POSTTRAUMATIC STRESS DISORDER

Important note: This article is an extract from **Froggatt, Wayne (2009).** ***The Rational Treatment of Anxiety.*** **Hastings: Rational Training Resources**. References to page numbers refer to other parts of that document.

Human beings possess remarkable resilience, as shown by our ability to bounce back from negative experiences. Sometimes, though, this resilience is stretched too far. This happens when an unusually severe experience (or set of them) occurs to a person with a pre-existing vulnerability – a combination that leads to symptoms like the following:

- *Re-experiencing:* reliving the event via dreams or intrusive thoughts.
- *Hyperarousal:* excessive vigilance, startle response, angry outbursts.
- *Numbing:* emotional numbness, social withdrawal, loss of interest.
- *Avoidance* (of activities or situations that remind of the traumatic event): suppressing emotions associated with the event, staying away from people or situations that remind of the event, failing to recall important features of the event, feeling detached or isolated from other people and restricted in ability to feel strong emotions including love.

PTSD is most common with survivors of combat, floods, earthquakes, rape, abduction, kidnapping, hostage situations and aeroplane crashes. It may also occur with people who have learned about severe trauma suffered by others to whom they are close. (NB: it excludes ordinary life experiences such as bereavement, divorce or serious illness). About half recover within a few months; some experience years of incapacity.

See p.12 for DSM-IV criteria. To qualify for a diagnosis of PTSD, the symptoms must last longer than one month. If all the elements required for PTSD are present within four weeks of the trauma and last from two days to four weeks, the correct diagnosis is Acute Stress Disorder. Note that there is some controversy over diagnostic aspects of PTSD, with concerns about its rapid growth and extension of the concept of 'victimhood' to increasing numbers of people.[39]

Other disorders that may co-exist include: substance dependence or abuse (common); phobic disorder; generalised anxiety disorder; major depressive disorder; dysthymic disorder; dissociative amnesia; dissociative fugue.

Causation

Activating events

Events that contain a high number of traumatic characteristics are more likely to lead to PTSD: threat to life; involvement in intensive combat situations; physical harm, rape, torture; sudden significant loss (or multiple losses); injury; surgery; violent displacement; natural disaster; multiple traumatic events (e.g. sexual or physical abuse over a period of time) that have a cumulative effect.

Perception of the event

As we shall see shortly under the heading of *Cognition*, the individual's *view* of the event is just as important as its actual severity; in particular: (1) there was a perception of threat to life; (2) the event was seen as unpredictable and uncontrollable; or (3) the location or circumstances had previously been viewed as safe.

Vulnerability

Most people will experience trauma in their lifetime – but not everyone exposed to trauma will develop PTSD. For the disorder to develop, there is likely to be a pre-existing vulnerability:

- *Biology*. One hypothesis points to cortisol, a hormone secreted by the adrenal gland when a person is stressed, as being implicated (it has been found that PTSD patients have lower-than-average levels in their blood[40]).
- *Previous life events.* Experiences such as childhood abuse or a series of losses may create vulnerability to later post-traumatic stress.

---

[39] Summerfield, Derek. (2001). The Invention of Post-Traumatic Stress Disorder and the Social Usefulness of a Psychiatric Category. *BMJ 2001; 322: 95–8*

[40] Yehuda, R. (1997): reported in *Pychology Today*, 30:6, p.9, Nov/Dec 1997.

- *Personality.* A person prone to *low discomfort-tolerance* will react more strongly to both trauma and its sequelae, and is thus more likely to develop avoidance coping mechanisms. *Lack of self-acceptance* means that a person will, following trauma, be more likely to blame global personal characteristics rather than specific behaviours, and fear disapproval from others for having experienced the trauma or for having difficulty coping with the aftermath.[41] An *external locus of control* will create an attitude of helplessness in the face of traumatic external events.

Successful avoidance behaviour

Following a traumatic event, avoidance behaviour that succeeds in reducing anxiety can become self-reinforcing and thus serve to promote the development of PTSD.

Cognition

Vulnerability is closely associated with certain ways of viewing the world and oneself. There are two key belief patterns involved with PTSD – (1) *'just world'* beliefs, and (2) *vulnerability, safety and comfort* beliefs:[42]

Type of belief:	Inferential beliefs (assumptions):	Corresponding evaluative rules:
'*Just-world*' '*Safe-world*'	The world is a fair/just/safe place. People get what they deserve and deserve what they get. Bad things do not happen to good people.	The world should be a fair/safe/just place. Bad things should not happen to good people. If bad things do happen to me, it must be because I am a bad person.
'*Vulnerability*', '*safety*' *and* '*comfort*'	'It can't happen to me' (an illusion of unique invulnerability to victimisation).	The world should be a safe place. I must not experience emotional pain. Bad things must not happen to me.

