

Counseling trauma victims: 4 brief therapies meet the test

Focused cognitive-behavioral interventions can provide lasting benefits



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- 33% of women experiencing sexual assault²
- 30% of male war veterans³
- 30% of the 5 million U.S. children exposed to trauma each year⁴ (*Box, page 56*).⁵

We offer recommendations on how to prepare traumatized adults and children for cognitive-

continued on page 55

<u>Dose Dependency of Adverse Brents in Short Term, Planche Controlled Trials</u> <u>Batrapyconidal</u>
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behavioral therapy (CBT) and discuss four tested models—prolonged exposure (PE), cognitive processing therapy (CPT), eye movement desensitization and reprocessing (EMDR), and stress inoculation training (SIT)—that psychiatrists may find effective when treating PTSD.

PREPARING TRAUMA PATIENTS FOR CBT

Before starting CBT, evaluate patients thoroughly to determine if they meet DSM-IV-TR full or subthreshold criteria (<3 "C" symptoms or <2 "D" symptoms) for PTSD. Look for other psychiatric conditions (such as bipolar disorder) and address contraindications to PTSD treatment.

Not all patients are ready to confront their traumas when they arrive for psychiatric evaluation. For example:

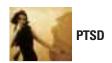
- For a domestic violence victim, the therapist's priority is to help begin safety planning and to address trauma after the patient is out of danger.
- Patients with poor coping skills and little social support often find it difficult to begin trauma treatment. For them, focus on building skills to offset the distress that accompanies trauma therapy.
- Patients with PTSD and substance abuse may benefit more from CBT if the therapist first addresses the substance dependence.

Seeking Safety⁶ is a recent cognitive therapy designed to treat PTSD and substance dependence concurrently. Initial applications appear promising, but its efficacy with various trauma groups needs further evaluation.

CBT CORE CONCEPTS

CBT therapists typically help patients identify and evaluate disruptive cognitions, which helps them challenge and modify emotions, thoughts, and behaviors related to traumatic experience(s). Other CBT components include:

continued



Box

Adapting CBT trauma interventions for children and adolescents

xposure therapy with children is usually more gradual than with adults, and the child is first taught relaxation techniques to use while recalling traumatic experiences. Although re-exposing children to traumatic events may seem harsh, exposure-based cognitive-behavioral therapy (CBT) appears to be most effective when trauma memories or reminders are most distressing to the child.

As with adults, CBT with children typically includes:

- exposure
- identifying and challenging unhealthy or distorted trauma-related thoughts
- teaching anxiety management techniques such as relaxation or assertiveness training.

In initial studies, CBT has been found safe and effective for treating posttraumatic stress disorder (PTSD) in children and adolescents.¹⁷ Through therapy, they can learn not to be afraid of their memories and can develop healthier, more-appropriate thoughts about the trauma. Children with uncomplicated PTSD—without severe, long-term physical injury—typically receive 12 to 20 CBT sessions. More sessions are needed for complex cases, such as when the trauma perpetrator was an integral family member.

Comorbid conditions—such as conduct disorder, attention-deficit/hyperactivity disorder, or depression—may need to be treated before PTSD or concurrently, using medication or other interventions.

- educating patients about PTSD
- exposing them to the traumatic material
- challenging and modifying their disruptive thoughts.

Some CBT outcome studies⁷ suggest that linking exposure with direct cognitive challenging may not be necessary. Patients who are exposed to the traumatic experience through mental imagery but are not challenged on their cognitive distortions still report more-adaptive thought patterns after treatment.

International Society for Traumatic Stress

Studies (ISTSS) practice guidelines for PTSD⁸ include assessment and treatment suggestions (*see Related resources, page 64*). Whatever the model, CBT appears help patients manage their distress, not only during treatment but up to 5 years after completing therapy.⁹

Which CBT? Comparison studies have shown all four CBT interventions to be effective in treating PTSD, although initial trend data suggest that patients with:

- fear-based PTSD may do better with PE or EMDR
- PTSD-related guilt, anger, or other cognitive distortions may benefit more from CPT.

Because CPT's written worksheets could be difficult for illiterate patients, an exposure-based treatment may work better in those cases. SIT can reduce some PTSD symptoms but has not performed as well as other therapies in comparison studies. It is most useful to help patients build coping skills before starting other treatments.

If you refer a patient, make sure the therapist is trained in CBT interventions and in working with trauma patients. To be effective, the therapist must be skilled in handling trauma processing work, suicidal

thoughts/intent, and comorbid personality disorders.

