CBT for PTSD aims to modify the behaviors and cognitions that developed in response to trauma and are presumed to maintain PTSD. It emphasizes a collaborative alliance; therefore, it routinely begins with education about the cognitive-behavioral model and an in-depth treatment rationale, so that patients can be educated participants in treat- ment. Treatment also typically targets avoidance behavior and unrealistic or unhelpful thinking, which according to the CBT model are key factors that maintain PTSD. A number of variants of CBT for PTSD have been developed. Different forms can be la- beled by their core components (e.g., cognitive restructuring or exposure), or they may be referred to by specific names such as cognitive processing therapy (Resick & Schnicke, 1993) or prolonged exposure (Foa & Rothbaum, 1998). Yet most forms of CBT for PTSD consist of three core components emphasized to varying degrees: psychoedu- cation, exposure, and cognitive restructuring. Each holds true to the defining character- istics listed earlier. In this book, we will teach you how to use each of these core compo- nents to treat PTSD.

Briefly stated, psychoeducation provides patients with information about the cog- nitive behavioral formulation of PTSD. It facilitates patients' understanding of the treatment rationale, which is necessary if patients are to make informed therapy deci- sions. Establishing a shared understanding of PTSD also helps you build a collabora- tive relationship with your patients. You will rely on the persuasive rationale (dis- cussed in Chapter 5) and collaborative relationship to help patients tolerate the challenging moments in trauma-focused therapy.

Exposure targets avoidance and involves encouraging patients to approach feared stimuli, so that they learn that safe (but feared) stimuli need not be avoided. During ex- posure, your patients will approach stimuli (1) for prolonged periods of time to bring about an immediate decrease in fear (i.e., within-session habituation) and (2) over re- peated trials to promote more enduring fear reduction (i.e., between-session habitua- tion). Exposure can take several forms. During imaginal exposure, patients repeatedly recount trauma memories, whereas during in vivo (live) exposure, patients confront specific situations or stimuli in real life. Finally, interoceptive exposure involves experi- encing avoided physical sensations. Exposure may involve presenting stimuli in either a graduated or concentrated manner.

Cognitive restructuring teaches trauma survivors to become aware of and modify unhelpful thoughts. Your patients will learn to observe their thoughts, to identify and systematically challenge maladaptive thinking, and to formulate adaptive responses. Cognitive restructuring for PTSD sometimes is organized around specific trauma- related themes, as in cognitive processing therapy (Resick & Schnicke, 1993). It also may be applied to all distressing thoughts that result from traumatic experiences.

CONCEPTUALIZATION OF PTSD Shared Basic Assumptions

Cognitive-behavioral models rest on several shared assumptions. First, models typi- cally view PTSD as an anxiety disorder that is associated with nonanxiety symptoms.[1] According to such models, anxiety and fear consist of cognitive (e.g., fearful thoughts), behavioral (e.g., avoidance behaviors), and physiological features (e.g., autonomic arousal; see Figure 2.1). Each factor influences the others. For example, Susan is afraid of heights. When she starts to climb a ladder to change a light bulb in a chandelier hanging from a vaulted ceiling, she experiences fearful thoughts (e.g., "Climbing this ladder is dangerous; I could fall and break my neck"), physiological arousal (e.g., pounding heart, rapid breathing, trembling), and avoidance behaviors (e.g., getting off the ladder after climbing only two rungs and asking someone else to do the task for her). Thus, changing fearful thoughts about a situation (e.g., "I've seen Karen do this a million times without any problems; the ladder is strong and very stable; I can do this even though I feel anxious") may decrease avoidance and arousal. Similarly, by ap- proaching instead of avoiding a feared situation or object, the individual's perception of the danger may diminish (e.g., after successfully climbing the ladder, Susan con- cludes that climbing the ladder was safer than she originally thought).

Second, cognitive-behavioral models assume that mechanisms involved in the de- velopment of adaptive fear also operate in the development of maladaptive fear. For example, it is widely recognized that humans are born fearing only a few situations (e.g., loud noises and falling; O'Leary & Wilson, 1987). CBT practitioners assume that all remaining fears, both adaptive and maladaptive, are learned. The adaptive function

[1]Although the terms "anxiety" and "fear" can sometimes be used interchangeably, "anxiety" refers to a state of apprehension or anticipation of a future negative event, whereas "fear" typically denotes the "fight–flight" response to a specific stimulus.

of anxiety is to encourage us to avoid (and escape from) objectively dangerous situa- tions. For example, anxiety keeps us from going swimming with crocodiles and signals us to get out of the water when we notice a crocodile. Anxiety about situations that are not objectively dangerous (e.g., avoidance of swimming in a pool) can be learned, and therefore unlearned, by similar processes.

Behavioral and Conditioning Factors

Mowrer's (1947) behavioral two-factor conceptualization of anxiety is the foundation of the CBT conceptualization of PTSD presented here. Mowrer proposed that two types of learning, "classical" and "operant" conditioning, are involved in development of fears. He suggested that anxiety initially develops via classical conditioning, when a neutral stimulus is paired with a fear-producing stimulus. This is akin to the experience of Pavlov's dogs learning to salivate in response to a tone after it was repeatedly paired with food. Similarly, a neutral stimulus, such as a baseball bat, often after only one such pairing with a fear-producing situation, such as being beaten with a bat while being mugged, can evoke fear.

Rules of classical conditioning suggest that conditioned fear reactions should dissi- pate over time ("extinguish") if the feared object is not truly dangerous—much like Pavlov's dogs no longer salivating when they repeatedly experience the tone without being fed. The fact that many "irrational" fears of objects or situations that are not dan- gerous persist, however, suggested to Mowrer that something else must account for the maintenance of fears. Mowrer reasoned that a second factor, operant conditioning, might be responsible for the perpetuation of fear. "Operant conditioning" is learning that is based on the result that follows a behavior. Behavior that produces a favorable result (i.e., is "reinforced") tends to recur and increase in frequency, whereas behavior that produces an undesirable result (i.e., is "punished") tends not to be repeated. Mowrer reasoned that escape behavior is reinforced by a rapid decrease in fear when a person moves away from the feared object or situation; thus, it tends to recur and in- crease in frequency. He also proposed that fear is maintained over time because escape and avoidance behavior persist and prevent extinction. In summary, fear is initially learned via classical conditioning and maintained by operant conditioning.

For example, James developed a pronounced fear of large dogs after being bitten by a Labrador retriever. After the attack, James discovered that his anxiety rapidly di- minished when he escaped because the dog's owner took it away, or because he himself left the situation. As a result, his escape behavior was reinforced and therefore in- creased. He started by crossing the street whenever he saw a dog coming toward him and eventually limited his activity outside his home to avoid any possible contact with dogs. According to Mowrer, escape and avoidance behaviors, by limiting the time James spent with dogs without being harmed, prevented James's anxiety from dimin- ishing naturally. Thus, James failed to learn that his anxiety was unnecessary around most dogs, because the presence of a dog does not reliably predict being bitten.

Mowrer's theory is directly applicable to patients with PTSD, who after experienc- ing a traumatic event, typically avoid objects or situations closely associated with the event, and report (like James) extreme anxiety if forced into contact with such situa- tions or objects. In addition, many trauma survivors attempt to block trauma memo- ries, which may produce an effect similar to that of behavioral avoidance of real-life

stimuli (Keane, Fairbank, Caddell, Zimering, & Bender, 1985). In other words, trauma survivors may fail to extinguish conditioned fears because they avoid trauma remind- ers both behaviorally and cognitively. For example, Sandra, who was beaten with a baseball bat during a mugging, coped with the fear evoked by bats and her memories of the mugging by giving up softball (i.e., avoiding bats) and avoiding thoughts about the mugging. Thus, she failed to learn that neither bats nor her traumatic memory could hurt her.

One noteworthy feature of PTSD in comparison to other anxiety disorders, such as specific phobia, is the wide range of fears that trauma survivors develop. Two funda- mental principles of conditioning, higher-order conditioning and stimulus generaliza- tion, may account for the wide range of feared stimuli (Keane et al., 1985). Higher-order conditioning occurs when a previously neutral stimulus triggers a conditioned re- sponse by being paired with a conditioned stimulus; for example, James began to fear streets in the neighborhood where he encountered large dogs, and Sandra began to fear softball games. Neither the streets nor the softball games were ever paired with their assaults (the unconditioned stimuli), but both were associated with conditioned stimuli (dogs and bats). Stimulus generalization occurs when the individual responds to stim- uli that resemble the conditioned stimulus; for example, James began to

fear small dogs, and Sandra began to fear field hockey sticks. It is easy to see how higher-order conditioning and stimulus generalization rapidly expand the array of feared stimuli and lead to fears that "don't make sense."

Studies have shown that Mowrer's original theory suffers from several problems. In particular, it is clear that pathological anxiety can develop without classical condi- tioning. For example, fears can be acquired via information (e.g., you read about barra- cudas shortly before your Caribbean vacation and then fear swimming in the ocean) or vicariously (e.g., you observe your friend get stung by a dangerous jellyfish and come to fear ocean swimming; Rachman, 1977). Moreover, Mowrer's original theory does not easily account for nonanxiety symptoms associated with PTSD, such as shame.

