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Research Article

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Self-Empowerment Therapy for Depression Associated with PTSD

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ABSTRACT

Background: Post-traumatic stress disorder (PTSD), depression, anxiety, alcohol and drug addiction, domestic violence and violence generally, suicide and the like have become epidemics crippling western society requiring significant allocation of funds to address them. Research shows that regardless of therapy used, nature and severity of the presenting problem and diagnosis, the modal frequency of patients attending counselling services is 1 [1-4]. With this in mind, Self Empowerment Therapy (SET) was pioneered at the Australian Trauma Research Institute.

Aims: The aim of this study was to look at effectiveness of SET as a single session in the treatment of depression associated with PTSD.

Method: A cumulative cohort of 102 subjects diagnosed with PTSD resulting from work and motor vehicle accidents were assessed using the Beck Depression Inventory at the start and at the conclusion of the single shot two hour therapy.Single session SET consisting of recording baseline measures, four clinical exercises, questionnaire administration and results analysis.

Results: Results of the tests (n= 102; 46F & 56M) showed clinically significant therapeutic effects from SET in a single therapy session with 81% improvement.

Conclusions: Results for the in -person single shot two-hour SET depression intervention demonstrated clinically significant impact on dep ression symptoms associated with PTSD.

Keywords: Self-Empowerment Therapy, Single Session Self-Empowerment T herapy, PTSD, Depression

Introduction

Post-traumatic stress disorder (PTSD), depression, anxiety, alcohol and drug addiction, domestic violence and violence generally, suicide and the like following traumatic events have become troubling epidemics crippling western society requiring significant allocation of public funds and resources to address them.

The Australian experience has reached crisis point. In a 2019 investigation, The Australian Productivity Commission found that mental health complaints are costing the Australian economy approximately $500 million per day and called for "generational changes" to mitigate the problem despite increasing allocation of taxpayer funds to cover the cost of mental health services. Indeed, one in eight visits to the family doctor relates to mental health issues and presentations to hospital emergency departments have increased by 70% in the past decade. In addition, in a 2020 analysis, the Commission found people with major depression had high rates of unemployment in Australia of around 40%. However, the relationship of mental health and unemployment is complex with unemployment contributing both as a cause and a consequence of mental illness.

Also, the Commission report found that 75% of those with a mental illness experience symptom before the age of twenty-five and that the mental health system was inadequate to deal with many people seeking treatment who were presenting with symptoms too complex to be effectively managed by a GP with limited sessions provided for under Medicare. Despite billions

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being spent by governments all around the world each year to combat mental health issues within society, mental health scourges appear to be increasing rather than leveling out or decreasing.

In the last several decades there has been a push towards evidence-based therapies to combat the increasing trends in mental health complaints whilst the application of evidence-based treatments into practice has been slow. Consequently, those most in need of treatment have not been able to access innovative evidence-based treatments which have not permeated through to mainstream practices. This study aims to demonstrate the effectiveness of the clinical application of Self-Empowerment theory in the form of Single Session Self-Empowerment Therapy in the treatment of depression associated with PTSD.

Research at The Australian Trauma Research Institute over the past two decades has yielded promising results in reducing the cost to the public purse and potentially improving the individuals' mental health and general wellbeing. Conventional interventions for health or psychological symptom management require multiple individual or group consultations which are costly, time consuming often inaccessible or unfeasible, thus often leaving depression untreated.

Research shows that regardless of therapy used, nature and severity of the presenting problem and diagnosis, the modal frequency of patients attending counselling services is 1 [1-4].

With this in mind, Self-Empowerment Theory and its clinical application, Self-Empowerment Therapy (SET) was pioneered at the Australian Trauma Research Institute. The theory is based on four core assumptions:

1. We know ourselves better than anybody else.
2. People are not disturbed by things but by their powerlessness to change them.
3. We don't have a multitude of problems in our lives but a problem pattern that permeates our life domains in counterproductive, pathological and predictable ways.
4. The unique problem pattern that permeates our life domains has exponential and cumulative features and emerges as our personality evolves, especially in the formative and developmentally sensitive transition periods from childhood to adolescence and adolescence to adulthood and is the byproduct of skills deficits and our inability to reconcile discrepancies within the self, leading to significant disintegration between actual, ought, ideal and undesirable components of the self.

The self is viewed as a dynamic, transitioning and evolving agency which consists of four domains distinguished by intrapersonal and interpersonal functioning as actual self, ought self, ideal self and undesirable self [4]. Findings of research into self-discrepancies has yielded inferences that can be drawn based on the magnitude and scope of the measured differences. The findings and conclusions of the self-discrepancy study confirm that:

Those people whose actual selves are discrepant from their ought selves are vulnerable to anxiety and related disorders, this may be because, the Actual person is not being accepted by those important to them and they are always having to defend themselves, their actions and choices.

Those people whose actual selves are discrepant from their ideal selves are vulnerable to depression, dejection and related disorders. This may be because the person feels powerless with the insight that as each moment passes, they are moving further away from who they would ideally like to be.

Finally, those whose actual selves are congruent with their undesirable selves are vulnerable to hopelessness, self-destructive behaviours and suicidal tendencies. This may be because the hardest form of depression to treat is self-directed aggression. Therefore, if self-directed self - destructive behaviors are predominant, the Actual self, in this instance, also becomes the Undesirable self and therefore, devalued and punished. It may also be the case that, when the Undesirable and accompanying self-hatred permeates all aspects of the person's life domains, they resort develop suicidal tendencies and suicidal behavior.

