Chapter 10

Post-traumatic stress disorder

Treatment

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INTRODUCTION

In this chapter, the evidence for the treatment of post-traumatic stress disorder (PTSD) following traumatic experiences in adulthood is briefly reviewed. The further aim is to provide clinicians with an introduction to practical strategies to treat people with PTSD following trauma as an adult. Ehlers and Clark's (2000) cognitive model of PTSD and the treatment derived from this are detailed. This includes the role of exposure/reliving and cognitive therapy for negative appraisals. The focus will be on those techniques that are most particular to PTSD, rather than on more general cognitive therapy strategies. Complicating factors in the treatment of PTSD are also considered.

WHAT TO DO SOON AFTER A TRAUMATIC EVENT

For many years clinicians have provided immediate treatment for people who have experienced traumatic events. The general term commonly used is 'debriefing'. This is taken to refer to asking the individual to recount in great detail what occurred during the trauma as soon as possible afterwards. It was seen as promoting emotional processing of the event. However, there is increasing evidence that individual debriefing in the immediate aftermath of a traumatic event is at best of no benefit or at worst positively harmful (Rose and Bisson, 1998; Mayou et al., 2000). The original conceptualisation of debriefing was for ready-formed groups of people who had all experienced the same event, such as emergency service personnel. There are no studies of group debriefing that provide firm evidence whether it is in fact beneficial or harmful.

The current accepted clinical wisdom is to provide advice and support after a traumatic event. People should be encouraged to access their usual supports and to look after themselves physically and psychologically. This includes regular eating and sleeping, maintaining valued activities and limiting alcohol

and drug use. In addition, specific information about reactions to traumatic events should be provided, both verbally and in written form. This aims to normalise common early reactions, such as intrusive memories, nightmares, hyper-vigilance and numbness. Formal treatment should not be provided until at least about 4 weeks post-trauma.

PHARMACOLOGICAL TREATMENT OF PTSD

There are a limited number of controlled trials of medication for PTSD and no controlled trials that examine a combination of medication and psychotherapy (Nagy and Marshall, 2002). Selective serotonin re-uptake inhibitors (SSRIs) are currently the only medication with data to support an indication for PTSD. Paroxetine and sertraline are the only ones licensed in the UK. They should be given in similar dosages as used for depression and response is gradual. Improvements may be seen at 3–4 weeks and continue over 8–12 weeks. Improvement is usually partial and there are no data guiding the length of treatment (Nagy and Marshall, 2002).

PSYCHOLOGICAL TREATMENT OF PTSD

Exposure-based treatments are the most effective for PTSD (Foa et al., 2000; National Institute for Health and Clinical Excellence (NICE), 2005). These involve discussing the details of the traumatic event, usually many times, and often listening to the audiotapes of such sessions, or writing a narrative of the experience. There are a number of different versions of such treatment. The traditional explanation for their effectiveness is due to 'emotional processing' of the memory and habituation to the anxiety associated with it.

In addition, there are brand-named treatments, which are also exposure based, such as Eye Movement Desensitisation and Reprocessing (EMDR; Shapiro, 1995). EMDR is a well-structured treatment that includes therapist-directed saccadic eye movements while the client holds images of the traumatic event in mind. Practically, the therapist moves his or her fingers or some other cue back and forth in front of the client to direct the eye movements. However, 'EMDR appears to be no more effective than other exposure techniques, and evidence suggests that the eye movements integral to the treatment, and to its name, are unnecessary' (Davidson and Parker, 2001). Adherents of EMDR would refute such findings. EMDR and other novel trauma treatments are sometimes referred to collectively as 'power therapies', as they make claims to cure PTSD in a single session or very few sessions. There is little evidence that these treatments are more effective than existing exposure-based treatments and the effects seen may be explained due to the exposure components of the protocol (Lohr et al., 2003).

Studies have investigated the role of cognitive restructuring in the treatment of PTSD, as excessively negative appraisals of threat are a feature of PTSD. Two found no differences between exposure, cognitive restructuring and a combination of the two (Marks et al., 1998; Tarrier et al., 1999). These studies show that cognitive therapy alone, without explicit exposure instructions, can be an effective treatment for PTSD. A further study indicates that cognitive restructuring in combination with imaginal exposure may enhance treatment gains (Bryant et al., 2003).

