CHAPTER 10

Cognitive Therapy

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Cognitive therapy for posttraumatic stress disorder (CT-PTSD) aims to help an individual update the idiosyncratic, often highly personal distressing meanings that they have taken from traumatic experiences, so that these meanings become less threatening to their sense of self and their perception of the world. This central aim remains essential to treatment even when aspects of complexity are apparent, whether that may be experiences of multiple traumatic events over a lifetime, the presence of comorbid social or psychological difficulties, or complicating features such as dissociative episodes. In this chapter, we first outline Ehlers and Clark's (2000) cognitive model for PTSD, the core treatment procedures, and the evidence base for CT-PTSD. We then describe how the treatment interventions can be applied when working with various issues of complexity. In a case study, we describe how CT-PTSD was used to treat a multiply traumatized woman with a complex presentation of PTSD.

Cognitive Therapy for PTSD

Traumatic events are extremely negative events that everyone would find highly threatening and distressing. Yet what people find *most* distressing about a traumatic event, and what it means to them, varies greatly from person to person, and influences the probability of developing PTSD. The personal meanings of trauma and their relationship with features of trauma memories are central to Ehlers and Clark's (2000) cognitive model of PTSD, which suggests that PTSD develops when traumatic experiences are processed in a way that produces a sense of serious current threat, driven by two key processes (Figure 10.1).

The first source of current threat is *negative appraisals* (personal mean-

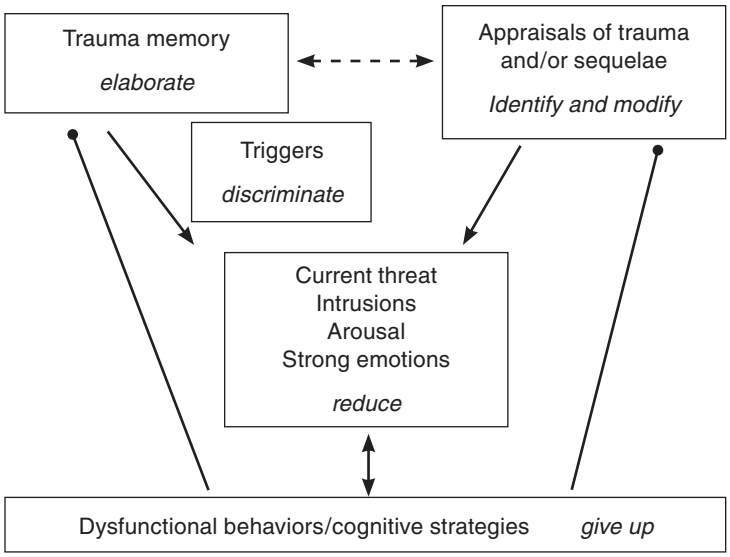

FIGURE 10.1. Treatment goals (in italics) in cognitive therapy for PTSD (Ehlers & Clark, 2000). Pointed arrows stand for "leads to." Round-arrows stand for "prevents a change in." Dashed arrows stand for "influences." From Ehlers (2013). Copyright © 2013 by Wiley. Reprinted by permission.

ings) of the trauma and/or its sequelae (e.g., reactions of other people, initial PTSD symptoms, physical consequences of the trauma). The perceived threat can be external or internal, and the negative emotions depend on the type of appraisal: Perceived *external* threat can result from appraisals about impending danger (e.g., "I cannot trust anyone"), leading to excessive fear, or appraisals about the unfairness of the trauma or its aftermath (e.g., "I will never be able to accept that the perpetrator got away with it"), leading to persistent anger. Perceived *internal* threat often relates to negative appraisals of one's behavior, emotions, or reactions during the trauma, or to the perpetrator's or other people's humiliating or derogatory statements, and may lead to guilt (e.g., "It was my fault"), or shame (e.g., "I am a bad person"). A common negative appraisal of consequences of the trauma in PTSD is perceived permanent change of the self or one's life (e.g., "I have permanently changed for the worse"), which can lead to sadness and hopelessness. For multiply traumatized individuals, personal meanings tend to become more generalized (e.g., "I do not matter"; "I deserve bad things happening to me"; "I am worthless"), leading to an enduring sense of degradation, defeat, or low self-worth. The appraisals can become more embedded in a person's internal belief systems over time. For example, if an early life trauma has led a person to feel that he or she is damaged in some way, or unlucky in life, experiencing further trauma is likely to further confirm this belief.

The second source of perceived current threat according to Ehlers and Clark (2000) is characteristics of the individual's memory of the trauma. The worst moments of the trauma are poorly elaborated in memory, that is, inadequately integrated into their context (both within the event, and within the context of previous and subsequent experiences/information). The effect of this is that a person with PTSD remembers the trauma in a disjointed way. When he or she recalls the worst moments, it may be difficult to access other information that could correct impressions he or she had or his or her predictions at the time: In other words, the memory for these moments has not been updated with what the person knows now. The effect of this is that the threat experienced during these moments is reexperienced as if it were happening right now rather than being a memory from the past. This "nowness" of the memories can be so severe that a person may experience a dissociative flashback and lose awareness of his or her present surroundings. The reexperiencing can include reexperiencing of bodily sensations and emotions from the trauma in the absence of a recollection of the event itself. The disjointedness of memories may also be affected by repeated exposure to traumatic experiences, with poorer integration into autobiographical memory with each subsequent trauma exposure, explaining in part why repeated exposure to traumatic events makes PTSD more likely to develop, and why dissociation is common.

