Treatment of adults with PTSD

Posttraumatic stress disorder (PTSD) can be successfully treated, and it may even be preventable (see Chapter 9). Once PTSD has developed, two basic approaches have proven the best to address the needs and circumstances of the person seeking help. Psychotherapy is the best-researched treatment approach for PTSD, for adults as well as children (see Chapter 8). Pharmacotherapy—the use of therapeutic medications—is the other major approach for PTSD treatment (Bernardy & Friedman, 2015; Friedman & Davidson, 2014; Opler, Grennan, & Ford, 2009). Pharmacotherapy involves medicines prescribed by a medical doctor/psychiatrist or a specially qualified advanced practice nurse or psychologist. Medications that originally were used to treat depression, other anxiety disorders, seizure disorders, and medical conditions such as hypertension have shown promise in the treatment of adults with PTSD. In this chapter, we summarize the results of a number of randomized clinical trials (RCTs; scientifically rigorous research studies) that have been conducted to test the efficacy (the ability to achieve definite positive results) of approaches to psychotherapy and pharmacotherapy for PTSD (Box 7.1).

At the present time, the spectrum of evidence-based (i.e., having scientifically tested efficacy) PTSD treatments for adults is ever-broadening. There are a number of trauma-focused psychotherapies such as cognitive and behavioral therapies, emotion and interpersonal regulation therapies, psychodynamic and experiential therapies, marital and family therapies, and group therapies (Courtois & Ford, 2009, 2013). In addition, there are innovative variations to trauma-focused psychotherapies such as enhancement with computer-generated three-dimensional virtual reality (VR; Motraghi, Seim, Meyer, & Morissette, 2014; Rothbaum et al., 2014), neurofeedback to stimulate distinctive patterns of brain activity (Kluetsch et al., 2014).

As noted by McLean and Foa (2013) in a recent review on the topics of the diagnosis of PTSD and treatment with evidence-based treatments, new information about the effectiveness and the choice of trauma-focused treatments is being released all the time. To date, CBTs such as Prolonged Exposure therapy (PE), Cognitive Processing Therapy (CPT), Narrative Exposure Therapy (NET), and Eye Movement Desensitization and Reprocessing therapy (EMDR) have the strongest scientific evidence of efficacy—that is, research showing that the treatment is directly responsible for improvements in or recovery from PTSD. However, no one size fits all, and there is growing evidence that other psychotherapy approaches may be effective for (and in some cases, equally or better accepted by) persons of different backgrounds and circumstances who are seeking help for PTSD.

In addition to the many different specific methods of psychotherapy for PTSD, there are core treatment goals and practices that both clinicians and researchers have found to
Box 7.1 Key Points

1. The spectrum of PTSD psychotherapies for adults is broad, including those with the strongest evidence base, cognitive behavior therapies (CBTs), and PTSD affect and interpersonal regulation (PAIR) therapies, as well as hypnotherapy, experiential and psychodynamic therapies, body and movement therapies, marital and family therapies, group therapies, and pharmacotherapy (medications).

2. Across all types of PTSD treatment for adults, a three-phase approach (of shorter or longer duration, depending on the needs and resources of the client) is the most standard, with each phase focused on a core treatment goal: (i) safety and preparation for therapy; (ii) modifying traumatic stress reactions, often (but not always) by a therapeutic reexamination of memories of specific traumatic experiences; and (iii) regaining or acquiring a productive and rewarding life by overcoming or managing PTSD symptoms.

3. The primary goal of PTSD treatment for adults is to reduce the intensity and frequency of PTSD symptoms to a level that is no longer troubling or is manageable (i.e., to no longer have the diagnosis). When other symptoms or disorders (such as depression or substance abuse) co-occur with PTSD, they also must be reduced or managed because improvements in PTSD are likely to be lost in conditions of psychological instability caused by other disorders. PTSD treatment also should enhance the person’s social and emotion regulation skills and support personal effectiveness. Because there are differences in each person’s capacities to engage in therapy and to tolerate and benefit from the emotional intensity of PTSD therapy, it is important to gauge the success of treatment according to goals that are achievable for each unique client and to collaboratively determine these goals.

4. Since 2000, a number of formal guidelines for adults with PTSD based on research findings (evidence-based treatments) have been published, including by the International Society for Traumatic Stress Studies (ISTSS), the US Department of Veterans Affairs, the American Psychiatric Association, the Institute of Medicine of the National Academies, the British National Institute for Clinical Excellence, the Northern Ireland Health Service, and the Australian Centre for Posttraumatic Mental Health.

5. The CBT approach to psychotherapy has strong scientific evidence of efficacy for the treatment of PTSD—that is, research showing that the treatment is directly responsible for improvements in the disease condition. The three principal components in CBT for PTSD are (i) education about PTSD and training in skills for managing stress reactions (“anxiety management” or “stress inoculation” training), (ii) therapist-guided recollection of specific past traumatic experiences (PE), and (iii) training in skills for modifying stress-related thoughts (“cognitive restructuring, CR”).

6. Extensions of CBT for PTSD have been developed that address self-regulation problems such as emotional instability, impulsivity, anger and aggression, self-harm, and suicidality and are gathering consistent research support. These PAIR therapies have shown promise in addressing the complex problems of adults who have substance use disorders (SUDs) or borderline personality disorder (BPD) in combination with PTSD.

7. Group psychotherapy has been widely used clinically for adults with PTSD and appears to be promising as a method for conducting PE/CR with military veterans with PTSD. Pharmacotherapy involving medications originally developed to treat depression, anxiety, hypertension, and seizure disorders has been found to be associated with positive outcomes for adults with PTSD, with the strongest evidence for two antidepressant medications (sertraline and paroxetine) and an antihypertensive (prazosin). Medicines such as d-cycloserine have been investigated for use in enhancing exposure therapy for PTSD.
contribute to the successful resolution of PTSD. Therefore, before we discuss specific treatment methodologies, we first examine the fundamentals of PTSD treatment that form the foundation for all approaches to psychotherapy and pharmacotherapy for PTSD.

**Best practice principles in the treatment of PTSD**

The first principle of all therapeutic interventions is *primum non nocere* (translated from Latin, “first do no harm”). *Personal and interpersonal safety is an essential condition for successful treatment of PTSD.* Ensuring that clients are safe, in their lives as well as in therapy, to the fullest extent possible takes time and careful attention. Some clients with PTSD have lived and continue to live in conditions of danger or chaos that constantly threaten their safety (such as domestic or community violence). Others are involved in lifestyles or repetitive behaviors that place them at high risk for harm (such as due to persistent self-injury, suicidality, addictions, prostitution, or risk-taking). These conditions may become so second nature to them that they may seem “normal” (or unavoidable). When a therapist pays attention to and seeks to help the client to reduce these threats to safety, it may seem to the client that the therapist is being unrealistic due to not understanding or fully appreciating her or his life circumstances. Despite this, a first order of treatment is to help the client to (re-) consider the possibility that safety could be achieved and to help the client to establish conditions of safety to the fullest extent possible under the circumstances. If the client continues to be in a situation that is not safe (such as ongoing domestic violence, incest, sexual harassment, war, or political repression), the therapist should focus almost entirely on developing safety plans and should not move beyond the initial assessment and stabilization stage of treatment until the client’s actual life circumstances can be made safe enough that further victimization and retraumatization are not imminent (http://www.nationalcenterdvtraumamh.org/wp-content/uploads/2013/03/NCDVTMH_EBPLitReview2013.pdf. Accessed 4/14/15).

The second key principle of PTSD treatment is that the therapy must enhance the client’s ability to manage extreme bodily states at both ends of the spectrum from high arousal to being completely detached and shut down. As discussed in previous chapters, PTSD is characterized by alternating states of hyperarousal (such as panic, terror, impulsive risk-taking, rage, or addictive cravings) and hypoarousal (such as emotional and physical numbness, spiritual and interpersonal alienation, dissociation, or feeling utterly defeated and hopeless). All PTSD psychotherapies must help patients to recognize their physical state of hyper- or hypoarousal and teach skills for reducing and increasing arousal in order to achieve a midlevel or “window” of optimum tolerance (neither too much nor too little) of bodily and emotional arousal (Fosha, Paivio, Gleiser, & Ford, 2009; Ogden, Pain, & Fisher, 2006; Siegel, 2007). This may be done, for example, with anxiety management skills such as focused breathing or progressive muscle relaxation (PMR), mindfulness meditation practices, or emotion regulation and/or bodily awareness techniques. Learning to modulate (i.e., to adjust levels of) arousal is a prerequisite to being able to manage stress reactions sufficiently to be able to deal with day-to-day stressors, as well as to constructively and therapeutically face and come to terms with traumatic memories.
The third principle of PTSD treatment is that it must enhance the client’s ability to approach and gain mastery, rather than avoid or shut off awareness, of internal bodily/affective states and external events that trigger PTSD symptoms. Avoidance (and dissociation, a process that is a form of avoidance that is automatic and occurs without conscious intention on the part of the individual) is a hallmark of traumatic stress disorders. Resolving avoidance is a benchmark for successful PTSD treatment (Foa et al., 1999), as is enabling the client to regain conscious awareness when dissociation is a problem (van der Hart, Nijenhuis, & Steele, 2006). However, avoidance in PTSD initially is driven by a healthy motivation to not become overwhelmed when confronted by traumatic experiences. Avoidance thus must be understood in therapy as a reaction that is very difficult to stop, because it was adaptive for survival and may seem necessary to the client in order to not become overwhelmed by PTSD symptoms even when traumatic events no longer are placing her or his survival in jeopardy. Both conscious and unconscious forms of avoidance and dissociation become problematic when they develop into inflexible or automatic reactions that then generalize to other activities and behavior, causing emotional, relational, and behavioral constriction. A fundamental challenge, beginning in Phase 1 of PTSD treatment and continuing throughout all phases of treatment, is to enhance clients’ awareness of both subtle and obvious forms of avoidance or dissociation and to help them become aware of signs that they are safe enough to be able to pay attention to and handle upsetting reminders of past traumatic experiences.

A fourth key principle of PTSD treatment is to provide clients with useful new information as soon as possible and to continue to add to and reinforce this education throughout the therapy in order to enable them to understand PTSD and the recovery process in a way that engages their active participation and empowers them to take charge of their life. PTSD is a condition in which the individual perceives herself or himself as having become powerless and ineffective as a result of traumatic events that were (or seemed at the time to be) inescapable and uncontrollable. Therapeutic education validates the reality of these emotional reactions to traumatic events, while simultaneously helping the client to gain the knowledge and understanding that is necessary in order to (re)gain the power that comes from confidence in herself or himself and trustworthy other person—while recognizing that it also was understandable that she or he was actually (or felt) powerless in past traumatic experiences. This type of therapeutic education can demystify both the symptoms of PTSD and the process of psychotherapy and recovery from PTSD. Education about traumatic stress reactions and PTSD seeks to extend clients’ understanding of the connection between experiences of traumatic stressors (whether in the more recent or distant past) and the development of symptoms of PTSD. It further aims to help clients understand and accept their own reactions as expectable and in important ways actually adaptive and at times even admirable, in the face of the complex, highly demanding, and abnormal circumstances created by traumatic events. Thus, therapeutic education does not “correct” the client’s misunderstanding or “instruct” the client on how to better handle past traumatic experiences or current PTSD symptoms. Instead, therapeutic education enables the client to gain a fuller understanding of how she or he adapted to survive traumatic experiences and how those necessary adaptations can become PTSD symptoms now that they no longer are needed—or are not needed to the
degree or constancy with which they have habitually become manifested—because survival is no longer at stake. Therapeutic education is designed to foster client self-understanding, realistic self-confidence, and self-compassion. Education thus lays the foundation for clients to learn and apply specific skills as therapy proceeds, in order to become able to manage and overcome PTSD symptoms.

The fifth principle of PTSD treatment is that the therapist must gain sufficient accurate information about the client in order to provide the client with guidance based upon respect for who the client is as a person; what the client values and believes in based on her or his formative family, cultural, and community experiences; and what the client has experienced that necessitated the survival adaptations that have become PTSD symptoms. As discussed in Chapter 6, this requires a thorough and sensitive assessment that involves learning from, as well as about, the client. In order for the therapist to achieve the other core goals of PTSD treatment, the assessment may also involve (with the adult client’s consent) input from other key people in the client’s life, records documenting the client’s health and health care, achievements and problems in education and work, and legal or financial status. This information is used not simply to categorize whether the client has a PTSD diagnosis and needs treatment but to provide the therapist and client with a broader and deeper understanding of how surviving traumatic events has altered the client’s life path (which may include symptoms of comorbid disorders as well as PTSD) and the strengths and personal characteristics that the client can draw upon to find a new (or regain a past) path that is safe, meaningful, and true to her or his values and identity.

The sixth principle of PTSD treatment is that every decision is made collaboratively, with neither the therapist nor the client making important choices about how the therapy shall proceed without reaching a shared consensus that honors the client’s personal integrity and autonomy and the therapist’s professional expertise and values. The client ultimately is the expert, and therefore the sole arbiter of all decisions regarding her or his life. Although the therapist can provide new knowledge and perspectives to inform the client’s life choices, it is not within the purview of the therapist to make those choices for any client. By the same token, although the therapist has unique expertise about the nature of PTSD and the process of recovering from PTSD, the client also is an expert about her or his own life and therefore must have meaningful input into decisions regarding the treatment based upon her or his preferences, values, and cultural and spiritual beliefs. Whatever course the therapist recommends for PTSD treatment must therefore be informed by the input of both client and therapist.

The seventh principle of PTSD treatment is that treatment always follows a sequence of three-phases (Herman, 1992). Exactly how long each phase takes and the specific techniques utilized vary, depending on the needs and circumstances of each individual client and the therapeutic method being applied. However, the three phases are universal because each phase addresses an essential treatment goal.

1. The first phase of treatment focuses on safety, education, assessment, and treatment planning in order to accomplish the goal of enabling the client to achieve sufficient stability in her or his life to be able to fully engage in and benefit from treatment.

2. The second phase of treatment continues all of these foundational activities but also adds an important new dimension: trauma processing, which involves helping the client to shift from
avoiding awareness of traumatic memories and PTSD symptoms to becoming intentionally aware and (re)gaining a sense of self-confidence and empowerment.

3. The third phase of PTSD treatment continues the activities of the first two phases, with the addition of helping the client to apply her or his new knowledge and skills to (re)building a satisfying and successful (based on the client’s personal standards and values) life—including healthy and fulfilling relationships, success in work or school, and meaningful personal and spiritual activities (Cloitre et al., 2011; Courtois & Ford, 2013; Ford & Courtois, 2009, 2013; Foa, Keane, Friedman, & Cohen, 2009).

In addition to the three-phase model proposed by Herman, the Stages of Change model proposed by Prochaska and DiClemente (1992) is useful in assessment and as an explanation for the client. Readiness to engage and motivation are important determinants of change; therapeutic gain therefore is dependent on the client’s degree of motivation and effort. Motivational Enhancement Therapy (Miller & Rollnick, 2009), Dialectical Behavior Therapy (DBT; Harned, Korslund, Foa, & Linehan, 2012; Harned, Korslund, & Linehan, 2014; Linehan, 1993), and Acceptance and Commitment Therapy (ACT; Hayes, Luoma, Bond, Masuda, & Lillis, 2006) are models of psychotherapy originally developed for clients dealing with problems other than (but often comorbid with PTSD)—such as addictions, self-harm, and severe mental illness—by designed to enhancing clients’ sense of autonomy, ability to manage extreme emotion states, and acceptance of the need for change and commitment to making changes. Although these treatments substantially differ from one another, they also have commonalities, such as an emphasis on increasing mindfulness, self-determination and self-management (empowerment), and self-regulation and interpersonal skills (Box 7.2).

Phases of therapy for PTSD

Phase 1. The first phase often is the longest portion of PTSD treatment and always the foundation for its success. At the outset, the therapist must explain how treatment will proceed and the client’s rights and responsibilities in order to obtain a truly informed consent from the client to undergo the treatment (Box 7.3). This is the beginning of teaching not only about traumatic stress and PTSD but also what psychotherapy is about and how to participate most successfully and collaboratively.

<table>
<thead>
<tr>
<th>Box 7.2 Informed Consent (and Refusal) for Trauma-Focused Treatment for PTSD</th>
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<td>At the outset of therapy for PTSD, informed consent/refusal for participation in treatment is necessary for every client. Informed consent includes an explanation of protection of the client’s privacy (“confidentiality” of personal information), which is the client’s right (called “privilege,” meaning that clients legally have control over what information is given by the therapist and to whom, with certain exceptions). The exceptions to confidentiality and to the client’s privilege involve situations where “mandated reporting” is a legal requirement. This is particularly relevant in many PTSD cases, because the “mandate” is a requirement that</td>
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therapists “report” (i.e., disclose) to proper authorities (usually state agencies responsible for protecting the safety and rights of people, such as the police and the public child protective services agency) any information that indicates that a vulnerable individual may be in serious danger. The most common example of mandated reporting is when a therapist learns that a child has been and may still be in danger of being physically or sexually abused or severely neglected. These cases are more common when children are in treatment (see Chapter 8), but they may occur with adults who reveal that they were abused or neglected as a child or that their child or a child they know is potentially being abused or severely neglected currently. In many states, therapists also are required (“mandated”) legally to report situations in which they have reason to believe that an older adult is being physically harmed or is in life-threatening danger as the result of actions or neglect by persons responsible for their safety or care (“elder abuse”).

Abuse, severe neglect, and the threat of being severely harmed or killed are likely in and of themselves to be psychologically traumatic, and the remedies for these dangers (typically an investigation by law enforcement or child welfare organizations) can be frightening despite their goal of protecting people from harm. Thus, when mandated reporting is necessary, traumatic stressors may be causing additional acute psychological stress that must be dealt with in the treatment process along with the issues that may originally have led the client to seek treatment in the first place.

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**Box 7.3 Everything You Wanted to Know About PTSD But Were Afraid to Ask**

**Educating clients at the beginning of psychotherapy for PTSD**

Teaching clients about the effects of experiencing (directly or vicariously or witnessing) traumatic stressors, including PTSD, can be done in many ways. Most often, a description of the types of events that often are traumatic stressors is provided (such as the descriptions in the Traumatic Events Screening Inventory; see Chapter 6), followed by a review of the 20 symptoms that are included in the diagnosis of PTSD (such as the descriptions in the PTSD Checklist; see Chapter 6). It is very helpful for clients to know how therapists define traumatic stressors and PTSD in order to “demystify” these technical terms (which are commonly used but rarely well understood, even by professionals).

