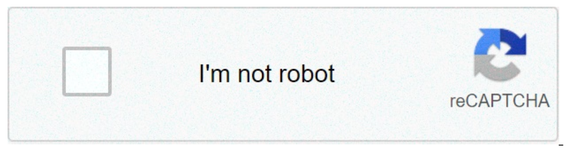

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Example cbt treatment plan for ptsd

Part of our behavioral health resources, this is a broad overview of our treatment plan for the treatment of anger (see our Stress and Trauma page). Age- and gender-specific resources are available for adults and juveniles (males and females). For more information, feel free to contact us or fill out our phone consultation form. Major Goals This material addresses various sources of trauma. 1. Increased understanding of PTSD (psychoeducation) Objectives/treatment focus: Develop vocabulary to describe PTSD feelings Identify cues and symptoms that he is experiencing PTSD (and similar symptoms of anxiety) Link those feelings to specific triggers and areas of vulnerability Develop a short-term action plan for dealing with PTSD Accept that his PTSD is causing him problems Link cues and symptoms of PTSD with triggers and with harmful coping behaviors 2. Identify and address the events and issues underlying PTSD Objectives/treatment focus: Identify issues of PTSD from the past and resolve or let go Identify troublesome feelings and symptoms Address current symptoms intrusive thoughts (exposure therapy) flashbacks (exposure therapy) trauma-related fears, panic, and avoidance (exposure therapy, cognitive restructuring, and coping skills) numbing, detachment from others loss of interest in life (cognitive restructuring) irritability, angry outbursts (cognitive restructuring, coping skills) general anxiety (hyperarousal, exposure therapy) sleep disturbances (coping skills) difficulty concentrating (coping skills) Identify grief and loss issues; take initial steps toward managing grief Identify client symptoms and sources of guilt Reduce guilt, increase understanding of responsibility for the event Identify and addresses issues of: (1) isolation and avoidance; (2) effects of past abuse or trauma Identify symptoms and sources of hurt 3. Correct irrational thinking which leads to PTSD and interpersonal problems Objectives/treatment focus: Identify and address specific areas of cognitive distortion (�Stinking thinking�): anxiety , guilt, survivor guilt, blaming self for being a victim (i.e. rape), catastrophizing: (just because someone is angry does not mean they are about to kill someone) Challenge irrational thoughts with reality Use positive thinking and self-talk for dealing with anticipated problems or when confronting stressors 4. Effectively manage anxiety and stress Objectives/treatment focus: Learn coping techniques to reduce PTSD and prepare to handle future stressful situations (thought stopping, thought switching, creative visualization, progressive muscle relaxation, deep breathing, etc.); this is sometimes called �stress inoculation training� reduce risk of accidental exposure to specific triggers and stressors See Also The following pages may also be helpful: Behavioral Health and Dual Diagnosis — specific behavioral health and dual diagnosis treatment planning and program resources for more than 20 DSM-IV diagnoses and issues, including anxiety disorders, depression, PTSD, ADHD, etc. Behavioral health resources include counselors' tools, model treatment plans, and client workbooks. [more] Anger/Aggression/Violence Resources — Aggression and Violence, an extensive workbook-based resource, and Managing Your Anger, based on individual skill-building lessons, support programs up to 120 hours in length. [more] Phone Consultation Form — fill out this form if you are interested in purchasing our treatment programs. [more]

It's a surprisingly common way for the mind to respond to situations of intense panic and fear, but it can have a debilitating impact on the lives of those affected. We spoke to people living with the condition about the things they wish others understood about PTSD.It doesn't only affect military veterans A lot of work has been done by organisations like Combat Stress and Help For Heroes to raise awareness of the prevalence of PTSD amongst those serving in the armed forces - particularly in the aftermath of wars in Iraq and Afghanistan - but trauma is not limited to the horrors of war. The idea that only soldiers who have seen active comabat get PTSD is one of the most common misconceptions surrounding the condition."Prior to being diagnosed myself, I thought PTSD was something that only affects soldiers coming back from overseas, who've seen terrible things or had limbs blown off," says 50-year-old Jeane.She was diagnosed with PTSD three years ago, when her husband of 10 years became abusive after she was diagnosed with an incurable inflammatory bowel disease.For Charlotte*, who's 29, PTSD was triggered by traumatic labours with both her children - which were made particularly stressful by her history of repeated miscarriage."Both my labours were incredibly frantic and panicked. Having already suffered four miscarriages, I just kept thinking I wasn't going to take a baby home," she explains. "I now have two wonderful children, but I constantly panic about them dying. The flashbacks still render me incapable of doing anything for at least 20 minutes - I have to just