Such core beliefs will mean that a person is less likely to accept traumatic events as a part of life, because the trauma, in effect, shatters the individual's basic view of how the world is supposed to be. Absolutistic demands (like, for example 'The world must be a safe place'), when contradicted by trauma, result in greater emotional pain than beliefs that are preferential (e.g. 'I prefer the world to be a safe place'). Other types of thinking that commonly contribute to PTSD include:

- *Thoughts related to guilt:* 'I should have been able to prevent it happening – because I did not, I must be a bad person / weak / etc.' 'I should not have survived when others died.'
- *Evaluative thinking about reminders of the trauma.* Conditioned stimuli may remind a person of the trauma; but the emotional response is *not* conditioned – it depends on how one *views* the stimuli: 'It is terrible to have these flashbacks/bad dreams/etc.' (awfulising); 'I can't bear the feelings' (discomfort-intolerance); 'I must not experience them' (demandingness).
- *Demands directed at other people.* Demands about how others should react, for example: 'They should be understanding and supportive', create anger and may alienate others from providing support. Demands toward others perceived as responsible for the event, e.g. 'People must not do such things', lead to 'demonising' of those concerned and over-generalisations like: 'All people are bad and no-one can be trusted.'
- *Secondary emotional disturbances*. Negative thinking about the PTSD itself (such as highly negative thoughts about flashbacks and other reminders of the trauma as described above); or self-downing for not being able to control the feelings ('I am weak/stupid/pathetic/etc.'), may lead to hopelessness about overcoming the problem and possibly depression.

The three 'solutions'

Traumatic experiences may contradict deeply-held schema. An individual who holds absolutistic rules about justice and invulnerability will have difficulty integrating the experience into their current belief system. Consequently, thoughts of the event will continue to intrude into consciousness and create distress. There are three ways a person may try to resolve the conflict between beliefs and reality: *assimilation*, *over-accommodation*, and *accommodation*. The following chart describes each of these methods, along with an example of thinking that might typify each one:

[41] An issue here is that victims often *do* receive disapproval when they are victimised – people may blame victims in order, for instance, to maintain their own 'just world' beliefs.

[42] Warren, R. & Zgourides, G. (1991). *Anxiety Disorders: A Rational-Emotive Approach*. NY: Pergamon Press.

Trauma solution 1: ASSIMILATION	Trauma solution 2: OVER-ACCOMMODATION	Trauma solution 3: ACCOMMODATION
Alter information about the *event* to make it conform to one's pre-existing belief system.	Switch the pre-existing belief system to the opposite extreme.	Alter one's *belief system* to bring it into line with the reality of the event.
'The world is still a totally safe place – it is me that is the problem.'	'The world is a totally dangero.us place.'	'The world is not after all a totally safe place – there are some dangers I need to be aware of.'

The most functional solution is accommodation – and this is the aim of PTSD treatment.

Summary of causative factors

In summary, PTSD appears to result from:

1. a *traumatic event* (or series of events) …
2. *occurring to a person who is already vulnerable* by virtue of: (a) their biology / previous experiences / personality characteristics; and (b) 'justice' and/or 'safety' beliefs that are contradicted by the event …
3. *which leads to current dysfunctional thinking* about: (a) the pervasiveness of danger; (b) responsibility for the event; (c) the symptoms experienced; (d) oneself for experiencing the problems and being unable to control them …
4. *which maintains negative emotions and leads to avoidance behaviour* – thus turning an otherwise acute stress reaction into more chronic PTSD.

Treating PTSD: an introduction

Treatment principles

The main aim of treatment for PTSD is to help the client achieve *accommodation*. As we saw earlier, many people cope with an experience that contradicts their worldview by altering their perception of the event itself, in order to avoid having to change their old view of the world. In other words, they 'assimilate' a view of the event into their existing belief system. They may do this by using a number of strategies, such as simply avoiding reminders of the event (by staying away from situations or experiences that act as cues), by reframing the event (e.g. redefining an assault as due to one's own fault), or by seeing what happened as 'justified' (e.g. 'I must have done something to deserve this'). Assimilation is usually unhelpful because it denies reality – thus leaving the person at risk of (1) further contradictions to their value system in the future, and (2) real dangers that mght exist in their environment.

Accommodation, on the other hand, involves changing one's beliefs about the world to a view that is more consistent with reality – like, for example:

Old Belief	New Belief
The world is, and must be, a totally safe place.	The world is (and always has been) a place that contains some dangers, and it is better to acknowledge this rather than demand that reality not exist.
I must be immune from danger.	There is no 'Law of the Universe' that says I should be immune from the same dangers faced by the rest of humankind.

The therapist will be on the alert for *over*–accommodation where the client goes from one extreme (e.g. 'The world is a totally safe place') to the other (e.g. 'The world is a totally dangerous place and no-one can be trusted').

Accommodation is achieved when the person revises pre-existing basic assumptions regarding self, others, and the world, so that recollections of the traumatic event become integrated and tolerable.

