

# Posttraumatic Stress Disorder

## DESCRIPTION AND DIAGNOSIS

### Symptoms

Posttraumatic stress disorder (abbreviated PTSD in the text of this chapter) is the only diagnosis in the DSM-IV (American Psychiatric Association, 1994) that specifies an etiology. By definition, PTSD is a reaction to an extreme traumatic event. In order to qualify as “extreme,” the event must involve death, threat of death, serious physical injury, or threat to physical integrity. Typical experiences that can lead to PTSD include combat, sexual or physical assault, serious accident, human-made or natural disasters, incarceration or torture, and being diagnosed with a life-threatening illness.

PTSD has three cardinal sets of symptoms: (1) reexperiencing of the trauma (including memories, nightmares, and/or flashbacks); (2) avoidance of internal and external cues associated with the trauma (which can include feelings of numbness or detachment); and (3) increased arousal (including insomnia, irritability, impaired concentration, and hypervigilance).

### Prevalence and Life Course

Lifetime prevalence estimates for PTSD in community samples range from 1% to 14% (American Psychiatric Association, 1994). In populations that have been exposed to traumatic events, the prevalence is much higher. For example, a prevalence rate of 30% was found for Vietnam veterans in one study (Foy, 1992), while prevalence rates between 31% and 57% have been found for rape victims (Foa & Riggs, 1994).

PTSD can occur at any age. Symptoms generally appear shortly after the trauma; however, in some cases symptoms will not develop until months or even years after the event. In approximately half of cases, the symptoms spontaneously remit after 3 months (American Psychiatric Association, 1994). However, in other cases symptoms can persist, often for many years, and can cause long-term impairment in life functioning.

It is not clear why some people who are exposed to trauma develop PTSD and some do not. Some characteristics of the trauma are known to predict the likelihood and sever-

ity of symptoms. Direct exposure to the event, greater severity, longer duration, and perceived threat of death are all associated with increased risk. Premorbid factors that predict development of PTSD include a family history of mental disorder, previous psychiatric illness, personality traits of high neuroticism and poor self-confidence, early separation from parents, poverty, limited education, parental abuse, misconduct in childhood, and a prior history of trauma. Good social supports after the event can moderate the risk (Davidson, 1995).

### **Genetic/Biological Factors**

Little has been written about the role of genetic and biological factors in PTSD, probably because environmental events play a central role in the disorder. Foy (1992) has suggested that biological factors may play a mediating role in determining who develops the disorder after a traumatic event and who does not. However, he does not specify the nature of the biological factors or the mechanism involved.

### **Coexisting Conditions**

It has been estimated that between 60% and 100% of PTSD sufferers meet criteria for at least one other Axis I disorder (Litz, Penk, Gerardi, & Keane, 1992). The most common comorbid disorders are major depression and substance abuse. Other anxiety disorders are also common, including panic disorder, agoraphobia, obsessive-compulsive disorder, and social phobia (American Psychiatric Association, 1994). Psychotic disorders are less common, but can cooccur with PTSD. Axis II disorders are common, including borderline, antisocial, paranoid, obsessive-compulsive, and schizoid personality disorders.

A number of features are commonly associated with PTSD, including intense feelings of guilt, shame, disgust and/or despair; excessive anger and hostility; impaired interpersonal relationships; marital/couple distress and sexual difficulties; poor work performance; impaired affect regulation; impulsive and self-destructive behavior; and somatic complaints, such as headaches, joint pain, colitis, and respiratory problems.

### **Differential Diagnosis**

PTSD is differentiated from adjustment disorder by the severity of the traumatic event; in order for a diagnosis of PTSD to be given, the event must be extreme. Acute stress disorder is given as a diagnosis if the symptom picture resembles PTSD but the event occurred less than 4 weeks ago. If intrusive thoughts are present, they must be related to a trauma; otherwise, a diagnosis of obsessive-compulsive disorder should be considered. Similarly, intense flashbacks may at times resemble the hallucinations associated with psychotic disorders. However, as long as they are associated with a trauma, PTSD is the more likely diagnosis.

An important differential diagnosis to be made with PTSD involves malingering. This must be ruled out any time there is the possibility of gain from the disorder (e.g., a damage award or veterans' benefits). In such cases, verification of the trauma should be

obtained, most commonly from police or military records. More extensive assessment, including use of the Minnesota Multiphasic Personality Inventory (MMPI), may be appropriate. The clinical presentation may also hold some clues. If the patient tells the trauma story with eagerness or ease (as opposed to the avoidance more commonly seen), or if the trauma appears vague and nonspecific, the clinician should be alert to the possibility of malingering.

Figure 6.1 is a diagnostic flow chart that depicts the differential diagnosis of PTSD in greater detail.

## UNDERSTANDING POSTTRAUMATIC STRESS DISORDER IN COGNITIVE-BEHAVIORAL TERMS

### Behavioral Factors

The behavioral conceptualization of PTSD is based on Mowrer's (1960) two-factor theory of anxiety. According to this model, anxiety and other emotions experienced during a traumatic event become linked in the patient's mind to sights, sounds, and other sensations that occur during the event. This process is a form of classical conditioning. These sights, sounds, and other sensations thus become cues that evoke anxiety when they are experienced again later.

The range of cues that can elicit anxiety increases over time, due to two processes: (1) generalization, whereby cues that are similar to the original cue begin to evoke anxiety; and (2) higher-order conditioning, whereby a cue that was originally neutral begins to evoke anxiety because it has become associated with anxiety triggered by other cues. For example, a woman who was raped while walking home alone at night may begin to fear not only being out at night (the original cue), but also any dark place (generalization). She may also come to fear her therapist's office, where she has been discussing the rape (higher-order conditioning). It should be noted that anxiety-arousing cues can be external (places, sights, sounds) or internal (thoughts, memories, or emotional states).

The second part of the two-factor theory involves avoidance. Because cues that remind the person of the event evoke anxiety, he or she tries to avoid them. When a cue is avoided, the person's anxiety decreases. The reduction in anxiety serves as a reward that increases the likelihood of the person's avoiding the cue in the future. This is a form of operant conditioning. Thus avoidance becomes used increasingly often as a coping strategy. Because the cues that are avoided can be internal, such as thoughts or emotions, avoidance may lead to emotional numbing. Often alcohol or drugs are used as a way to avoid internal cues, and this leads to substance abuse or dependence.

### Cognitive Factors

The behavioral model provides explanations for both the reexperiencing and avoidance symptoms of PTSD. However, it has been criticized as failing to account adequately for the repeated alternation between reexperiencing and avoidance/numbing that is com-

