COGNITIVE BEHAVIORAL THERAPY: POST-TRAUMATIC STRESS DISORDER

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Abstract

Cognitive behavioral therapy (CBT) is based on social learning theory and is one of the most widely used form of psychotherapy in research. Emphasis is placed on how the individual's thoughts and emotions interact with their actions and assists them to develop adaptive or modify cognitions and behaviors. Cognitive behavior therapy is a collaborative and goal-oriented therapy which the clinician and patient work towards a change in mood and lifestyle. It is one of the most recommended treatment for many mental health disorders (Chand & Kuckel, 2019; & Fenn & Byrne, 2013). This paper will discuss an overview of CBT as well as include a brief discussion on its theory and practice. This writer will conclude this paper with an exploration of the effectiveness of CBT in the research of post-traumatic stress disorder (PTSD).

Introduction

Cognitive behavioral therapy (CBT) explores the relationship between an individual's thoughts, emotions and behavior in order to direct them towards developing a change in thinking patterns and behavior to improve their mood, functioning and well-being (Chand & Kuckel, 2019; & Fenn & Byrne, 2013). CBT has been demonstrated to be an effective psychological treatment for a variety of mental health disorders including but not limited to anxiety disorders, depression, addiction and substance abuse, somatoform disorders, eating disorders as well as severe mental illness. Research in the utilization of CBT suggests it leads to significant improvement in coping skills to overcome obstacles which in turn enhances the person's quality of life (David, Cristea & Hofmann, 2018; & American Psychological Association, 2017).

As earlier stated, CBT is one of the most widely used psychological treatments in assisting individual and/or their family to identify and manage triggers of symptoms as well as provide the tools to assist in coping with thoughts and feelings. Therefore, this writer has chosen post-traumatic stress disorder for this assignment because of its insidious onset and non-discriminatory effects on the human psyche after a traumatic event.

Historical view of Cognitive Therapy

The precursors of cognitive therapy were noted in the time of the ancient Greeks, specifically in the teaching of Plato (427-347 B.C.E.) whose idealism of reality was experienced by individual's perception within the mind (Chaffee, 2015). Socrates (444-c.-357 B.C.E.) believed that those who lived reflective lives would find that the truth already existed in the mind of the individual and their perceptions of innate forms needed to be only clarified through education and moral conduct. Kant (1724-1804) believed knowledge begins with experience and individuals receive

impressions by sorting, organizing or categorizing each collection of data into schemas that is unified to form personalized experiences (good or bad). According to Kant, those experiences become a part of the thoughts and perceptions of the individual which shapes the mind and behavior (Chaffee, 2015). Bentham (1748-1832) argued that experiences came from more than associations or categorization but was also learned through things such as rewards or punishment (good or bad). Thus, this way of thinking brought a close to associations or categorizing perceptions to attain knowledge through experience and brought into the idea that knowledge was ones' own point of view (Chaffee, 2015).

In the early years this change brought about the birth of psychotherapy with the practice of psychoanalysis pioneered by Freud (1856-1939) to comfort hidden thoughts that may influence behaviors in the view of the multi-level of the self through talking in order to generate a cure. New conceptions related to psychological functioning and change were introduced by Adler (1870-1937) and Jung (1875-1961) which later developed into psychodynamic therapy and included a range of therapies based on Freud's theory on the conscious and unconscious mind (Burger, 2018). As time progressed, theory models were developed that focused on behavior. During this era of behaviorism, clinicians used techniques of classical and operant conditioning as well as social learning to bring about change (Burger, 2018). Two of the major contributors of this school of thought was Skinner (1904-1990) and Wolpe (1915-1997) whose contributions generated the inquiry into different methods to induce changes in thought and behavior. With that being said, researchers such as May (1909-1994), Frankl (1905-1997) and Rodgers (1902-1987) brought a different type of thought in response to behaviorism. Those researchers developed theories from the humanistic view, focusing predominantly on promoting positive holistic change through unpretentious support and instilling an empathetic relationship between client and therapist (Burger, 2018).