put my toddler in front of the television while I calm myself down."A traumatic event could be anything that places you at risk of injury or death - or a situation where you witness the death or injury of someone else. PTSD can therefore affect people affected by a wide range of experiences, including: war, torture, and natural disasters; domestic violence, physical assault, sexual abuse or rape; serious accidents; a sudden and unexpected death, diagnosis, or relationship breakdown; traumatic childbirth; or being a witness to any of these events.Likewise the symptoms vary widely, and are often mistaken for other common mental health conditions such as depression or anxiety."PTSD is made up of various clusters of symptoms, and some of those symptoms within those clusters actually mimic other conditions, which leads to a lot of misdiagnosis," explains clinical psychologist Dr Claudia Herbert, director of The Oxford Development Centre and The Cotswold Centre for Trauma Healing, and author of Overcoming Traumatic Stress.Flashbacks, or intrusive traumatic memories, are probably the best known of these symptoms. Other symptoms include: hypervigilance (feeling 'on edge'), panic attacks, phobias, irritability or angry outbursts, dissociation (feeling disconnected from yourself), nightmares and trouble sleeping, depression and anxiety, self-destructive or reckless behaviour like substance abuse or self-harm, and feelings of shame, guilt, and self-blame.People affected by PTSD may also experience physical symptoms of anxiety, such as muscle tension, heart racing, nausea, or sweating. Avoidance of distressing situations or subjects is another key symptom which, Herbert explains, adds to the difficulty of diagnosis."Often it's too painful to people even to talk about, so they're avoiding it, and their GP may not be aware of the traumatic experience."47-year-old Carole suffered from PTSD after helping out with recovery from the 2004 tsunami in the Maldives, but says the symptoms didn't start as soon as she returned to the UK."I was alright for a month, maybe a month and a half, and apparently that's normal; it sort of creeps up on you," she says. "Then one morning I got up to work, sat in front of the computer, and just felt stuck; I wasn't able to do anything."Likewise, for former Army Officer John Winskill, PTSD didn't set in until about a year after he'd returned from a harrowing mission, overseeing the exhumation of women and children massacred during the Bosnian War more than two decades ago."On that posting I lifted the bodies of more than 50 kids out of a hole in the ground. The smell was unbelievable, so we used to have a Vicks inhaler stuffed up each nostril all day," he explains."A year after I got back, I was in Boots in Colchester on a Saturday morning, and a woman dropped a glass jar of Vicks on the floor. As soon as I smelt it, I collapsed on the floor of the shop, crying my eyes out."PTSD symptoms are typically triggered by sensory reminders of the traumatic event. Besides Vicks, John's triggers include the smell of wet grass, and children's birthday parties. For Charlotte, being around raw meat being cut is a visceral reminder of her episiotomy (a cut during labour), while Carole's PTSD is triggered by waves, as well as everyday items like toothbrushes."You'd be amazed how many waves there are in films, or how the water falling into the sink can look like a wave, or the clouds can look like a wave," she says. "My outstanding memory is of toothbrushes, children's shoes and teddy bears being stuck in the sand.""One of the biggest misconceptions is that you're unstable, volatile and likely to react violently at any second," says sci-fi author Devon C Ford. He suffers from PTSD after being attacked at an English Defence League protest, while working as a public order police officer. "I'm very used to mass disorder and thought I was bulletproof. Physically I'd been hurt way worse in the past, but this incident was different; I just tucked up into a ball and literally waited to die - like I knew it was going to happen," he explains."If I'd come back to work with my arm in a cast I'd have been a hero, but because I came back with a non-visible injury I was weak and to be avoided. That was basically the end of my career in the police," he adds. "I've spent years getting over the shame of having mental health issues, and I've genuinely had someone usher their child away from me when I've mentioned it - as if I'd admitted to having just come off the register or something. It's embarrassing. I just wish people would treat it as it is - it's an injury, not a weakness or a madness."The recommended treatments for PTSD are trauma-focused cognitive behavioural therapy (CBT) or eye movement desensitisation reprocessing (EMDR), Herbert explains. "It's very important that every treatment is tailored to each client's individual needs; you can't rush through repairing very painful things," she says."I think a lot of people think it's something where you go and have a few therapy sessions, you talk about it, and you get over it in a few weeks," says Jeane. "That doesn't happen. I had therapy for nearly a year, I'm having a bit