intervalla: Vol. 2, 2014 ISSN: 2296-3413

Thoughts and Trauma – Theory and Treatment of Posttraumatic Stress Disorder from a Cognitive-Behavioral Therapy Perspective

Julia König
Catholic University Eichstätt-Ingolstadt

Julia König. "Thoughts and Trauma – Theory and Treatment of Posttraumatic Stress Disorder from a Cognitive-Behavioral Therapy Perspective." *intervalla: platform for intellectual exchange* 2, "Trauma, Abstraction, and Creativity" (2014-15): 13-19.

When talking about trauma from the perspective of a psychologist and psychotherapist, a few issues frequently emerge where concepts differ from those used in other fields. I will briefly go into these issues and then move on to an example of a successful cognitive-behavioral treatment of a patient suffering from posttraumatic stress disorder (PTSD). While "trauma" is a term that can have different meanings depending on the context it is used in, PTSD is a mental disorder with clearly defined symptoms that may occur after a traumatic event has been experienced. And this is the first issue where terms need to be defined: what is a trauma and who do we work with in therapy? From a clinical psychology perspective, what constitutes a traumatic event is defined in the diagnostic classifications. The most important ones are the World Health Organization's (WHO) *International Classification of Diseases* (ICD; WHO, 2005) and the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association (APA), which is currently in its fifth edition (DSM-5; APA, 2005). Both classifications are the result of collaborative efforts from professionals from different fields and (especially in the case of the ICD) countries and cultures. The DSM-5 defines trauma as "exposure to actual or threatened death, serious injury or sexual violation" (APA, 2015) and continues to specify:
The exposure must result from one or more of the following scenarios, in which the individual:

- directly experiences the traumatic event
- witnesses the traumatic event in person
- learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental), or
- experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related) (APA, 2015)

However, having experienced a traumatic event does not mean that a person develops mental health problems. On the contrary, depending on the type of traumatic event, the majority of survivors will experience distress in the aftermath, but eventually recover. This is one of the reasons why PTSD can only be diagnosed four weeks after the event at the earliest. Different types of events cause PTSD at different rates: sexual violence, for example, leads to PTSD more frequently than accidents (Kelley, Weathers, McDevitt-Murphy, Eakin, & Flood, 2009). Other important factors influencing the development of symptoms include the social support after the event and one's initial reaction during the trauma (Brewin, Andrews, & Valentine, 2000; Ozer, Best, Lipsey, & Weiss, 2003).

The symptoms that frequently develop after a trauma are grouped into four categories in the DSM-5. Survivors frequently experience intrusive memories of the event in the form of thoughts, pictures, dreams, or flashbacks. They also tend to try to avoid reminders of the experience, both in the external world (places, people, or activities) and in the internal (thinking or talking about the event). Frequently, trauma survivors have very negatively distorted thoughts about themselves, others, and the world, blame themselves or others, have trouble remembering the whole of the trauma, and feel alienated from others. Also there is a change in reactivity; many PTSD sufferers report exaggerated startle reactions, heightened vigilance, irritability and trouble concentrating, to name a few. To fulfill DSM-5 criteria, a specified number of symptoms in each category have to be present.

PTSD is one of the very few mental disorders where an external event is necessary for the diagnosis. At the same time, having experienced a traumatic event does not equal PTSD – some people recover all by themselves, while others develop other mental health problems. So there are two important differences between clinical psychology and general language: "trauma" has a more narrow definition, with some challenging and difficult events (such as a difficult divorce or losing a loved one after a long illness) not being regarded as traumatic. PTSD is a disorder that people often develop after being exposed to a traumatic event, but does not reflect the possible range of adjustment and non-adjustment post-trauma.

When working with PTSD patients, society and its views come into play maybe more than with other disorders. This can be in the shape of lawsuits and the accompanying stress of testifying, it can be in the shape of insurance companies trying to ascertain whether symptoms stem from the event or some previous vulnerability. Social support is one of the strongest predictors of recovery after a trauma, and social support depends on the existence and quality of personal relationships, the resources in the social network (some traumatic events affect whole families or communities), and the culture and subculture to which an individual belongs. For example, a rape victim will face very different responses depending on whether she lives in a culture where victims are routinely blamed or believed.

