Chapter Four:
Psychological Treatments for PTSD

This chapter answers the following:

- **What Specific Psychological Treatments are Available for Adults with PTSD?** — This section reviews the treatment approach and effectiveness of psychoeducation, individual psychotherapy, and group therapy for adult patients with PTSD.
- **What Psychological Treatments are Available for Children and Adolescents with PTSD?** — This section covers the treatment approaches used specifically for children and adolescents with PTSD.

What Specific Psychological Treatments are Available for Adults with PTSD?

THERE are many treatments for PTSD, all of which share the general stages and focus of treatment issues discussed in chapter three. Treatments generally fall into three categories:

1. **Psychoeducation** — Designed to help patients understand the nature of PTSD and its impact on their lives
2. **Individual Psychotherapy** — Geared to treat specific symptoms of PTSD through, typically, one of three approaches: Cognitive Behavioral Therapy (CBT), Eye Movement Desensitization Reprocessing (EMDR), or Psychodynamic Psychotherapy (see pages 36 through 44)
3. **Group Therapy** — Structured to treat PTSD in a group setting that promotes a connection among members through shared experiences, which can foster adaptive coping strategies, reduce symptoms, and/or help patients derive meaning from the traumatic experience. (see pages 44 through 46)

In this chapter, efficacy research results are covered immediately following the discussion of the approach for each individual therapy. General efficacy information appears with the general overview of each category of treatment..

Psychoeducation

It is relatively easy to move from a comprehensive diagnostic assessment (see chapter two) into a psychoeducational phase of treatment by showing patients how their various reexperiencing, avoidant/numbing, and arousal symptoms fit into a coherent syndrome. Patients need to understand that they are not losing their minds (as many of them genuinely fear to be the case); that their constellation of symptoms has a specific name; and that many other people have suffered in a similar way after exposure to catastrophic stress.

Psychoeducation is not considered an effective treatment for PTSD (or ASD) on its own..

There has been no systematic evaluation of psychoeducation as a stand-alone PTSD treatment. However, there is a strong consensus among clinicians that it is a very important component of any therapeutic approach. In fact, most cognitive-behavioral treatments have a specific psychoeducational component during early treatment sessions.

Psychoeducation may also be especially useful as a societal and community intervention utilizing the mass media to promote resilience and ameliorate distress for the population at large following terrorism or mass casualties (see chapter 6).[33]

Psychoeducation to Initiate Therapeutic Activity

Information helps patients recognize that they are not losing their minds; that there is no stigma attached to this kind of all-too-human response to an overwhelming experience; and that they do not have to be ashamed of having PTSD symptoms.

The benefits of psychoeducational intervention make it a very powerful and productive way to help patients:

- **Achieve Normalization** — Just telling people that the nature of their post-traumatic emotional disturbance is no different than the experience of millions of men, women, and children exposed to similar stresses engenders a profound sense of relief in most people.
- **Remove Self-Blame and Self-Doubt** — Telling patients that PTSD is fundamentally about being in the wrong place at the wrong time, and being overwhelmed by a stressor with which no one could have been expected to cope, is a powerful message that most patients can hear readily. It is an important message that helps remove self-blame and self-doubt because most humans do not face these overwhelming events as they would have wished, despite tales of heroes and heroines glorified throughout history.
- **Correct Misunderstandings** — Another important benefit of psychoeducation is that the PTSD model helps people understand disturbing behavior that they may have interpreted erroneously. For example, a wife who blames herself for the sexual and emotional withdrawal of her spouse will learn that this is not a personal rejection but rather the expression of her husband's PTSD avoidant/numbing symptoms due to a traumatic event; reframing the problem can focus treatment and often save a marriage before things deteriorate beyond repair.
- **Enhance Clinician Credibility** — The final advantage of psychoeducation is that it quickly lets patients know that the clinician understands their problem at its most fundamental level. It is a rapid and effective communication that the clinician deserves trust and is qualified to treat them, helping them make sense of their disturbing and disruptive symptoms.

Community Psychoeducation Examples

Two impressive examples of psychoeducation occurred after the Loma Prieta Earthquake in California in 1989 and the World Trade Center attacks. In the first, local mental health centers immediately distributed age-appropriate pamphlets and coloring books in English and Spanish to help residents understand normal symptoms and when to ask for help.

New York's Project Liberty responding to the 9/11 disaster, utilized 30-second TV commercials, radio announcements, printed brochures, a cost-free "800" crisis line, and Web site (see chapter six for more information on Project Liberty)..

Psychoeducation through Peer Counseling

One type of psychoeducation, peer counseling, is a powerful group process for PTSD sufferers similar to Alcoholics Anonymous. Peer counseling provides a context of peer support within which participants can take control of their lives by seeking more effective ways to cope with their PTSD symptoms.