In addition, it can be helpful to teach clients about the changes in the body, emotions, and thought processes that occur as adaptive acute responses (i.e., beneficial ways of coping with) to traumatic stressors, and how and why these stress reactions can become chronic problems in the form of PTSD. This can help clients to feel more hopeful about benefiting from therapy, especially when the education includes explanations of how therapy can increase one’s ability to overcome or manage PTSD symptoms. For example, Figure 7.1 is excerpted from the Trauma Affect Regulation: Guide for Education and Therapy (TARGET©) psychotherapy model for PTSD (Ford, 2015) (Figure 7.1).

(Continued)
Figure 7.1 Understanding posttraumatic stress: TARGET© Education Sample. PTSD is the result of a healthy brain getting stuck in ALARM mode after (“post”) a person faces extreme danger or injury (traumatic stress). The brain tries to protect you when you experience severe danger by staying highly alert and ready to deal automatically with any threat to your survival. PTSD happens when the brain gets stuck in survival or ALARM mode and this interferes with doing the ordinary things that we count upon our brain to do, like managing emotions, thinking clearly, and getting along with other people. So preventing or recovering from PTSD means helping the brain to shift out of ALARM mode and back to information processing, thinking, and taking charge of ordinary living. It means getting the THINKING CENTER back into action so you are not being automatically controlled by your ALARM System. The skills in TARGET are designed for that purpose.
Extreme Stress: The ALARM Takes Control

**ALARM System**
- Signals a crisis/emergency
- Goes on red alert to survive danger

**FILING CENTER**
- Slows down/becomes disorganized
- Fails to file incoming information
- Gets shut out of the decision-making process

**THINKING CENTER**
- Shuts down normal thinking/problem-solving process
- Relies on automatic survival-related beliefs
- Gets shut out of the decision-making process

**Autonomic Nervous System**
- Goes into “ALARM Mode”
- Gets super-activated or shuts down

Figure 7.1 (Continued) Re-setting the alarm when it’s stuck in survival mode doesn’t happen by simply trying to “relax” or “calm down.” However, it is possible to reset the ALARM system by using the THINKING CENTER in some ways that anyone can learn. If someone is routinely operating in survival mode and having extreme stress reactions, the one thing that can help is turning down the ALARM. To do this you have to turn on the THINKING CENTER so that it can make adjustments to the FILING SYSTEM; these adjustments actually turn down the ALARM. This takes specific skills that enable the THINKING CENTER to become focused so that information processing and affect regulation shift from being on automatic pilot to once again being guided by the THINKING CENTER.

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Box 7.3 Continued

**FREEDOM Steps**

TARGET teaches a sequence of seven (7) skills described by the mnemonic FREEDOM. Each skill is designed to engage the THINKING CENTER and the Filing System in the brain, in order to directly counteract the bodily reactivity, mental confusion, emotional distress, and social isolation caused by an ALARM Center that is stuck in emergency/survival mode (PTSD).

**FOCUS**

Being focused helps you pay attention and think about what you know from your past experience that can help you figure out what’s happening and what’s most important to you instead of just reacting based on ALARM signals tied to past trauma. When you sweep your mind clear and focus on one thought that reminds you of who you are and what you value and believe, you are using your THINKING CENTER to guide you in deciding what you want to pay attention to. Then when you heighten your mental focus by concentrating on a single thought that you choose because it represents what is most important to you at this moment based on your core values, you’re creating files of information in your FILING CENTER that help you pay attention to and remember what gives your life meaning and hope right now, instead of only creating and accessing the “ALARM” files that are about past danger and harm. Then you can mentally mark those new memory files by rating your Stress Level and your Personal Control Level using a quick and simple 10-point numerical rating scale. By carefully applying those three simple steps—which the TARGET model calls the “S-O-S”—you are mentally focused.

**RECOGNIZE Triggers**

Triggers are reminders of intensely negative experiences in the past. If you know specifically what Triggers set off your ALARM, this can help you prepare for and manage ALARM reactions. Most Triggers are not really a signal of life-or-death threats, but may be interpreted as such by a person’s ALARM System. A Trigger can seem like an emergency to the ALARM System unless the THINKING CENTER is used to change the file in the brain from “horrible emergency” to “manageable stress.” If you recognize Triggers in advance you are activating your THINKING CENTER and preparing your FILING CENTER to catch future ALARM reactions. This allows you to refile the information in categories that are helpful, such as “something that upsets me because it’s a reminder of the past, but I can handle it now,” rather than based on the ALARM, such as “something too upsetting for me to handle” or “something that takes away all my personal control.” Recognizing Triggers enables you to anticipate and reset ALARM signals as you learn to distinguish between a real threat and a reminder.

**EMOTION Self-Check**

Emotions come together in an area of the brain’s THINKING CENTER that specializes in motivating us with positive emotions and guiding us to make changes with negative emotions. When the brain is in ALARM mode, negative emotions are dominant in both the THINKING CENTER and the FILING CENTER. As a result, positive emotions are not sufficiently available to help us feel hopeful and able to manage life. The purpose of identifying emotions is to jump-start the THINKING CENTER so the negative emotions produced by the ALARM System are balanced by positive

*Figure 7.1 (Continued)*
emotions that reflect the good as well as the stressful in life. The goal of this skill is to identify two types of emotions. The first are “ALARM” or “reactive” emotions such as terror, rage, shame, hopelessness, and guilt. Because these emotions are the most noticeable after a person has experienced trauma, they are the ALARM System’s way of keeping you primed and ready to fend off further danger. Second, it is crucial to also identify “MAIN emotions” which include positive feelings (such as happiness, love, comfort, and compassion) and feelings that represent positive strivings (such as hope, interest, and confidence). By identifying both types of emotions, the THINKING CENTER is not disregarding input from the ALARM System but is balancing that input with awareness of emotions that reflect what a person values and hopes for in life instead of just the feeling of being in danger. This helps the FILING CENTER create folders for those positive feelings, values, and hopes so even when feeling danger or distress you can draw on positive emotions as well.

**EVALUATE Thoughts**

When the brain is in ALARM mode, thinking tends to be rigid, global, and automatic because your thoughts are based on categories in the Filing System that are very negative (such as, “I’ll never be able to get through this,” “I always mess things up,” or “I can’t trust anyone”). As with identifying emotions, achieving a healthier balance of positive as well as negative thinking requires two steps. It is important first to pay attention to reactive thoughts that reflect the ALARM Center’s attempt to keep you focused on potential dangers. However, by labeling these as reactive ALARM thoughts, you are helping your THINKING CENTER get back in action. You are defining these thoughts as the product of an ALARM signal rather than as the absolute “truth.” This puts these negative thoughts into new folders in the FILING CENTER; instead of being filed as “true facts about how dangerous or bad life is,” these thoughts are filed in folders such as “this is my ALARM telling me that I may not be safe.” Then it is possible to use the THINKING CENTER to evaluate these ALARM/reactive thoughts and decide what your MAIN thoughts are. For example, “I don’t feel safe but I know that I’ve prepared for this situation, so I can handle it.” Transforming reactive/ALARM thoughts into MAIN thoughts jump-starts the THINKING CENTER and enables it to both improve your filing categories and turn down the ALARM. This two-step process is “smart thinking”—moving from ALARM signals to evaluating the situation and your options with a focus on what you value most in life and how you choose to act. This is a fundamental change from the PTSD pattern, which causes problems by taking you straight from ALARM signals to automatic survival reactions. When trauma is no longer occurring, it is your MAIN thoughts that are most helpful. But to get those MAIN thoughts in focus it is first necessary to turn down the ALARM System by using the THINKING CENTER to think clearly about and appropriately file ALARM/reactive thoughts.

**DEFINE Goals**

When in survival/ALARM mode, goals tend to be limited to just making it through the immediate situation or away from the source of danger. These reactive goals are necessary in true emergencies, but they do not reflect a person’s MAIN goals for doing worthwhile things right now and for ultimately achieving a good and meaningful life. As with emotions and thoughts, in order to turn down or reset the ALARM System and create a FILING CENTER system that can help you access your MAIN life goals, it is necessary to begin by paying attention to the ALARM System’s input and define reactive goals as what they are: the product of your ALARM system, but not your MAIN goals in life. For example, reactive goals such as, “I want to never see this person again” or...

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(Continued)
Box 7.3 Continued

“‘I’m going to take off and never come back,” may seem compelling in a crisis, but they don’t include many other counterbalancing goals. Labeling these as ALARM/reactive goals (e.g., “I feel like running away but that’s my ALARM trying to protect me and not my MAIN goal”) helps the THINKING CENTER to turn down the ALARM System so you can begin to create or locate MAIN goals that reflect your deeper hopes and values (such as, “I want to build relationships in which I am respected and loved” or “I can take one step at a time to face and resolve my problems”). When you can learn to recognize both reactive and MAIN goals, your THINKING CENTER is using input from the ALARM System but balancing this with input from past experiences and hopes for the future. The result is not just more balanced and positive goals, but also an enhanced ability by the THINKING CENTER to signal to the ALARM System that you are able to deal with any potential dangers without having to be on automatic pilot in survival mode. This helps you to set goals based on what you realistically want and can achieve, instead of getting caught up in reacting primarily based on ALARM signals and the frightening things you are afraid might happen.

Identify MAIN OPTIONS

The only options that are available when the ALARM is turned on and won’t go off are automatic “fight or flight” reactive behaviors necessary in emergencies but often unhelpful in ordinary living. However, the ALARM System never completely overrides the THINKING CENTER. Even when a person seems to be reacting completely automatically their actions also reflect positive intentions based upon the “better judgment” of the THINKING CENTER. These positive intentions often are hidden by the more extreme reactive options that occur when automatic self-protective reactions dominate a person’s choices under the influence of the ALARM System. TARGET is designed to help people to recognize these positive intentions so they can build on this underlying motivation and identify MAIN options instead of simply repeating the ALARM-based reactions. As you come to recognize your positive intent, your THINKING CENTER becomes more able to not only identify and choose a wider range of MAIN options but also to strengthen the FILING CENTER’S ability to remember those options. These changes signal the ALARM System you are safe enough to move away from survival mode, and thus can reset the ALARM so that it is less reactive. This helps you to make smart choices that have positive consequences for you and for others around you.

MAKE a Contribution

When the ALARM is turned on and reacting to ordinary stressors as if they were emergencies, it is very difficult to come away from experiences with a feeling that you have made a positive difference. ALARM reactions can keep you from realizing you have made a positive contribution to the lives of your family members, friends, co-workers and neighbors. This can lead to feelings of alienation, worthlessness, or spiritual distress. This disconnect from one’s own sense of self-worth and accomplishment and from feeling valued by others in the community is not an indicator of your real worth, your inherent ability to relate to others, or your true desire and ability to find and follow a spiritual path. If you are living in a constant state of ALARM, or are on the verge of being in ALARM/survival mode all of the time, you may be trying very hard to do things that make a positive difference and to figure out extremely difficult questions about morality, ethics, spirituality, and the value of your own life. Although you may feel you are failing at figuring out these questions because your beliefs and feelings have been deeply affected by a sense of never being safe or at peace, as a result of having a hypersensitive ALARM System. If you are able to turn down the inner ALARM, you may feel more able to recognize the true value you have as a person.

Figure 7.1 (Continued)
Careful listening and thoughtful reflection about what the client describes as her or his primary concerns and goals, and relevant life experiences (including successes as well as problems and stressors), are essential to encouraging client “buy-in” to treatment. The client needs to be motivated to actively participate in processes that are enhanced when enough trust and confidence in the therapist are developed to enable open disclosure of often painful and shameful experiences and feelings. When traumatic events have involved betrayal or trauma by other individuals and by institutions and have thus disrupted, compromised, exploited, or ended relationships, the risk of investing emotionally in yet another relationship—this time with the therapist—can be daunting. Trust and respect need to be earned by therapists and not automatically given or assumed by clients in PTSD treatment, even when they admire and value their therapists. PTSD therapists who are savvy to these dynamics know that the first sessions (and sometimes even the entire treatment) may constitute a test, whether deliberate or not, on the part of the client that should be expected and can be discussed openly and nondefensively. Traumatized individuals need to determine if the therapist has the ability and strength to undertake the therapeutic exploration of horrible experiences and extreme suffering that make up the client’s personal history and day-to-day reality when living with the psychic pain of PTSD.

Some clients benefit so much from this “alliance-building,” education, and personal acceptance (of them personally and of their story) during this first phase of psychotherapy that they feel able to resolve or manage their PTSD symptoms and those associated with depression or anxiety. In consequence, they and their therapist may choose to end therapy without a period of formal “retelling” or processing of the trauma. In such a case, Phase 1 is directly followed by Phase 3 and the closure of...
treatment. Whether Phase 1 must represent only a first step, or can be the basis for complete successful psychotherapy, is an important question.

Herman (1992) described how therapy for PTSD can be undertaken episodically rather than in one long progression. Others such as Courtois (2010) discussed how therapy for PTSD is often layered, and the resolution of one issue, while very important, may later cause the emergence of other issues. Internal and external triggers (including those that are decremental—that is, involving some sort of loss, reexposure to the trauma, and revictimization—and those that are additive—involving positive life events that in some way paradoxically serve as reminders of the trauma and its cost)—can cause the emergence or reemergence of PTSD symptoms. At those times, treatment that had been complete may need to be resumed in order to enable the person to manage and overcome the (re)emerging PTSD symptoms.

When clients drop out of treatment in the first phase, this often is due to avoidance of dealing with traumatic memories or distressing PTSD symptoms. Or it might be seen as constituting a “flight into health” (i.e., an attempt to deny inner distress and psychic conflict from a psychodynamic perspective). However, clients can greatly benefit even from a less than complete therapy. Some are highly comforted by the personal and emotional support received in this first phase, even to the point that they remain in Phase 1 and never move beyond or complete it. This sometimes occurs when they do not have the personal resources or motivation necessary to move on (sometimes due to the degree of their suffering and impairment, their age, and or health status). Whatever the case, the therapeutic challenge is not to “make” the client move forward into the next phase of therapy (or to graduate from therapy, for that matter), but to provide support and help the client with whatever resolution of emotional distress is possible so that she or he feels ready and actually is prepared to move to the next phase of therapy.

Although Phase 1 does not specifically focus on trauma memory reconstruction and processing, recollections of trauma are dealt with in other ways. The major difference between Phases 1 and 2 is that in Phase 1, the impact of past psychologically traumatic experiences is assessed (see Chapter 6), and clients are offered information about the impact of traumatic stressors, how traumatic stress reactions can lead to PTSD symptoms, and how PTSD symptoms can be overcome or managed (Box 7.4). This foundational knowledge may include body awareness and relaxation techniques, mindfulness practices, addiction recovery skills, and cognitive behavioral strategies for managing anger, depression, and anxiety. Once a relative degree of stabilization and active engagement in developing a therapeutic partnership (“alliance”) has been achieved, assessment of the client’s needs and readiness for Phase 2 can commence.

Phase 2 trauma processing is recommended if a client continues to be troubled by specific intrusive memories or has dissociative symptoms that continue to impair quality of life. Clients are ready for trauma processing if they understand how PTSD symptoms are adaptive stress reactions “gone-wrong,” can apply skills for emotional modulation and self-management, have sufficient emotional stability and social support, and are not in immediate crisis or danger. Because Phase 2 is designed for clients to face and come to grips with trauma memories, they must be advised that they might feel worse for a period of time before they begin to get some relief; therefore, some
The evidence supporting the efficacy of CBT for adults with PTSD is quite strong and still growing (Jayawickreme et al., 2014; Powers, et al., 2010; Wang, 2014). However, it is important to also look carefully at who actually receives CBT treatments for PTSD and how much they improve in the scientific studies that comprise this evidence base, and also who might not be included and who does not complete or benefit from the standard approaches to CBT for PTSD—and how best to meet their needs.

A review of the results of more than 30 studies that were included as scientifically rigorous investigations of PTSD treatments in the first Practice Guidelines from the ISTSS (Foa, Keane, & Friedman, 2000) found that persons who were not permitted to participate to begin with had characteristics and problems that would tend to make them less likely to benefit from any treatment than persons who were included in the studies (Spinazzola, Blaustein, & van der Kolk, 2005). The studies tested several approaches to PTSD treatment, including CBT (both PE/CR and EMDR), group therapy, and pharmacotherapy. More than two-thirds of the studies excluded people who had a psychotic disorder or SUD, and more than one-quarter excluded persons with suicidal thoughts. Over one-third of the studies excluded people who had serious medical illnesses. People with chronic PTSD commonly have one or more of these serious psychiatric or health problems (see Chapter 4), so excluding them from studies testing the efficacy of PTSD treatments results in outcomes that do not necessarily apply to the use of these treatments with these more severely impaired adults. This is a problem of “external validity” or “generalizability,” because study results may not be validly generalized to apply to people with characteristics different from those of the “included” participants in a study.

CBT for persons of ethnoracial minority backgrounds

Although no studies purposefully excluded persons of ethnoracial minority backgrounds, most (82%) had fewer than one in four participants from such a background. Fortunately, several rigorous scientific studies of PTSD treatment with adults have reported including a majority of participants who are of ethnoracial minority backgrounds (Cloitre et al., 2002, 2010; Ford et al., 2013, 2011). A particularly innovative study was conducted providing black African women in the Congo who had been sexually assaulted with CPT adapted to align with their cultural practices. The outcome tested also was culturally adapted, with the results showing that CPT resulted in women’s increased involvement in social groups and likelihood of seeking emotional support in their local village (Hall et al., 2014).

Nevertheless, relatively few studies have been conducted to test the efficacy of PTSD treatments with persons of ethnoracial minority backgrounds, and it is not clear that even the PTSD treatments with the strongest evidence base will be accepted by and will produce improvements in PTSD for persons of ethnoracial minority backgrounds (Pole, Gone, & Kulkarni, 2008). It is important to note
that there is no evidence that people of ethnoracial minority backgrounds do not benefit from PTSD treatment when they have been included in rigorous studies, but many questions remain unanswered that may influence the success of PTSD treatment with individuals of different backgrounds.