of a break at the moment to process everything, and I'll be continuing it again. It's certainly not something that gets cured in a few weeks or months."For her, an important part of that process was realising she wasn't alone and support was available. "It's very easy to feel that you're the only one suffering, or that you're going mad, but you don't have to feel ashamed or hush it up," she adds. "It's not something you've brought upon yourself, it's just circumstances, so it's important to take away the guilt and recognise that it's actually quite a normal response to trauma." Barbara Rothbaum, Ph.D. This presentation is an excerpt from the online course “Prolonged Exposure for PTSD: A Comprehensive Guide for Clinicians”. Highlights CBT for PTSD involves helping the patient confront the reminders of the trauma in a therapeutic manner so that distress decreases.Exposure therapy has more evidence of efficacy for PTSD than other interventions.Prolonged Exposure (PE) has been found effective across trauma populations and in different cultures. Hello. This is Dr. Barbara Rothbaum. I’m a professor in psychiatry and a clinical psychologist. I’m at Emory University School of Medicine in Atlanta, Georgia. I have been treating and studying treatments for posttraumatic stress disorder since 1986. So I’ve been doing this a long time. And I’m very happy to talk to you about prolonged exposure therapy and cognitive-behavioral treatments for PTSD. So thank you for attending. We’ll start the first video, which is on cognitive-behavioral treatments for PTSD. What are they? In general, CBT, cognitive-behavioral therapy, for PTSD, what we’re doing is helping people confront what they’re scared of but in a therapeutic manner. So we’re helping to promote these safe confrontations via exposure. And exposure is to the memories; It’s to real-life triggers. It’s also to discussions about the trauma. And we are aiming to modify dysfunctional thoughts that are underlying PTSD. We’re also aiming to modify the distress associated with these thoughts and reminders. In general, cognitive-behavioral treatment—especially for PTSD, but in general—can be divided into three large categories. The first are exposure procedures. So those are the ones that we’re helping people to confront what they’re scared of in a therapeutic manner. The second category is anxiety management procedures and those are ones that we’re teaching patients coping skills and coping strategies to help manage their anxiety, such as cognitive restructuring or relaxation. The third category is cognitive therapy. And in cognitive therapy, that’s where we’re looking at these dysfunctional thoughts. In general, a number of CBT techniques have been used to treat chronic PTSD. And these include exposure therapy and particularly prolonged exposure therapy, PE, which we’re going to be talking about a lot in this series; cognitive processing therapy, or CPT; stress inoculation training, or SIT; cognitive therapy. And I just want to mention systematic desensitization because it was one of the earlier techniques used for PTSD, actually before PTSD was officially PTSD. And nobody really uses it anymore, but sometimes people ask me about it so I wanted to mention it and mainly mention to say we don’t really need it anymore. Let’s talk first about SIT, stress inoculation training. The theory behind SIT is that fear and anxiety are a normal response to trauma. The idea is that certain cues and the fear and anxiety are conditioned at the time of the trauma even to nonthreatening cues. Originally, a long time ago when I learned SIT, the idea was that it could be unlearned. These fears and anxiety could be unlearned to nonthreatening cues. Now, we don’t think that there’s unlearning. We think that there’s new learning on top of it, so learning that they don’t have to be scared to these nonthreatening cues. References Foa, E. B., & Rothbaum, B. O. (1998). Treating the trauma of rape: Cognitive-behavioral therapy for PTSD. Guilford Press. SIT assumes—and just like CBT—in general, that we experience fear and anxiety in 3 channels of responding: cognitive, or how we’re thinking; physiological, what we’re feeling in our bodies; and behavioral, what we’re doing, our actions. References Foa, E. B., & Rothbaum, B. O. (1998). Treating the trauma of rape: Cognitive-behavioral therapy for PTSD. Guilford Press. SIT’s approach to treatment includes anxiety management techniques for all 3 channels.And we teach patients the stage response of anxiety. So what I mean by that is that usually unless it’s the time of the trauma, you’re not totally relaxed one minute and panicking the next or at the top of your fear and anxiety. Usually, and this is for chronic PTSD, it goes in stages. And if a patient can learn to recognize those stages, it’s easier to do something about it because it’s easier to intervene at an earlier stage than when anxiety is maxing out. And this next one is important. The goal is to manage anxiety, not to eliminate it. So many of our patients come in with anxiety and they want us to get rid of it. They hate anxiety. And I always try to explain: one, we couldn’t if we wanted to. We’re animals