Ehlers and Clark (2000) also noted that intrusive trauma memories are easily triggered in PTSD by sensory cues that overlap perceptually with those occurring during trauma (e.g., a similar sound, color, smell, shape, movement, or bodily sensations). They suggest that if people during trauma mainly process perceptual features of the experience (data-driven processing), this will lead to strong perceptual priming, such that stimuli similar to those in the trauma are more easily identified in the environment. Through learned associations, the stimuli also become associated with strong affective responses, which can generalize to similar stimuli. Both priming and generalized associative learning lead to a poor discrimination of the stimuli in the current environment from those in the trauma. This means that perceptually similar stimuli are easily spotted and can trigger reexperiencing symptoms.

The third factor that maintains a sense of current threat in Ehlers and Clark's model is cognitive strategies and behaviors that people with PTSD use in response to the perceived current threat. These correspond to the problematic appraisals in meaningful ways and include effortful suppression of memories, avoidance of reminders, rumination, excessive precautions to prevent future trauma ("safety behaviors") and alcohol or drug use. These behaviors and cognitive strategies maintain PTSD by preventing change in the appraisals or trauma memory, and/or by increasing symptoms, and thus keep the sense of current threat going. For some individuals, especially those with long-standing PTSD, these behaviors may become highly disabling, and may be the reason an individual comes into therapy.

Figure 10.1 illustrates the three factors (appraisals, memory characteristics, cognitive/behavioral strategies) that maintain a sense of current threat and PTSD symptoms according to Ehlers and Clark's (2000) model. CT-PTSD uses

the theoretical framework of this model and targets these three factors. The model suggests three treatment goals:

1. To modify threatening appraisals (personal meanings) of the trauma and its sequelae.
2. To reduce reexperiencing by elaboration of the trauma memories and discrimination of triggers.
3. To reduce cognitive strategies and behaviors that maintain a sense of current threat.

Core treatment procedures (described in greater detail below) in CT-PTSD include the following[1]:

- *Individualized case formulation.* The therapist and client collaboratively develop an individualized version of Ehlers and Clark's (2000) model of PTSD, which serves as the framework for therapy. Treatment procedures are tailored to the formulation.
- *Reclaiming/rebuilding one's life assignments* is designed from the first session onwards to address the client's perceived permanent change after trauma and involves reclaiming or rebuilding activities and social contacts.
- *Changing problematic appraisals* of the traumas and their sequelae through guided discovery and behavioral experiments.
- *Updating trauma memories* is a three-step procedure that includes (1) accessing memories of the worst moments during the traumatic events and their currently threatening meanings, (2) identifying information that updates these meanings (information from either the course of events during the trauma, or from cognitive restructuring and testing of predictions), and (3) linking the new meanings to the worst moments in the memory.
- *Discrimination training with triggers of reexperiencing* involves systematically spotting idiosyncratic triggers (often subtle sensory cues) and learning to discriminate between "now" (cues in a new safe context) and "then" (cue in the traumatic event).
- *A site visit* completes the memory updating and trigger discrimination.
- *Dropping unhelpful behaviours and cognitive processes* commonly includes discussing their advantages and disadvantages and *behavioral experiments* in which the patient experiments with reducing unhelpful strategies such as rumination, hypervigilance for threat, thought suppression, and excessive precautions (safety behaviors).
- A *blueprint* summarizes what the client has learned in treatment and includes plans for any setbacks.

[1]Video extracts of the procedures and therapy materials can be accessed at *https://oxcadatresources.com.*

Empirical Support

The factors proposed to maintain PTSD in Ehlers and Clark's (2000) model of PTSD have been supported in prospective and experimental studies (e.g., Beierl, Böllinghaus, Clark, Glucksman & Ehlers, 2019; Ehlers, Mayou, & Bryant, 1998; Ehlers, Maercker, & Boos, 2000; Ehlers, Ehring, & Kleim, 2012; Ehring, Ehlers, & Glucksman, 2008; Kleim, Ehlers, & Glucksman, 2007; Kleim, Ehring, & Ehlers, 2012). The efficacy of CT-PTSD has been evaluated in several randomized controlled trials in adults (Ehlers et al., 2003, 2014, 2019b; Ehlers, Clark, Hackmann, McManus, & Fennell, 2005) and children (Meiser-Stedman et al., 2017; Smith et al., 2007). In these research trials, CT-PTSD was found to be highly acceptable to clients, as indicated by very low dropout rates (3% on average) and high client satisfaction scores. It led to clinically significant improvements in PTSD symptoms (intent-to-treat pre–post treatment effect sizes around 2.5), disability, depression, anxiety, and quality of life. Over 70% of these studies' participants fully recovered from PTSD. Outreach open trials treating consecutive samples of survivors of the Omagh and London bombings replicated these results (Brewin et al., 2010; Gillespie, Duffy, Hackmann, & Clark, 2002). The percentage of clients whose symptoms worsened with treatment was close to zero, and smaller than in clients waiting for treatment (Ehlers et al., 2014). This suggests that CT-PTSD is a safe and efficacious treatment.

Three further studies (Duffy et al., 2007; Ehlers et al., 2013, 2019a) implemented CT-PTSD in routine clinical services. The samples treated in these studies included a very wide range of clients, including those with complicating factors such as serious social problems, living currently in danger, very severe depression, borderline personality disorder, or multiple traumatic events and losses. Therapists included trainees, as well as experienced therapists. Outcomes remained very good, with large intent-to-treat effect sizes of 1.25 and higher for PTSD symptoms. Around 60% of the clients who started therapy remitted from PTSD. Dropout rates were somewhat higher than in the randomized controlled trials of CT-PTSD (around 15%), but rates were still below the average for trials of trauma-focused cognitive-behavioral therapy of 23% (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013). Very few clients experienced a mild degree of symptom worsening (1.2% in Ehlers et al., 2013). Thus, the evidence suggests that CT-PTSD is an effective treatment for individuals with a broad range of presentations, including many of the complex symptoms experienced by people with prolonged trauma histories.