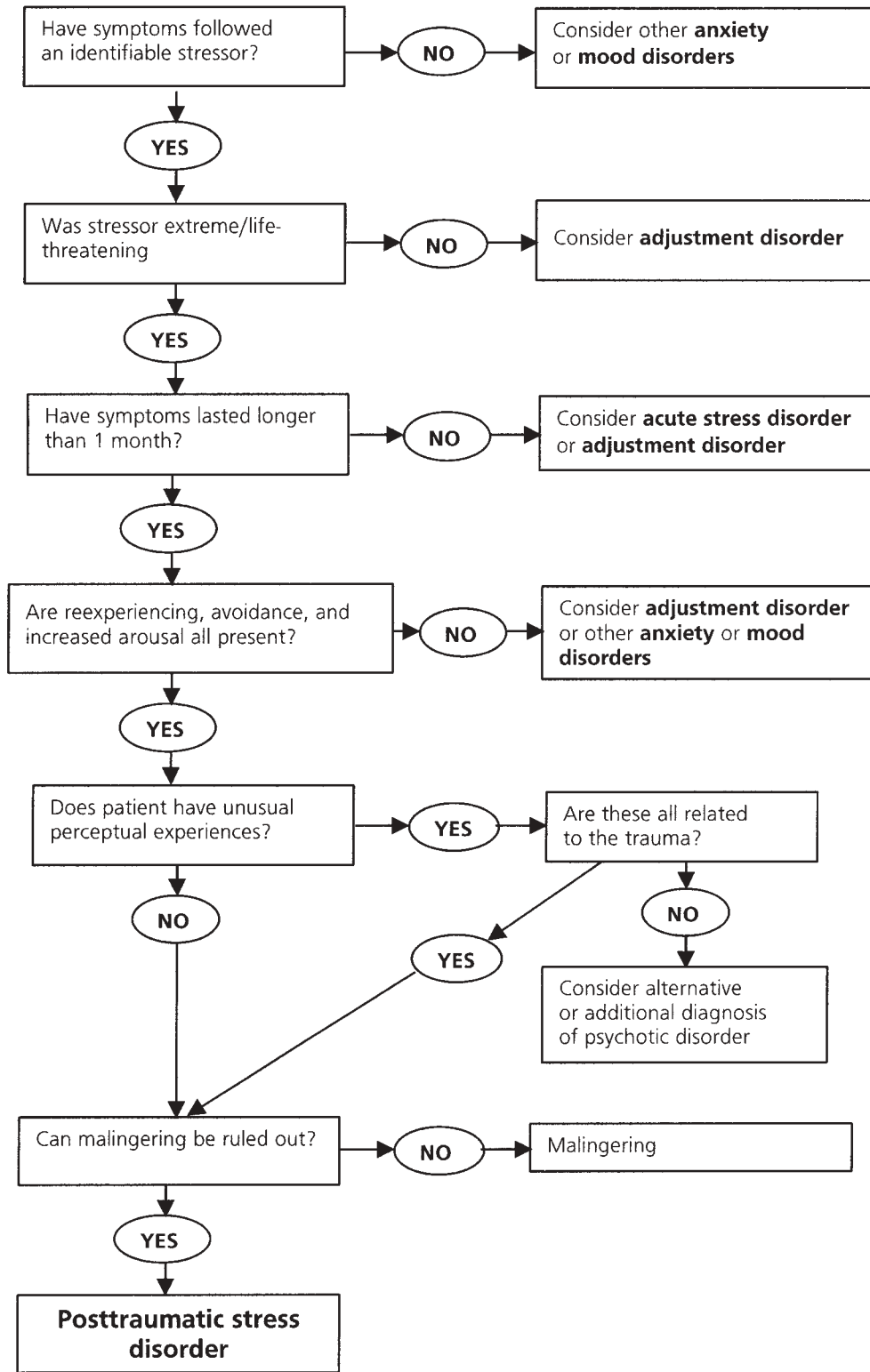


FIGURE 6.1. Diagnostic flow chart for posttraumatic stress disorder.

monly seen in the disorder, or for the persistent hyperarousal. It also fails to account for the altered sense of meaning that many PTSD patients report (Foa & Riggs, 1994).

Foa and her colleagues (Foa & Riggs, 1994; Foa, Rothbaum, & Molnar, 1995; Foa, Steketee, & Rothbaum, 1989) have proposed a cognitive model of PTSD that incorporates elements of the behavioral model. They propose that when a person experiences a trauma, a “fear structure” is formed in memory, consisting of three elements: (1) stimuli (the sights, sounds, and other sensations associated with the event); (2) responses (physiological and emotional reactions to the event); and (3) the meanings associated with the stimuli and responses. This fear structure forms a program for escaping from danger. Like the behavioral model, Foa’s model proposes that cues associated with the trauma activate the fear structure—causing reexperiencing of the memories and responses, and leading to attempts to avoid such cues.

However, Foa’s model also emphasizes the importance of the meaning element of the fear structure. Traumatic events often violate several commonly held assumptions and schemas: (1) “The world is safe,” (2) “Events are predictable and controllable,” (3) “Extreme negative events will not happen to me,” and (4) “I can cope with whatever events arise.” In keeping with Piagetian theory, Foa proposes that when an event is experienced that contradicts such basic schemas, there is a natural push to make sense of the experience. If the meanings associated with the trauma (e.g., “Dangerous events can happen without warning,” “They can happen to me,” and “I may be unable to cope”) cannot be assimilated into existing schemas, there will be a need to revise the schemas—a process referred to as “accommodation.”

What makes this cognitive processing of the trauma difficult for people with PTSD is the fact that activating the meaning element of the fear structure also activates the response element, leading the person to reexperience the intense emotional responses associated with the trauma. Since the emotions feel overwhelming, the person then tries to stop thinking about the memories. This avoidance blocks the process of assimilation and accommodation. A pattern then develops of alternating between attempts to assimilate (which lead to reexperiencing), and attempts to avoid the memories and negative emotions. According to Foa’s model, the tension between the need to find meaning and the need for avoidance leaves the person in a persistent state of hyperarousal.

Examples of the distorted automatic thoughts, maladaptive assumptions, and dysfunctional schemas found in patients with PTSD are provided in Table 6.1.

## Outcome Studies for Cognitive-Behavioral Treatments

Most of the cognitive-behavioral treatments developed for PTSD have been based on some form of exposure. Early studies typically utilized systematic desensitization, in which the patient is repeatedly exposed to brief presentations of trauma cues in imagination while undergoing relaxation. More recent studies have used prolonged exposure, in which the patient is exposed to cues (either in imagination or *in vivo*) for extended periods without using relaxation, until the anxiety response diminishes. Prolonged exposure is now believed to be more effective than systematic desensitization (Foa et al., 1995). A variant of exposure, eye movement desensitization and reprocessing (EMDR), has been introduced by Shapiro

**TABLE 6.1. Examples of the Three Types of Cognitive Distortions in Posttraumatic Stress Disorder**


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<u>Distorted automatic thoughts</u>
“What happened is my fault.”
“I should have been able to prevent it.”
“I should have been able to handle the situation.”
“I should be over this by now.”
“I am weak.”
“I can’t stand these feelings.”
“Something terrible could happen at any minute.”
“I’m in danger now.”
“I can’t let my guard down.”
“I can’t handle this situation.”
“I’m helpless.”
“You can’t trust anyone.”
“No one cares.”
“No one will be there to help me if I need it.”
 <u>Maladaptive assumptions</u> 
“Because I could not control what happened, there is no point in trying to control anything.”
“Because I could be in danger at any time, I must maintain control at all times.”
“I must always be on the alert.”
“I’ll be overwhelmed if I think about what happened.”
“It is better to avoid any potentially dangerous situation than endure risk.”
“All risk is bad.”
“I wouldn’t be able to stand another loss.”
 <u>Dysfunctional schemas</u> 
“The world is inherently unpredictable and dangerous.”
“Bad things can happen at any time.”
“You can’t trust anyone.”
“I am powerless to prevent catastrophe.”
“I am a bad person.”
“Life is meaningless.”
“The future is bleak.”

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(1989). Controversy exists regarding the mechanisms responsible for the effectiveness of EMDR and whether they differ substantially from those at work in standard imaginal exposure (Acierno, Hersen, Van Hasselt, Tremont, & Meuser, 1994).

In addition to exposure, two other cognitive-behavioral techniques have been studied for PTSD: cognitive restructuring and anxiety management training. Cognitive restructuring uses standard cognitive techniques to address the meaning element of the fear structure. Anxiety management training uses a variety of techniques, including progressive muscle relaxation, visualization, biofeedback, assertion training, thought stopping, and distraction, to help patients manage their emotional and physiological responses.

van Etten and Taylor (1998) performed a meta-analytic review of 39 studies of PTSD

treatment. They found that behavior therapy (generally including some form of exposure, and sometimes including cognitive restructuring and/or anxiety management training) and EMDR were equally effective, and that both were more effective than control conditions. Both behavior therapy and EMDR produced larger effect sizes than other forms of psychotherapy. The effectiveness of behavior therapy and EMDR was comparable to the effectiveness of SSRIs, and superior to that of other forms of medication. Patient gains were found to be well maintained at follow-up periods averaging 15 weeks after the end of treatment.

Foa and her colleagues have recently attempted to determine the relative contribution of various techniques in cognitive-behavioral treatment of PTSD. In a series of studies (Foa, Rothbaum, Riggs, & Murdock, 1991; Foa et al., 1995), they compared stress inoculation training, which includes anxiety management and cognitive restructuring; prolonged exposure; supportive counseling; a waiting-list condition; and the combination of stress inoculation training and prolonged exposure. Both cognitive-behavioral treatments were found to be superior to counseling or the waiting-list condition. Those patients who received the combination of stress inoculation training and prolonged exposure had the best outcome at follow-up.