PROLONGED EXPOSURE

PE (*Table 1*) is typically conducted in 9 to 12 sessions lasting 90 minutes each and has been used to treat PTSD after sexual assault, combat, sexual abuse, and natural disasters. Although frequently offered in individual sessions, group PE has also been found to be effective.¹⁰

After educating the patient about PTSD and the treatment rationale, the therapist repeatedly asks the patient to describe the traumatic event as



if it were occurring. During 45 to 60 minutes of this exposure, the therapist frequently asks the patient to rate his or her distress. This identifies "hot spots" in the account that need to be repeated. The therapist does not necessarily challenge distorted cognitions about the event (such as "I am to blame for the rape" or "No one can be trusted").

Researchers hypothesize that exposing a PTSD patient to traumatic memories engages his or her brain's pathologic "fear network," which triggers an excessive fear response to nonthreatening stimuli. Continued exposure allows the patient to habituate to this network, with subsequent extinction of fear and anxiety reactions. Foa et al11 found that mentally reexperiencing a traumatic event helps patients organize memory cues about it, which encourages cognitive restructuring of the trauma.

PE has been shown to enhance the trauma survivor's self-control and personal competence and to decrease generalization of fear to nonassault stimuli.12 For example, many combat vet-

Building patients'

coping skills may

exposure's relatively

high drop-out rate

cut prolonged

erans report fear of situations such as going to the beach or into the woods—that bring back memories of traumatic events. Their fears may keep them from enjoying a walk in the park or family vacations.

Through in vivo exposure, these patients can face associations between environmental cues and their trauma. As they learn to modify the fears associated with these cues, their personal and social functioning improves.

PE can be successful for those who complete

Using prolonged exposure therapy to treat PTSD, session by session

Session	Content
1	Education Treatment rationale Review of PTSD symptom response Introduce breathing retraining
2	Review handout, 'Common reactions to trauma' Introduce Subjective Units of Distress Create fear hierarchy for in vivo exposures
3	Provide rationale for imaginal exposure Conduct imaginal exposure Assign <i>in vivo</i> exposure homework
4 to 8	Conduct imaginal exposure Discuss in vivo exposures
9 or 9 to 12	Conduct imaginal exposure Suggest continued <i>in vivo</i> exercises Termination

Source: Foa EB, Rothbaum BO. Treating the trauma of rape: cognitive behavioral therapy for PTSD. New York: Guilford Press, 1998.

> therapy, but it has a relatively high drop-out rate, reported as 8%13 to 41%.14 The pain of continually reliving a traumatic event probably causes many patients to quit. To

reduce drop-out rates, many therapists combine PE with cognitive restructuring or other techniques that help build patients' coping skills.

CPT (Table 2, page 58) was created as a protocol to treat PTSD and related symptoms in rape survivors.7 Sessions can be group, individual, or combined, depending on the needs and resources of the patients and clinic.

Originally, CPT contained 12 weekly sessions, although versions up to 17 weeks have been

COGNITIVE PROCESSING THERAPY

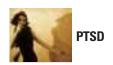


Table 2

Using cognitive processing therapy to treat PTSD, session by session

1 Education Review of symptoms Introduce 'stuck points'/rules Write impact of event statement (IES) 2 Review IES Identify stuck points Introduce A-B-C sheets 3 Review A-B-C sheets Assign writing of traumatic account Identify stuck points Rewrite the account Identify stuck points Rewrite the account Identify stuck points Introduce challenging questions sheet (CQS) Assign writing of next-most traumatic incident and CQS
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Identify stuck points Introduce challenging questions sheet (CQS) Assign writing of next-most traumatic incident
6 Review CQS Assign review of faulty thinking patterns (FTP)
7 Review FTP Assign safety module and challenging beliefs worksheets (CBW) on safety
8 Review CBWs on safety Assign module on trust
9 Review CBWs on trust Assign module on power/control
10 Review CBWs on power/control Assign module on esteem
11 Review CBWs on esteem Assign module on intimacy
Rewrite IES

Source: Resick PA, Schnicke MK Cognitive processing therapy for rape victims: a treatment manual. Newbury Park, CA: Sage, 1993.

developed for adult survivors of child sexual abuse, domestic violence survivors, and war veterans.¹⁵ Sessions can be added or adapted to address each population's type of traumatic experience (such as developmental impairment of sexual abuse survivors).

CPT is based on information processing theory, which suggests that as people access a traumatic memory, they experience and extinguish emotions attached to the event. Guided by the therapist, the patient identifies and challenges distortions the trauma created in three cognition domains: the self, others, and the world. Patients learn to change or replace these cognitive distortions—which therapists often call "stuck points" or "rules"—with moreadaptive, healthier beliefs.

Common byproducts of trauma are feeling out of control or hopeless. Thus, CPT focuses on personal safety, trust, power/control, esteem, and intimacy within each of the three domains. Modules on assertiveness, communication, and social support can also be added.

Although CPT is being adapted for populations other than rape survivors, comparison studies are needed to determine if it is as effective as other CBT therapies for these groups.