Another benefit of peer counseling is that there is no authority figure such as a doctoral-level clinician. Instead, everyone is an equal authority based on his or her own personal experience. Participants are simultaneously patients and clinicians, able to give and receive assistance to one another through honest disclosure and genuine response in the context of absolute trust and confidentiality.

Rape crisis centers and battered women's shelters use peer counseling, as counselors have survived their own sexual trauma and/or domestic violence, found meaning in their suffering, and transformed their personal suffering into knowledge that they use to help others cope with similar experiences. It is reaffirming to know that others have been able to pick up the pieces of their shattered lives and move on to a future that is gratifying and productive.

Since peer counseling is a consumer-driven approach that excludes professional clinicians, it does not lend itself to scientific research protocols in which some patients receive active treatment while others do not. It is clear that people who continue to participate in peer counseling do so because they find the format and support beneficial.

Individual Psychotherapies

Clinicians primarily use three different types of individual psychotherapy to treat PTSD:

From the Patient's Perspective

Had my fifth session of exposure treatment today. It is hard to admit how scared I was at first. After all, Dr. Owen wanted me to imagine I was back in the car and to go through the whole accident detail by detail. I really was terrified and sure that I'd fall apart. But, she was patient. Didn't rush me. And backed off when I started to lose it. Before I knew it, I could really let myself begin to remember what happened. And the more I did it, the easier it got, and the less upset I became.

I'm not there yet. It's still very painful to keep bringing back all that stuff about the accident. But I am getting stronger, and I have another five sessions to go.

1. **Cognitive Behavioral Therapy (CBT)** — Based on principals of learning theory and cognitive psychology
2. **Eye Movement Desensitization Reprocessing (EMDR) —** Based on the theory that rapid eye movements reprogram the brain's processing of traumatic memories
3. **Psychodynamic Psychotherapy** — Based on the theory that symptoms of PTSD result from repressed memories of the traumatic event and that the patient's insight into those memories and their impact on symptoms will help restore psychological balance.

These therapies can be used in combination and focus on PTSD symptoms through various methods.

Cognitive Behavioral Therapy (CBT)

Given the fact that PTSD develops when exposure to an overwhelming stimulus (the Criterion A_1 event) elicits a profound emotional reaction (the Criterion A_2 response), it is understandable why learning and conditioning models have provided such a powerful conceptual approach to PTSD. The sudden, intense anxiety experienced by Mary T. in response to the sight or sound of a large tractor-trailer truck is an excellent example of fear conditioning. Here, the traumatic stimulus (the truck) automatically evokes the post-traumatic emotional response (fear, helplessness, and horror). The intensity of this emotional reaction provokes avoidant behaviors that will reduce the emotional impact of such a stimulus. Successful reduction of intrusion/hyperarousal symptoms will increase the likelihood that avoidant behaviors will be repeated in the future because of their protective value.

There are more published well-controlled studies on CBT than on any other PTSD treatment. Furthermore, the magnitude of treatment effects appears greater with CBT than with any other treatment. Two comprehensive reviews are Cognitive-behavioral Treatment section of ***Practice Guidelines for PTSD*** *(pp. 60–83) and the* ***VA/DoD Clinical Practice Guidelines for the Management of Post-Traumatic Stress***.[34, 53]

From a cognitive psychological perspective, trauma exposure is thought to evoke erroneous automatic thoughts about the environment (as dangerous and threatening) and about oneself (as helpless and incompetent). CBT directly confronts such PTSD-related distortions in thinking.

Various CBT approaches seek to attack these conditioned responses and automatic thoughts with different techniques. The ultimate goal is to normalize the abnormal feelings, thoughts, and behaviors exhibited by individuals with PTSD. CBT has proven to be the best treatment for PTSD in the current published literature; CBT techniques are typically used in combination with one another. Figure 4.1, on the following page, provides an at-a-glance introduction to CBT techniques.

Figure 4.1 Cognitive Behavioral Techniques Used in PTSD Treatment[53, 59–60]

CBT Technique	Treatment Focus
Prolonged Exposure (PE) Therapy	Disconnecting the overwhelming sense of fear from trauma memories
Cognitive Therapy	Relearning thoughts and beliefs generated from the traumatic event, which impede current coping skills
Cognitive Processing Therapy (CPT)	Understanding both the emotional and cognitive consequences of trauma exposure
Stress Inoculation Training (SIT)	Anxiety management to increase coping skills for current situations
Interapy	Exposure and cognitive restructuring through a protocol-driven CBT treatment accessed via the Internet
Imagery Rehearsal Therapy	Changing disturbing traumatic nightmares by rehearsing a "new dream"
Biofeedback and Relaxation Training	Anxiety management to help patients master overwhelming anxiety feelings elicited by a trauma reminder
Dialectical Behavior Therapy (DBT)	Treating borderline personality disorder, a syndrome often compared with PTSD and Complex PTSD

