Cognitive Behavioral Treatment of PTSD in Vulnerable Populations

Kim T. Mueser, Ph.D.
Center for Psychiatric Rehabilitation
Boston University
SYMPTOMS OF PTSD

• Exposure to DSM-V traumatic event

Symptom criteria:
• Intrusion symptoms (e.g., intrusive memories, flashbacks)
• Avoidance of trauma-related stimuli (e.g., avoiding memories, situations related to trauma)
• Over-arousal (e.g., hypervigilance, difficulty sleeping, anger outbursts)
• Negative alterations in cognition or mood (e.g., inability to remember parts of event, persistent negative feelings, detachment from others)
SPECIAL POPULATIONS

• Severe mental illness
• Survivors of disaster and mass violence
• Addiction
• Adolescents
• Ethnic / cultural minorities
ASSESSMENT OF TRAUMA AND PTSD

• Brief trauma and PTSD screening measures validated in special populations
• No “typical” client with PTSD
• Screening recommended for all clients
• Measures can be administered by self-report or interview
• Prepare client by explaining you will ask about some difficult experiences he/she may have had in the past
• Be matter-of-fact and use behaviorally specific language
• Avoid “loaded” words such as “abuse” or “rape” unless client uses them
STRESSFUL EVENTS SCREENING QUESTIONNAIRE

• 16 questions, takes 5 minutes to administer
• Covers most common traumatic events (sexual abuse/assault, physical abuse/assault, witnessing violence, accident, combat, unexpected death of loved one)
• Traumatic experience that is currently most distressing selected to evaluate PTSD symptoms
PCL-S

PTSD Checklist (PCL): 17 item self-report rating scale
- Items correspond to the DSM-IV symptoms of PTSD
- Clients rate how much they have been bothered by each symptom in the past months on an anchored 5-point scale
- Total PCL scores over 45 indicate probable PTSD
- PCL has good reliability with structured interviews for PTSD, such as Clinician Administered PTSD Scale
- PCL also useful for monitoring effects of CBT for PTSD program
COGNITIVE MODEL OF PTSD

- Horowitz; Ehlers & Clark
- Traumatic events challenge previously held beliefs about self, others, or the world (e.g., “I am safe in the world” ---> “The world is an unsafe place”; “I can have a good life” ---> “I have been defeated by this event and can’t have a worthwhile life”)
- Difficulty integrating new and old beliefs leads to intrusions related to traumatic events
- Underlying beliefs related to traumatic event (or schemas) influence how person interprets and responds to events, including PTSD symptoms
- Cognitive restructuring makes people aware of relationship between thoughts and feelings, and teaches how to identify thoughts and beliefs (including trauma-related ones) underlying upsetting feelings, examine their accuracy, and change when inaccurate
GOALS OF COGNITIVE RESTRUCTURING PROGRAM

- Instill hope that symptoms can be improved through treatment
- Teach a practice skill for managing anxiety immediately in person’s day-to-day life
- Educate about trauma and PTSD to normalize reactions, reduce feelings of being alone, and increase motivation for treatment
- Teach cognitive restructuring as skill to cope with and reduce negative feelings
- Help client use cognitive restructuring to challenge and change trauma-related thoughts and beliefs responsible for PTSD symptoms
COMMONLY ENDORSED TRAUMA-RELATED BELIEFS

- The world is a dangerous place
- You can never know who will harm you
- People can’t be trusted
- My life has been destroyed by the trauma
- I have to be on guard all the time
- People are not what they seem
- I will never be able to have normal emotions again
- I’m worthless and “damaged goods” because of what happened to me
LOGISTICS

• 6-16 week manualized CBT treatment (depending on population)

• Individual weekly sessions

• Treatment provided at local community mental health centers, addiction settings, schools, or other community locations

• 8 therapy modules for basic program
STRUCTURE OF SESSIONS

• Review previous session
• Review homework
• Present brief agenda for session
• Cover material for session
• Assign homework
SYMPTOM MONITORING

• Self-reported assessment of PTSD (PCL) and depression (BDI) at beginning of first and every third session thereafter