Although, cognitive therapy from the viewpoint of a historical perspective as a basis to gaining answers into the drives and behaviors of unconscious emotions for psychotherapy is not new, the approach to cognition as the "key" to therapy was during that time period, and came about in the research of Beck (1921-present). According to his early writings, he concluded that people perceived and interpreted daily life through their perceptions of those events (Beck, 1976; & 1967). Hence, the marriage of behavioral modification techniques and cognitive therapy formed what is not known as cognitive behavioral therapy (CBT) (Burger, 2018).

Cognitive Behavioral Therapy: Modality Overview

Cognitive behavioral therapy (CBT) also known as cognitive therapy (CT) is based on a model that one's perception and cognition is centered on events and beliefs that are constructed by interpretations. This model was initially developed by Dr. Aaron T. Beck in 1964 while he was researching patients with depression and their dreams. In his research he found that the dreams of his patients formed a common thread of loss, failure and emptiness and their perceptions were characterized by a negative view of reality. Furthermore, he noticed their verbalizations during treatment sessions were "cognitively distorted" and true to only themselves

(Chand & Kuckel, 2019; & Fenn & Byrne, 2013). As a result of his inquiry, Dr. Beck focused on the role and thoughts of the patient's view of themselves coupled with their behavioral reactions. In addition, he constructed his psychotherapy modality on a phenomenological approach as proposed by ancient philosophers of Stoic Greek methodology. According to Beck, the automatic maladaptive thoughts, beliefs, schemas about the world or self, contributed to emotional upheaval or the display of negative behavior when distressed (Ruggiero, Spada, Caselli, & Sasaroli, 2018; Fenn & Byrne, 2013 & Beck, 1976).

Cognitive behavioral therapy is based around a framework of three (3) levels of the cognitive model such as the individual's core beliefs, dysfunctional assumptions negative automatic thoughts. The levels proposed by Beck (1976), are explained to have derived from earlier experiences learned in childhood and are perceived as real or "truths," are rigid, unrealistic rules that individuals adapt and are involuntary negative thoughts activated in stressful situations. The therapist uses various techniques based on the patient specific problem and goals for each session and the questions generated by the clinician guides him/her in planning treatment (Ruggiero, Spada, Caselli, & Sasaroli, 2018; Fenn & Byrne, 2013 & Beck, 1976).

Cognitive behavior therapy is structured and educational because patients use skills learned to regulate their cognitive state, emotions and behavior so they can solve problems for those that produce the most distress. Therefore, this type of therapy is time-limited to 6-20 sessions or more depending on intellectual disabilities as well as the personality disorder. Nevertheless, the ultimate goal is for the patient to be their own therapist by giving them the tools to change maladaptive thinking and behavior patterns. Depending upon the agreement made between the patient and therapist, the central components of CBT can assist in fostering an environment of collaborative pragmatism or provide a predefined problem-oriented focus (Ruggiero, Spada, Caselli, & Sasaroli, 2018; Fenn & Byrne, 2013).

A positive factor in utilizing CBT is that there is no one specific patient for this approach because researchers have produced numerous studies on its effectiveness in treating a variety of disorders and behaviors such as schizophrenia, bipolar and depression, anxiety, somatoform, eating disorders, personality, chronic pain and fatigue, anger and aggression and criminal to name a few (Hoffman, Asnaani, Vonk, Sawyer & Fang, 2012).

