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CONCEPTION OF A MODEL FOR SENSITIVE COMMUNICATION WITH PTSD PATIENTS

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Abstract: *Communication with patients suffering from posttraumatic stress disorder (PTSD) requires particularly sensitive and careful interaction on the part of the treating doctors and psychologists. This article develops a model for trauma-sensitive communication based on the models of Schellong and Epple as well as Schulz von Thun and Rogers. The aim is to ensure safe and supportive conversation that avoids re-traumatization and strengthens the therapeutic relationship. The article first describes the basics of PTSD, its symptoms and the importance of adapted communication. The theoretical models that serve as the basis for the communication model are then presented: the trauma-informed conversation model and the client-centered conversation model. The communication framework developed includes an empathic attitude, the planning of the conversation setting and the structured course of the conversation, which is divided into two main phases: the narrative phase and the processing and securing phase. In the narrative phase, active listening and anamnesis are the main focus, while in the second phase, further treatment and affect-regulating measures are discussed. The model emphasizes the importance of freedom of choice and control for patients and highlights the need for continuous adaptation and expansion of the model through empirical research. Finally, the limitations of the model and the need for further research are discussed.*
Keywords: *Posttraumatic stress disorder, communication, affect regulation, trauma-sensitive communication, resource orientation*

INTRODUCTION

Patients with posttraumatic stress disorder (PTSD) are particularly characterized by the fact that they react in a chronic manner to an exceptionally stressful event (Michael et al. 2018, 106–107). This includes, for example, reliving certain situations over and over again, and there is excessive stimulation of the autonomic nervous system. Anxiety disorders and depressive states are also closely related to this. In addition, dulling on an emotional level is also possible. For example, a person may no longer be able to feel joy (Layne et al. 2018, 235–236).

In this context, a particular significance arises when it comes to communication with people with PTSD. This applies from at least two perspectives. On the one hand, unreflective communication can have negative consequences for patients. In extreme cases, a thoughtless statement can even encourage re-traumatization (Grossmann et al. 2021, S. 1–3). On the other hand, there are various potentials for targeted communication with a view to improving symptoms and the risks of re-traumatization (Maercker 2021, 1–3).

Against the background of this challenging initial situation, the present work deals with the conception of a communication framework for the design of conversations with patients suffering from PTSD. It is primarily aimed at people who interact with them professionally, primarily doctors and psychologists. However, it should also give caregivers and relatives impulses for communication with PTSD patients. The core of this is raising awareness of the special initial situation and the needs of the burdened people and the conscious communication that builds on this. The communication framework is based in particular on three communication models: trauma-informed conversation according to Schellong and Epple (2018), combined with the four messages of a communicative message according to Schulz von Thun and the resource-based approach of client-centered conversation according to Rogers. Both approaches focus on the recipient of a message and the sensitive, trusting and at the same time goal-oriented interaction with them (Schellung/Epple 43–45).

The structure of the article is derived from these considerations. First, there is a brief introduction to the topics of PTSD and the two communication models mentioned. Both aspects are then brought together by designing the communication framework and describing it transparently using a concrete example. The results are then briefly

discussed. Further research needs are then addressed, particularly with regard to the existing limitations.

BASICS

Now we will first give a brief presentation of the basics of PTSD, the basics of trauma-informed conversation and the two communication models by Schulz von Thun and Rogers, especially with regard to the current state of research.

Posttraumatic stress disorder (PTSD)

In the DSM-5 and ICD-10, PTSD is characterized in particular by the following criteria, which occur more than one month after the traumatic experience:

– intrusions and reliving the traumatic situation;
– avoidance symptoms;
– chronic hyperarousal and
– negative developments in cognition and emotions. (Michael et al. 2018, 6–8).

Rogers' model

Rogers' model is particularly used in therapeutic contexts. It starts with the basic attitudes of the people. Congruence refers to the authenticity with which the person treating the patient conducts the conversation, and an empathetic and appreciative attitude also counts (Weinberger 2013, 19–22). It is a resource-centered approach: It is assumed that the solution to existing problems is already anchored in the person themselves. The client has a disproportionate share of the conversation (Weinberger 2013, 19–22). The therapist focuses on active listening. When answers are given, targeted impulses are given to support the person in finding a constructive solution. Paraphrases and mirroring are also used (Weinberger 2013, 19–22).