Nonetheless, conditioning models explain many core features of PTSD, such as the wide range of stimuli that trigger traumatic memories, and the physiological and emo- tional arousal generated by these stimuli (Brewin & Holmes, 2003), and the model makes sense to patients. For example, Elizabeth, who had been repeatedly raped by her mother's boyfriend, reported experiencing a panic attack whenever she saw a wall clock. A clock hung over the bed in which she was raped and Elizabeth always stared at it while waiting for the rape to end. Using Mowrer's two-factor theory, we can hypoth- esize that Elizabeth's fear of wall clocks did not extinguish after the rapes stopped, be- cause she avoided the room with the wall clock and averted her gaze whenever she en- countered a wall clock. Elizabeth reported feeling "crazy," because she did not understand why something harmless that was associated with her rape would produce fear. The two-factor conceptualization helped her understand why and how she had come to fear wall clocks. She then reported that she no longer felt quite so crazy, be- cause the model made sense and pointed to specific solutions.

One disadvantage is that the two-factor model does not account for individual fac- tors, such as childhood experiences that predate the traumatic experience and may in- fluence whether a trauma survivor develops PTSD. Addressing this weakness, Keane and Barlow (2002) developed a more detailed learning model of the etiology of PTSD. Figure 2.2 is a graphical depiction of the model.

FIGURE 2.2. Keane and Barlow's (2002) model of the etiology of PTSD. From Keane and Barlow (2002, p. 429). Copyright 2002 by The Guilford Press. Reprinted by permission.

As illustrated at the top of the model, Keane and Barlow (2002) argue that both ge- netic and psychological factors can predispose an individual to develop PTSD after a traumatic event. "Generalized biological vulnerability" refers to a person's genetically based predisposition to develop any psychopathology after a traumatic event, if his or her early environment did not permit prediction or control of reinforcement and pun- ishment (Barlow, 2002). Such early life experiences represent a generalized psychologi- cal vulnerability. Other factors, such as the nature of the trauma and repeated traumatic experiences, also can increase risk of developing PTSD by increasing the individual's generalized psychological vulnerability (Keane & Barlow, 2002).

Moving down the model, we see that during the actual traumatic event, the trau- ma survivor experiences a "true alarm," which has an evolutionary basis (Barlow, 2002). Our ancestors undoubtedly experienced true alarms when faced with dangerous animals (e.g., lions, wolves, snakes) or people and natural hazards. True alarms are fear reactions to actual dangerous situations. The adaptive function of a true alarm is to pro- mote survival by activating a rapid response to physical threat. Much as firefighters fly into action in response to an alarm that alerts them about a real fire, true alarms mobi- lize our physical and cognitive resources to respond to threatening situations. Al- though most of us will not encounter dangerous animals such as lions, in today's world, true alarms can be activated in response to modern threats posed by explosions, car accidents, natural disasters, and dangerous people.

The mobilization of resources during a true alarm is usually referred to as the "fight–flight" response, although a more accurate name might be the "flight–fight–

freeze" response (Beck, Emery, & Greenberg, 1985). Our natural reaction to dangerous situations is to flee if possible. If we cannot flee, we tend to fight back. If both options are ruled out (as is often the case in sexual assaults and many other types of trauma), we fall back on an alternate response, which is to freeze—like a deer freezing in the woods so as not to be seen by a predator.

The physiological responses associated with the fight–flight system are numerous, well documented, and

commonly observed in individuals with anxiety disorders. Heart rate increases and blood is redirected from hands and feet to major muscle groups to facilitate fleeing and fighting. In addition, peripheral areas of the body, which are most likely to be injured, will be less likely to bleed excessively if cut. A secondary result is that these parts of the body may appear pale and cold. Breathing also deepens and becomes more rapid to increase oxygen intake, which is needed for sudden bursts of activity. As we commonly note to patients, when faced with a snarling lion, one can- not typically ask for a 5-minute warmup period. Thus, the sympathetic branch of the autonomic nervous system, which is largely responsible for the fight–flight response, is "hard-wired" to enable instantaneous preparation for intense physical exertion. When the brain detects threat, it directs the body to release adrenaline, which immediately produces involuntary changes in physical functions that enable short-term survival ac- tivities. Many of the sensations reported by individuals experiencing a fight–flight re- sponse, such as dry mouth and queasiness, occur because long-term survival needs, such as digestion of food, are put on hold. Other symptoms, such as dizziness, are thought to be secondary effects caused by a lack of physical exertion. In other words, because there is no lion, the individual does not fight or flee. This produces a cascade of secondary effects (e.g., overoxygenated blood results in constriction of blood vessels in the brain) that result in additional symptoms (e.g., feeling lightheaded).

Keane and Barlow (2002) suggest that during the traumatic event, individuals as- sociate a variety of stimuli (e.g., as in Elizabeth's case, the wall clock) with the experi- ence of a "true alarm" and as a result develop learned alarms via classical conditioning. Learned alarms are subsequently triggered by situations that resemble or contain fea- tures of the traumatic experience. They may also be triggered by situations that sym- bolize the event, such as anniversaries. Learned alarms produce the same response as a true alarm, but differ because of the absence of objective danger. A learned alarm is equivalent to a false fire alarm. Firefighters still fly into action, but there is no fire to fight. During the initial weeks after a traumatic event, it is common for most people to experience recurring distress in reaction to reminders of the event and to relive the event in memories, dreams, and flashbacks (North, Smith, McCool, & Lightcap, 1989; Riggs, Rothbaum, & Foa, 1995; Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). These early posttrauma learned alarms, however, usually fade over time.

Because traumatic events, in addition to fear, can also evoke intense emotions such as shame and guilt, these emotions may also be elicited by the same stimuli that pro- duce learned alarms (Keane & Barlow, 2002). For example, Elizabeth reported that feel- ings of shame usually accompanied fear when she was exposed to wall clocks. In some cases, these emotions may be the predominant learned experience when individuals encounter stimuli that remind them of the traumatic event.2 Regardless, because all of these emotional states (i.e., fear, anger, guilt, sadness, and shame) are unpleasant, survi-

2Often referred to as trauma "triggers" or "cues."

vors develop anxiety (i.e., "anxious apprehension") about encountering triggers and the emotional responses associated with them. This anxiety motivates trauma survi- vors to avoid trauma-related stimuli, and they may also seek to avoid their emotions al- together via emotional numbing.

Interestingly, Keane and Barlow (2002) argue that development of PTSD is not yet a fait accompli. Rather, whether the initial learned alarms become a persistent problem and snowball into full-blown PTSD depends on the trauma survivor's coping style and resources, and the accessibility of social support. For example, after returning from Af- ghanistan, Paul realized that no one wanted to hear about the horrible things he wit- nessed during combat. Rather, they wanted him to "just put it behind him." Thus, he adopted a coping strategy of avoiding thoughts about Afghanistan and situations that reminded him of combat; this coping strategy increased his risk for PTSD. What began as learned alarms snowballed via stimulus generalization and higher-order condition- ing into more generalized fears and intensified efforts to avoid unpleasant emotions. In contrast, Steve, also a veteran, coped by turning to his support network, talking about what happened (even though he also had urges to avoid), and exposing himself to situ- ations that reminded him of his combat experiences. Thus, he was less likely to develop PTSD.

All models of PTSD, including that of Keane and Barlow, point to avoidance as a critical factor in the development and maintenance of the disorder. Thus, trauma survi- vors who are exposed to triggers of learned alarms soon after the event are less likely to experience persistent distress (Wirtz & Harrell, 1987), which explains why distress dis- sipates for the majority of trauma survivors. Likewise, people

whose posttrauma reac- tions have persisted over time can extinguish their conditioned responses by systemati- cally exposing themselves to trauma triggers. This is one of the mechanisms of action presumed to underlie exposure. Considerable research supports both of these supposi- tions (Keane & Barlow, 2002), and conditioning models are very helpful in understand- ing many aspects of PTSD, particularly those related to anxiety. Yet they do not fully ex- plain nonanxiety symptoms.

Cognitive Factors

Multiple cognitive models have been developed (Chemtob, Roitblat, Hamada, Carlson, & Twentyman, 1988; Ehlers & Clark, 2000; Foa et al., 1989; Resick & Schnicke, 1992). Cognitive models share a number of features, including a focus on the need to "pro- cess" or make sense of traumatic events as a part of adaptive coping, and an assump- tion that PTSD results from a failure to organize traumatic experiences successfully. Al- though there are differences between the models, all generally point to the need to reduce avoidance behaviors in a systematic manner and to process traumatic events so that they may be understood in an accurate and realistic way.

Cognitive Processing of Traumatic Events

Our brains like things to "make sense," to fit together in logically coherent ways. There- fore, after experiencing a trauma, it is natural to want to think things through—to orga- nize and understand what happened. Consider, for example, how your mind works af- ter you watch a movie with a twisting plot in which the loose ends come together in the
final minutes of the film. As you leave the theater, you may find yourself reviewing the entire story from start to finish to make sense of the details in light of the new informa- tion. If there is incompatible or missing information, you may continue for the rest of the evening to review it, trying to fit all the pieces together. You may even dream about it that night.