Cognitive Behavioral Therapy: Practice Techniques

Therapist incorporate different variations of CBT to assist the patient in changing their behavior, cognition and mood as well as functioning. As mentioned earlier, techniques are based on the ongoing assessment of the patient with his/her problems and specific goals for each session. Specifically, the therapist collaborates with the patient and may select techniques that are behavioral, environmental, biological, cognitive, supportive, experiential or interpersonal. The therapist will continually ask of themselves how they might help the patient feel better or have a better week, such self-interrogations also assist in guiding the therapist towards better planning strategies (Ruggiero, Spada, Caselli, & Sasaroli, 2018; Fenn & Byrne, 2013). Likewise, due to the

structure involved in treatments, each session may include a mood check, reassessing the meeting agenda, discussions to bridge previous sessions or problem solving and teaching, summations and feedback (Fenn & Byrne, 2013). Therefore, cognitive behavioral therapy places substantial emphasis on the subject experience of the patient and examining the constructs of the patient's reality and to make modifications of negative schemas and automatic thoughts to more sensible and positive occupations.

Cognitive behavioral therapy stems from cognitive therapy and behavioral therapy where components of both branches are joined together to create a treatment regimen for an individual suffering from a "stressor." According to Beck (1996), cognitive techniques invites the therapist to understand the view of the patient and assist the patient in o developing awareness of underlying assumptions and look at alternative views to find solutions.

Questioning is guided and is based on the way in which Socrates (469-399 B.C.E.) helped his students by asking questions in such a way for them to formulate their own conclusion. The probing of patient negative assumptions helped the therapist in collaboration looks at the reasons and verification of the patient's beliefs (Chaffee, 2015; & Fenn & Byrne, 2013). The therapist will also examine core beliefs that have maladaptive schemas by asking the patient to keep a journal or a log of positive affirmations during each day such as "I am a great cook,' or "I have a beautiful smile." To challenge thoughts that are negative and generated automatically out of anxiety such as "I'm going to fail at my job," or "I'm going to fail this test," the therapist will ask the patient to submit proof that will support or not support that assumption. By challenging the patients thought process, assist to guide them into considering alternate thoughts to change the emotion felt (Ruggiero, Spada, Caselli, & Sasaroli, 2018; Fenn & Byrne, 2013). The second component in CBT is establishing behavioral techniques that will enhance functioning and increase experiences that are satisfying and productive. The therapist and patient work collaboratively to create a list of tasks with steps that he/she can manage in order to help overcome situations that may elicit anxiety or procrastination. For example, a patient may be treated for feeling of death and doom when out in public such to the store; therefore, the therapist may conduct behavioral experiments that allows the patient to test their calamitous predictions. The patient will then take a walk or drive to the local store and then write down if what they predicted came true. The aim of the above is for the patient to perform the task and reevaluate their thoughts each time the task was positively completed. Likewise, the therapist may teach the patient breathing techniques to decrease the physiologic effects from autonomic arousal related to anxiety or a panic attack (Ruggiero, Spada, Caselli, & Sasaroli, 2018; Fenn & Byrne, 2013).

Cognitive Behavioral Therapy and Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PSTD) is defined by the DSV-V as "a classification of exposure to at least one traumatic or stressful event or as a consequence to a traumatic event which meets one of the below listed criteria occurring over months or years. The following criteria must be met for this classification (Trauma and Stressor Related Disorders);

1. Criterion A (one required): The person was exposed to death, threatened death, actual or threatened serious injury or actual or threatened sexual violence.
2. Criterion B. (one required): The traumatic event is persistently re-experienced.
3. Criterion C (one required): Avoidance of trauma related stimuli after trauma.
4. Criterion D (two required): Negative thoughts or feeling that began or worsened after the trauma.
5. Criterion E (two required): Trauma related arousal and reactivity that began or worsened after the trauma.
6. Criterion F (required): Symptoms lasting more than 1 month.
7. Criterion G. (required): Symptoms create distress or functional impairment
8. Criterion H (required) Symptoms are not due to medication, substance use or other illness.

Post-traumatic stress disorder (PSTD) possesses negative changes in cognition and mood and can have devastating effects on the individual's quality of life as well as employment and meaningful interpersonal relationships. Therefore, Cognitive behavioral therapy has be utilized as an intervention to confront the manner of thinking and behavior of individuals suffering with PTSD. Researchers have studied the effects of CBT in the treatment of PTSD in order to ascertain if emphasis placed on cognitive strategies can alter erroneous thinking and behavior created by the traumatic event. Below this writer has examined three (3) research articles in relation to CBT utilization with adults and children who have been diagnosed and are experiencing the symptoms of post-traumatic stress disorder.

