



Lily A. Brown

Optimizing CBT for PTSD



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1 PTSD Diagnostic Criteria, Prevalence Rates, Comorbidities, and Differential Diagnosis

Diagnostic Criteria

To meet the criteria for posttraumatic stress disorder (PTSD), an individual must report experiencing, witnessing, or learning about a traumatic event. According to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; DSM-5-TR) (2022), traumatic events include (but are not limited to) threats to one's physical integrity, such as physical or sexual assault, natural disasters, life-threatening illness or injury, serious accidents, or combat exposure. DSM-5-TR also considers occupational exposure to trauma or repeated exposure to the details of others' trauma as grounds for a criterion A trauma. As will become clear later, exposure to a trauma alone is insufficient for a diagnosis of PTSD; trauma exposure must be accompanied by symptoms from the following clusters: intrusions (criterion B; 1 symptom); avoidance (criterion C; 1 symptom); negative alterations in cognitions or mood (criterion D; 2 symptoms); and alterations in arousal and reactivity (criterion E; 2 symptoms). Symptoms must last at least one month (criterion F) and cause clinically significant distress or impairment (criterion G). Finally, the symptoms cannot be purely substance-induced or attributable to a medical condition. Some individuals experience dissociative symptoms that accompany PTSD, which are either of a depersonalized (feelings of detachment) or derealized (experiences of unreality) nature.

Prevalence

The most commonly experienced traumatic events in the United States include exposure to physical or sexual assault, with over 53% of women and 29% of men reporting sexual violence (Basile et al., 2022) and witnessing such assaults (Coalition for National Trauma Research, 2024). The

unexpected death of a loved one affects over 50% of US adults (Benjet et al., 2016), while natural disasters affect approximately 19–25% of Americans, especially those living in disaster-prone areas (Kessler et al., 2017). Serious accidents, such as motor vehicle crashes, fires, or severe injuries, are reported by 25–35% of individuals, highlighting the widespread nature of such traumatic experiences (Coalition for National Trauma Research, 2024).

Most people will directly experience, witness, or learn about a traumatic event (Kilpatrick et al., 2013) at some point in their life. The traumatic events experienced most frequently in the United States include exposure to physical or sexual assault (53%), death of a family member/close friend due to violence/disaster (51.8%), disaster (50.5%), or accident/fire (48.3), and witnessing physical or sexual assault (33.2%) (Kilpatrick et al., 2013). Survivors of interpersonal trauma and combat have the highest rates of PTSD (Reger et al., 2019). Fortunately, despite the near-ubiquitous exposure to trauma, lifetime rates of PTSD are between 8–9%, with rates among people who identify as women (12.8%) twice as high as those among people who identify as men (5.7%; Kilpatrick et al., 2013). Gender differences in the rate of PTSD may partially be explained by the type of trauma to which people are exposed, as when people with the same index trauma type are studied (i.e., motor vehicle accident), rates of PTSD diagnosis are similar, though still somewhat higher among women (Olf, 2017).

Individuals who identify as a member of the lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) community report significantly higher rates of exposure to trauma compared to the general population (Craig et al., 2020). In terms of race, Black and Latina/Latino individuals are more likely to meet criteria for PTSD than White individuals but often report lower overall PTSD severity (Ruglass et al., 2020). Approximately 38–45% of patients with PTSD meet criteria for the dissociative subtype (Swart et al., 2020; White et al., 2022). About one in four patients (24.8%) report delayed symptoms of PTSD (Utzon-Frank et al., 2014), but most of those who experience delayed PTSD report elevated subthreshold symptoms in the immediate aftermath of the traumatic event compared to patients who never meet criteria for PTSD (Bonde et al., 2022).

