

A theoretical Approach to Cognitive-Behavioral Therapy for Post-Traumatic Stress Disorder

مقاربة نظرية للعلاج المعرفي السلوكي لاضطراب إجهاد ما بعد الصدمة

Une approche théorique de la thérapie cognitivo-comportementale pour le trouble de stress post-traumatiqueRima ,SANDELI^{*1} ; Mohamed , CHALBI^{*2}

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ملخص:

يعد العلاج المعرفي السلوكي من أبرز الأساليب العلاجية في مجال الصحة النفسية و العلاج النفسي يستند في مبادئه إلى الفهم العميق لتفاعلات الفرد مع أفكاره و مشاعره و سلوكياته و يتميز بفعاليته في علاج العديد من الأمراض و الاضطرابات النفسية و من بين هذه الاضطرابات اضطراب إجهاد ما بعد الصدمة يتطلب هذا الأخير علاج سريع و فعال و من هنا يأتي هذا البحث لتسليط الضوء و الكشف عن أهم طرق و أساليب العلاج المعرفي السلوكي لعلاج الحالات التي تعاني من اضطراب إجهاد ما بعد الصدمة.

الكلمات المفتاحية: إجهاد ما بعد الصدمة؛ العلاج المعرفي السلوكي.

Abstract:

Cognitive Behavioral Therapy (CBT) is one of the most prominent therapeutic approaches in the field of mental health and psychotherapy. It is based on a deep understanding of an individual's interactions with their thoughts, emotions, and behaviors. CBT has proven effective in treating numerous psychological disorders, including Post-Traumatic Stress Disorder (PTSD). Given the urgent need for swift and effective intervention for PTSD, this study aims to highlight and explore the key methods and techniques of CBT in treating individuals suffering from this condition

Keywords: Post-Traumatic Stress Disorder; Cognitive Behavioral Therapy

Résumé :

La thérapie cognitivo-comportementale (TCC) figure parmi les approches thérapeutiques les plus reconnues dans le domaine de la santé mentale et de la psychothérapie. Elle repose sur des principes fondés sur une compréhension approfondie des interactions de l'individu avec ses pensées, ses émotions et ses comportements. Elle se distingue par son efficacité dans le traitement de nombreux troubles et maladies psychologiques, parmi lesquels le trouble de stress post-traumatique. Ce dernier nécessite une prise en charge rapide et efficace. Ainsi, cette recherche vise à mettre en lumière et à examiner les principales méthodes et techniques de la thérapie cognitivo-comportementale pour traiter les cas souffrant de stress post-traumatique.

Mots clés : Stress Post-Traumatique ; Thérapie Cognitivo-Comportementale

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Introduction:

Humans live in a world filled with sudden and potentially dangerous events that can leave deep psychological, social, and emotional scars. These events, particularly when unexpected and overwhelming, often result in what are termed as traumatic experiences. Such experiences, which frequently exceed an individual's ability to cope, are among the most impactful in a person's life. Sudden, unanticipated incidents can trigger intense fear and an inability to adapt, leading to anxiety, social withdrawal, avoidance behaviors, and other maladaptive responses. Regardless of whether the event is collective or personal, the experience is deeply subjective. If the stress response persists beyond a month, it may develop into Post-Traumatic Stress Disorder (PTSD)—a psychological challenge that arises after exposure to a traumatic or painful experience.

Potential causes of psychological trauma include the loss of a loved one, sexual assault, physical or sexual violence, early childhood trauma, and large-scale disasters such as natural catastrophes (earthquakes, floods, volcanic eruptions), wars, or other forms of intensified violence.

The diagnosis of PTSD relies on specific criteria outlined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, which identifies the symptoms and conditions necessary for accurate diagnosis. Accurate diagnosis is essential in alleviating symptoms and facilitating treatment. Given the complex emotional and psychological challenges associated with PTSD, effective interventions are critical to restoring psychological stability. To address this, various treatments have been developed, including Cognitive Behavioral Therapy (CBT).

CBT is a structured form of psychotherapy that combines behavioral modification strategies rooted in behavioral science with cognitive therapy, which draws on cognitive models of psychopathology. CBT posits that psychological disorders, such as PTSD, stem from learned reactions that can be altered through new learning. By helping individuals modify overt behaviors and underlying thought processes, CBT aims to bring about changes in emotions and behaviors.