In general, cognitive behavioral therapy is the most proven treatment for PTSD to date, although differences exist among various CBT approaches (as shown below). CBT treatments involve carefully scripted treatment manuals and usually require nine to 16 sessions. See indivudal approaches for specific efficacy studies to date.[59]

Prolonged Exposure (PE) Therapy

PE was developed to separate the traumatic memory from the conditioned emotional response so that the memory no longer dominates thoughts, feelings, and behavior. This approach uses both *imaginal* and *in-vivo exposure*.[53, 59-62]

Clinicians ask patients receiving imaginal exposure to narrate the traumatic event. If numerous traumatic episodes exist (as with survivors of recurrent child abuse, domestic violence, war trauma, or torture), the clinicians ask patients to construct narratives about the worst events they clearly remember. The clinician prompts patients to close their eyes and visualize (imagine) what happened while repeating the narrative several times during a single session. Initially, patients will experience great anxiety as they begin to imagine themselves back in the traumatic situation. They are asked to rate the level of subjective distress every 10 minutes on a 10–100 *Subjective Units of Distress Scale* (SUDS), where 10 is no distress and 100 is the most fear/helplessness/horror they have ever experienced. Distress levels are usually in the 70–90 range during initial Imaginal Exposure sessions. However, through repeated exposure to the traumatic memory, patients experience a progressive reduction in distress

imaginal exposure — Systematically assisting trauma survivors to confront distressing trauma memories though the use of mental imagery

in-vivo exposure — With the clinician present, patients practice techniques learned in therapy in the environment that represents their most-feared situation

Subjective Units of Distress Scale — A scale ranging from 10–100 with 10 being the least anxiety provoking and 100 being the most anxiety provoking. The SUDS scoring system allows the patient to express exactly how upsetting or distressing certain stimuli are in comparison to other anxiety experiences.

An interesting variant of PE is Virtual Reality Exposure Therapy, which uses a computer–generated visual, auditory, and kinesthetic model of the patient's own traumatic experience.[38]

levels so that they may fall to the 10–20 range by the end of a single session and remain at negligible levels by the end of an 8- to 10-session Exposure Therapy treatment. Following successful exposure treatment, patients can confront traumatic memories without having the recollections trigger intrusive and/or hyperarousal PTSD symptoms.

When ready, patients are encouraged, as part of a homework assignment, to confront situations associated with their traumatic experiences in the context of in vivo exposure.[36, 37]

PE may not be for everyone; some patients are either not ready or not willing to confront traumatic reminders, and the intense anxiety provoked by this technique.

PE, with or without cognitive therapy, has been tested with survivors of a greater variety of traumatic events including sexual assault, war-zone exposure, or childhood sexual abuse, than other treatments.

Efficacy — PE has consistently proven superior to supportive counseling or untreated patients monitored while on a "waiting list" for therapy. It is equal in efficacy to other forms of CBT treatment; results have shown 60 to 70 percent improvement in all three PTSD symptom clusters with improvements generally maintained six and 12 months later.[55–59]

Cognitive Therapy

Cognitive Therapy addresses the thoughts and beliefs generated by the traumatic event rather than the conditioned emotional response addressed by exposure therapy.[63–67] This approach focuses on how individuals with PTSD have interpreted the traumatic event with respect to their appraisals about the world and themselves. For example, those who have been overwhelmed by a catastrophic stressor typically perceive the world as dangerous and themselves as incompetent. As a result, PTSD patients see themselves as perennial victims powerless to cope with life and take charge of their personal destiny. Such a belief system then becomes a hard-wired, self-fulfilling prophecy.

Case Study Notes

Mary T.'s persistent inability to overcome her PTSD symptoms and resume her life as before has destroyed her confidence in herself. She has come to think of herself as a failure, someone unable to cope with even minor stressors. Because of this pervasive sense of personal inadequacy, she is easily overwhelmed and unable to perform routine tasks. It is a vicious circle since the more she fails to perform, the more she feels inadequate, and the more she finds the world overwhelming.

Clinicians often combine cognitive therapy with exposure therapy to work on both conditioned emotional responses and automatic dysfunctional thoughts. One somewhat different approach for combining cognitive and exposure therapy is cognitive processing therapy (CPT)..

In cognitive therapy, the first step is to identify automatic thoughts (such as Mary's thoughts about herself) and to understand that, although originally developed from the trauma, these thoughts currently hinder adaptive functioning. Second, the therapy focuses on correcting erroneous thoughts with more accurate information, replacing automatic, dysfunctional thoughts with

more realistic and adaptive ones. Successful cognitive therapy creates an accurate appraisal of:

- Situations perceived as either safe or dangerous rather than automatically perceiving all external events as dangerous.

Case Study Notes

Mary needs to learn that there is nothing inherently dangerous about trucks or about driving a car. She needs to separate the specific tragic circumstances of her personal trauma from the trauma-related generalizations that currently make her afraid to travel on the highway.