Overall, these results support the effectiveness of cognitive-behavioral approaches for treating PTSD. It appears that a treatment combining anxiety management, cognitive restructuring, and exposure is likely to yield the best results.

## ASSESSMENT AND TREATMENT

### Rationale and Plan for Treatment

In keeping with the findings of the outcome literature, the treatment package described in this chapter combines anxiety management training, prolonged exposure, and cognitive restructuring to address the symptoms of PTSD.

Anxiety management training is used to reduce symptoms of hyperarousal and the emotional distress associated with reexperiencing. Exposure targets the symptoms of reexperiencing and avoidance. Repeated exposure to memories of the event weakens the association between the memories and the emotional reactions they evoke, so that patients are able to think about what happened to them without feeling distress. Exposure to previously avoided situations breaks the pattern of avoidance and reduces emotional responses to environmental cues. Cognitive restructuring is used to eliminate the pattern of alternating between thinking about and avoiding thinking about the trauma. It does this by altering maladaptive meanings associated with the event and helping patients either assimilate the experience into existing assumptions or modify those assumptions to accommodate the knowledge of what has happened.

Most studies of cognitive-behavioral treatment for PTSD have involved between 10 and 15 sessions lasting from 60 to 120 minutes each, scheduled once to twice a week (Marmar, Foy, Kagan, & Pynoos, 1994). Although this intensity will be required for some patients, it is not practical in many clinical settings, where 45-minute sessions have become the rule. We have attempted to address this in designing the treatment package by having a substantial portion of the imaginal exposure take place as homework. Still, it

is advisable to leave 90 minutes for at least the first, and possibly the first several, exposure sessions. Using this approach, we have found that 12 to 20 sessions, the majority of which last 45 minutes, are often sufficient for patients who have had a single trauma. Patients who have severe or chronic PTSD, who have a history of multiple traumas, or who show substantial disturbance in life functioning will frequently require longer treatment.

The treatment plan for PTSD is outlined in Table 6.2.

## Assessment

While some patients with PTSD will present for treatment describing their symptoms as a response to a specific traumatic event, many others will present complaining of anxiety, depression, substance abuse, or problems of living without revealing a history of trauma. This may be because they do not make the link between their symptoms and the event, or because they are reluctant to discuss the trauma.

### *Initial Clinical Evaluation of Trauma and Related Symptoms*

Given the high prevalence of PTSD in clinical populations, all patients, regardless of their presenting problems, should be screened for a history of trauma. Questions that can be included in standard intake interviews include the following:

- What is the most upsetting thing that ever happened to you?
- Have you ever felt your life was in danger?
- Have you ever been attacked or assaulted?
- Have you ever been physically or sexually abused?

Even when patients reveal a recent trauma, clinicians should always inquire about any history of prior trauma.

**TABLE 6.2. General Plan of Treatment for Posttraumatic Stress Disorder**

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Assessment
Initial clinical evaluation of trauma and related symptoms
Tests and other evaluations
Consideration of medication
Socialization to treatment
Anxiety management training
Exposure
Imaginal exposure to trauma memory and to related cues
<i>In vivo</i> exposure to avoided situations
Cognitive restructuring
Coping with life problems
Phasing out treatment

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Once a patient has disclosed a traumatic event, he or she should first be asked to describe the event in an open-ended manner. Even this process may be therapeutic, as it may be the first opportunity the patient has had to tell a neutral and sympathetic party about what happened.

After the patient has told his or her story, the clinician should inquire about any details of the event and its aftermath that have been omitted, including (1) physiological and emotional reactions at the time of the event; (2) choice points and actions taken before, during, and after the event; (3) meanings attached to the event, the patient's reactions, and his or her behaviors; (4) responses of others to the patient during and after the event; (5) cues that trigger memories; (6) the specific nature of reexperiencing symptoms; (7) all avoidance, including situations avoided, attempts to avoid memories/thoughts/emotions, and psychic numbing; (8) symptoms of physiological arousal (insomnia, startle responses, etc.); and (9) any difficulties in interpersonal, academic, or work functioning that have developed since the trauma. The patient's current social supports should also be assessed. The patient should be asked to list all cues that trigger memories on the Patient's Trauma Trigger Record (Form 6.1). This can be used either to list cues that have triggered memories in the past, or as a log to record any triggers and intrusive memories experienced between sessions.

Patients who have been diagnosed with PTSD should also be evaluated for comorbid conditions, including depression and other anxiety disorders. If the patient is so depressed that he or she is suicidal or cannot actively participate in therapy, the depression must be treated before treatment for PTSD is undertaken.

Any legal or financial issues related to the PTSD should be explored, and malingering should be ruled out. Inquiry should be made regarding the patient's premorbid level of functioning, including strengths and weaknesses, as well as developmental history. If the trauma included head injury, possible cognitive deficits need to be assessed.

### *Tests and Other Evaluations*

Self-report questionnaires can be useful for assessing patients with PTSD. The Posttraumatic Stress Questionnaire (PTSQ) for Patients, which we have developed, allows patients to rate the degree to which they are bothered by common PTSD symptoms. This scale is shown in Form 6.2. Noting the degree of distress for each symptom can help in making a diagnosis. Totalling the items of the PTSQ yields a total score, which can be used to evaluate progress when the scale is readministered during therapy.

Another self-report measure is the Crime-Related Post-Traumatic Stress Disorder Scale (CR-PTSD), developed by Saunders, Arata, and Kilpatrick (1990) and based on 28 items selected from the SCL-90-R (Derogatis, 1977). The 28 items are as follows: 3, 12, 13, 14, 17, 18, 23, 24, 28, 38, 39, 41, 44, 45, 51, 54, 56, 59, 66, 68, 70, 79, 80, 81, 82, 84, 86, and 89. The authors recommend that the entire SCL-90-R be administered, rather than just these 28 items. The CR-PTSD score is then calculated by averaging the scores for each of the 28 items. A cutoff score of 0.89 was found to maximize correct classification. Because this scale was validated on samples of female sexual assault victims, it may not be as successful in classifying victims of other types of traumas.

## FORM 6.1. Patient's Trauma Trigger Record

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Patient's Name: \_\_\_\_\_ Week: \_\_\_\_\_

*Instructions:* Please list any sensations, places, or situations that evoke traumatic memories, or that you avoid out of fear they might evoke memories. In the second column, write the memory or sensation that you get when you are in contact with the trigger. In the third column, note whether the trigger is something you avoid. Finally, note how much distress you feel (or would feel) when you encounter the trigger, from 0 (no distress) to 10 (maximum distress).

Trigger	Memory or Sensation	Avoided? (Yes/No)	Distress (0-10)

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## FORM 6.2. Posttraumatic Stress Questionnaire (PTSQ) for Patients

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Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Listed below are symptoms people often have after experiencing a traumatic event or events. Please check how much you have been bothered by each symptom in the past month.

Symptom	None (0)	A little (1)	Moder- ately (2)	A lot (3)
Upsetting memories about what happened.	_____	_____	_____	_____
Nightmares about the event(s).	_____	_____	_____	_____
Feeling like you are living the event(s) all over again (flashbacks).	_____	_____	_____	_____
Anxiety or distress when you see or hear things that remind you of the event(s).	_____	_____	_____	_____
Avoiding things that remind you of the event(s).	_____	_____	_____	_____
Lack of interest in work and/or leisure activities.	_____	_____	_____	_____
Difficulty feeling close to other people.	_____	_____	_____	_____
Feeling emotionally numb.	_____	_____	_____	_____
Feeling unable to imagine the future.	_____	_____	_____	_____
Difficulty sleeping.	_____	_____	_____	_____
Feeling irritable or angry.	_____	_____	_____	_____
Finding it hard to concentrate.	_____	_____	_____	_____
Feeling on edge or unable to relax.	_____	_____	_____	_____

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In addition to the PTSQ and SCL-90-R patients should be given other measures from the standard intake battery described in earlier chapters (the BAI, BDI, GAF, SCID-II, and Locke–Wallace) and perhaps other anxiety questionnaires (the ADIS-R, the Fear Questionnaire, etc.), as appropriate. Form 6.3 provides space for recording scores on the standard intake battery and other questionnaires. It also enables the therapist to record a patient's medication, alcohol, and other drug use (it should be emphasized that any substance abuse or dependence must be treated before treatment of PTSD can be undertaken); to record (at intake only) the history of any previous traumatic episodes or other anxiety episodes; to note (on later evaluations) which situations are now avoided and which the patient can now approach; and to indicate treatment recommendations.

