trauma. Consequently, a broader approach to dealing with the traumatic event and its personal meaning for the patient could be more effective in treating intrusions. A major advantage of the proposed module is its relative flexibility and similarity to natural coping with traumatic experiences. The narrative is reconstructed through discussion with a therapist who is listening again and again to the story and expressing support and interest. Repeated exposure to the traumatic memory is performed in the presence of a supportive therapist and not in the solitude of “homework” assignments. Indeed our clinical experience demonstrated increased acceptance of the intervention by the patients and reduced dropout rates. Treatment that involves a written detailed narrative of the event, as in NET, has been shown to be effective (Ertl, Pfeiffer, Shauer, Elbert, & Neuner, 2011). Whereas NET focuses on the traumatic event per se, NR attempts to integrate the traumatic event into the broader context of autobiographical memory and the person’s life story. The working through of personal meaning and psychodynamic elements bear some similarity to the psychodynamic elements in BEP, an approach that has also shown to be effective (Gersons, Carlier, Lamberts, & van der Kolk, 2000; Schnyder et al., 2011). The combination of these elements in NR results in a somewhat novel intervention that combines cognitive–behavioral and psychodynamic elements which help patients to deal directly with their shame and guilt surrounding the trauma and their coping response during the traumatic event, as well as to integrate dissociated elements of the trauma. Detailed clinical case reports may demonstrate changes in the narratives, newly gained understanding of personal significance, and integration of dissociated personal aspects achieved using this module and will be reported elsewhere.

The preliminary results presented in this article have several obvious limitations. The results remain preliminary as no control group was included. Furthermore, being such a small sample size, the findings are inconclusive. Despite the limitations and in light of the urgent need for new interventions which are well accepted and tolerated by PTSD patients, we present here preliminary and encouraging data. A randomized controlled study testing the efficacy of NR for PTSD is currently in its first steps.

References


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