In the following paragraphs, I will give a brief overview of a cognitive model of PTSD and the therapy built on this model: Cognitive Processing Therapy (CPT; Resick, Monson, & Chard, 2007). There are other theoretical models and other treatments, some very similar and some very different. CPT has a strong focus on cognitive work, that is, changing dysfunctional beliefs about oneself, others, and the world. It relies on a socio-cognitive model, which focuses on the ways a traumatic experience is processed within the context of existing beliefs. On the one hand, people strive to keep their cognitive schemas intact, and, on the other, they aim for their schemas to be congruent with reality. There are two ways to integrate schema-discrepant information: either the event can be interpreted in such a way that it fits into the schema (assimilation) or the schema can be changed so the new information can be incorporated (accommodation). Both mechanisms can be functional: if a good friend says something unkind, it can be sensible to assimilate, that is to interpret the comment in a way that still fits with our positive view of the person and the relationship ("my friend is just stressed, she did not mean that"). This way the positive belief can be kept and the relationship is not damaged. However, if someone is repeatedly or excessively unkind or untrustworthy, it would be more functional to accommodate, that is to change one's belief ("this person frequently hurts me with her remarks, I no longer want to be close to her"). That way, one could spend more time and energy on other relationships.

A traumatic event is schema-discrepant, and so much so that assimilation would only be possible by severely distorting reality. Assimilation of traumatic events often shows in self-blame or mental undoing and hinders processing of the event. Self-blame ("I should have known", "it's my fault") often has the function to protect beliefs about one's safety ("I can protect myself from harm", "if you're careful enough, nothing bad will happen"). Giving up these beliefs, even if they have been proven wrong, can be very scary. At the same time, the feelings of guilt and shame associated with assimilation are very distressing. This happens in many contexts, such as sexual violence, where sometimes society focuses more on whether the victim did all they could to protect themselves than on the fact that the perpetrator committed a crime. Also other people may try to protect their own safety beliefs by telling a victim it was her own fault. According to Patricia Resick, who developed CPT, assimilation is also very frequent in traumatized soldiers because they are trained with the belief that if everybody does their job right everybody gets out alive. This is not a realistic view in combat areas and will often lead to the conclusion that someone must be blamed after traumatic events.

The "just world belief" also plays a major role in assimilation. When prompted, most people will say "I know that the world is not fair", while simultaneously entertaining situations in which they think "why did this happen to me?" or "why that person?" This is an indication of a just world belief because it expresses that some people *should* not experience bad (or good) things. The "just world belief" often leads victims to blame themselves, because "if bad things happen to bad people and this horrible thing happened to me, I must have done something to deserve it."

Assimilation can also appear in a mental undoing of the event. If people try to mentally undo, their thinking often circles around the "how could this happen" and "this should not have happened, therefore it cannot have happened". This makes processing trauma and its

consequences impossible because the reality of the event is not accepted. Assimilated thoughts usually concern the past, that is, the traumatic event(s).

After a traumatic event, accommodation would be the adaptive mechanism. However, PTSD patients often change their beliefs too much and over-accommodate. This leads to the development of extremely negative beliefs and expectations. Examples include statements such as "now I know that nobody can be trusted", "I'm worthless", or "it is not safe to leave the house". Such extreme beliefs lead to anxiety, over-vigilance, and distrust. These over-accommodated thoughts usually deal with the present or future and thus can severely impact both interpersonal relationships and daily life.