### *Consideration of Medication*

Medication is considered an adjunctive rather than a primary treatment for PTSD. It is generally recognized that some form of psychotherapy is necessary in treating the disorder (Marmar et al., 1994; Peterson, Prout, & Schwarz, 1991). However, in cases of severe or chronic PTSD, medication may provide enough symptom relief to allow patients to participate in therapy. In addition, medication can be helpful in treating comorbid conditions and related features of the disorder, such as depression, substance abuse, rage, and impulsivity (Friedman & Southwick, 1995).

There have been case reports involving almost every class of psychotropic drugs in the treatment of PTSD, including antidepressants, benzodiazepines, mood stabilizers, and neuroleptics. van Etten and Taylor (1998), in their meta-analysis of controlled studies, found that the SSRIs were more effective than other forms of medication. The mood stabilizer carbamazepine was found to be as effective as the SSRIs in one study. Benzodiazepines were not found to be very effective, which is notable because these medications have been widely prescribed for PTSD in the past. No data are available for the effectiveness of medication after discontinuation.

### **Socialization to Treatment**

Once a diagnosis is established, the patients should be educated regarding PTSD, the rationale for treatment, and treatment options (including medication). This often has a therapeutic effect, as it may be the first time many patients have had a way to understand their symptoms and may allay fears that they are “going crazy.” Discussing the rationale for treatment and getting a patient's specific consent before proceeding will also help build and maintain motivation for the treatment phase. Form 6.4 is an educational handout about PTSD that can be given to patients. The handout about cognitive-behavioral therapy in general (Form B.1 in Appendix B) can also be used.

### **Anxiety Management Training**

The goal of anxiety management training is to provide patients with ways to cope with their heightened arousal and other emotional and physiological reactions to reex-

**FORM 6.3. Further Evaluation of Posttraumatic Stress Disorder:  
Test Scores, Substance Use, History, Treatment Progress,  
and Recommendations**

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Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Therapist's Name: \_\_\_\_\_ Sessions Completed: \_\_\_\_\_

**Test data/scores**

Beck Depression Inventory (BDI) \_\_\_\_\_

Beck Anxiety Inventory (BAI) \_\_\_\_\_

Global Assessment of Functioning (GAF) \_\_\_\_\_

Crime-Related Post-Traumatic Stress Disorder Scale (CR-PTSD) \_\_\_\_\_

Other Symptom Checklist 90—Revised (SCL-90-R) scales \_\_\_\_\_

Structured Clinical Interview for DSM-III-R, Axis II (SCID-II) \_\_\_\_\_

Locke–Wallace Marital Adjustment Test \_\_\_\_\_

Anxiety Disorders Interview Schedule—Revised (ADIS-R) \_\_\_\_\_

Other anxiety questionnaires (specify): \_\_\_\_\_

**Substance use**

Current use of psychiatric medications (include dosage) \_\_\_\_\_

Who prescribes? \_\_\_\_\_

Use of alcohol/other drugs (kind, frequency, amount, consequences) \_\_\_\_\_

**History (intake only)**

Previous traumatic episodes (specify nature):

Onset	Duration	Precipitating events	Treatment
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Previous episodes of other anxiety (specify nature):

Onset	Duration	Precipitating events	Treatment
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***Treatment progress (later evaluations only)***

Situations still avoided: \_\_\_\_\_

\_\_\_\_\_

Situations approached that were previously avoided: \_\_\_\_\_

\_\_\_\_\_

***Recommendations***

Medication evaluation or reevaluation:

Increased intensity of services:

Behavioral interventions:

Cognitive interventions:

Interpersonal interventions:

Marital/couple therapy:

Other:

\_\_\_\_\_

## FORM 6.4. Information for Patients about Posttraumatic Stress Disorder

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### What Is Posttraumatic Stress Disorder?

Posttraumatic stress disorder (or PTSD) is a common reaction to very stressful or traumatic events. Many different kinds of events can lead to PTSD, including being in a car accident; being raped or being the victim of another crime; being physically or sexually abused; living through a disaster such as a flood or a bombing; or seeing someone else die.

People with PTSD have three main types of problems or symptoms:

1. **Reliving the trauma.** This can include memories that seem out of control, nightmares, and flashbacks that make people feel as if they are living the event all over again. Memories often come back when something people see or hear reminds them of the event.
2. **Avoiding.** Because it is upsetting to remember what happened, people with PTSD try not to think about it. They also stay away from people, places, or things that bring back memories. Often they feel numb or detached from other people. Some turn to alcohol or drugs to dull the pain.
3. **Signs of physical stress.** These can include trouble sleeping, feeling irritable or angry all the time, trouble concentrating, and feeling tense or on guard.

### What Causes Posttraumatic Stress Disorder?

When people live through a trauma, the memories of what happened get connected in their minds with what they saw, heard, smelled, or felt at the time. Later a similar sight, sound, smell, or other feeling can bring the memories and emotions flooding back.

A second reason why the memories come back is that people have a need to make sense of what happened. Traumatic events often make people question things they once believed—for example, that the world is basically safe or that bad things won't happen to them. To understand the trauma, they have to think about it. But thinking about it brings the memories and feelings back. So they try not to think about it. Instead of finding understanding and peace, people often end up going back and forth between remembering and trying to forget.

### How Does Posttraumatic Stress Disorder Develop?

Most people begin to have symptoms of PTSD shortly after the trauma. For about half of these people, the symptoms get better on their own within 3 months. For others, the symptoms can last for years. Some people don't start to have symptoms until many years after the event.

### How Does Cognitive-Behavioral Therapy for Posttraumatic Stress Disorder Help?

There are three steps in cognitive-behavioral therapy for PTSD. First, your therapist will teach you ways to cope with the feelings and tension that come with the memories. These include ways to relax your body and to take your mind off the pain.

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Second, your therapist will help you face the memories. He or she will guide you in retelling the story of what happened. The more you do this, the less upsetting the memories will become, and the more you will be able to find a sense of peace.

Finally, your therapist will teach you ways to change negative thinking and handle problems in your life.

A number of studies have found that cognitive-behavioral therapy helps people with PTSD feel better. These studies have included combat veterans as well as victims of rape, assault, and other traumas.

### **How Long Does Therapy Last?**

How long treatment for PTSD lasts depends on how many traumas you suffered and how severe they were, how bad your symptoms are now, and how many other problems you are having in your life. For people who have been through a single traumatic event, 12 to 20 sessions are usually enough. Most of these sessions will be 45 to 50 minutes long, but a few may be as long as 90 minutes.

### **Can Medications Help?**

Drugs by themselves are usually not enough for treating PTSD. However, they can be helpful for some people when combined with therapy. Your physician or a psychiatrist can suggest which medication might be best for you.

### **What Is Expected of You as a Patient?**

It is best not to start treatment for PTSD if you are currently abusing drugs or alcohol or have a major crisis in your life. Your therapist can help you deal with these problems first, and then can help you begin working on your PTSD symptoms. Other than that, all you need to do is to be willing to try therapy and to spend some time each week practicing the things you learn.

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periencing the trauma. This provides a degree of immediate relief for their distress, increases their sense of self-efficacy, and helps them tolerate the arousal necessary for exposure and the emotional processing of the trauma. Although a number of techniques are useful, we most commonly use the following: (1) breathing relaxation, (2) progressive muscle relaxation, (3) visualization, (4) thought stopping, and (5) distraction. The procedures for these techniques are described in detail in Appendix A and in the CD-ROM that accompanies this book. Each patient is taught all of the anxiety management techniques and is asked to practice them as homework before exposure is initiated.