Summary of the treatment approach

Revising basic assumptions occurs through the use of three key interlocking strategies:

1. *Teaching cognitive and other coping skills such as relaxation* to help the client gain initial symptomatic relief, develop confidence in their ability to cope, and prepare them for exposure work.
2. *Exposure work:* exposure for PTSD is carried out *using new information* that will alter the existing world view that has been contradicted by the trauma, and usually takes two forms: (1) *Imagery* exposure; and (2) *In-vivo* exposure.

3. *Cognitive restructuring:* change in the underlying belief system involves the usual range of cognitive, emotive and imagery techniques.

Additional strategies will sometimes include:

- Attention to any safety issues.
- Linking the client with their support systems.
- Sleep management, anger management, problem-solving, relationship counselling, medication.

Begin with preparation and assessment

Establish a therapeutic alliance with the client

Convey understanding and sensitivity, act supportively – and encourage the view that recovery is possible and likely.

Assess the problem

- Clarify the diagnosis (see p.12 for DSM-IV criteria).
- Ask about the traumatic event: find out what happened (but only in broad outline – any more detail at this stage may be too soon for the client).
- List the symptoms:
  - *Intrusive ideation:* unwanted thoughts, images, dreams; anxiety when exposed to reminders of the traumatic experience.
  - *Avoidance behaviour:* emotional numbing, detachment from other people; difficulty recalling significant aspects of the event; staying away from certain situations or places that act as reminders.
  - *Associated physical symptoms:* tension, panic, sleeplessness, irritability, difficulty concentrating, jumpiness, etc.
- Identify any related problems:
  - *Depression* (if significant, may need treatment before the PTSD).
  - *Substance abuse* (this will usually need to be treated first, as the increase in discomfort may lead to increased abuse; also, exposure therapy will be negated if a person is in an altered state of consciousness).
  - *Other anxiety disorders*; any *personality disorder*.
  - *History of repetitive self-harming* (PTSD treatment, by raising discomfort levels, may lead to an increase in self-harming. Such clients need help with tolerating their emotional discomfort before exposure begins).
- List typical triggers to symptoms, and currently-avoided situations.
- Assess the person's current functioning and check for any immediate problems, including safety issues.

Assess suitability for therapy

Check the client's ability and willingness to tolerate the increased discomfort of facing what they would normally avoid. Be honest about the fact that, as with all the anxiety disorders, one may 'get worse before getting better'. (But add that the increase in discomfort will be short-term – and needs to be compared with the long-term gain that will result from dealing with the problem).

Establish the baseline

Obtain an initial baseline from which progress can be measured. Ask the client to keep a diary listing: (1) the occurrence of symptoms and their nature and content; (2) activating events; (3) cognitions; (4) daily ratings of general anxiety level.

Assess the person and their background

Ask about (1) the client's mental health prior to the trauma; (2) previous traumatic experiences; (3) current relationships and how they affect or are affected by the PTSD; (4) social support systems – family, friends, other helping professionals, etc. and (5) other standard assessment factors (see p.27).

Identify any secondary emotional disturbances

Look for self-talk like the following:

- 'I'll never get over this.' 'I'm going crazy.'
- 'Other people are handling it better – I shouldn't be this way.' 'I should be able to handle my feelings.' 'I'm weak/stupid/hopeless/etc. because I can't handle this.'
- 'I can't stand (the flashbacks, intrusive thoughts, bad dreams, etc.).'

Provide education about the nature of PTSD

Provide information about how PTSD develops, in particular that:

- PTSD is most likely to develop when a traumatic event is unpredictable and perceived as uncontrollable;
- Fear becomes conditioned to situations that remind the person of the traumatic event;
- The event contradicts basic, core beliefs about the world as a safe place and oneself as invulnerable – leading to either assimilation or over-accommodation (NB: don't try to dispute any core schema at this early stage).

Where it appears that the client may not have been taking appropriate precautions, it may also be appropriate to discuss basic strategies for keeping safe in the future.

Discuss the treatment

Given that exposure will usually be a key component of treatment, and sufferers may have been avoiding their negative emotions for some time, it is important to help the client understand how exposure will help them and why it may be an essential part of treatment.

Explain that in the early stages of treatment, symptoms may temporarily worsen before they get better. (It may also help to communicate this to the client's partner, family doctor and other key helpers).

Where the client is anxious about the treatment process, discuss the concept of discomfort intolerance. Point out that while most human beings dislike discomfort, tolerance may be reduced by *unplanned* exposure to extreme trauma. Then discuss how facing discomfort (in a planned manner) in the short term will mean less pain and dysfunction in the long term (see 'low discomfort-tolerance' on p.18 and 'long range enjoyment' on p.24).

As well, it might be helpful to point out that exposure work will only commence when the client has developed some strategies that will help them cope with the increased discomfort involved.