Problematic cognitions that hinder processing of the traumatic event, such as assimilation or accommodation, are called "stuck points" in CPT. The cognitive work is a very important part of the therapy; of course emotions are also important. Patients are taught early on that it can be helpful to differentiate between "natural" and "manufactured" emotions. Natural emotions are those directly caused by the traumatic event, such as sadness from a loss, fear of a threat, or anger at a perpetrator. Natural emotions can be very intense and painful, but if they are allowed to run their course, they will subside with time. Manufactured emotions result from interpretations and appraisals of the traumatic event, that is, from cognitions. Compared to natural emotions, they are much more stable and don't necessarily decrease when fully felt. Some feelings, such as guilt, are usually manufactured, but the differentiation is not between types of emotion. Anger is a good example: it is completely normal to be angry with the guilty party in a traffic accident. If this anger (as all other natural emotions) is really felt, it will subside with time. If patients, however, think "something like this must not happen" or "this injustice must not be", they can stay angry for years. Then the anger would be considered a manufactured emotion. The difference is important for therapy because it is believed that natural emotions cannot and should not be changed but have to be felt and allowed to take their course. Manufactured emotions, on the other hand, are based on thoughts and can be changed via cognitive work. In the remainder of this article, I will draw on a case example to illustrate the most important steps of CPT. Some personal information has been changed so as to make the patient unrecognizable.

Mrs. A. came to seek help at the university outpatient clinic where I was working at the time. She was 24 and had been raped five years previously. She came in because she had decided that her life could "not go on like this" and she wanted to make a change. Eighteen months after the rape she had been in a psychiatric hospital for ten weeks and had been given benzodiazepines and antipsychotic medication which caused her to have amnestic episodes and feel like she wasn't really there. Two years after the rape she married an acquaintance who had once helped her in a confrontation with the rapist (she had not reported the incident to the police and they both lived in the same town), but who had beaten her during the marriage and forced her to have sexual intercourse. At the time she started therapy, she was divorced and living with her parents, but her ex-husband was still trying to get in touch with her. At intake, she suffered from difficulty falling asleep and sleeping through the night; she was irritable, prone to be verbally aggressive; she had intrusive memories of the rape and also the marriage; and avoided contact with other people, especially men. She felt alienated from her friends and had withdrawn from most of them; she did not participate in any leisure activities. As she was working from home when starting therapy, she hardly had contact with people outside her family.

After spending one session getting to know the patient and the most important facts about her background (the formal diagnostics had been done by someone else because the therapy was part of a study), the first "real" CPT session was given to psychoeducation. It is very important for patients to understand why every step of the therapy is done and one of the most important parts is to "avoid avoidance". In this first phase of therapy, the ground for cognitive work is laid with "ABC-sheets", which help patients learn to differentiate between thoughts and feelings and to become aware of their own internal dialogue.

Avoiding any reminders connected with the traumatic event, from activities to natural emotions, is among the core symptoms of PTSD. Avoidance is what sustains the disorder because patients never experience that they can deal with their memories and whatever else they fear. In the second session, I asked Mrs. A. to write an "Impact Statement", an essay about why she thought the traumatic event had happened and what changes it had caused in her thinking and feelings regarding safety, trust, power/control, esteem, and intimacy. When reading this essay back to me in the next session, it became apparent to both of us how deeply all areas of her life had been affected by the event.

In the fifth session, I asked Mrs. A. to write an account of the traumatic event, from the time she knew something was going to happen to the time she felt halfway safe again. Ideally, patients should write the account soon after the therapy session and read it to themselves every day until the next session, when they are asked to read it aloud to the therapist. Mrs. A. did write an account, but it read very much like a police statement, very matter-of-fact with no emotions or details. After her first statement, she reported not being able to write the story anymore, so I asked her tell it to me during the session, taped it, and had her listen to the tape every day[i]. The whole exposure part of therapy took several weeks because Mrs. A. only gradually dared to approach the memory. Her accounts became more and more detailed and emotional. In the beginning, she avoided confronting the event by digressing from the story or by rushing through the difficult parts; however, week by week she could face her emotions more and more, especially the disgust she had felt during and after the event. When Mrs. A. remembered this, she started experiencing strong disgust again and scratched her arms. The technique of stimulus discrimination, that is, concentrating on similarities and differences between the here and now and the trauma, and therefore learning to differentiate between now and then, was very helpful in this context. After six sessions of talking about the traumatic event (in contrast to two in the original manual), Mrs. A. did not find remembering the rape difficult anymore; the natural emotions had dissipated and she could remember it as something that had happened, but not with very much current affect. During this time, symptom scores declined. After spending some time talking about the events during the marriage (which had been less distressing to her than the rape) she talked about her fears about accidentally meeting the rapist in town. We considered things she could do and she indeed had some chance encounters with him, which did not lead to a physical stress reaction. This really strengthened Mrs. A.'s belief in herself and her ability to protect herself.

