



Treating Post-Traumatic Stress Disorder: Cognitive Behavioral Therapy

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Abstract

Post-Traumatic Stress Disorder, or PTSD, is defined as an altered reaction to the typical “fight-or-flight” response. While previous research has been done on the disorder, there is still much to learn about the condition in order to better improve its treatment. This paper serves to explore the possibilities of PTSD treatment via cognitive behavioral therapy (or, more specifically, prolonged exposure therapy). Case studies assessed for this literature review have provided that these behaviors can be corrected effectively via several prolonged exposure therapy sessions held over an extended period of time. In conclusion, prolonged exposure therapy currently stands as the ideal treatment pathway for those diagnosed with PTSD.

When in danger, it is nothing less than natural to experience fear. That being said, the normal and healthy human response to fear is typically the “fight-or-flight” response. In those that are diagnosed with Post-Traumatic Stress Disorder, or PTSD, this reaction is altered in some form. Therefore, this mental disorder can develop as a reaction to such trauma, or even genetics. Common symptoms include, but are not limited to, re-experiencing said traumatic event, avoidance, and hyperarousal (National Institute of Mental Health, 2014). While there has been a moderate amount of research done on the disorder and those who are affected by it, it is clear that there is so much of the human experience that cannot be defined so concretely. Being a citizen of a country with an active military, it is crucial that further research be done on the disorder, and there will always room for improvement of the methods that are currently utilized to treat the condition. In order to better pursue a solution for

those who are diagnosed with PTSD, and also knowing that individual experience is one of the major components that keeps our findings on it so vague, the best way to approach research in this area would be to prioritize by targeting a specific physiological or even psychological symptom. This paper serves to explore the possibilities of PTSD treatment—namely, cognitive behavioral therapy, or prolonged exposure therapy, more specifically—and discuss the advantages of this treatment over other forms of psychotherapy for treating males whose PTSD diagnosis resulted from exposure to warfare.

Literature Review

Seven to eight of every one hundred people are diagnosed with PTSD at some point in their lives (U.S. Department of Veterans Affairs, 2014)—not to mention that this makes the overall topic any less significant—and because those who are diagnosed with PTSD are mentally sensitive, as the definition of the disorder suggests, it would not be ideal to seek out those who are affected and utilize a survey-based method to conduct any research on the topic. There are a number of unethical implications that would take precedence over the purpose of the research, such as an invasion of privacy. Therefore, a better alternative would be to delve into the research of other, authorized, professionals who have already considered the same questions and conducted their own research. More specifically, looking into case studies it would be ideal for the research behind this literature review.

In the first case study assessed, a twenty-four-year-old Caucasian Marine veteran was presented to the U.S. Department of Veterans Affairs and was tested positive for PTSD. Among his primary military responsibilities, he was to secure neighborhoods and homes. Many of his experiences in the field included, but were not limited to, experiencing life-threatening situations such as firefights, experiencing split-second life-or-death situations, being exposed to dead or mutilated bodies, and losing two of his own friends in combat-related death. Upon returning to the United States from war, he claimed to have experienced at least eight distinct and traumatic combat-related memories; he also reported a need to check to see that his front door was locked ten to thirty times a day and to peek out his front windows thirty to fifty times a day. He avoided human contact, attempted to suppress his own thoughts, became overly obsessed with his work, and abused alcohol consumption. As a result of this, he dropped out of college because of his inability to focus on his academics.

This client's treatment included prolonged exposure treatment—in this case, vivid retelling and visualization—in which he engaged in a total of twelve ninety-minute sessions and a reintroduction to common tasks that he had been avoiding, like going to the post office to mail his bills, for example. As a result of this sort of treatment over several weeks, professionals found that his PTSD score was drastically lowered from forty to twenty-two, and his BDI—Beck

Depression Inventory, in which depression severity is measured—score was also drastically lowered from twenty-two to nine. The final result was that the client no longer met the criteria for diagnosis of PTSD via the SCID, or Structured Clinical Interview for Disorders (Tuerk, 2009).