More recently, Ehlers and Clark (2000) have proposed a newly synthesised cognitive model, described below, which provides specific treatment implications. Their treatment approach results in the largest treatment effect sizes seen in the field (Ehlers et al., 2003, 2005). Importantly, their approach has also been disseminated to frontline health service therapists without any reduction in effectiveness (Gillespie et al., 2002).

The studies above focused on the experience of a single, or a few, traumatic event(s). Far fewer studies have examined the treatment of multiple or prolonged traumatisation. Those that exist investigate the use of exposure-based treatments for refugees and asylum seekers, and suggest that these treatments can successfully be used in such populations (Paunovic and Ost, 2001)

COGNITIVE THERAPY FOR PTSD

Harvey et al. (2003) provide a general review of cognitive behaviour therapy for PTSD. This chapter focuses on the Ehlers and Clark's (2000) model, as the treatment derived from it is highly effective, as noted above. An alternative, but similar, cognitive model is Brewin's Dual Representation Theory (Brewin et al., 1996; Brewin, 2001, 2003) and is directly compared to Ehlers and Clark's (2000) model in Brewin and Holmes (2003).

Ehlers and Clark (2000) suggested that PTSD becomes persistent when traumatic information is processed in a way that leads to a sense of serious *current* threat. This can be a physical threat and/or a psychological threat to one's view of oneself (Figure 10.1).

Due to high levels of arousal at the time of the trauma, the trauma memory is poorly elaborated and poorly integrated with other autobiographical memories, and can be unintentionally triggered by a wide range of low-level cues. In particular, there is no 'time-code' on the memory that tells the individual that the event occurred in the past. Thus, when the memory intrudes, it feels as if the event is actually happening again to some degree.

The persistence of the sense of current threat, and hence PTSD, arises from not only the nature of the trauma memory but also the negative interpretations of the symptoms experienced (e.g. 'I'm going mad'), the event itself (e.g. 'It's my fault'), and sequelae (e.g. 'I should have got over it by now',

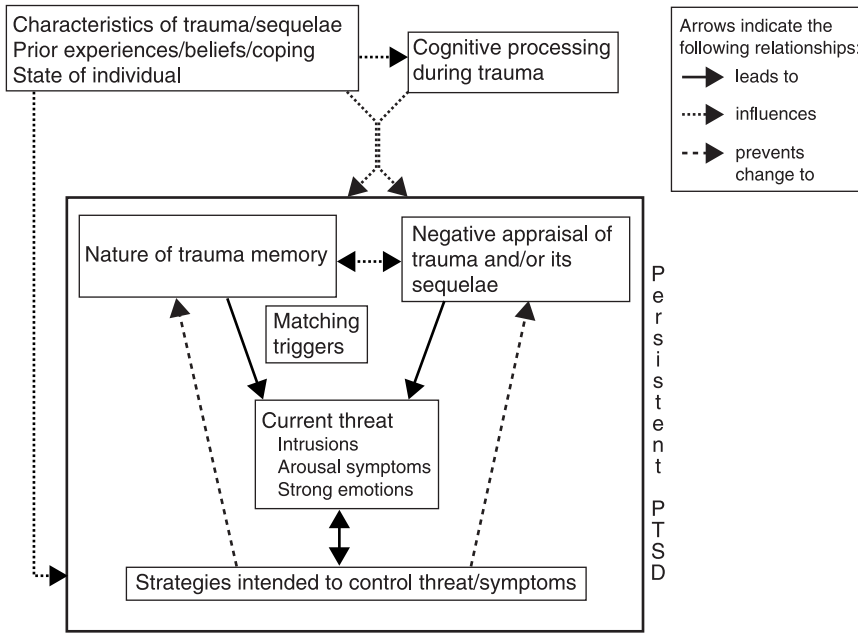

Figure 10.1 Cognitive model of post-traumatic stress disorder (PTSD).

Reprinted from Ehlers and Clark (2000), with permission from Elsevier.

'Others don't care about me'). Change in these appraisals and the nature of the trauma memory is prevented by a variety of cognitive and behavioural strategies, such as avoiding thoughts and feelings, places or other reminders of the event, suppression of intrusive memories, rumination about certain aspects of the event or sequelae, and other avoidant/numbing strategies such as alcohol and drug use.

The aim of treatment derived from Ehlers and Clark (2000) is therefore threefold:

1 To reduce re-experiencing by elaboration of the trauma memory and discrimination of triggers, and integration of the memory within existing autobiographical memory.
2 To address the negative appraisals of the event and its sequelae.
3 To change the avoidant/numbing strategies that prevent processing of the memory and reassessment of appraisals.