Comorbidities

Psychiatric Comorbidities

PTSD has very high rates of comorbidity with other psychiatric illnesses, with some estimates as high as 90% of patients with PTSD who meet criteria for

Table 1. Types of return of fear, their definition, and their clinical management in exposure therapy

Type of return of fear	Definition and example in the laboratory	Clinical example	Clinical management
Spontaneous recovery	Return of fear due to the passage of time alone; a subject has little CR at the end of extinction training, but after the passage of time, when tested for extinction retention with a presentation of the CS, the CR returns.	The patient is doing well in exposure therapy and is reporting low rates of fear and anxiety after several sessions. Then, the patient takes a break from exposure therapy for a few weeks and when they return, their fear is increased again.	Remind the patient to continue exposure therapy practice between sessions, including when they are on breaks from therapy or when they are tapering the frequency of sessions. Provide psychoeducation that return of fear after the passage of time is very normal and should not be a source of concern. If they continue practicing exposure therapy, they are likely to resolve the issue quickly (relative to the amount of time that learning initially took in therapy). The more that they can continue practicing exposures between sessions and after therapy is completed, the less likely it is that spontaneous recovery will set them back in their progress.
Rapid reacquisition	Return of fear following extinction training. When the CS is paired with the US for a reinforced trial, the CR will return.	A patient with PTSD from a motor vehicle accident is doing well in exposure therapy and has a reduction in fear and anxiety associated with driving. Then, the patient has another car accident. Fear and anxiety about driving return.	Provide psychoeducation to the patient about rapid reacquisition. Tell the patient that while we only do exposures that we collectively deem as objectively safe, there is no way to guarantee the patient's complete safety. There is still a chance that they could get into a car accident when doing exposure therapy practice or in other situations. Remind them that if this happens, it is likely that they will experience a surge in their fear and anxiety. Provide them with psychoeducation that if they continue with exposure practice after this stressful experience, exposure therapy can work just as effectively next time. For some patients, the next exposure therapy will reduce their fear even more quickly compared to the first time that they went through the exposure.

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Therapist: I agree with you, so we'll take it a step further. In CBT, we can work on each of the emotional components separately to help you learn skills for how to manage your emotions differently. Some of the skills that we're going to work on will be behavioral skills, whereas some will be cognitive skills and some might be skills to respond differently to physical sensations. Each patient is unique, and so the emphasis that we place on each of these domains varies based on your needs. You and I will come up with a treatment plan together to help you to slow down your emotions, understand them better, and respond differently to them.

To summarize, the goal of the general rationale for CBT for any condition is highlighting that every emotion has distinct, discernable components. By understanding these components with greater clarity, patients will gain an opportunity to respond to emotions differently to reduce the intensity of the emotions in the future.

The Rationale for CBT for PTSD

The rationale for CBT for PTSD centers around two core components that are known to contribute to the development and maintenance of PTSD: avoidance and trauma-related cognitions. Below, I describe a rationale for treatment that highlights how these two factors are directly targeted, building on the rationale for the cognitive model in general. A brief handout for the rationale that you can share with patients is presented in Handout 1.

Therapist: Okay, so we have spoken in general about reducing emotional intensity through cognitive, behavioral, and physical strategies, but let's talk more specifically about how this relates to PTSD. I think it can be helpful to start with an example from the past week of a time when you noticed feeling particularly triggered by a reminder of the bus accident [the index trauma that brought the patient into treatment]. Can you think of an example like that?

Patient: I mean it happens constantly. I was late to work this week, and my partner was telling me that I should just take the bus instead of walking—I've been walking 45 minutes instead of taking the bus because I'm just terrified to get on one again. When my partner suggested that I just take the bus, I flipped out.

Therapist: This is the perfect example. Try to put yourself back in that moment when you were upset for a moment to jog your memory.

you've been avoiding for [months? years? decades?]. What's going through your mind about this?

Here, I am attempting to elicit the cognition that directly predicts “minimizing accomplishment” behavior. It might also be important to elicit the emotional contributor to that behavior as well (e.g., “What are you feeling when you say that it’s no big deal?”) Either way, this allows us to build a mini-cognitive model on how even an accomplishment can be punishing, as described in Figure 1.