CT-PTSD has also been successfully used in an intensive format in which therapy is delivered daily over the course of 5–7 working days (Ehlers et al., 2014; Murray, El-Leithy, & Billings, 2017), and in a briefer self-study assisted[2] format (Ehlers et al., 2019b).

[2]The self-study modules will be made available at *https://oxcadatresources.com*.

Treatment Procedures

Format of Treatment

CT-PTSD is usually delivered in up to 12 weekly treatment sessions for clients who currently reexperience a small number of traumas, and up to 20 weekly sessions for clients with multiple traumas and complex presentations. Sessions that involve work on trauma memories should be 90 minutes long to allow the client time to refocus on the present before leaving the session. Weekly measures of PTSD symptoms, depression, and cognitions are helpful in monitoring the effects of interventions and spotting problems that remain.

Therapeutic Style and the Therapeutic Relationship

In common with other forms of cognitive therapy, CT-PTSD uses guided discovery as the primary therapeutic style. As the main focus of the intervention is the cognitions that stem from the traumas and induce a sense of current threat, strategies such as Socratic questioning aim to gently guide the client to explore and examine a wider range of evidence by asking questions that help him or her consider the problem from different perspectives, with the aim to generate a less threatening alternative interpretation. CT encourages a perspective of curiosity rather than trying to undermine or prove the client's perspective to be wrong.

A nonthreatening, collaborative style of working is essential to working with trauma survivors, particularly those with complex presentations. Establishing a good therapeutic relationship based on mutual trust, respect, and warmth is fundamental, especially with individuals who have had experiences of interpersonal trauma and may believe they can no longer trust people. Setting up an open and collaborative alliance is also important to empower clients to have control over the therapeutic relationship, to question the therapist and the interventions if they are uncertain or uncomfortable. For those with interpersonal difficulties, this enables swifter resolution of issues that could lead to an impasse in the therapeutic relationship or to treatment dropout.

Generating an alternative interpretation (insight) is usually not sufficient to generate a large emotional shift. Crucial steps in therapy are therefore to test the client's appraisals in behavioral experiments, which create experiential new evidence against the client's threatening interpretations, and to link the new meanings to the relevant moments during the trauma in memory with the updating memories procedure (i.e., by simultaneously holding the moment and the new meanings in mind to facilitate an emotional shift). This is also important to address "head–heart lag," which can be a problem when beliefs have been long-held and may shift intellectually but not emotionally.

Case Formulation, Psychoeducation, and Treatment Planning

At the start of treatment, therapist and client discuss the client's symptoms and treatment goals, and explore cognitions to develop an individualized case formulation.

The therapist normalizes the PTSD symptoms by explaining that they are common reactions to extremely stressful, overwhelming events, and that many of the symptoms are a sign that the memories of the traumas are not fully processed yet.

The therapist asks the client to give a brief account of the traumas and starts exploring the personal meanings ("What was the worst thing about the trauma?"; "What were the worst moments, and what did they mean to you?"). The emotions that the client experiences are further indicators of the type of problematic meanings that need to the addressed in treatment, and the *Post-traumatic Cognitions Inventory* (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999) can help with identifying cognitive themes, some of which the client may not mention in the early sessions.

In the case of clients with histories of multiple traumatic events, it is important to determine which events are linked to the current PTSD. The therapist aims to discover which events the client is reexperiencing, since these will be the primary focus of the intervention. The therapist also may assist the client in developing a timeline of the client's life, or trauma history, to facilitate the identification of focal traumas.

The therapist asks the client what strategies he or she has used so far to cope with his or her distressing memories. Suppression of memories, avoidance, and numbing of emotions (including substance use) are common, as well as rumination. The therapist then uses a *thought suppression experiment* (asking the client to try hard not to think about an image such as a green rabbit sitting on the therapist's shoulder) to demonstrate experientially that suppressing mental images has paradoxical effects.

The model in Figure 10.1 is rarely presented to clients, due to its complexity. Rather, the therapist summarizes with clients an individualized case conceptualization and treatment plan that relates to the three main processes inherent to the model:

1. Many of their symptoms are caused by the nature of trauma memories. Addressing these during treatment will reduce the intrusions and make the traumas feel more like memories from the past.
2. Understandably, the traumas have affected clients' views of themselves and the world, leading them to feel more under threat and more negative about themselves. These views will be considered in therapy, to understand whether they are being colored by the trauma memories.
3. Some strategies that clients have used so far to control the symptoms and threat are understandable, but may be inadvertently counterpro-

ductive (as clients have experienced in the thought suppression experiment). Clients will experiment with replacing these strategies with alternatives that may be more helpful.

As the CT-PTSD case formulation is tailored to each individual, it can be applied to a wide variety of presentations, traumas, and cultural backgrounds, and can incorporate comorbid conditions and the effects of multiple traumas. For example, comorbid depression may be related to some of the client's appraisals of the trauma and other life experiences (e.g., "I am worthless") and cognitive strategies (e.g., rumination). Comorbid panic disorder may have developed from interpretations of the reexperiencing symptoms (e.g., reexperiencing difficulty breathing leading to the thought "I will suffocate"). And comorbid obsessive–compulsive disorder (OCD) may be linked to appraisals such as "I am contaminated" and linked to behaviors such as excessive washing. Cultural beliefs may influence an individual's personal meanings of trauma and his or her attempts to come to terms with trauma memories in helpful and unhelpful ways. Treatment is tailored to the individual's beliefs, including cultural beliefs.