A wide range of both general and PTSD-specific cognitive-behavioural interventions can be used to achieve such changes (Ehlers and Clark, 2000; Ehlers et al., 2005; Mueller et al., 2004).

Overall structure and therapy context

The therapeutic relationship is of utmost importance when working with people who have experienced traumatic events. The provision of a safe environment, both physically and psychologically, is paramount. This includes factors such as client choice of therapist gender. The therapist must clearly demonstrate empathy and be comfortable with hearing about traumatic experiences in some detail (the effects of which are discussed later). Treatment sessions should be 90 minutes long, as talking about the trauma may take some time and the client may become very distressed. All sessions are audio-taped for the benefit of the client, who listens to them for homework in order to consolidate discussions from within the session. Other exposure-based treatments also audio-tape the detailed discussion of the trauma in order for the client to repeatedly listen to it.

In the Ehlers and Clark group, after initial assessment, clients are offered 12 weekly 90-minute sessions followed by three sessions on a monthly basis. Following assessment, the first one or two sessions cover normalisation of symptoms, starting 'reclaiming your life' and the formulation and rationale for reliving. The next session will include reliving of the trauma and identification of hotspots and peri-traumatic cognitive themes. Following this there is an interleaving of work on the trauma memory directly, such as reliving, use of a written narrative, discrimination of triggers and *in vivo* exposure, and work on changing excessively negative post- and peri-traumatic appraisals using cognitive therapy techniques.

Initial interventions

Providing information

The first intervention for PTSD is to provide information about the disorder and the symptoms experienced both verbally and in written form. This helps normalise the symptoms experienced, address particular misinterpretations of symptoms such as 'I must be going mad' and validate the client's experience.

A general treatment rationale is provided for the patient based on the cognitive model outlined above. This is individualised to the particular symptoms that are most prevalent and distressing for the client, and covers each of the three main areas of the model: differences in memory, negative appraisals and unhelpful coping strategies. This can be done partly in the form of metaphor as described below. For some people it can be helpful to more fully describe the potential differing memory systems in PTSD and processes underlying the phenomena (Ehlers and Clark, 2000; Brewin, 2001).

Reclaiming your life

Following traumatic events, people often withdraw from activities they previously enjoyed and/or valued. This results in a loss of pleasure and may also contribute to a sense of being 'in limbo' or 'stuck' in their lives. It is helpful to identify any areas of the person's life that have changed, such as relationships with friends and family, work, exercise and other leisure activities, and to restart some activities as soon as possible, such as spending some time playing with the children, going for a run, going back to bingo with friends. 'Blocking' cognitions such as 'I won't enjoy it', 'It won't be like it used to be', 'They won't want me there' can be tested in the form of a behavioural experiment (Mueller et al., 2004).

Thought suppression

An important early intervention is to discus the role of thought suppression. This is best done experientially (from Ehlers and Clark, 2000):

Therapist: Let's look at the effect of deliberately pushing thoughts out of your mind. For the next couple of minutes I want you to think about whatever you want except one thing. I want you to make sure that you don't think about a green rabbit sitting on my head [or some idiosyncratically meaningful memorable image]. Now make sure you're not thinking about it . . . still don't think about it . . .

Invariably, people have the image come into their mind. This leads into a discussion that active suppression increases intrusions and decreases perceived control. Further discussion should identify that this strategy does not allow the memory to be more fully processed and that it will be important to allow the memory to pass through one's mind. An analogy can be drawn between the intrusive thoughts and memories with a train passing through a station. Rather than standing on the tracks trying to push the train back to prevent it coming into the station the person should be like a detached observer on the platform noticing the train pass in and pass out of the station (their mind). Such a mindful approach should be encouraged from the start of treatment. The train analogy can be extended to rumination, which is akin to jumping on the train and closely examining all the parts (and hence thoughts about the trauma).

Elaboration/processing of the trauma memory

A number of strategies can help elaborate and process the trauma memory. The most used is prolonged exposure, also known as reliving. Other

complementary approaches are constructing a written narrative, *in vivo* exposure and working on the discrimination of triggers.

Reliving/exposure

This has a number of functions, which may be seen as 'processing' the memory. Overall, it allows for reconstruction of fragments and elaboration of the memory. Within a cognitive framework it allows access to meanings that are contained within the trauma memory and that may not be ordinarily accessed during more general discussion.