After exposure, we moved on to the cognitive work. CPT makes use of several cognitive worksheets designed to help patients challenge and change their stuck points. For Mrs. A., the most important stuck point was "all men are bad". She had a difficult relationship with her father, who had also sexually abused her older sister (but not her), then she had been raped, and then she had been treated badly by her husband, so in her opinion she had ample proof for this belief. However, both the therapy and the experiences she made in her increasing social life lead to the change of very negative beliefs. Other important, over-accommodated stuck points were about her own feelings ("I can't handle remembering the event fully"), which showed in the very long exposure phase and worries about being changed forever by the event ("will I ever be able to have sex again?"). Mrs. A. mostly blamed the perpetrator for the rape, but there was some self-blame along the lines of "I should have known", "I shouldn't have made it possible for him to do what he did" and "I'm a person that gets treated badly by others". CPT helps patients challenge stuck points by asking "Challenging Questions" first (which is also the title of a worksheet). There are ten questions that deal with the evidence for and against a stuck point and whether the patient uses words that are exaggerated ("always", "never", "all"). In the next session, patients are asked to assess whether they use "Problematic Thinking Patterns," such as over-generalizing from one event to "always" or from one person to a whole group, all-or-none-thinking, or mind-reading. The last and most complex cognitive worksheet, "Challenging Beliefs", combines all previous worksheets and adds the possibility to add an alternative to the

stuck point challenged. For Mrs. A., the assimilated stuck points changed rather quickly, as if daring to really think about her role in what happened made it clear that it was not her fault. Also in CPT assimilated stuck points are targeted first, as only an event that is accepted as having happened can be processed. The over-accommodated stuck points took longer and some took several worksheets to gradually change. Toward the end of therapy, five issues are discussed in more detail: safety, trust, power/control, esteem, and intimacy. Each of these issues is considered from the view of the patient (e.g. self-esteem), as well as with respect to others (e.g. esteeming others). Many trauma survivors have stuck points in one or more of these areas. For Mrs. A., the esteem and intimacy sessions were especially important. Even though it was not part of the protocol, she wrote essays on these topics, linking self-worth and esteem of others to her religious beliefs. We could successfully terminate therapy after 25 sessions (the standard duration of short term cognitive-behavioral therapy in the framework of German compulsory health insurance). At the follow-up measurement six months after the end of therapy, Mrs. A. was in a relationship, getting ready to start a new job and doing well overall. She reported having "ground beneath her feet" again and did not suffer from PTSD symptoms.

This short case example was designed to offer a little insight into one way of treating people suffering from PTSD. While the efficacy of CPT has been established in many studies (Watts et al., 2013), it is by no means "the best" or "the only" treatment.

EPILOGUE

How does this clinical psychology perspective fit into a volume concerned with abstraction and creativity? Doesn't a manualized therapy take creativity out of the process, and isn't the writing of a trauma narrative an exercise in concretization rather than abstraction? To the latter question my tentative answer would be, that depends on the definition of "abstraction". There is a whole body of literature (Pennebaker, 1997) that shows that writing about adverse experiences benefits mentally healthy people in a variety of ways. This effect cannot be explained by having expressed one's feelings, but seems to have something to do with putting the experience into words. But is this really a way of rendering it "unabstract", as one reviewer of this paper put it? Traumatic memories tend to be very concrete and connected to the senses – the sound of a siren, the look of a bedroom wall from a certain angle, the smell of a perpetrator's perfume. In writing the trauma narrative, these details become part of a story, embedded in a person's autobiographical memory, and, therefore, the person gains more control over the memory. In a way, this process could probably be viewed as an abstraction, even though the re-telling and re-listening seem like a very concrete exercise on the surface. I had one patient tell me that writing the trauma narrative was difficult, but also a relief: "Now that it's written down, I feel like I don't have to have it in my head all the time." Is this a concretization, putting recurring thoughts and images on a piece of paper that can be touched and stored away? Or is it an abstraction? By changing role from victim to author, is telling a story in words (most often, written words) a way of distancing oneself from the event?