CT-PTSD allows for flexibility in the order in which the core treatment procedures are delivered, depending on the individual formulation and client preference. The memory updating procedure often has a fast and profound effect on symptoms and is generally attempted early on, if possible. For patients with severe dissociative symptoms, training in stimulus discrimination is conducted first, and narrative writing is preferred over imaginal reliving. In addition, for certain cognitive patterns, the memory work is prepared through discussion of the client's appraisals and cognitive processing at the time of the trauma. For example, when a client profoundly believes him- or herself to be at fault for a trauma, and the resultant guilt and/or shame prevents the client from being able to describe it fully to the therapist, therapy would start with addressing these appraisals. If a client experienced mental defeat (the perceived loss of all autonomy) during an interpersonal trauma, therapy would start with discussing the traumatic situation from a wider perspective to raise the client's awareness that the perpetrators intended to control and manipulate his or her feelings and thoughts at the time, but that they are not exerting control now.

For clients displaying complex features of PTSD, other problems may need to be an initial priority. Particularly, if reexperiencing symptoms and coping strategies are currently placing a client at risk, for example, through severe dissociative episodes, excessive use of substances, self-harm, or risky sexual behavior, these behaviors require immediate attention. In addition, a comorbid condition, such as severe depression with acute suicidal intent or acute psychosis, is a clinical priority that would interfere with the successful or safe delivery of CT-PTSD and would require prior treatment. In some cases, it may also be necessary to prioritize other problems or events for a few sessions during treatment if they become the client's primary problem.

Reclaiming/Rebuilding Your Life

An early intervention in CT-PTSD is to encourage clients to reintroduce activities and relationships that were important to them before the trauma but have been relinquished, in order to address the common appraisal that their lives have been permanently changed since the trauma. This involves a discussion of previous interests and activities, and a gradual reintroduction to them via homework assignments. For the individual who has a long history of trauma and cannot readily identify previously valued activities, who was very young when the trauma occurred, or who has lost much of his or her former life since the trauma (e.g., loss of a significant other or home, life-changing injuries), the focus is on "(re)building your life." The therapist and client identify together what activities and interests would fit with the client's goals for the future, and plan small achievable steps toward them.

Stimulus Discrimination

Although they may appear to come "out of the blue," many reexperiencing symptoms of PTSD are triggered by subtle sensory reminders of the trauma, such as visual patterns or colors, sounds, smells, tastes, or bodily sensations. One sensory similarity between the trauma and the current situation may be sufficient to trigger reexperiencing. This makes the triggers hard to spot. Helping a client to become more aware of his or her triggers using systematic observation in the session, and as homework, helps the client to feel more control over the intrusions, and learn to break the link between the trigger and the trauma memory.

This involves several steps. First, the client learns to distinguish between "then" and "now" (i.e., to focus on how the present triggers and their context ("now") differ from the trauma ("then"). Second, the therapist and client practice focusing on the differences, while intentionally introducing triggers during a therapy session (e.g., the sound of shouting or brakes squealing on Internet audio libraries, red fluids that look like blood, pictures of people who look like the perpetrator). The "then" versus "now" discrimination can be facilitated by carrying out actions that were not possible during the trauma (e.g., moving around if the client was trapped in the trauma, touching objects or looking at photos that remind the client of his or her present life). Finally, clients apply the "then" versus "now" discrimination between sessions as triggers arise.

Updating Trauma Memories

In CT-PTSD, the meaning of the trauma to an individual is central to understanding the maintenance of PTSD. These meanings are often associated with so-called "hot spots" (Foa & Rothbaum, 1998), the moments in the trauma memory that are most distressing and have the strongest sense of "nowness." These moments may be accessed through imaginal reliving (Foa & Roth-

baum, 1998) or narrative writing (Resick & Schnicke, 1993). Imaginal reliving involves the client visualizing the traumatic event (usually with his or her eyes closed) and describing to the therapist, moment by moment, what is happening, including sensory details, thoughts, and feelings. Narrative writing involves preparing a written account of the trauma, usually with the therapist, with a similar level of detail. Imaginal reliving is generally more immersive than narrative writing and can lead to quicker access to the difficult thoughts and feelings associated with a particular hot spot in trauma memory. For some individuals, this can be overwhelming, and narrative writing is recommended in preference to imaginal reliving for those who dissociate easily or experience strong physical reactions when accessing the trauma memory (e.g., vomiting or feeling faint). Narrative writing is also preferable when a trauma memory is very long, or when the client is very confused about what happened or has long gaps in memory (e.g., due to loss of consciousness or drugs).

In CT-PTSD, the aim of memory work is not to relive the trauma repeatedly until habituation occurs, but to identify hot spots and their meanings, and information that will help understand and update them. This usually takes only one or two sessions. Once a hot spot has been identified, the personal meanings are carefully explored. The therapist and client then begin to identify information that does not fit with the problematic meanings, which can "update" the hot spot. In some cases, this will be simple, factual updates the client may already be aware of, but may not yet have fully integrated into the trauma memory. For example, if the client believes he or she was going to die and leave his or her children behind, it may be helpful to update the hot spot with the knowledge that he or she survived, and to look at a recent family photo to help consolidate this information. In other cases, it may take research and psychoeducation to identify updating information, for example, interviewing experts to understand why an event occurred. Some appraisals require more thorough cognitive techniques to generate meaningful updates. For example, if someone believes that he or she is to blame for a trauma, techniques such as Socratic questioning, systematic discussion of evidence, behavioral experiments, pie charts, discussing hindsight bias, or a survey may be required to access an alternative explanation. Imagery may also be helpful in generating a new perspective, for example, imagining what would have happened if the client had fought back when being threatened with a knife.

Once updating information that the client finds compelling has been identified, it is actively incorporated into the trauma memory, by holding the relevant hot spot and its original meanings in mind (through imaginal reliving or reading the corresponding part of the narrative) simultaneously with the updating information. This may be done verbally (e.g., "I know now that . . . "), through imagery (e.g., visualizing how one's wounds have healed; visualizing the perpetrator in prison; visualizing a deceased in a peaceful place; looking at a recent family photo), using movements or actions that are incompatible with the original meaning of this moment (e.g., jumping up and down for hotspots that involved predictions about dying or being paralyzed), or incom-

patible sensations (e.g., touching a healed arm; eating or drinking something that has taste different from blood). It is important to look for an emotional shift during the updating to see whether the updating information has been adequately processed. Clients report feeling surprised or relieved when the updating is successful, and reexperiencing decreases and sleep improves in the following days (Woodward et al., 2017). For clients with severe dissociation, it can take a few attempts to find the best way to make the updating information "sink in" when recalling their hot spots.