Building this cognitive model (and drawing it out whenever possible) can help to highlight how punishing good behavior makes it less likely for the behavior to occur. When a patient accomplishes their homework practice (even partially) but follows this with negative self-talk about how they should have done it *years ago*, or how they should have done *more*, it reduces the likelihood that they will do future homework. Thus, it is essential to increase patients’ awareness of this pattern when it emerges. Then, it is essential to have the patient practice acknowledging and celebrating their accomplishments with homework completion going forward. Patients with PTSD often need guidance and coaching on this, and if you offer labeled, genuine praise, a critical learning opportunity emerges.

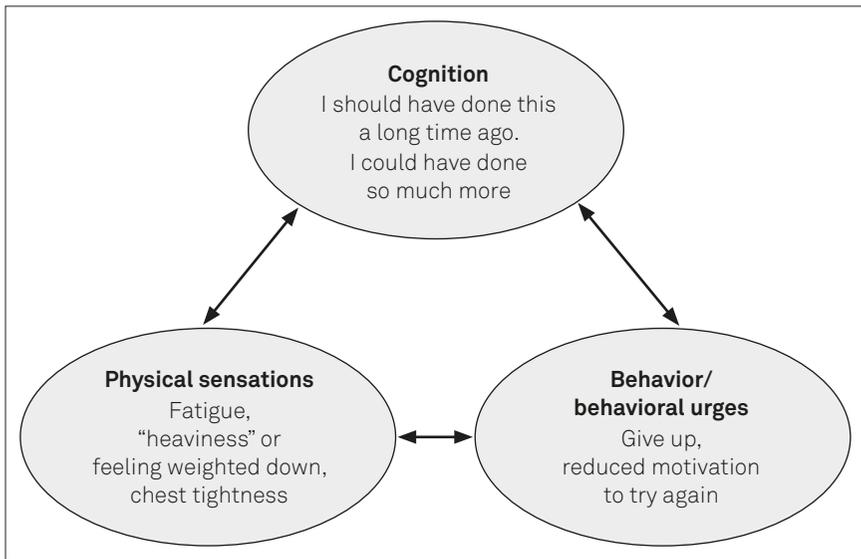


Figure 1. Cognitive model describing a patient who minimizes an accomplishment

Table 4. Objectives when observing an *in vivo* exposure practice

Topic	Goal	Challenges	Tips
Present moment awareness	Assist the patient to stay in the present moment.	The patient engages in distraction, talks about unrelated topics, or jumps into discussions about what's to come later.	Observe and describe what you are noticing (e.g., <i>It seems like we have gotten out of the exposure – let's jump back in. Talk me through what we're doing here.</i>).
Optimizing learning during the exposure	Support the patient in gathering the data necessary to support/violate their expectancies.	The patient engages in post-hoc hypotheses ("I knew this wouldn't be hard all along").	Direct the patient to gather data (and track that data) about the actual outcome(s) of the exposure.
Following through on the exposure	Coach the patient to initiate and complete the agreed upon exposure.	The patient struggles to get started, refuses to start, or wants to end the exposure prematurely.	Make warm and supportive but directive coaching statements about starting the exposure (<i>I know that you can do this. Let's go ahead and begin</i>), sticking with the exposure (<i>I can tell that this is really difficult, but I believe in you – I know that you can keep going. It's really important for you to stick with it.</i>). Brief reminders of the rationale may help, but that can come at the cost of getting started or can distract from the exposure, so they should be limited.
Reducing/stopping safety behaviors	Provide feedback to the patient about safety behaviors that you observe and support them in reducing/stopping those behaviors.	The patient is terrified to stop the safety behavior, and the behavior reduces learning for the patient.	Observe and describe what you notice (<i>I'm noticing that you keep looking around you, almost as though you are checking who is near you</i>). Coach the patient to reduce/stop the safety behavior (<i>I'm wondering if we can practice engaging in the exposure as though you're not nervous, even though I know you are. Practice acting 'as if' you don't need to keep checking to see who is around. Can we try that?</i>).