The inclination to process our personal experiences is even stronger for emotion- ally charged ones than for less personally relevant ones, such as a movie. For example, imagine having been in a serious car accident. No one died, but several cars were wrecked. When you arrived home to family or friends, what would you do? Most peo- ple say "I would tell them what happened." Would you tell one person or many peo- ple? Would you simply say, "I was in a car accident," and leave it at that? Or would you describe the event in greater detail? For an event such as this, most people respond that they would tell several people what had happened in great detail. Clinically, this is of- ten referred to as "telling the story" or "making sense of the story." Thus, clinical obser- vation supports what has been tested by research: People seem to have an inclination to discuss difficult events, and discussing these events helps us to understand or "pro- cess" them. Studies of how people cope immediately after traumatic events also indi- cate that people who mentally disconnect from events and inhibit their emotional reac- tions tend to be at greater risk for developing PTSD (Ozer, Best, Lipsey, & Weiss, 2003).

A variety of factors can interfere with adequate processing of a traumatic experi- ence. For example, the extreme nature of some traumatic events can disrupt memory and attention, and thereby impede processing of the event (Foa & Rothbaum, 1998; Foa et al., 1989). For example, during a mugging at gunpoint, Susan was only vaguely aware of what was happening to her boyfriend, because she was unable to pull her at- tention away from the gun pointed at her. Thus, she had difficulty making sense of the entire mugging event, which involved her boyfriend being extensively beaten. In our experience, this type of difficulty may be particularly true for childhood abuse survi- vors, possibly because children do not have fully developed cognitive abilities.

In addition, because traumatic events are typically characterized by a lack of pre- dictability and control, individuals who hold beliefs about the importance of being able to predict and control events in their lives face an inherently challenging cognitive task when the traumatic event strongly contradicts these beliefs. For example, Evelyn be- lieved that "everyone makes choices and is in control of what happens to them" and that "when bad things happen to you, it is because you made bad choices." As a result, she experienced significant shame about being raped by a stranger and blamed herself, even though there was little evidence that she could have prevented the event. Evelyn had difficulty reconciling her prior beliefs and evidence that the rape was not her fault.

When initial processing of the event is incomplete, disorganized, or inaccurate, a variety of strategies, such as exposure and cognitive restructuring, may be used to pro- mote "reprocessing" of the event. "Reprocessing" simply refers to a meaningful reex- amination and reorganization of the event aimed at promoting more successful, accu- rate, and realistic understanding. Most forms of trauma-focused treatment involve the patient communicating, at some point, the details of the traumatic event to the thera-

pist and potentially others (e.g., group therapy members). The importance of reprocess- ing traumatic events has been recognized by various schools of therapy; trauma- focused treatment is not the exclusive domain of CBT. Nonetheless, for some clinicians, encouraging patients to revisit highly distressing events, such as rape, torture, and wit-

nessing death, seems counterintuitive, particularly for highly distressed patients who may seem too fragile or lack coping skills. This, in general, has been the rationale for staged treatment of PTSD. Although some patients need to develop a base of skills be- fore proceeding with exposure (see Chapter 9), it is important to note that many pa- tients who appear fragile can tolerate and substantially benefit from processing their traumatic experiences.

Incomplete Processing and the Development of PTSD Pathological Fear

Cognitive models suggest that pathological fear develops when, as a result of a trau- matic event(s), an individual (1) begins to label incorrectly benign stimuli as dangerous due to mistaken associations and interpretations, then (2) fails to learn corrective infor- mation. Thus, Elizabeth labeled the clock as dangerous and failed (because she avoided clocks when she encountered them) to learn that it was not. According to cognitive models, trauma-related information is organized in the mind of the trauma survivor in a "fear network" (Foa & Kozak, 1986; Foa et al., 1989; Lang, Levin, Miller, & Kozak, 1983). Fear networks link specific details regarding the event (including stimuli and memories), responses to the event (e.g., behaviors, thoughts, and sensations), and meanings/interpretations of the event. Fear networks can be thought of as programs we use to promote survival when faced with life-threatening danger.

When fear networks incorrectly link stimuli or contain flawed assumptions, the in- dividual fears safe situations and objects. For example, cognitive models suggest that when encoding and storing the experience of being raped, Elizabeth associated wall clocks with danger. Thus, wall clocks activate her fear network, which contains the emotional experience of fear (including heightened arousal) and memories of the rape, as well as interpretations of the world (e.g., "All men are dangerous"). Elizabeth also experiences the urge to avoid both memories and the actual stimuli (wall clocks). In addition, because associations formed during dangerous situations are particularly strong, wall clocks now activate the fear network rather than previous, positive experi- ences with wall clocks. Yet wall clocks are not in themselves dangerous, nor are they ac- curate signals of danger.

Maladaptive conclusions (e.g., that wall clocks predict danger) result when trau- ma survivors trauma survivors interrupt processing before they incorporate correc- tive information that would allow them to draw more helpful conclusions. Two con- ditions are necessary to complete processing and reduce unhelpful fears (Foa et al., 1989). First, the fear network must be activated; that is, the individual must experi- ence fear elicited by trauma cues and memories. Second, corrective information must be available at the same time to promote new learning. For example, Elizabeth avoided her fear by avoiding wall clocks and other danger cues associated with the rape, which prevented her from drawing more accurate conclusions about them. To reduce her fear of wall clocks, Elizabeth must experience the fear triggered by seeing a wall clock, and she must realize that she is safe—even though she is looking at a wall clock and feeling fear. Avoidance behaviors interfere with both activating the fear network and integrating corrective information about safety. In summary, Eliza- beth's fear of wall clocks would diminish were she to conclude that wall clocks do not always signal danger.

18 COGNITIVE-BEHAVIORAL THERAPY FOR PTSD GUILT, SHAME, AND ANGER

Nonanxiety-related emotions such as anger, guilt, and shame play a prominent role in many cases of PTSD. In some cases, nonanxiety emotions such as shame and anger, along with related beliefs, influence the degree to which trauma survivors are willing or able to process the event either through verbal disclosure or by mental review. For example, many people in our society are uncomfortable with the topic of rape, making it difficult for many rape survivors to talk about their experiences. In addition, survi- vors often want to protect family and friends from the details of their experiences. For example, Adele reported that after being raped, she did not tell her family what had happened, because she did not want them to realize that she was now "damaged." She also noted that when she finally told her best friend, she left out most of the details: "What was I going to say? You don't talk about the blow-by-blow details of being raped. You just don't."

Negative reactions from others also can exacerbate the shame of trauma. For exam- ple, veterans of the Vietnam War often perceived themselves as unwelcome by their fel- low Americans, and feeling shame

upon homecoming from Vietnam was associated with greater risk for PTSD among such veterans (Johnson et al., 1997). Similarly, disbe- lief, disapproval, or other negative reactions to disclosure of sexual assault or abuse have been associated with greater posttraumatic symptoms (Everill & Waller, 1995; Ullman, 1996). Shame the survivor experiences when the social environment is un- supportive of his or her disclosure can lead to increased avoidance of thinking about the event, which thus disrupts processing. Thus, negative emotional reactions can play a central role in maintaining PTSD and be the cause of substantial suffering in their own right. Therefore, they warrant attention in treatment. Many patients benefit from interventions specifically directed at reducing these emotions, particularly when they are not reduced by exposure (Resick et al., 2002; Smucker et al., 2003).

THE ROLE OF PREEXISTING BELIEFS

Cognitive models typically assume that individuals who experience traumatic events hold preexisting beliefs that are challenged by the event (Brewin, Dalgleish, & Joseph, 1996). Thus, after the traumatic event, individuals must resolve conflicts between what they believed about the world and themselves prior to the event and what the traumat- ic experience tells them. For example, Elizabeth believed that she was generally safe in the world as long as she took certain precautions that she could control. Being as- saulted in her home, an environment that she assumed was safe, provided experiential evidence that refuted her belief that she was "safe unless proven otherwise." According to Resick and Schnicke (1992) there are three main cognitive solutions to this conflict. First, Elizabeth may alter her interpretation of the experience to fit with her belief sys- tem (e.g., "I made him want to rape me by wearing sexy clothes, because I thought he was good looking; women don't get randomly raped in their own house by friends" or "It wasn't really a rape, because I liked him and let him do it"). Second, Elizabeth might radically alter her belief system in a maladaptive way (e.g., "No place is safe anymore; I will never be safe"). Third, she might alter, or accommodate, her belief system in a more moderate, productive manner ("Although I liked him, I didn't ask him to rape me. Some men are dangerous, but many are not. I am still mostly safe as long as I am reasonably careful"). PTSD is associated with the first two cognitive solutions.

In Elizabeth's case, the new evidence led her to conclude that "no place is safe." Because it is extremely important for our survival to avoid danger, we, like Elizabeth, may be prone to err on the side of safety and assume danger even where none exists. Resick and Schnicke (1992) refer to conclusions such as "no place is safe" as "stuck points." Stuck points are trauma-related thoughts that contribute to negative posttrau- matic reactions. In addition to focusing on danger, stuck points may focus on issues such as lack of trust, guilt, or other negative emotional reactions. Stuck points are often associated with reconciling previous beliefs and the traumatic event. As in Elizabeth's case they also may arise as a result of blaming comments by people she expected to be supportive (e.g., "Why did you tempt him by dressing provocatively?"), or because she is so avoidant that she refuses to think about anything unpleasant, and, therefore, can- not make sense of what happened to her. Finally, if Elizabeth has no relevant beliefs to help her make sense of the rape (e.g., if the traumatic event happened early in life), she may lack the tools to understand the event at all.