Although specific CBT techniques for treating PTSD may vary depending on the individual, certain core principles remain consistent. These include goal-setting, data collection, establishing a collaborative therapeutic relationship, teaching new responses to life situations (i.e., skills training), and focusing on observable, concrete objectives. CBT operates on the premise that there is a strong connection between an individual's thoughts, emotions, physical sensations, and behaviors. External factors, such as life events and circumstances, can influence these elements. However, it is not solely the events themselves but rather the individual's interpretation of these events that determines emotional, physical, and behavioral responses.

The effectiveness of CBT in addressing PTSD symptoms becomes evident through its focus on understanding how individuals process and respond to traumatic events. It facilitates behavioral changes, challenges negative assumptions about oneself and the world, and promotes the development of effective coping strategies. Ultimately, CBT empowers individuals to build adaptive mechanisms that help them overcome trauma and resume a normal life.

Based on the above, the significance of this treatment in caring for trauma victims or those suffering from Post-Traumatic Stress Disorder (PTSD) becomes evident. Accordingly, the following questions are posed:

- What is the concept of PTSD?
- What is Cognitive Behavioral Therapy (CBT), and what are its principles?
- What are the foundations and techniques of CBT used in treating PTSD?

Study Significance:

The importance of this study lies in the significance of its subject matter. Identifying the key methods and foundations of CBT for PTSD helps mental health practitioners provide care for victims suffering from this disorder. This group is in urgent need of such treatment due to its proven effectiveness in alleviating the impacts of PTSD.

Study Objectives:

The following study aims to achieve the following objectives:

- To understand PTSD.
- To explore CBT and its principles.
- To identify the foundations of CBT for PTSD.
- To examine the techniques of CBT used in treating PTSD.

1- Concept of Post-Traumatic Stress Disorder (PTSD):

The term PTSD first appeared in 1980 in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), where it was classified under anxiety disorders. PTSD develops following exposure to a severe traumatic event, leading to feelings of fear, horror, or intense helplessness, accompanied by a range of symptoms that follow the traumatic event. According to the DSM definition, PTSD is a delayed reaction to an extremely stressful event or situation of a threatening or catastrophic nature, causing psychological distress to almost everyone who experiences it. Such events may include human-made disasters, combat, serious accidents, or witnessing the death of others. The response typically involves intense fear, helplessness, or horror, which results in symptoms of anxiety and hyperarousal that were not present before the trauma (Association, 1994, p. 24).

The American Psychiatric Association has categorized PTSD symptoms into three main clusters, as outlined in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV):

- Re-experiencing the traumatic event
- Increased physiological arousal
- Avoidance and emotional numbing (Institute of Medicine, Board on Population Health and Public Health Practice, Committee on Gulf War and Health, 2006, p. 08).

2- Definition of Cognitive Behavioral Therapy (CBT):

According to (Beck J. S., 1995), cognitive behavioral therapy encompasses methods aimed at modifying or alleviating existing psychological disorders through the correction of faulty mental concepts or cognitive processes.

(Glass and Shea ,1986) define CBT as one of the modern therapeutic approaches, primarily focusing on the cognitive aspect of psychological disorders. This type of therapy persuades the patient that their irrational beliefs, negative thoughts, and incorrect self-statements are responsible for maladaptive reactions (Hoffman, 2012, p. 34).The goal of CBT is to correct distorted cognitive aspects and replace them with more appropriate ways of thinking, ultimately inducing cognitive, behavioral, and emotional changes in the patient (Al-Ghamdi, 2013, pp. 144-145).

(Eysenck, 2000, p. 72)considers CBT a development of cognitive therapy, seeking to alter behavior by changing the content of thought and reconstructing beliefs through cognitive procedures.