Agree on goals and tasks

Develop an agreement on the goals of therapy and the strategies that will be used to achieve them. This will not always be easy. For instance, the therapist may see the goals as reducing anxiety and avoidance behaviour – whereas the client may want to keep their anxiety (because it motivates avoidance which, they think, protects them from a recurrence of the traumatic event)[43]. In such a case, discuss the wisdom of the client's goal. The 'benefits calculation technique' (see p.47) may be helpful here.

Introduce the cognitive model

Help the client differentiate activating events, thoughts, and feelings. Explain the model (the ABC approach is a useful way to do this), using, as appropriate, either general illustrations or examples from the client's own experience. Provide relevant reading about the approach. The ABC log used in the assessment phase can be useful here. Through collecting information about typical reactions, their triggers, and the dysfunctional thoughts involved, the client can see how all three are related to each other.

Address any identified secondary problems

If the client sees getting better as hopeless, or themselves as useless for experiencing their symptoms, they will find it hard to do the work necessary to recovery. Accordingly, it is usually necessary to address these issues first. *Time-projection* (p.51) may be useful for addressing the belief that there is no hope of getting better. Self-downing is addressed later in this chapter under the heading *Addressing specific issues*.

Teach coping skills

As soon as possible, begin training the client in the usual range of cognitive and physiological techniques used to manage anxiety. This will serve two purposes: (1) to help them get some initial control over their distressing symptoms, and (2) prepare them for exposure work.

Relaxation training

Letting go of rising tension helps inhibit the feedback loop where the mind observes the body tensing and interprets this as a signal of real danger. Relaxation training (p.149) can be started at an early stage and continue while other skills are introduced.

---

[43] See Muran, E.M. & DiGiuseppe, R. (1994). Rape. In: Dattilio, F.M. & Freeman, A. (Eds.). *Cognitive-Behavioural Strategies in Crisis Intervention*. New York: Guilford.

Cognitive strategies

While relaxation training is in progress, begin training the client in the use of techniques to identify and modify the dysfunctional thinking involved with their anxious reactions:

- *ABC diary* (p.40). Start by having the client collect dysfunctional thoughts and connect them to the situations that trigger them and the symptoms that follow.
- *Rational analysis* (p.37). As soon as the client is ready, show them how to dispute and replace the thoughts identified through their diary-keeping. The *daily thought record* (p.187) is a useful alternative format that may be relevant at this stage.
- *Reframing* (p.47) is a helpful disputing technique. Show the client how to re-label their anxious feelings as uncomfortable rather than unbearable.
- *Rational cards.* Have the client record old and new beliefs on a card (see p.56), which they then use to prepare for and cope with exposure.
- *Self-instruction.*[44] The client can repeat phrases that summarise self-help concepts developed during therapy, e.g. 'Stay with it, it is worth the pain now to feel better later', 'Anxiety is uncomfortable – not terminal', 'I don't like it, but I can stand it', etc. It will usually be helpful for the client to write these down on small cards they can have with them in exposure situations. Warn them, though, against using superficial or unrealistic 'affirmations' that are unlikely to stand up in the real world.

Introduce imagery exposure

Imagery exposure involves confronting the memories while dealing with the associated dysfunctional thinking, over an extended period of time until the anxiety diminishes.[45] Imagery exposure can be carried out in several ways:

- One way is to have the client write out an account of the traumatic experience, describing in particular the sensations, emotions, and thoughts involved. This can be done either as homework or in the interview setting.
- Alternatively, the client could describe their story verbally to the therapist, making a recording which they will take home and listen to between sessions (or the recording can be made as part of their homework and played to the therapist at the next interview).

Whichever method is used, the following steps illustrate the usual process of imagery exposure.

Prepare the client

- Explain that their distress will increase as they confront their story, but it is important they stay with their discomfort until the anxiety reduces;
- Ensure they understand the point of telling their story, painful though it is, and how it will help them;
- Teach coping skills, as described earlier, *before* commencing exposure.

Have the client engage in the exposure

Usually this would be done in a graduated fashion, something like the following:

1. First, the client talks or writes about the *effects* of the traumatic experience on the way they think about themselves, others and the world in general. If written, the client then reads it to the therapist (at the next session if completed as homework). While engaging in the exposure, the client makes use of relaxation, breathing control and cognitive strategies to manage their anxiety.
2. Next, the client prepares a detailed account of *the event itself*, covering (1) what happened and (2) the thoughts and emotions experienced during the event; and presents this to the therapist.
3. Finally, the client rewrites their account of the event with the thoughts and feelings they experienced at the time, (1) increasing the level of detail about the experience, and (2) adding to the record their *current* thoughts and feelings as they carry out the exposure exercise.

As each stage of exposure proceeds

- Check that the client is using to good effect the physiological and cognitive coping skills developed earlier. Bring in additional skills as needed.

---

[44] Adapted from Beck, Emery & Greenberg, 1985

[45] Resick & Schnicke (1992) state that for fear to reduce, (1) the fear memory must be activated, while (2) new information is provided that is incompatible with the current fear structure, in order for a new memory to be formed.