• Used to track outcomes over treatment

• Client responses scored and briefly discussed with therapist at beginning of session

• Sometimes assessments used to address distressing symptoms (e.g., use cognitive restructuring to target upsetting feelings related to trauma-related thoughts identified on PCL)
THERAPY MODULES

1. Overview
2. Crisis plan
3. Breathing retraining
4. Psychoeducation I
5. Psychoeducation II
6. Cognitive restructuring I
7. Cognitive restructuring II
8. Generalization Training & Termination
MODULE 1: OVERVIEW

• Review of overall program
• Discussion of psychoeducation, breathing retraining, cognitive restructuring
• Logistics of treatment program
• Homework, cancellations, etc.
MODULE 2: CRISIS PLANNING

- Identification of warning signs of crisis
- Exploration of social supports
- Agreement on monitoring strategies
- Formulation of crisis plan
- Discussion of who to involve in crisis
MODULE 3: BREATHING RETRAINING

- Education about impact of breathing on anxiety
- Instructions on how to modify breathing to reduce anxiety
- In-session practice and assigned homework
MODULE 4: EDUCATION I

• Common reactions to trauma I: PTSD symptoms
  – Reexperiencing
  – Avoidance: Active & passive (numbing)
  – Overarousal
MODULE 5: EDUCATION II

• Common reactions to trauma II: Associated difficulties
  – Negative feelings: Fear & anxiety, sadness, depression, guilt, shame, anger
  – Relationship difficulties
  – Alcohol and drug abuse
PRINCIPLES OF EDUCATION

• Interactive
• Pause frequently & ask questions to help clients relate information to their own experiences
• Adopt client’s language
• Use worksheets to help clients identify their own symptoms & trauma consequences
• Complete some worksheets in session; assign homework to complete others
• Ask review questions to check client understanding
• Abbreviate material when working with severely impaired clients
WRAPPING UP: UNDERSTANDING CLIENT’S TREATMENT PRIORITIES

• Explore how trauma and PTSD have affected client’s life
• Identify specific ways client would most like life to be different
• Consider commonly desired areas of change: better relationships, intimate relationship, work, school, health, parenting, leisure activities, self-care
• Probe: “If you didn’t have these problems related to PTSD any more, what would you be doing? How would things be different?”; “In what ways has PTSD affected you life that you care most about?”
• Explain that program can help make meaningful changes in his/her life
MODULE 6: COGNITIVE RESTRUCTURING I

• Cognition-emotion model
• Common styles of thinking
  – All or nothing thinking
  – Overgeneralization
  – “Must,” “should,” or “never” statements
  – Catastrophizing
  – Emotional reasoning
MODULE 6: COGNITIVE RESTRUCTURING I

• Normalized common styles as errors everyone makes, but may be more common in PTSD
• Explain how correcting common styles can reduce negative feelings associated
• For each style, briefly explain, try to elicit personal examples from client
• When example elicited, explore why it is a common style (i.e., why inaccurate) and identify more accurate thought
• 1-3 sessions
MODULE 7: COGNITIVE RESTRUCTURING II

• 5 steps of cognitive restructuring:
  – Describe situation
  – Identify strongest emotion
  – Identify strongest thought or belief (“Guide to Thoughts and Feelings”)
  – Evaluate the thought
  – Take action: Either change the thought, develop an action plan to deal with the situation, or both
GUIDE TO THOUGHTS AND FEELINGS

<table>
<thead>
<tr>
<th></th>
<th>What bad thing do I expect to happen?</th>
<th>Thoughts that something bad will happen.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear or anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sadness</td>
<td>What have I lost hope in? What’s missing in my life?</td>
<td>Thoughts of loss.</td>
</tr>
<tr>
<td>Guilt or Shame</td>
<td>What bad thing have I done?</td>
<td>Thoughts of having done something wrong.</td>
</tr>
<tr>
<td>Anger</td>
<td>What’s unfair about the situation?</td>
<td>Thoughts of being treated unfairly.</td>
</tr>
</tbody>
</table>
5 STEPS OF COGNITIVE RESTRUCTURING

1. **Situation**
   Ask yourself, “What happened that made me upset?” Write down a brief description of the situation.