Model of trauma-informed conversation

Schellong and Epple (2018) have created a model for trauma-informed conversation. It is structured into a total of four areas. The first level addresses the requirements for basic knowledge on the subject of trauma and the basic attitude. Then, after three W questions, the basic areas are addressed: what (the content elements of the conversation), how (the principles on which the design of the communication is based) and what (i.e. how the feeling is controlled) (Schellong/Epple 2018, S. 43–47).

The model initially starts with the content basics. A person who conducts a conversation needs relevant and current specialist knowledge about the origin, the symptoms (physical and psychological) and the treatment of the patient. The content of the conversation is then based on this. This includes first of all the anamnesis of the previous symptoms. The security status and the quality of the previous social network with a view to support potential are also recorded. The conversation typically has a narrative character: the person is the focus. Elements of psychoeducation can be integrated at this point in acute cases. Interventions in the event of crises are also important, also with regard to the patient‘s skills in regulating their emotions. After the content level has been completed, professional advice on further treatment is given, whereby the patient should be made aware that he or she has freedom of choice. This is followed by referral to an expanded treatment network (Schellong/Epple 2018, S. 43–47).

The basic attitudes of the treating person also play a central role. The conversation should take place in a safe atmosphere and be free of disruptions. The expert‘s approach to the patient is congruent, appreciative and attentive, but at the same time objective. The patient‘s own resources are put into focus and understandable explanations are given if necessary (Schellong/Epple 2018, S. 43–47). Finally, based on the aspects presented so far, the question is what should be communicated. Three aspects in particular are in focus here: The patient's sense of security and control should be strengthened. In addition, the patient should be aware that he has freedom of choice regarding the further course of treatment, but also regarding his own behavior. Overall, the conversation should contribute in particular to normalizing the patient's own feelings (Schellong/Epple 2018, S. 43–47).

CONCEPT OF THE COMMUNICATION FRAMEWORK

On the basis of the previous representations, a communication framework can now be specified that supports sensitive and goal-oriented communication for patients with a PTSD diagnosis and is sensitive to the consequences of the interaction. The model by Schellong and Epple forms the starting point, and a synthesis takes place with the models by Schulz von Thun and Epple.

The basic attitude of the person providing therapy is specified as the basis for the conversation. This includes in particular an empathetic and appreciative attitude, but also the acceptance of the person, their current feelings and situation and the openness to respond to the patient. In addition, specialist knowledge in the medical and

psychological field is also important, especially on the subject of PTSD and the treatment options.

There are three aspects in particular that are important when preparing for the conversation. Firstly, the therapist's basic attitude. The relationship level plays a central role: congruence, appreciation and empathy are the guiding principles for conducting the conversation. Acceptance of the person and their personality is also important, as is openness to dealing with it. In addition, particular sensitivity must be shown. Secondly, the setting of the conversation must be planned. It should take place in a setting that is pleasant for the patient and as uninterrupted as possible. Potential triggers should also be avoided. For example, the door can be left slightly open and any form of coercion should be avoided if it is known in advance that the person will find this challenging. On the content level, the person should have sound professional skills and experience in dealing with PTSD. Psychological knowledge, particularly with regard to conducting conversations, is also relevant. In addition, the person should have familiarized themselves with the documentation of previous treatment.

The following phase is the start of the conversation. The patient is the focus here. With a view to resource orientation, the therapist assumes that the person already has essential approaches for the further process within themselves. The patient can tell a story freely in the form of a narrative, and the therapist listens actively. When feedback is given, it is primarily targeted impulses that are given and paraphrased. Advice is refrained from being given in this phase. For the patient, it is primarily about giving the patient a feeling of being in control - they should open up. Here, too, the focus is on protecting the patient. On a content level, it is about taking a medical history and assessing current feelings. The second phase is about discussing and processing what has been said. The therapist and the patient communicate about the next steps. In particular, the therapist shows which next steps are now available and which treatment approaches are available. It is important to give the patient freedom of choice. At the same time, direct support is also provided for regulating affective regulation, which is particularly important here. Exercises are also possible in this context. In addition, the person should continue to be strengthened in their sense of control and security. The individual phases can be varied and, if necessary, repeated if this should arise for logical reasons.