- One's own strengths and weaknesses in different situations rather than an automatic belief that one is personally incompetent and unable to cope with life's challenges.

Case Study Notes

Mary needs to understand that what happened during the accident was not due to a failure on her part. She also needs to learn that her current immobility is due to PTSD and not due to her own personal inadequacies.

Efficacy — Several studies comparing cognitive therapy with PE (alone and in combination) found equal effectiveness, producing 60 to 70 percent improvement in PTSD symptoms. Additionally, these individual or combined approaches outperformed relaxation therapy.[41, 55, 60]

Cognitive Processing Therapy (CPT)

CPT also uses written narratives to address both the emotional and cognitive consequences of trauma exposure so that patients can access and process the natural emotions that have been distorted and obscured by their personal interpretations of the traumatic event.[43, 44, 61]

According to CPT theory, negative belief systems that a person generates following a trauma (e.g., "I am powerless," "I am inadequate," "The world is a dangerous place,") make it impossible to process normal emotional reactions produced by the catastrophic event (e.g., sadness and fear). This happens because the trauma survivor is preoccupied with inappropriate and intolerable emotions (e.g., guilt and shame) that evolve because of erroneous beliefs and interpretations about the traumatic experience. Only by confronting the distorted traumatic memories, can patients challenge/modify these erroneous beliefs, thereby dissipating inappropriate emotions.

CPT is similar to exposure therapy except the narratives are written by patients rather than elicited by the clinician. The written format gives the CPT patient more control over the pace and intensity of disclosure than is the case in exposure treatment..

Case Study Notes

Mary T.'s inappropriate feelings of guilt about the accident and shame about her current feelings of inadequacy have dominated her feelings about the traumatic event. They have prevented her from normal grieving about the loss of her husband, her marriage, her future, and the person she was before the accident. Psychological recovery depends upon moving beyond trauma-engendered cognitive distortions and inappropriate emotions so that she can freely process normal emotions (e.g., sadness and fear) that have been inaccessible up to this point.

Efficacy — In studies conducted with patients having rape-related PTSD, CPT performed as well as PE initially and six and 12 months after. All patients had significant reduction in all three PTSD symptom clusters, and none continued to meet PTSD diagnostic criteria at the six-month follow up. A recent, very large study comparing both approaches demonstrated equal effectiveness.[43, 44, 61]

Stress Inoculation Training (SIT)

SIT aims to reduce avoidance behavior through anxiety reduction and foster a sense of personal competence..

Originally adapted for treating rape victims, SIT provides PTSD patients with a repertoire of tools and skills they can utilize to control anxiety elicited either by trauma-related stimuli or during threatening situations.[73–74] It combines a variety of anxiety management techniques including relaxation and biofeedback training (see page 41). In addition, SIT utilizes:[59]

- **Social skills training** — Clinicians help patients increase specific interpersonal skills necessary for positive relationships.
- **Role-playing** — Clinicians and patients practice responses to specific situations.
- **Distraction techniques** — Clinicians teach patients to yell "stop" to themselves each time certain thoughts start.

Efficacy — Four studies on women with rape-related PTSD or male or female motor vehicle accident survivors tested SIT alone or in combination with PE. In all cases, results from SIT were equal to those from PE, producing a 60 to 70 percent reduction in PTSD symptom severity. Three-month follow-up assessments showed substantial improvement in one study and improvement slightly better with PE than SIT in another study.[45, 54, 55, 62]

Interapy[46]

Given avoidant behavior that characterizes PTSD, growing Internet access worldwide, and the shortage of skilled CBT clinicians, interapy has much to recommend it for addressing the spectrum of post-traumatic distress, from acute stress reactions to PTSD..

Interapy is an Internet approach that modifies standard CBT (especially CPT) components (e.g., psychoeducation, exposure, and cognitive therapies) for this unique medium. Thus far, it has only been tested in the Netherlands. Interapy involves 10 sessions (twice a week for five weeks) where patients submit essays

(approximately 450 words) to a Web site and receive clinician feedback. Major components are exposure/"self confrontation" and cognitive reappraisal much along the lines of CPT.

Efficacy — There have been two controlled trials of interapy, one with students and one with 184 Dutch participants, who reported mild-to-severe, post-traumatic symptoms. Neither study included formal PTSD diagnostic assessment; however, researchers observed a 50 percent or greater improvement in PTSD, depression, and other symptoms.[46,63] More rigorous testing is needed for this exciting treatment option.

Imagery Rehearsal Therapy (IRT)[47]

IRT was developed to decrease the traumatic nightmares central to PTSD, reduce insomnia, and decrease PTSD symptom severity. IRT treatment consists of three weekly sessions in which patients learn cognitive-behavioral techniques for replacing unpleasant images with pleasant ones. Then they focus on a single, intolerable nightmare and are instructed to "change the nightmare" in any way they wish. Finally, they rehearse this new dream 5–20 minutes every day.