2-1. Principles of Cognitive Behavioral Therapy:

CBT operates based on several principles:

- Principle 1: CBT is an educational treatment aimed at enabling the patient to become their own therapist by equipping them with the necessary skills to prevent relapse.
- Principle 2: Sessions are conducted according to a set agenda or specific work schedule, which the patient attempts to follow as closely as possible (Beck J. , 2007, p. 21).
- Principle 3: CBT is an intensive, short-term therapy, with most cases being treated in 4 to 12 sessions, although it may extend beyond this duration in some cases.
- Principle 4: Sessions are structured according to a predefined agenda. The therapist aims to identify the patient's emotional state, request a summary of the past week, and collaboratively set the session's agenda. This involves reviewing homework, summarizing session progress periodically, and soliciting the patient's feedback at the end of each session.
- Principle 5: CBT teaches patients to identify, evaluate, and respond to ineffective thoughts and beliefs (Al-Muhareb, 2000, pp. 38-39).

2-2. Foundations of CBT in Post-Traumatic Stress Disorder (PTSD):

CBT for PTSD is based on several foundational elements, the most notable of which include:

2-3. Presentation of Therapy Rationale:

Once intrusive traumatic memories are identified as the intervention target, a brief description of the therapy is provided to the patient (rephrased in the therapist's own words), as follows:

“This therapy is designed to help you process and gain control over your traumatic memories, thereby enhancing your sense of control over your life. Much of our work will involve using imagery, meaning we will ask you to visually recall and engage with the painful images,

thoughts, and feelings you experience when revisiting these memories (or nightmares). We will then modify these distressing images to create a more positive outcome, enabling you to see and feel yourself responding to your trauma not as a victim but as an empowered individual. This will not alter the traumatic event itself or what actually happened, but it will change the images, thoughts, feelings, and beliefs you associate with the trauma. Do you have any questions?"

Patients are provided with comprehensive information about the therapy used, as well as details about PTSD, emotional distress, and heightened arousal, which are likely to occur when recalling distressing images during therapy sessions. The patient's experience of traumatic memories in therapy differs from their daily experience, as the therapist's supportive presence offers therapeutic assistance during the imagery sessions (Smucker & Niederee, 1995, p. 293).

3- Primary and Secondary Cognitive Processing in Cognitive Therapy:

In cognitive therapy for PTSD, an important distinction is made between primary and secondary cognitive processing. These concepts are extensions of Freud's terms "primary process" and "secondary process." Freud viewed the primary process as the oldest and most primitive form of thinking, characterized by symbolic nature, a lack of temporal dimension, and reflected in mental activities such as dreams and fantasies. In contrast, the secondary process is governed by logical, reality-based thought, manifested in delayed gratification and active problem-solving.

The interplay between these levels of processing is crucial for the effective treatment of traumatic material. In brief, the activation and reformatting of imagery are considered "primary cognitive processes" (non-verbal, non-linguistic mental activity, primarily visual and auditory). Conversely, linguistic processing of thoughts and emotions about an event (e.g., verbal expression through speaking or writing) is viewed as a "secondary cognitive process." Successful emotional processing of traumatic material in PTSD therapy necessitates addressing both primary and secondary levels.

3-1. Type 1 vs. Type 2 Traumatic Events:

According to Meichenbaum (1994) and Terr (1991), assessing and treating PTSD involves determining whether the trauma-inducing factor is a Type 1 or Type 2 trauma. Type 1 trauma refers to an unexpected, isolated traumatic event of limited duration (e.g., a single rape incident, physical assault, sniper attack, natural disaster, or industrial accident) from which recovery is typically quicker.

In contrast, Type 2 trauma is more enduring and involves a series of expected, repeated traumatic events (e.g., ongoing sexual or physical abuse during childhood). This leads to a negative transformation in one's schema of self and the world. Type 2 trauma often results in more complex, chronic PTSD responses associated with other psychological conditions, including higher rates of substance abuse, eating disorders, mood disorders, depressive and anxiety disorders, and panic disorders (Leahy, 1997, p. 194).

3-2. Traumatic versus Non-Traumatic Memories:

The nature of traumatic memory itself has significant implications for how trauma-related material is accessed and processed in therapy (Rothschild, 2023, p. 100). According to Vander Kolk

and Van der Hart (1989-1991), traumatic memories are encoded and utilized differently than non-traumatic or narrative memories.

As (Reviere, 1996, p. 40)explains, traumatic experiences remain in memory in a distinct manner because traumatic events often evoke unspeakable terror in the affected individual. This makes the experiences difficult to articulate in words and, therefore, impossible to process at linguistic levels, categorize, store, or retrieve. As a result, traumatic memories are relegated to sensory and bodily levels.

