

Counseling trauma victims: 4 brief therapies meet the test

Focused cognitive-behavioral interventions
can provide lasting benefits



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Therapists once believed trauma survivors required years of treatment, yet we now know that relatively brief cognitive-behavioral interventions can yield long-term gains in psychosocial and psychological function.¹ Many psychiatric patients meet diagnostic criteria for posttraumatic stress disorder (PTSD), including:

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

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

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Box

Adapting CBT trauma interventions for children and adolescents

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

As with adults, CBT with children typically includes:

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

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

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

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

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

International Society for Traumatic Stress

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

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

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

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

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

PROLONGED EXPOSURE

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

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

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

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

PE has been shown to enhance the trauma survivor’s self-control and personal competence and to decrease generalization of fear to non-assault stimuli.¹² For example, many combat veterans report fear of situations—such as going to the beach or into the woods—that bring back memories of traumatic events. Their fears may keep them from enjoying a walk in the park or family vacations.

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

PE can be successful for those who complete

Table 1

Using prolonged exposure therapy to treat PTSD, session by session

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

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

Building patients’ coping skills may cut prolonged exposure’s relatively high drop-out rate

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

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

COGNITIVE PROCESSING THERAPY

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

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



Table 2

Using cognitive processing therapy to treat PTSD, session by session

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

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

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

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

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

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

EYE MOVEMENT DESENSITIZATION AND REPROCESSING

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

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Table 3

Where to learn more about cognitive therapies for PTSD

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

EMDR: Eye movement desensitization and reprocessing

ISTSS practice guidelines⁸ present it as a separate category.

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

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

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

- visual images of the trauma
- his or her affective and physiologic responses to the trauma
- negative self-representations the trauma created
- positive, alternate self-representations.

The therapist then asks the patient to focus



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on an image most proximal to the trauma and associated affective and biological reactions. While the patient is thinking, the therapist introduces the distraction stimulation. After a set number of stimulations—such as 20 bilateral eye movements—the therapist asks the patient to “let go” of the memory and discusses any new reactions to the trauma. As patients become less distressed in response to the trauma, they are asked to focus increasingly on alternate positive cognitions while they imagine the trauma.

EMDR has been effective in treating male war veterans, rape victims, and other trauma groups.¹⁷ Initial dismantling studies suggest that eye movements (or other distracting cues) might not be essential for trauma reprocessing, calling into question the mechanisms thought to create change in EMDR. Studies with larger samples comparing EMDR with other CBT models are needed to assess EMDR’s efficacy for trauma survivors.¹⁷

EMDR is effective, but eye movements might not be what helps patients reprocess trauma

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

For example, a patient might receive relaxation training while role-playing a difficult scenario she may face in the future. This helps her learn to remain calm in anxiety-provoking situations.

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

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

STRESS INOCULATION TRAINING

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

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

BottomLine

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Related resources

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

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

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