Efficacy—Four randomized **IRT** trials with crime victims, sexually abused adolescent girls and women, and Vietnam veterans have reported 50 to 60 percent reduction in nightmare frequency and overall PTSD symptom severity.[47, 64, 65] Further testing is needed, but IRT appears to be a promising, unique approach for PTSD patients experiencing nightmares.

Biofeedback and Relaxation Training[34)]

Biofeedback is a process to reduce tension and anxiety in which the patient is given information about her/his own physiological processes. For example, the patient is given continuous feedback about heart rate, or muscle tension. S/he learns to consciously control these processes. Success is demonstrated by reductions in heart rate, muscle tension, or other physiological processes. Relaxation training is a treatment in which patients learn to relax their musculature through breathing and meditation-like tensing and untensing exercises, often assisted by audio tapes. Learning to induce muscle relaxation at will is used as a technique to control anxiety, when it occurs.

Efficacy — Biofeedback and relaxation training are ineffective stand-alone treatments but function as anxiety management techniques used with other CBT approaches, such as stress inoculation training (SIT) (reviewed on page 40).[59]

borderline personality disorder — A personality disorder characterized by extreme instabilities fluctuating between normal functioning and psychic disability

See page 23 for more info on establishing trust and safety..

For a specific model for integrating DBT with prolonged exposure for PTSD, refer to one recently proposed by C. B. Becker and C. Zayfert.[52]

Dialectical Behavior Therapy (DBT)[48–51]

DBT is a comprehensive CBT approach designed specifically for patients with *borderline personality disorder* and other difficult-to-treat patients too unstable to adhere to other treatments. Since DBT candidates often have significant trauma histories and often meet diagnostic criteria for PTSD or complex PTSD, this option may be appropriate for the initial stabilization (e.g., establishing trust and safety) phase of PTSD treatment.

DBT patients acquire skills to reduce chronic impulsive behavior marked by chaotic life problems, suicidal behavior, emotional lability, substance abuse, binge eating, and frequent hospitalizations. DBT is characterized by a balanced and flexible approach to therapy based on a strong patient-clinician relationship through which problem behaviors are explicitly addressed.

Efficacy— Although a number of reports describe moderate improvement for complex PTSD patients receiving **DBT** for suicidal, self-mutilating, impulsive, self-damaging, and binge-eating behaviors, no specific reports exist on DBT as a first-line or adjunctive treatment.[48–51]

Eye Movement Desensitization and Reprocessing (EMDR)

saccadic eye movments — Rapid intermittent eye movement, such as that which occurs when the eyes fix on one point after another in the visual field.

Proponents of EMDR believe that *saccadic eye movements* reprogram brain function so that the emotional impact of a trauma can be finally and completely resolved.[83–84] When conducting EMDR, the clinician instructs the patient to imagine a painful, traumatic memory and an associated negative cognition (e.g., guilt, shame). Then, the patient is asked to articulate an incompatible positive cognition (e.g., personal worth, self efficacy, trustworthiness). The clinician then has the patient contemplate the traumatic memory while visually focusing on the rapid movement of the clinicians' fingers. After each set of 10–12 eye movements, the clinician asks the patient to rate the strength of both the distressing memory and his/her belief in the positive cognition.

Despite the name of this therapy, research evidence suggests that eye movements do not appear necessary for EMDR to work.[85, 68] In published studies comparing conventional EMDR to EMDR minus eye movements, patients who received EMDR minus eye movements did just as well as those who received conventional EMDR. Therefore, it is difficult to substantiate that eye movements form the crucial ingredient in EMDR and even more difficult to defend the hypothesis that EMDR reprograms the brain's processing of traumatic memories.

Because empirical evidence suggests that EMDR is effective in treating PTSD (despite the apparent unimportance of eye movements), more research is needed to understand the actual mechanism by which EMDR works. Some theorists believe that EMDR is actually a variant of CBT. In practice, it does have some unique components

that may account for its appeal among clinicians as well as its therapeutic efficacy. Most notable is the practice of having patients select the traumatic material, which they process in their own ways and at their own paces — in contrast to other approaches.[86]

Efficacy — EMDR appears to be more effective than no treatment (among patients assigned to a wait list). It is also superior to psychodynamic, relaxation, or supportive therapies.]

Several studies have shown that, in comparison with wait list patients (who show little improvement), approximately two-thirds of those receiving EMDR no longer met PTSD diagnostic criteria.

Published results indicate that following treatment, 50 to 77 percent of those receiving EMDR no longer met criteria for the PTSD diagnosis in comparison to 20 to 50 percent receiving supportive therapy or treatment-as-usual.[70–73]

EMDR proponents argue that their treatment is not only as effective as CBT, but that it is shorter and better tolerated by patients..