3-3. Trauma-Induced Schemas:

For survivors of Type 2 trauma, especially when experienced during childhood, PTSD symptoms are often embedded within trauma-based schemas (Smucker & Niederee, 1995). These schemas function as cognitive templates that sort and organize mental processes, significantly influencing how subsequent events are perceived, interpreted, encoded, and remembered. The persistent presence and activation of these "trauma-induced schemas" (e.g., schemas of helplessness, worthlessness, guilt, and unlovability) keep trauma survivors in a prolonged state of victimhood even after the abuse has ceased. They form the foundation for developing chronic PTSD.

For Type 2 trauma survivors in particular, the "helplessness schema" appears central to their PTSD syndrome, often leaving them in a state of "functional paralysis."

3-4. Initial Therapeutic Interviews:

During the initial sessions, information is gathered about the patient's current life situation, family history, history of traumatic experiences, current psychological adjustment, medical history, substance use, depression, and the severity of PTSD symptoms. The primary focus of the clinical interview is on immediate problems, the degree to which they interfere with daily functioning, and the social environment's reactions (e.g., family, friends, coworkers). Additionally, the interview explores how the patient has attempted to cope with their symptoms(Leahy, 1997, p. 202)

3-5. Current Behavioral and Cognitive Coping Strategies:

This involves identifying how the patient currently manages to move past the traumatic event and determining the most effective coping strategies for them. For instance, what do they avoid? How do they handle intrusive thoughts? What do they believe will happen if they dwell on the trauma? Do they ruminate on aspects of the event? (Cottraux, 2011, p. 195)

3-6. Specific Therapy Goals:

While the primary objective of cognitive therapy for PTSD patients is to facilitate the successful emotional processing of the trauma, the secondary therapeutic goals include:

- Reducing physiological arousal and minimizing intrusive traumatic recall (e.g., recurrent flashbacks, nightmares), as well as replacing distressing imagery with supportive and encouraging images.

- Converting traumatic imagery into narrative language while altering trauma-inducing beliefs and schemas(Leahy, 1997, p. 202).
- Developing more effective coping strategies to handle daily life stressors.
- Enhancing psychological skills to manage distress, self-soothe, and reassure oneself. CBT plays a crucial role in addressing symptoms, fostering resilience, and leveraging the trauma to improve the patient's quality of life and maturity, ultimately leading to wisdom (Younis, 2018, p. 131).
- Reframing the traumatic event to give it a coherent meaning within the world by comparing oneself to those less fortunate and considering potential benefits from the experience.
- Modifying behavior to help prevent a recurrence of the event.
- Seeking social support (Abdullah, 2000, p. 232).

3-7. Intervention Techniques in Cognitive Behavioral Therapy for PTSD:

Most forms of CBT for PTSD consist of three main components, and any treatment plan must include these elements:

- Psychoeducation: Educating the patient about the nature of their condition, understanding symptoms, the beginning of therapy, and the importance of the therapeutic alliance.
- Exposure Therapy: Includes both real-life exposure (facing situations typically avoided because they trigger traumatic memories) and imaginal exposure.
- Cognitive Restructuring: Teaching patients how to evaluate their thought patterns about themselves and the world to ensure they are accurate and helpful. This includes learning to challenge intrusive, unhelpful thoughts (Younis, 2018, p. 131).

Below is a detailed discussion of these components along with some supportive techniques:

4- Cognitive Therapy Techniques:

4-1.Psychoeducation:

Conducted during the initial sessions and throughout the treatment, psychoeducation provides the patient with information about common symptoms of traumatic events and explains how core symptoms will be addressed in therapy. The goal is to help the patient understand their symptoms, establish a rationale for therapy, and enable them to become an expert in their condition. This empowers them to actively participate in their recovery by recognizing the elements of anxiety (Lahad & Doron, 2010, p. 34).

4-2. Building a Therapeutic Relationship:

Establishing a strong therapeutic alliance can account for more than 40% of therapeutic success. Several methods and strategies can help therapists build an effective relationship, including:

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- Introducing oneself in a balanced manner. While it's important for the therapist to demonstrate competence in handling the patient's issues, they should also convey that progress depends on the patient's active participation.
 - Ensuring the patient feels valued and viewed as more than just a "patient," reinforcing the relationship's significance.
 - Focusing on the psychological distress caused by core symptoms, addressing lived negative experiences, and alleviating those feelings by maintaining regular attendance and adhering to therapeutic guidance (Younis, 2018, p. 132)

4-3. Cognitive Therapy Methods:.