- Introduce cognitive restructuring on the dysfunctional thinking that becomes apparent (see notes on this under the next sub-heading).
- Encourage the client to experience whatever emotions come forth without trying to suppress them, using their coping skills to manage the accompanying anxiety. Reinforce the person to continue telling the story – and, gradually, to complete it.
- Continue assessing the problem – take note of: (1) any additional PTSD symptoms that become apparent; (2) difficulty with telling or avoidance of parts of the story; (3) dysfunctional ways of thinking.
- Take every opportunity to reinforce any *adaptive* reactions – functional thoughts and helpful emotions – the client may describe.

Ask the client to practice the exposure at home

Have the client take home their written account or recording and read or listen to it daily; making use, as they do so, of their newly-learned coping strategies.

Notes on imagery exposure

Work at the client's pace

Because they may have been encouraged by well-meaning friends and family to avoid thinking about the trauma, this may be the first time the client has really told their story.

Sometimes the person will be unable or unwilling to relate the whole story straight away. Given that imagery exposure for PTSD is usually carried out in a graduated fashion, the level of emotion will be heightened as the client gradually increases, at their own pace, the level of detail in their telling of the story.

On the other hand, discomfort cannot be avoided if the person is to overcome their PTSD. Accordingly, keep in mind the principle outlined earlier in this manual: make exposure 'challenging but not overwhelming'.

Introducing cognitive restructuring

When initiating work on underlying dysfunctional beliefs, watch especially for the client's thinking around areas like the following:

- Assuming responsibility for what happened.
- What kind of person they think they are.
- Hope for recovery.
- Perception of personal vulnerability.
- Key assumptions that have been contradicted by the traumatic event.
- How they view their distressful symptoms – intrusive thoughts, flashbacks, bad dreams and so on – especially watching for any awfulising, demands that the symptoms not occur, and self-downing for not being able to control them.

Correction of dysfunctional thinking would usually be introduced in a graduated fashion. The therapist might begin with work on inferential thinking, gradually extending to core beliefs as the client expands their understanding of the link between beliefs and reactions. Take care not to be too confronting, especially in the early stages. At times, it may be appropriate to simply note a dysfunctional belief for later work

It is usually best to have the client write down the old and new ways of thinking developed in the session, or alternatively make an audio recording of this section of the interview, so that they can refer to their notes or the recording at home as required.

Alternative ways to graduate exposure

Where appropriate, the steps can be abbreviated into a few sessions. Conversely, each step can be spread over several sessions if desirable.

Another approach to graduating the steps is for the client to do the writing or recording at home (which constitutes one exposure step), then read it or play the recording to the therapist at the following interview (which constitutes the next exposure step).

Making imagery exposure more effective

Adopt an accepting and controlled empathic reaction to what the client is revealing. A non-judgmental approach to what they may see as reprehensible will help them keep sharing. Showing empathy will aid development of an atmosphere of trust. *Strong* emotional reactions from the therapist, however, are liable to be misinterpreted. (If you as the therapist experience strong emotional reactions to what your client is saying, ensure that you make use of appropriate supervision to work through your own response).

Where the client is resistant to telling their story: (1) explain that this is not uncommon for people who have experienced trauma; (2) ask how they feel about recounting the story – identify any dysfunctional reactions (shame and discomfort-intolerance are the two most common); (3) explain how such reactions block progress in therapy; and (4) help the client uncover and deal with the self-defeating thoughts involved.

If the client has difficulty identifying their emotional blocks, consider a more direct approach where you describe the most common blocks and ask the client which might apply to them.

Difficulties with exposure work can often be overcome by further preparation of the client, especially training in coping skills. The *Benefits calculation* technique (p.47) may also be useful: the client can complete a cost-benefit analysis of experiencing the pain versus trying to avoid it; then keep this on hand to read as a reminder.

Move to in-vivo exposure assignments

When ready, assist the client to engage in real-life exposure. Specific areas for in-vivo exposure will usually involve situations the client has been avoiding because they serve as reminders of the traumatic event. If shame is prominent, shame attacking exercises may be relevant. Where the client has developed an overly-restrictive lifestyle, general (appropriate!) risk-taking may be called for. For more detailed information on the use of in-vivo exposure, see the section beginning on p.57.

Extend cognitive restructuring

As exposure work progresses and begins to decrease, move the primary focus to restructuring of dysfunctional core schema: safe world beliefs, ideas of unique invulnerability, negative self-concept, and so on. Focus especially on those assumptions that have been contradicted by the traumatic event. These areas, along with relevant techniques, are dealt with under the heading *Addressing specific issues* later in this chapter.

There is one important point to mention. Sometimes therapists fall into a trap of debating the badness of the traumatic event itself. An example of this would be challenging a client's belief that 'What happened was 'awful''. There are two problems with doing this. First, it is likely to alienate the client. Second, it will direct attention away from the cause of their pain in the present. Rather than dispute: 'The event was awful', it is much more appropriate and useful to focus on the thoughts creating *current* distress (e.g. 'I can't stand these flashbacks I keep having'), and on core beliefs that existed *prior* to the event (e.g. 'The world should be a totally safe place for me').

