Cognitive Behavioral Therapy (CBT) for Posttraumatic Stress Disorder: a short theoretical review

Elena Buneru

Private Practice, Clinical Psychology, Călăraşi, Romania

Abstract

DSM-5 includes the Posttraumatic Stress Disorder (PTSD) in the category of Trauma and Stressor-Related Disorders. This category includes disorders where an unfavorable event, of traumatic nature or not, precedes the mental disorder. Posttraumatic Stress Disorder is triggered by exposure to such stimuli as death, death threats, and serious injuries to one's person or sexual assault. It is either the direct experience of a traumatic event or witnessing one. However, the realization that a traumatic event occurred to a close family member or close friend (such as the threat of death, violent death or accident) might trigger PTSD. Moreover, PTSD is maintained by repeatedly reliving the trauma or even exposure to adversive stimuli of the traumatic event through media, images, pictures, videos, TV reports and movies. From a clinical point of view, the disorder causes significant stress with consequences in terms of changes in the individual's social interactions, work capacity and other functions.

Keywords: *Posttraumatic Stress Disorder, Diagnostic and Statistical Manual of Mental Disorders, traumatic event, Cognitive Behavioral Therapy, narrative trauma*

Corresponding author: Elena Buneru
Phone number: -
E-mail address: buneruelena@gmail.com

I. CHANGES IN THE DIAGNOSIS CRITERIA OF THE POSTTRAUMATIC STRESS DISORDER (PTSD) IN DSM -5

In contrast with Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, 1994), the depiction of a traumatic event becomes clearer, which is essential in the diagnosis of PTSD. Sexual aggression as a traumatic event is explicitly accentuated. The emotional reactions of the individual to the traumatic event may include: intense fear, absence of hope, affright. These diagnostic criteria of the PTSD in DSM-IV-TR (American Psychiatric Association, 2000) have been removed as they are not relevant to the PTSD diagnosis anymore. Particular attention is paid to behavioral symptoms divided into DSM-5 (American Psychiatric Association, 2013) into four groups against three groups as in DSM-IV-TR (American Psychiatric Association, 2000):

1. Reliving the events: the spontaneous occurrence of memories of the traumatic event, repetitive dreams, the so-called flashbacks or other stressful, repeated, prolonged mental manifestations.
2. Avoidance: it refers to avoiding stressful memories of the traumatic event, thoughts, emotional states or external stimuli that remind of trauma.
3. Negative thoughts or moods: it refers to emotions, so that stable, lasting, distorted feelings of self-deception or others may lead to estrangement from others, a decreased interest in daily activities that once were enjoyed until the inability to recall the key aspects of the traumatic event.
4. Hypervigilance and hyperexcitation: the person experiencing it is slightly offended and responds with aggression, reacting quickly to external stimuli, hence sleep disorders.

Thus, DSM-5 (American Psychiatric Association, 2013) emphasizes the fight-or-flight response associated with PTSD and cancels out the acute and chronic phase of PTSD. At the same time, the six months-length as a symptom is removed as a diagnostis criterion, the period of time for the symptoms being reduced from six months to more than one month.

Two new PTSD subtypes are included in the DSM-5:

- PTSD in children younger than 6 years;
- PTSD with prominent dissociative symptoms (either experiencing the feeling of detachment from one's body or own mind, or experiencing the feeling that the world is unreal, distorted).

The disorders considered post-traumatic reflect both biological predispositions and the social factors that shape the clinical presentation (McNally, 2009). Clinicians are familiar with this diagnosis, perhaps because it suggests an etiology and they understand that it is particularly complex. The definition offered in DSM-5 associates a supposed cause (a traumatic event) with a

set of characteristic symptoms. Criterion A describes the trauma: an event that either threatens life or can result in serious harm or rape. However, the diagnosis has been broadened, including the case of the patient only having heard of the traumatic event, which could increase the prevalence of PTSD.

Some authors consider that the nature of trauma responses can be materialized as a syndrome that reflects more intrinsic sensitivity than a reaction to life-threatening events (Mylle, & Maes, 2004). The disorder is characterized by four groups of symptoms: intrusion (trauma recurrence), avoidance (avoiding memories), alterations of cognition and mood, as well as increased excitability. All have to last more than one month.

Several trauma-specific theories explain how CBT can be helpful in reducing post-traumatic symptoms. For example, the emotional processing theory (Rauch & Foa, 2006) suggests that those who have experienced a traumatic event can develop objectively associations between the "safe memories" of the event (e.g. news, situations, people) and responses such as fear, or the numbness of feelings. Modifying these associations that lead to the unhealthy functioning of the individual is the core of emotional processing (Brewin, & Holmes, 2003; Bradley, Green, Russ, Dutra, & Westen, 2005).