____________________________________________________________________

2. **Feeling**
   Circle your strongest feeling:
   Fear/Anxiety       Sadness/Depression       Guilt/Shame       Anger

3. **Thought**
   Ask yourself, “What am I thinking that is leading me to feel this way?” Write down your thoughts below:

____________________________________________________________________

____________________________________________________________________

Is this thought a **Common Style of Thinking**?
   If yes, circle the one:
   • All-or-Nothing       Over-Generalizing       Must/Should/Never
   • Catastrophizing       Emotional Reasoning       Overestimation of Risk
   • Self-Blame           Mental Filter
4. **Evaluate Your Thought:**
Now ask yourself, “What evidence do I have for this thought?” Write down the answers that do support your thought and the answers that do not support your thought.

*Things that DO support my thought:*
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

*Things that DO NOT support my thought:*
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

5. **Take Action!**
Next, ask yourself, “Do things mostly support my thought or do things mostly NOT support my thought?”

☐ **NO**, the evidence does *not* support my thought. Come up with a new thought that is supported by the evidence.
New Thought______________________________________________________________

☐ **YES**, the evidence *does* support my thought. Decide what you need to do next in order to deal with the situation. Write down your Action Plan for dealing with the upsetting situation:
Action Plan: ______________________________________________________________
1. **BRIEFLY DESCRIBE THE UPSETTING SITUATION**

   Ask yourself, “What happened that made me upset?” Write down a brief description of the situation.

   **Situation:** Thinking about the sexual assault

---

- **IDENTIFY YOUR STRONGEST FEELING**

   Ask yourself, “Am I feeling fear or anxiety? Am I feeling sad or depressed? Am I feeling guilty or ashamed? Am I feeling angry?” Write down the strongest feeling you are experiencing.

   **Strongest Feeling:** Guilt and Shame
3. **IDENTIFY YOUR THOUGHTS**

Ask yourself, “What am I thinking that is leading me to feel this way?” Write down your thoughts below.

Thoughts: 1) I am responsible for the sexual assault.

2) I am a sick, twisted, weak individual who acted against his own principles.

3) I am disgusting because I willing engaged in a relationship with another man.

Choose one thought, from the list above, that is **most strongly** related to your strongest feeling (identified in Step 2).

Thought **most strongly** related to strongest feeling: #1

Ask yourself, “What common style of thinking am I using here?”

Common Style of Thinking: **All or None Thinking**
4. CHALLENGE YOUR THOUGHT

Thought most strongly related to strongest feeling (from Step 3):

I am responsible for the sexual assault.

Now, ask yourself, “What evidence do I have for this thought?”, “Is there an alternative way to look at this situation?”, “How would someone else think about the situation?” Write down the answers that do support your thought and the answers that do not support your thought.

Things that DO support my thoughts:

- I was drinking that night and passed out.
- I engaged in a consensual relationship with him following the assault.
- I should have known better.
- He was a friend.
- I should not have been hanging out with him, but I needed a place to live.
Things that **DO NOT** support my thought:

- It was against my will. I was held down by one man and raped by another.
- I did not want to be raped.
- I was unable to protect myself.
- I was in a compromised situation (i.e. I needed him to provide me with shelter).
- I had no reason to suspect that a "friend" would rape me.
Next, ask yourself, “Do things mostly support my thought or do things mostly NOT support my thought?” Look at all the things that support your thought and balance that against all the things that do not support your thought. Check below whether your thought is supported by the evidence or not.

☐ NO, my thought is NOT supported by the evidence.

☐ YES, my thought IS supported by the evidence.
5. **TAKE ACTION!**

If your thought is **NOT** supported by the evidence, come up with a new thought that is supported by the evidence. These thoughts are usually more balanced & helpful. Write your new, more helpful thought in the space below. And remember, when you think of this upsetting situation in the future, replace your unhelpful automatic thought with the new, more accurate thought.