## Exposure

There are three primary targets for exposure: (1) the memory of the trauma; (2) other internal and external cues that trigger anxiety and reexperiencing; and (3) situations that are avoided. Of these, exposure to the memory of the trauma is the most important. Note, however, that before exposure work begins, any therapy-interfering behaviors need to be addressed. See the “Coping with Life Problems” section later in this chapter.

### *Imaginal Exposure to the Trauma Memory and to Related Cues*

Exposure to the trauma memory is initiated in the therapist’s office. The first exposure session should be scheduled for 90 minutes in order to allow enough time for habituation to occur. The patient is asked to relax in a comfortable position with eyes closed and to tell the story of the trauma while attempting to visualize it in his or her mind. This procedure is tape-recorded. The therapist functions as a guide and asks questions, which serve two main functions: (1) to focus the patient on details (such as specific sights, sounds, smells, and other sensory experiences, as well as emotions and internal physical sensations) in order to help fully activate the memory; and (2) to ensure that all significant details of the story are included and nothing is avoided. Periodically during the retelling of the story, the patient is asked to rate the distress he or she is feeling on a scale from 0 to 10. The therapist explains that these are called “subjective units of distress” or “SUDs” ratings.

The second step in the exposure session is to have the patient listen to the tape recording of the story, again closing his or her eyes and attempting to “relive” the experience. During this process, the patient again gives SUDs ratings. The patient listens to the tape repeatedly until the SUDs ratings begin to decrease. Ideally, exposure should continue until the SUDs ratings have decreased by at least half. When the trauma is complex or involves multiple events, it may be necessary to break the story into segments, and to devote several sessions to the telling of the whole story.

It is crucial that exposure not be terminated until the patient has experienced some decrease in anxiety. This is important for two reasons. First, terminating exposure while the patient is highly distressed will only serve to strengthen the association between the memory and the emotional distress. Second, the first time a patient experiences a reduction in distress during exposure is usually a very powerful experience. It contradicts the

patient's belief that focusing on memories will make him or her feel even more anxious, and it provides motivation to continue exposure work.

Once the patient has habituated to the tape of the trauma story in the therapist's office, he or she is assigned to continue listening to the tape as homework. The patient is instructed to set aside at least 45 minutes each day for this purpose, and to listen to the tape repeatedly until the SUDs score for that day is reduced by half. The results of practice sessions (either in the office or as homework) should be recorded on the Patient's Imaginal Exposure Practice Record (Form A.1 in Appendix A).

After the initial session, if the patient is able to do the exposure homework successfully, it may be possible to shorten the exposure sessions to 45 minutes and have most of the work of habituation done through listening to the tape as homework. In addition to retelling the story, exposure to trauma memories may be accomplished by having the patient write about the trauma or draw or paint images from the trauma.

Patients who have anxiety reactions to specific cues can be exposed to these during sessions. For example, a patient who has been in an automobile accident and has developed a startle reaction to loud noises can be repeatedly presented with loud noises in the therapist's office, until he or she habituates to them and the anxiety decreases.

### ***In Vivo Exposure to Avoided Situations***

Once the patient has completed exposure work to the trauma memory, *in vivo* exposure should be undertaken for any avoided situations. For example, a patient who has avoided driving on limited-access highways since experiencing an automobile accident can be assigned to begin driving again. *In vivo* exposure can generally be done as homework without the therapist present. However, in cases where the patient is extremely anxious, it may be necessary to have another person (such as a supportive family member) present during early exposure trials. When the PTSD has been chronic, the patient may have developed extensive avoidance. In such cases it will be helpful to develop a hierarchy of feared situations, ranked from least to most anxiety-producing and to have the patient work slowly up the hierarchy. A more complete description of exposure procedures can be found in Appendix A; *in vivo* exposure practice should be recorded on Form A.2 in Appendix A.

### **Cognitive Restructuring**

Cognitive restructuring in PTSD targets the patient's distorted automatic thoughts, maladaptive assumptions, and dysfunctional schemas associated with the trauma. The most common categories of distorted automatic thoughts in PTSD are overgeneralization, all-or-nothing thinking, and personalization. These reflect underlying assumptions about how things "must" or "should" be, and even deeper-seated schemas about the nature of the self and others. In other words, faced with a traumatic event that contradicts commonly held assumptions about the safety of the world, the predictability and controllability of events, and the ability of the self to cope, people who develop PTSD tend to go to the opposite extreme—seeing everything and everyone as dangerous, unpredictable,

and malevolent, and themselves as weak and incompetent. It should be noted that people who have had multiple prior traumas may have already developed extremely negative assumptions and schemas. In such cases, the most recent trauma may have served to strengthen existing negative assumptions and schemas, rather than to contradict positive ones.

The goal of cognitive restructuring for PTSD is to return the patient to a more balanced view, in which the world is seen as safe within limits, events are seen as generally predictable and controllable, and the self is seen as competent to cope with most situations, while at the same time there is acknowledgment of the existential reality that sudden, unpredictable, and extreme negative events, including death, can and do happen. Table 6.3 lists some techniques that may be helpful in addressing typical cognitive distortions in PTSD. (Many of these techniques are among the cognitive techniques listed in Table B.3 of Appendix B, but some are behavioral in nature.)

It should be noted that exposure alone will often lead to cognitive change. This is because exposure reduces the anxiety and avoidance associated with the trauma memories and allows the natural process of assimilation and accommodation to take place.

### **Coping with Life Problems**

People who present with PTSD often have problems of living that are related to the trauma. Depending on the severity of the trauma, the chronicity of the PTSD, and personality factors, these problems can range from relatively mild to complex and highly disruptive. In addition, the type of life problems faced varies with the type of traumatic event. The issues faced by a woman who has been raped are likely to be different from those faced by a male combat veteran.

In general, any problem that has the potential to interfere with therapy needs to be addressed before exposure work can begin. For instance, substance abuse or dependence must be treated first, and the patient must have established a period of sobriety before undergoing treatment for PTSD symptoms. In addition, the patient must have a stable living situation and be in good physical health. For some patients, this means that substantial therapeutic work must be done before beginning PTSD treatment.

For many patients, however, this phase of therapy can be done after exposure has been completed. The full range of cognitive-behavioral techniques can be brought to bear on these life problems, including cognitive restructuring, exposure, and skills training. It may be helpful to include a patient's spouse or significant other in some sessions. Interventions that help the patient locate and/or utilize social supports may be particularly important. In some cases, the therapist may need to act as an advocate on the patient's behalf.

### **Troubleshooting Problems in Therapy**

Several problems commonly arise when exposure-based treatment for PTSD is employed. These are described below, with recommendations for how to deal with each one.

