

ABREACTION REVISITED TREATMENT OF PTSD BY ABREACTION

Fawad Kaiser, Hamayon B Dewan

ABSTRACT

This paper describes the successful treatment of a 38year old man with a three months history of PTSD. The distressing dreams began shortly after the October earthquake after he had witnessed his family members dying under the collapsed roof. Previous psychiatric treatment including psychotherapy had failed to bring about any improvement. Abreaction was induced by the oral administration of sodium amytal and methylphenidate. Patient was interviewed on more than one occasions while he was under the influence of these drugs. After six sessions the nightmares stopped and normal sleep was restored. Two months after his discharge from the clinic there had been no recurrence. Drug-induced abreaction is a valuable technique in particular clinical cases. By using the oral route, its complications and inconveniences can be reduced.

Key words: Posttraumatic Stress Disorder, nightmares, abreaction

Posttraumatic Stress Disorder (PTSD) is a psychiatric disorder that can occur following the experience or witnessing life-threatening events such as military combat, natural disasters, terrorist incidents, serious accidents or violent personal assaults like rape¹. Most survivors of trauma return to normal given a little time. However, some people will have stress reactions that do not go away on their own, or may even get worse over time. These individuals may develop PTSD. People who suffer from PTSD often relive the experience through nightmares and flashbacks, having difficulty in sleeping, and feel detached or estranged, and these symptoms can be severe enough and last long enough to significantly impair the person's daily life².

PTSD is one of the most prevalent psychiatric disorders in young adults³. Early diagnosis and treatment of PTSD are essential to avoid possible long- term neuropsychiatric changes in brain physiology and function. If untreated, PTSD often contributes to substance abuse and the development of other co-morbid psychiatric disorders such as depression⁴. Once PTSD is diagnosed, drug treatment should begin with anti-depressant therapy⁵. If anti-depressants do not improve the sleep disruption, adjunctive treatment with cognitive behavioral therapy or other agents should be considered.

Fawad Kaiser, MBBS, MRCPsych, LLM, MSc, DAMP Asst Professor Shifa College of Medicine, Consultant Psychiatrist Shifa International Hospital, Islamabad E-mail: fawad_Kaiser@hotmail.com

Hamayon B Dewan, MBBS, MRCPsych, Dip Forensic Psychiatry, Consultant Psychiatrist, Care Principle Limited, Suffolk, United Kingdom

Correspondence:
Dr. Fawad Kaiser

The condition of many victims of shell shock after the First World War showed that the sequelae of extreme psychological trauma sometimes included horrific night dreams⁶. In the case we are describing the precipitating events occurred after the earthquake in AJK. Showing no tendency to resolve spontaneously, these symptoms persisted for five months with undiminished malignancy and only brief remissions. Since conventional methods failed to result in any improvement, the disorder was treated successfully with serial abreaction, a form of therapy that is currently not very popular and is considered by some authorities to be obsolete.

CASE HISTORY

The patient, a 38year old banker by profession, informed us on admission that the persistent of his nightmares and his failure to seek any relief from previous psychiatric treatments had brought him to the verge of suicide. His medical records revealed that he had been hospitalized on two occasions, mostly with the same complaint, and that his nightmares had not responded to anti-depressants, neuroleptics, anxiolytics or cognitive behavior therapy

The patient's nightmares began one month after the earthquake disaster when he had witnessed those horrifying incidents. His elder brother, who had recently returned from UK after completing his education died crushed under the rubble while the patient was standing in front of him. On the day after his brother's funeral the patient heard the sad news that his wife and youngest daughter succumbed from the fatal injuries they had received in the earthquake. Five days later he and his friend heard a scream while walking in town. Entering the shop from which it came, they were confronted with the half mutilated bodies of two young children who were gasping their last breadth stuck under the rubble.

In his dreams, the patient saw a burnt face in black attire with a spade in his hand he referred to him as the "caretaker". Night after night, he had to watch reproductions of these incidents and listen to the accompanying screams. From time to time the "caretaker" would say, "I think you need me". He would describe the dream where the "caretaker" would be running around him and he would see the dead ends and lonely streets. All this seemed to be in slow motion.

In the final phase of the nightmare, which he described, he seemed to be wrestling with the "caretaker" and struggling to wake up. During such times he made frightening feral noises, which had been heard by the nursing staff during his periods of hospitalization. He mentioned that on many occasions he had hurt himself while struggling and the self-inflicted injuries included a dislocated shoulder, bruised eyes and a broken nose. He had an on going fear that anyone who might try to wake him up during his nightmare would be vulnerable to a serious harm.

Due to the nightmares his father refused to sleep in the same room. He would not sleep with his infant son, thinking that he might fall asleep and inflict some injury. He was very depressed as a result of these restrictions and this led to series of hospitalization in the past. He was able to resume to work but was frustrated by his inability to perform at his best. Although he was physically strong and healthy, he was in reduced circumstances, living alone in a house that had belonged to his parents. He had placed his mattress directly on the floor and other potentially dangerous items had been removed from the bedroom. During child hood he had spent ten years of his life in a boarding house and as a gesture of defiance, he had decided that he would never permit his child to go away from him. This enhanced self control was evident when attempts were made to treat the disorder with inter personal psychotherapy. He gave an emotionless account of his life history, including the traumatic events. At times it appeared during the sessions as if he was reading television news.