For example, in a recent study with men and women in treatment for SUDs, a psychotherapy for PTSD was found to be less effective than standard substance abuse treatment in preventing substance use relapse with African American men (Frisman et al., 2008). The PTSD psychotherapy was no less effective than standard substance abuse treatment in preventing substance use relapse with African American or Latina women or white men or women, and more effective than standard substance abuse treatment in sustaining all participants’ self-efficacy. The finding concerning relapse and African American men also involved a very small number of participants (fewer than 10) and may have been due to factors other than the specific PTSD psychotherapy (such as the match of ethnoracial background between participants and counselors: no African American male counselors delivered the PTSD therapy, but there were ethnoracial minority female counselors).

**CBT for adult survivors of childhood maltreatment**

Additionally, most (79%) PTSD treatment studies included only persons whose PTSD was due to traumatic stressors experienced in adulthood, primarily accidental injuries. Although victims of assault or military veterans with PTSD were included in several studies of PTSD treatment efficacy, only one in five studies included adults with PTSD due to psychological trauma experienced in childhood (Spinazzola et al., 2005). However, a number of studies that either specifically recruited women with PTSD related to childhood abuse (Chard, 2005; Cloitre et al., 2002; Cloitre et al., 2010; Edmond, Rubin, & Wambach, 1999; McDonagh et al., 2005) or had a large subgroup of participants with PTSD related to childhood abuse (Ford et al., 2013, 2011; Resick, Nishith, & Griffin, 2003) have provided evidence that three approaches to CBT (PE/CR, EMDR, and CPT) and two emotion regulation psychotherapies (STAIR-PE and TARGET) are effective in reducing the severity of PTSD and associated psychiatric and psychosocial problems experienced by adult survivors of childhood abuse.

However, questions remain about how best to deliver PTSD psychotherapy to persons with the complex PTSD symptoms that often occur among survivors of childhood abuse and other forms of developmentally adverse interpersonal trauma (such as growing up in a violent family). CPT and skills training for affective and interpersonal regulation-prolonged exposure (STAIR-PE) have made adjustments to reduce the risk of clients becoming overwhelmed or incapacitated emotionally when doing Phase 2 trauma memory reconstruction (such as more extensive preparation in Phase 1 with emotion regulation skills, and using written recall of memories rather than vividly imagining trauma memories) (Jackson, Nissenson, & Cloitre, 2009). The study of PE/CR with women
with histories of sexual abuse found that almost half dropped out of therapy, mostly when PE was beginning or at the midpoint when encouraged to reflect on how well the treatment was working for them (McDonagh et al., 2005).

A study of depressed men and women found that those with histories of childhood traumatic loss or abuse showed higher rates of remission from depression following either CBT or pharmacotherapy than participants with no childhood trauma history—but that pharmacotherapy was less efficacious in achieving remission from depression than CBT among the participants with childhood trauma histories (Nemeroff et al., 2006). Although most studies of PTSD with people with histories of childhood abuse involve only women, a sizable subgroup of military veterans with chronic PTSD have histories of childhood abuse. One study found that compared to those with no history of childhood abuse, male military veterans with histories of childhood abuse had a poorer response to intensive CBT treatment for chronic PTSD (Ford & Kidd, 1998).

Overall, there is evidence that CBT may be beneficial for adults with PTSD due to childhood abuse and potentially more beneficial than pharmacotherapy with childhood trauma survivors. However, in contrast to several studies showing that PE is the primary source of benefit to rape or assault survivors with PTSD (Foa et al., 2005), studies showing CBT to be beneficial with people with histories of childhood abuse or traumatic losses either did not include PE (Nemeroff et al., 2003) or included modified PE to reduce the risk of emotional destabilization (Chard, 2005; Cloitre et al., 2002, 2010; Edmonds et al., 1999; Resick et al., 2003). The one study that found that PE/CR to be effective with women with PTSD due to childhood sexual abuse did so with just over half of the PE/CR recipients because 43% dropped out and did not complete post-therapy assessments (McDonagh et al., 2005). Consistent with the view that intensive processing of traumatic memories can be beneficial but that caution is warranted with clients who have complex symptoms associated with childhood exposure to traumatic maltreatment (such as severe emotional and behavioral dysregulation, volatile or victimizing adult relationship, and flashbacks or dissociation), proponents of PE/CR and CPT recommend that the memory processing component of treatment should be adjusted in several ways in order to promote a sense of safety, trust, and empowerment for these clients. This includes encouraging clients to keep their eyes open, maintain eye contact with the therapist, and talk about trauma memories rather than vividly reliving them (Cook et al., 2004) or dealing with traumatic memories by developing cognitive strategies for handling the distressing effects of present-day reminders rather than reconstructing a memory narrative (Cook et al., 2014). For example, a client might be helped to describe a traumatic past experience by talking about how reminders of it now affect her or him while referring to the memory in the past tense as an observer rather than as a participant: “I get so upset that I can’t think straight whenever I hear someone talking in an angry tone of voice, but I know now that that’s because it was really scary when I was a kid, and I never knew how bad someone

(Continued)
was going to get hurt when I saw my parents fighting.” This is in contrast to the standard PE and CPT approach of describing or writing one’s perceptions, feelings, and thoughts in the first-person, present tense as if the event was happening right at the present moment: “I can see them hitting each other, and I cover my ears so I can’t hear them screaming; my body is feeling numb and my heart is pounding; I’m thinking that they’re going to kill each other, and I can’t do anything to stop it.” For some clients, the immediacy and intensity of such recall can be a way to learn that they can face even very horrible memories and come away feeling stronger and no longer a helpless victim. For other clients, trauma memory exposure or narrative reconstruction can exceed their psychological and physical window of tolerance, and adaptations are necessary in order to ensure that therapy reduces rather than reactivates PTSD symptoms.

**Patient-centered outcome research: guiding clinical flexibility with scientific methods**

These adjustments to CBT procedures for PTSD clients tend to be based on clinical experience rather than scientific research, consistent with the basic requirement that clients’ safety always is the first priority, including safety from psychological crises as well as from physical harm or danger. However, there is a paradigm shift in therapy outcome research that could provide a path to the best of both worlds: patient-centered outcome research (PCOR). PCOR is a set of research strategies to enable researchers, clinicians, and clients to partner together and answer critical research questions such as how they together can deal with the complex and often confusing choices involved in achieving and sustaining recovery from PTSD while accessing and navigating through complicated health care systems. Traditional treatment outcome research has produced powerful interventions for PTSD such as the CBT models, but it has not been intended or designed to enhance our understanding of how clients subjectively experience, participate in, and are affected by health care and interactions with treatment providers. Research shows clear linkages between clients’ trust in and willingness to fully participate in PTSD treatment (McLaughlin, Keller, Feeny, Youngstrom, & Zoellner, 2014), but these findings have not been applied to systematically adapt how CBT is delivered to clients. PCOR takes on these critical questions that clients and their clinicians face daily in treatment and their personal lives.

PCOR is a systematic approach to patient-centered comparative clinical effectiveness research (CER), in which client and clinician preferences, choices, actions, and interactions are studied in order to determine tools, strategies, resources, and courses of action that are associated with cost-effective health care outcomes. For clients, PCOR involves testing and then providing guidance about which approaches to care work best, given their life circumstances, personal and familial concerns, socioeconomic circumstances, and sociocultural preferences. For clinicians, PCOR is designed to provide evidence-based
guidance addressing the questions they face daily in practice. For insurers, PCOR produces evidence that can help them make the best decisions on how to improve PTSD outcomes while also containing costs, especially with high-impact health problems such as PTSD. For PTSD therapists and the broader mental health field, PCOR provides opportunities and an impetus to conduct real-world clinical research on topics such as:

- When, for whom, and how does CBT provide the most scientifically effective and personally acceptable way for trauma survivors to “talk about it” (Angelo et al., 2008)?
- What are the mechanisms—the subtle, step-by-step changes—that enable trauma survivors to benefit from CBT, and how do different CBT models activate these mechanisms?
- What sequencing of CBT’s components—psychoeducation, coping and stress inoculation skills, trauma memory exposure or narrative reconstruction, or desensitization—best benefits and is most acceptable to different clients?
- Can CBT be adapted to incorporate or to work together with other approaches to PTSD therapy, and when and for whom does this enhance the acceptability or benefit of therapy?

Studies of CBT as delivered in clinical practice—as opposed to in the restrictive context of randomized controlled trial (RCT) studies in which therapists have little leeway to accommodate individualized needs or preferences of the client—indicate that clinicians tend to make numerous adaptations of the therapy in order to best fit different clients and treatment settings (Cook et al., 2014; Kaysen et al., 2014; Morland et al., 2014; Walter, Dickstein, et al., 2014; Walter, Varkovitzky, et al., 2014; Zoellner et al., 2011). If those critical decisions could be guided by scientific evidence that incorporates the perspectives of objective research, clinicians’ field experience, and client’s preferences and experiences, the chances of CBT—or any therapy for PTSD—benefitting most or all of the clients to whom it is provided—rather than only the subset for whom a good client–treatment match happens to occur by good luck—could be greatly increased, to the benefit of society as well as the individual.

Thus, by considering the limitations and cautionary findings from research studies, a highly effective treatment approach for adults with PTSD—CBT—potentially can be further improved. This is a good example of keeping the “baby” (the effective treatment) while “throwing out the bathwater” (developing adjustments to reduce potential adverse reactions to the therapy). In the PTSD field, as in all mental health and medical disciplines, there is no treatment that is beneficial for all recipients and completely free of potential adverse effects. The combination of good science (i.e., rigorous research testing treatments with the full range of clients to whom they are to be delivered) and good clinical practice (i.e., noting possible adverse reactions and creating and testing modifications to address these potential problems) results in continuous improvement in evidence-based treatments for PTSD such as CBT.
degree of relapse is to be expected, and safety and relapse planning is undertaken before moving forward. Clients are advised that they are not expected to “perfectly” face their memories and emotions—that is, without distress and occasional backward steps. Lapses and relapse are treated as opportunities for therapeutic problem solving and as normal parts of the growth and change process involved in recovering from PTSD.

Phase 2. Safely becoming able to face traumatic memories and gaining an understanding of how to overcome or manage the emotional reactions that reminders of memories trigger in daily life are the goals of Phase 2 PTSD treatment. This may result in a complete and emotionally manageable autobiographical narrative (i.e., a story with a beginning, middle, and end) of memories of specific traumatic events. Narrative reconstruction of memories must be timed and structured to support the client’s ability to not only tolerate trauma memories and emotions but also to gain a sense of self-efficacy and a coherent life story that encompasses personal success and growth as well as the psychological trauma and PTSD symptoms.

In this phase, clients are encouraged to feel their emotions—first anxiety, but also fear, terror, grief, shame, anger, and guilt (to name but a few)—that are associated with psychologically traumatic events—that is, to become aware of rather than avoiding or dissociating from stress reactions and emotions triggered by trauma memories or reminders. Some treatment models specifically do not prescribe recalling traumatic memories, focusing instead on enhancing the client’s capacities for self-regulation in their current lives (e.g., McDonagh et al.’s, 2005 present-centered therapy) or on strengthening the client’s ability to reflectively examine many past and recent memories without focusing on traumatic experiences per se (Courtois, 1999; Ford & Russo, 2006). These therapies explicitly link the client’s processing of current stressful or emotionally evocative experiences that involve reminders of past traumatic events (sometimes unbeknownst to the client) in order to enable the client to achieve a resolution of the sense of distress and helplessness related to those reminders and memories that can lead to avoidance of current experiences. Thus, Phase 2 trauma processing emphasizes helping the client be prepared for current situations in which reminders of past traumatic events trigger distress in order to counter the avoidance of feared or overwhelming memories by building confidence based on the ability to emotionally handle trauma reminders or triggers. When trauma processing involves recalling specific memories of traumatic events, this should always be done with the client’s full and informed consent so that the client gains a sense of personal control and effectiveness and does not feel coerced into involuntarily “dredging up” trauma memories simply because the therapist dictates that this is a requirement of therapy. Therapists empower their clients to come to grips with their traumatic memories and/or the distress that everyday reminders of such memories evoke, rather than prescribing memory recall as a required component of treatment.

It is important to emphasize that there is controversy in the PTSD field about whether therapy must include intensive recollection of specific trauma memories in order to be effective. Some CB Ts for PTSD insist that this is essential and that therapy is incomplete without helping the client to therapeutically reexperience traumatic
Memories through “exposure” or “narrative processing” or “desensitization” procedures. Other treatment models utilize a similar “narrative reconstruction” approach to assist clients in gaining a sense of mastery or authority over their memories first in relation to the full range of life experiences as a preparation for or alternative to systematically revisiting and reconstructing traumatic memories (e.g., Cloitre, Cohen, & Koenen’s, 2006, skills training for affect and interpersonal regulation (STAIR) in the Life Skills Life Story model). That is, clients are guided in developing a more detailed oral or written/drawn account of the events and circumstances that they feel have been most important in their entire lives (e.g., the “lifeline” in the TARGET model [Ford, 2015]). The goal of traumatic memory narrative reconstruction is to restore clients’ sense of authority over their own memories (Harvey, 1996) to desensitize them to their traumatic memories, allowing them to become “normalized” (more like memories of nontraumatic events), thus reducing their negative impact. Clients are not encouraged to forget what happened to them but instead to be willing and able to recognize when reminders are triggering the recall of distressing traumatic memories so that those triggers and memories no longer seem unmanageable but rather become an accepted (although still unpleasant) part of their ongoing life experience.

Exposure therapy, often undertaken in prolonged format (PE; Foa & Kozak, 1986), was the first systematic approach to therapeutic processing of traumatic memories. PE involves detailed recounting of a traumatic event and emphasizes preparation for this typically distressing activity. It is conducted in a variety of different formats and offers the option of talking about the event rather than “reliving” it (Cook, Schnurr, & Foa, 2004). PE involves the client recalling a specific traumatic memory as vividly as possible in first-person mode (i.e., as if it was happening immediately at the present moment), in imaginal form (with an audiotape of the trauma) (PEI), or in vivo form (PEIV). Exposure therapy seeks to directly counter anxiety-based avoidance of traumatic recollection and to give the client a sense of self-determination and hardiness in recalling traumatic memories with feelings of mastery (in contrast to feeling helpless in the face of memories intruding in an unwanted and overwhelming manner—that is, PTSD’s intrusive reexperiencing symptoms). Clients are helped to experience emotions that arise and, with repeated exposure, to see that the intensity and distress of these trauma-related emotions will lessen as the trauma is desensitized.

Since PE was developed, several approaches to traumatic memory desensitization and reconstruction have been developed, including EMDR (Shapiro, 1995, 2002) based on adaptive processing theory and CPT (Resick et al. 2008). These methods are designed to help the client to experience and work through painful emotions, traumatic memories, and altered beliefs about self, others, and life meaning, in the process bolstering the client’s internal and external resources. Throughout the treatment, but particularly during Phase 2 memory reconstruction and processing, the client must be assisted in maintaining an adequate level of functioning consistent with past and current lifestyles and circumstances and benefits from additional emotional support of loved ones and the therapist.

Phase 3. PTSD psychotherapy concludes with a third phase in which the new knowledge and ability to face and cope with reminders of troubling memories without
avoidance acquired in the first two phases are applied to all areas of the client’s life. Common challenges include the development (or regaining) of trustworthy relationships and intimacy, healthy parenting, having a productive career, and dealing with continuing conflicts, limitations, or victimization in relationships. It is in this phase of the treatment that the client has many more resources to be more self-determined and empowered, free of some of the constraints of the past. Phase 3 PTSD treatment often involves refresher discussions to solidify the client’s understanding and acceptance of PTSD symptoms as survival adaptations that have become an unnecessary demand on the body, emotions, and mind now that traumatic events are no longer occurring (assuming this is actually the case!). Phase 3 PTSD treatment also engages the client in using the self-regulation skills learned or strengthened in Phase 1 to continue to be aware of and actively manage reactions to current-day reminders of traumatic memories. Thus, in Phase 3 the client puts into practice in daily life the approach to dealing with traumatic memories and reminders that she or he learned in the therapy setting in Phase 2. In this way, PTSD therapy provides the client with a personal foundation for continuing to deal with reminders of traumatic experiences in a self-aware and confident manner so that avoidance and hypervigilance do not resume their domination of the client’s life. Rarely, if ever, are traumatic memories “erased” because no memory is ever completely deleted from the brain (see Chapter 1), but successful PTSD treatment enables the client to gain mastery of those memories and to be able to handle distressing reminders effectively when they occur (Harvey, 1996).

PTSD treatment: practical issues

Treatment, like PTSD symptoms, is complex and multimodal. As just mentioned, the range of symptoms and comorbidities involved may require a number of treatment goals and a variety of treatment approaches. Thus, treatment should incorporate a variety of theoretical perspectives and clinical modalities individualized to best fit the client, rather than only one approach.

The client’s development of a support system outside of therapy is essential. A personal support network outside of treatment and apart from the therapist is the best source of positive reinforcement of the gains achieved in therapy in the client’s daily life. The greatest challenge to clients and therapists in PTSD therapy often is not addressing traumatic memories (as difficult and important as that can be) but helping the client to overcome PTSD’s emotional numbing and social detachment/alienation symptoms in order to build relationships with trustworthy others and, in the process, to lessen dependence on the therapist and therapy as the sole source of support and understanding. This might also involve the client assessing the quality of his or her relationships and the ability of others to support their recovery. Especially in circumstances of embedded and ongoing family and community violence and addictions, the client may need to make a break from those who remain unhealthy, violent, and/or addicted, and develop more positive and trustworthy attachments.

Duration of treatment. One limitation of most research studies on PTSD treatment is that they impose a requirement that treatment must involve a predefined number
of sessions, most often in the range of 9–12 sessions (Cook, Dinnen, Thompson, Simiola, & Schnurr, 2014), and as few as 4 or 5 sessions when treating clients with relatively recent traumatic events (see Chapter 9). In actual practice, PTSD therapy (especially when involving its complex variant) more often requires between 6 months and several years in order to provide sufficient time and therapeutic assistance to enable the client to traverse the three phases fully and without rushing. The more complex the client’s trauma history, generally the more lengthy treatment is needed (e.g., when traumatic stressors include childhood abuse or family violence occurring over prolonged periods of time—including up to the present—than for a single assault or accident). Even PTSD therapies that are designed to be completed within 20–30 sessions or in a single episode of hospital treatment may require several repetitions of “cycles” or episodes of the intervention over many months or years.