Cognitive therapy focuses on processing emotions to alter perceptions of danger, raising the threshold of fear response through new, compatible information—a process called "emotional reprocessing." This reprocessing involves confronting fear-inducing situations, apart from physiological responses, and assigning new meaning to the event. This enables the patient to reconstruct memories for a renewed approach to life (Cottraux, 2011, p. 195).

Foa (1986) introduced the concept of the fear structure, which arises when an individual experiences a traumatic event. The fear structure comprises three elements:

- Stimuli (e.g., sounds, scenes, and sensory experiences related to the event)
- Responses (both physical and emotional responses to trauma)
- Meanings attributed to these stimuli and responses

Foa's model proposes that fear structures act as danger signals and are triggered by trauma-related cues, leading to re-experiencing the event and avoidance behaviors. The model highlights the critical role of interpretation within the fear structure. Individuals share certain pre-existing positive beliefs and personality traits, such as:

- "The world is safe."
- "Events are controllable."
- "Nothing painful will happen to me."
- "I can handle any event that may occur in my life."

A traumatic experience disrupts these foundational beliefs, prompting the victim to seek meaning and develop a stable understanding of the world, which includes replacing erroneous beliefs (Jehel, Lopez, Kremp, Sabouraud-Séguin, & Sadlier, 2006, p. 206).

4-4. Cognitive Restructuring:

The goal of cognitive restructuring is to alter faulty thinking patterns by helping individuals develop the ability to evaluate traumatic events more realistically. Various strategies rely on this approach, including Albert Ellis's Rational Emotive Behavior Therapy (REBT) and Aaron Beck's

Cognitive Therapy. Both models emphasize the influence of thoughts and beliefs on an individual's behavior and emotions. According to these models, an individual's emotions and behavioral patterns are governed by their interpretation of the world around them.

Cognitive therapy aims to increase the individual's awareness of how negative thoughts affect their behavior and to restructure cognitive processes to reduce or eliminate the stress caused by traumatic events. This involves training individuals to identify automatic self-defeating and self-critical thoughts and replace them with more objective, problem-solving alternatives.

Albert Ellis highlights that emotional arousal and maladaptive behavior are influenced by an individual's interpretations of events, which act as symbolic mediators. The more irrational beliefs and expectations an individual holds, the more likely they are to misinterpret situations, leading to emotional arousal and maladaptive behavior (Abou Aisha, 2012, p. 225).

This therapeutic technique encourages individuals to focus on their current environment and evaluate the perceived level of threat in specific situations more rationally and adaptively (Jehel, Lopez, Kremp, Sabouraud-Séguin, & Sadlier, 2006, p. 207).

4-5. Identifying Faulty Automatic Thoughts:

Beck (1976) based his theory on the concept of functionally distorted thoughts responsible for depression. Clinicians working with PTSD have used this theory to understand the cognitive dimension of the disorder, particularly feelings of guilt, shame, and fear, especially in relation to the world and others.

The primary goal here is for patients to monitor their negative thoughts rationally. Therapists must adopt a critical approach to strengthen the patient's "self-criticism" by utilizing Socratic dialogue, acceptance, and empathy. This helps patients identify and modify their faulty thoughts (Cottreaux, 2001, p. 72).

5- Behavioral Therapy Techniques:

5-1. Exposure Therapy:

Exposure therapy involves presenting situations and mental images that recall traumatic events. The therapy may be conducted individually or in groups.

The patient is encouraged to halt the distressing image whenever they wish, practicing new exercises until they reach a point where the image can be tolerated without anxiety. Subsequently, anxiety levels are gradually increased to the desired degree. This progressive approach is known as in-vivo exposure (Cottraux, 2011, p. 195).

One major challenge in this therapy is the frequent occurrence of avoidance. Approximately 50% of individuals who have experienced significant trauma in their lives avoid discussing it, leading to emotional distress. These individuals often refuse therapies that expose them to the thoughts and emotions associated with their trauma because they do not want to relive the experience, as the emotions tend to resurface involuntarily in the form of flashbacks.