Within this context, the primary goal of SET is helping individuals empower themselves to reclaim aspects of their lives that have been lost to depression and PTSD. Therefore, Self-Empowerment Theory suggests that as well as uncovering the problem pattern permeating our life domains, we need to adopt cognitive and lifestyle restructuring micro- strategies to regulate the discrepancies between various components of the self to create an integrated, functioning, resilient, desirable and productive self [5].

This is especially complicated by traumatic events as the impact permeates the effected person's health, family, relationships, profession, education, finances and self, life -domains. Single Session SET, constituting assessment and intervention is directed at creating shifts in the individuals' cognitive processing and lifestyle factors which maintain and perpetuate undesirable aspects of their life domains [4].

Objective

The objective of this study was to look at effectiveness of SET as a single session in the treatment of depression associated with PTSD amongst patients diagnosed with PTSD and referred to an outpatient specialist clinic by their primary treating doctor for treatment of depression associated with PTSD as a result of car and work accidents.

Design

A two-hour single therapy session consisting of recording baseline measures for health (Physical. Psychological, spiritual, sexual health), family, relationships, profession, education, finances and self, life-domains, administration of four clinical exercises incorporating psycho-education and skills acquisition (Self Differentiation Exercise, Desert Island Fantasy Exercise, Picture Perfect Discrepancy Exercise and Linear Comparison Exercise) as outlined in Self-Empowerment Therapy: From Theory to Practice questionnaire administration and results analysis design with no follow up assessment post single session [4].

The study was deliberately limited in theory and hypotheses.

Method

102 adult subjects (46F & 56M) fulfilling the DSM V diagnostic criteria for depression associated with PTSD following a work or motor vehicle accident were selected from a broader patient group referred to a private specialist outpatient clinic. Baseline measures for health, family, interpersonal relationships, profession, education, finances and self-life-domains were obtained. Subjects were assessed using the Beck Depression Inventory (BDI) and the Beck Anxiety Inventory at the start of the single-session and at the conclusion of the single-session consultation, but only the results of the BDI will be referred to here.

Subjects requiring more than single session were allocated to suitable psychologists for on-going support. Informed consent was obtained from subjects participating in the study.

Ethical approval and trial registration were not required as every subject provided informed consent.

Results

Broadly, analysis of the results of the tests showed (n=102; 46F, 56M) 19 Increase in BDI score, 6 equal or no change and 77 decrease in BDI scores). Subjects showed clinically significant therapeutic effects from SET in a single shot two-hour therapy session with 81% improvement in PTSD related depression symptoms as measured by an equal or lower BDI score at the conclusion of the session as compared to the start of the single session.

As expected, a number of variables impacted on therapeutic effects of SET in a single therapy session. These included amongst other variables, the personality of the therapist, the specific trigger incident, health, family, relationship, profession, education, finances and self-life-domain history and pre-existing and presenting issues of the subjects.

Conclusions

Results for the in-person single shot two hour SET for depression intervention demonstrated clinically significant and meaningful impact across a range of depression related symptoms associated with PTSD.

Post SET follow up measures may indeed yield results which demonstrate meaningful and enduring symptom reduction.

The Author is of the view that there are four issues which give rise to the argument that the intervention is much more effective than indicated. Firstly, this cohort is prone to malingering due to compensation neurosis. Secondly, the issue of test familiarity may have influenced those who need to appear to be much worse than they are. Thirdly, a desire to please the therapist coupled with poor language skills or inability to follow the four clinical exercises may have contributed to a higher score at post intervention.

Finally, some in this cohort may indeed be suffering from treatment resistant depression. These issues clearly will need to be accounted for in future research.

Expected outcomes of SET:

1. Innovative novel therapy for symptom management
2. Increased uptake and reduction in prevalence and incidence of depression and mental health sequalae
3. Reduced cost of mental health to the public purse
4. Contribution to global mental health policy
5. Contribution to scientific knowledge
6. Provide better health outcomes and effective social interventions to reduce rates of substance use and abuse, suicide, crime, depression, and other social scourges such as pathological gambling and addictions

DSM-5 Criteria for PTSD, DSM V-TR

All of the criteria are required for the diagnosis of PTSD. The following summarizes the diagnostic criteria:

Criterion A (1 required): The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

- Direct exposure
- Witnessing the trauma
- Learning that the trauma happened to a close relative or close friend
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

Criterion B (1 required): The traumatic event is persistently re-experienced, in the following way(s):

- Unwanted upsetting memories
- Nightmares
- Flashbacks
- Emotional distress after exposure to traumatic reminders
- Physical reactivity after exposure to traumatic reminders

Criterion C (1 required): Avoidance of trauma-related stimuli after the trauma, in the following way(s):

- Trauma-related thoughts or feelings
- Trauma-related reminders

Criterion D (2 required): Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):

- Inability to recall key features of the trauma
- Overly negative thoughts and assumptions about oneself or the world
- Exaggerated blame of self or others for causing the trauma
- Negative affect
- Decreased interest in activities
- Feeling isolated
- Difficulty experiencing positive affect

Criterion E (2 required): Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):

- Irritability or aggression
- Risky or destructive behavior
- Hypervigilance
- Heightened startle reaction
- Difficulty concentrating
- Difficulty sleeping

Criterion F (required): Symptoms last for more than 1 month.

Criterion G (required): Symptoms create distress or functional impairment (e.g., social, occupational).

Criterion H (required): Symptoms are not due to medication, substance use or other illness.

Two specifications:

1. **Dissociative Specification.** In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

- Depersonalization. Experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
- Derealization. Experience of unreality, distance, or distortion (e.g., "things are not real").

2. **Delayed Specification.** Full diagnostic criteria are not met until at least 6 months after the trauma(s), although onset of symptoms may occur immediately.

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