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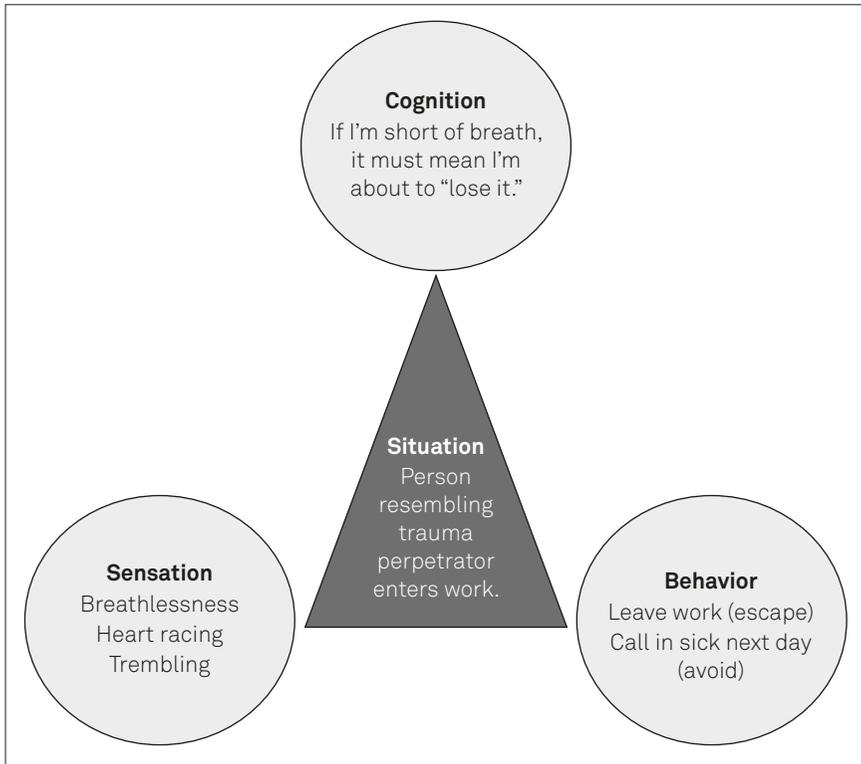


Figure 2. Cognitive model of interoceptive sensitivity among patients with PTSD.

As with all exposures, the goal of interoceptive exposures is to create a new inhibitory association, wherein physical sensations become paired with the perception of safety, rather than the excitatory association, wherein they are paired with the perception of danger. Over time, interoceptive exposures work to retrain the brain and reduce false alarms about low-grade physical sensations. For patients with PTSD who are very bothered by physical sensations in the context of trauma reminders, these exposures can be key to improving self-confidence.

Information Gathering for Interoceptive Exposures

Following protocols from CBT for panic disorder (Craske et al., 2007), interoceptive exposures are always preceded by a data gathering exercise, the goal

Therapist: I'm so delighted that you're going to make plans with one of your friends for your behavioral activation activity this week. I know that in the past, there have been times when you attempted to make plans like this with other people and ultimately backed out at the last minute. I know you had some good reasons for doing so at the time –do you remember that?

Patient: Yes, I know exactly what you're talking about because it happens to me all the time.

Therapist: OK, that's helpful to know. Maybe we can use that to our advantage and proactively think this through. What might happen this time that will make it harder for you to stick to the plan of keeping your social plans?

Patient: The biggest thing is just not feeling like it. Sometimes I'm actually looking forward to seeing my friends when I make the plans, but by the time the day comes for the plans, I'm usually so exhausted. Between work and all the stuff I have to do just to get by, sometimes it feels like there is nothing left over. Then I start to think that maybe I just don't have the energy to keep the plans, and I end up bailing.

Therapist: I see, that makes a lot of sense. What happens when you bail?