Introduce additional strategies as appropriate

Increasing self-control

In addition to the strategies described above, other procedures that may enhance the client's sense of self-control include:

- Thought-stopping (p.70) for intrusive recollections and obsessive ruminations that remain after cognitive reprocessing has been completed;
- Sleep management training (p.173);
- Anger management training (discussed under the heading *Addressing specific issues* later in this chapter);
- Relaxation training (p.149) and/or breathing control (p.149) to aid exposure work, assist with sleep management, reduce general hyperarousal, etc;
- Problem-solving training (p.68)for dealing with environmental difficulties;
- Helping the client more effectively and functionally assess safety and danger;
- Learning rational analysis (p.37) to aid general coping with emotions in the long term.

Relationship counselling

Where the person's relationship has been under strain due to the PTSD counselling for the couple may be indicated.

Using social support

The client's ability to use support systems can be enhanced via:

- Social/communication skills training;
- Creating realistic expectations of what others can provide;
- Developing rational thinking skills to deal with fears of criticism or disapproval;
- Helping the client link with appropriate community resources.

Medication

Antidepressant medication will help some clients, especially where symptoms of depression are present. However, as with other anxiety disorders, benzodiazepines are usually unhelpful: they contribute to the avoidance that promotes development of PTSD – and any relief gained will only be temporary.

Addressing specific issues

Safe-world beliefs

As discussed earlier, a core schema that is contradicted for many people who develop PTSD is the belief that the world is a safe place. First, carefully *help the client see how the safe-world belief is unhelpful* for them (they may have difficulty grasping this at first). Second, *introduce the client to an alternative belief about the world* – namely, that many dangers abound and it is impossible to totally guarantee one's safety; but we can reduce the chance of many traumatic experiences by taking appropriate precautions. Relevant techniques include:

- *Education* (p.55): discussion with the therapist, reading assignments.
- *Benefits calculation* (p.47) to examine the wisdom of holding the belief.
- *Double standard technique* (p.47) – would the client want their child/best friend/etc. to hold such beliefs?

Vulnerability

Following victimisation, people often jump from an illusion of unique invulnerability ('I in particular am invulnerable') to the other extreme of unique vulnerability ('I in particular have been singled out to suffer this'). The solution is to help the client move toward the idea of *universal vulnerability* ('Myself and others are equally vulnerable'). Useful techniques include: reading, discussions; Socratic questioning (p.44).

Self-blame and competence

Closely linked to the issues of vulnerability and self-blame is that of a person's perception of their competence or ability to keep themself safe in the future. PTSD clients may view themselves as weak, powerless, helpless, out of control, or deviant because of what happened. This results from core beliefs such as: 'Bad things only happen to people who deserve them'. Such beliefs may be reinforced by blaming from others. Begin by clarifying what the person is blaming: their *behaviour* ('It happened because of what I did / did not do'); or *character trait(s)* ('It happened because I am unassertive'); or their *total self* ('It happened because I am a bad person').

If the client blames their behaviour or character traits, help them check out the evidence. Where their behaviour is wholly or partly a causative factor, help them (1) take responsibility for their *actions*, (2) move to self-acceptance in spite of those actions, and (3) look at reducing the likelihood of a repeat.

Where blame is attached to the total self, and especially if there was a poor view of self prior to the traumatic event, general self-acceptance training (p.24) may be appropriate. The 'double-standard' technique (p.47) is useful when dealing with self-blame.

Where there is doubt about a person's ability to keep themself safe, education and training in the requisite skills may be needed.

Trust

Some clients, especially where they have experienced trauma at the hands of another person or group whom they trusted, may swing from a pre-existing belief like: 'People can be generally trusted' to: 'No-one can be trusted'. The therapist can assist by helping the person move to a more realistic perception, e.g. 'People can be trusted to varying degrees – some very little, others to a reasonable degree, some a lot'. It may also be appropriate, where a person appears to be too trusting, to provide education about how one can assess the degree to which it is wise to trust another person or group.

The search for meaning and demands for fairness and order

People who understand why they were victimised are less distressed and socially better adjusted than those who cannot make sense of the event. Clarifying why the event occurred, if it is possible to do so, can assist.

There is, however, a trap here. Asking 'Why did this happen to *me*?' keeps people locked into their bad feelings. This happens where the 'question' is actually a *statement:* 'This should not have happened to me.' Because the 'question' is not really a question, it can never be answered! The underlying issues here are 'just-world' and 'fairness' demands. Strategies that can be used to help with this issue include:

- *Disputation of demands* through Socratic discussions (p.44). A common way to deal with the demand for fairness is help the client move from 'Why me?' to 'Why not me?'