SECONDARY REACTIONS, AVOIDANCE, AND INCOMPLETE PROCESSING

Avoidance may be motivated by emotional reactions (e.g., fear and shame) to the reexperiencing symptoms themselves (Ehlers & Steil, 1995), and these secondary reac- tions can play a prominent role in driving the avoidance that maintains the disorder. For example, Betsy was assaulted at knifepoint in the parking lot of her workplace. Af- ter the assault, she found that she was flooded with memories of the assault when she anticipated going to the parking garage at the end of her workday. These memories of- ten seemed so real that she felt compelled to check her office to make sure no one was there. Betsy began to fear these memories, because they disrupted her ability to work, and she did not want to lose her job. Thus, she struggled to suppress the memories. Yet the harder she tried to focus, the less control she seemed to have, and coworkers no- ticed her "acting weird." Betsy worried that she was "going crazy," because she could not dismiss her memories and was having "paranoid" thoughts. In summary, her emo- tional reaction (fear) to the intrusive memories (rather than her reaction to the assault itself) was her greatest source of distress and led to increased efforts to avoid the mem- ories.

Such secondary emotional reactions also can involve feelings of shame (e.g., "The fact that I can't get over it means I'm weak"), hopelessness (e.g., "The fact that I'm still having these intrusive thoughts after all this time means I'm a failure") or anger (e.g., "It's not fair that I'm still suffering from what he did to me

and he's just going about his life as if nothing happened"). By motivating further avoidance of processing the trau- ma, secondary emotional reactions themselves can not only play a significant role in maintaining PTSD but also cause substantial suffering.

EXPOSURE AND COGNITIVE RESTRUCTURING

Both conditioning and cognitive models point to the need to reduce avoidance behav- iors, and this reduction in avoidance is presumed to underlie the efficacy of both expo- sure and cognitive restructuring. We discuss the presumed mechanisms of action for exposure in greater detail in Chapter 6. Briefly, however, during exposure, patients

learn that trauma-related stimuli and memories are in fact not objectively dangerous in the present. Thus, patients learn to better discriminate between cues that reliably pre- dict danger and cues that predict safety. According to cognitive models, exposure also facilitates reprocessing, which can lead to more accurate conclusions about the mean- ing of the event, thereby reducing a broad range of negative emotions associated with PTSD.

Cognitive restructuring also reduces avoidance by requiring patients to carefully examine trauma-related thoughts, and to review the event so as to gather evidence for and against specific conclusions. In addition, cognitive restructuring teaches patients to systematically explore their thinking, with the goal of helping them to understand (i.e., "process") the traumatic event better. Finally, cognitive restructuring helps patients be- come aware of and challenge stuck points.

Important Areas of Assessment: Trauma History, PTSD, Comorbidity, Physical Status, and Complicating Factors

Gathering basic information about patients' trauma histories is a core component of PTSD assessment. Unless your patient is one of the rare individuals whose symptoms improve after telling the story once, trauma history assessment involves walking a fine line. You need to gather enough information to develop a basic understanding of your patients' trauma histories without digging so deep that you inadvertently start expos- ing patients to their memories before it is therapeutic to do so. Patients who become overwhelmed by the assessment may not return. Yet underassessment of trauma his- tory may leave you without enough information to generate an accurate case formula- tion and treatment plan. Also, some patients identify traumatic events that do not meet the following DSM-IV traumatic event criteria: (1) "The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to physical integrity of self or others," and (2) "The person's

response involved intense fear, helplessness, or horror" (American Psychiatric Associa- tion, 1994, p. 428). Determining whether an incident meets criteria for a traumatic event is important, because formulations for patients who have experienced traumatic events typically differ from those who are distressed by events that do not meet criteria for a traumatic event. Assessing the trauma history is not sufficient, however. You also need to determine whether patients actually meet criteria for PTSD, because case formula- tions for patients who meet criteria for PTSD differ from those who do not, even if both have experienced trauma.

We find that the best tool for assessing PTSD is the Clinician-Administered PTSD Scale (CAPS; Weathers & Litz, 1994), a structured clinical interview designed to assess PTSD and associated features, such as guilt and dissociation. The CAPS provides care- fully developed questions aimed at eliciting the information needed to determine whether your patients have suffered a DSM-defined trauma and meet criteria for PTSD. You can purchase a CD-ROM (www.ntis.gov/products/pages/caps.asp) that provides guidance in administering the CAPS. You also can request a copy of the CAPS from the National Center for PTSD by going to their website (www.ncptsd.va.gov/ publications/assessment/).

It is also important to assess comorbid disorders and associated problems, espe- cially other anxiety disorders, mood disorders, hypochondriasis, eating disorders, and substance use, as well as Axis II disorders. Assessing these conditions will help you cre- ate your case formulation and may help you clarify a patient's readiness for trauma- focused treatment. For example, many patients with comorbidity, including Axis II dis- orders such as borderline personality disorder (BPD), can benefit from CBT. However, patients with especially severe Axis II disorders (e.g., those who severely self-injure, are highly suicidal, and/or are prone to extreme dissociation) may benefit from dialectical behavior therapy (DBT;

Linehan, 1993a) or from limited, DBT-based skills training prior to starting trauma-focused treatment. DBT, a variant of CBT designed to address emotion regulation and destructive behaviors associated with BPD (Linehan, 1993a), differs from standard CBT in a variety of ways, particularly with respect to its emphasis on validation, mindfulness, and the dialectic of acceptance and change (see Chapters 4 and 9 for more information on DBT).

Our preferred measure for assessing comorbid problems is a structured interview, the Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV; Brown, DiNardo, & Barlow, 1994). The ADIS-IV takes a time to administer. To reduce its length, you can se- lectively focus on the questions most relevant for the case at hand. For example, if you assess PTSD using the CAPS, skip the ADIS-IV PTSD section. Also, many sections of the ADIS-IV ask patients if they began regularly using any drugs or developed a physi- cal problem prior to the onset of the assessed psychological problem. If a patient does not take drugs or have any physical problems, you can skip these questions. You can order an ADIS-IV kit from Oxford University Press. If you choose to order online, go to www.oup.com/us and search for anxiety disorders.

The ADIS-IV assesses the primary comorbid conditions that commonly present with PTSD, including mood and substance use disorders. We supplement the ADIS-IV with an assessment of eating disorders (e.g., the Eating Attitudes Test; see below) in fe- male patients, because eating disorders are not assessed by the ADIS-IV. Our research indicates that a meaningful number of female PTSD patients have eating disorders, and that clinicians do not always detect these eating disorders if they rely exclusively on the ADIS-IV (Becker, DeViva, & Zayfert, 2004).

It is essential to assess patients' physical status. Common health problems include headaches, irritable bowel syndrome, and chronic pain. Many of these problems inter- act with anxiety and/or may have a strong underlying anxiety basis. For example, Stu- art, who developed PTSD after losing his hand in an industrial accident, reported chronic pain. His pain worsened markedly during his exposure sessions, then gradu- ally improved over the course of treatment. Stuart's therapist used cognitive restructur- ing to challenge Stuart's belief: "If treating my PTSD makes my pain go away, it means that my pain was 'all in my head.' " The therapist was alert to the possibility of such be- liefs, because he knew about Stuart's chronic pain and had developed a case formula- tion that hypothesized a relationship between Stuart's PTSD and his chronic pain.

Finally, it is important to assess factors that can either complicate or facilitate treat- ment. For example, assess for ongoing abusive relationships, life problems (e.g., mari- tal, legal, housing, financial, work problems), and life demands (job, children, elderly parents, etc.), along with support systems and resources. Having a good understanding of both the stresses and strengths that patients bring to treatment helps you structure your treatment and troubleshoot when you encounter obstacles.

BECOMING A TEAM: THE THERAPEUTIC RELATIONSHIP

A strong therapeutic relationship is critical in CBT for PTSD. We have noticed that some trainees initially are so focused on the techniques of CBT that they forget the im- portance of the therapeutic relationship. When implementing CBT for PTSD, you are asking your patients to quickly make large changes by facing their past in a manner that is challenging. Your patients will be reluctant to attempt the tasks employed in CBT if they do not trust you.

For example, when Steve's therapist proposed exposure, he looked her directly in the eye and stated, "I

wouldn't do this if anyone else asked me. You'll be there for me, right? I feel like I am jumping off a cliff. I need to know that you are going to be jump- ing with me." Steve's therapist responded that (metaphorically) she would be holding his hand as he jumped. After completing his first exposure session, Steve noted that the only reason he had been willing to try exposure was because of his profound trust in his therapist. We hear this frequently.

Similarly, a strong therapeutic relationship helps you to create a setting that is con- ducive to learning safety during exposure. For example, Julia was very reluctant to complete exposure. Her therapist encouraged Julia to proceed by gently saying, "Tell me exactly what happened." Later, while processing her brief thought that the therapist was "mean," Julia also noted, "Although I thought you were being mean, I knew you wouldn't ask me to do anything that wasn't for my own good; I also knew that if I said I really needed to stop, I could, and you would be there for me." Had Julia not trusted her therapist, her experience could have been markedly different, and she might have felt forced.