New Thoughts: **While my drinking and other circumstances may have put me at risk, I am not responsible for the abuse.**

If your thought **IS** supported by the evidence, decide what you need to do next in order to deal with the situation. Ask yourself, “Do I need to get more information about what to do?” “Do I need to get some help?” “Do I need to take steps to make sure I am safe?” Below, write down below the next step you will take to deal with the upsetting situation.

Next Step:

_____________________________________________________________
APPROACH TO TEACHING 5 STEPS OF CR

• Use 5 Steps of CR worksheet
• Teach as self-management skill for dealing with negative feelings
• Therapist first explains steps and shows how they work on easy situation with client
• Client then takes lead in using steps with therapist’s help
• Initial focus on any distressing feelings; gradual shift to focus on trauma-related situations as client becomes more skilled
DEVELOPING EFFECTIVE ACTION PLANS

• Not all negative feelings are result of faulty thinking
• Action Plans = problem solving
• Don’t be afraid to help client develop Action Plan if review of evidence supports thought (even if therapist isn’t totally convinced)
• Action Plans are important: they provide a skill that counters usual avoidant pattern of people with anxiety
• Action Plans need to be specific, written, and followed up
General Uses of the Action Plan worksheet (Handout 11):

1. To cope with distressing PTSD or other symptoms
2. To deal with a specific current problem or meet a goal
3. To develop strategies to remember to use a new thought modified via the 5 Steps

* Clinician should initially look out for at least 1 situation in which to develop a detailed Action Plan with the client within the first few sessions of teaching the 5 Steps of CR
ADDRESSING TRAUMA-RELATED BELIEFS

• Focus initially just on teaching CR as skill for managing negative feelings

• Trauma-related thoughts often emerge spontaneously without any special attempts to uncover

• If trauma-related thoughts don’t occur over a few sessions of CR (e.g., by session 8-10) there are several strategies to use
SPECIFIC TIPS FOR ASKING ABOUT TRAUMA-RELATED THOUGHTS

1. Ask directly if thought may be trauma-related

2. Mention commonly heard theme (“I’m to blame”) or scenario (fear of shopping; being afraid of men in public) and ask about connection to trauma (mugging; sexual abuse)

3. Remind client about trauma-related beliefs that were discussed in previous sessions

4. Pull items from PCL and BDI for trauma-related material (i.e., re-experiencing symptoms) to open door to discussion about client’s perception about why that particular symptom is so upsetting

5. Address trauma-related thoughts from previous home assignment, “How Trauma Affects Our Thoughts and Feelings”
HONING IN ON TRAUMA-RELATED BELIEFS

• General trauma-related thoughts can be made more explicit by overtly linking it to trauma:
  – “I’m shameful” because: I didn’t tell anyone about the sexual abuse & should have / I didn’t stop it & could have / I felt some sexual feelings which means I’m bad or not normal”
  – “Because I was physically abused by my parents & boyfriend, nobody can’t be trusted”
  – “I have to be on guard all the time because because I was abused as a child & have been assaulted as an adult”
CASE STUDY – “Rosemary”

Psychotic Symptoms:
-- Delusional Elaboration: drug smuggling, forced to fly plane as teenager during drug drop, dove underneath boats to pick up drugs, planted bombs underneath boats, jumped out of helicopters during drug runs,
-- Voices: related to thoughts and memories about trauma; brother’s voice
-- Disorganization, tangentiality

PTSD Symptoms:
-- Avoidance
-- Intrusive thoughts and images
-- Voices
-- Guilt and shame
-- Drug/alcohol abuse
CASE STUDY – “Rosemary”

Intervention Techniques:

-- Consistent redirection back to current distressing situations
-- Start with non-trauma scenarios (anxiety toward group member)
-- Shaping behavior in sessions towards current situations for CR
-- Focus on how trauma affecting current functioning
-- Examination of content of voices – “You are a horrible person”
-- Not getting bogged down in details of delusions
-- Not challenging veracity of delusional beliefs or “elaborations”
-- Examining underlying content of beliefs and using for CR:
  “I had to jump out of a helicopter when I was 10” → “It was my fault that my family did these terrible things” → “I was a child and it was wrong that I was mistreated and put in situations that a child should never be put in”
CASE STUDY – “Rosemary”