- *Acceptance of reality* (see p.25) about the event: first, acknowledgment that it has happened, and that it could happen again (though one hopes it does not); and second, changing any demand (e.g. that it not have happened, or not happen in the future) to preferences.

Anger

PTSD clients sometimes have difficulty with anger. They may be angry at *themselves*: for not avoiding the trauma; about their behaviour during the trauma; over their coping since the trauma occurred; or, in some cases, for surviving when significant others died ('survival guilt'). They may be angry with *others* for failing to be understanding or supportive; or angry with perceived perpetrators, 'God', or 'the world'.

Anger can, of course, be appropriate to the situation and is not always a problematical emotion. If, though, a person is sitting on excessive anger that is not leading to constructive action, this may result in distressful symptoms and difficulty resolving the trauma. To help angry clients:

- Assess with them the extent to which the anger is functional or dysfunctional to their adaptation;
- Dispute any underlying demands that are fuelling the anger;
- Help the client move toward acceptance of: (1) self and own behaviour; (2) other people and their behaviour;[46] (3) the world and what happens in it.

Anger is, often, a difficult emotion to give up. The 'benefits calculation' technique (p.47) can help the client, by showing them why it might be in their interests to do the hard work required.

Low tolerance for the symptoms of PTSD

As discussed earlier, PTSD can be perpetuated by intolerance of its symptoms. The solution is to decatastrophise the flashbacks, bad dreams or other current symptoms. Relevant techniques might include:

- Catastrophe scale (p.47).
- Reframing symptoms as 'unpleasant' rather than 'awful' (p.47).
- Rational-emotive imagery (p.49).

NB: ensure that decatastrophising is directed at the client's thoughts about their *current symptoms* – not their thoughts about the event itself. Trying to convince a client that the trauma was not 'awful', or that they could 'stand it' if it happened again, is likely to be seen as insensitive and may only serve to alienate them. Instead, help the person change their view of the *symptoms*. First, show them that fearing their *current* intrusive thoughts or bad dreams serves to focus their attention on those phenomena and thus perpetuate them. Second, help them view these *symptoms* as unpleasant rather than a source of terror, as uncomfortable rather than unbearable.

Intimacy

In some cases, for example where sexual assault has occurred, intimate activity may trigger reminders of the assault and consequent anxiety. This can be helped via exposure assignments, where gradually increasing levels of intimacy between the client and their partner are accompanied by appropriate cognitive restructuring.

Assisting refugees

Many people entering a new country as refugees have been exposed to the trauma of torture, violent dislocation, rape, or observing others who have been victimised. Sometimes doctors or other professionals have been involved as perpetrators in these events, so special care is needed in assisting such refugees. Following are some guidelines:[47]

- Arrange an interpreter acceptable to the individual.
- Discuss the confidential nature of the interview.
- Identify the person's concerns.
- Ascertain relevant demographic factors (country of origin, date left, current residency status).
- Avoid writing down any comments about politically sensitive issues.
- Avoid asking questions in a way that sounds like an interrogation, and explain the purpose of each question.

---

[46] A useful resource for helping clients manage hostile anger directed at others is Froggatt, 1997: *The Rational Management of Anger*. Located on the World Wide Web: http://www.rational.org.nz/prof/docs/anger.htm . Clients may also benefit from the chapter on managing anger in *Choose to be Happy* (Froggatt, 1993).

[47] Adpated from the Treatment Protocol Project. (1997). *Management of Mental Disorders (Second Edition)*. Sydney: World Health Organisation, Sydney.

- While focussing on the person's expressed concerns (which may be their presenting physical, emotional or social problems), encourage them to share any additional problems they may be experiencing (which may help them overcome reluctance to volunteer information about what has happened to them).
- If a physical examination is required, try to arrange a doctor who will explain the purpose of each procedure and be especially careful with any invasive techniques.
- In addition to psychotherapeutic intervention, work may be needed on various social problems associated with the person's move to a new country.

Preventing PTSD

Try to have trauma victims seen as soon as possible: evidence suggests that early ventilation reduces the likelihood PTSD behaviour will consolidate[48]: however, there are some cautions.

- Immediately after a traumatic event, people don't generally need therapy – the need *support*. Help them identify and make use of their existing 'natural' support systems as far as possible.
- Check the need for medical assessment and treatment (and provide any appropriate support with this, especially where assessment may involve invasive procedures).
- If appropriate, invite them describe what has happened – but only if they want to talk about it. Everyone is different: some people benefit from 'talking it out', others prefer to deal with it in their own way.[49] Make it clear that you are available without insisting things be done according to 'the book'.
- Provide information: help the person understand: (1) that their reaction is normal; and (2) what other symptoms to expect, and what to do when they occur.
- As necessary, check their ongoing safety and assist with any arrangements required.