Patient: Well that's kind of the problem – nothing happens. Usually, my friends are pretty nice and understanding of everything that I'm going through, so most of them don't give me a hard time. They always know there's a chance of me flaking when I make plans with them – sometimes they even joke about it with me, which doesn't

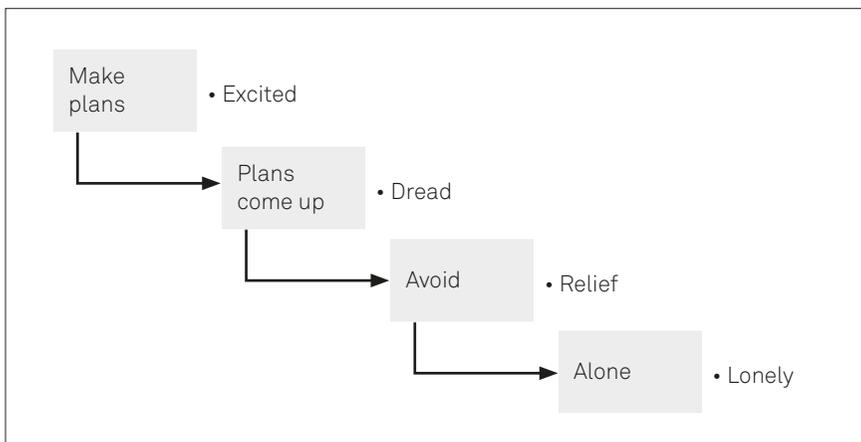


Figure 4. Social plans paradox, Part 1: The trap.

Negative Thoughts About the World

In addition to general negative thoughts about themselves and self-blame, survivors of PTSD commonly struggle with negative thoughts about the world. These thoughts can pervade relationships with intimate partners, work colleagues, friends, roommates, and neighbors. I bucket these types of thoughts into two global categories: cognitions about trust and about burdensomeness.

Inability to Trust Others

Following a trauma, particularly a trauma that involved perpetration of harm by another person, it is common for survivors with PTSD to report having less trust in other people. While this is an understandable cognitive reaction to experiencing psychological and/or physical harm, it can prevent a deepening of relationships with others and result in significant impairment for survivors. The ability to trust people, within reason, is foundational to relationship building. In the absence of a capacity to trust others, interactions become surface level and unfulfilling for both parties. A superficial relationship sometimes results in other people interpreting the trauma survivor as uninterested in connection and leads them to slowly back out of the survivor's life. This fizzling of a relationship ultimately confirms the trauma survivor's perception that other people cannot be trusted, resulting in a greater need to pull back from intimate connections.

To build an intimate connection requires some level of vulnerable expression by both parties. When a trauma survivor has a history of being abused or taken advantage of, it is unsurprising that they might feel extremely uncomfortable with showing vulnerability. In fact, some survivors of trauma might believe that something about their younger selves was interpreted as vulnerable by a perpetrator of trauma, further reinforcing the need to come across as strong and guarded. An inability to trust anyone results in reinforcement of shame and worsening of negative cognitions about the self. Specifically, when a trauma survivor experiences embarrassment, they might be more reluctant to disclose that embarrassment to other people. Hiding embarrassing details prevents opportunities for others to validate an experience by normalizing or providing support. The more a person hides, the more they feel convinced that they have something to hide, further reinforcing the shame.

The recommendation for trust building is to encourage the trauma survivor to select one or two seemingly trustworthy people and to practice gradually opening up to them with low-stakes personal disclosures. Sometimes these vulnerability exercises are officially included on an *in vivo* exposure hierarchy, and they can start with seemingly trivial exercises. To begin, patients

may practice expressing a genuine opinion rather than “going with the flow” of others. Based on the results of this behavioral experiment, the survivor might decide to gradually disclose a bit more about their genuine feelings about things. Over time, as more trust is built, they might choose to disclose more personal details about their life. The decision about what to share and who to share it with should always remain with the patient so that they feel empowered to remain in control of their story.