**Frequency of and type of services.** Most therapy for PTSD occurs on a once or twice a week basis in an outpatient setting—that is, in a therapist’s private practice office or a counseling clinic. Usually this is done in 50- to 75-minute sessions for one-to-one, couples, or family therapy and/or 75- to 120-minute sessions for group therapy (with groups usually including five to nine members). If pharmacotherapy is included in the treatment, after a 60- to 90-minute initial assessment for psychiatric medication, briefer sessions (usually 20–30 minutes) are then the norm for checkups. At times, patients will require specialized services and settings, including inpatient, partial hospital or day treatment, residential rehabilitation or supportive housing, or intensive outpatient programs (e.g., for substance abuse, eating disorders, sexual addiction, or suicidality). Such intensive treatment often provides, in addition to a secure environment for patient safety, groups on self-management or relationship skills, psychopharmacology services for medication evaluation and management; peer support programs (such as “12-step groups” sponsored by Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, or Gamblers or Debtors Anonymous), and case management to address vocational, educational, residential, financial, and legal needs.

**Treatment outcomes.** The primary goal is to reduce the intensity and frequency of PTSD symptoms to a level that is no longer troubling to the client or that the client can manage well enough that they no longer substantially interfere with the client’s life activities, goals, and well-being. When other symptoms or disorders (such as depression or substance abuse) co-occur with PTSD, these problems also must be reduced or managed concurrently because improvements in PTSD are likely to be delayed or lost if the other disorders cause psychological instability (Ford, Russo, & Mallon, 2007). Untreated traumatic stress symptoms also have been found to be associated with less positive outcomes in the treatment of other disorders, such as substance dependence, because they create a major risk for relapse (Anderson, Ziedonis, & Najavits, 2014; Ford, Hawke, Alessi, Ledgerwood, & Petry, 2007).

Additionally, a focus on clients’ strengths or posttraumatic growth such as is advocated by the “positive psychology” orientation (Seligman, Rashid, & Parks, 2006) suggests that goals should include the enhancement of clients’ social and emotional regulation skills and sense of personal effectiveness. Spiritual connection and healing and meaning-making are advocated in spiritually oriented treatments for trauma (Walker, Courtois, & Aten, 2015). Due to the differences in each client’s capacities
to engage in therapy and to tolerate and benefit from the often emotionally intense interactions that occur in PTSD therapy, it is important to gauge the success of treatment according to goals that are achievable for each unique client.

**Evidence-based treatments for PTSD**

PTSD, especially when chronic or complex in nature and due to its myriad symptoms and their varying manifestations, can be difficult to successfully treat. It is to be expected, therefore, that resourceful and creative therapists and trauma survivors will be searching for and experimenting with alternative or multimodal therapeutic approaches in order to increase the likelihood of successful treatment. It is important that a quest for new “tools in the tool kit” for the treatment of PTSD is encouraged publicly and politically (such as through governmental, foundation, and private industry grants for clinical innovation) while being scientifically and professionally scrutinized to ensure that the safety and health of those undergoing treatment are protected. There is no single best way to develop new or improved therapies for any psychiatric or medical disorder, but clinical practice guidelines are now available that have been designed to simultaneously encourage innovation while preserving the scientific and clinical integrity of the process and the resultant treatments. These guidelines initially were developed to ensure that ethical and legal/regulatory requirements were fulfilled in biomedical research, and have been adapted for psychological and psychiatric research on psychotherapy and for PTSD treatment research more specifically.

The guidelines for biomedical research include recommendations that scientific studies of human participants should be designed and conducted to achieve three principles that are articulated in the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1979) Belmont Report: respect for persons, beneficence, and justice. Definitions of these principles are excerpted from the report (italics added):

> Respect for persons involves recognition of the personal dignity and autonomy of individuals, and special protection of those persons with diminished autonomy. Respect for persons is manifested in the informed consent process in which potential subjects are provided information about the study in a manner comprehensible to them and then allowed to choose whether or not they wish to participate. … Beneficence entails an obligation to protect persons from harm by maximizing anticipated benefits and minimizing possible risks of harm. Beneficence requires that investigators and IRB [institutional research review board] members engage in an analysis of the risks and benefits to the subjects, making sure that anticipated risks are proportional to the potential benefits. Risk should be minimized as much as possible. … Justice requires that the benefits and burdens of research be distributed equitable. The principle of justice instructs us that subjects should not be chosen simply because they are available and easy to manipulate. In addition it requires that subjects who are likely to benefit from a study should not be excluded. (pp. 4–7)
It might seem that any attempt to help people recover from PTSD would, by definition, automatically fulfill these criteria, but, in fact, that is not the case. An untested therapy for PTSD may be intended to provide recipients with relief from its symptoms; however, until the therapy has been carefully tested, it is not possible to provide a recipient with sufficient information about its specific features (i.e., what exactly the therapy involves, including what the therapist will do and what the recipient is expected to do) and not only its potential benefits but also its risks/adverse effects and their likelihood. Informed consent (and refusal) requires an entirely voluntary and fully knowledgeable (“informed”) agreement by the recipient to undertake the therapy (“consent”) or to refuse it, and it is not possible without this information (see Box 7.2). Without the assurance of respect and beneficence, justice cannot be guaranteed, even if the intent of the therapist is to provide the best possible help to those who most stand to benefit.

The mental health professions have established rigorous scientific standards for research on psychotherapy treatments in order to address these issues. Therapies for psychological or psychiatric problems such as PTSD are evaluated according to these standards so that providers and recipients will know in advance the likelihood that a therapy will provide benefits and the degree of confidence that they can place in this estimate of beneficence. The term that is used to describe the adaptation of ethical and scientific principles to psychotherapy research is evidence-based practices or treatments. Per the American Psychological Association Statement Task Force on Evidence-Based Treatments (2006), the evidence based includes the best research evidence but also a consensus among clinicians and client values and preferences. There remains debate in the mental health and traumatic stress fields as to whether an entire treatment model can be considered “evidence-based” or whether the specific strategies or components “practices” that make up a treatment (that may be found in more than one treatment) are more appropriately certified as evidence-based.

For example, in PTSD psychotherapy, a core component in several treatment models is the “narrative reconstruction” of memories of traumatic event(s). This can involve a process described as “exposure therapy” or “prolonged exposure (PE),” during which the client is encouraged to repeatedly describe one or more memories of traumatic event(s) while imagining every detail of the experience as if the event(s) were occurring to the client at that moment (i.e., in the first-person, present tense—for example, “I was just about to fall asleep when I felt jolted by a loud noise, and the whole room was shaking”). Thus, the client is therapeutically being “exposed” in imagination (sometimes written out or audiotaped) or in vivo (i.e., in a similar real-life circumstance) to the traumatic event(s) or their reminders, not just once briefly, but for a “prolonged” number of repetitions. As discussed earlier in this chapter, trauma memory processing can be done in a number of different ways in different treatment models, typically in combination with other interventions (such as education about PTSD and learning skills for managing anxious thoughts and emotions). In some studies in which PE has been used to treat PTSD, recipients have discontinued treatment (“dropped out”) in sizable numbers (McDonagh et al., 2005), while in other studies there has been no difference in dropout rates between treatments that include trauma memory processing and those that do not (Jayawickreme et al., 2014). Recent
studies have found that trauma memory exposure may be effective in reducing PTSD symptom severity when done on a less prolonged basis, with fewer sessions of shorter length, and this may help some clients to tolerate the distress of the intensive memory recall (Foa, McLean, Capaldi, & Rosenfield, 2013).

The acceptability of intensive therapeutic recollection of traumatic memories to different clients in different formats thus requires additional study. However, studies of clients’ preferences indicate that they often do want to talk about what happened to them, and they tend to prefer a talking therapy to the use of medication (Angelo, Miller, Zoellner, & Feeny, 2008). On the other hand, PE per se is not the only approach to talking about traumatic memories or current PTSD symptoms, and studies suggest that it is not as widely used by practicing therapists as it is studied in research investigations (Cook et al., 2014; Zayfert & Becker, 2007). Many therapists have not had the specialized training that is necessary in order to effectively use PE (Foa, Hembree, & Rothbaum, 2007), and others have reservations about using it for fear of retraumatizing their clients if the intensive recollection of traumatic memories overwhelms their capacities to cope (van Minnen, Harned, Zoellner, & Mills, 2012); this is true despite evidence that the majority of clients who agree to undertake PE report substantial benefits (Hagenaars & van Minnen, 2010; Ruzek et al., 2014). Due to its strong empirical substantiation, PE (and also CPT) is being used routinely in the US Department of Veteran Affairs (VA) after a systematic rollout of training for hundreds of VA mental health clinicians (Foa, Gillihan, & Bryant, 2013; Ruzek et al., 2014). Its use in other organizations and by private practice clinicians is much less systematized, although that may change with the emphasis being placed on cognitive-behavioral treatments in the professional curricula of many psychology, social work, counseling, marriage and family therapy, and psychiatry graduate clinical training programs (Courtois & Gold, 2009).

Since 2000, a number of formal guidelines for treating adults with PTSD have been published. Each has made recommendations based on the evaluation of the quality of the aggregate research database and on expert opinion. These PTSD clinical and practice guidelines published to date include a definitive set by the ISTSS based on reviews assessing the strength of the available evidence for a range of psychological and psychiatric treatments (Foa, Friedman, & Keane, 2000; Foa, Friedman, Keane, & Cohen, 2009); the US Department of Veterans Affairs and Department of Defense (US VA/DoD, 2010; see http://www.healthquality.va.gov/guidelines/MH/ptsd/cpg_PTSDFULL-2010111612.pdf); the Clinical Resource Efficiency Support Team (part of the Northern Ireland Health Service) (CREST, 2003); the American Psychiatric Association (APA, 2004); the British National Institute for Clinical Excellence (NICE, 2005); the Institute of Medicine of the National Academies (IOM, 2007); and the Australian Centre for Posttraumatic Mental Health at the University of Melbourne (ACPMH, 2007/2014) (see http://www.trauma-pages.com/s/tx_guides.php). Additional practice guidelines for complex forms of PTSD have been published by the ISTSS (2012) (see http://www.istss.org/AM/Template.cfm?Section=ISTSS_Complex_PTS_D_Treatment_Guidelines&Template=%2FCM%2FContentDisplay.cfm&ContentID=5185) and the American Psychological Association’s Division of Trauma Psychology (2015).
Each practice guideline system uses different criteria (standards and requirements) for judging the scientific and clinical evidence in support of each treatment model or practice, and designates several “levels” of support (such as “evidence-based,” “promising,” and “empirically informed,” or grades ranging from A to F) with recommendations ranging from “strongly recommend” to “do not recommend.” There is some consistency across the various systems in the interventions or best practices that are supported by the scientific research base, but there is much disagreement as well. There also is controversy as to the relative weight that clinicians’ experiences in using treatment models or practices and clients’ views of the treatments should have compared to scientifically rigorous research findings (American Psychological Association, 2006). And there is also debate about whether the physical science paradigm of experimental research of distinct treatment interventions is adequate to accurately and fully demonstrate the benefits of treatments for PTSD as well as other psychological or psychiatric disorders (Westen, Novotny, & Thompson-Brenner, 2004) and whether these give adequate attention to the values and preferences of clients. A major practical challenge is to actually get psychotherapists to fully utilize evidence-based interventions in their day-to-day treatment of clients with PTSD (Zayfert et al., 2005).

The most current PTSD treatment guidelines indicate that several versions of cognitive behavior therapy (CBT) with trauma memory processing have the strongest research evidence base for PTSD treatment with adults. PTSD affect and interpersonal regulation (PAIR) psychotherapies designed to facilitate the recognition and adaptive management of PTSD symptoms in current daily life without requiring in-depth processing of trauma memories also have developed a scientific evidence base. Medications developed for depression also have a growing scientific evidence base for the treatment of PTSD, including two selective serotonergic reuptake inhibitor (SSRI) antidepressants (fluoxetine and paroxetine), which are Food and Drug Administration (FDA) approved for adult (but not child) PTSD treatment.

**CBT for PTSD**

A long-held tenet in the PTSD field has been that memories of traumatic event(s), along with all of the associated bodily reactions, emotions, and thoughts or beliefs, must be faced directly until they are no longer incomplete, intrusive, and intolerable (Foa & Kozak, 1986). Memories of traumatic events are not expected to become less emotionally disturbing and painful—although this can occur—but the goal is to enable the client to gain a sense of mastery of the memories rather than feeling haunted, tortured, or too terrified to recall them (Harvey, 1996). This shift enables the client to stop, or reduce, her or his hypervigilance and avoidance of reminders of traumatic experiences, resulting in their being more like memories of nontraumatic events and less likely to perpetuate a vicious cycle of PTSD symptoms (intrusive memories triggering avoidance, dysregulated emotions and thinking, and hypervigilance, which in turn elicit stronger and more frequent intrusive memories). Interestingly, this view of the importance of facing and overcoming toxic memories was evident in psychoanalytic schools of psychotherapy for patients suffering from what was labeled as “hysteria”
Posttraumatic Stress Disorder

Posttraumatic Stress Disorder (symptoms currently understood as forms of dissociation, often related to traumatic experiences such as sexual assault or abuse; Nijenhuis & van der Hart, 2011).

CBT directly addresses the thoughts and beliefs that are often associated with fear and other negative emotions that occur when traumatic stress reactions persist and become a problem after the traumatic experiences have ended. It also addresses the avoidance of trauma-related thoughts, feelings, and situations that is often extensive. The general goal of CBT is to help the survivor process (remember and understand from a new perspective, often with new insight) and figure out what is most personally meaningful (for better or worse) in the memory of the traumatic event and to attain a realistic perspective on it. This, in turn, is believed to help the client develop or resume satisfying life activities by reducing or eliminating the avoidance behaviors and the posttraumatic symptoms (Hembree & Marinchak, 2008, pp. 126–127).

CBT for PTSD is based on the rigorously tested theoretical model that postulates that intrusive reexperiencing (unwanted memories and psychophysiological reminders of traumatic events) occurs as the paradoxical result of avoidance of thoughts or emotions about trauma memories or their reminders (Foa & Kozak, 1986). Common sense would indicate that avoiding trauma memories and reminders should provide relief, as suggested by advice such as “What you don’t know can’t hurt you,” or “Don’t dwell on the past.” However, just the opposite has been found: the more someone tries not to think about something disturbing like a traumatic memory or not to feel upset when reminded of it, the more that individual actually is thinking about it (you have to think about something in order to know what you are trying to avoid), and the more bodily, mental, and emotional energy is being used to stay on guard for any signs of the memory or the reminders (i.e., being “hypervigilant,” but in this case not watching out for the danger itself but rather for reminders of past danger or harm).

In order to reverse this cycle of instability, it is necessary to find a way to face rather than avoid the traumatic memory and reminders of it. In PE, the exposure is not to more actual trauma but instead to memories of traumatic events (in imagination—hence the term imaginal exposure) and to current (in vivo) situations that have reminders of the traumatic past event(s). As described earlier, by vividly recalling, imagining, or actually being in a situation that is strongly reminiscent of a past traumatic event (such as visiting the scene of a mass-casualty accident or disaster, or looking at pictures of an assailant or abuser), the client can therapeutically reexamine, clarify, and reconstruct a complete and emotionally manageable memory of what was previously overwhelmingly. The memory and reminders of it no longer evoke the same feelings of horror, terror, or helplessness that the person experienced at the time of its actual occurrence. The “emotion processing” involved in PE (Foa et al., 2007) thus may enable people to not just wish but to actually know and feel that “that was then, this is now.” When a memory can be faced (with the support of an empathic and skilled guide in the person of the therapist) and the feelings it evokes can be felt fully but in a way that is emotionally manageable, the anxiety about being overwhelmed by the memory can be reduced to the point that it no longer seems (or is) necessary to fearfully avoid or defend against it.

CBT for PTSD involves careful preparation, including education about traumatic stress, PTSD, how facing rather than avoiding traumatic events and their memory can reduce its symptoms, and skills for managing anxiety (such as ways of breathing or
tensing and relaxing muscles that enhance relaxation and counteract fear). This preparation typically is accomplished very efficiently in three 60- to 90-minute sessions in research-based CBT models (Hembree & Marinchak, 2008). Another six to eight sessions are devoted to PE, imaginal, and in vivo.

Imaginal exposure involves repeatedly revisiting the trauma memory in imagination. Imaginal exposure is designed to help the survivor to emotionally process her or his experience of the traumatic event(s) by vividly imagining the traumatic event(s) as if the event(s) were happening right at the current moment, while also being fully aware that the event(s) are not actually happening. This is typically done with the eyes closed and describing the event(s) aloud, including the thoughts, emotions, and physical sensations that were experienced during the event(s). This imaginal revisiting of the traumatic event(s) is typically repeated over and over throughout treatment or until the trauma memory ceases to elicit intense anxiety or distress.

In vivo exposure entails repeatedly facing safe but avoided situations, places, activities, or objects that evoke unrealistic anxiety because of their association with the trauma memory. In vivo exposure further enhances the processing of the traumatic experiences by asking the person to confront and remain in these planned situations until anxiety decreases or habituates significantly. Such therapeutic exposure provides powerful learning experiences that help the person to feel safer and attain more realistic views of the world (Hembree & Marinchak, 2008, p. 128). The “cognitive” aspect of CBT for PTSD involves the therapist helping the patient to identify thoughts or beliefs that increase rather than decrease anxiety and avoidance, as well as alternative thoughts that can be substituted to instead increase personal confidence and positive emotions. This “CR” is a dismantling of automatic anxiety-intensifying thoughts (such as “I’m helpless,” or “Nobody will help me,” or “There is no safe place in this world”) and rebuilding new thoughts (such as “I can’t stop every bad thing from happening, but I can handle those events and my own emotions in a way that helps to make things better,” or “I can ask for help from people in my family and circle of friends who I know are trustworthy”). When new thoughts are practiced intentionally and repeatedly, they take the place of those that were automatic. The result is that the client may feel less anxiety and depression and more hope and confidence. He or she no longer needs to feel afraid of (and avoid) the anxiety-evoking thoughts. CR teaches that “thoughts are just thoughts—“sticks and stones can break my bones, but names can never hurt me”—similarly to how PE teaches that “memories and reminders are just memories and reminders.” With PTSD, these are lessons that cannot only be talked about but must be experienced behaviorally. Hence, the name “cognitive behavior therapy”: the therapy depends on the client experimenting with nonavoidant ways of facing and gaining mastery of the anxiety-evoking memories and thoughts that are at the core of PTSD—not just thinking positively or hoping not to feel so upset but taking decisive action to behave differently by choosing what to remember and what to think. In other words, insight is not enough. Application of new information to core beliefs that shape (or disrupt) a person’s self-concept, emotions, and relationships and skill-building to develop the confidence and competence that enable a person to overcome adversity are the most important components and go a long way in undercutting anxiety and depression that so often co-occur with PTSD.
PE/CR was developed originally by Foa, Rothbaum, Riggs, and Murdock (1991) in their work with rape trauma survivors. Two variations on this approach have been scientifically tested in numerous studies and are widely used by therapists. Some studies have shown benefits from adding CR (Bryant, Moulds, Guthrie, Dang, & Nixon, 2003), whereas others (Foa et al., 2005; Jayawickreme et al., 2014) have found no benefits. Another recent innovation has been the use of the drug d-cycloserine (de Kleine, Hendriks, Smits, Broekman, & van Minnen, 2014), as well as VR simulations of traumatic events (Rothbaum et al., 2014), to enhance PE for treatment of PTSD. Interestingly, recent research also suggests that PE leads to changes in trauma-related beliefs without the therapist formally attempting to do cognitive restructuring; careful therapeutic exposure may be sufficient to change PTSD cognitions (Zalta et al., 2014). RCT research studies have shown that PE leads to substantial reductions in PTSD and depression symptoms with a majority of adult clients who undertake the treatment after having developed PTSD as a result of experiencing traumatic sexual assault or abuse or community or military combat violence (Jayawickreme et al., 2014; Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010).