Addressing Unhelpful Behaviors and Dissociation

Usually, the first step in addressing cognitive strategies and behaviors that maintain PTSD is to discuss their problematic consequences. This is generally done using guided discovery, listing the advantages and disadvantages of the behavior, and behavioral experiments to demonstrate their effects. For a nonrisky behavior, this may include increasing the behavior. For example, the effects of selective attention to danger cues can be demonstrated by asking the client to attend to possible signs of danger unrelated to trauma, such as watching traffic on a busy road. This demonstrates experientially that hypervigilance can lead to anxiety based on a heightened appraisal of risk. Behavioral experiments in dropping the behavior and observing the consequences can then be attempted.

Many cognitive strategies and behaviors that maintain PTSD, such as thought suppression and hypervigilance to danger, do not place clients directly at risk. However, strategies such as excessive use of drugs and/or alcohol, self-harm, risky sexual behavior, and severe dissociation can be dangerous. The therapist and client work together to understand the role the behavior is playing in maintaining PTSD and how it is contributing to other psychological, social, relationship, health, and financial problems. A plan is then developed to reduce the behavior, anticipating potential obstacles and how they can be overcome. Behavioral experiments allow the testing of beliefs associated with coping strategies (e.g., "I won't be able to sleep without alcohol"). In some cases, associated beliefs require additional cognitive work, for example, when someone believes that he or she deserves to be harmed by others, and deliberately places him- or herself in risky situations. For individuals who have a long history of trauma and may struggle to assess how risky a situation is, work on recognizing and assessing danger may be required.

Dissociation can also be formulated as a coping strategy, albeit an unintentional one. The therapist and client explore how and why dissociation occurs, and learn to recognize triggers to dissociation. Clients are taught to use stimulus discrimination (discussed earlier) to deal with triggers. In cases in which the client is experiencing strong loss of awareness, he or she is encouraged to experiment with strategies that make the difference between the trauma and the current situation more salient. Such strategies are often referred to as *grounding strategies* or reminders of the "here and now." Therapist and client

discuss and practice these in the session to find the most effective strategy. The best strategies are generally easily accessible, with powerful cues to the present moment, such as strong tastes, smells, or sensations, or visual or auditory cues that were not present at the time of the trauma. Once the client's attention has been refocused on the here and now, therapist and client try to identify what triggered the dissociation, and use stimulus discrimination.

Further Imagery Work

If reexperiencing symptoms persist after successful updating of the client's hot spots and discrimination of triggers, imagery transformation techniques can be useful. The client transforms the trauma image into a new image that signifies the trauma is over. Transformed images can provide compelling evidence that the intrusions are a product of the client's mind rather than perceptions of current reality. Image transformation is also particularly helpful with intrusions that represent images of things that did not actually happen during the trauma (e.g., images of the future that represented the client's worst fears, such as images of his or her children growing up sad and alone).

Revisiting the Scene of the Trauma

A visit to the site of the trauma completes the work on trauma memories and appraisals. Visiting the site can help correct remaining problematic appraisals, as the site provides many retrieval cues and helps access further information to update the appraisals. The site visit also helps complete the stimulus discrimination work. Clients realize that the site "now" is very different from the way it was "then," which helps place the trauma in the past. Using Google Street View to visit the site virtually can be an effective alternative when it is unsafe or impractical to visit the site in person. In other cases, it can be a useful preparation for visiting a site, when the client is reluctant or anxious. In all cases, giving a clear rationale for the visit, addressing beliefs about returning to the site of the trauma, and planning for any potential difficulties is helpful preparation for the returning to the scene of the trauma (for further details, see Murray, Merritt, & Grey, 2015).

Clinical Case Example

Case Description

Carmen (whose name and details are disguised), a 35-year-old Colombian woman referred for treatment of PTSD, had a long history of traumatic experiences, beginning when she was a child. Her father would shout and insult Carmen if she displeased him, which was often, and beat her with his belt or a stick if she was disobedient. He would require her to stand absolutely still while she was being punished, and he would beat Carmen harder if she moved.

At the age of 16, Carmen married and moved out of the house, with the primary motivation of escaping her father. However, the man she married was also violent. Carmen described him as a local "bad man," involved with criminal gangs in the neighborhood. He was twice Carmen's age and was unfaithful to her throughout their marriage, as well as being sexually and physically violent toward her. Carmen explained that as a woman in Colombia, she was expected to stay at home and raise their children, but she had ambitions to work and study, having done well at school despite the violence at home.

Carmen was isolated, with little support, but she did manage to stay in touch with her sister, who had moved to the United Kingdom and was working as a nurse. With her help, Carmen left her husband and traveled to London with her three children. Carmen was also training to be a nurse, although at the time of treatment, she had taken a break from her studies.

At assessment, Carmen met criteria for PTSD and had reexperiencing symptoms relating to five episodes of violence at the hands of her ex-husband. She was also suffering from depression, and fulfilled most, but not all, criteria for a diagnosis of borderline personality disorder. Her sister had persuaded her to come for treatment when she had found Carmen self-harming by cutting her inner thighs, a long-standing behavior. She denied suicidal intent, citing her children as a protective factor, but described an occasion in which she had wandered alone at night to a bridge over the river, in an apparently dissociated state, and a member of the public had alerted the police, who took her home.