1. Acosta, M.C., Possemato, K., Maisto, S.A., Marsch, L.A., Barrie, K., Lantinga, L., Fong, C., Xie, H., Grabinski, M., & Rosenblum, A. (2017). Web-Delivered CBT reduces heavy

drinking in OEF-OIF veterans in primary care with symptomatic substance use and PTSD

Behavior Therapy, 48 (2017), 262-274.

Researcher studied symptomatic veterans with PTSD who served in Iraq and Afghanistan war and were diagnosed with PTSD and suffering from alcohol and/or substance abuse. The total number of veterans participated in the study was 162 from four Veteran hospitals in New York. The researchers conducted the clinical trial to ascertain if interventions using a web-based program called *"Thinking Forward*" instead to the conventional face-to-face sessions with a therapist would return positive results for the veteran. The soldiers were given five scales (questionnaires) prior to entry into the study in order qualify as a participant. The soldiers were divided into two groups (Treatment as Usual or TAU; and Treatment as Usual and Thinking Forward) for 24 weeks. The computer program consisted of 24 modules and setup to be self-directed. Each of the modules were designed to teach the soldiers various cognitive behavioral skills that was identified, evaluated and challenged negative thoughts related to PTSD symptoms as well as a functional analysis of their alcohol or drug use. The program also included a printable workbook with exercises and copes of the modules to be completed. The study also stated that there were modules that included relaxation techniques with some linking things such as insomnia, pain and problems with communication with the symptoms of

PSTD. In conclusion of their study, researchers observed significant reduction in alcohol use for veterans who used the program but did not see significant results for PTSD symptoms. Researchers suggested that the absence of results in those areas were probably due to the self-directed intervention where the veterans selectively avoid a particular module that may produce stress. Veterans who were given the usual treatment of medication and therapy did have a reduction in their PSTD symptoms and alcohol use. The researchers concluded that the veterans using a web-based program such as *Thinking Forward*, my also need more professional contact in maintaining gains made in treatment. Nevertheless, researchers provided data on the strengths of the computer program in improving relationships and communication, with self-efficacy mediating the effects.

2. Bryant, R.A., Kenny, L., Rawson, N., Cahill, C., Joscelyne, A., Garber, B., Tockar, J.,
Dawson, K., & Nickerson, A. (2019). Efficacy of exposure-based cognitive behavior
therapy for post-traumatic stress disorder in emergency service personnel: a randomized Clinical trial. *Psychological Medicine*, 49, 1565-1573

Researchers investigated post-traumatic stress disorder in emergency service personnel (police officers, fire fighters and paramedics) in order to assess the usefulness of cognitive behavioral therapy for brief exposure (CBT-B for 10 & 60 minutes) to traumatic memories in comparison to prolonged exposure (CBT-L for 90 & 40 minutes). It was postulated that emergency services personnel have traumatic memories of on the job observations place them at a greater risk to experience PTSD symptoms which also increases the potential for that group to participate in alcohol and substance use as well as experience depression. Investigators assessed the effectiveness of CBT interventions for emergency service personnel with PTSD in relation to a waiting list. Researcher chose 100 participants by a controlled randomized trial all of whom attended a Traumatic Stress Clinic and was provided a scale to establish level of PTSD. A total of six inventory questionnaires were given to the participants and they were divided into three groups (CBT-L, CBT-B and Wait List). Participants in groups CBT-B and CBT-L were given 12 weeks with one session of psychotherapy (education), four training sessions of CBT, six session in imaginal and *in vivo* exposure as well as one session in relapse prevention. Therapy session topics varied and were dependent on the participants comorbid diagnoses such as pain and anger management, depression, and emotional regulation at the time of questioning. Each participant was given a workbook to write down feelings and accomplishments as well as questions. At the conclusion of the study results demonstrated post-treatment that exposure-based interventions CBT 1 And CBT B) both reduced PTSD severity in the participant emergency service personnel. Investigators stated that the results extended previous studies dating as far back as 2000 and 2007. Authors stated that CBT is efficacious as compared to other imaginal studies showing that brief CBT exposure therapy was just as efficient as long CBT exposure even after 6-month follow-up.