The Social cognitive theory (of posttraumatic recovery) suggests that those who attempt to incorporate the trauma experience into existing beliefs about oneself and the others, are often left with unnecessary comprehension of the experiences, the self-control perception or the environment (self-efficacy coping). For example, if someone thinks that awful things happen to bad people and that only they can do such things (Benight & Bandura, 2004).

II. THE USE OF COGNITIVE BEHAVIORAL THERAPY IN POSTTRAUMATIC STRESS DISORDER

Cognitive Behavioral Therapy in the context of PTSD usually involves psychoeducation on trauma reactions, the use of relaxation training and the identification and modification of cognitive distortions (Foa, Keane, Friedman, & Cohen, 2009).

A variety of cognitive distortions are to be observed in PTSD, depending on the traumatic experience and the nature of the one's psychological state (Ehlers, Clark, Hackmann, McManus, & Fennell, 2005). Many survivors feel guilty, thinking that they could have done more in order to lessen the damage or to prevent the wounding or death of their loved ones, and some of them may have suicidal ideation (Ehlers, & Clark, 2000). One study also indicated that PTSD is associated with negative self-beliefs that can influence self-esteem and interpersonal relationships (Chung, Farmer, Grant, Newton, Payne, Perry, & Stone, 2002). PTSD often co-occurs with depression, both of which may share common risk factors. A possible common

cognitive risk factor is the absence of hope. In a study of female survivors that were victims of interpersonal violence, the relationship between the absence of hope and symptoms of PTSD was due almost entirely to the co-existence with depression (Mills, & Turnbull, 2004).

Thus, when PTSD and MDD (major depressive disorder) occur together, this may be a manifestation of underlying vulnerability to respond to behavioral and affective trauma (Post, Zoellner, Youngstrom, & Feeny, 2011). That is, people who report a high level of neuroticism are prone to react to stressors and daily challenges with anxiety, worry, irritability, and sadness (for example, negative affects). This style is invoked especially when the challenge involves loss, threat or frustration.

To such a degree, when exposed to a traumatic experience, the person who develops PTSD and has an internal-oriented personality type can be vulnerable to MDD development (Clak, & Beck, 1999). In support of this view, Spinhoven and colleagues (2014) examined the influence of neuroticism and extraversion on PTSD and MDD rates in a longitudinal study of over 2400 adults. The results showed that high neuroticism and low extraversion assessed at the baseline were associated with the development of comorbid PTSD and MDD four years later. Longitudinal research is needed to understand better the structure and etiology of PTSD (Spinhoven, Penninx, van Hemert, de Rooij, & Elzinga, 2014).

Spinhoven and colleagues (2014) also reported that the relationship between high neurosis - low extraversion and subsequent development of comorbid PTSD and MDD was fully represented by retrospective reports of sexual and physical abuse in childhood. A similar result was reported by Hovens and colleagues who found a strong correlation by association between retrospective reports of childhood physical abuse and mood disorders and comorbid anxiety in a large sample for adults (Hovens, Wiersma, Giltay, Van Oppen, Spinhoven, Penninx, & Zitman, 2010). Hence, childhood maltreatment, especially physical abuse, can mediate the association between the internalization dimension and the development of MDD/ PTSD (Hyer, 2013).

Cognitive therapy is based on fundamental theoretical reasoning: an individual's emotions and behavior are largely determined by how he/she believes and structures the world around him/her (Beck, 1979). CBT addresses both the issues of lack of control and inherent unpredictability in traumatic situations. Victims generally begin to experience the relief of symptoms and behavior as they begin to think and act more realistically and adaptive in terms of their situational and psychological difficulties (Foa, & Rothbaum, 2001; Foa, Keane, Friedman, & Cohen, 2009).

In children and adolescents with PTSD, it is noticeable that the effects are partially mediated by changes or modifications of maladaptive cognitions, as predicted by the cognitive PTSD models in CBT (Smith, Yule, Perrin, Tranah, Dalgleish, & Clark, 2007; Jones, & Stewart, 2007; Copeland, Keeler, Angold, & Costello, 2007).

It has been proposed that successful treatment of traumatic events comprises emotional involvement with the memory of trauma, organization of narrative trauma and correction of dysfunctional cognitions that often follow trauma. Imagery rescripting has been a part of CBT, especially for patients who struggle with painful, disturbing images in the treatment of PTSD (Arntz, Tiesema, & Kindt, 2007; Holmes, Arntz, & Smucker, 2007a). The results suggested that imagery rescripting during CBT is not critical to symptom reduction, but can promote conceptual processing, which in itself predicts a better outcome for the PTSD treatment (Arntz, Sofi, & van Breukelen, 2013).

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