Treatment

Carmen received 18 sessions of treatment. The early sessions focused on engagement, risk management, and developing a shared understanding of Carmen's problems. Carmen expressed reluctance to come to the sessions and often gave brief answers or said "I don't know" when asked certain questions, particularly relating to her trauma history. The therapist focused on normalizing her symptoms and giving information about PTSD. She also agreed to write a letter to the housing association that accommodated Carmen and her sister, as they were hoping to move to a bigger flat now that her children were older.

Carmen had a flashback during Session 2, triggered by the sound of a male voice shouting nearby. The therapist took this opportunity to begin the process of helping Carmen to identify her triggers and to learn stimulus discrimination. They also experimented with different reminders of the here and now. Carmen began to carry a stress ball in her purse that she could squeeze if she began to dissociate, and also taught her sister how to recognize whether she was dissociating and help her. Carmen's self-harm tended to occur when she was dissociating in response to a trauma trigger. The use of stimulus discrimination as an alternative proved effective in reducing the self-harm.

After three sessions working on these techniques, Carmen and her therapist began to construct a timeline of her traumatic experiences. She was able

to identify which of the events she reexperienced in nightmares, flashbacks, and intrusive memories, and which events were important in terms of belief formation. For example, she reported that the belief "I deserve to be punished" (which she believed 100%) started when her father would beat her for minor misdemeanors, but it grew stronger during her marriage.

The most distressing trauma memory for Carmen was the first time she was raped by her husband, which was on her wedding night. Carmen understood that she was expected to have sex with her husband that night, but she asked him to stop because she was experiencing pain, which he refused to do. As their marriage continued, Carmen was raped many times, and learned to dissociate when it was happening, something she had also done when her father was punishing her. Understanding dissociation as a strategy that had helped her in dangerous situations, but was no longer needed, was an important step in making sense of Carmen's trauma symptoms, which had previously made her believe she was going mad.

Due to her dissociation, Carmen and her therapist worked on the trauma memories using written narratives. The first trauma memory revealed many important cognitive themes, including a sense of shame, degradation, and contamination linked to Carmen's belief that she deserved such treatment. They worked on these beliefs using a range of techniques, including a review of the evidence and a survey. The survey was sent to a range of respondents via Survey Monkey for anonymous responses. Carmen and her therapist devised several questions to address Carmen's beliefs (e.g., "Does a woman have a right to refuse sex, even once she is married?"). The new evidence was then used to update the trauma memory ("I know now that he is wrong and I do not deserve to be treated this way"). Her belief that she deserved bad treatment dropped to 20%, although she still described head–heart lag. To consolidate the verbal updates, Carmen wrote a letter to her younger self, and read it to her in imagery, telling her that she was a good person, who did not deserve bad treatment.

Work on the other reexperienced memories progressed quickly, as many of the same emotions and appraisals were present, and could be updated rapidly. Carmen and her therapist wrote the updates into the trauma narratives and, in later sessions when her dissociation was better controlled, Carmen was able to read the narratives and the updates aloud, taking in the new updated meanings while holding her hot spots in mind.

As her reexperiencing symptoms reduced, Carmen was able to increase her range of activities, and she and her therapist reviewed the "reclaiming your life" plan she had made at the start of treatment. She determined with nursing college personnel when she would restart her course and began to study at home. Carmen had previously avoided situations in which she would be alone with men, and she and her therapist planned some behavioral experiments in which Carmen could safely experience and discriminate triggers, such as ordering an online shopping item and conversing with the deliveryman. She had also avoided events with the Colombian community in London, for fear

that someone might know her husband, but through a risk calculation with her therapist, Carmen concluded that this was highly unlikely, and experimented with visiting a Colombian café with her sister.

Toward the end of treatment (Session 15), Carmen and her therapist used Google Street View to find the house where she had lived with her husband in Colombia. To her surprise, she could zoom in on the exact house on their old street. With encouragement from her therapist, Carmen noticed several differences in how the house and the street had looked when she lived there. The front garden was tidier and the front door had been painted (leading Carmen to conclude that her husband had moved away), signage on the street had changed, and some graffiti had been painted over.

Carmen and her therapist prepared a blueprint summarizing her work in treatment, and identifying a plan for any possible setbacks in the future. Carmen was adamant that she would never again enter a romantic relationship, but in the final few sessions of treatment had agreed to go on a date with a friend of her sister. She felt anxiety about the possibility of violence, and a lack of confidence in recognizing whether he could be trusted. Given that Carmen had limited experience in nonabusive relationships, her therapist helped her to make a list of acceptable and unacceptable behaviors to watch out for. They agreed on a plan for what to do if he behaved in an unacceptable manner, including to check with her sister if she was unsure.

Session Transcript

This session transcript is taken from Session 9, after Carmen and her therapist had completed a detailed narrative of the first rape she experienced.

THERAPIST: You've done such a brilliant job with this. I'm really impressed.

CARMEN: I didn't think I would be able to say it all.

THERAPIST: You've said lots, and we've got it written down now. How does it feel to see it?

CARMEN: It's a bit much, you know, but I'm glad I did it.

THERAPIST: Are you feeling OK? Are you fully in the here and now?

CARMEN: Yes, I'm here, I've got my ball! (*showing the therapist her stress ball*)

THERAPIST: That's great. Are you OK to talk a bit more about what we've written down?

CARMEN: Yes.

THERAPIST: OK, good. Tell me if you want a little break or if you need anything. Squeeze the ball if you feel like you are losing touch, yes?

CARMEN: I am. I will.

THERAPIST: So, I know the whole story is really horrible, but sometimes there

are certain moments which are stronger than others, that feel really bad. Are there any moments like that here?

CARMEN: When he is on me and I can't move. And he pressing here (*indicating her throat*).

THERAPIST: On your neck?

CARMEN: Yes, I can't breathe, too scary. I dream about it, and I wake up like this (*gasping*).