Results are mixed regarding the relative efficacy of EMDR and CBT. Although head-to-head comparisons of the two treatments suggest that CBT produces better and longer lasting outcomes, other studies suggest that both are comparable.[74, 75, 76] However, four meta-analyses have concluded that both are generally equally effective.[71–73, 75]

Psychodynamic Psychotherapy

For over 100 years, clinicians have used psychodynamic psychotherapy to treat post-traumatic disorders. Psychodynamic theory focuses on *psychic balance*, which sometimes requires the patient to force intolerable thoughts and feelings out of conscious awareness through the process called *repression*. However, these now–unconscious traumatic memories are still powerful enough to become expressed as symptoms, such as PTSD's intrusion, avoidant/numbing, and hyperarousal symptoms.[76]

psychic balance — A dynamic equilibrium state between those thoughts, feelings, memories, and urges the conscious man can tolerate and those it cannot

repression — A hypothetical, unconscious process by which unacceptable (often trauma-related) thoughts and feelings are kept out of conscious awareness

Psychodynamic treatment seeks to understand the context of the traumatic memories and the defensive processes through which the unconscious transforms repressed memories into the maladaptive symptoms that initially drive treatment. According to psychoanalytic theory, simply focusing on symptom reduction can achieve little as long as repressed memories remain.[76]

A new, healthier balance must be achieved by confronting unconscious processes that have repressed the memories and produced maladaptive compromises (e.g., symptoms). As these feelings, behaviors, and memories are explored, patients gain insight or understanding of how their repressed memories (along with associated thoughts and feelings) have been transformed into their current symptoms. This awareness ideally enables patients to exercise more control over the repression defense and thereby achieve symptom reduction.

Psychodynamic treatments vary from 10–20 sessions to open-ended treatment lasting many years. Longer psychodynamic treatments seek to create a fundamental change in psychic balance while briefer forms (12–15 sessions) seek to foster improved self-understanding and ego-strength.

Several experts provide detailed information on psychodynamic therapy for PTSD.[25, 78–80]

self-cohesion — knowledge and integration of previously unconscious motivations

Brief Psychodynamic Psychotherapy (BPP), conducted within 12–15 sessions, focuses on the traumatic event itself. Through the retelling of the trauma story to a calm, empathic, compassionate, and non-judgmental clinician, the patient achieves a greater sense of *self-cohesion*, develops more adaptive defenses and coping strategies, and successfully modulates intense emotions that emerge during therapy.[79] While working through the traumatic memories, the clinician also addresses the linkage between post-traumatic distress and current life stress. Patients learn to identify current life situations and environmental triggers that set off traumatic memories and exacerbate PTSD symptoms.

Efficacy — Because psychodynamic treatment focuses primarily on psychic processes rather than psychiatric symptoms, there exists only one randomized clinical trial on treatment efficacy for reducing PTSD symptoms.

In some ways, BPP has similar goals to PE/CBT yet different conceptual underpinning and therapeutic techniques..

This study involved the use of BPP for 18 sessions and compared results with Hypnotherapy and CBT (Systematic Desensitization). BPP effectively reduced PTSD intrusion and avoidance symptoms by approximately 40 percent. This improvement was:[80 [82?]]

- Sustained for three months
- Comparable to results from the other two treatments
- Significantly greater than a wait list group that received no treatment

Much more research is needed to demonstrate psychodynamic treatment efficacy for PTSD.

Group Therapies

Group therapies utilize a psychodynamic focus, CBT focus, or supportive techniques (each with a different focus) and can be combined with the other therapies.[97] In all cases, trauma survivors learn about PTSD and help each other with the aid of a professional clinician.

Group therapy is effective and popular for those who have all survived the same type of trauma (e.g., war, rape, torture, terrorist bombing, etc.). As members share experiences, they become connected to one another by recognizing their common human fears, frailties, guilt, shame, and demoralization. Through clinician guidance, validation and normalization of these thoughts, feelings, and behaviors progresses to acquisition of more adaptive coping strategies, symptom reduction, and/or derivation of meaning from the traumatic experience.

Psychodynamic Focus Group Therapy

Group members help one another understand how their assumptions about themselves (e.g., weak, shameful, guilty, undeserving) have been shaped and distorted by their traumatic experiences. By revisiting this material in the safety of the group, they are empowered to confront the traumatic memories to gain new insight about these memories and themselves, and integrate such knowledge into their

lives. Personal growth results from improved ego strength and self-understanding. While symptom reduction is not the major treatment goal, theorists expect resolution of trauma-related disruptions to normal psychic processes will promote PTSD amelioration.[97–98]

Efficacy — There is very little empirical research with psychodynamic focus group treatment for PTSD, and the few findings that have been reported are equivocal. In the one study of psychodynamic group treatment with childhood sexual abuse survivors, PTSD symptom severity was reduced by 18 percent.[97]

During the retelling of the trauma story, emotion is mobilized; as a result, the patient hopefully experiences a profound catharsis or "abreaction." Achieving catharsis is an important mediator of recovery in this treatment approach.