Taking into account the suppressed emotions engendered by the trauma it was decided to consider treatment with serial abreaction. To induce the abreaction state, the patient was given 300mg of sodium amyta and 80mg of methylphenidate by mouth. These quantities have been reported to be effective in other cases of Posttraumatic stress disorder⁷. Abreaction sessions began 25minutes after the drugs were ingested and abreactions took place twice weekly and a single session lasted for 1-2 hours. During these sessions a female nurse was present to monitor the vital signs. While the patient was under the influence of the two drugs he talked freely about the life events, expressing anger, sadness, guilt, fear and remorse, wringing his fingers and clenching his fists with frequent tearful episodes.

He recalled the deaths of his brother and wife, for some of which he blamed himself. He described his feelings of helplessness and suppressed anger during these sessions.

The patient attended outpatient clinic for 6 weeks and the course of treatment was stopped after 6 sessions. During closure, he admitted that he had talked about every significant feature of his personal history. Moreover, he had become desensitized and even when he was under the influence of the two drugs he was able to discuss the most horrific aspects of the earthquake trauma without experiencing painful emotion. He confirmed that the nightmares, having gradually diminished, had now totally stopped. He was seen for a follow up 4 weeks after the discharge when he stated that he had experienced only one nightmare since leaving the hospital. The "caretaker" had not returned and he was going to bed with confidence and averaging 6hrs of comfortable sleep.

DISCUSSION

PTSD is treated by the combination of cognitive behavior therapy CBT and drug therapy preferably SSRI's. There is no definitive treatment but some treatments appear to be quite promising, especially CBT, group therapy and exposure therapy. Exposure therapy involves having the patient repeatedly relive the frightening experience under controlled conditions to help him or her work through the trauma⁸. Studies have also shown that medications help ease associated symptoms of depression and anxiety and help with sleep.

Drug facilitated interviewing techniques achieved peak popularity into the early 1940's⁹. During this period psychiatrists were enthusiastic advocates of abreaction therapy and it was considered that the future of narcoticsynthesis was infinite and endless¹⁰. Since then, interest in this technique has waned and result from the recent British survey suggests that abreaction may be entirely abandoned¹¹. The reasons for the rejection of drug facilitated interviewing may be found in the way in which the procedure is usually carried out, which involves intravenous injection of sodium amyta or another phenobarbitone. Psychiatrists are generally uncomfortable with parenteral administration and they have concerns about side effects such as the laryngospasm or respiratory depression. These problems can be safely overcome if given by mouth and in moderate amounts.

The case described above shows that even the latest anti-depressant drugs have limitations in treating PTSD and abreaction was successful where other methods had failed. It can be argued that abreaction therapy may be of extraordinary value in certain cases and that it is a technique that should be made available to every practicing psychiatrist¹².

REFERENCES

1. Howorth P. The treatment of shell shock. *Psychiat Bull* 2000; 24:225-7.
2. Blumenthal D. Quality of Care: What Is It? *N Engl J Med* 1996; 335: 891-94.
3. Fontana AF, Rosenbeck RA. Effects of compensation-seeking on treatment outcomes among Veterans with Posttraumatic stress disorder. *J Nerv Ment Dis* 1998; 186: 223-30.
4. Blake DD. Rationale and Development of the Clinician-administered PTSD Scales. *PTSD Res Quart* 1994; 5: 1-2.
5. Davidson JR. Biological therapies for Posttraumatic stress disorder: An Overview. *J Clin Psychiatry* 1997; 58 (Suppl 9): 29-32.
6. Friedman MJ, Rosenbeck RA. PTSD as a Persistent Mental Illness. In: Soreff SM. *The seriously and persistently mentally ill: The state of the art treatment handbook*. Washington: Hogrefe & Huber; 1996: 369-89.
7. Denson R. Abreaction. *Psychiat Bull* 2002; 26:276.
8. Johnson DR, Rosenbeck RA, Fontana A, Lubin H, Charney D. Outcome of Intensive Inpatient Treatment for Combat related PTSD. *Am J Psychiatry* 1996; 6: 771-7.
9. Dysken MW, Chang SS, Casper RC, Davis JM. Barbiturate-facilitated interviewing. *Biol Psychiatry* 1979; 14: 421-32.
10. Tilkin L. The present state of narcoticsynthesis using sodium pentothal and sodium amyta. *Dis Nerv Syst* 1949; 110: 215-8.
11. Wilson S. Survey of the use of abreaction by consultant psychiatrists *Psychiat Bull* 2002; 26: 58-60.
12. Naples M, Hackett TP. The amyta interview: history and current uses. *Psychosomatics* 1978; 19: 98-105.