THERAPIST: That must be very scary.

CARMEN: Very scary and, I don't know . . .

THERAPIST: It gives you another feeling, too?

CARMEN: Him on me, it's so nasty, makes me (*shuddering and scratching her arms*) . . .

THERAPIST: It feels nasty? What kind of nasty? Like it makes you feel dirty?

CARMEN: Nasty, dirty, bad.

THERAPIST: You are scratching your arms a bit. I don't want you to hurt yourself. Can you squeeze the ball instead?

CARMEN: Yes.

THERAPIST: Well done. So, with this moment, when he was on you and pressing on your neck, what were you thinking? What was in your mind?

CARMEN: That maybe he will kill me. He is very heavy, and I can't breathe.

THERAPIST: So you were thinking he might kill you? It might sound a strange question, but what would have been the worst thing about that?

CARMEN: Well for me it would be bad, I am so young. But also it is disgrace for my family.

THERAPIST: Can you explain a bit more about that to me?

CARMEN: I don't know. People would talk about it in the town, it would be a big thing. And he is an important man, people know him. He would say it was my fault maybe.

THERAPIST: Your fault that he killed you?

CARMEN: Yes, he is clever. He would make it like it was my fault.

THERAPIST: OK, so at that moment you were thinking "I can't breathe; he might kill me, and I would be causing a disgrace to my family, people will think it is my fault."

CARMEN: Yes, all that.

THERAPIST: And you were feeling frightened, and also nasty, dirty? Tell me more about that.

CARMEN: It's like I am covered in him, he is sweaty, disgusting. And I am wrong somehow . . .

THERAPIST: So he is sweaty and disgusting, and it is also making you feel disgusting?

CARMEN: I think it is the sex thing. You know, in my country, young girl has sex, she is dirty.

THERAPIST: Even when you are married?

CARMEN: Well, not so much, but this wasn't normal, didn't seem like normal husband–wife sex. It was wrong somehow, so it seemed like I was making it wrong.

THERAPIST: OK, let me check if I understand: He is disgusting, but also you are feeling like you are doing something wrong because this isn't normal sex?

CARMEN: Yes, and my dad always said I was a slut, you know, even though I didn't do nothing, so maybe that was in my mind.

THERAPIST: I think you've noticed something really important there. It makes sense that some of those thoughts were influenced by everything you had already been through, like some of the things your dad used to say and do.

CARMEN: Yes, he got in my mind too much. In some ways my dad and my husband were the same. Both want to scare me, be the big man.

THERAPIST: Yes, that's interesting, isn't it? And it makes sense that some of the things they said to you got in your head. One thing I want us to do together is try and understand whether what they said is true.

CARMEN: I know it isn't true, most of it. I didn't know then, but I know now. And sometimes it is hard to believe it. If I feel down, it's like they are still here, still telling me things.

THERAPIST: That makes a lot of sense. Do you remember how we talked about, with PTSD, that things from the past can feel like they are happening now? You might know it isn't true now, but when the memories come, or you feel down, it feels true again.

CARMEN: Yes, exactly that.

THERAPIST: OK, so let's think about how you were thinking that night, on your wedding night, when he was pressing on top of you. And we can start thinking about whether those things are true, and whether we know anything now which is different.

Commentary on the Case Example

Building an Alliance

A major priority, especially when working with someone with interpersonal difficulties, is to build a strong therapeutic alliance. Carmen had been persuaded to attend treatment by her sister, and initially expressed reservations about the process. The therapist was concerned that she might drop out of treatment, so she focused primarily on creating a shared understanding of Car-

men's difficulties and creating hope that they could be overcome. Having a better understanding of what was causing and maintaining her problems helped Carmen to believe that they were treatable. Engagement was also increased by teaching Carmen usable skills during the early sessions, such as stimulus discrimination, giving her more control over her symptoms and helping her to see that therapy could be helpful. This took priority in early sessions over beginning the trauma narrative. It was important that Carmen have control over the pace of therapy, and not feel pushed or coerced at any point.

Working with Risk

Another priority was to establish Carmen's safety. This involved developing an accurate profile of the nature and frequency of Carmen's self-harm and any risky behavior when she dissociated. In Carmen's case, the self-harm occurred when she was dissociating, and was an effective means of "grounding" her. Carmen found the behavior distressing, and was willing to learn alternative methods of returning her attention to the here and now. Given Carmen's history of abuse by others, the therapist hypothesized that there was also an element of self-punishment to her self-harm. Carmen found it hard to identify what thoughts triggered the urge to self-harm, but she did link it to intrusive memories of sexual assaults by her husband. These memories, and their related meanings, were prioritized in treatment.

Carmen was suffering from dissociative episodes, both in the form of flashbacks and "blanks," in which she was unaware of her surroundings for periods of time. In such cases, it is important to assess whether a client is at risk when dissociated, for example, if he or she is driving or entering risky situations. In Carmen's case, this had occurred on only one occasion, when she had wandered onto a bridge after a row with a neighbor. Again, identification of triggers and practicing stimulus discrimination were effective in reducing this risk in Carmen's case. However, the dissociative episodes and self-harm were monitored throughout treatment, especially while working on the trauma memories, and narrative writing was used as an alternative to imaginal reliving to minimize the risk of triggering a dissociative flashback.

Carmen's risk from others was also assessed. She did not judge either her father or ex-husband to currently pose a risk, as they continued to live in Colombia, and there had been no recent contact or threats made. In cases where individuals are still at risk, for example from ex-partners, establishing safety should be a priority before treatment continues. This usually involves developing a safety plan, and contacting the police and relevant safeguarding organizations.