In the second case study assessed, a thirty-eight-year-old Black Army veteran was presented to the U.S. Department of Veterans Affairs and was also tested positive for PTSD. Among his primary military responsibilities, he was to provide security for truck convoys by patrolling alongside them and checking for bombs. Many of his experiences in the field included, but were not limited to, exposure to multiple life-threatening situations, witnessing an explosive device detonate during a convoy, being exposed to dead or mutilated bodies, and witnessing a truck run over a young girl. Upon returning to the United States from war, he claimed to have experienced at least ten distinct and traumatic combat-related memories. He also reported an effort to avoid human contact by running his errands late at night, for example, and stayed at home as much as possible; further, he checked under and in his car for bombs two to eight times a day.

This client's treatment included prolonged exposure treatment—in this case, vivid retelling and visualization as well—in which he engaged in a total of fifteen ninety-minute sessions (which included exercises that helped him become aware of and tolerate his physiological symptoms, such as rapid

breathing, for example). As a result of this sort of treatment over several weeks, professionals found that his PTSD score was drastically lowered from sixty-eight to thirty-two, and his BDI (Beck Depression Inventory) score was also drastically lowered from thirty-one to seventeen. The final result was that the client no longer met the criteria for diagnosis of PTSD also via the SCID, or Structured Clinical Interview for Disorders (Tuerk, 2009).

Other popular form of treatment includes dialectical behavior therapy, in which the disorder is treated by improving their emotional and cognitive regulation via the identification of personal triggers and the skills to cope with them (Harned, 2008). However, even the dialectical behavior therapy manual encourages the utilization of exposure-based methods to reduce posttraumatic responses or even treatment relapses.

Discussion

PTSD, like many mental disorders, is relatively difficult to diagnose because there is so much ambiguity in the way that is defined. Where is the fine line drawn in between a “traumatic event” and an unfortunate incident? Where is the fine line drawn in between someone who has diagnosable PTSD and someone who simply possesses a negative memory? UC Merced's Director of Disability Services for the Veteran Services Office, Dr. Holly Mayo, and Clinical Psychologist, Dr. Alex Khislavsky, provide answers to some of these very questions and discuss their professional opinions on the topic.

Mayo agrees that many of the distinguishing lines mentioned above are difficult to identify, simply because the human experience for each individual is so unique; we all have different backgrounds, and our own history is a part of what makes us who we are. In terms of treatment, Mayo has worked with several clients in the past, and various diagnosing professionals have provided a great variety in assessment quality; this deviation from a single standard poses as a significant problem. However, Mayo does note that those professionals who do follow a clinical diagnosing standard are the ones who provide a clear picture of how the client is currently impacted by the condition and by their past, and this could be key in further aiding the client. Mayo's opinion in terms of a "cure" reflects a similar attitude. Primarily, Mayo refers to the idea of a "Medical Model," in which a cure could be discussed. However, Mayo argues that there is no common baseline for "normal;" as such, how can we ask for a cure to a condition such as PTSD? Mayo focuses more on how we can better help each client function better in society.

Alex Khislavsky, a Clinical Psychologist on campus, also seemed to agree with several of Mayo's points in that there are no real defining lines to more clearly demonstrate what it means to have PTSD. However, Khislavsky did point to a handful of resources that can define PTSD to an extent--some of these resources being a reference to psychological professionals around the world; one example of such a resource includes The Diagnostic and

Statistical Manual of Mental Disorders, in which there is a definition for all of the common causes and effects of PTSD. In conclusion, Khislavsky further emphasized that PTSD must be treated like the flu, in which the condition is merely a combination of various symptoms, behaviors, and problems.