and we’re hardwired for anxiety. And we don’t want to. Anxiety helps us survive. Unfortunately, we live in a dangerous world and that anxiety is going to motivate us to do something that will probably help our survival if we find ourselves in a situation. The SIT skills can be applied trans-situationally, across situations. And that’s wonderful because PTSD patients have problems across situations. They have problems at home. They have problems sleeping. They have problems at work. They have problems in their car driving to work. They have problems at the grocery store. So these SIT skills can be applied in all of those situations.Another thing that we try to teach people with SIT, and probably in cognitive-behavioral therapy in general, is that anxiety becomes a cue to use these skills. So for example, for most of us, if we have not had a history of starvation, if we’re hungry, it doesn’t trigger anxiety. If we’re hungry, it triggers us to eat, to get food. Same with anxiety. Very often, when people come in to see us, their anxiety is a cue to get more anxious. They feel their heart pounding. Oh my gosh, here it happens again. And then they get more anxious. And what we want to teach them in SIT and in CBT is you feel your heart pounding, okay, good, you noticed that. Use your breathing. If you use your breathing, it should slow your heart rate down. If you noticed that you’re clenching your jaw, use one of the relaxation skills to decrease that. So the anxiety becomes a cue to use these skills rather than for more anxiety. Now, I’m going to switch to prolonged imaginal exposure. And again, we’re going through an overview now. We’re going to go through PE in a lot more detail in the modules to come. In general, the theory behind prolonged imaginal exposure, we think in terms of an information or emotional processing theory. I make a lot of analogies to the grief process with this theory. And the idea is that when something important happens to us there’s no way to the other side of the pain except through it. And the way through it is we need to emotionally process it. I’ll give you an example not related to this. Say you’re driving to work and you have a near miss. Somebody almost hits you. The first person you see at work, you may talk about it. Then you see the secretary and you say, “Man, this Jeep Cherokee came out of nowhere, almost got me.” By the end of the day, you’re not talking about it anymore. You don’t need it. You’ve processed it.So again, with PE, we think that fear and anxiety are a normal response to trauma. Someone holds a knife to your throat and says, “Don’t scream or I’ll cut you,” you’re going to be scared. That’s normal. References Foa, Hembree, Rothbaum, & Rauch (2019). Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences, Therapist guide, 2nd edition. New York. Oxford University Press. Rothbaum, Foa, Hembree, & Rauch (2019). Reclaiming Your Life from a Traumatic Experience: Client workbook, 2nd edition. New York. Oxford University Press. Fear, anxiety, and what I call social conventions then lead to avoidance. So the fear and anxiety, if I think about it and it makes me feel bad, my natural inclination is going to be not to think about it. If I go outside after dark by myself and I get very scared, maybe I stop doing that. And what I mean by social conventions, our society is not very good about talking about negative events, and certainly not the kinds of events that lead to PTSD. And very often, trauma survivors receive the message implicitly and sometimes explicitly. Go on with your life. Forget about it. Put it behind you. In other words, don’t talk about it, I don’t want to hear about it. And then this avoidance is reinforced. If I’m not going outside by myself anymore, I’m not feeling as anxious. If I’m not talking about it as much—sometimes, I’m explicitly reinforced by others. We’re so glad we have our old Barbara back. We’re so glad you put that behind you.But when we need to think about it and feel it to process it, this avoidance prohibits emotional processing. And that’s how we think that it festers and haunts people. References Foa, Hembree, Rothbaum, & Rauch (2019). Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences, Therapist guide, 2nd edition. New York. Oxford University Press. Rothbaum, Foa, Hembree, & Rauch (2019). Reclaiming Your Life from a Traumatic Experience: Client workbook, 2nd edition. New York. Oxford University Press. For adequate emotional processing, we think we need two important processes. One is activation of the trauma memory. Now, a lot of my PTSD patients tell me, “Doc, what are you talking about? I get triggered 100 times a day. How is this different?” So they get activated, but then they push it down immediately. When we activate it, we want the other component, corrective information. We want to activate the memory, but we want to put it back differently. References Foa, Hembree, Rothbaum, & Rauch (2019). Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences, Therapist guide, 2nd edition. New York. Oxford University Press. Rothbaum, Foa, Hembree, & Rauch (2019). Reclaiming Your Life from a Traumatic Experience: Client workbook, 2nd edition. New York. Oxford University Press. The approach to treatment in prolonged imaginal exposure is that we can activate this memory for most people pretty easily through exposure to the trauma memories and to nonthreatening cues, nonthreatening reminders.They receive corrective information when they do these exposures via, one, safety. So they’re going outside by themselves and nothing bad is happening. Habituation. And some people use the term habituations; some, extinction. I’ll use both pretty interchangeably here. So what that means is when you’re doing it and you do it over and over again and nothing bad happens, the distress comes down. The fear comes down. And also, they receive corrective information through acceptance. When they are telling their therapist the most scary, shameful, embarrassing, terrible moments of their lives and the therapist isn’t responding with horror or “I can’t hear it” or disgusted looks on their face, when the therapist is responding with acceptance, then that’s important corrective information as well. References Foa, Hembree, Rothbaum, & Rauch (2019). Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences, Therapist guide, 2nd edition. New York. Oxford University Press. Rothbaum, Foa, Hembree, & Rauch (2019). Reclaiming Your Life from a Traumatic Experience: Client workbook, 2nd edition. New York. Oxford University Press. We’re going to talk in detail later on that habituation is important between sessions.And just an important comment, the habituation is to the traumatic memory, not to harm. In 1986 we were doing prolonged exposure therapy with rape survivors with PTSD. And at first, we were criticized and someone said, women should be scared of getting raped. You shouldn’t desensitize that memory. And obviously, we agree. And the distinction we want to make is the desensitization or habituation or extinction is to the traumatic memory, not to harm. References Foa, Hembree, Rothbaum, & Rauch (2019). Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences, Therapist guide, 2nd edition. New York. Oxford University Press. Rothbaum, Foa, Hembree, & Rauch (2019). Reclaiming Your Life from a Traumatic Experience: Client workbook, 2nd edition. New York. Oxford University Press. Some of the exposure therapy principles are based on extinction training and that comes from the animal literature and it’s based on learning principles. So I wouldn’t do a whole primer on conditioning extinction. But briefly, for example, you can pair, say, a tone with a shock and the animal will learn to be scared of the tone. This is just like Pavlovian conditioning. And so you present the tone and that’s called fear conditioning. When you want to do extinction training, you present the tone by itself repeatedly and the animal learns that the tone no longer predicts shock. And so the fear to the tone decreases. And that’s called extinction training and extinction learning and it’s based on learning principles. Not all exposures are therapeutic. I will give you an example unrelated to this. Say a child is bitten by a dog and develops a phobia or PTSD so severe that that child doesn’t want to leave the house for fear of encountering dogs. If you put that child in a room with a dog and the kid runs away screaming, this is an exposure, but it’s not a therapeutic exposure because nothing has changed. What you might want to do is start with a cute puppy, maybe work up to dogs that are bigger or resemble the dog that bit the child. And what you want to happen is for the child to stay with the animal long enough to learn in their bodies, in their brains that this animal poses no threat. So I’m always asking for therapeutic exposure, “What does your patient need to learn from this exposure?” ReferencesFoa, Hembree, Rothbaum, & Rauch (2019). Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences, Therapist guide, 2nd edition. New York. Oxford University Press. Switching to cognitive therapy, the focus is identifying dysfunctional erroneous thoughts and beliefs that usually we call cognitions. And we teach the patient how to challenge these cognitions and we want to replace these cognitions with more functional realistic cognitions. Emotional processing in therapy, as we mentioned earlier, requires accessing the fear structure. You want to activate it and put it back differently. So in general, there are several CBT programs that are very effective for PTSD. PE, or prolonged exposure, has received the most empirical evidence with a wide range of traumas of any intervention for PTSD, including two medications with an FDA-approved indication for PTSD. So the key points for the first video are that cognitive-behavioral treatments, or CBT for PTSD involve helping the patient confront the reminders of the trauma in a therapeutic manner so that the stress decreases. Exposure therapy has more evidence for its efficacy for PTSD than any other intervention. And prolonged exposure therapy, PE, is a specific protocol for exposure therapy for PTSD that has been found effective across trauma populations and in different cultures. More PE presentations

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