The question of creativity is also not so easy to answer. As a psychotherapist my job is to help people with mental disorders get better. I believe that this means that I should, while working, place my patients' expected benefit higher than my own gratification in "being creative". There is a whole discussion in the field about the use of therapy manuals, one of the concerns being that they impede therapists' creativity. At the same time, if one keeps an open mind (something that *is* possible when conducting a manualized therapy), creativity will often seep in. Patients and therapists will find new metaphors and images to reframe and convey meanings new and old. I have one patient who is a very creative dreamer – the dreams she reports in session are perfect allegories of the issues she finds most difficult at the moment. A certain type of creativity, of flexibility and inventiveness will also be needed if problems arise.

But maybe the work I do has to be done especially in cases when the challenge is too big and human ability to deal creatively with challenges not sufficient enough. Not everybody develops PTSD after a traumatic experience, so maybe therapy is more a way of helping people get back to their lively, creative selves rather than a creative endeavor in itself.

REFERENCES

American Psychiatric Association. Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC, 2013.

American Psychiatric Association (APA). (2015). Posttraumatic Stress Disorder Fact Sheet. www.dsm5.org. Last accessed 05-30-15.

Brewin, C. R., Andrews, B. & Valentine, J. D. Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology* 68/5 (2000): 748-766.

Kelley, L. P., Weathers, F. W., McDevitt-Murphy, M. E., Eakin, D. E. & Flood, A. M. A comparison of PTSD symptom patterns in three types of civilian trauma. *Journal of Traumatic Stress* 22/3 (2009): 227-235.

Ozer, E. J., Best, S. R., Lipsey, T. L. & Weiss, D. S. (2003). Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis. *Psychological Bulletin 129* (1), 52-73.

Rauch, S. & Foa, E. B. Emotional processing theory (EPT) and exposure therapy for PTSD. *Journal of Contemporary Psychotherapy* 36 (2006): 61-65.

Pennebaker, J. W. Writing about emotional experiences as a therapeutic process. *Psychological Science* 8/3 (1997): 162-166.

Resick, P. A., Monson, C. M. & Chard, K. M. *Cognitive Processing Therapy: Veteran/military Version.* Washington, DC: Department of Veterans' Affairs, 2007.

Watts, B.V., Schnurr, P. P., Mayo, L., Young-Xu, Y., Weeks, W. B, & Friedman, M. J. Meta-Analysis of the Efficacy of Treatments for Posttraumatic Stress Disorder. *Journal of Clinical Psychiatry,* 74/6 (2013): e541-e550.

Weltgesundheitsorganisation [WHO]. *Internationale Klassifikation psychischer Störungen ICD-10 Kapitel V (F). Klinisch-diagnostische Leitlinien. 5., durchgesehene und ergänzte Auflage.* Bern: Hans Huber, 2005.

Julia König is a licensed psychotherapist and assistant professor in clinical psychology at the Catholic University of Eichstätt-Ingolstadt. She received her doctorate in clinical psychology from the Ludwig-Maximilian-University in Munich for research on cognitive processing therapy for PTSD. This is still the focus of her clinical work in the Catholic university's outpatient clinic. Her research interests include psychotherapy research and PTSD after childbirth.
julia.koenig@ku.de

[i] This is very similar to the process employed in another, very well-established therapy for PTSD, prolonged exposure, developed by Edna B. Foa Rauch, S. & Foa, E. B, "Emotional processing theory (EPT) and exposure therapy for PTSD," *Journal of Contemporary Psychotherapy* 36 (2006): 61-65.