3. Tutus, D., Goldbeck, L., Pfeiffer, E., Sachser, C., & Plener, P. (2019). Parental dysfunctional post-traumatic cognitions in trauma-focused cognitive behavioral

therapy for children and adolescents. *Psychological Trauma: Theory, Research, Practice and Policy*, 11(7), 722-731

Researchers of this study investigated dysfunctional post-traumatic cognitions (PTC) in the development of mental health disorders in children and adolescents. The investigators looked at whether trauma focused (TF) CBT helped the parents in correcting dysfunctional thinking in relation to PTC of their child or whether the maladaptive thinking will mediate their child's outcome in terms of PTC. The authors stated that PTSD created intrusive emotions such as anxiety, anger, sadness and shame after a traumatic event often inclusive to the parents as well. Their participant sample comprised of 113 children and their parents who attended mental health clinics in Germany. A criterion to be chosen, children and the adolescents had to exposed to at least one event starting at the age of three and three months prior to investigative assessment. Investigators utilized trauma-focused CBT short term therapy interventions in three treatment phases (stabilization and building skills, exposure and cognitive processing, and fostering safety and future development) in 12 weekly 90 minute conjoined or parallel session with their parent/caregivers. Investigators limited result inclusion to only those participants who completed a minimum of eight session which comprised of modulation skills in relaxation, cognitive restructuring and exposure, and psychoeducation. Two group of participants were assigned 57 to trauma focused CBT group and 56 to the wait list participant group. Although there were two inventory scales used (University of California at Los Angeles Post-Traumatic Stress Disorder Reaction Index for children and Adolescents (UCLA) & the Post-Traumatic Cognitions Inventory scale), children and their parents were assigned one each; both however measure PSTD. According to the authors results, 46 of the 57 participants completed treatment and participants on the wait list were promised treat in four months. It was no surprise to investigators that a change in dysfunctional thinking was significantly greater in parents who were in treatment than the wait list group. Authors were happy to suggest that changes in thinking was due to the treatment given in relation to the child's trauma. The authors also acknowledged that their results were in line with other studies that showed TF-CBT was effect in alleviating intrusive ideations and emotional reactions from distress from abuse, symptoms of depression following trauma. Post treatment the authors stated they could observe a reduction in parental post-traumatic stress dysfunction and how it impacted the child's post-traumatic symptoms. However, as with past researchers, study investigators could not definitively establish through post questionnaire with the parents or children an association between parental dysfunction post-traumatic stress symptoms and the child's post-traumatic stress symptoms.

CONCLUSION

In conclusion, cognitive behavioral therapy is a type of psychotherapy that utilizes the subjective admissions of the patient to treat a variety of mental disorders and behaviors and thought processes. Patients receiving this type of therapy assists them in making sense of painful or unhealthy memories, teach more helpful ways in dealing with frightening events that trigger depressive feeling, inappropriate behaviors or unhealthy responses. This therapy also involves having patients face

and control their fears in a safe structured way by using imagery, visiting the place of trauma or keeping a journal where the patient can write down intrusive thoughts (Ruggiero, Spada, Caselli, & Sasaroli, 2018; Fenn & Byrne, 2013). By this writer going back of the historical context of cognitive therapy, it was easy to see how the treatment modality evolved and branched off into directions of strength and notable effectiveness. By this writer reviewing three articles cemented my understanding of the importance of having a therapeutic relationship with patient and therapist as well as training in order to be effective in delivering treatment.

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