**TABLE 6.3. Examples of Techniques for Addressing Trauma-Related Cognitive Distortions**

Target belief	Techniques
“The world is dangerous.”	<ol style="list-style-type: none"> <li>1. Calculating probabilities of specific events.</li> <li>2. Listing advantages/disadvantages of world view.</li> <li>3. Doing a cost–benefit analysis of specific vigilance and avoidance behaviors.</li> <li>4. Identifying reasonable precautions.</li> </ol>
“Events are unpredictable and uncontrollable.”	<ol style="list-style-type: none"> <li>1. Listing advantages/disadvantages of belief.</li> <li>2. Listing all areas of life in which patient has some control, and rating degree of control for each.</li> <li>3. Doing a cost–benefit analysis of specific efforts at prediction/control.</li> <li>4. Keeping a daily log of behaviors that produce predicted outcomes.</li> <li>5. Engaging in behaviors with high probability of predictable outcome.</li> <li>6. Accepting that some events are unpredictable.</li> </ol>
“What happened was my fault.”	<ol style="list-style-type: none"> <li>1. Examining knowledge and choices available to patient at the time. Were any better choices actually available? Could patient reasonably have predicted outcomes?</li> <li>2. Using double-standard technique: “Would you blame a friend in a similar situation?”</li> <li>3. Constructing a “pie chart” assigning responsibility for event to all relevant parties.</li> <li>4. Examining societal biases (e.g., men are sent to war, then blamed for killing; women are urged to look “sexy,” then blamed for being raped).</li> <li>5. Practicing self-forgiveness—all humans make mistakes.</li> </ol>
“I am incompetent.”	<ol style="list-style-type: none"> <li>1. Examining evidence for competence in daily life.</li> <li>2. Examining unreasonable expectation of competence in extreme and unusual circumstances.</li> <li>3. Keeping a daily log of competent coping.</li> <li>4. Using graded task assignment (see Appendix A).</li> </ol>
“Other people cannot be trusted.”	<ol style="list-style-type: none"> <li>1. Listing known persons who are trustworthy, and listing specific ways in which each can be trusted.</li> <li>2. Rating people on a continuum of trustworthiness.</li> <li>3. Examining patient’s history of relationship choices. Are better alternatives available?</li> <li>4. Carrying out behavioral experiments that involve trusting others in small ways.</li> <li>5. Keeping a daily log of people who honor commitments.</li> </ol>
“Life is meaningless.”	<ol style="list-style-type: none"> <li>1. Listing activities that formerly were rewarding (see Appendix A).</li> <li>2. Scheduling pleasurable/rewarding activities (see Appendix A).</li> <li>3. Recognizing feelings of loss as a way of confirming meaning.</li> <li>4. Examining which goals and activities no longer seem meaningful and which now appear more important.</li> <li>5. Working toward an acceptance of death.</li> <li>6. Finding meaning in each day.</li> </ol>

### ***Resistance to Doing Exposure Work***

The patient's beliefs about doing exposure should be elicited. Usually they involve fear that the anxiety will be overwhelming and unbearable, that it will go on forever, and/or that exposure will not work. The patient's understanding of the rationale for exposure should be reviewed. The patient can be asked this question: "If you were to tell the story 10 times in a row, how upset do you think you would feel by the tenth telling? How upset by the 100th? How upset by the 1,000th?" Most patients are able to see that eventually they would become "bored" and their anxiety would decrease. Patients can also be told of the experience of others who have been through exposure. Finally, a therapist and patient can contract to start the exposure work with some portion of the story or other cue that evokes less than maximum anxiety, so that the patient can experience habituation.

### ***Failure to Become Anxious during Exposure***

The most common causes for failure to become anxious during exposure are as follows: (1) The patient is distracting himself or herself from the anxiety-provoking cues; and (2) the cues being used in the exposure are not the ones that actually trigger anxiety.

The patient should first be asked about anything he or she is doing to attempt to reduce anxiety during exposure. The need to experience anxiety temporarily in order to get better should be emphasized, and the patient should be asked to focus his or her full attention on the exposure task. If the patient continues to experience minimal anxiety, other cues should be tried.

### ***Becoming Overwhelmed with Anxiety during Exposure***

As patients tell the trauma story, they usually move from cues that evoke mild to moderate anxiety to cues that evoke maximal anxiety. If a patient begins to feel overwhelmed during the exposure session, it is advisable to return to an earlier part of the story and allow the patient to habituate to that part before continuing with the most difficult cues. In general, if the patient's SUDs rating reaches 7 or 8, it is a good idea to allow some habituation to take place before proceeding. It may be necessary in some cases to have the patient employ anxiety management skills (e.g., distraction or relaxation) before resuming exposure. It is not advisable to terminate exposure while the patient is in a high state of anxiety, as this will strengthen rather than weaken the connection between the cues and the patient's emotional reaction. In such a case, it may be necessary to meet more than once a week during the initial phase of exposure, in order to help the patient cope with the strong emotions elicited.

### ***Failure to Habituate***

The most common reason for failure to habituate is that exposure has not continued long enough. Some patients will require an hour or more before habituating. Patients

who complain of failure to habituate during homework are usually making their exposure sessions too short. An alternative explanation is that the patients are distracting themselves during exposure, thereby preventing habituation.

### *Noncompliance with Homework*

Patients who do not complete homework assignments should be asked what kept them from doing the homework. Simple explanations, such as lack of time, should be explored first. In such a case, a therapist can work with a patient in the session to schedule time for exposure homework during the following week. If this fails, motivational factors should be explored. Further in-session exposure may be needed in order for the patient to experience sufficient habituation to feel motivated to continue on his or her own. Advantages and disadvantages of doing exposure homework can be reviewed. Finally, the possibility of resistance from one or more members of the patient's social support system, or of secondary gains from the patient's symptoms, should be considered.

## CASE EXAMPLE

The following example is based on a composite of cases.

### Sessions 1–2

*Presenting problem* Ralph was a 25-year-old single white male. He lived with his divorced mother and worked as a salesman. When asked what brought him in for treatment, he replied, "Death."

*Trauma history* Ralph reported that 3 years earlier he had been in an automobile accident in which his girlfriend of 5 years, Sara, was killed. They had spent the day at the beach and waited until late evening to drive home in order to avoid traffic. Although they'd both had three or four beers during the day, Ralph denied that either of them had been drunk. Because Ralph was feeling sleepy, Sara had volunteered to drive. Ralph had no memory of what happened next, except that he knew from later reports that their car left the road and struck a tree. Sara was thrown from the car and killed instantly. Ralph sustained a broken leg. Ralph's only memories of the accident were of looking up and seeing Sara's body, and of himself being carried on a stretcher to the ambulance. Ralph was kept overnight in the hospital and released the next day. While he was in the hospital, he was informed of Sara's death. Ralph attended Sara's funeral and recalled being shocked at the sight of her body in the casket.

*Symptoms and impairment* After the accident, Ralph became depressed and started drinking daily. He had previously been considered a good worker,

but his work attendance and performance became erratic, and he was fired from two jobs. He also withdrew from friends and did not date. This pattern continued for 2 years. Eight months prior to intake, Ralph was threatened with being fired again and decided to seek help. He underwent a brief hospital detoxification and began attending Alcoholics Anonymous (AA) meetings. He also resumed going to church. He stayed sober until shortly before the intake and maintained stable employment during that time. However, he continued to be socially isolated.

A few weeks before the initial session, Ralph learned that a cousin, Kate, to whom he had been close as a child, was in the hospital with AIDS complications. Ralph reacted by becoming depressed and resuming his drinking. He went on a 4-day “bender,” missing several days of work. It was this event that prompted him to seek treatment.

*Current symptoms*

When asked how the accident affected him now, Ralph reported that he had nightmares about it and that he still thought about Sara “constantly.” He did not want to date, because “It’s not worth the trouble to get involved and have to go through hell like that again.” He also reported that he was unable to go to hospitals to visit sick relatives or friends, and that he avoided funerals. He reported difficulty sleeping, was often irritable, and frequently got into conflicts at work. Ralph reported automatic thoughts such as the following: “If I get close to someone else, they’ll die on me,” “If I have to say goodbye to people, I will have a nervous breakdown,” “Everything is a waste,” and “Why is the world so cruel?” Ralph also felt responsible for Sara’s death because he had asked her to drive that night.

*Automatic thoughts*

*Socialization to treatment*

The therapist told Ralph that his symptoms were common for someone who had been in an accident and had seen someone die. Ralph was given assessment forms to complete—the Patient’s Trauma Trigger Record (Form 6.1), the PTSQ (Form 6.2), and the standard intake battery (see Form 6.3)—as well as information handouts about PTSD (Form 6.4) and cognitive-behavioral therapy (Form B.1). He was assigned to write his goals for therapy as homework.

*Assessment and homework*

### Session 3

*Goals*

Ralph brought in the following goals: (1) being able to go to hospitals and funerals, and (2) staying sober. Ralph’s assessment forms, combined with the clinical interview, indicated that he met criteria for major depression and alcohol dependence in addition to PTSD. He denied any thoughts of killing himself, but did say,

*Assessment results*

*Comorbid conditions*

*Coping with life problems*

*Developmental history*

*Further socialization to treatment*

*Homework*

“I’ll be glad when I’m dead.” The therapist explained that treatment could not proceed if Ralph resumed drinking. He agreed to remain abstinent and to attend AA meetings. At Ralph’s request, the therapist called his boss to confirm that Ralph was undergoing treatment, which was a condition of his return to work.