Progress in CBT Treatment

Scores

Sessions

BDI
PCL

Sessions

Scores

42
77
21
33
45
22
24
22
4
1
1
CASE STUDY – “Rosemary”

Treatment Outcome:
- Significant drop in both depression and PTSD symptoms
- Transfer from partial hospital program to outpatient and then to private practice
- Going to school for CNA degree
- Staff and client noted fewer psychotic symptoms; less disorganized speech
- Voices reduced and less related distress
CHALLENGES & SOLUTIONS

- Psychotic distortion/preoccupation with voices
- Motivation
- Cognitive impairment
- Substance abuse
- Multiple life stressors
- Anger
- Nightmares
- Persistent distress related to PTSD
- Dissociation
MOTIVATION

• Explore how PTSD has affected person’s life
• Identify functional goals for PTSD treatment
• Track functional goals over time, address as needed
• Use CR to address perceived obstacles to achieving desired goals
• End early when PTSD symptoms have improved
PSYCHOTIC DISTORTION

• Avoid trying to “get to the bottom” of psychotic distortion
• Focus on underlying feelings
• Explore connections between psychotic beliefs & trauma exposure
• Use Socratic method to help make connections
• Don’t get bogged down in details related to the delusional beliefs – instead, fish out the important trauma-related material
• Treat the belief as you would any other type of overvalued idea that people have which is amenable to CR
PERSISTENT DISRUPTIVE AND DISTRESSING VOICES

• Voices content often ties back to trauma-related beliefs

• Use voices content directly in 5 Steps practice

• Utilize in-vivo breathing retraining as needed in session to reduce distress from voices
COGNITIVE IMPAIRMENT

• Simplify 5 Steps of CR:
  1. Focus on only a few Common Styles
  2. Catch it-Check it-Change it (“3 C’s”)
  3. Meta-cognitive awareness
     (“There goes my stinking thinking!”)

• Involve significant others, including clinical staff, in helping client practice CR outside of session

• More concrete, less abstract examples
SUBSTANCE ABUSE

- Monitor from outset
- Negotiate rules of use (not before session, practice without use)
- Talk openly, enhance motivation to reduce/not use
- Try to postpone when dependence present (motivation)
- Look for opportunities to initiate when client is sober
MULTIPLE LIFE STRESSORS

- Evaluate motivation to work on PTSD
- Explore ways of minimizing life stressors
- Use problem solving to manage stressors
- Postpone treatment until stressors are manageable
ANGER

- Anger different than anxiety, depression, guilt/shame
- Less motivation to make anger go away
- Explore whether anxiety or loss feelings underlie anger & can be focus of CR
- Link anger to problems & interference with other personal life goals to harness motivation
ANGER (Cont.)

- Avoid attempting to persuade clients when weighing the evidence
- Problem solve options for dealing with “anger supported by evidence”
  - Forgiveness
  - Letting go
  - Resolution
- Consider exploring advantages & disadvantages of holding onto vs. letting go of anger
NIGHTMARES

- Teach client to keep nightmare log by bed
- Review nightmares with client at session
- Identify nightmare themes, explore relationship to trauma, do CR on them
- Do CR on fear of going to sleep
- Develop action plans for relaxation around sleep time
PERSISTENT DISTRESS

• Encourage continued use of CR and explain it works in long-run
• Use analogies to help person understand it takes time to change thinking
• Shift towards acceptance/mindfulness based approaches
• Increase focus on functional goals
DISSOCIATION

• Conceptualize dissociation as early developed coping response to protect self against effects of overwhelming trauma
• Learned dissociative response to perceived threats becomes automatic
• Facilitate awareness of implicit negative feelings in situations where dissociation occurs
• Use CR to examine and address those identified feelings
CBT for PTSD program has potential to be helpful to a broad range of people with SMI who don’t typically receive treatment for their trauma-related problems.