CPT (Resick, Nishith, Weaver, Astin, & Feuer, 2002) is a particularly detailed method of CR for PTSD. Similar to PE, in CPT the client repeatedly replays the memory of a traumatic event in his or her mind, but the emphasis in CPT is on the therapist and client collaboratively developing a narrative—a step-by-step story-like description—that helps the client to figure out what is most meaningful personally rather than focusing primarily on becoming less emotionally distressed by the memory. The CPT trauma narrative also can be written rather than spoken or used with clients or cultures where oral storytelling and giving personal testimony (for healing rather than legal purposes) is traditional, it can be spoken as a way to give voice to the meaning that the experience has for the client and her or his family and community (Hall et al., 2014).

A primary goal that distinguishes CPT from PE is helping the client to learn how currently troubling and problematic thoughts and beliefs originated in the traumatic events or in their attempts to cope in the aftermath, and to adopt a more complete and less self-blaming or self-deprecating appraisal of the traumatic experience by providing corrective information that had been overlooked or dismissed as irrelevant or insignificant. Support for the proposed CR mechanism of change in CPT was provided by a study showing that depression and PTSD symptoms changed in tandem (Liverant, Suvak, Pineles, & Resick, 2012). Another study showed that PTSD clients receiving CPT were more likely than those receiving PE to report reduced thoughts of hopelessness, and the greatest reductions in PTSD symptoms achieved by CPT occurred when hopelessness also was reduced (Gallagher & Resick, 2012). PE showed similar overall benefits to those achieved by CPT, but in PE the apparent mechanism of change was a reduction in the overall level of distress that clients reported when recalling traumatic memories in therapy.

CPT has been shown to be effective in reducing PTSD in RCT scientific studies with both male (Mullen, Holliday, Morris, Raja, & Suris, 2014) and female (Hall et al., 2014; Jayawickreme et al., 2014; Suris, Link-Malcolm, Chard, Ahn, & North, 2013) survivors of sexual assault. A variation of CPT that does not involve creating a
written narrative of a traumatic event but instead focuses on helping clients to rework their current beliefs contributing to PTSD—CPT-CR Only—has been shown to be equally as effective as the original CPT in reducing PTSD symptoms with combat veterans who had traumatic brain injuries but not as effective in reducing depression symptoms (Walter, Dickstein, Barnes, & Chard, 2014; Walter, Varkovitzky, Owens, Lewis, & Chard, 2014). Thus, as with PE, CR appears to have benefits, but it is the focused reconstruction of the narrative of the traumatic memory that seems to yield the greatest benefit. Both CPT and PE were found to be associated with reductions in suicidality in female sexual assault survivors over a 5- to 10-year period, with CPT showing a small but statistically significant greater benefit than PE (Gradus, Suvak, Wisco, Marx, & Resick, 2013).

EMDR is another exposure treatment based on an alternative theoretical model of adaptive information processing (EMDR; Shapiro, 1989, 1995). Following a detailed assessment that is part of an 8-step protocol, the client is encouraged to go through a specific traumatic memory silently (“imaginal exposure” in CBT terms), while simultaneously engaging in an alternative task that is somewhat distracting. This distractor task often involves simple movements or shifts in attention back and forth from left to right, such as side-to-side—or saccadic—eye movements, alternating audio tones in the left and right ear, or left-right finger or shoulder tapping. This dual bilateral attentional focusing occurs as the client replays the traumatic event in imagination and also pays attention to the accompanying thoughts, feelings, and bodily sensations in as vivid detail as possible.

Although similar to PE in its emphasis on intensive step-by-step recall of a traumatic event and reactions that occurred at the time, EMDR differs from PE not only in providing the bilateral distractor task but also in emphasizing careful examination of how all the parts of the event—especially thoughts that continue to be troubling to the client—form a logical narrative that makes sense in light of the specific sequence of events and the circumstances in which they occurred. In that respect, EMDR is more similar to CPT than PE. Also similar to CPT, EMDR systematically helps the client to challenge self-blaming or self-deprecating thoughts that occurred during the traumatic event (assessing the validity of cognitions, in EMDR terms) and to identify beliefs about personal strengths and supportive or protective relationships and keep those cognitions in focus (to install them as a positive resource, in EMDR terms) while recalling the traumatic event. EMDR differs from both PE and CPT in its brevity: as few as a single session and generally fewer than five to seven sessions are used to address each traumatic memory.

A statistical meta-analysis of the results of 26 RCT scientific studies demonstrated that EMDR resulted in moderate to large improvements in symptoms of PTSD, depression, and anxiety, and large reductions in overall personal distress with clients diagnosed with PTSD (Chen et al., 2014). In addition, the review concluded that therapy sessions longer than 60 minutes and experienced PTSD therapists were most likely to achieve the best outcomes, especially with depression and anxiety symptoms. The reason for the latter findings is not known, but one possibility is that clients often may need enough time and skillful therapeutic guidance to accomplish the multiple tasks involved in EMDR and to gain a sense of mastery of traumatic memories.
Although the exact mechanism by which EMDR achieves its results with PTSD clients is not yet fully understood, and early research casted doubt on whether the distractor tasks such as saccadic eye movements had any added value (Davidson & Parker, 2001), results of a more recent meta-analysis indicated that “the eye movements do have an additional value in EMDR treatments” (Lee & Culjpers, 2013, p. 239). Another meta-analysis concluded similarly that eye movements may help clients to access trauma memories more fully (as a more complete narrative), actively (rather than as a passive victim), and with more manageable distress (potentially enhancing self-confidence), but noted that most findings of benefit from distractor tasks came from studies of simulated therapy with healthy individuals rather than PTSD clients (Jeffries & Davis, 2013). While the fact that EMDR has been found to have similar neurobiological benefits to other CBT models for PTSD—reduced levels of hyperarousal in the body and brain—supports its use, the findings do not indicate that EMDR has any distinct effects compared to other CBT interventions on PTSD clients’ stress reactivity or memory.

NET (Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004) is a generally briefer approach than PE or CPT (more comparable in length to EMDR) to CBT with both exposure therapy and cognitive restructuring. NET was designed for settings with limited socioeconomic or health care resources and politically traumatized individuals (including refugees, torture survivors, former political prisoners, sexual assault survivors, and military combatants). NET provides between 4 (Neuner et al., 2004) and 5 (Bichescu, Neuner, Schauer, & Elbert, 2007) to 10 (Halvorsen & Stenmark, 2010) or 12 (Hensel-Dittmann et al., 2011) individual therapy sessions in which the client creates a spoken or written narrative that encompasses not only memories of traumatic stressors but of his or her entire life that include detailed descriptions of traumatic events (similar to PE) and are recorded in writing by the therapist for the client to take home. Active listening, positive regard, and creative tasks (e.g., creating a lifeline by placing flowers and stones that represent positive and negative events along a rope to illustrate key events; reenacting body positions that were experienced or used to cope during traumatic events) also are used in helping the client to achieve therapeutic exposure to traumatic memories while constructing a life story that includes a reevaluation of basic beliefs that have been altered by traumatic experiences.

NET has been conducted with adults (and children; see Chapter 8) in some of the most severely traumatized nations and cultures in the world, both in the very middle of dangerous and chaotic communities and with displaced persons who have fled traumatic societies and are faced with the additional challenges (and potential traumatic stressors) of immigration as a refugee (see Chapter 10, Box 10.2 Evaluating Traumatic Stress Issues for Individuals Seeking Asylum). In several small RCT studies, NET’s acceptability to clients and efficacy in reducing PTSD and depression symptoms with a majority of the adults (and children; see Chapter 8) receiving the treatment have been confirmed as lasting benefits with follow-up assessments up to a year after therapy ended (Dossa & Hatem, 2012; Hensel-Dittmann et al., 2011; Robjant & Fazel, 2010). In several creative studies, NET has also been shown to alter brain processing by increasing “top-down” (Adenauer et al., 2011) activation of the
cortex—leading to active attention to reminders of danger rather than avoidance—and to enhance the body’s immune system despite evidence of persistently low immune capacity to fight off illness even when PTSD improved (Morath, Gola, et al., 2014). In addition, when PTSD symptoms declined during the year following NET, there also was evidence that the breakdown of the body’s basic genetic building blocks (DNA) was prevented (Morath, Moreno-Villanueva, et al., 2014). Thus, NET has demonstrated the ability not only to help traumatized adults recover from PTSD but also to enable them to shift from a survival brain to a learning brain (Ford, 2009) and to regain some of their bodies’ vital healing capacities.

**CBT interventions for special populations of adults with PTSD**

CBT has been adapted for adults with three particularly problematic comorbid psychiatric disorders: SUDs, severe mental illness (including schizophrenia and bipolar disorder), and BPD. Each of these adaptations is discussed next.

**CBT for PTSD and SUDs.** From a cognitive-behavioral standpoint, PTSD and SUD both are the result of dysfunctional (i.e., threat-based or addiction-based) beliefs, cognitive biases, and reactive behavior patterns involving chronic avoidance that lead to an escalating sense of anxiety, anger, isolation, hopelessness, and helplessness (Ford et al., 2007). From a stress and coping perspective, PTSD and SUD involve maladaptive coping in response to stressors that range in intensity from mild to traumatic (Stewart & Conrod, 2003). From an empowerment or strengths-based perspective, PTSD and SUD involve a loss or breakdown of the person’s psychological and interpersonal resources (e.g., sense of safety, trust in others, hope, self-efficacy, motivation) (Ford et al., 2007).

PTSD may negatively influence the course and outcome of SUD treatment. Najavits et al. (2007) found that cocaine-dependent outpatients with comorbid PTSD improved less than ASUD-only participants on measures of alcohol use and psychosocial problems. However, PTSD was not found to be a negative prognostic factor in several other studies (Ford, 2013). Pharmacotherapy, either associated depression symptoms with the SSRI antidepressant sertraline or for alcohol craving with disulfiram and naltrexone, has been shown to be safe and effective with adults with comorbid PTSD and alcohol use disorders. Clinically diagnosed PTSD was not associated with poorer opiate substitution treatment outcomes with military veterans or with treatment dropout in an adolescent residential therapeutic program. However, teens in the latter study who had experienced traumatic stressors (whether or not they had PTSD) were more likely to drop out of residential treatment for SUD. A comparing CBT for SUD and depression with a 12-step support group showed that clients with PTSD benefited as much as those without PTSD while they were in treatment and for several months thereafter. However, when reassessed 18 months after completing the treatment, those with PTSD reported achieving fewer days abstinent than clients who did not have PTSD (75% versus 91%).

A possibility suggested by the Cohen and Hien (2006) study of Seeking Safety (SS) for comorbid SUD and PTSD is that it may be the complex problems with self-regulation (such as depression, dissociation, social and sexual problems) rather than
PTSD per se that interferes with adherence and change in SUD treatment. Ford et al. (2007) conducted secondary analyses of data from a multisite study of the efficacy of a SUD treatment, called contingency management (CM), in community-based clinics and found that, over and above the strong benefits of CM intervention, the severity of self-regulation problems—but not history of traumatic stressor exposure, PTSD symptom severity, or overall psychiatric symptom severity—predicted poorer outcomes in terms of retention in treatment and objectively verified continuous abstinence from cocaine and heroin use during treatment, only in the CM condition. Self-regulation problems were the link between having witnessed violence in the past and premature termination from SUD treatment. Although PTSD and self-regulation problems were interrelated, only the self-regulation problems appeared to interfere with immediate treatment outcome, consistent with Ford and Kidd’s (1998) findings with military veterans in treatment for chronic PTSD. Comorbid PTSD-ASUD often involves severe self-regulation problems (such as impulsivity, extreme emotion states, and abusive or empty relationships), and therefore treatments that address these complex outgrowths of PTSD may be needed when comorbid SUD and PTSD are treated.

Interestingly, clients who reported more severe self-regulation problems completed CM activities just as often as others, suggesting that self-regulation difficulties do not diminish their motivation or ability to engage in SUD treatment. Moreover, a high level of baseline PTSD symptoms actually was a positive predictor of achieving abstinence at 9-month follow-up assessments, in contrast to prior studies’ findings suggesting that PTSD symptoms are a negative prognostic indicator in SUD treatment—here again, only for patients receiving CM. Thus, SUD treatment may provide a welcome distraction from and adaptive focus for persons experiencing intrusive trauma memories or hyperarousal and hypervigilance, or a source of predictability, controllability, and positive emotions in contrast to PTSD’s negative cognitive biases and emotional distress and numbing. This hypothesis received indirect support from the results of three RCTs of SUD clients with childhood sexual abuse histories. These data showed that they were more likely than others to achieve abstinence (verified by urine tests) from substance use during treatment—and, only if they received CM, but not those receiving a less effective SUD treatment, clients with sexual abuse histories had significantly longer durations of abstinence during treatment than those without sexual abuse histories (Petry, Ford, & Barry, 2011). Highly structured SUD treatment may actually work best with clients who, as a result of severe childhood exposure to traumatic abuse, need to develop the kinds of self-regulation skills that interventions such as CM teach or strengthen. Gains in self-regulation skills may translate into reductions in PTSD symptoms, and this may help to explain the finding from several studies that as PTSD symptoms improve, SUD treatment outcomes also improve (Hien et al., 2010).

CBT interventions for co-occurring PTSD-SUD therefore consistently teach complementary cognitive and behavioral skills not only for overcoming PTSD and SUD symptoms but also for building or acquiring personal strengths or interpersonal resources and for coping with the effects of both current and past stressors without relying on substances or addictive behaviors. Psychotherapies with the strongest evidence of efficacy for treating comorbid PTSD and SUD extend CBT by adding affect and interpersonal regulation interventions.
Psychotherapy for comorbid PTSD and SUD begins with providing trauma-informed stabilization, safety, and education interventions (Phase 1 in PTSD psychotherapy), with the addition of a focus on understanding that stress reactions lead to and exacerbate substance use. Historically, treatment of addictions such as SUDs and PTSD developed independently and were kept in “silos,” even as the common interrelationship (comorbidity) between PTSD and SUDs has been increasingly and incontrovertibly demonstrated (Fareed et al., 2013; Ford, 2012; Najavits & Hien, 2013). Contemporary approaches now stress the need for concurrent treatment of the addictive disorder and PTSD (Najavits & Hien, 2013). If one disorder remains active and untreated, it has a high probability of derailing recovery from the other. For example, achieving sobriety from alcohol or other substance use often is accompanied by a resurgence of PTSD symptoms, leading to an increased risk of relapse to the substance of choice. Or when clients find trauma memory processing distressing, they may be tempted to resume or increase their use of substances in order to quell or manage the distress they are experiencing.

Cognitive Behavior Therapy for Severe Mental Illness (CBT-SMI; Mueser, Descamps, Jankowsky, & Rosenberg, 2002; Mueser et al., 2008) is a 16-session one-to-one psychoeducation intervention for individuals with severe mental illness and PTSD in community mental health or in client psychiatric settings. In addition to teaching clients to recognize specific PTSD symptoms and ways they can intertwine with and exacerbate mental illness symptoms, CBT-SMI uses cognitive therapy to assist clients in challenging and revising distorted beliefs (similar to CPT) and anxiety management. CBT-SMI does not utilize PE but instead focuses on here-and-now coping skills to assist clients in managing intrusive memories. In an RCT research study, CBT-SMI was shown to be superior to standard community mental health center treatment in improving PTSD and psychiatric symptoms, reducing negative trauma-related beliefs, and enhancing clients’ relationships with their case managers, particularly for clients who completed homework assignments that supported assertive methods of coping with stress reactions and trauma-related thoughts (Mueser et al., 2008). Similar to findings for PE, clients who reported less endorsement of trauma-related beliefs tended to also benefit the most in reducing severe PTSD symptoms.

Only 15% of the clients in the Mueser et al. (2008) study of CBT-SMI were diagnosed with a primary psychotic disorder. A European clinical research team demonstrated that adults with comorbid PTSD and psychotic disorders could not only safely tolerate exposure therapy for PTSD (de Bont, van Minnen, & de Jongh, 2013) but also showed evidence of benefits from both PE and EMDR in an RCT study comparing the two CBT treatments (van den Berg et al., 2015). In the first smaller feasibility and safety study with 10 outpatient clients, no serious adverse events were reported while the clients received 12 weekly sessions of therapy and over the next 3 months following PTSD therapy, nor was there any evidence of worsening of psychotic symptoms (hallucinations, delusions), other psychiatric symptoms, or interpersonal functioning. In a larger study with 155 outpatient clients who had past psychotic disorders and current PTSD, a briefer course (eight weekly sessions of 90 minutes in length) of PE or EMDR resulted in clinically significant reductions in PTSD symptoms for 57–60% of the clients (compared to less than half that percentage, 27%, for clients who received
no PTSD treatment) that were generally sustained at a 6-month follow-up assessment. PE and EMDR were equally effective, and the number of serious adverse events (such as suicide attempts) was very low (occurring for only seven of the clients, less than 5%) and lower for PE and EMDR recipients than other clients. Although most of the clients in these studies had relatively mild psychotic symptoms, they were at risk for developing severe psychotic symptoms due to having had this occur in the past, and neither PE nor EMDR appeared to trigger this kind of relapse.