Comorbid Social and Psychological Problems

Like most people with PTSD, Carmen met criteria for at least one comorbid psychological disorder. In her case, depression had developed as a consequence

of her traumatic experiences and of having PTSD. The main maintenance factors in Carmen's depression were negative, self-critical thinking and a reduction in positive activities. The symptoms of depression, which did not interfere with her PTSD treatment and were regarded as a secondary problem, began to improve as her PTSD symptoms lifted. In other cases, comorbid conditions would require treatment in their own right if deemed to be the primary problem for a client, if related closely to the client's treatment goals, or if they interfered with PTSD treatment or remained problematic even after PTSD has been successfully addressed.

Social problems are also common for individuals with PTSD and, likewise, may take priority over PTSD treatment if they having a significantly negative impact. In Carmen's case, her main problem was with housing, which, although not an urgent issue, was causing her distress. Her therapist helped her problem-solve the issue and helped her access the Citizen's Advice Bureau, and wrote a letter in support of her housing application. They then agreed to prioritize work on PTSD for the remainder of the sessions.

Working Cross-Culturally

Cultural beliefs may influence an individual's personal meanings of trauma and their attempts to come to terms with trauma memories in helpful and unhelpful ways. As CT-PTSD uses an individual case formulation, treatment is tailored to the individual's beliefs, including cultural beliefs. Carmen often spoke about gender roles in Colombian culture and on the normalization of violence within relationships. The therapist took a stance of empathic curiosity, encouraging Carmen to reflect on how her cultural background had impacted on her beliefs. Updates to memories must feel relevant to clients in order to be effective, so the therapist also took care to work collaboratively with Carmen to identify updates and to make sure that they felt personally meaningful.

English was Carmen's second language, and she spoke it well, without the need for interpreter. The therapist took care to avoid jargon and to check understanding, using Carmen's words where possible. CT-PTSD can be conducted via an interpreter, if needed, although awareness of the additional interpersonal dynamics requires consideration (Tribe & Raval, 2014), and some practical adaptations, such as longer sessions, may be needed. Additional issues should also be considered when working with refugees and asylum seekers; for further details, see Grey and Young (2008).

Working with Multiple Trauma Memories

Working with clients who have experienced multiple traumatic experiences raises several issues, including a decision about which memories to prioritize. It can be helpful to make a timeline of the client's life, or the period in which he or she experienced traumas, to start putting the events in the context of a narrative, to identify the most troublesome experiences, and to understand when

different beliefs developed. Working on the most problematic event, in terms of distress and frequency of reexperiencing symptoms (using an intrusions diary can help identify this, if needed), has the biggest impact on PTSD symptoms. However, not all clients are willing to tackle the worst trauma first and, if there are concerns about risk, dissociation, or dropout, it can be preferable to work on a less distressing memory first that has straightforward updates, such as "I did not die." This can often have the effect of demonstrating the updating procedure and, hopefully, its effectiveness, thereby building confidence to repeat it with other traumas.

Carmen had identified five traumatic events that she reexperienced, all from adulthood. Although her childhood experiences were traumatic, she did not reexperience them. They were, however, very important in formulating her PTSD, as they laid the foundation for the development of relevant beliefs such as "I attract bad people" and "I deserve to be punished," and influenced how she experienced the adult traumas. As such, her childhood experiences were discussed in therapy but were not the subject of detailed narrative writing and updating. Had she been experiencing intrusive memories, nightmares, or flashbacks to her childhood, these techniques could have been applied. However, it should be noted that CT-PTSD has been developed and tested primarily for traumatic events in adolescence and adulthood, and is only recently being subjected to rigorous testing with clients who primarily experienced early childhood trauma.

Working with Long-Standing Beliefs

Many clients who have experienced multiple traumatic experiences, especially early life trauma, present with long-standing beliefs that are strongly held. These beliefs require targeting in treatment, in order to develop meaningful alternatives. Carmen had believed since childhood that there was something defective about her that attracted bad people, and meant that she deserved punishment. She often experienced "head–heart lag," for example, knowing that her experiences were not her fault but not truly believing it. Carmen and her therapist addressed these beliefs with a range of techniques. As well as cognitive discussion techniques, such as drawing up a list of evidence for and against her beliefs, they also arranged a survey to hear opinions from a range of other people. To help Carmen connect with this new information at an emotional level, the therapist used experiential techniques, such as writing a compassionate letter and reading it to her younger self in imagery.

One of Carmen's beliefs was that she could no longer trust her judgment and would be vulnerable to further abuse in the future. Because Carmen had very limited experience of nonabusive relationships, she found it difficult to clearly judge what behavior within a relationship was acceptable, and what was a warning sign of future violence. To address this, Carmen and her therapist took a more skills-based approach to develop a "warning sign" system to help Carmen recognize, and deal with, risky situations.

Virtual Site Visits

Returning to the scene of the trauma is a recommended procedure in CT-PTSD. However, in some cases, there are practical or safety considerations that make it impossible, for example, when the trauma happened in another country. In these cases, a virtual site visit can be used. Online tools such as Google Street View and Google Earth can be used to locate the scene of the trauma. This allows many of the same activities as a real site visit, such as noticing the differences between the trauma memory and the site as it currently appears. For Carmen, seeing how her old street had changed made the memories of domestic abuse feel more remote. She also believed that she would see her ex-husband when she looked up her old address (a sign of the "nowness" of her memories) and felt relieved that he no longer seemed to live at their old house.

Conclusion

CT-PTSD is an effective treatment for individuals with PTSD, including those with more complex presentations. The formulation-based treatment allows for flexibility in how and when different interventions are applied according to clinical need and client choice. The focus on individual meanings of the trauma and its consequences means that treatment is highly individualized to each client. The therapist aims to see the trauma through the eyes of the client, and help the client to develop less threatening appraisals of what has occurred, which can then be linked back into the trauma memory. As such, CT-PTSD is a collaborative and flexible approach to addressing complex traumatic stress disorders.

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