When asked about his family history, Ralph reported that his parents had separated when he was 8. His father had moved to another state and had since been largely uninvolved in Ralph’s life. Ralph’s mother had not remarried. She worked two jobs to support Ralph and his younger brother as they were growing up, and consequently she was often emotionally unavailable. Although Ralph was a poor student, he completed high school. He reported no prior history of trauma. He reported a history of heavy weekend drinking in high school, but denied having had any serious problems with alcohol prior to the accident.

The therapist and Ralph then further discussed the cognitive-behavioral model of PTSD and the nature of the treatment. Ralph agreed to proceed. He reported that just talking about the accident felt good, because he had never talked to anyone about it before. For homework, Ralph was asked to list any cues that triggered memories of the accident. He quickly replied, “Just hospitals, funerals, and driving.” He was asked to notice anything else that triggered memories in the coming week and write it down, again using the Patient’s Trauma Trigger Record (Form 6.1).

## Sessions 4–6

*Reward planning/ activity scheduling*

*Rational responding to automatic thoughts*

*Anxiety management training*

*Cognitive restructuring*

The main tasks in the fourth through sixth sessions were anxiety management training and preparing Ralph for exposure. First, however, Ralph was asked what activities he found relaxing or pleasurable. He listed taking walks, working in his mother’s garden, and calling old friends. He was assigned as homework to engage in these activities. When Ralph was asked what might keep him from reaching out to friends, he reported these automatic thoughts: “I am going to say something stupid,” and “Everyone is too busy.” These thoughts were used to teach Ralph rational responding.

Next Ralph was taught several anxiety management skills, including breathing relaxation, progressive muscle relaxation, thought stopping, and distraction. He was assigned to practice these between sessions.

In the sixth session, Ralph’s guilt about the accident was discussed. Using Socratic dialogue, the therapist helped Ralph see



that the choice to have Sara drive was a rational one at the time. Because of his fatigue, it might not have been safe for him to drive. Sara had said she felt “OK” to drive. In fact, each of them had often driven while the other one slept. Finally, since the cause of the accident had never been determined, there was no way to know whether Ralph could have prevented it had he been driving.

By the end of the sixth session, Ralph reported feeling somewhat better. He found the progressive muscle relaxation particularly helpful, and his sleep had improved. He was more active and felt less depressed.

*Planning exposure*

Ralph had not been able to add any triggers to his original list of funerals, hospitals, and driving. Because he expressed anxiety about exposure, the therapist agreed to begin with something other than the actual memory of the accident. Ralph’s cousin Kate was out of the hospital and reportedly doing better, so it was decided to start with an imaginary scenario in which he visited Kate in the hospital. The next meeting, which would be the first exposure session, was scheduled for 90 minutes.

## Session 7

*Imaginal exposure*

After briefly explaining the exposure procedure, the therapist narrated an imaginary scenario for Ralph that included his arriving at the hospital, seeing other patients, seeing Kate, and then learning she had only a few weeks to live. Periodically throughout the scenario, Ralph was asked to describe what he was seeing, hearing, and feeling. All of this was tape-recorded.

During the initial exposure, Ralph’s SUDs rating rose to 8. However, after he listened twice to the scenario played back on tape, his SUDs level dropped to 5. Ralph was pleased with this reduction in distress. He was assigned to listen to the tape daily as homework.

*Homework*

## Sessions 8–11

*Further imaginal exposure*

In the eighth session, Ralph reported that he had listened to the exposure tape several times and that his SUDs ratings had continued to decrease. Another imaginal exposure scenario was done, this time of Ralph’s attending a funeral. Ralph’s SUDs rating peaked at 7 and decreased minimally after he listened to the tape one time. Although the session was only scheduled for 45 minutes, Ralph was offered the option of continuing in order to have time to habituate. He declined and said he would rather work on the tape at home.

*Imaginal exposure to the accident*

The ninth session was scheduled for 90 minutes, in order to do exposure to the memory of the accident and Sara's funeral. Ralph told the story in detail, with prompting by the therapist, and then listened to the tape several times. His maximum SUDs ratings declined from 8 to 4. At the end of the session, he commented:

*Cognitive effects of exposure*

"It doesn't feel as depressing. I still love her and would like to have her back. But I don't feel angry or too much alone. . . . I feel kind of rested. Like I've been carrying a lot of weight alone and I just put it down."

Ralph then expressed some fears about letting go of Sara, including that if he got married to someone else he wouldn't get to see her in heaven. He finally concluded, "I would like to put her down for a while. I don't want to lose her either. I guess I already did."

*Further exposure to the accident*

The 10th session was again scheduled for 45 minutes. Ralph said that he had listened to the memory tape only twice. After he listened to the tape once more in the session, he reported that he had begun to recall some additional details about the accident. He continued to express ambivalence about letting go of Sara emotionally, but indicated that he was beginning to imagine what it would be like to date again. He was assigned to listen to the tape daily.

*Coping with life problems**Homework*

In the next session, Ralph reported that listening to the tape of the accident was "like a rerun now. Like I went to a movie and someone died. I feel sad, but not really upset." He reported a dream in which he met an attractive girl and started going out with her. He said he had been thinking more about dating someone else, and was starting to accept the idea. He also reported spending more time with friends. When the therapist commented that it sounded as though he was handling the pain of his loss, Ralph replied, "Everyone else does it. I know I can, too." Ralph also reported that Kate was back in the hospital. He was assigned as homework to go visit her.

*Homework***Sessions 12–13***Coping with life problems*

In the 12th session, Ralph reported that he had not been able to see Kate because her condition had worsened and she was no longer allowed to have visitors. He reported that he thought he would be able to handle going to her funeral. He commented, "I can't believe I wasted all this time and missed seeing her. Now I'll be in a hurry to do everything so I can catch up." He also re-

*Phasing out treatment*

ported that he met a woman while bicycling with friends. He had asked her out, but she already had a boyfriend.

Ralph said that he was feeling much better and wanted to meet with the therapist less often. His negative automatic thoughts and other cognitive distortions associated with the accident had, in large part, spontaneously changed during exposure. Ralph was making progress in resuming his social life and had continued to be abstinent from alcohol. The therapist recommended meeting in 2 weeks.

*Coping with life problems*

In the next session, Ralph reported that Kate had died and that he had attended her funeral with no difficulty. He had been glad to see many family members there whom he had not seen in some time. He had also gone bicycling again with the woman he met several weeks earlier. In the session he talked about future plans, including traveling, buying a house, and eventually getting married. Since he was continuing to do well, Ralph and the therapist agreed to wait a month before meeting again.

**Session 14***Phasing out treatment*

In the final session, Ralph reported that he was feeling good and had no desire to drink. He had continued to attend AA meetings and church. He also said that he hardly ever thought about Sara. Although he was not yet dating anyone, he was socially active and meeting women he found attractive. He felt he had met his goals for therapy. The therapist had Ralph review which techniques he had found helpful and what he would do if he found himself under stress in the future. The therapist reminded Ralph that he could always contact him if he had further problems, and therapy was terminated.

## DETAILED TREATMENT PLAN FOR POSTTRAUMATIC STRESS DISORDER

**Treatment Reports**

Tables 6.4 and 6.5 are designed to help you in writing managed care treatment reports for patients with PTSD. Table 6.4 shows sample specific symptoms; select the symptoms that are appropriate for your patient. (See Zuckerman's [1995] *Clinician's Thesaurus* for other suitable words and phrases.) Be sure also to specify the nature of the patient's impairments, including any dysfunction in academic, work, family, or social functioning. Table 6.5 lists sample goals and matching interventions. Again, select those that are appropriate for the patient.