The ultimate goal for both psychodynamic and cognitive-behavioral group therapy is for group members to gain "authority" over traumatic material so that it no longer becomes a dominant factor in their lives.[25]

Cognitive Behavioral Focus Group Therapy

These groups embody the concepts and approaches described earlier for individual Cognitive Behavioral Therapy (see pages 38-39).[69, 97] One specific group approach uses PE and CBT, where the clinician guides one group member at a time through a typical exposure session followed by cognitive restructuring.[99] During the exposure session, the other members are vicariously exposed to their own traumatic memories through observing someone else's treatment.

Group members do more for each other than provide social support. They validate one another's post-traumatic reactions, share their struggles to cope with PTSD-related problems, and provide honest criticism of fellow members' maladaptive coping behavior based on accurate empathy and their own experiences. Since group time is limited, group members must carry out homework assignments in which they focus or expose themselves to traumatic material. This homework is done through writing exercises or by repeatedly listening to an audio tape previously recorded during a group session in which they underwent exposure to their own traumatic material.

Other group approaches employing CBT have been utilized. Most notably CBT (see pages 36–37) and SIT (see page 40).[43, 86 (43,86)]

Efficacy — There is a great deal of empirical support for cognitive behavioral focus group treatment. In three studies of CBT group treatments (including CPT, assertiveness training, and SIT) on women traumatized by childhood or adult sexual abuse, PTSD symptoms were reduced 30 to 60 percent with reductions in all PTSD symptom clusters measured. Improvement was sustained for six months in all studies. One CBT group treatment for combat veterans showed a 20 percent reduction in PTSD symptom severity.[68–70, 97–98]

Supportive Group Therapy

Supportive Group Therapy provides psychoeducation and focuses on members' current life issues.[88, 97–98] The goal of treatment is not to revisit, reframe, or master traumatic material, but to discuss here-and-now issues. Traumatic consequences, as expressed by PTSD symptoms, are only relevant if they affect present-day functioning. To improve emotional and interpersonal comfort and overall functioning, group members are encouraged to develop better interpersonal and coping skills, problem-solving skills, and more adaptive responses to predictable challenges.

There is also a report of group EMDR treatment for Vietnam War veterans (see pages xx–xx).[87]

Supportive groups emphasize here-and-now issues and try to redirect discussion of past traumatic experiences to present problems or concerns..

Efficacy — In a recent, large randomized trial in which 360 Vietnam combat veterans with PTSD were randomized to 30 weekly sessions of either CBT or supportive therapy, results were similar for both groups. Thirty-eight percent of the veterans improved, 43 percent were unchanged, and 18 percent had worse symptoms after treatment.[89]

Additionally, one controlled trial of supportive group therapy for female sexual assault survivors showed a 19 to 30 percent reduction in intrusion and avoidance symptoms that was maintained for six months.[68]

Untested Treatments

A number of treatments, found effective for other psychiatric disorders, have not been tested systematically with PTSD patients. However, those often utilized in PTSD treatment despite lack of efficacy evidence are:

Despite a lack of empirical evidence, clinical experience indicates that spouses and families should be included in treatment for partners, parents or children with PTSD..

- **Couples/Family Therapy** — This treatment focuses on how relationships can either be disrupted by a family member's PTSD (systemic treatment) or foster a better healing environment for the PTSD patient (supportive treatment).[103–109]
- **Hypnosis —** Although no longer considered a PTSD treatment, hypnosis has demonstrated equal efficacy with both CBT (systematic desensitization) and psychodynamic psychotherapy in the single randomized trial.[82] It is now utilized primarily as an adjunctive procedure for confronting difficult traumatic memories, nightmares, or dissociative symptoms.[110]
- **Social Rehabilitative Therapies —** Effective for those with persistent mental illnesses (e.g., schizophrenia, severe affective disorders), these therapies are used with chronic, severe, and incapacitating PTSD (often indistinguishable from other persistent mental illness)[111, 11] The seven psychosocial rehabilitation techniques recommended for severe and chronic PTSD are:[113]

    1. Patient education services
    2. Self-care/independent living skills techniques
    3. Supported housing services
    4. Family support
    5. Social skills training
    6. Supported employment techniques/ sheltered workshops
    7. Case Management

There is currently no data supporting social rehabilitative therapies for PTSD. It is an important area for future research..

What Psychological Treatments are Available for Children and Adolescents with PTSD?