**CBT for Comorbid PTSD and BPD.** In the Mueser et al. (2008) study of CBT for SMI, 25% of the clients were diagnosed with BPD. This is consistent with evidence from nationally representative samples in the United States that approximately 30% of adults meeting criteria for either PTSD or BPD also met criteria for the other disorder, and closer to 40% of adults diagnosed with BPD had an episode of PTSD at some point in their lifetime (see Ford & Courtois, 2014 for a summary). A 10-year follow-up of adults diagnosed with BPD and PTSD found that even when they recovered from PTSD, almost half had a recurrence of PTSD, especially those who had a history of childhood sexual abuse (Zanarini et al., 2011). Thus, PTSD appears to be a persistent problem for adults who are dealing with the often severe emotional, behavioral, and interpersonal problems of BPD. This may be due in part to the toxic link between experiencing betrayal traumas such as sexual, physical, or emotional abuse in childhood and developing the severe self-regulation problems of BPD. DBT is well established as a treatment for preventing self-harm and enhancing interpersonal functioning with adults diagnosed with BPD (Neacsiu, Lungu, Harned, Rizvi, & Linehan, 2014). However, DBT did not show greater effectiveness than expert treatment as usual (TAU) with regard to symptoms that are strongly connected to PTSD and its self-regulation problems: guilt, shame, anger suppression, anxiety, core schemas, and impulse control. Therefore, an adaptation of DBT has been developed with a modified form of PE for PTSD. In a feasibility and safety study with women diagnosed with comorbid BPD and PTSD, DBT + PE yielded similar completion rates (67–70% when therapists had acceptable fidelity) and better outcomes for self-harm, depression, anxiety, guilt, and shame than DBT alone (Harned et al., 2014). A subsequent RCT study tested the efficacy of DBT-PTSD (“DBT-PTSD”) with 74 women diagnosed with PTSD related to childhood sexual abuse (Bohus et al., 2013). Half of the participants met criteria for comorbid BPD. DBT-PTSD was associated with substantial reductions in PTSD severity for women with or without BPD, while those in a TAU condition showed almost no change: reductions on average of 33 versus 2 points on the Clinician Administered PTSD Scale. Dysfunctional behaviors such as self-harm were monitored carefully and did not increase for participants in DBT-PTSD. These findings provide an independent and well-controlled replication demonstrating the efficacy of combining PE for PTSD with DBT for women with that difficult-to-treat comorbidity.

**Psychotherapies for Affect and Interpersonal Regulation (PAIR)**

PTSD involves both a reduction in emotional experiencing (the “emotional numbing” and “social detachment” symptoms) and periodic “bursts” of distress in the form of
unwanted trauma memories (“intrusive reexperiencing” symptoms) and intense anxiety and anger (“hyperarousal symptoms”). Experiential therapies are designed to help the client with PTSD to achieve a midlevel of emotional intensity and a full range of emotions by becoming more proactively aware of these symptomatic extremes of too little or too much emotion.

*Living a life of vitality, resilience, and human connectedness in the face of adversity requires ready access to emotional experience. Access to basic emotions is necessary in order to harness adaptive resources (e.g., assertiveness, self-protection, humor, conscientiousness, creativity, self-efficacy, trust), as well as to be able to rely on others to help bolster these coping resources. Experiential psychotherapies are designed to systematically assist people in enhancing the ability to access emotions and the psychosocial resources linked to emotions.*

*(Fosha, Siegel, & Solomon, 2009)*

Several approaches to psychotherapy for PTSD do not require clients to engage in therapeutic exposure or intensive narrative reconstruction of specific detailed memories of traumatic events, but focus instead on addressing the emotional difficulties and dysregulation and relationship problems that accompany severe stress reactions in the daily lives of people with PTSD. Although these PAIR psychotherapies originated between 1 and 2 decades after the first CBT models for PTSD, they are developing a scientific evidence base that is encouraging.

*STAIR* (Cloitre et al., 2006). STAIR-MPE provides an attachment-based (Cloitre, Stovall-McClough, Zorbas, & Charuvastra, 2008) and DBT-informed first phase of therapy aimed at enhancing affect and interpersonal regulation skills, followed by a modification of PE similar to that in DBT + PE, which carefully titrates trauma memory processing intensity to not exceed the client’s affect regulation capabilities. Two RCT studies have demonstrated STAIR-MPE’s efficacy in reducing severe PTSD, depression, and dissociation with women with chronic childhood victimization- or interpersonal violence–related PTSD (Cloitre, Koenen, Cohen, & Han, 2002; Cloitre, Petkova, Wang, & Lu Lassell, 2012; Cloitre et al., 2010; Koenen, Cohen, & Han, 2002).

*Trauma Affect Regulation: Guide for Education and Therapy* (TARGET). TARGET was developed in field tests with low-income women and men in mental health and SUD treatment programs (Ford & Russo, 2006) and with boys and girls in juvenile justice programs (Ford, Chapman, Hawke, & Albert, 2007). TARGET is applied in a 12-session individual therapy version and a 10-session group version and provides education and skills training for processing and managing trauma-related reactions triggered by current nontraumatic stressors. The skills are taught in a practical seven-step sequence summarized by a mnemonic (“FREEDOM”): Focusing, Recognizing current triggers; Emotion identification and reappraisal; Evaluation of reactive beliefs; Defining personal goals; Options for incrementally achieving goals; and Making a contribution by managing traumatic stress reactions. The FREEDOM skill sequence is used as a basis for trauma/PTSD education, emotion regulation, cognitive reappraisal, goals/values clarification, and experimentation with new behavior in current stressor situations. A creative arts exercise—the personal “lifeline”—utilizes collage, drawing, poetry, music, and crafts to assist participants in developing a
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In contrast to PE, traumatic events are neither recounted repeatedly nor treated as the primary focus. The goal in TARGET is to help participants recognize their personal strengths using the FREEDOM skills and to use these skills consistently and purposefully when they experience stress reactions in their current lives. In rigorous research studies, TARGET has shown evidence of effectiveness in rigorous research studies in reducing PTSD and trauma-related beliefs and psychiatric symptoms, sustaining the capacity for forgiveness and sobriety-related self-efficacy, and improving emotion regulation skills with women with chronic PTSD (Ford, Chang, Levine, & Zhang, 2013; Ford, Steinberg, & Zhang, 2011) and men and women with chronic comorbid PTSD and SUD (Frisman, Ford, Lin, Mallon, & Chang, 2008).

Interpersonal psychotherapy (IPT). IPT was developed to treat depression by enhancing social support and preventing acute crises in relationships. IPT is a one-to-one therapy typically involving between six and 20 sessions (with extended booster sessions to prevent relapse), in which skills for interpersonal decision-making and communication are taught, role played, and applied in carefully structured homework activities. A 14-session adaptation of IPT for adults with chronic PTSD was found to be equivalent to prolonged exposure (PE) in reducing PTSD symptoms, and almost two thirds of IPT recipients (compared to fewer than half of those receiving PE) achieving a clinically significant reduction in an independent assessor’s ratings of PTSD symptoms (Markowitz et al., 2015). IPT also had fewer drop-outs than PE, particularly among persons with major depressive disorder (who were nine times more likely to drop out of PE than those with PTSD but no depressive disorder). Both IPT and PE resulted in improvements in quality of life and interpersonal functioning that were superior to a relaxation skills intervention. IPT’s approach of teaching social skills relevant to recovery from depression and PTSD does not involve intensive recall of trauma memories, yet it appears to be comparably effective to the PE trauma memory processing therapy, as well as possibly more tolerable or acceptable than PE for severely depressed adults.

Present Centered Therapy (PCT). PCT is a 12- to 14-session individual therapy that provides education about the links between psychologically traumatic events, PTSD symptoms, and problems in relationships, and teaches social problem-solving skills to address “traumagenic dynamics” of betrayal, stigma, powerlessness, and sexualization (found in child sexual abuse in particular, but applicable to other traumas as well) (Finkelhor, 1987). As in TARGET, PCT focuses on addressing current problems rather than trauma memory–based PE and uses a distinctive mnemonic to organize the skill set (“SIBEDR,” pronounced “see better”: State the problem, Information gathering, Brainstorm, Experiment with alternatives, Decide and Do it, Review and Revise the plan). PCT also has the client keep a journal of relational stressors and responses as between-session homework. In a rigorous research study, PCT has been shown to be of comparable immediate benefit to PE/CR in reducing PTSD and psychiatric symptoms (although a lesser degree of continued improvement after treatment was concluded) and to have far fewer dropouts (9% versus 43%) in women with PTSD related to childhood sexual abuse (McDonagh et al., 2005). PCT also has been found to have comparable benefit to TARGET in reducing PTSD and anxiety.
symptoms and slightly greater benefit in reducing depression and guilt symptoms in a study of women with chronic PTSD (Ford et al., 2011). A different version of PCT, which shares the name but does not provide the systematic instruction in social problem-solving skills, has been found to be equally as effective as PE/CR as a group therapy with male military veterans with chronic PTSD (Schnurr et al., 2003) and less effective than PE/CR as an individual therapy with women military veterans with PTSD (Schnurr et al., 2007). Overall, the PCT social problem-solving skills component appears effective in improving present-day relationships (and reducing PTSD, depression, and related symptoms) in a manner that clients find helpful and engaging but not as directly beneficial in reducing PTSD intrusive reexperiencing symptoms and improving self-regulation as PE/CR and TARGET (Ford et al., 2011; McDonagh et al., 2005). A meta-analysis of five RCT research studies comparing PCT to PE or a comparable CBT for PTSD reported that PCT was equally effective across several measures of treatment outcome (including PTSD, depression, and anxiety symptoms) and had less than half the number of dropouts (14% versus 31%), indicating that PCT is efficacious for adults with PTSD.

**Emotion Focused Therapy for Trauma (EFTT).** Putting feelings into words enables a person to recognize and use the information provided by basic emotions, such as fear, anger, and sadness, that are experienced in wordless body feelings. In CBT, emotions are considered secondary to and largely defined by thoughts or beliefs. In contrast, in EFTT, emotions are seen as a basis for developing new ways of thinking and new beliefs about oneself and the world. This is particularly important in light of the strongly held negative beliefs that often accompany (and possibly intensify) PTSD. EFTT helps clients to reclaim rather than become desensitized to painful feelings and memories, while assisting them to create or regain positive beliefs about themselves, relationships, and the world. Although EFTT utilizes standard emotion management skills for severe emotion dysregulation (e.g., attention to breathing, relaxation, present-centered awareness), the primary focus in EFTT is empathic responding to client feelings and needs. Empathic responding fosters regulation capacities by increasing clients’ awareness of their emotions, and in the process helping them to accurately label and express the meaning of each emotion. Feeling understood emotionally also helps to reduce distress. Empathic responses also help to adjust emotional intensity by reducing feelings of isolation and distress, as well as increasing physical and emotional arousal and making emotions more available to the person as useful information. Additionally, empathic responses set a model for appropriate emotional expression.

EFTT usually involves 16–20 weekly 1-hour sessions, individualized to each client. After initial sessions focused on ensuring safety, defining goals, and developing a therapeutic relationship through the use of empathic responding, EFTT uses an “imaginal confrontation” (IC) technique to reduce fear, avoidance, shame, and self-blame and improve emotion regulation. In IC, clients imagine perpetrators of abuse or neglect in an empty chair, observe their own thoughts and feelings, and express these directly to the imagined other. A third phase focuses on resolving issues with abusive/neglectful others and accessing adaptive anger and sadness. Finally, closure sessions help clients apply new learning in their daily lives. EFTT has been supported
in scientific studies with both men and women with PTSD due to childhood traumatic abuse (Paivio, Jarry, Chagigiorgis, Hall, & Ralston, 2010; Paivio & Nieuwenhuis, 2001).

Seeking Safety (SS; Najavits, 2002) is a CBT intervention for the combination of PTSD and SUDs that provides up to 25 sessions that can be flexibly applied to teach more than 80 “safe coping skills” (such as “grounding” to detach from and cope with distress or dissociation; interpersonal assertiveness; self-monitoring; healthy self-nurturing; asking for help; and time management). Similar to CBT-SMI and CPT, SS uses cognitive therapy to challenge demoralizing or risky beliefs, including distortions specifically related to PTSD and addiction and the necessity of safety for healing. PE is also not used in SS. Instead, this method teaches skills for managing PTSD symptoms in daily life and in addiction recovery. Women completing SS in ongoing addiction treatment have improved on both addiction and PTSD symptoms comparably to an addiction-focused intervention (relapse prevention skills training) and better than in addiction treatment as usual, as well as of greater improvement in anxiety, depression, hostility, suicidality, and interpersonal problems than either relapse prevention or treatment as usual (Najavits, 2002). SS has shown evidence of efficacy in a scientifically rigorous study with adolescent girls with PTSD and SUD (Najavits, Gallop, & Weiss, 2006) and to have moderate benefits in a large but less scientifically rigorous study with homeless women (Desai, Harpaz-Rotem, Najavits, & Rosenheck, 2008). SS also is being adapted and appears to be suitable for men with PTSD and SUD (Weaver, Trafton, Walser, & Kimerling, 2007). Similar to work being done with STAIR, SS has been combined with a modified (abbreviated) version of PE, with promising results in case studies but no RCT evidence of efficacy as yet (Najavits, Schmitz, Gotthardt, & Weiss, 2005).

Anxiety Management Skills Training. Similar to PCT, anxiety management skills training, also known as “stress inoculation training” (SIT; Novaco, 1977), teaches specific skills that can be used to handle stress reactions in current life. SIT focuses on skills for managing anxiety or stress reactions, whereas PCT teaches skills for social problem-solving. SIT coping skills include relaxation, CR, self-dialogue, assertiveness, and behavioral rehearsal (role-playing, and covert modeling) skills (Hembree, 2008). Among several potential approaches to purposeful relaxation, the most commonly used is PMR. PMR involves tensing and then relaxing specific muscle groups throughout the body, while focusing attention on the difference in how these muscles feel when tense versus when relaxed. This learning is then applied to the recognition of physical tension in daily life. CR is taught as in the PE/CR approach to CBT for PTSD to enable the client to recognize and modify thoughts or beliefs that intensify stress reactions or reduce self-confidence and trust in relationships. Self-dialogue complements and extends CR by teaching ways to change an individual’s internal dialogue—what the client “says” to herself/himself—in order to prepare for and cope with distressing feelings when confronted by stressful memories or current experiences. Self-dialogue also involves learning to offer internal praise and encouragement when challenging stressors and for the small as well as large successes. Assertiveness skills involve addressing conflicts or personal goals with others with direct, non-judgmental, and respectful verbal and nonverbal communication. Finally, behavioral
rehearsal involves practicing other anxiety management skills in order to be prepared and to feel confident before using the skills in real-life situations. Through rehearsal, the therapist provides modeling, and the client experiments with using the skills, either in imagination (“covert modeling”) or by role playing (taking on different roles in simulated interactions). With repeated practice in a nonthreatening context, anxiety management skills can become well learned, and clients can become sufficiently confident to apply the skills. Behavior rehearsal enables clients to actually see the therapist and then see themselves (in imagination) and experience (both in imagination and in role playing) coping successfully with stressful situations. Despite its obvious logic and appeal, anxiety management skill training has been found to be less effective than PE or PE/CR in reducing PTSD symptoms in several research studies and to be generally ineffective when single skills are taught apart from the entire SIT package. When combined with biofeedback—a procedure in which the client and therapist get real-time feedback from machines that show the client’s level of physiological arousal on several dimensions (such as heart rate, muscle tension, and brain wave patterns)—anxiety management skills have shown evidence of reducing PTSD symptoms, particularly hyperarousal (Clum, 2008). Therefore, SIT or anxiety management skills training is used primarily in Phase 1 preparation for either PE, CR, or both, except with clients who have particularly severe anxiety symptoms and may benefit from learning skills for symptom management and biofeedback.

_Trauma Recovery and Empowerment Model (TREM; Ford, Fallot, & Harris, 2009; Harris & Fallot, 2001)._ TREM is a group psychoeducational intervention initially designed for women with co-occurring major mental illness and PTSD and was subsequently adapted for men with severe mental illness, women with severe addictive disorders and histories of victimization, and adolescent girls with addictive or psychiatric disorders. TREM has versions ranging from a 4-session introduction to a 24- to 33-session extended group. TREM focuses initially on the survivor’s personal and relational experience in order to facilitate the reinstatement of psychosocial and psychosexual development that was interrupted by adversity (e.g., family and community poverty, racism, mental illness) and trauma. TREM then provides a supportive (gender-separated) group milieu in which each survivor can disclose memories of trauma to help overcome feelings of fear, grief, and shame while reintegrating those memories into a personal life narrative. TREM is similar to TARGET in teaching that symptoms originate as legitimate responses to trauma and to TARGET and STAIR-PE in teaching skills for affect awareness and relational engagement. TREM was found to be associated with greater improvements in PTSD, SUD, and psychiatric symptoms than mental health or SUD treatment-as-usual in a multisite study of interventions for women in recovery from addiction and violence (Morrissey et al., 2005).

**Hypnosis and hypnotherapy for PTSD**

Hypnotic techniques have been used with ASD and PTSD for 200 years, and contemporary therapists use hypnosis within CBT or psychodynamic therapy rather than
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in isolation (Cardena, 2008). Hypnosis involves the therapist encouraging the client in focusing internally and suggesting that she or he is experiencing changes in body sensations, perception, thoughts, emotions, or behavior without the client intending or willing them to happen. The contrast between what the client is aware of consciously and intends to feel, think, or do and what the therapist suggests the client is feeling, thinking, or doing is the “induction” of (i.e., leads to) an altered state of consciousness (the hypnotic “trance,” which is a mental “disconnect”). The hypnotic trance increases the ability to focus attention and thereby to make changes in dissociative symptoms such as PTSD intrusive reexperiencing (e.g., unwanted memories or flashbacks of traumatic experiences).

Hypnotic techniques such as self-hypnosis may be used in the first, stabilizing, phase of psychotherapy to achieve a calm mental focus or guided imagery to provide clients with an imaginary “safe place” and an altered view of themselves as effective (“ego strengthening”). During Phase 2, hypnotherapy techniques may be used to enhance clients’ ability to vividly recall and successfully cope with the anxiety elicited by traumatic memories, including projective and restructuring techniques, age regression, and imaginal memory containment.