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

Like other PTSD treatments, EMDR is based on an "accelerated information-processing" model.¹⁶ Because it also incorporates dissociation and nonverbal representation of traumas (such as visual memories), EMDR is often classified as a cognitive treatment, although

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continued from page 58

— Table 3

Where to learn more about cognitive therapies for PTSD

PTSD related to	Resources
Combat experience, sexual assault, childhood abuse, motor vehicle accidents	Foa EB, Rothbaum BO. Treating the trauma of rape: Cognitive-behavioral therapy for PTSD. New York: Guilford Press; 1998
Sexual assault, childhood abuse, incarceration (of adolescents)	Resick P, Schnicke M. Cognitive processing therapy for rape victims: a treatment manual. Newbury Park, CA: Sage Publications; 1996
Combat experience, sexual assault, civilian disasters (for children or adults)	Shapiro F. Eye movement desensitization and reprocessing: basic principles, protocols, and procedures (2nd ed). New York: Guilford Press; 2001 EMDR Institute, Inc. Available at: http://www.emdr.com
Sexual and physical assault, motor vehicle accidents	Meichenbaum D. Stress inoculation training for coping with stressors. Available at: http://www.apa.org/divisions/div12/rev_est/sit_stress.html
	Combat experience, sexual assault, childhood abuse, motor vehicle accidents Sexual assault, childhood abuse, incarceration (of adolescents) Combat experience, sexual assault, civilian disasters (for children or adults) Sexual and physical assault, motor vehicle

EMDR: Eye movement desensitization and reprocessing

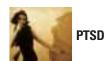
ISTSS practice guidelines⁸ present it as a separate category.

EMDR protocols call for the trauma patient to watch rapid, rhythmic movements of the therapist's hand or a set of lights to distract attention from the stress he or she feels when visualizing the traumatic event. The original technique—developed by Francine Shapiro, PhD—is based on the observation that persons with PTSD often have disrupted rapid eye-movement sleep. In theory, inducing eye movements inhibits stress, allowing patients to more freely access their memory networks and process disturbances. Subsequently, Dr. Shapiro has suggested that

using other auditory cues or hand taps may be as effective as eye movements.¹⁶

EMDR is often conducted in 12 to 15 sessions, although some studies report positive changes after 3 to 6 sessions. After obtaining a patient history, establishing rapport, and explaining the treatment, the therapist asks the patient to identify:

- visual images of the trauma
- his or her affective and physiologic responses to the trauma
- negative self-representations the trauma created
- positive, alternate self-representations. The therapist then asks the patient to focus



on an image most proximal to the trauma and associated affective and biological reactions. While the patient is thinking, the therapist introduces the distraction stimulation. After a set number of stimulations—such as 20 bilateral eye movements—the therapist asks the patient to "let go" of the memory and discusses any new reactions to the

trauma. As patients become less distressed in response to the trauma, they are asked to focus increasingly on alternate positive cognitions while they imagine the trauma.

EMDR has been effective in treating male war veterans, rape victims, and other trauma groups.¹⁷ Initial dismantling studies suggest

that eye movements (or other distracting cues) might not be essential for trauma reprocessing, calling into question the mechanisms thought to create change in EMDR. Studies with larger samples comparing EMDR with other CBT models are needed to assess EMDR's efficacy for trauma survivors.¹⁷

STRESS INOCULATION TRAINING

SIT was designed by Meichenbaum¹⁸ (*Table 3*, page 61) to treat anxiety and stress and was adapted for use with trauma survivors. It appears most effective in relieving fear, anxiety, and depressive symptoms associated with traumatic experiences. SIT includes education, muscle relaxation train-

Relatively short-term CBT interventions can produce life-altering symptom improvements in trauma patients. These changes can endure and even continue to improve over time. Four tested models are helpful for adults and can be adapted for use in children.

Bottom'

ing, breathing retraining, covert modeling, roleplaying, guided self-dialog, and thought stopping. Therapists often teach these skills to patients in modules that build on each other.

For example, a patient might receive relaxation training while role-playing a difficult scenario she may face in the

> future. This helps her learn to remain calm in anxiety-provoking situations.

Unlike PE, SIT does not directly ask patients to recount their traumatic memories, although exposure may be indirect (such as during role-playing exercises). Its purpose is to give patients new skills to manage their anxiety, which in turn decreases PTSD symptoms.

Studies suggest that PE is more effective than SIT alone or SIT/PE combined.¹³ Thus, instead of using SIT as a trauma-focused treatment, some therapists find it useful to help patients gain coping skills before beginning other trauma treatments.

References

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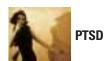
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Related resources

- ▶ International Society for Traumatic Stress Studies. www.istss.org.
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DISCLOSURES

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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