Module: Psychological Foundations of Mental Health

Week 3
Introduction to emotion and emotional processing

Topic in Action
Maladaptive styles of emotion processing and regulation, and mental health – Part 1 of 4

Dr Victoria Pile
Department of Psychology, King's College London

Lecture transcript

Slide 2
Let's think about a young person with PTSD I worked with and how some of the processing styles we have covered in the previous lectures might be at play here.

Slide 3
Hannah is a nine-year-old girl who lives with her mum and two siblings. She is the youngest child.

Slide 4
There was an incident two years ago where she had been trapped in the closing doors of a London bus. The bus started to drive away while she was trapped. Both Hannah and her mother became very distressed during the incident, as both believed she was going to die. Her leg was also hurt during the incident, but has now recovered.

Slide 5
Hannah reports intrusive images of the accident approximately three times a week and having nightmares once per week. The intrusive images are of the time she was trapped in the bus doors and her thoughts such as I'm going to die, I'm going to lose my leg, why is no one helping me.

Slide 6
When Hannah is asked to describe what happened to her, she becomes very upset and is unable to give a clear narrative. She reports that she was very scared. She describes trying not to think about the incident and to suppress thoughts about what happened.

Slide 7
Hannah tries to avoid buses as much as possible. When she does have to board the bus to go to school, she shows marked distressed and clear physiological symptoms of anxiety, such as palpitations and sweating.

Her mum reports that she is more irritable, cautious, and hypervigilant since the accident. For example, she will constantly look around when they walk down the street in case there is a bus coming.

Slide 8
When she is boarding the bus, she clings tightly to her mother and forces herself onto the bus

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before anyone else. She remains alert and watchful throughout the journey.

Slide 9
Before the accident, Hannah had good friendships at school and she enjoyed going to the park and visiting family friends. She has struggled much more with friendships since the incident, preferring not to leave the flat and trying to avoid meeting other people.

Slide 10
First, let's think about whether Hannah would receive a diagnosis of post-traumatic stress disorder. Mental health disorders are classified and diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders. In 2013, the 5th Edition, DSM-5, was issued. This manual is used in the United States as a universal authority for psychiatric diagnosis. Similarly, in the UK, the ICD-10 is used, the International Statistical Classification of Diseases and related health problems. These classifications have high practical importance as they are used to structure treatment recommendations and often determine payment by health care providers.

Slide 11
For a diagnosis of PTSD, the following criteria must be met. Criteria A is exposure to a trauma. The person has experienced or witnessed an event that involves actual or threaten of death or serious injury or threat to their physical integrity of their self or another. This can include experiencing repeated or extreme exposure to details of the traumatic events, for example, as police officers or ambulance workers might experience. The three most common traumas for men and women are the violent death of a friend or family member, witnessing severe injury or death, and being involved in a serious motor vehicle accident.

So when we think about Hannah, she meets this criteria. She experienced actual injury and believed that her life was in danger.

Slide 12
Criteria B is that there is at least one intrusion symptom associated with the event and beginning after the event. So examples of this include recurrent distressing memories or dreams of the event, sometimes called flashbacks, dissociative reactions or psychological distress and physiological reactivity when exposed to the reminders of the event.

So Hannah experienced intrusive images of the accident and nightmares. She also shows distress and physiological reactivity when reminded about the event or when near buses.

Criteria C is avoidance symptoms. This can include avoiding memories, thoughts, feelings, talking about the event, and avoiding reminders of the event, including activities, places, or people. Hannah attempts to avoid thoughts about what happened and to avoid buses as much as she can.

So D is negative alterations in cognitions and mood. Examples of this would be not being able to remember an important aspect of the event, having persistent negative beliefs about the world, the self or others. The loss of interest in significant activities or detachment from others is also included in this category. Hannah cannot describe what happened to her in any detail. She is also struggling more with friendships and no longer wants to leave the flat.

E is alternations in arousal and reactivity. This might include irritability or outbursts of anger, reckless or destructive behaviour, hypervigilance or difficulty concentrating. Hannah is described as hypervigilant, so fulfils this criteria.

Slide 13
Symptoms must be present for more than one month and cause clinically significant distress or impairment in important areas of functioning. The symptoms must also not be attributable to physiological effects of a substance or another medical condition.

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So Hannah has been experiencing symptoms for around two years. They clearly distress her, and they impact on her social functioning. Hannah, therefore, did meet criteria for post-traumatic stress disorder.

Slide 14
Post-traumatic stress symptoms are often thought of as a common reaction to a horrible event. The majority of people, 74% of women and 81% of men, will experience a traumatic event in their lifetime.

Most initially develop PTSD symptoms following trauma. And most recover with time. This is partly why the duration of the disturbance is included as a criteria in DSM-5. Approximately 11% of women and 6% of men will develop PTSD.

Slide 15
Even for those that develop PTSD, many will recover with time. It is, therefore, important to consider the factors that make someone vulnerable to develop chronic PTSD. There are several established risk factors including, as you can see in the graph, sex and type of trauma.

Slide 16
Two other factors that have been identified as important are the recovery environment and psychological factors. In the recovery environment, a lack of social support and negative responses from others as well as further stressful events maintain PTSD.

In terms of psychological maintaining factors, dysfunctional appraisals of the trauma itself, or the sequelae, so for example having these intrusions means I am going out my mind; trauma memory characteristics, for example, the memory is disorganised and lacks a coherent time code; and dysfunctional behaviours. So for example, avoiding places that remind the person of what happened or cognitive strategies, say suppressing thoughts related to the trauma, are powerful predictors of PTSD.

Slide 17
Can you identify any cognitive processing biases that you think might be maintaining Hannah's PTSD?

Slide 18
Two cognitive processing factors that we will highlight here are her increased attention to threat-- so for example, she is hypervigilant, constantly looking around when walking down the street in case there is a bus coming-- and secondly, the fragmented nature of her trauma memory for the incident. So she is unable to give a clear narrative of what had happened to her and this narrative lacks a coherent time code.

Slide 19
These cognitive factors are included in Ehlers and Clark's cognitive model for PTSD. This model attempts to explain why the person experiences a strong sense of current threat, even though the trauma is over. These maladaptive information processing styles are included in their model. The fragmented trauma memory contributes to this as the person experiences intrusions of the event.

The person's increased attention to threat is a strategy used by the individual to try and decrease the current threat in their environment. Instead what this is actually doing is increasing the sense that there is danger, so for example on all buses, and prevents the memory from being processed and elaborated.

A key therapeutic target for cognitive therapy is to process the trauma memory in order to reduce its fragmented nature. It is also important to identify and address attention to threat and think about appraisals that might be underlying it, such as I am in danger.

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Included in this model are characteristics of the trauma and its sequelae, prior experience of the individual in cognitive processing during the trauma. These are linked to the predictors of who develops chronic PTSD that we spoke about previously.

This model is used in clinical practise to develop an individual formulation that guides psychological treatment. Trauma focus EBT has shown good effect sizes and is a recommended treatment for PTSD.

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