Research studies have shown that hypnotherapy was comparable to psychodynamic therapy in reducing PTSD and enhancing adjustment (Brom, Kleber, & Defares, 1989), and it increased the benefits when added to CBT for ASD (Bryant, Moulds, Guthrie, & Nixon, 2005). However, experts recommend that hypnosis not be to “recover” (i.e., enable clients to recall) traumatic memories that are not consciously available to them (Cardena, 2008; see Chapter 1). Hypnosis does not necessarily increase memories’ accuracy or completeness, but it does increase the recaller’s confidence in what they believe to be a memory—even if this is not a valid memory (Cardena, 2008). Hypnosis does not “cause” false memories, but it may lead therapists or clients to mistakenly believe they can purposefully search for and find lost memories when this is not the case (Courtois, 1999; Scoboria, Mazzoni, Kirsch, & Jimenez, 2006).

Psychodynamic therapies for PTSD

Psychodynamic therapy for PTSD is based on psychoanalytic theory and Freud’s view that “hysteria” (in contemporary terms, dissociative and conversion symptoms) are the result of psychological defenses (such as denial, repression, or reaction formation) against the anxiety caused by memories of traumatic events. Freud distinguished traumatic neuroses from other neuroses, postulating that some psychic conflicts and anxiety were the result of actual traumatic events rather than a failure of the person to overcome psychological complexes. Psychodynamic psychotherapy for PTSD relies upon interpretation of defenses and of the anxiety that is being defended against (often due to an unacceptable wish or fear stimulated by a traumatic memory) to enable clients to relinquish or modify the defense and cope with anxiety in more adaptive ways (Kudler, 2008; Kudler, Krupnick, Blank, Herman, & Horowitz, 2008).
Psychodynamic psychotherapy involves helping the client to recognize unconscious defensive attempts to repress traumatic memories and associated thoughts and feelings when this occurs in the interaction with the therapist. This enables the client to understand and relinquish or modify these unconscious psychological defenses and “work through” (i.e., figure out how to live with) rather than perpetuating (“reenacting”) the distress that they feel as a result of traumatic memories.

Psychodynamic psychotherapy has been tested for PTSD in only one study that meets rigorous scientific standards, in which Brom et al. (1989) showed that a brief form of psychodynamic psychotherapy was superior to placebo and equal or superior to hypnotherapy in reducing PTSD symptoms and improving clients’ adjustment. Psychodynamic therapy is used by many PTSD therapists, but further research is needed to bolster its evidence base. The strongest scientific evidence for psychodynamic psychotherapies with adults who often have experienced severe childhood traumatization has been provided by an RCT study of a psychodynamic psychotherapy for BPD (Bateman & Fonagy, 2009). Fonagy and Bateman (2006) describe how attachment theory can be translated into an approach to regulating the extreme emotional states in BPD that they call “mentalization.” To mentalize is to examine one’s own thoughts and thought processes as if looking into one’s own mind in order to sort out and organize those thoughts and mental processes. When adults with BPD were helped to develop this mentalization capacity in therapy, they were less likely to have suicidal incidents or to be hospitalized for psychiatric crises than if they were provided with the more standard form of therapy designed to help them manage their symptoms. While PTSD was not assessed in that study, it is likely that some, perhaps many, of the clients with BPD had comorbid PTSD, and the benefits of mentalizing psychotherapy for those individuals will be an important clinical and research question.

Integration of experiential and psychodynamic psychotherapies for PTSD

Accelerated Experiential Dynamic Psychotherapy (AEDP; Fosha et al., 2009; Gleiser, Ford, & Fosha, 2008) draws on research on emotional development in the caregiver–child attachment relationship in early childhood to hypothesize that PTSD psychotherapy should provide “(a) dyadic affect regulation of intense emotions in the context of an attachment-based therapeutic relationship” and “(b) a secure base through the therapist’s actively and explicitly empathic, caring, emotionally engaged, affirming stance [so that the client does not feel] alone with intense emotional experience” (Fosha et al., 2009). Dyadic affect regulation means that therapists provide modeling and guidance while they interact in therapy sessions in order to work with the patient (the therapy “dyad”) so the patient can observe and put bodily feelings into emotion words that make the emotions more manageable and livable.

AEDP accomplishes these goals with several therapeutic interventions, including “(a) somatic focusing (e.g., ‘What are you feeling in your body right now?’), (b) explicit relational joining (e.g., ‘We can work on how to make sense of these feelings together’), (c) affective mirroring (e.g., ‘Before you turned away, I saw grief in
your face’), and (d) deepening evocative portrayals (e.g., ‘You felt you were drowning in terror’) (Fosha et al., 2009). Although AEDP has not been rigorously scientifically tested, it provides therapists with ways to help clients reduce avoidance of trauma-related memories, reminders, and emotional distress that are more detailed and fully defined than the general procedures for PE or NET (Gleiser et al., 2008).

A number of other “creative arts” and expressive therapies derived from the experiential and psychodynamic traditions have been adapted for PTSD treatment (Johnson, Lahad, & Gray, 2008). These include art therapy, involving the use of artistic forms of expression to describe and manage traumatic events, the emotions and beliefs that result, and the hopes and changes that can serve as a basis for recovery from PTSD. Music, dance, theater, and guided imagery (i.e., mentally visualizing traumatic stress reactions and adaptive ways of coping with or overcoming them) also have been creatively utilized in assisting trauma survivors to cope with or recover from PTSD. Creative arts modalities are used in a number of other PTSD psychotherapies, including some forms of CBT (e.g., guided imagery in the “resource installation” component of EMDR), hypnosis (which also uses guided imagery), and emotion regulation psychotherapies (such as the “lifeline” in TARGET). Creative arts therapies for PTSD have not been systematically tested.

Body-focused psychotherapy for PTSD

The distinctive changes in body physiology and brain structure and function that occur in PTSD (see Chapter 5) highlight the importance of helping people with PTSD to be aware of and regain healthy functioning in their bodies. Sensorimotor Psychotherapy (SP) is the most fully developed and widely practiced body-focused therapy for PTSD (Fisher & Ogden, 2009), along with the Somatic Experiencing method of Peter Levine. SP and SE, like hypnotherapy, provide other therapeutic interventions—most often experiential or psychodynamic therapies or CBT—rather than alone. Both techniques first guide clients in learning to recognize and nonjudgmentally observe rather than avoid being aware of bodily sensations and associated thoughts, emotions, and behaviors. Such “mindful” observation enables clients to notice that PTSD symptoms begin with subtle (or not so subtle) physiological changes, the foundation of emotional responses (such as fear, anger, or shame) and the thoughts that accompany them. These in turn lead to PTSD symptoms (such as an unwanted intrusive memory or reminder of the trauma). Mindful observation of body states and associated feelings, thoughts, and actions and modulation of these responses help clients learn to cope, thus assuaging their panic and perceived helplessness.

In addition to increasing internal awareness, SP and SE also teach skills for directly altering bodily arousal levels so that clients learn to restore states of calm and mobilize physical energy in productive ways. “Clients learn to decipher the body’s signals: to notice impulses to move, to slow down, and to take self-protective action. When these impulses are noticed, the therapist helps the client to engage in conscious, intentional movements that increase the experience of the body as a resource, a body that can set a healthy boundary, stand its ground, or effectively fight and flee”
(Fisher & Ogden, 2009). SP and SE also use interventions to enable the client to “uncouple” traumatic memories from their intense emotional and somatic responses, thereby increasing the client’s sense of safety in his or her body even when faced with reminders of past psychological traumas. The “uncoupling” process involves shifting mental focus away from the details of a memory to the way in which the body is responding currently during the remembering.

For example, as a client recalls being beaten by his father as a child, what is his internal experience of that event? Does recall trigger body sensations? Or a thought or belief? Some feelings or emotions? Or impulses to move in some way? With the guidance of the therapist, the client is asked to report “what is happening right here, right now.” If one of the characteristics of trauma-related disorders is the loss of present time orientation, SP addresses that issue by helping clients to differentiate past and present: “When you remember that experience then, what happens here and now inside you?” (Fisher, 2008, p. 598).

**Family and couples therapies for PTSD**

The entire family is affected when a family member experiences psychological trauma and develops PTSD. When parents experience PTSD, whether due to experiencing psychological trauma directly or due to harm to their spouse or children, their ability to provide their spouse and children with a sense of security, nurturance, and healthy encouragement of growth is likely to be compromised despite their best efforts. Therefore, models of psychotherapy that focus on assisting couples or families recover from PTSD have been developed for both adults and children (Catherall, 1998; Figley, 1989; Ford, 2008; Ford & Courtois, 2013; Ford & Saltzman, 2009; Johnson & Courtois, 2009).

Family and couples therapies for PTSD have two common denominators that involve assisting family members in (i) establishing a functional “family system” or couple relationship by communicating with one another and solving problems in ways that enhance their actual and perceived sense of safety, respect, caring, trust, and healthy development, and (ii) accessing social support and resources (e.g., from neighbors and community members, or educational, governmental, or religious organizations or family/parent support programs) (Riggs, Monson, Glynn, & Canterino, 2008). Across a wide variety of psychosocial problems (e.g., family crises, psychiatric disorders, addictions, school failure) family therapy interventions have shown consistent evidence of effectiveness in achieving those goals (Diamond & Josephson, 2005).

However, few studies have investigated the efficacy of family therapy for those who have experienced psychological trauma or PTSD (Riggs et al., 2008). Although behavioral and cognitive behavioral approaches to marital therapy have shown some promise with couples in which one member has PTSD, only one scientifically valid study has been conducted to date in which participants were randomly assigned to receive family therapy or not. In that study, conducted on adult military veterans with PTSD, most of the subjects were adult partners in couple’s therapy (a small number of cases involved a sibling or a parent), and the addition of family therapy to CBT for PTSD did not show evidence of incremental benefit (Glynn et al., 1999).
In the investigation of another population of interest, a family education and support intervention for families with a terminally ill adult member showed some evidence of benefiting the grieving process after 13 months of therapy (Kissane et al., 2006).

**Group therapies for PTSD**

Group therapies are widely utilized as a therapeutic and psychoeducational intervention for PTSD (Ford et al., 2009; Ready & Shea, 2008; Shea, McDevitt-Murphy, Ready, & Schnurr, 2008). Group therapy has been used with adult survivors of childhood abuse, domestic or community violence, traumatic military service, disasters, terrorism, and genocide and torture. Group therapies use many clinical models, including CBT, PAIR, and psychodynamic. In some cases, trauma-focused treatments such as PE and NET are being conducted and studied as to their efficacy in group settings.

Classen et al. reported on a study they conducted that compared supportive (“present-focused”) and trauma memory (“trauma-focused”) group modalities to a wait list with women survivors of childhood. They found both group therapies to be associated with reductions in self-reported dissociative and sexual symptoms, vindictiveness, and nonassertiveness, as well as with lowered risk of revictimization (Classen et al., 2011). Another study compared 10 sessions of individual or group psychotherapy for women who had experienced childhood sexual abuse, finding group and individual therapy to be associated with comparable benefits; however, half of the women sought additional treatment during the study, suggesting that neither therapy fully addressed their needs (Stalker & Fry, 1999). With incarcerated women, an emotion regulation group therapy was associated with improvements in PTSD and depression symptoms and reduced interpersonal problems compared to a treatment as usual—although 45% of the group participants dropped out, compared to 28% of the controls (Bradley & Follingstad, 2003).

With military veterans diagnosed with chronic PTSD, Schnurr et al. (2003) conducted a large ($N = 360$) study comparing group therapy using either PE/CR or “present centered” group therapy conducted during 35 sessions over the course of a year. Both therapies reduced PTSD symptom severity by 15–20%. The PE-based group therapy had a higher dropout rate treatment phase (23%) than PCT (13%), but participants receiving at least 24 group sessions showed evidence of greater reductions in PTSD symptom severity in the PE versus present centered treatment. Ready et al. (2008) later modified PE group therapy so that participants received more opportunities to therapeutically recall and recount traumatic memories both at home and in group sessions. In a field trial with 102 male veterans, clinically significant reductions in PTSD symptoms were found (based on therapist as well as client report) and were sustained, with few therapy dropouts.

A specialized brief CBT group therapy for insomnia associated with PTSD in women who were sexually assaulted as adults, Imagery Rehearsal Therapy (IRT) was found to be more effective in reducing nightmare frequency and PTSD symptom severity than a wait list condition (Krakow and Zadra, 2006). In an independent replication with an adaptation of IRT that included systematic trauma memory Exposure
work (using nightmares as the focus), Rescripting of nightmares, and Relaxation training for sleep hygiene (EERT), researchers Davis and Wright (2007) found that after a three-session intervention, adult survivors of traumatic accidents and assaults reported reduced symptoms of PTSD and depression and improved sleep attributed to less fear of sleep, compared to a randomized control group who reported no changes. At a 6-month follow-up, 84% of the treatment completers reported no nightmares in the past week.

**Pharmacological therapies (medication) for PTSD**

Several new medication options for the treatment of symptoms of PTSD are being developed, researched, and reviewed by the US FDA and similar safety regulatory agencies in countries worldwide. Medications that are efficacious for depression are the most widely approved and used pharmacotherapy agents for PTSD, not surprising in light of the frequent comorbidity of PTSD and depression and the fact that PTSD emotional numbing symptoms overlap with the symptoms of depression (Bernardy & Friedman, 2015; Friedman & Davidson, 2014). Only two medications, both of which are selective serotonin reuptake inhibitors (SSRIs), sertraline (Zoloft) and paroxetine (Paxil) are FDA approved by the United States Food and Drug Administration (FDA) for the treatment of PTSD symptoms in adults, based on large studies demonstrating the medications’ safety and efficacy for this purpose.

However, many other medications are being applied to PTSD treatment based on the growing research on the biology of PTSD (see Chapter 5). For example, an anti-hypertensive drug, prazosin, was first shown to help people with PTSD who suffer from nightmares. Recently, it has been found to be helpful to many with the chronic daytime anxiety and tension associated with the hyperarousal symptoms of PTSD (Opler et al., 2009). Pharmacotherapy for the treatment of PTSD follows a similar set of phases, as described earlier. It is most often applied in conjunction with psychotherapy because the anxiety, mood, and behavioral problems associated with PTSD require a number of different modalities.

**Conclusion**

In the four decades since the diagnosis of PTSD was codified, dozens of therapies have been developed for the treatment of its various problematic and often vexing symptoms. To date, both PE and EMDR, along with CPT, have the strongest empirical support as to their efficacy in symptom reduction. Many modifications to these treatments are now available and are being tested. Several medications—especially the SSRI class of antidepressants (Zoloft and Paxil in particular)—have been shown to ameliorate symptoms over short periods of time. Experiential, body-focused, expressive, hypnotic, and psychodynamic therapies provide additional tools that may enhance PTSD recovery in individuals, in couples, and in families, and need ongoing scientific investigation (Box 7.5).
Box 7.5 Case Example of Experiential Psychotherapy for PTSD

Angela, a pseudonym for a composite client, is a 37-year-old Caucasian woman who works as a paralegal for a criminal law firm. She grew up in a middle-class suburban family with two siblings. An average student, teachers observed her to be quiet and well behaved. She had no close friends and did not participate in extracurricular activities. However, Angela had an unwanted “secret life”: her parents sexually and physically molested her and other young children while filming child pornography. She recalled feeling confused as a young child because her parents were either angry with or ignored her at home or in their group, but they acted “normal” in public. They frequently harshly punished her (drugging, starving, and forcing her to witness and participate in terrifying and humiliating sexual and physical violations) for offenses that she did not understand. In response, Angela tried not to draw attention to herself, and she understandably came to the belief that her parents truly hated her and wanted her dead.

To survive, Angela learned to empty her mind of all thoughts and erase all feelings; however, as a teenager, she increasingly could not hide feelings of rage and contempt. She escaped by setting fire to her family’s house, whereupon she was placed in a juvenile correctional facility. At age 16, she became an emancipated minor, and she lived on the streets, where she survived by prostituting herself and selling drugs. Fortunately, the stage crew of a touring musical band took Angela under their wing and off the street. Angela got a GED and put herself through college, becoming a paralegal in order to “go after the bastards” who hurt innocent people. Despite achieving financial stability and feeling satisfaction in her work, Angela struggled with severe bouts of depression. Cutting herself and drinking or using drugs to the point of blackouts were her only means of relieving her depression. When promoted to oversee a paralegal office, she began—for the first time since childhood—to experience a deep sense of terror. She had increasing periods of “losing time” and was no longer able to numb herself by cutting. She was terrified of seeking therapy, believing she would be labeled crazy and institutionalized, a threat made repeatedly by her parents when she was a child. But after having a dissociative episode that led her boss to question her reliability, Angela decided that therapy might be her only way to forestall the complete breakdown that she’d always feared. She reluctantly made an appointment with a therapist, saying that she wanted therapy because she’d been depressed.

AEDP applied to the case example

Helping Angela to move from defensive avoidance, terror, and isolation to awareness, connection, and glimmers of core affective experience constitutes the first (step in AEDP).