Although exposure/reliving is a very successful treatment for PTSD, it is a frightening prospect for people and a clear rationale must be provided. The first stage of this is to use the person's individual circumstances and information concerning all of the possible maintaining factors, fitting within the model as discussed above. This should lead to some understanding as to why talking about the trauma may be helpful. Socratically presented metaphors are also useful to explain this and can be elaborated to account for the particular circumstances of each client (Richards and Lovell, 1999; Ehlers and Clark, 2000). Two examples are provided below:

Therapist: The memory can be compared to a duvet cover that has just been stuffed into a linen cupboard and it keeps making the door pop open. What needs to happen is for you to take out the duvet, fold it up properly, make space for it in the cupboard and then put the duvet back in so that the door doesn't pop open.

Therapist: Processing the memory is like it going down a conveyor belt before being stored away with normal memories in a filing cabinet. Those memories in the filing cabinet you have more control over and can bring them out when you want to. At the moment every time the memory comes back onto the conveyor belt, when it pops into your mind, you just push it off not allowing it to be fully processed.

Before starting reliving, the moment that the event started or 'became traumatic' for the client should be ascertained, and also when he or she felt safer again. It may have continued to be traumatic during time in hospital or getting to a place of safety. The person is asked to describe the event from shortly before the agreed start in as realistic a way as possible. Clients are asked to close their eyes, imagine the events clearly and to talk in the first person and present tense. They are encouraged to provide information on all senses and also the emotions and thoughts experienced (Foa and Rothbaum, 1998).

During the first reliving it is usually best to allow the patient to describe the

whole event without much questioning or interruption, while still being attentive, supportive and encouraging. If people do not give much detail, cue in information with occasional questions: 'What can you see, hear, smell?', 'What are you feeling?' They can be helped to remain in the present tense by repeating any statements in the past tense again in the present tense: 'I was walking down the street' to 'So, you *are* walking down the street'.

During or after the reliving, ratings (0–100%) of distress and vividness of the imagery should be taken as a guide. After the reliving, a number of questions should be asked:

'How did you find that?'
'How did it compare to how you predicted?'
'Were there any changes or differences to how you remembered it before?'
'Did anything surprising come up?'
'Were you holding back at all?'
'What were the worst moments?'

For homework, the person is asked to listen to the tape of the reliving each day if possible, rating the distress each time, and any other information he or she thinks is significant.

A number of authors have highlighted the need to focus on the moments of highest emotion experienced during the traumatic event, referred to as 'hotspots' (Foa and Rothbaum, 1998; Richards and Lovell, 1999; Ehlers and Clark, 2000; Grey et al., 2002). Treatment failures with the use of reliving alone may be as a result of not directly addressing peri-traumatic (within-trauma) appraisals. Equally, cognitive therapy in a non-reliving session is very helpful for post-traumatic negative appraisals but it is unlikely to affect the emotions and cognitions experienced peri-traumatically, as these structures are accessed only during reliving. Thus there is a need to explicitly address the meanings attached to these hotspots and use this information to 'update' the traumatic memory during reliving, including the information that the event occurred in the past – providing a 'time-tag' for the memory (Ehlers and Clark, 2000).

The cognitive restructuring of these hotspots follows the outline given below:

- Initial reliving.
- Identify peri-traumatic hotspots during reliving: ask what were the worst moments and observe any indicators of affect change and ask about those moments.
- Identify the associated cognitions/meanings ('What was going through your mind at that moment?', 'What does that mean to you?').
- Outside of reliving, discuss these meanings and use cognitive restructuring to address distortions in the appraisals. This may take some sessions in the case of particular self-evaluations, such as 'I'm weak' and 'I'm to blame'.
- Discuss that these new meanings are needed to help update the trauma

memory (see Grey et al., 2002) and rehearse the specific cognitive reappraisals and at which points they will be introduced.
- Begin reliving again, either of the whole event or focusing only on a particular hotspot.
- Ask the client to hold the hotspot vividly in mind and prompt the person to bring in the 'new' (and rehearsed) information into their mind in order to update the previous meaning. This can be done either verbally or with an image that conveys the new meaning.