**TABLE 6.4. Sample Symptoms for Posttraumatic Stress Disorder**


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Specify traumatic event(s)
Intrusive memories
Nightmares
Flashbacks
Intense distress when exposed to memories or cues
Avoidance (specify what is avoided)
Inability to recall parts of the trauma
Withdrawal from usual activities (specify)
Detachment
Emotional numbness
Restricted affect
Inability to imagine the future
Insomnia
Irritability
Anger outbursts
Impaired concentration
Hypervigilance
Startle response

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**TABLE 6.5. Sample Treatment Goals and Interventions for Posttraumatic Stress Disorder**


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Treatment goals	Interventions
Reducing symptoms of hyperarousal	Anxiety management training
Reducing distress associated with memories to 2 or less on a scale of 0-10	Imaginal exposure
Eliminating avoidance of memories	<i>In vivo</i> exposure
Engaging in previously avoided activities (specify)	<i>In vivo</i> exposure
Eliminating anger outbursts	Anger management training
Increasing range of affect	Exposure to emotional cues
Increasing social contacts to three times a week	Activity scheduling, support groups
Eliminating feelings of guilt	Cognitive restructuring
Stating reduced belief (10%) in schemas of danger, lack of predictability/control (or other schemas—specify)	Cognitive restructuring, developmental analysis
Eliminating intrusive memories (and/or flashbacks/nightmares)	Imaginal exposure
Eliminating impairment (specify—depending on impairments, this may be several goals)	Cognitive restructuring, problem-solving training, or other skills training (specify)
Finding sources of meaning in life	Life review, activity scheduling/reward planning
Eliminating all anxiety symptoms (SCL-90-R and/or PTSQ scores in normal range)	All of the above
Acquiring relapse prevention skills	Reviewing and practicing techniques as necessary

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### **Phasing Out Treatment**

Four criteria should be met before a patient is considered ready to terminate treatment: (1) Symptoms have remitted sufficiently that the patient no longer meets criteria for PTSD; (2) the patient can discuss the trauma without feeling overwhelmed by emotion; (3) avoidance no longer interferes with the patient's daily functioning; and (4) significant cognitive distortions have been modified.

As with all disorders, we recommend emphasizing relapse prevention in the final phase of treatment for PTSD. The patient is asked to review the techniques he or she has found most helpful. The possibility that the patient may have a recurrence of symptoms when subject to life stress is discussed, and the patient is asked to envision which techniques he or she would use under those circumstances. In order to build patients' confidence in their ability to manage their symptoms, patients are encouraged to assign their own homework in later sessions, and the last several sessions are spaced 2 weeks to a month apart.

### **Session-by-Session Treatment Options**

Table 6.6 shows the sequence of interventions for a 16-session course of treatment for PTSD. We have found this format to be useful in working with patients whose symptoms are responses to a single, discrete traumatic event. Patients who have suffered multiple traumas, who have serious impairment in life functioning, and/or who present with significant Axis II psychopathology may require more sessions, although the components of the treatment remain the same. This package can also be used as part of more complex treatment when PTSD is one, but not the only, presenting problem.

**TABLE 6.6. Session-by-Session Treatment Options for Posttraumatic Stress Disorder****Sessions 1–2***Assessment*

- Ascertain presenting problems
- Inquire about history of trauma, including possible multiple traumas
- Inquire about triggers (Form 6.1) and about reexperiencing, avoidance, and hyperarousal symptoms (the PTSQ—Form 6.2)
- Administer standard battery of intake measures (see Form 6.3), plus additional anxiety questionnaire as appropriate
- Evaluate for comorbid conditions (e.g., major depression, other anxiety disorders)
- Assess need for medication
- Rule out contraindications for PTSD treatment (e.g., current substance abuse/dependence, current suicidal threat, unstable life circumstances)
- Rule out malingering (use MMPI if necessary)
- Assess premorbid functioning (including strengths, weaknesses, prior treatment, etc.)
- Obtain developmental history
- Assess social supports

*Socialization to Treatment*

- Inform patient of diagnosis
- Indicate that the symptoms are a common and understandable response to a traumatic event
- Inform patient that short-term treatment is available with high probability of a significant reduction in distress
- Provide patient with information handouts on PTSD (Form 6.4) and in cognitive-behavioral therapy in general (Form B.1, Appendix B)
- Discuss option of medication
- Explore and discuss any fears/reservations patient has regarding treatment

*Homework*

- Have patient begin using Form 6.1 to monitor trauma triggers
- Have patient begin listing avoided situations
- Have patient write out goals for therapy

**Session 3***Assessment*

- Evaluate homework
- Evaluate anxiety (BAI and PTSQ) and depression (BDI)
- Assess automatic thoughts, assumptions, and schemas related to the trauma

*Socialization to Treatment*

- Continue discussing conceptualization of PTSD, treatment, and rationale
- Discuss advantages/disadvantages of proceeding with treatment
- Obtain patient's consent to proceed

*Coping with Life Problems*

- Discuss any current life problems that might interfere with treatment
- Intervene on patient's behalf if necessary

*Homework*

- Have patient continue monitoring triggers, avoided situations

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**Sessions 4–6***Assessment*

- Evaluate homework
- Evaluate anxiety (BAI and PTSQ) and depression (BDI)
- Assess patient's current coping skills

*Behavioral Interventions*

- Teach anxiety management techniques (breathing relaxation, progressive muscle relaxation, visualization, thought stopping, and distraction)
- Have patient write out list of possible coping strategies (including patient's own preferred methods) to use when distressed

*Cognitive Interventions*

- Teach patient to identify and write automatic thoughts
- Teach patient rational responding

*Homework*

- As in Session 3
- Assign practice of at least one anxiety management technique daily
- Have patient write automatic thoughts and rational responses

**Session 7**

*Note:* Be sure to allow a minimum of 90 minutes for this session

*Assessment*

- Evaluate homework
- Evaluate anxiety (BAI and PTSQ) and depression (BDI)

*Behavioral Interventions*

- Create first imaginal exposure tape
- Have patient listen to tape in session until habituation occurs

*Homework*

- Have patient continue practicing anxiety management techniques
- Have patient listen to exposure tape daily; this should continue until some habituation has occurred

**Sessions 8–11***Assessment*

- As in Session 7
- Note:* Depending on how quickly patient habituates and the extent to which patient is able to do self-directed exposure homework, some of these sessions may need to be 90 minutes long

*Behavioral Interventions*

- Review progress of anxiety management practice and deal with any problems encountered
- Continue imaginal exposure to trauma memory until entire event is covered and patient can discuss it without significant anxiety
- Expose patient in session to cues that trigger trauma memories
- Plan self-directed *in vivo* exposure to avoided situations

(cont.)

**TABLE 6.6** (cont.)*Cognitive Interventions*

Note cognitive distortions (at all three levels) revealed during exposure  
 If cognitive distortions do not spontaneously change with continued exposure, use various techniques to challenge them (see Table B.3, Appendix B)

*Homework*

Have patient continue practicing anxiety management techniques  
 Have patient continue listening to exposure tape  
 Have patient continue writing automatic thoughts and rational responses  
 Assign self-directed *in vivo* exposure to avoided situations

**Sessions 12–13***Assessment*

As in Session 7

*Behavioral Interventions*

Encourage continued practice of anxiety management techniques  
 Continue any exposure items not completed

*Cognitive Interventions*

Identify any problematic cognitions remaining and challenge these

*Coping with Life Problems*

Identify any remaining life problems and teach patient appropriate coping skills

*Homework*

As in Sessions 8–11  
 Have patient practice coping strategies for life problems

**Sessions 14–16 (Scheduled Biweekly or Monthly)***Assessment*

As in Session 7

*Behavioral Interventions*

Encourage continued practice of anxiety management techniques  
 Continue exposure to any cues that remain problematic  
 Review techniques patient has found useful  
 Discuss possible sources of stress in future, predict possibility of temporary renewal of symptoms, and discuss ways of coping with them

*Cognitive Interventions*

Address any remaining cognitive distortions  
 Review techniques patient has found useful  
 Discuss possible sources of stress in future, predict possibility of temporary renewal of symptoms, and discuss ways of coping with them

*Coping with Life Problems*

Discuss ways of coping with any remaining life problems



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*Homework*

- Have patient self-assign homework
  - Encourage continued practice of anxiety management techniques
  - Encourage self-assigned exposure to avoided situations
  - Encourage continued practice of cognitive techniques
  - Encourage continued practice of life-problem-related skills
  - Have patient write list of favorite techniques to be used after termination
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