Some survivors of trauma have an altered threat detector following the trauma so that they might become *too trusting* of individuals who have not earned their trust. This can sometimes occur when a child is exposed to repeated instances of abuse or neglect and learns that their environment is very unsafe, and it might help their survival if they latch onto *anyone*, given that it is impossible for them to trust people whom they should be able to trust. Other survivors of trauma have witnessed family members suffer abuse in intimate partner violence and have come to interpret such violence as an expected part of being in a family. Survivors of families with intimate partner violence might trust new partners who display a propensity to abuse because they have learned that violence is a predictable part of being close to others. Given that trauma exposure can change propensity to threat in either direction, it can be important to coach patients to evaluate the safety of vulnerable disclosure to or closeness with partners through an ongoing analysis of the data supporting versus refuting the trustworthiness of a particular partner. When a patient is actively involved in a relationship characterized by intimate partner violence, the therapist and patient must carefully assess the appropriateness of engaging in PTSD therapy. For more details, see Chapter 11.

Perceptions of Being a Burden to Others

PTSD can convince survivors of trauma that other people would be better off without them and that they are a burden on their loved ones. Sometimes the beliefs of burdensomeness are reinforced in individuals who need to take leaves of absence from work or who, in the case of active-duty service members, might need to leave their jobs altogether due to the lasting repercussions of trauma exposure. Burdensomeness is independently associated with suicide risk (Joiner, 2005) and can contribute to attempts to isolate from other people, creating more loneliness and despair.

Some trauma survivors come to believe that the trauma ruined them and their ability to regulate their reactions, including anger-driven reactions. Individuals with PTSD are often worried about lashing out in anger at other people, whether or not they have engaged in violent behaviors in the past. When an individual with PTSD expresses anger or irritability, they might become overwhelmed with regret and use this reaction as evidence that they

If you are doing clinical work with patients who have PTSD, it is essential to be aware of the full spectrum of possible consequences for your patients who disclose suicidal ideation. For those patients who require more thorough evaluation by a psychiatric emergency team, it is extremely helpful if you know about that process. Table 9 includes a checklist of items to help you familiarize yourself with the emergency psychiatric response options where you live.

Table 9. Things to know about your local emergency psychiatric response options

Issue	Key point(s)	Things to investigate
Availability of beds	Not all hospitals have inpatient psychiatric beds; in cities with different inpatient psychiatric facilities, your patient will likely be transported to a facility based on the availability of a bed for them.	Which facilities that have inpatient psychiatric beds are closest to your practice?
Psychiatric crisis response centers versus emergency departments	While a person can present to any emergency department with a psychiatric crisis, they might be transferred to a psychiatric crisis response center before they are thoroughly evaluated. For psychiatric evaluations that the emergency department deems are not urgent, they might encourage the patient to transport themselves to the psychiatric crisis response center.	Are there psychiatric crisis response centers where you live, and if there is more than one, which is closest to where your patient lives? Explain to your patient that they are welcome to go to any emergency department, but that their experience will be more efficient if they go to one with the capacity to conduct a psychiatric evaluation for inpatient hospitalization.
Transport for an emergency psychiatric evaluation	Some locations have mobile crisis response teams that can provide support with transport to the hospital. As described previously, if a patient presents to a general emergency department, they might first be transferred to a psychiatric crisis response center. If deemed appropriate for psychiatric inpatient admission, they may then be transferred again to a facility with an open bed.	Does your city have a mobile crisis team? If so, what services are available through the team? Who staffs the crisis team (e.g., clinicians, mental health support staff, police)? What services do they provide?

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patient and therapist should discuss the pros and cons of starting CBT while the patient is still in their relationship. This decision should be made *by* the patient rather than *for* the patient.

Trauma-Related Cognitions for Survivors of Intimate Partner Violence

For survivors of intimate partner violence, beliefs about self, others, and the world can shift dramatically and result in the maintenance of PTSD symptoms and of the relationship itself. Examples of negative beliefs about the self include “I am responsible for what happened” or “I deserve to be treated this way,” whereas negative beliefs about other people include “Other partners would be even worse,” and negative beliefs about the world include “There is nowhere safe from violence.” These beliefs, when unaddressed, lead to decisions to stay in violent partnerships, risking further exposure to trauma.