Coping as the therapist

When working with clients who have experienced traumatic experiences, the therapist is confronted with a reminder that *everyone* is vulnerable to negative experiences of a traumatic nature. This may challenge the therapist's own 'safe-world' and 'unique invulnerability' beliefs – creating anxiety, or, worse, denial that leads to blaming the client for what happened in order to avoid one's own feelings of vulnerability.

Another difficulty for some therapists is fear of disturbing the client by asking them to discuss the traumatic experience – which means they don't get help to resolve the trauma.

In both cases, the solution is for therapists to be aware of their own feelings when working with trauma survivors (and, indeed, with any client!) and be able to identify and change the dysfunctional cognitions involved. PTSD work highlights the need for therapists to have regular and effective supervision where they can work through their own feelings about their work with clients.

The end of therapy and relapse prevention

When does therapy end?

Therapy (ideally) ends when: (1) the client can experience reminders of the event with manageable levels of anxiety; (2) they are able to enter all previously-avoided situations; and (3) any other problems associated with the PTSD, e.g. depression, substance abuse, relationship difficulties, etc. are resolved.

In actual practice, termination may occur when there is only partial relief, perhaps because the client feels well enough to cope as they are. Whatever the reason for early termination, it will be helpful to ensure the client knows they can return for further work at any time in the future.

---

[48] See Muran, E.M. & DiGiuseppe, R. (1994). Rape. In: Dattilio, F.M. & Freeman, A. (Eds.). *Cognitive-Behavioural Strategies in Crisis Intervention*. New York: Guilford.

[49] See: 'It's not always good to talk' (American Psychological Assn., 2003). Found on the Internet at: http://www.leili.net/psynews/e/It%20s%20not%20always%20good%20to%20talk2003-6.htm.

Summary: Treating Post-Traumatic Stress Disorder

Carry out assessment

- Clarify diagnosis.
- Clarify event (in general only at this stage).
- List symptoms: intrusive ideation, avoidance behaviour, physical symptoms.
- Identify any related problems: depression, substance abuse, other anxiety disorders, personality disorders, repetitive self-harming.
- Assess suitability for therapy.
- Establish baselines: occurrence, nature, content of symptoms; activating events; cognitions; daily ratings of general anxiety level.
- Assess person and background: prior mental health, previous trauma, relationships, etc.
- Note support systems available to client.
- Identify any secondary disturbances: hopelessness about getting better, self-downing for having the problem, low tolerance for symptoms.

Prepare client for therapy

- Provide education about the nature of PTSD.
- Discuss content of treatment, incl. exposure.
- Agree on goals and tasks.
- Introduce the cognitive model.
- Deal with any secondary disturbances.

Teach coping skills

- Relaxation training or breathing control.
- Cognitive strategies: ABC diary, rational analysis, reframing, rational cards, self-instruction, etc.

Introduce imagery exposure

- Prepare client to cope with distress.
- Begin exposure: client shares (verbally or in writing) about the trauma in steps;
  1. effects on their thinking about themselves, others and the world;
  2. the event itself;
  3. the event with their thoughts and feelings, in gradually increasing detail.

  Work at the client's pace. As exposure proceeds: ensure client uses coping skills, introduce cognitive restructuring as appropriate, reinforce any adaptive thoughts and emotions.
- Have client practice exposure as homework.

Following imagery work …

- Move to in-vivo exposure to situations the client has been avoiding.
- Extend cognitive restructuring: safe-world beliefs, vulnerability, self-blame and competence, trust, search for meaning, demand for fairness and order, anger, low-discomfort-tolerance for symptoms, intimacy. Main aim is accommodation.
- Introduce additional strategies as appropriate: thought-stopping, sleep management, anger management, problem-solving, relationship counselling, social support, medication.

Suggested reading on post-traumatic stress disorder

Professional resources

Cohen, Judith A. (2010). Practice Parameter For The Assessment And Treatment Of Children And Adolescents With Posttraumatic Stress Disorder. *J. Am. Acad. Child Adolesc. Psychiatry,* 2010; 49(4): 414 – 430. Found on the Internet 16 May 2011 at: www.aacap.org/galleries/PracticeParameters/JAACAP_PTSD_2010.pdf

Foa EB, Davidson JRT, Frances A. (1999). The Expert Consensus Guideline Series: Treatment of Posttrau40matic Stress Disorder. *J Clin Psychiatry* 1999;60 (Suppl 16).

Meichenbaum, Donald. (1997). *Treating post-traumatic stress disorder: A handbook and practice manual for therapy.* Brisbane: John Wiley.

Resick, P.A. & Schnicke, M.K. (1992). Cognitive Processing Therapy for Sexual Assault Victims. *Journal of Consulting and Clinical Psychology*, 60:5, 748-756.

Sookman, Debbie & Leahy, Robert L. (Eds.). (2009). *Treatment Resistant Anxiety Disorders: Resolving impasses to symptom remission.* Hove: Routledge.

Reading resources for clients

Froggatt, W. (2003). *FearLess: Your guide to overcoming anxiety*. Auckland: HarperCollins.