



Cautions Regarding Cognitive-Behavioral Interventions Provided Within a Month of Trauma

How effective is Cognitive-Behavioral Therapy for early intervention?

Researchers have conducted over 30 studies examining the effectiveness of Cognitive-Behavioral Therapy (CBT) in treating PTSD and several studies examining a brief, five-session treatment for Acute Stress Disorder (ASD). In general, CBT has proven very effective and produced significant reductions in PTSD symptoms. CBT treatments are often carefully scripted in treatment manuals. There are more published well-controlled studies of CBT than of any other PTSD treatment. Furthermore, the magnitude of treatment effects appears greater with CBT than with any other treatment.

Bryant et al. ¹, in treating motor vehicle and industrial accident victims who met criteria for ASD, compared five sessions of nondirective supportive counseling (providing support and education and teaching problem-solving skills), with brief cognitive-behavioral treatment (trauma education, progressive muscle relaxation, imaginal exposure, cognitive restructuring, and graded in vivo exposure to avoided situations). At the conclusion of treatment, 8% of the participants in the CBT group and 83% of the participants in the supportive counseling (SC) group met criteria for PTSD. Six months posttrauma, 17% in the CBT group and 67% in the SC group met criteria for PTSD. There were also significant reductions in depressive symptoms in the CBT group compared to the SC group. Clearly, this is one of the most important developments in years regarding early intervention.

What are the obstacles to using Cognitive-Behavioral Therapy in early intervention?

Excerpted with permission from Bryant, R.A., & Harvey, A.G. ². *Acute Stress Disorder: A handbook of theory, assessment, and treatment*. Washington, D.C.: American Psychological Association Press.

There are a proportion of people for whom any early intervention may be inappropriate. The following issues are commonly encountered in individuals with Acute Stress Disorder, and must be carefully addressed in considering treatment options for these individuals:

Excessive Avoidance

Excessive avoidance may be an important warning sign that the client needs containment and support vs. exposure. If so, it is recommended to take a supportive approach until they are better able to use therapy. However, if therapist determines that exposure treatment can be tolerated, compare the benefits and disadvantages of proceeding with therapy, give more attention to cognitive therapy to assist in perceiving response to exposure, implement a graded exposure regime that commences with less distressing material, and make sure that all features of the narrative description of the trauma are eventually integrated in exposure treatment.

Dissociation

Dissociation may indicate a defense or protective mechanism against overwhelming distress. If dissociative symptoms are present, it may be best to take a supportive approach until the individual is better able to use therapy. However, if the therapist determines that even with dissociative symptoms, exposure treatment can be tolerated, modified exposure techniques may be effective, such as directing clients to imagine a scene that they can feel emotional about and then switch to the traumatic memory.

Anger

Anger may serve to inhibit anxiety, especially when avoidance is unsuccessful. Exposure not the optimal treatment if primary presentation is anger. It is best to implement CBT program specifically addressing anger.

Grief

The bereavement process is normal and takes time. It may not be appropriate to provide exposure during early phases of grieving. It may be best to provide support until better able to use trauma therapy.

Extreme Anxiety

Any individual who suffers extreme anxiety or panic attacks in the acute phase should be monitored carefully. Provide instruction in anxiety management prior to exposure treatment (SIT). Give more attention to cognitive therapy to assist client in appraising exposure in more adaptive way. Temporarily suspend exposure if panic or extreme anxiety which is intolerable by the client occur.

Catastrophic Beliefs

Proceeding with exposure without addressing clients' interpretations of the recalled memories may simply reinforce their maladaptive beliefs. Clients who manifest entrenched beliefs arising from their experience should receive substantive cognitive therapy

Prior Trauma

If prior trauma(s) are too distressing to engage in CBT, allow the posttraumatic upheaval to settle before directly addressing the traumatic memories, and take a supportive approach until the client is better able to use therapy. If, however, the therapist determines that exposure treatment can be tolerated, prioritize the memories that will be addressed, mutually agree on compartmentalizing the intrusive memories into an order that the client feels comfortable addressing. It is usually best to address memories of the recent trauma first -- they are more accessible and were the reason for presentation to treatment.

Comorbidity

Comorbid disorders may be exacerbated by the distress elicited by exposure therapy. Borderline personality disorder and psychotic disorders may be particularly affected. If deterioration of preexisting disorders is present, it is best to offer support to contain preexisting disorder first.

Substance Abuse

Substance abuse is a common posttraumatic response -- is a form of avoidance behavior that assists in distraction from distressing intrusive symptoms. If the individual exhibits marked substance abuse, require sobriety for several months before commencing exposure treatment, and provide support until better able to use trauma therapy.

Depression and Suicide Risk

Exposure treatment may enhance attention towards negative aspects of experience. Therefore, it is important to ensure clients who are severely depressed are provided the appropriate assistance to stabilize the depression prior to exposure. If the client is a suicide risk, they require support, containment, and possibly antidepressant medication and hospitalization.

Poor Motivation

If clear ambivalence exists, attempt to educate the client about the advantages of proceeding with therapy. It is better to not proceed with therapy in the acute phase if the client is not willing.

Ongoing Stressors

Ongoing stressors can impede with resources to engage in therapy, and the demands of therapy can impede coping with other stressors. Delay active treatment until threats to safety or severe ongoing stressors subside.

Cultural Issues

The rationale for exposure needs to be integrated in to the client's value system in a way that is congruent with his or her view of recovery. If discrepancy persists, recognize that a client's culturally driven outlook must be recognized and validated.

Appropriate versus Inappropriate Avoidance

There are many instances in the initial period when avoidance behavior is appropriate because of the recency of the trauma. It is important for clinicians to recognize the functional, and sometimes safety-enhancing roles of some avoidance behaviors in the acute phase.

Multiple Survivors of the Same Trauma

Sometimes clients' adjustment is directly influenced by the responses of others also involved in the traumatic event.

References

1. Bryant, R.A., Sackville, T., Dang, S.T., Moulds, M., & Guthrie, R. (1999). Treating Acute Stress Disorder: An evaluation of cognitive behavior therapy and supportive counseling techniques. *American Journal of Psychiatry*, *156*(11), 1780-1786.
2. Bryant, R.A., & Harvey, A.G. (2000). *Acute Stress Disorder: A handbook of theory, assessment, and treatment*. Washington, D.C.: American Psychological Association Press.