

## **Guidelines for Mental Health Practitioners**

### **Normality of Trauma Response**

Our understanding of Post-Traumatic Stress Disorder has changed dramatically over the past 10 years. We now recognize that it is normal for people to experience psychophysiological changes following trauma. These can include disruptions in sleep, concentration difficulties, increased anxiety, sadness, anger, grief, irritability, hypervigilance, disruptions in work or social functioning, avoidance of thoughts or situations associated with the trauma, and involuntary re-experiencing of traumatic events.

The normality of these reactions post trauma is reflected in the diagnostic criteria for PTSD which requires persistence of these symptoms four weeks or longer after the traumatic event before a diagnosis can be made. In fact, most people who experience these reactions post-trauma naturally recover without intervention. This empirical observation leads psychotherapists to be cautious about offering psychological interventions within the first month after a trauma. Such caution is warranted because some early interventions, such as critical incident stress debriefing (CISD), may be ineffective or even potentially harmful in some formats.<sup>1</sup>

### **What psychological interventions should therapists offer in the initial weeks after trauma?**

In the initial weeks after a trauma, those people who seek psychological help can be offered interventions that have been called “psychological first aid.” The goal of psychological first aid is facilitation of normal emotional processing of the traumatic event(s). Helpers are advised not to include psychological techniques at this early phase but instead to (1) assess and provide for immediate physical needs (e.g., injury treatment, food and water), (2) ensure the person’s physical safety (e.g., arrange safe shelter if necessary), (3) offer practical help (e.g., arrange babysitting help for a parent who is overwhelmed, protect from media intrusions, assist with paperwork requirements, etc.), (4) make sure the traumatized person makes contact with the people who might be a normal source of comfort in his or her life (e.g., family, friends, spiritual community), (5) facilitate contact with loved ones (nearby and far away), (6) educate about the normality of a variety of responses immediately following trauma, (7) support real life task decisions (what can you continue to do? what needs to be delayed? Help the individual prioritize life tasks that need attention).

Any discussion of the trauma in the initial weeks should include only what the individual wants to talk about. Therapists are advised not to encourage the person to retell the trauma story again and again in the belief that this will help prevent PTSD. In fact, such retelling in a therapeutic setting in the early weeks following a trauma may encourage unhelpful rumination, linked to risk for persistent PTSD. Also, therapists should be careful not to overwhelm the person with information.

### **What psychological interventions are effective once PTSD is diagnosed?**

Expert Consensus Guidelines are published (Foa, Davidson, & Frances, 1999) which describe current practices in the treatment of PTSD by experts in the field. These are available on-line for review at: [http://www.psychguides.com/gl-treatment\\_of\\_PTSD.html](http://www.psychguides.com/gl-treatment_of_PTSD.html)

The Expert Consensus Guidelines describe in broad detail what therapies are considered effective for PTSD. Two of the recommended therapies are exposure therapy and cognitive therapy (which usually includes exposure therapy as a part of the treatment). The consensus guidelines do not provide detailed information for clinicians on how to implement these effective therapies. Here we recommend some specific references that can help clinicians learn how to use cognitive therapy effectively for PTSD.

### **Exposure Therapy**

Exposure therapy can help clients overcome one of the central behavioral features of PTSD: avoidance. A detailed description of how to do exposure therapy can be found in Foa & Rothbaum (1998). Exposure therapy for PTSD consists of having the client gradually confront anxiety-producing images and situations associated with the trauma. Facing these feared stimuli enables the client to learn that his/her

anxiety can decrease, that he/she can tolerate reminders of the event, and that avoidance is not necessary.

Exposure therapy allows the client to process and appraise the trauma and related memories in an integrated and less distressing manner. Exposure can be either imaginal or *in vivo*. In imaginal exposure, the client describes the trauma in elaborate detail, noting his/her thoughts, mood, behavior, and specific, vivid descriptions of the event. The imagery used should be as detailed and realistic as possible. The story is told in the present tense. The therapist facilitates the use of present tense by asking questions that aid in recall such as "What are you doing now?", "What is going through your mind?" and "What are you feeling now?". Throughout the retelling the client is asked to rate his/her current distress level on a 0 - 100 scale. Initially the client describes the entire event. The therapist and client can then pick particularly anxiety-producing aspects to focus on subsequently. The exposure exercise is repeated until the client habituates to the anxiety-provoking imagery and does not become as distressed.

In *in vivo* exposure, the client confronts actual cues or activities associated with the trauma that are being avoided. It is important to ask people to generate a specific list of all the things they are avoiding post-trauma (e.g., places, situations, people, and other memory triggers which evoke significant emotions) so exposure can proceed for each of these areas. Exposure teaches the client that fear is not warranted, that negative mood associated with reminders of trauma can subside, and it provides concrete information to counteract negative beliefs. As with imaginal exposure, the client rates his/her level of distress and treatment proceeds along a hierarchy.