Table 1. Conception of a conversation process for communication with PTSD patients

Prerequisites of the conversation		
Attitude	Contents	Situation
Basic attitude of the therapist	Basic atmosphere of the conversation	Content competencies
• Congruence • Appreciation • Empathy • Openness • Sensitivity	•Undisturbed atmosphere •Protection from triggers •Objectivity •Resource orientation	•Preparation for the interview •Basic medical and psychological knowledge •Basic knowledge of PTSD (origin, symptoms and treatment) •Experience in dealing with PTSD patients
Phase 1: Narration		
Behavior of the therapist		Goals

•Resource orientation: restraint and narration •Advice only within a narrow professional framework •Support in affect regulation •Narration •Active listening •Paraphrasing	•Anamnesis and sensitization to the situation • Calming and normalization • Protecting the patient • Opening up the patient
Phase 2: Processing and security	
Behavior of the therapist	Goals
•Support the patient in regulating their emotions (possibly active exercises) •Show options for actions, but allow freedom of choice •Referral to follow-up treatment	• Support in affect regulation •Providing basic knowledge about PTSD and regulation •Cooperative planning of further treatment •Sustainable provision of a sense of control and security

CONCLUSION AND LIMITATIONS

The model presented shows key aspects that need to be considered when dealing with PTSD patients – both from a content and process-logical perspective. Important focuses are on raising awareness among therapists and other people who interact with individuals from this group in a professional setting. Essentially, it is a synthesis of the models by Schellong/Epple and Rogers. At the core are the narrative and counseling phases, with both showing close mutual connections. It offers connection points to other communication models and individualization for special settings – for example, people who have only recently been diagnosed with PTSD or who have other aspects relevant to communication.

An important aspect is that the communication model presented has not yet been subjected to empirical testing. Studies would therefore still need to be carried out. It should be noted that the ethics committee of the treating institutions should be involved in particular, because the associated research is carried out with subjects who are ill. For this reason, an appropriate approach should anticipate possible consequences and the study should only be carried out under intensive medical and psychological supervision. A mixed methods design is recommended: the effects of the application of the model can be both broadly and concretized in detail in interviews and observations. The latter applies particularly in view of the fact that the subjective perceptions of people suffering from PTSD play a prominent role. In addition, it would be useful to include other communication models with a view to their suitability for the current question. In this way, the model could be expanded. Specialization with a view to different manifestations of PTSD should also be examined in this context.

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КОНЦЕПЦИЯ НА МОДЕЛ ЗА ЧУВСТВИТЕЛНА КОМУНИКАЦИЯ С ПАЦИЕНТИ С ПТСР

Резюме: *Общуването с пациенти, страдащи от посттравматично стресово разстройство (ПТСР), изисква подчертано чувствително и внимателно отношение към тях от страна на лекуващите лекари и психолози. В тази статия е разработен модел за комуникация, съобразен с травмата, въз основа на моделите на Шелонг и Епъл, както и на Шулц фон Тун и Роджърс. Целта е да се осигури безопасен и подкрепящ диалог, който избягва травматизирането и укрепва терапевтичните взаимоотношения. В статията първо се описват основите на посттравматичното стресово разстройство, неговите симптоми и значението на адаптираната комуникация. След това са представени теоретичните модели, които служат за основа на модела на комуникация: моделът на разговор, базиран на информация за травмата, и моделът на разговор, ориентиран към пациента. Разработената комуникационна рамка включва емпатично отношение, планиране на обстановката за разговор и структурирано протичане на разговора, който е разделен на две основни фази: фаза на разказване и фаза на обработка и сигурност. Във фазата на разказване основният фокус са активното слушане и анамнезата, докато във втората фаза се обсъждат по-нататъшното лечение и мерките за регулиране на афекта. Моделът подчертава значението на свободата на избора и контрола за пациентите и изтъква необходимостта от непрекъснато адаптиране и разширяване на модела чрез емпирични изследвания. Накрая се обсъждат ограниченията на модела и необходимостта от по-нататъшни изследвания.*

Ключови думи: *посттравматично стресово разстройство, комуникация, регулиране на афекта, чувствителна към травмата комуникация, ориентация към ресурсите, ориентираност към пациента*

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