Even when a violent relationship has ended, survivors of trauma struggle with beliefs about themselves that keep them stuck in misery. For example, a patient who is high achieving in their professional circle might be mortified about having been abused in the home, and after the relationship is over, they might prolong their pain by saying, “I should have known better than to be in this relationship” or “Other people like me would have left sooner.” It is easy for survivors of violence to invalidate themselves by forgetting some of the legitimate reasons why they remained in the relationship. In these circumstances, it can be helpful to ask the patient to make a list of 10 reasons why it made perfect sense that they stayed in the relationship. Patients might counter with “But even my friends told me to leave,” in which case it can be helpful to ask them to reflect on how there must have been many compelling reasons to stay at the time, in light of how other people tried to encourage them to leave.

If a patient has the belief that “I should have known better,” it might be helpful to engage in a normalizing exercise by prompting the patient to take a perspective of a loved one in a violent relationship. For instance, the therapist might ask, *If your sibling was in a violent relationship and finally mustered the strength to leave, would your first thought be to blame them?* Typically, patients respond with, “Absolutely not, I would never think that!” In such cases, it can be helpful to ask the patient to make a list of 10 reasons why they should be held to higher standards than other people.

Handout 4

Brainstorming Interoceptive Exposure Ideas

Let's brainstorm some options for interoceptive exposure practice. Remember, just because you write it on this sheet does not mean that you are committing to doing it. This is just about getting possibilities on paper.

What are some **physical sensations** that you avoid in general?

What **activities** do you avoid because they may bring on uncomfortable physical sensations?

What **food, beverage, or medications** do you avoid because they may bring on uncomfortable sensations?

What **clothes** do you avoid wearing because they may bring on uncomfortable sensations?

What **situations** do you avoid because they may bring on uncomfortable sensations?

Prepping for Interoceptive Exposure

For any of the uncomfortable sensations (or situations that provoke uncomfortable sensations) above, work with your therapist to choose one on which to focus. Write it down here:

This is a **preview** of the content that is available in the downloadable material of this book. Please see p. 163 for instructions on how to obtain the full-sized, printable PDF.

Peer Commentaries

“This book is a clear and practical guide for mental health providers at any stage of their career seeking to personalize and optimize CBT for trauma survivors. Drawing on research data, established interventions, and clinical experiences, it offers rich illustrations and hands-on tools for real-world practice. It is very comprehensive, yet accessible, and addresses key factors in providing CBT optimally to trauma survivors, including therapeutic strategies, barriers to engagement with and effective implementation of CBT, contextual influences for the client, and training/supervision.”

Ateka A. Contractor, PhD, Professor, Department of Psychology, University of North Texas, Denton, TX

“Dr Lily Brown provides a concise and yet comprehensive overview of CBT for PTSD in practice. Both experienced providers and those new to CBT for PTSD will find useful tips and specific tools to help them in their work with patients, training other providers, and consideration for program development. She provides clear background for her recommendations based on experimental psychopathology and clinical trials research. The handouts and figures provide quick guides to complex issues, like what is the role of the therapist in imaginal exposure, how to set up the in vivo hierarchy, etc. I would recommend this book for anyone clinically working with survivors of trauma.”

Sheila A. M. Rauch, PhD, ABPP, Professor, Emory University School of Medicine, Deputy Director, Emory Healthcare Veterans Program, Atlanta, GA

“This book distills the best of evidence-based trauma-focused psychotherapy for PTSD – like cognitive processing therapy and prolonged exposure – into clear, practical guidance you can use right away. Grounded in science and packed with real-world examples, it’s an indispensable companion for both new and seasoned clinicians seeking to elevate their trauma-focused clinical practice.”

Lori A. Zoellner, PhD, Professor, Department of Psychology, University of Washington, Director, UW Center for Anxiety and Traumatic Stress, Seattle, WA