Treatments for children and adolescents are often age-appropriate interventions extrapolated from adult treatment methods. For children who develop PTSD, the impact of the trauma as well as the expression of symptoms may be significantly affected by the developmental stage at which the trauma occurred.[105] For example:

- **Abused infants and toddlers** may have impaired ability to form attachments with significant others.
- **Traumatized preschoolers**, who lack the conceptual and communication capacities of older individuals, may express nonverbal symptoms (e.g., aggression, withdrawal, or sleep problems).
- **Trauma in children** may result in restructured emotional expression, social isolation, problems with impulse control, self-injurious behaviors, dissociation, and development of *dissociative identity disorder* or borderline personality disorder.
- **Trauma during adolescence** may severely disrupt normal adult development by producing problems in separation from parents, personality evolution, symbolic thinking, and moral development.[106–110]

dissociative identity disorder — Previously called Multiple Personality Disorder, which is characterized by one's personality becoming so fragmented that pronounced changes in behavior and reactivity are noticed between different social situations or social roles

Treatment Efficacy for Children and Adolescents

A consistent body of evidence supports the efficacy of CBT treatment for children with PTSD.

There has been very little research on treatment for children with PTSD. However, the strongest findings, to date, indicate that the best results are achieved when the family is included in treatment, and that school-based treatments may offer the most efficient and effective approach for many children.[100–102]

A number of experts have written thoughtful articles on developmentally sensitive treatment approaches for children with PTSD.[91] There is very little empirical evidence to guide us. Randomized trials of 10–18 sessions of CBT with children exposed to sexual trauma, natural disasters, and single-incident stressors, such as criminal assault or an automobile accident, have shown this approach superior to comparison treatments.[97–101] Among these, three studies on CBT group interventions in the school setting have shown impressive results:

1. In a study of nine- to ten-year-old survivors of the 1989 earthquake in Armenia, 20 to 40 percent experienced reduced PTSD symptoms compared to a non-treatment control group of children, whose symptoms worsened over the subsequent 18 months.[100]
2. An impressive, 18-week, school-based group CBT treatment was offered to children (grades four to nine), who had been exposed to a single-incident stressor (e.g., criminal assault, car accident, natural disaster — in contrast to protracted physical or sexual abuse). By the end of treatment, 57 percent no longer met PTSD diagnostic criteria; at the six-month follow-up, 86 percent no longer had PTSD.[101]
3. A school-based approach among Hawaiian children exposed to Hurricane Iniki successfully reduced PTSD intrusion and avoidance symptoms by 30 to 35 percent.[99]

Another, school-based CBT approach successfully reduced depressive and anxiety symptoms among sexually abused preschool children, but PTSD symptoms were not monitored.[111]

It is important to include parents in treatments for children with PTSD. Many studies have shown that the parents' emotional reaction to the trauma and the amount of family support available to the child will have a significant impact on the child's symptoms.[111] The best predictor of a favorable outcome for children is if parents and other significant adults can cope with the trauma.[110] Therefore, psychoeducation and supportive family therapy described earlier (see pages 24–25 and 33–35) are especially relevant to PTSD treatment for children.[111]

play therapy — A technique for treating young children in which they reveal their problems on a fantasy level with dolls, clay and other toys

Other approaches, such as *play therapy*, SIT, and psychoeducation, have primarily been the subject of speculation and uncontrolled clinical trials but have not been tested rigorously.

Key Concepts for Chapter Four:

1. Psychoeducation helps patients understand that their symptoms reflect a response to catastrophic stress shared by many as well as the nature of the disorder and its impact on their lives. It is especially useful as a societal and community intervention, using mass media, following terrorism or mass casualties due to a natural disaster.
2. Psychoeducational interventions help patients achieve normalization in their lives, remove self blame and doubt, correct misunderstandings about what's causing their symptoms, and enhance the clinician's credibility as someone truly understands the patient's struggles.
3. Individual psychotherapy used to treat PTSD includes cognitive behavioral treatments (CBT), eye movement desensitization (EMDR), and psychodynamic Psychotherapy. Of these, research suggests that CBT approaches are the most effective.
4. Prolonged exposure therapy (PE), which focuses on the details of the traumatic event itself, and cognitive therapy, which focuses on changing how the patient perceives the traumatic event, appear to be equally effective for improving PTSD symptoms (60-70 percent) when studied alone and in combination.
5. Despite mixed results for how EMDR impacts PTSD symptoms, empirical evidence suggests that it is effective in treating PTSD, perhaps as effective as CBT.
6. It is difficult to determine effectiveness of psychodynamic treatment due to its focus on psychic processes instead of psychiatric symptoms, which are far more measurable.
7. Group therapies are most effective for people who have all survived the same type of trauma (e.g., veterans). These approaches use either psychodynamic, CBT, or supportive techniques and can be combined with other therapies.
8. Children and adolescents with PTSD face additional treatment challenges based on their development stage when the trauma occurred and the impact of that stage on how they were able to put what was happening into some overall context. Family and school involvement appear critical to treatment success.