In a recent review of the PTSD literature, Foa and her associates (Foa, Keene, & Friedman, 2000) report on the efficacy of diverse treatments. Exposure therapy was examined in twelve methodologically rigorous studies. Six of these studies included only Vietnam veterans, two were limited to women who experienced sexual assault, while four had a heterogeneous trauma sample. All of the studies reported positive outcomes for PTSD.

### **Cognitive Therapy**

Cognitive therapy, which usually includes behavioral exposure therapy as a part of the treatment, is one of the evidence-based therapies considered most effective for treatment of PTSD in both adults and children. Not all [certified cognitive therapists](#) have experience with PTSD so it is important to ask a therapist if PTSD is a specialty.

Cognitive therapy emphasizes identification and testing of beliefs maintaining PTSD. Thus, cognitive therapists use exposure methods (both *in vivo* and *in vitro*) to identify and test key beliefs rather than simply as a method for desensitization. Thus, someone who avoids walking in the vicinity of tall buildings (following PTSD resulting from observing the World Trade Towers collapse) might be gradually encouraged to walk toward and then adjacent to skyscrapers as part of classic exposure interventions. A cognitive therapist would also include this type of exposure in therapy. However, such exposure exercises would be linked in cognitive therapy to identifying and testing beliefs thought to be maintaining the current PTSD (e.g., "If I walk near a tall building, I will be hit by falling debris," and "I am more likely to die in a terrorist attack than most, so if I avoid places where such an attack might occur, I can reduce the likelihood of such an attack").

Why do cognitive therapists emphasize PTSD-related beliefs when exposure has been found to be an effective treatment for PTSD? New cognitive therapy research suggests that the origins of PTSD lie not simply in the occurrence of trauma but in the nature of the trauma memory and the cognitive appraisals of the trauma and its sequelae (Ehlers & Clark, 2000). That is, particular cognitive factors are correlated with whether someone recovers naturally from a trauma or develops persistent PTSD.

### Cognitive Model of PTSD

Compare the following beliefs that might follow terrorist attacks such as the September 11, 2001 attacks in New York City, Washington, D.C., and Pennsylvania:

Situation	Beliefs Associated with Natural Recovery	Beliefs Associated with Persistent PTSD
Nightmares on September 30	“Nightmares can be expected after such a traumatic event”	“I’ll never sleep normally again.”
Conversation with a friend who is coping better than me	“Everyone has their own pace. I’ll cope better soon.”	“This trauma has changed me (for the worse) forever.”
An invitation by a friend to attend a vigil at the site	“Going will help me come to terms with what happened.”	“I’ll feel worse if I go. Better stay home.”
Hearing an airplane overhead	“I still jump when I hear one! It’s OK, just a regular flight.”	“If I don’t watch it until it is out of sight, it may crash.”
A party with friends	“I’m going to just have two drinks. I’m driving home.”	“It’s best to drink until I forget. I want to be numb.”

As shown in this table, people who experience a natural recovery from trauma are likely to appraise their trauma responses as normal reactions to an abnormal event. Natural recovery is hastened if people continue their activities, normalize their trauma-related symptoms, and don’t avoid reminders of the trauma. In contrast, people with persistent PTSD tend to view their trauma symptoms as permanent, negative changes that won’t be overcome. Persistent PTSD is maintained by avoidance (of trauma reminders), rumination, and safety-seeking behaviors (staying home, hypervigilance to danger).

In addition, people who experience a natural recovery from trauma are more likely to have an organized, coherent memory of the trauma event. People who experience persistent PTSD often have a fragmented and disorganized memory of the event. This latter finding is consistent with the observation that persistent PTSD is more common in people who cope with traumatic events using dissociation. Dissociation may interfere with the formation of an organized, coherent memory of events.

### Research Support for the Cognitive Model of PTSD

Research supports this cognitive model of PTSD. A number of studies cited in Ehlers and Clark (2000, p. 342) demonstrate the link between persistent PTSD and: appraisals of the trauma, beliefs about PTSD symptoms, and negative judgments about other people’s post-trauma responses. A recent study (Dunmore, Clark, & Ehlers, 2001) demonstrates that cognitive variables predict PTSD severity 6 and 9 months after a physical or sexual assault.

A study done in Northern Ireland (Clark, 2000) following the 1998 terrorist bombing in the town of Omagh’s crowded marketplace (which killed 29 people and injured hundreds of other people), found that seven factors were significantly associated with scores on the PDS ([The Posttraumatic Stress Diagnostic Scale](#)). Of these seven, the factors most strongly associated with subsequent development of PTSD were cognitive factors (negative view of the symptoms/self and rumination following the bombing). Other factors in order of statistical strength were: thought/emotion suppression, the thought during the bombing that one was going to die, presence in the marketplace during the bombing, “unsafe world” beliefs, and the occurrence of an injury during the bombing. Interestingly, the occurrence of an injury was only half as strongly associated with subsequent PTSD than negative views of symptoms/self.