In many cases, a solid therapeutic relationship develops naturally during the psy- choeducation phase of treatment (see Chapter 5) and strengthen during cognitive restruc- turing and exposure, as long as you employ good clinical skills. In other cases, however, you may find that your patients have profound problems with trust.

Maintaining a Nonjudgmental Stance

You may find it difficult to like some patients with PTSD. In working with other clini- cians (e.g., psychiatrists, primary care physicians, or therapists who cover for us when we are on vacation), it has become clear to us that some clinicians really seem to dislike our patients! Embracing the least judgmental conceptualization of patient behavior is an important strategy for facilitating the therapeutic relationship and developing a pos- itive view of your patients (Linehan, 1993a). To help us maintain a nonjudgmental stance, we rely on the biosocial model of emotion regulation problems (Linehan, 1993a), which proposes that emotion regulation difficulties develop as a result of an in- born biological vulnerability to emotional sensitivity coupled with an invalidating en- vironment. Symptoms and dysfunctional behaviors are conceptualized as evidence that patients have inadequate skills to manage their emotional reactions.

It is very easy to conceptualize the behavior of PTSD patients in a judgmental man- ner. For example, Amy angrily stormed out of the waiting room, sobbing when her therapist was 60 seconds late for her appointment. Other clinicians who observed this behavior concluded that Amy was being deliberately manipulative, and that they would not want to deal with such a manipulative patient. Amy's therapist used the biosocial model to maintain a nonjudgmental stance. She interpreted this behavior as indicating that Amy felt invalidated or rejected when her therapist was late, and that she lacked the necessary skills to communicate her distress appropriately. The therapist also surmised that Amy's behavior indicated that she was a poor manipulator, because skilled manipulators usually accomplish their goals without appearing manipulative. This view reduced any frustration that Amy's therapist might have experienced. Diffi- cult or "manipulative" behaviors become less annoying when they are conceptualized as unskilled attempts to meet valid needs. Thus, it is easier to continue liking your pa- tients even when they behave in ways that might produce negative reactions.

Maintaining a nonjudgmental stance also may help you and your therapeutic rela- tionship in the several other ways. First, you will be less frustrated by avoidance be- haviors. Second, you will find it easier to tolerate objectionable features of your pa- tients' histories, particularly those that they themselves seem to cause. Third, research indicates that a nonjudgmental stance may facilitate a reduction in parasuicidal urges (Shearin & Linehan, 1994).

Finally, maintaining a nonjudgmental stance reduces the risk of inadvertently ap- pearing judgmental, which could exacerbate shame in your patients. Thus, you provide a safer environment to explore the function of your patients' behaviors. For example, Linda was raped after leaving a party with a group of men, because she was mad at her boyfriend, who was late. Maintaining a nonjudgmental stance allowed the therapist to help Linda process the rape and her behavior without appearing critical. Linda's thera- pist maintained this stance by viewing Linda's behavior as an unskilled attempt to manage the intense negative affect triggered by her boyfriend's behavior (temperamen- tal vulnerability). She also

hypothesized that Linda felt invalidated by her boyfriend's behavior. When viewed using the biosocial model, Linda's behavior becomes under- standable, if not functional.

Using Validation to Build Trust and Reduce Misunderstandings

Validation is another DBT strategy that can be helpful in establishing and maintaining your therapeutic relationship, particularly with patients who have difficulty trusting others (Linehan, 1993a). Many patients with PTSD have experienced invalidating envi- ronments, as described in the biosocial model. As such, they often are exquisitely at- tuned to potential invalidation. Moreover, as Linehan points out, they may feel misun- derstood if you ask them to make changes that seem unachievable. Validation involves communicating to your patients that their behaviors are completely understandable given their circumstances. More specifically, when you validate, you observe what is happening, reflect your observation, then note that your patient's response is under- standable.

Validation occurs at some level in all good therapy. In DBT, however, validation is a core intervention (Linehan, 1993a). We have found that explicit use of validation, as promoted by Linehan, often preempts misunderstandings and fosters the trust needed in CBT for PTSD. For example, after Amy stormed out of the waiting room, the thera- pist telephoned her and noted, "It looks like I really upset you by being late" (i.e., ob- servation and reflection). Amy angrily confirmed this and said that she always knew her therapist really did not care about her. Her therapist continued: "I obviously really upset you, and I can really understand why you would feel that way and think that I don't care" (i.e., communicating that Amy's response is understandable). Amy's thera- pist did not initially challenge Amy's interpretation by saying that she did care. Rather, she validated Amy's perspective, until it became clear that Amy had registered the val- idation. At that point, Amy noted that she could think of some reasons why her thera- pist might have legitimate reasons for being late, and that the phone call probably meant that her therapist did care. Amy then agreed to reschedule; subsequently, when her therapist was a bit late, Amy did not flee the waiting room.

ADDRESSING YOUR OWN ISSUES

A number of therapist factors may influence treatment. For example, if you fear that trauma-focused treatment will "retraumatize" your patients, you will be unlikely to use this approach. PTSD experts also have focused on the need for ongoing supervision and support for less experienced therapists (e.g., Foa, Zoellner, Feeny, Hembree, &

Alvarez-Conrad, 2002). Moving beyond issues of expertise, others have noted that suc- cessful implementation of CBT for PTSD requires that therapists both believe in the treatment (i.e., believe that the treatment will not harm your patients and have confi- dence that it will work) and tolerate intense arousal during treatment (Litz, Blake, Gerardi, & Keane, 1990). Below we provide information to help you address possible concerns that you may have about CBT for PTSD.

First Do No Harm: "Will CBT 'Retraumatize' My Patients?"

If you are like many clinicians, you may have concerns that CBT for PTSD could "retraumatize" some of your patients. Obviously, you will find it difficult to administer a treatment if you believe it poses substantial risk of harm. The term "retrauma- tization" is used to indicate that a patient experiences dramatic worsening of symp- toms and deterioration of functioning, in this case, as a result of the treatment itself (Chu, 1998). A session may be considered "re"-traumatizing if recollections of a past traumatic event are elicited in a manner that continually escalates fear and helplessness rather than promote new learning about safety. The evidence for retraumatization in CBT is difficult to interpret, because CBT does sometimes result in a temporary increase in symptoms, even when it is proceeding well. For example, approximately 25% of pa- tients experience a temporary increase in intrusive symptoms (e.g., nightmares, flash- backs) after starting exposure (Foa et al., 2002). Yet, research indicates that these pa- tients benefit from exposure at rates similar to those of patients who do not experience this exacerbation. Nonetheless, we know of patients who appear to have experienced a more pro- found and lasting negative reaction to trauma-focused treatment. For example, Harriet, a single, 50-year-old woman, was completing imaginal exposure to being raped. Ac- cording to Harriet, she began flashing back and repeatedly "begged" to stop, but her therapist said she "needed to keep going." Harriet appeared not to have felt that she had a choice about continuing or stopping exposure, and she did not experience a sense of safety during exposure. She noted, "He said I had to keep going, and it was just like my rape. I was out of control." Within days of this session, Harriet began experiencing nightmares and stopped

eating. Shortly thereafter, she experienced a complete relapse in a previously treated eating disorder. Harriet also began abusing alcohol and was un- willing to resume PTSD treatment, even after she switched therapists. We should note that the vast majority of patients who complete exposure in both research studies and clinical settings do so without experiencing long-term negative effects. Thus, we believe that when the treatment is delivered appropriately, the risk of retraumatization from CBT for PTSD is minimal.

Lasting negative reactions to trauma-focused therapy appear to happen when cer- tain therapeutic conditions are absent. As we noted in Chapter 2, to benefit from expo- sure, patients must experience both activation of their fear network and a corrective ex- perience of safety. Patients who experience prolonged negative reactions have failed to experience and integrate corrective information (i.e., safety) with regard to their trau- matic memory. This appears to be what happened with Harriet. Conditions that appear to contribute to this failure are a lack of trust in the therapist and a sense of lack of con- trol over the exposure process. In other words, if patients feel out of control during ex- posure (i.e., do not believe they have the choice to continue or stop on a moment-by-

moment basis) or do not trust that their therapist truly has their best interests at heart, they are less likely to experience the corrective experience of safety and may be at risk for negative reactions.

In summary, patients may be reluctant to proceed with exposure based on their fear and may need significant encouragement to engage in exposure. They are less likely to have a corrective experience, however, if they feel out of control and do not trust you. Thus, you must strike a balance between encouraging them to proceed with exposure and making sure that the conditions necessary for a corrective experience of safety (i.e., real safety, control, and trust) are present. In our experience, when these conditions are present, patients are remarkably resilient in proceeding with exposure.