Mark had been raped and presented with classic PTSD symptoms, including nightmares each night. During the first reliving he went very quiet at one point and looked downwards for a few moments before continuing his narrative. After completing the reliving I asked him what had been going through his mind at the moment that he had gone quiet. He looked downwards again and remained silent. I said that it was very common for men who are raped to get an erection themselves and asked whether this had happened to him. Mark looked up, appearing surprised. He said that that was what had happened to him at that moment. The particular meaning for him was that it must have meant that he wanted it to happen and that it must mean he is gay. I gave him further information about physiological responses to sexual assault. After this he said that he no longer believed that he had wanted it to happen or that it meant that he was gay. He listened to the tape of the session for homework. However, at the next session he reported that he had continued to have his nightmares and that it was always of that moment during the rape when he had an erection. In his nightmares, and when he had flashbacks to it, he still believed that he must have wanted it to happen. A theoretical understanding of this is that although the discussion about normal physiological responses to rape had affected his beliefs in his normal autobiographical memory they had not affected the meaning held in the differently stored and processed trauma memory. Thus it was necessary to explicitly update this traumatic memory in order to change the meaning of this hotspot. A table was drawn up of all the hotspots experienced together with updates of what he knew now in reality, which followed from discussion and cognitive restructuring outside of reliving (Table 10.1).

Mark then began the reliving again and at each hotspot he was guided to bring in the new updated (and rehearsed) information by asking at the appropriate moment in the narrative 'And in reality what is the case' 'What do you know now?':

Table 10.1 Mark's hotspots

Situation	*Cognition*	*Emotion*	*Update ('What I know now')*
At gunpoint	They're going to shoot me and kill me	Terrified	They don't shoot me. I don't die
Get an erection when penetrated	I must have wanted this to happen. I must be gay	Ashamed	It's a normal physiological response. It doesn't mean I wanted it to happen. It doesn't mean I'm gay
Left on floor at end	I should've known this would happen. It's my fault	Guilty	It's not my fault. I couldn't've known what was going to happen. [They] are to blame. They are bad people

Therapist: What is happening now?
Mark: They are standing next to me. I can see the gun pointing at my head. I'm shaking. I'm really afraid they are going to kill me.
Therapist: And in reality what is the case?
Mark: They don't shoot me . . . I don't get killed . . . [with some surprise evident in his voice] . . .
Later . . .
Therapist: What is happening now?
Mark: I am being penetrated. I am getting an erection. [looks downwards]
Therapist: Holding this image clearly in your mind, how do you feel right now?
Mark: Really bad.
Therapist: What do think this means?
Mark: I must have wanted it to happen. I must be gay.
Therapist: And in reality what is the case?
Mark: It's common to get an erection if you are raped. It doesn't mean I'm gay. I didn't want it to happen.
Therapist: That's right . . . and now what is happening?
And so on . . .

Following this reliving, Mark reported that he felt strongly relieved at the moment he brought this new information about the erection into his mind. He listened to the tape with this 'updated reliving' for homework. The following session he reported a decrease in the frequency and severity of the nightmares and flashbacks. Grey et al. (2002) give a number of further examples of this procedure with therapy transcripts.

Caution should be used with reliving when there is an objective ongoing threat and when the person is unable to effectively process information. Some established sense of safety is a requirement to allow the memory to be 'put in the past'. If people are still in a situation in which they are at genuinely high objective risk of further traumatic events, such as in ongoing abusive situations, practical safety should be ensured first. An inability to effectively process information during the session may occur for various reasons. One common reason is alcohol or drug abuse and/or dependence. Second, if the client dissociates very easily then no effective processing can occur and grounding strategies will be important (see below). Third, if the person is extremely depressed it may be necessary to lift his or her mood at least somewhat before using reliving techniques.

Written narrative

It can also be helpful for the client to write a narrative account of the trauma (Resick and Schnicke, 1993). This may be particularly helpful in those with prolonged duration of trauma or with a very confused or fragmented memory of the trauma. It can be done either for homework or together with the therapist in the session. Ideally, the narrative should be in the present tense. Commonly, clients will also include their thoughts about the consequences of the trauma or questions and issues that they dwell and ruminate on. It is important to help the client identify which parts of the narrative are ruminative (i.e. post-traumatic) and which are truly peri-traumatic. The points at which they became most emotional when writing the account can identify hotspots. The narrative at these points can then be expanded with further details, in particular the emotions and thoughts and meanings. Discussion and cognitive restructuring of these meanings can then be later added to the narrative. To make it clearer these sections can be written in different colour ink or a different font used on a word processor. For example:

> They are holding me down and one of them penetrates me. I can feel pain. I get an erection. I feel really bad and think that this must mean that I am gay and want this to happen. But I know now in reality that this is a

normal physiological response and it does not mean that I am gay or wanted it to happen. They continue . . .

Restructuring images

This chapter cannot do this topic justice. Images can contain a wealth of meanings not easily verbalised and changing images or introducing new images has the aim of changing meanings (Hackmann, 1998). Imagery can be used to update a trauma memory in a similar fashion to verbal restructuring and updating. For example, individuals who feared during the traumatic event that they would never see their children again can bring into their mind an image of their children as they are now at that point of the reliving. Another use of imagery is to try to gain a new perspective on the event. If someone is inappropriately guilty about what they did or didn't do, it can be helpful if he or she runs through the event from an observer's perspective in imagery, and then be asked whether or not that person could have done anything different and who is truly responsible? Actions *not* taken can be explored in imagery. For example, a man who thought he should have fought back against his attackers vividly imagined in the session what would have occurred if he had. He realised that things would have probably been very much worse for him if the level of violence had escalated.

Discrimination of triggers

Trauma memories, which feel as if they are being relived, often appear to come out of the blue. However, careful questioning may identify triggers. These may be a match of sensory information or emotions experienced at the time of the trauma. It is helpful for the client to keep a diary of flashbacks and intrusions in order to identify the possible triggers. This can increase the sense of control over the re-experiencing symptoms.

For example, Dawn, a pedestrian, was hit by a car that mounted the pavement on a dark and cool evening. Her main intrusive memory was seeing the headlights of the car. One day she had a severe flashback when she opened her fridge door. This was initially inexplicable to her and she was frightened that she was 'losing it'. On discussion, she realised that unusually on this occasion her fridge had been empty and hence she could see the light at the back of the fridge very clearly. This, together with the blast of cold air, was enough to trigger the memory of her accident. This understanding eliminated her belief that this showed she was 'losing it'. We explicitly wrote out the similarities and differences of these situations as in Table 10.2.

The homework following this session was deliberately to open her empty fridge and, if the memory was triggered, explicitly remind herself of all the differences to the accident. This allowed her to gain control and not experience further flashbacks in this situation.

Table 10.2 Discriminating triggers: 'then' versus 'now'

Then	*Now*
Cold air	Cold air
Light in front of me	Light in front of me
Car coming towards me	Just the fridge
Outside on the pavement	In my kitchen
In danger	Safe

This approach can be used in a wide range of situations that may act as reminders and helps to update the memory with a 'time-code' that it is happening in the past rather than again right now. The overall procedure is:

- Identify the trigger and the similarities between this situation and/or object and the traumatic event.
- Identify explicitly all the differences between the traumatic situation and the current situation in which the memory is triggered. In particular, focus on the fact that the current situation is safe.
- Deliberately trigger the exact bit of the trauma memory. A variety of cues can be used, such as visual cues, sounds or even physical posture.
- When the memory is triggered, the person should explicitly remind him- or herself of what is different now, both verbally and physically, by acting in ways that he or she was unable to at the time. For example, if the person was trapped during the event, he or she can stand up and move around when the memory is triggered.

Revisiting the site of the event

If it is practically possible, it can be very helpful to accompany the client back to the site of the traumatic event, even if reliving and other memory-focused techniques have been successfully used. Commonly, this will occur in the second half of a 12-session treatment programme.

Clients often report that the site does not appear the same as it is in their memory, and they are often surprised at changes that may be present (such as changes to road layout, or simply different weather). Identifying these differences can be useful to help the discrimination between what was happening *then* versus what is happening *now*. New memories or further aspects of the trauma may also return. The procedure can be set up as a behavioural experiment, first identifying the beliefs about what would happen if they do re-visit the site (such as 'I'll go mad' or 'I'll be attacked again', etc.).

It can also help clarify confusion and to work out how an event may have occurred. For example:

John was attacked after he had been drinking. He had a very patchy memory of what occurred, with many gaps, and much confusion about both chronological order and how events unfolded. Prior even to reliving we visited the area where the attack occurred. Whilst very distressing, it allowed John to recall a couple of further fragments, and for us to piece together a possible account of events, given the geography of the area. He continued to have gaps in memory but felt relieved that he had a plausible narrative for the attack and he felt more in control of his symptoms.

Cognitive restructuring negative appraisals

The restructuring of negative appraisals in PTSD can proceed in the same manner as any other cognitive restructuring. Some specific reactions in PTSD are highlighted below.

Guilt

Guilt is common in PTSD. People may feel guilty about the fact that the event happened at all, the fact that they survived while others didn't, and most commonly about what they did or did not do during the event. Usually, people are displaying a hindsight bias, when knowledge about the outcome of the event biases or distorts beliefs about knowledge possessed before the outcomes were known. In addition they discount other explanations for events and any positive actions they may have done.

A large number of well-established cognitive therapy strategies can be used to address guilt, including the use of a pie chart to examine relative responsibility for the event. Socratic questioning is used to address the hindsight bias, violation of personal standards and emotional reasoning (Kubany, 1998).

Shame

People may feel shame about what actually happened, how they reacted at the time and about the development of symptoms. Clients rarely report the things that they are most ashamed of early in treatment. It is only with the establishment of an empathic, trusting relationship that shame can be addressed. However, there are some common reactions during trauma that people may feel ashamed of that can be helped with education and normalising. For example, people may wet themselves when very frightened, and may become aroused during a sexual assault. Shame may be spotted in a session

through possible behavioural indicators, such as gaze aversion and silence. The underlying meaning of these moments needs to be addressed. Sometimes they may be linked to long-standing negative beliefs about the self such as 'I'm weak' or 'I'm unworthy'. Work by Gilbert is very helpful for working with shame (e.g. Gilbert, 1999). In addition Lee et al. (2001) provide helpful clinical models of shame-based and guilt-based PTSD.

Anger

People with PTSD are often angry at what others did or did not do, both during the experience and following it. In such situations it is important to first very clearly empathise with the person, without rushing in to challenge or change things ('*I'd be angry*', '*I'm not surprised you're angry*', '*It* is *unfair*'). The person should be allowed time to explain exactly who and what his or her anger is focused on. To aid this it can be helpful for the person to write a letter to those he or she is angry with, explaining the effects of the trauma. This letter need not be sent.

If the person is angry at the behaviour of others during and after trauma, explanations for a person's behaviour can be explored. *Distorted* assumptions, such as those about malicious intent, can be challenged *if appropriate* (such as 'they deliberately drove the car into me') once the whole context and information is taken into account. Rigid standards that lead to anger ('no one should ever make a mistake driving') can be addressed with traditional cognitive therapy. Anger may be masking shame or humiliation, particularly in interpersonal trauma.

A crucial approach is to challenge assumptions about letting anger go: '*If you weren't angry what would that mean to you?*'. Common beliefs are that the event will be forgotten or that the perpetrator will have 'got away with it'. Socratic questioning around these assumptions can follow the line '*And how does remaining angry stop this?*'. Finally, a functional approach can be taken: '*Who wins if you remain angry?*'. People can take a conscious decision to stop someone else controlling their life. Equally, it is understandable if people remain angry following a trauma – it is only if it continues to interfere with their life that it remains a concern (Chemtob and Novaco, 1998).

Overgeneralisation of danger

People with PTSD feel that further bad events could happen at any time. They overestimate risk in situations where the objective risk has not changed. Strategies include evaluating the actual risk using sequential probabilities '*How many times have you driven in the past?*', '*How many accidents have you had*?', etc. This can lead to developing behavioural experiments to test out their predictions. The aim is to help people make a fairer assessment of risk,

and to learn to live with that. The role of deliberate hypervigilance can be highlighted by asking people to be hypervigilant in a non-trauma-related situation to investigate the effect of hypervigilance on their level of anxiety. For example, somebody who has been assaulted can be asked to stand by a roadside and look for any signs of road danger – this hypervigilance invariably leads to increased anxiety.

Common additional problems

Rumination

Rumination is common following trauma. The content of rumination is often addressed when addressing the cognitions underlying guilt, shame and anger. In addition, it is also important to address the process of rumination and the possible beliefs that underlie it by discussing the pros and cons of continuing to ruminate. 'Banning' rumination, using distraction or later 'worry' time, may be an initial intervention.

Dissociation

Broadly, dissociation is a sense of detachment or a compartmentalisation of experience. It includes experiences such as day-dreaming, spacing out, feeling unreal or dreamlike and out-of-body experiences. Flashbacks are truly dissociative when the person loses the sense of where they are in reality and act as if the traumatic event is actually happening again. In these cases, 'grounding' strategies should be developed to maintain an awareness of 'here and now'. This can include the use of grounding objects, images, smells and phrases (Kennerley, 1996). The work on discriminating triggers also will help in this regard. Wagner and Linehan (1998) provide further approaches to work with dissociative behaviour. If the client fully dissociates during reliving it precludes any processing of new information into the trauma memory. They should be 'grounded' by telling them repeatedly where they are in reality, what is happening, and they are safe. They should not be physically touched unless this has been discussed in advance. A more graduated approach to addressing the trauma memory such as using a written narrative and keeping the eyes open during reliving can be adopted.

Physical injuries

Physical injuries following a traumatic event are often associated with more persistent PTSD symptoms. Within treatment, the meaning of injury both now and in the future should be identified. Any *distorted* sense of permanent change can be addressed while empathising for the losses that the person has experienced, and the associated grief. For distorted appraisals regarding

others' beliefs and reactions to scars, etc., social phobia treatment techniques can be employed (Clark and Wells, 1995).

Panic attacks and co-morbid panic disorder

Panic attacks occur only on exposure to trauma-related triggers, or else a separate panic disorder may be present. Specific treatment for the panic attacks may be necessary prior to, and concurrent with, PTSD treatment so that people are willing to tolerate raised affect during reliving and other procedures. This can be well integrated within the overall cognitive therapy approach (Falsetti and Resnick, 2000).

Substance misuse

It is important to help people see the maintaining role of the misuse of alcohol and other substances. Treatment will not work if people are not able to do the necessary cognitive and emotional processing. Usually, dependence on alcohol or drugs will require specific treatment prior to PTSD treatment (although see Najavits, 2002, for treatment of co-morbid PTSD and substance misuse).

Further information

It may be important to obtain further information to discuss with the client. For example, some people who initially are not cut out of their car in an accident by the first emergency services to arrive at the scene perceive this as others not caring, whereas in fact it may have been due to a fear of back or neck injury or waiting for the correct cutting equipment. Information about the nature and effects of alcohol and certain drugs, e.g. following drug-rape, may help make sense of memory gaps or confusion and disorientation at the time of the trauma. Some confusion or disorientation during hospitalisation may occur when given medication.

Court proceedings

Ongoing court proceedings are not a contra-indication for treatment but may be obstacle. It may be maintaining specific beliefs, particularly underlying anger. An open discussion about the effect of treatment on any financial settlement, and the pros and cons of delaying treatment, might be necessary. If the person is a witness in criminal proceedings, it is wise to check with the solicitor that starting treatment now is acceptable, and not seen as 'coaching' of the story.

PROLONGED AND MULTIPLE TRAUMATISATION

A detailed analysis of how to flexibly alter treatment in more complicated traumatic stress presentations is beyond the scope of this chapter. All treatment approaches for this group can be summarised by the framework presented by Herman (1992), which was initially developed to help adult survivors of childhood abuse. First, a sense of safety must be established. Second, work on recollecting and understanding the nature of the traumatic event, which includes any reliving work. Third, reconnection to people, communities and the world. Within this framework the specific techniques described above can be used. Kimble et al. (1998) present a phasic model of treatment for complicated PTSD that focuses on when to apply particular techniques. Possible treatment guidelines for refugee and asylum-seeker populations have been provided by Van der Veer (1998) and Young and Grey (2004).

EFFECTS ON AND EFFECTS OF THE THERAPIST

The therapist's reactions can be examined on a number of levels. First, the immediate counter-transference and assumptions evident in the session. Even many experienced therapists do not use exposure-based treatments much of the time, even though they are the best treatment for PTSD (Becker et al., 2004). Therapists may have concerns about their own skills and/or inaccurate beliefs, such as 'they'll be re-traumatised'. Second, there are the general effects on therapists of providing psychological therapy encompassed by terms such as 'emotional exhaustion', 'compassion fatigue' and 'burn-out'. These refer to a general sense of no longer being able to empathise with the client and not experiencing any personal accomplishment in one's work. Third, and more specific to working with people who have experienced traumatic events, there is the possibility of secondary PTSD or vicarious traumatisation. On hearing and discussing traumatic events it is common and normal for the therapist to experience intrusive memories or bad dreams related to the client's experience.

Like clients, therapists should not suppress such intrusions. More generally, it is important for therapists to look after themselves. In addition to formal supervision, it can be helpful to have a colleague that you can simply 'off-load' to straightaway after a difficult session. It is important that therapists not only receive training in treatments for PTSD but that they also receive ongoing supervision. This can address the problems that arise in applying such treatments and also the therapist's own concerns about what may occur. In addition the therapist's own emotional reaction should be a standard part of supervision.

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