This research demonstrating the importance of cognitive factors in the subsequent development and persistence of PTSD suggests new foci for targeted treatment of PTSD. Rather than supportive counseling or repeated retelling of trauma events (in the absence of reframing), the most effective therapy for PTSD may be interventions which (1) test beliefs about the long-term effects of the trauma and particular personal trauma responses and (2) help the person organize and complete their trauma memory. A brief summary of helpful treatment methods is included in Ehlers & Clark (2000, pp 335- 342), available below as an electronic reprint due to the generosity of Elsevier Science. This article contains helpful guidelines for assessment, client education regarding PTSD, providing a treatment rationale to the client, methods to help the client “reclaim one’s life,” therapeutic processes for “reliving with cognitive restructuring, *in vivo* exposure, and use of imagery techniques.

The Ehlers and Clark treatment model has been empirically tested with diverse trauma populations including: survivors of the Omagh, Northern Ireland 1998 bombing, people experiencing chronic PTSD (a series of case studies), people involved in motor vehicle accidents. Although outcome data from these studies has not yet been published, early data analyses suggest this cognitive treatment for PTSD shows effect sizes of 2.5 (Clark, 2001). Such effect sizes are large and compare favorably to effect sizes in other studies of effective PTSD treatments (commonly effect sizes in the 1.25 range). These early results show that this new cognitive theory and therapy for persistent PTSD may offer an improvement over other therapy approaches for PTSD.

In sum, mental health professionals can be heartened by cognitive therapy research on PTSD. Although trauma responses are almost universal after certain types of events, most people recover on their own within a few months. And a majority of those people who experience persistent trauma are likely to be helped by focused and brief cognitive therapy. To learn more about the latest developments in cognitive therapy for PTSD, press on the links in the final paragraph (following the reference list) below to print a copy of the Ehlers and Clark (2000) paper.

<sup>1</sup>For those not familiar with it, CISD typically consists of a single session in which individuals are encouraged to recall and describe the event as a means of emotional processing. However, in classic CISD, participants are not taught specific cognitive or behavioral coping strategies. In addition, their retelling of their experience is not done in a systematic, gradual, or hierarchical manner.

Despite its widespread use, critical incident stress debriefing has not been subject to much empirical investigation. The Cochrane Library recently reviewed eleven studies of CISD (Rose, Bisson, & Wessely, 2001). Results indicate that CISD did not diminish general psychological distress, depression, anxiety, or prevent the development of post-traumatic stress disorder. Conversely, one trial reported that participants who received CISD had a greater risk of post-traumatic stress disorder than the control group. The authors conclude that CISD is not an effective treatment. It should be noted that these studies in the Cochrane report all involved single-session, individual debriefing. CISD is also conducted for groups and for more than a single session. There is no empirical evidence to suggest whether group or multiple-session CISD is helpful or not.

- Clark, D. M. (July, 2001). Social Phobia and Posttraumatic Stress Disorder: Why they persist and how to treat them. A keynote address presented at the World Congress of Behavioral and Cognitive Therapies, Vancouver, Canada.
- Clark, D. M. (June, 2000). A Community Survey of the Psychological Consequences of the Omagh Bomb and Predictors of PTSD. A paper presented as part of a symposium on the effects of the Omagh bombing presented at the International Congress of Cognitive Therapy, Catania, Italy.
- Dunmore, E., Clark, D.M., & Ehlers, A. (2001). A prospective investigation of the role of cognitive factors in persistent Posttraumatic Stress Disorder (PTSD) after physical or sexual assault. *Behaviour Research and Therapy*, 39, 1063-1084.
- Ehlers, A., & Clark, D.M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, 38, 319-345.
- Foa, E., Keane, T., & Friedman, M. (2000). Guidelines for treatment of PTSD. *Journal of Traumatic Stress*, 13, 539 - 588.

Foa, E., & Rothbaum, B. (1998). *Treating the trauma of rape: Cognitive-behavioral therapy for PTSD*. New York: Guilford Press

Rose, S., Bisson, J., & Wessely, S. (2001). Psychological debriefing for preventing post traumatic stress disorder (PTSD) (Cochrane Review). In: *The Cochrane Library*, 3. Oxford, UK: Update Software. Search for this article title on-line at <http://www.update-software.com/abstracts/titlelist.htm>

**Single copies of the Ehlers and Clark (2000) article can be downloaded and printed for personal research and study.** This electronic reprint is provided for this purpose and this purpose only with permission from Elsevier Science. Visit their website (<http://www.elsevier.com/locate/brat>) to learn more about the internationally respected journal, ***BEHAVIOUR RESEARCH AND THERAPY***, and other publications.