Confidence: A Vital Component of CBT for PTSD

Clinicians are trained to alleviate suffering, yet CBT for PTSD requires that you encour- age patients to engage in a task that is inherently distressing. Unfortunately, patients tend to detect ambivalence and a lack of confidence, which may result in you and your patients colluding in avoiding difficult tasks. To implement CBT for PTSD you must be willing to push patients gently to face their traumatic events. You also need to tolerate the possibility that patients may sometimes briefly feel that you are being “mean.” For example, during imaginal exposure, the therapist encouraged Julia to describe her rape in detail as opposed to saying “Then he took off my panties and raped me.” Crying, Julia stated, “I don’t think I want to.” The therapist validated this urge, saying “That’s understandable,” then gently asking, “Can you tell me exactly what hap- pened?” Julia later noted that, at the time, she thought her therapist was being mean. She also thought, “I can’t believe she is going to make me do this.” Yet after exposure, Julia felt as if she had lost a “50-pound load” and was grateful that her therapist had “pushed me to do what I needed to do.” Julia also appreciated learning that her thera- pist could know “every horrible detail” and still “look at me the same way and care about me.” If the therapist had lacked confidence, Julia might have stopped and would not have benefited. She also might have lost trust and confidence in her therapist. In summary, CBT for PTSD requires that you firmly believe that short-term, aversive tasks result in long-term improvement in functioning, and that the long-term relief is worth the short-term pain.

Developing Confidence

You can develop confidence by seeking supervision from an experienced CBT thera- pist, attending continuing education workshops, and/or reviewing the literature. If you were trained originally in other approaches, you may not be accustomed to relying on the scientific literature for confidence. The research supporting CBT for PTSD, how- ever, can be helpful. The first time one of us used exposure (C.B.B.), she had to tell her- self over and over during the session, “The research says this works, the research says this works.” Even after our years of experience, the research still helps us guide pa- tients through the treatment.

Another powerful means of developing confidence is to experience successful out- comes when you use CBT with either yourself or your patients. Thus, consider trying out exposure and cognitive restructuring in your own life. Personal experience with ex-

posure is particularly compelling and useful for developing confidence. For example, you can address

common fears (e.g., fears of animals, heights, closed spaces, or public speaking) by implementing exposure on your own (following the procedures in Chap- ter 6) or with an experienced behavior therapist (you can locate one via the Association for Behavioral and Cognitive Therapies, www.abct.org). You also can discover the ef- fects of exposure in situations that generate only moderate anxiety. For example, re- peatedly riding the same roller coaster can demonstrate how physical sensations and anxiety decrease in response to repeated exposure. Some subways have very steep es- calators, and many people feel anxious at first when they ride them. Riding these re- peatedly also will demonstrate the effects of exposure firsthand.

Finally, you can increase your confidence by implementing exposure for a simpler anxiety disorder. Exposure therapy for panic disorder, specific phobia, and some cases of obsessive–compulsive disorder (OCD) involves concrete tasks that promote rapid anxiety reduction. These forms of exposure also are often more straightforward than those for PTSD, because the treated fears are clearly irrational. Thus, if you have never implemented exposure clinically, you may find that beginning with exposure for other disorders is easier and more comfortable.

Ability to Tolerate Arousal

CBT for PTSD also requires that you tolerate anxiety and other negative emotions. Ob- viously, the more confident you feel, the less anxiety you experience. Nonetheless, no treatment is 100% successful, which means that some of your patients may not benefit. Thus, at times, when you find yourself encouraging a patient to engage in exposure, you may feel anxious and wonder, “Is this going to work for this person?” For example, you may feel anxious if you decide to use exposure with a patient who is not an ideal candidate, but for whom there are no other good treatment options. For instance, as a child, Steve had been sexually assaulted by his babysitter. After ex- tensive psychodynamic therapy and many trials of medication, he was referred for CBT as a last resort. Steve was highly suicidal, very hostile, and kept two loaded revolv- ers under his pillow. Steve refused to give up his revolvers permanently, and his suicidality and depression failed to respond to new medications or CBT for depression. Steve’s therapist and his psychiatrist decided that because nothing else had worked, there seemed to be little reason to not try exposure, as long as safety precautions were taken. For example, Steve agreed to give the revolvers to a friend for 1 week, though he was unwilling to give them up longer. His psychiatrist also made sure she was avail- able to admit Steve to the hospital if his suicidality escalated. During the first exposure session, Steve’s experienced therapist felt significant anxiety and urges to avoid using exposure.

Steve benefited tremendously from his first exposure session, and subsequent ses- sions were much less anxiety provoking for the therapist. This example, however, high- lights the reality that exposure may require you to confront your own anxiety. Exposure also may require you to tolerate other negative emotions that can be triggered by par- ticularly horrific events. For example, in listening to Kelly describe an exceedingly bru- tal gang rape in detail, her therapist experienced horror and profound sadness. The therapist later processed his own experience of listening to Kelly’s experience in confi- dential consultation with another trauma therapist.

“I FEEL CONFIDENT: WHICH TECHNIQUES SHOULD I USE?”

To a large degree, your decision to employ certain CBT techniques will be guided by your case formulation. At times, however, you may be unsure about whether to start with cognitive restructuring or exposure, or whether your patient is a good candidate for either intervention. This section addresses these treatment issues.

“Is My Patient Ready for Exposure?”

We believe that exposure is vastly underutilized and that its deployment is often post- poned much longer than is ideal. Patients with PTSD regularly relive their traumatic experiences in an uncontrollable manner, and exposure offers them a very good chance at recovery, often surprisingly quickly. At the same time, patients with PTSD often present with an array of complicating factors that understandably raise concerns. At present, clear empirical guidelines are not available regarding which patients at what point in therapy should start exposure for PTSD, and no consensus has emerged re- garding clinical guidelines (Frueh, Mirabella, & Turner, 1995; Litz et al., 1990). Thus, de- cisions regarding exposure require that you balance competing concerns.

When PTSD is the principal diagnosis, begin by assuming that exposure is the most efficient and rapid avenue to symptom relief, and that it should be implemented as quickly as possible. Determination of “as

quickly as possible" involves consideration of several other factors beyond the primacy of PTSD, including safety, willingness, and ability. You will begin to assess these factors at the start of treatment and continue to evaluate them throughout treatment. For example, after initially determining that a pa- tient seems to be a good candidate for exposure, you may reassess that patient's ability to complete exposure if things do not go according to plan. Also, you typically can as- sess willingness only after you have presented your case for exposure (see Chapters 5, 6, and 7).

Safety

Suicidality, aggression/homicidality, substance abuse, food restriction, self-injury, and impulsive or reckless behaviors (e.g., reckless driving) are examples of behaviors that can pose a danger to your patients or others. Whenever a patient with PTSD reports a history of such behaviors, formulate a plan for managing these behaviors. The plan might include referral for other treatment or a temporary focus on establishing safety. For example, Bill reported that he was using cocaine nightly, and assessment revealed that he met criteria for substance dependence. Given the risks involved with cocaine dependence and the possibility that the cocaine use might prevent Bill from benefiting from PTSD treatment, the therapist referred Bill for detoxification and substance abuse treatment before proceeding with CBT for PTSD. Amalia reported frequent anger out- bursts during which she threw dangerous objects such as knives, scissors, or pans at others; her therapist decided that this presented an unacceptable level of risk and post- poned trauma-focused therapy in favor of teaching Amalia anger management skills.

Alternatively, the plan might involve monitoring the dangerous behavior during treatment or creating a plan to increase safety (e.g., having Steve give his guns to his

friend). In such cases, exposure might proceed relatively quickly. Li Ming was notice- ably underweight and admitted to previous extreme low weight (40 pounds below nor- mal adult weight). Her therapist agreed to proceed with PTSD treatment after Li Ming agreed to monitor food intake and body weight. Likewise, Becky had a history of sui- cide attempts but had not been suicidal in quite some time. Given her history of prior suicide attempts and of increasing suicidality during periods of high stress, Becky and her therapist decided to proceed with exposure while implementing daily monitoring of suicidal urges during treatment.

In some cases, the threats to patients may be from others. Assessing the validity and imminence of such threats can be difficult, because patients with PTSD, given the nature of the disorder, are biased toward perceiving threat. For example, Kendra re- ported remaining watchful and on guard for her ex-husband, who had physically abused her until their divorce. She stated that she saw him around town and felt threat- ened by him. Careful questioning revealed that Kendra had never actually seen him, but she had seen vehicles that looked like his. In fact, Kendra was not certain of his ac- tual whereabouts or whether he was a threat. Similarly, Pamela reported that her ex- husband, the perpetrator of 25 years of physical abuse, continued to drive by her house and make his presence known to her. Although she was certain of his identity, she also noted that he had not violated the distance limits set by their divorce decree, had not made a threat in 3 years, and in fact was now married to another woman. In both cases, the women's therapists opted to proceed with treatment while continuing to assess threats periodically.

Conversely, however, some patients with PTSD underestimate or disregard threat. For example, Gregory continued to visit his mother weekly despite his stepfather's pe- riodic assaults that left him bruised and bleeding. His therapist focused on helping Gregory problem-solve options for maintaining a relationship with his mother, without tolerating being battered by his stepfather.

When deciding how to proceed, consider the recency of the behavior, the level of threat, and the conditions under which the behavior tends to increase. CBT for PTSD often will need to be postponed until the risk posed by very dangerous behaviors is no longer imminent. However, "often" does not mean "always." For example, significant suicidality typically is considered a contraindication for exposure. But, as noted earlier in Steve's case, the therapist successfully implemented exposure after arranging several safety precautions. Similarly, Lucy reported that she regularly scratched herself to the point of drawing blood. Her therapist determined that this behavior did not pose im- minent risk of serious harm, and was related to her PTSD. Thus, treating the PTSD would likely reduce the self-injurious behavior. The therapist decided to proceed with CBT for PTSD while monitoring the scratching behavior, and to address the scratching behavior in the course of treatment.

Willingness

Patients with PTSD seek treatment for many reasons; often, PTSD is not among them. For many individuals, a conceptualization that links their presenting complaint to the trauma is unexpected and discomforting. Such patients may not be willing to embark on trauma-focused treatment, particularly if they feel that they have dealt with the

event successfully, or if they fear that exposure might disrupt the tenuous level of func- tional stability they have achieved. It may take some time for such patients to be will- ing to proceed with exposure.

Some patients may become unwilling to engage in exposure if they experience an increase in symptoms with exposure. They also may dropout if they believe that you will disapprove of their decision, or that there are no other treatment options. For ex- ample, after her first exposure session, Emma stated, “I can’t continue this—I can’t go back to how I was 10 years ago. My husband and I discussed it, and I realize I can’t risk it.” For such patients, it is important first to validate fears about disrupting functioning. Next, remind patients that an increase in symptoms in the beginning of treatment does not predict outcome. Finally, communicate to patients that they have control over treat- ment decision making. Some patients find it helpful to weigh the pros and cons of ex- posure treatment (see “Decision Analysis” in Chapter 9). During this process, strike a balance between reminding patients that their chances of benefiting are good, and ac- knowledging that you cannot predict with certainty what will happen. The only way to find out is to try. In our experience, when validation is balanced with honest education about treatment options, patients feel supported and in control of their treatment deci- sions. In response, they often are willing to proceed with treatment, and do not feel co- erced.

Patients who continue to hope that they can fix their PTSD without having to think about the traumatic event may be unwilling to think about what happened, or may en- gage in well-rehearsed dissociative responses that, although apparently automatic, are nonetheless a form of unwillingness. For example, when prompted to begin imaginal exposure to her abuse memory, Isabella typically began shaking her leg, staring un- blinkingly, and slowing her speech to the point of being almost nonresponsive. When discussing her reactions to the exposure task, she described herself as deciding to “blank out.” For such patients, willingness to contemplate the event may involve not only reaching a decision to engage willingly in exposure but also effortful practice at experiencing the memories, emotions, thoughts, and sensations that accompany the memories (i.e., patient ability; see below).

It is easy to miss dissociative behaviors, because patients may be skilled at disguis- ing them. For example, patients may appear to be fully engaged in a discussion, yet have no recollection of it the next day, which indicates that they were probably dissoci- ating at the time of the discussion. You may not be able to detect dissociation in such patients until you get to know them well enough to recognize subtle changes in affect, lack of responsiveness to humor, or flattened facial expression that may signal its oc- currence. Even when you detect such dissociation, however, you may find that once it has begun, there is little you can do to stop it. Efforts to prevent dissociation by teach- ing your patient to maintain present awareness often are more successful than inter- rupting a dissociative episode once it has begun.

Other behaviors also may indicate a lack of willingness to engage in exposure. For example, unwilling patients may drop out of treatment or attempt to persuade you that therapy will not work. Patients with PTSD often have difficulty believing that anxiety will decrease as a result of treatment—no matter how logical the rationale. Many pa- tients believe that approaching trauma memories and stimuli will make matters worse. Thus, they may try to convince you that discontinuing their avoidance is ludicrous and dangerous. This behavior suggests that patients have not fully accepted the rationale.

In some instances, shame may underlie unwillingness. Patients who believe that their trauma is very shameful fear losing the relationship with you as it becomes more important to them. In such cases, as the therapeutic alliance strengthens, your patients paradoxically appear less, rather than more, willing to engage in trauma-focused inter- ventions.

Addressing willingness involves two steps. First, you need to assess willingness, which may be a matter of simply asking patients, “Are you willing to do this?” In other words, given the available information, and their personal goals, are they (1) per- suaded that exposure will work for them to achieve their goals and (2) willing to expe- rience intense emotions for the promise of eventual symptom relief. As highlighted ear-

lier, however, unwillingness also may require additional assessment (e.g., to determine that shame is driving the unwillingness).

If you determine that a patient is unwilling to try exposure, begin by revisiting the rationale for exposure. Your patient may have misunderstood the rationale, failed to re- tain it, or may have unanswered questions. Second, you may want to explore patients' concerns about lack of control over the exposure process or fear that you will "force" them to complete exposure. Third, if you suspect that shame may underlie unwilling- ness, you may find it useful to introduce cognitive restructuring first (see Chapter 8). This enables you to address thoughts underlying shame and thoughts about the conse- quences of disclosure that may inhibit patients' willingness to do exposure. In addition, you may explore the pros and cons of engaging in exposure (see "Decision Analysis" in Chapter 9).

Increasing a patient's control over exposure is another useful strategy to increase willingness. As with any therapy task, exposure must be conducted voluntarily, and you need to alleviate any of your patient's concerns that "you will force me to think about it." Voluntary participation in exposure is both ethical and practical, because con- trol over exposure may be important for its success. For instance, one perspective re- garding why exposure works (Mineka & Thomas, 1999) holds that anxiety reduction during exposure largely is due to increased perceptions of control. Also, as discussed in Chapter 2, theories of PTSD implicate loss of control over threat in the etiology of PTSD. Studies have not examined the role of patient control among individuals with PTSD. Several studies, however, have demonstrated its value in treatment of specific phobias and OCD. For example, two studies found that self-controlled exposure was superior to therapist-controlled exposure for specific phobias (Hepner & Cauthen, 1975) and OCD (Emmelkamp & Kraanen, 1977).

Exposure therapy can of course be given only to sufferers who are willing to carry it out.
—MARKS (1987, p. 458)

The prominent role of perceived loss of control in PTSD highlights the importance of increasing patients' sense of control over their lives. It follows that a therapy inter- vention will be counterproductive if patients do not believe that they have control of it. Indeed, as noted earlier, feeling out of control of exposure may be a risk factor for a negative reaction. Therefore, we suggest offering patients as much opportunity to con- trol the therapy process as possible. For example, we explicitly remind patients that ex- posure is completely voluntary. When Julie reported anxiety about starting exposure,

her therapist stated, "Don't forget, you have control over this. I can't and won't make you do exposure. This is your choice and under your control." Julie responded, "You're right. I think I can do this, though. I think I need to do this."

Patient Ability

At times, patients are willing to try exposure but seem to lack the skills needed to suc- cessfully complete it. Patients who lack the skills to experience and attend to anxiety, to the exclusion of other emotions, rarely do well with exposure. Yet they may be able to continue with exposure successfully after developing mindfulness skills, as provided in DBT (Linehan, 1993a). Mindfulness involves attending to present experiences, in- cluding emotion states. Mindfulness skills can therefore facilitate the engagement with anxiety necessary for successful exposure. We discuss the skills involved in exposure in greater depth in Chapters 6 and 7.

"Should We Start with Exposure or Cognitive Restructuring?"

Once you have decided to use exposure, you need to decide whether to start with expo- sure or cognitive restructuring. Typically, we start with exposure, unless there is good reason to do otherwise. The most common reason to start with cognitive restructuring is if your assessment indicates that your patient is experiencing strong feelings of guilt and/or shame in relation to the traumatic event. These feelings might impede willing- ness to engage in exposure, or they might interfere with habituation during exposure and result in diminished benefit for your patient (discussed in greater detail later in Chapter 8).

If you plan to include exposure and cognitive restructuring simultaneously throughout treatment, it also may make sense to initiate cognitive restructuring first, because thoughts that emerge during exposure sometimes are not addressed by expo- sure alone. In such cases, you use cognitive restructuring to address these thoughts im- mediately following an exposure, if your patient has already learned the skill. For example, Carlos, a survivor of childhood sexual abuse, expressed a great deal of shame about the abuse during the evaluation and scored high the Trauma-Related Guilt Inventory (Kubany et al., 1996).

Anticipating a prominent role for cognitive re- structuring in his treatment, the therapist taught Carlos cognitive restructuring imme- diately following psychoeducation. Initially, Carlos challenged fearful thoughts such as “It’s not safe to be home alone,” and hopeless thoughts such as “I’m never going to feel good.” Subsequently, Carlos’s therapist noted that thoughts related to shame and guilt were expressed during imaginal exposure. For example, Carlos said, ‘I let it happen, so I was a collaborator” and “It means I’m gay—I’m less of a man.” Following a 60-minute exposure, the therapist was able to segue immediately into cognitive restructuring, and Carlos made significant progress challenging the first thought in the remaining 15 min- utes in the session. Thus, when you are fairly certain that you need to use cognitive re- structuring, it often makes sense to teach the skill in advance, so that it may be de- ployed when needed.

Another reason you might introduce cognitive restructuring prior to exposure re- lates to comorbidity (particularly depression) and/or safety concerns. For example, if your patient exhibits very severe depression accompanied by suicidal ideation and low

functioning but does not require hospitalization, you may opt to spend a discrete pe- riod focusing on depression, and building momentum and trust before focusing more directly on PTSD. Cognitive restructuring is an empirically supported intervention for depression, so it makes sense to use it in this instance. This might include other cognitive-behavioral interventions for depression, such as activity scheduling (see Per- sons et al., 2001) or problem solving (see Chapter 9).

Typically, this phase of treatment is very brief (two to four sessions) and focuses on increasing functional activity and elevating hope about the potential of CBT for PTSD to reduce suffering. Consider moving forward to exposure as soon as you detect in- creasing hope and a modest improvement in functioning, rather than waiting for de- pression to resolve fully. This is unlikely without focused PTSD treatment. If improve- ment is not achieved quickly, a higher level of intervention, such as a partial hospital program, may be necessary. Also, if your patient’s depression has clear links to life is- sues beyond PTSD, such as a failing marriage, chronic pain, or family problems, or if depression is the principal diagnosis (see Chapter 3), then it may be necessary to focus your initial treatment plan on improving mood. After a full course of treatment for depression, reevaluate PTSD and determine whether CBT for PTSD is still indi- cated.

Cognitive restructuring may also be helpful in enacting behavior changes that might increase physical safety or reduce anger. For example, Gloria’s trauma symp- toms were related to the loss of her husband on 9/11 and childhood physical abuse by her stepmother. Yet the therapist was reluctant to start with exposure, because Gloria was engaging in cutting that followed her frequent contact with her elderly, emotionally abusive father. The therapist used cognitive restructuring to address Glo- ria’s thoughts that she was obligated to take care of her father in old age. As a result, Gloria decreased contact with her father, and her urges to cut also rapidly declined. Similarly, Nihla, who was sexually abused by her cousin, continued to have regular contact with him at family functions and via telephone, even though he was often subtly sexually suggestive during these encounters. These contacts fueled Nihla’s an- ger, so her therapist began by addressing Nihla’s thoughts that she was obligated to maintain a relationship with her cousin. Subsequent interventions also targeted an- ger.

Finally, the decision to introduce cognitive restructuring first also relates to practi- cal issues of timing. If you are beginning treatment with a new patient right before you leave for vacation, then this might not be a good time to start exposure. Thus, you might decide to introduce cognitive restructuring during the few weeks before you leave. This ensures that you will be available to monitor your patient during the first weeks of exposure, and it also maintains active therapy tasks during the interim. Al- though postponing the start of therapy until after your return is also an option, the gap may increase risk of dropout.

There are also instances in which cognitive restructuring may be unwise. For ex- ample, patients with obvious cognitive limitations often have great difficulty engaging productively in formal cognitive restructuring. You may also encounter this in patients with no apparent cognitive deficits at the outset. If you have clear information that your patient has cognitive limitations (e.g., a history of traumatic brain injury, develop- mental disability, or dementia), consider moving directly to exposure, even when other indications for cognitive restructuring are present.

“Should We Start with In Vivo or Imaginal Exposure?”

There are good reasons to start with in vivo exposure in many cases. It often is easier for patients to maintain their focus of attention on the concrete, observable stimuli of in vivo exposure compared to the abstract exposure stimuli (i.e., memories in their mind) of imaginal exposure. Memories also are typically more complex than in vivo exposure stimuli. As such, an in vivo exposure stimulus can be easier to attend to for an extended period than a memory, and in vivo exposure can result in rapid fear reduction, often in 30 minutes or less. Attaining rapid reduction in fear is more immediately reinforcing to the many patients who are leery of beginning exposure.

Starting with in vivo exposure has the added advantage of providing you with im- portant information before embarking on imaginal exposure. From the first in vivo ex- posure homework assignment, you learn to what extent your patients are willing and able to do exposure exercises independently, whether they understand and comply with the task and record keeping instructions, and how rapidly their anxiety dimin- ishes. You should use this important information to guide planning of treatment activi- ties. Disregarding such observations could jeopardize the therapeutic alliance and/or patients’ commitment to treatment activities and potentially result in diminishing treat- ment adherence and/or dropout. For example, if a patient does not carry out the in vivo exposure assignment, then this may forebode poor adherence when imaginal exposure homework is added to the assignment.

MANAGING PRACTICAL CONCERNS AND SYSTEMIC BARRIERS

Session Length and Frequency

Unfortunately, mental health delivery systems are sometimes not well adapted to CBT for PTSD. Nonetheless, whenever possible, we advocate implementing CBT in a man- ner that stays as true to the research as possible. Thus, we recommend that you use 90- minute sessions, if possible (i.e., you can obtain reimbursement), because CBT for PTSD often is delivered in 90- or 120-minute sessions in research trials (Bryant et al., 2003; Foa et al., 1991, 1999; Paunovic & Ost, 2001; Resick et al., 2002). Similarly, consider using twice weekly sessions, if indicated and feasible. A num- ber of researchers administer CBT for PTSD over a shorter time period by using twice weekly sessions (Foa et al., 1991, 1999). Although it is unclear whether twice weekly sessions improve outcome in PTSD treatment, CBT researchers in other areas (e.g., eat- ing disorders and depression) advocate twice weekly sessions at the start of treatment to encourage early momentum (Fairburn, Bohn, & Hutt, 2004). Moreover, even when your plan is for weekly sessions, some PTSD patients may benefit from biweekly ses- sions during the difficult phases of treatment. For example, if a patient is struggling with exposure, then you may decide to move to a biweekly schedule. Similarly, with a patient facing a crisis, you may be able to continue with exposure by meeting biweekly, one time per week for exposure and once to manage the crisis.

If you are in private practice and rely on third-party reimbursement, however, you may find such recommendations problematic. Many third-party payers refuse payment or construct time-consuming approval procedures for longer or more frequent sessions.

Thus, right from the start, you may face barriers that prevent you from implementing evidence-based CBT methods.

We advocate expending the effort needed to get past these hurdles, because CBT for PTSD can dramatically reduce your patients’ suffering. In other words, do not give up. Systems barriers usually can be managed with some creativity. For example, expo- sure sessions often can be reduced to 50 minutes after your patient has experienced a reduction in anxiety during the first session or two. Also, some benefit plans permit ei- ther longer or more frequent sessions, though they may not permit both. Thus, some patients can be scheduled twice per week for 50 minutes during early exposure ses- sions. Fortunately, insurance companies are becoming familiar with empirically sup- ported treatment guidelines. In such instances, showing that you are familiar with the research literature and speaking intelligently about CBT helps establish your clinical competency, which facilitates authorization. If faced with care managers who are not familiar with CBT for PTSD, you may find it helpful to initiate a discussion of the re- search supporting CBT. This might include faxing the care manager a list of references supporting the efficacy of CBT for PTSD (see Chapter 1), offering also to fax copies of some of the original research reports, and inviting the care manager to share research on alternative treatments that the insurance company would like you to use. Do not be afraid to use the research literature to advocate for your

patients. The literature sup- porting CBT for PTSD is substantial, and good outcome reduces long-term costs. Also, most reviewers will accept your point rather than have their fax machine tied up with page after page of original research reports.

In addition to other limitations, many plans restrict the number of sessions per year, a potential problem for any form of therapy. If you fear that premature termina- tion will leave your patient in a state of elevated distress, however, you may be reluc- tant to start trauma-focused therapy. This is understandable, and you will undoubtedly see some cases in which it does not make sense to start exposure when therapy is lim- ited (e.g., in some patients with severe suicidal ideation). Yet a surprising array of pa- tients can benefit by moving forward with CBT, which was designed to be short-term. Many patients experience considerable benefit from just a few sessions of exposure and/or cognitive restructuring. When all else fails, you can delay treatment to the later quarter of the year, which reduces the effect of yearly benefit limitations. Finally, some governments have enacted mental health parity laws that prohibit limitations of health care benefits for specific mental disorders, such as PTSD. Under such laws, session lim- itations often are not permitted. You should familiarize yourself with the mental health parity laws in the jurisdiction in which you practice. There may be times when you need to remind the care manager tactfully about the law.

Inadequate Support

One systems issue with which you may struggle is inadequate support for treating challenging patients. Many patients with PTSD experience a significant number of cri- ses during treatment, including suicidality, interpersonal disputes, and financial and le- gal problems. Moreover, borderline symptoms are not uncommon, even among pa- tients with PTSD who do not meet full criteria for borderline personality disorder

(BPD). For example, patients with PTSD may engage in stressful behaviors (e.g., self- injurious behavior) and reinforce you for conducting ineffective therapy (e.g., by rein- forcing you for avoiding trauma-focused treatment; Linehan, 1993a, p. 425). In sum- mary, treating a large, or even moderate, number of these patients can be challenging.

Trauma-focused therapy also requires you to listen to horrible events in graphic detail, over and over again. Although you adjust to this, listening to a different type of event, a particularly horrific event, or one that reminds you of personal experiences, may periodically leave you feeling somewhat overwhelmed, even if you are very expe- rienced.

In outlining treatment for BPD, Linehan (1993a) emphasizes the need for ongoing supervision and consultation. As noted earlier, therapists who treat PTSD and those who treat BPD encounter similar stressors. Thus, Linehan's advice seems relevant for PTSD therapists. Peer consultation can help to boost morale, provide alternative per- spectives when therapy seems stuck, and provide a safe, confidential setting for pro- cessing your own reactions. If you are in solo private practice, consider setting up a consultation group with other therapists who regularly treat PTSD, ideally using CBT or other trauma-focused therapies. If you are implementing CBT, you will likely find it less helpful to participate in a consultation group with therapists who are reluctant to address their patients' trauma histories directly.