A:  (avoiding eye contact and in a flat voice) This incident at work has been so upsetting to me. My boss swears that she came into my office and found me huddled under my desk, crying, but I don’t remember any of that ever happening. I don’t know why she would possibly lie to me about something like that, but ...
Box 7.5 Continued

Th: (in a soft, soothing voice) That sounds very distressing on many levels. What’s the worst part about it for you as you tell me right now? [empathy, specificity]
A: (breathing increases and voice becomes shaky) That she would see me in such a state. [shame and traumatic fear; hyperarousal]
Th: That brings up some strong feelings. [focus on immediate emotional experience]
A: No, I’m fine. [defense]
Th: You started to breathe faster just now and your voice trembled. It made me wonder if you weren’t getting scared as you remembered it. [somatic focus, mirroring, empathy]
A: (says nothing; looks dazed, staring off into space)
Th: I get the sense that you have so many feelings inside right now that maybe they feel overwhelming. [anxiety/affect regulation]
A: I don’t know. (looks panicked) [anxiety]
Th: (very softly and gently) Is there something scary about my seeing that in you? [empathic exploration of anxiety in the context of the relationship; N.B. the therapist’s directly exploring the anxiety in the context of the here-and-now of the therapeutic relationship]
A: (whispering) It’s dangerous. [the client takes the risk of sharing her authentic experience; the process is moving forward. Beginning of the first state of transformation.]
Th: Dangerous?
A: (fragmented voice) If people see, I’ll get fired, or something terrible will happen.
Th: Angela, I see this profound terror in your face and hear it in your voice. I don’t yet know what it’s linked to—though I’m sure we’ll get to that later when it’s safe to—but right now, I’m so struck by your courage in coming here to talk to me even though you have all this fear inside of you. [going to the positive side of the fear: somatic mirroring in context of relationship; structuring; affirmation of courage]
A: (looks surprised, fleeting smile, wary, but glances at therapist) Really? [taking in the affirmation] I feel like such a spaz. I can barely talk, I don’t know what’s happening to me.
Th: Oh, you’re anything but a spaz. This is what it’s like for anyone to be terrified. You freeze, you feel confused, your mind goes blank. [empathy, affirmation, psycho-ed, normalizing]
A: (making brief, intermittent eye contact) Well, I feel a little better knowing that. A little bit less like a freak. [decrease in anxiety and shame; first state of transformation is proceeding]
Th: Quite the contrary. It takes a tremendous amount of strength to decide to start facing the terror of trauma and the other feelings that go along with it. [affirmative reframing]
A: (soft, tremulous voice, tentative eye contact) I don’t feel very strong right now. [the client is taking the risk of allowing herself to feel vulnerable]
Th: Well, I don’t think anybody can when they’re facing these things alone. It’s too much. [empathy, support, explicit about things being too much when one is alone]
A: (steadier voice, gaze down) That’s my life. One kind of hiding after another.
Th: Can I ask, I notice that you’ve been sneaking little peeks at me while we’ve been talking. What have you been seeing in me? What do you see in my eyes?
complex intervention: dyadic engagement, dyadic relational desensitization, facilitating new corrective experience; seeking to undo projection by inviting the client to track the therapist
A: You look kind, like you want to help. But that’s your job, right? And I’ve known a lot of people in my life who go from Dr. Jekyll to Mr. Hyde in a split second.
Th: Wow. That must make it so hard to feel safe around anyone, like any minute they could turn on you. Must make it even harder for you to be here. [empathy]
A: Yeah, that’s why I’ve gotten so good at hiding.
Th: And yet, despite all the terror and the betrayal, here you are, starting to find a way to let me be with you. [recognizing, affirming, and amplifying positive healthy glimmers of healing, self-reparative tendencies coming to the fore]
A: (half-jokingly) Hopefully, I won’t find myself dead in an alleyway somewhere. But I can’t go on living this way either. (starts to tear up) [increase in the client’s motivation for therapeutic exploration: very important green light. Beginning of State 2 work]
Th: What way?

At this early point in therapy, Angela has just begun to acknowledge, and to touch upon the actual experience of, her deeper emotions. With the therapist’s consistent empathic and strength-based focus in the face of her dismissive and defensive stance, Angela is beginning to consider that the therapist might be genuinely respecting her competence rather than judging her based on what she presumes to be deficits or pathology (based on her abusive early life experiences and possible past encounters with trauma-insensitive professionals or systems). While the working alliance, the foundation for experiencing a secure attachment in therapy, is being formed, the therapist also is consistently tracking and mirroring Angela’s moment-to-moment emotional experience, leading her closer to fuller, felt experience of her feelings.

As clients such as Angela become able to experience core emotions, they realize that they can do so without feeling overwhelmed or trapped; instead, they often feel a surprising sense of relief and the buoyant yet grounded feeling of rejuvenation, resilience, and resourcefulness. This is the beginning of the second state transformation, a shift from core emotion to core state, which has been described as mentalization (Allen, Fonagy, & Bateman, 2008) or mindfulness (e.g., Siegel, 2007).

The second state transformation is completed by metaprocessing—that is, discussing how it feels to be able to safely experience a range of emotions, which accesses transformational affects (e.g., pride, mastery, gratitude) and culminates in core state (Fosha, 2000; Fosha et al., 2009). The turbulence of intense emotions
defines State 2, but calm, clarity, confidence, centeredness, curiosity, compassion, courage, and creativity define the core state. Work with core state phenomena culminates in the assertion of personal truth and strengthening of the individual’s core identity. Next we see the client fluctuating between State 2 core emotions, transformational affects, anxiety about this change, and core state phenomena.

A: She’s too afraid to let herself hope. (cries harder) [grief for the self; healing affects associated with positive transformational experience; second state transformation]
Th: She’s been so, so hurt, and so, so scared. [empathy]
A: (nods and continues to cry, sobbing now) [strong affects associated with corrective experience, a corrective experience in its own right]
Th: (waits until the crying slows down) It’s okay for her to be just where she’s at right now. It’s totally understandable given the fear. But can she let herself see your sadness and your tears? They are for her. [leading edge of exploring new experiences of intrarelational empathy and compassion for self; intrarelational State 2 work]
A: She sees, but she doesn’t know what to do with it. [client able to tolerate a positive but very new experience, staying right on the edge of positive trepidation]
Th: That’s okay; she doesn’t have to do anything. Just take it in, as much as she can. (moment of silence) [relational intervention: helping, coaching, support, warmth]
Th: How are you feeling?
A: Calm. Less scared. Like I know I’m not going to be dragged out of my hiding place, but also maybe I’m not going to waste away there alone anymore. [postaffective breakthrough transformational affects of calm; increased capacity for coherent self-reflection; creation of safety and possibility of deeper connection. Beginning of core state]
Th: I sense your calm and the strength that you’re accessing as you take the double risk of starting to let yourself feel some of this pain and aloneness and letting me be here with you and share in it with you. [affirmation with affective self-disclosure of admiration] What’s that like for you right now? [metatherapeutic processing of therapeutic experience]
A: Well, if you’d asked me, I’d have said I’d never let it happen! But it just kind of did. And, well, I don’t know if this makes any sense, but it feels kind of comforting. And at the same time scary. [transformational affects: the tremulous affects]
Th: Tell me about both. [addressing both bad and good, dread and hope, old and new]
A: Scary because the comfort is so foreign. Comforting because you saw something in me that it’s never been safe to let anyone see, and so far I’m not hurt worse for it. But it’s more than that. I actually feel better than I did before I came in here, and I never imagined that. It’s like getting a balm for a very deep wound. It’s not healed yet, but some of the sting is gone. Thank you for that. [Hallmark of core state: capacity for coherent and cohesive self-reflection]
Posttraumatic Stress Disorder

Box 7.5 Continued

EFTT applied to the case example

During initial sessions, the real risk of danger from others (e.g., family members seeking retribution) will be assessed, and adequate resources for ensuring safety need to be ensured. Safety and trust in therapy will be fostered in several ways:

1. Validating her distrust and fear of disclosure (“Of course, you don’t know me, so trust will take time. The things you’ve been through are very painful, so you want to be very careful about whom you share this with. My job is to understand how you see things and how you feel from your perspective, without judging you in any way.”)

2. Providing information about therapy processes and roles (“We are not going to hammer away at your traumatic experiences session after session. I am interested in you, Angela, as a whole person. You are in the driver’s seat. We will explore both past and present concerns, whatever is most important to you. My job is to ensure your safety and to support and promote your growth. That will mean helping you get in touch with painful feelings, but only so that you can work them through, here, in this safe environment, when you’re ready, and at a pace you can handle.”)

3. Communicating genuine compassion for her past and current suffering and acknowledgement and respect for her struggle to cope and build a life for herself (“I understand that depression is a major challenge for you, that it’s a big struggle at times just to keep going. You also have been through incredibly difficult and painful experiences, and you’ve struggled to cope with these alone and for a very long time. I don’t want you to be alone with this stuff anymore. Together we can work on whatever experiences are troubling to you, whatever you decide might be most helpful.”)

Angela could fear and resist the therapist’s efforts to help her approach painful and vulnerable feelings. This resistance could include the conscious or unconscious use of secondary anger to push the therapist away. In order to avoid alliance ruptures, the therapist must first communicate an understanding of Angela’s fear of disclosure and her own painful experience and then collaborate with her on how best to deal with these issues in therapy.

Th: I understand it must be very difficult to get close to those painful feelings.
A: (looking down) I wish you would stop harping on my “painful feelings.” It seems like your entire agenda is to make me cry, and I don’t want to cry.
Th: Oh, I see. I appreciate you bringing this up so directly; it’s important. I don’t want to push you into feelings you don’t want to feel or don’t feel ready for. If I understand, right now you don’t want to focus on things that could make you cry; you really don’t want to go there.
A: Not now, not ever. I just don’t want to get into all that past stuff. I need to forget it. I told you my only goal is to stop being so depressed and stop spacing out so I don’t lose my job. In terms of the past, all I want is to make sure those “sickos” don’t destroy any other kids’ lives.
Th: We can focus on current difficulties to help you with spacing out and depression. But we have to understand those experiences better to change them, the thoughts, feelings, and memories that contribute to depression and shutting down. If some of that is connected to your past, it’s going to be pretty hard to avoid the past entirely. Does that make sense?

A: Yes, I know that.

Th: Plus, many things that contribute to your current difficulties, I can only imagine, are extremely painful. It will take a lot of faith in yourself and your ability to handle it, as well as trust in me, in order to allow yourself to feel and open up about these things. But I think you know that continuing to push them away or keep them bottled up inside isn’t working.

A: Yes, I know. I’m just scared (eyes well up) I don’t think I can take it much longer. No one really knows what I’ve been through. I don’t know if I have the strength to tell.

Th: I understand you must be very scared, and I respect your caution. You don’t want to feel flooded by too many powerful feelings all at once. We can take all the time that you need to tell whatever you need to tell. But right now, I think you’re saying that some of these feelings have just gotten to be such a burden that you’re not sure how to carry them anymore. There are ways I can help, if you decide you maybe can trust me enough to share what you’re feeling.

A: What could you understand? You don’t know anything about my life, really.

Th: I realize I know very little about your life, and it’s always your choice what to share with me, but I’d like to understand and to know more about those deeper feelings and the experiences they come from. I also think it’s good to focus not only on painful stuff but on your legitimate anger and healthy desire for justice, these are very important.

Promoting affect regulation and reducing fear, avoidance, and depression will be the focus of the second phase of therapy. Difficulties with substance abuse and cutting behavior are understood as maladaptive strategies for coping with overwhelming affect. The primary source of fear and avoidance (including dissociation) is understood as the activation of a core insecure and vulnerable sense of self formed through childhood abuse experiences (“It’s as if that scared, helpless little kid gets activated, takes over, and you have no way of calming her”). Similarly, depression is viewed as the activation of core sense of self as weak, bad, and unlovable formed through childhood experiences of powerlessness, isolation, and sexual exploitation. A major focus of therapy therefore involves exploring and changing this core sense of self. As current difficulties (e.g., fear that her employer will find out about her past) or memories of abuse are discussed in session, interventions with Angela empathically affirm her vulnerability in approaching feelings such as shame and encourage her to stay with, rather than run away from or immediately try to change, these feelings. Therapeutic work with shame is particularly challenging because the associated
action tendency is to hide. EFTT involves accessing and exploring the complex of thoughts, feelings, somatic experiences, and behaviors that contribute to depression and shame. During this process, healthy resources may emerge spontaneously (“I can’t keep it all bottled up inside anymore; all those dirty secrets are poisoning me!”) or can be initiated by the therapist (“Can you get in touch with yourself at that time, hating what was happening to you, feeling trapped?”).

An important dual focus and aim is to monitor and strengthen Angela’s capacity to regulate her emotions while at the same time encouraging her to gradually confront trauma-related emotions, thoughts, and memories. Empathically Exploring (EE) trauma feelings and memories exclusively in interaction with the therapist initially could be more tolerable for Angela than IC abusive and neglectful others in an empty chair. Later in therapy, IC could be introduced occasionally at the emergence of assertiveness and other healthy resources. It also could be advisable to initially confront less threatening others, such as a minimally threatening but neglectful mother than a cruel or sadistic other. For Angela, it could be easier to first fully express and feel entitled to her anger at injustice and violation before she can allow herself to fully experience vulnerability and emotional pain. Adaptive anger is associated with energy, vitality, protest, standing up for oneself, finding one’s “backbone,” and appropriately holding others, instead of self, responsible for harm.

The goal of IC or EE initially is to help Angela shift from expressions of undifferentiated hurt and global distress to more differentiated expression of adaptive anger and sadness. At in-session indicators of unresolved feelings toward perpetrators (“He was such a disgusting pervert. I feel sick every time I think about him” or “It just eats away at me; how could she let him do that stuff?”), Angela will be encouraged to imagine the relevant person either in an empty chair or in her “mind’s eye,” attend to her thoughts and feelings (“What happens to you on the inside as you imagine him/her [there]?”) and express them either directly to this imagined other or to the therapist (“That’s very important. Try saying that to your father [points to empty chair]: ‘I don’t want you near me.’ And tell him why” or “Stay with that feeling; tell me more—what do you find so repulsive?” or “Tell her what she should have done, what a good mother would do”).

Th: I hear how much you hate him, despise him. Tell him, over there, what you hate, make him understand.

A: Yes, I despise how you manipulated and corrupted innocent children for your own sick needs, and did it in the name of God! You perverted everything. I was innocent, and you ruined my childhood, made sex disgusting, destroyed my trust in humanity and my faith in God. Damn you! I hope you rot in hell. Oh, I sound just like him. I can’t stand this!

Th: But you’re not him, Angela, you are justifiably angry and you want to see him punished for his despicable behavior, his crimes. Tell him.
A: Yes, I do want to see you punished; you deserve to be punished for all the harm you’ve done, and I’m going to find a way to see that that happens. You are not going to get away with it. You fucked me up royally. My life has been such a mess because of you, but I refuse to let you ruin my life anymore. This whole thing is about your sickness, not mine!

Th: How do you feel saying that?

A: It feels right. He was the adult, I was just a little kid. I deserved love and security, not that twisted life he imposed on me.

Th: How do you imagine your father over there would react [in his heart] if he knew how you really felt—defensive, remorseful, blaming, and angry?

A: It’s funny, he used to seem so huge and powerful; now I see a sick, pathetic old man. I don’t think he’s capable of understanding. But it doesn’t matter anymore. I know the truth.

These interventions support her anger and entitlement to justice and, like a victim impact statement, help her begin to articulate the effects of the abuse and hold the perpetrator(s) accountable for harm. One goal is for clients to arrive at a more differentiated perspective of perpetrators so they are seen as more human and life-size and less powerful. An important step is to elicit the client’s understanding of perpetrators’ responses to confrontation. Enacting or imagining the other also can elicit empathic resources. This can be particularly important in healing attachment relationships (if this is desirable for the client)—for example, coming to understand that one or both of her parents also were victims or would regret their behavior.

Allowing the pain of rejection and sadness of loss is also an important aspect of resolution. Accomplishing this is a gradual and complex process that involves the many emotions associated with traumatic experiences. Angela will need to face the pain of not being loved by her parents, all the losses and things she has missed out on (e.g., friends, healthy sexuality, security, self-esteem), and how profoundly she has been victimized by years of loneliness, exploitation, cruelty, and abuse. Allowing herself to fully feel the pain of these experiences (even for a moment) requires confidence in her ability to survive the pain as well as the therapist’s supportive presence (e.g., soothing voice, hand on her hand or knee), encouraging statements (e.g., “Let it come”), and help in symbolizing the meaning of the pain (e.g., “Put words to your tears”; “What’s the worst part of it for you?”; “So devastating—can you say more about what that meant to you?”). Accurate symbolization helps to create distance from the pain and to make her experience more comprehensible. Facing the emotional pain of traumatic experiences also includes facing associated but previously avoided aspects of self. Facing the pain of her isolation as a child, for example, could include feeling the shame associated with sexual abuse, prostitution, and self-destructive behavior; rage at years of victimization, violation, and abuse; and deep sadness at all the disappointments, losses, and suffering.

Finally letting go and allowing the self to fully feel the pain of traumatic experiences typically are followed by a sense of relief, an increased sense of agency or control, and an implicit challenging of beliefs that perpetuated avoidance (e.g., “I can handle it; it won’t destroy me”).

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Other treatment methods and modalities (including hybrids, concurrent treatments, modifications of the original evidence-based treatment, application to new and more diverse populations, and new applications of a variety of medications) are under development and investigation. Many hold great appeal and show promise but are as of yet unproven. While innovation is a cornerstone for the development of increasingly effective PTSD therapies, therapists should exercise caution and should ensure that clients make an informed consent before and throughout their involvement in any treatment for PTSD (Box 7.6).

**Box 7.6 A Cautionary Note About Popular PTSD Treatments That Are Not Evidence-Based**

There are different degrees of being “evidence based,” and there is controversy over what constitutes proper or sufficient evidence for a therapy or practice to be so designated. A treatment that is evidence-based for one purpose or population may not be for other purposes or populations, just as is the case for medications that are approved by the FDA only for certain illnesses until studies have validated the drug’s therapeutic safety and efficacy with other illnesses. For example, in the case of PTSD, two SSRI antidepressants have been approved for use with adults (fluoxetine (Prozac) and sertaline (Zoloft)), but neither has been shown to have benefits with children who suffer from PTSD, and one actually was shown in a scientific study to not add to the benefit provided by CBT psychotherapy (see Chapter 8).

As a result, it is important not to assume that a PTSD treatment automatically is beneficial simply because it seems appealing or even is widely utilized. For example, several therapies have been described as “power” therapies for PTSD despite relatively little scientific evidence of their effectiveness. Power therapies include EMDR, which has developed a scientific evidence base for PTSD treatment, and several others that have not been scientifically tested: Thought Field Therapy, Trauma Incident Reduction, Emotional Freedom Therapy (also known as Tapping Therapy) (Poole, 1999), and, more recently, Visual/Kinetic Dissociation (based on “Neurolinguistic Programming”; Hossack & Bentall, 1996) and many other variants. These therapies use a variety of techniques similar to those of hypnosis (such as repetitive movements that interrupt emotional distress and refocus mental attention), experiential therapies (such as shifting mental focus from being absorbed in a memory to being a detached observer), body-focused therapies (such as teaching clients to notice shifts in physical arousal and to visualize energy flow (“meridians”) in the body), and PE/CR or CPT (such as repeatedly recalling traumatic memories and reevaluating associated beliefs).

Thus, power therapies for PTSD largely involve creative but relatively minor adaptations of widely used and better-validated PTSD therapy methods. With the possible exception of EMDR (which has been modified extensively so that
it is not a single uniform technique but a variety of options for PE/CR), the “power” in these therapies is largely due to therapists’ beliefs that they confer unique benefits. With further careful scientific testing, some of the innovations of the power therapies may be shown to be reliably helpful (and safe) tools for PTSD psychotherapy, but until that is the case, caution is highly recommended in their use and promotion.

References


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