Introduction to Disaster Cognitive Behavioral Therapy (CBT)

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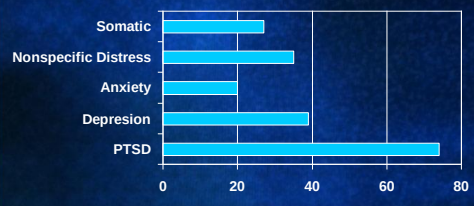
Goals of Presentation

- