

Effective Treatments for PTSD¹

Since approximately 1990, treatment research with PTSD victims has blossomed. A number of psychological treatments are very helpful, and some pharmacological treatments, mostly anti-depressant medications, show at least some short term benefit.

The type of treatment that has received the most consistent support in research studies is cognitive behavioral therapy (CBT), usually including a procedure called prolonged exposure. Prolonged exposure is, as it sounds, a treatment that involves the client repeatedly “reliving” the memory of the traumatic event for lengthy periods of time (e.g., an hour or more) until his/her anxiety diminishes. Within CBT treatment protocols, prolonged exposure is often combined with graduated in vivo exposure exercises in which the client places him/herself in situations that he/she typically avoids because of fear, but which are objectively safe. For example, motor vehicle accident (MVA) victims with PTSD often suffer a residual fear of car travel. In vivo exposure exercises in this case involve driving (or riding as a passenger) repeatedly through situations (e.g., unmarked intersections, highway on-ramps) that the individual fears.²

Forms of cognitive therapy are also often used in treating PTSD, including exercises to develop a more adaptive and realistic perception of threat or to re-evaluate one’s own responsibility for a traumatic event (e.g., sexual assault) and the implications of trauma exposure to one’s future life.³

Most experts in the CBT treatment of PTSD believe that two changes are necessary for PTSD clients to show clinical improvement. The first necessary change is reduced avoidance behavior. Avoidance behavior may be overt (e.g., reduced driving in cars, avoidance of men in women with rape-related PTSD), or covert (avoidance of memories). The “reliving” exercise described above is meant to reduce covert avoidance and the in vivo exposure exercises are meant to reduce overt avoidance. Overcoming avoidance through exposure exercises is an emotionally-draining task because it requires clients to tolerate high levels of anxiety during treatment in order to reduce the fear response in the long term. Some PTSD clients drop out of therapy during exposure therapy because of difficulty tolerating high levels of arousal. Nonetheless, exposure exercises like these are the first line of treatment for people with PTSD symptoms.

The second necessary change for successful treatment is to enable the client to change his/her “appraisals”, which maintain a sense of danger. These appraisals may be about the trauma survivor him/herself. For example, he/she may permanently changed for the worse. Sexual assault victims may feel themselves unworthy to have a rewarding intimate or family life or that they are stigmatized. MVA victims with physical injuries may view their entire lifestyle and self-image to have changed because of trauma-related

¹ Copyright © 2001 by William J. Koch, Ph.D.

² Koch, W.J. & Taylor, S. (1995). Assessment and treatment of motor vehicle accident victims. *Cognitive & Behavioral Practice*, 2, 327-342.

³ Resick, P.A. & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology*, 60, 748-756.

change in physical functioning. Trauma victims may also feel they are ineffectual in coping or defending themselves, thereby becoming hopeless about positive change in their lives. Very frequently, trauma victims come to believe that certain activities (e.g., car travel, dating men) are much more dangerous than previously assumed, and adopt excessively high levels of vigilance for specific types of threat. Finally, trauma victims are often disappointed in the safety net provided by society. They may come to believe that family, friends, employers, or insurance companies are non-supportive or adversarial. Such cognitive change is not always easy because a number of societal and social influences may reinforce trauma victims' maladaptive beliefs (e.g., "There are so many bad drivers out there.", "I can not protect myself." "No man can be trusted.").

CBT treatments can be effective for a large proportion of PTSD sufferers in 15 or fewer hours of therapy.⁴ Despite our increasing knowledge of treatments that work, a number of PTSD sufferers do not improve with current treatments. For example, individuals who have chronic pain conditions resulting from the same trauma that precipitated their PTSD show less improvement.⁵ Individuals who are more severely depressed⁶, have high levels of anger about the trauma also do worse in treatment.⁷ Therefore, treatment research continues to develop more effective treatments to provide more efficient treatments and to help individuals who do not currently benefit from available treatments.

⁴ For example; Fecteau, G. & Nicki, R. (1999). Cognitive behavioural treatment of post traumatic stress disorder after motor vehicle accident. *Behavioural and Cognitive Psychotherapy*, 27, 201-214.

⁵ Taylor, S., Fedoroff, I.C., Koch, W.J., Thordarson, D.S., Fecteau, G., & Nicki, R. (in press). Posttraumatic stress disorder arising after road traffic collisions: Patterns of response to cognitive-behaviour therapy. *Journal of Consulting and Clinical Psychology*.

⁶ Taylor, S., Fedoroff, I.C., Koch, W.J., Thordarson, D.S., Fecteau, G., & Nicki, R. (in press). Posttraumatic stress disorder arising after road traffic collisions: Patterns of response to cognitive-behaviour therapy. *Journal of Consulting and Clinical Psychology*

⁷ Foa, E.B., Riggs, D.S., Massie, E.D., & Yarczower, M. (1995). The impact of fear activation and anger on the efficacy of exposure treatment for posttraumatic stress disorder. *Behavior Therapy*, 26, 487-499.