The terror associated with these experiences is often indescribable, manifesting as physical sensations such as shortness of breath and limb pain, sometimes leaving individuals unable to speak about their experiences.

By the time patients reach this stage of therapy, they may have completed pharmacological treatment. Their recounting of events is often fragmented—not because of conscious avoidance but due to intense fear. The genuine terror is locked in their memory and only resurfaces when emotional triggers are reactivated, preventing full interaction with these memories as a survival mechanism.

5-2. Imaginal Exposure:

In this method, the patient recalls traumatic memories during the therapy session. The therapist asks the patient to mentally return to the time of the trauma and re-experience it in their imagination. The patient closes their eyes and describes the experience in the present tense and aloud as if it were happening now. Often, this narration is recorded, and the patient takes the recording home to practice daily between sessions. Although re-experiencing the trauma may initially be painful, the distress typically decreases with repeated exposure (Nutt, Stein, & Zohar, 2009, p. 101).

Different perspectives on the mechanisms of exposure include:

- Exposure promotes habituation, which in turn reduces tension.
- It facilitates desensitization, or stress-induced numbing.
- Exposure corrects the belief that stress is permanent unless avoided.
- It helps eliminate the negative reinforcement linked to fear reduction.
- Exposure aids in integrating accurate information into trauma memory.
- It frames the trauma as a distinct event, rather than a sign that the entire world is threatening.
- It enables self-regulation (Lahad & Doron, 2010, p. 34).

5-3. Relaxation:

Relaxation is one of the most important techniques in cognitive behavioral therapy and has been shown to produce positive results (Wood, 2020, p. 12) through the following:

- Facilitating a gentle entry into therapy.
- Helping patients reduce autonomic nervous system responses (symptoms of the autonomic nervous system).
- Using both physical and cognitive relaxation techniques to treat symptoms associated with PTSD.
- Assisting in the re-experiencing of traumatic events and gaining control over the trauma.

5-4. Stress Inoculation Training:

The goal of this training is to equip patients with coping skills to help them gain a sense of control over their fears and reduce arousal levels, particularly when exposed to painful memories. This training is delivered in two phases:

5-4-1. Educational Phase:

In this phase, the patient must be informed about the effects of stress, particularly the activity of the autonomic nervous system, as well as the resulting interpretations and emotions related to anger, anxiety, and depression.

5-4-2. Strategy Development Phase (Coping Strategies):

This phase involves:

- Verbal Expression: Using positive language to enhance adaptation and control over the initial traumatic situation.
- Stress Management: Combining stress reactivation with guided dialogue aimed at altering automatic thoughts, carried out in several stages:
 - Preparation for confrontation through information and discussion.
 - Confrontation through role-playing or imaginal exposure to recreate the traumatic scenario.
 - Discussion of concepts related to danger, personal responsibility, and criticism.
 - Homework practice to simulate stress confrontation, such as going out, meeting others, attending social gatherings, or taking a trip (Cottraux, 2011, p. 196).

4.5. Self-Talk Reorganization:

Meichenbaum posits that cognitive factors significantly influence behavioral change. His research program examined the role of cognitive factors in modifying behavior, with a focus on altering or understanding self-talk. He argued that changing self-talk could lead to changes in thought, emotion, and behavior. According to Meichenbaum, what individuals say to themselves determines their actions.

One function of self-talk is its role in changing emotions, thoughts, and behaviors by influencing attention and evaluation processes. The second function is its impact on and alteration of cognitive structures (Jeffrey, Hecker, & Thorpe, 2015, p. 390).

Conclusion:

Cognitive Behavioral Therapy (CBT) is one of the modern psychological treatments that has revolutionized psychotherapy by delivering positive outcomes for psychologists using it as a therapeutic approach for specific psychological disorders. It has proven particularly effective in treating disorders such as depression, panic attacks, behavioral disorders, anxiety, and post-traumatic stress disorder (PTSD).

This therapy is conducted within an intensive therapeutic framework and over a set number of sessions, depending on the type of disorder. CBT employs both cognitive and behavioral techniques to help individuals access and address deep emotions, reducing their rigidity in judging daily life challenges and promoting acceptance. This, in turn, positively impacts the individual's overall mental health.

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