For the purposes of this literature review, identifying males within the age range of forty to forty-five, diagnosed with PTSD as a result of warfare were compared. The disorder itself is most commonly linked to or associated with warfare, so studies on American males in the age range provided suggest a likely participation in the Iraq War or the War in Afghanistan. Despite the potential infinite differences of each individual's human experience, as emphasized above, the similarities between the two case studies assessed is apparent, and the data yields significant improvement of PTSD symptoms in both. Prolonged exposure treatment, a form of cognitive behavioral therapy or psychotherapy, helps to reduce intense physical reaction to reminders of the event, such as a pounding heart, rapid breathing, muscle tension, and sweating via exposure in growing increments over time (Tuerk, 2009). This is comparable to progressive alignment techniques, in which a skill is learned over time by building, very little by little, on that skill already possessed to reach an end-goal of another, different skill (Jung, 2009). Further, a greater consideration of ethics as well as a number of additional case studies may prove to be beneficial for more clearly identifying positive patterns

in future research.

Conclusion

In conclusion, cognitive behavioral therapy—prolonged exposure therapy, more specifically—has been proven to be statistically effective in treating PTSD and currently stands as the ideal treatment pathway. Interestingly, the case studies provided have suggested a pattern in which combat-related PTSD, in addition to the common symptoms listed above, often includes combat-specific compulsive checking disorders. The prolonged exposure therapy treatments in the case studies assessed for this literature review targeted compulsive checking disorders for military veterans whose primary responsibilities were not similar in structure. Results have strongly indicated that these behaviors can effectively be corrected via several prolonged exposure therapy sessions held over a period of several weeks, depending on response to the treatment. Further research may look into this, and further research is ideal as there is still much to be learned about this mysterious disorder that so affects our war veterans.

References

- Bartone, P., Adler, A., Vaitkus, M. (1994, June). Assessing Post Traumatic Stress Disorder and PTSD Symptomology in U.S. Army Personnel. Retrieved from <http://oai.dtic.mil/oai/oai?verb=getRecord&metadataPref>
- Bradley, R., Greene, J., Russ, E., Dutra, L., Westen, D. (2005, February). A multidimensional meta-analysis of psychotherapy for PTSD. Retrieved from <http://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.162.2.214>
- Ford, J., Courtois, C. (2009, February). Treating complex traumatic stress disorders. Retrieved from http://books.google.com/books?hl=en&lr=&id=qbS_lticFJIC&oi=fnd&pg=PA13&dq=de
- Jung, W., Hummel, J. (2009). Progressive Alignment Facilitate Learning of Deterministic But Not Probabilistic Relational Categories. *Proceedings of the Twenty-second Annual Conference of the Cognitive Science Society*, 770-75. Retrieved February 24, 2014, from http://cognitivesciencesociety.org/conference_overview.html
- National Institute of Mental Health. (2014). Post-Traumatic Stress Disorder (PTSD). Retrieved from: <http://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-:ptsd/index.shtml>

Tuerk, P., Grubaugh, A., Hamner, M., Foa, E. (2009, July 1). *Diagnosis and Treatment of PTSD-Related Compulsive Checking Behaviors in Veterans of the Iraq War: The Influence of Military Context on the Expression of PTSD Symptoms*. Retrieved from http://ajp.psychiatryonline.org/article.aspx?articleid=100938#Case_1fining+PTSD&ots=fTEZefxvQ4&sig=EHg4DQzaWeHOdYdb-VuSak2DmQ8%20-%20v=onepage&q=defining%20PTSD&f=false#v=onepage&q&f=false

Yehuda, R., Koenen, K., Galea, S., Flory, J. (2011). The role of genes in defining a molecular biology of PTSD. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/21508511>

As an upcoming graduate of University of California, Merced, Vanessa, throughout her four years, has been deeply involved with several organizations on campus, including Dance Coalition, Pilipinos in Science & Engineering, Alpha Phi Omega, the American Medical Student Association, the Pilipino American Alliance, the Cognitive Science Student Association, and the Research Journal Club. Vanessa has also been involved in undergraduate research in Dr. David Noelle's computational cognitive neuroscience lab; her own research interests include, but are not limited to, cognitive psychology (or, more specifically, learning and memory), cognitive neuroscience, and mental illness--namely, autism and Post-Traumatic Stress Disorder. She hopes, with her degree in cognitive science and writing, to continue to pursue a higher education and, eventually, a career in psychiatry.

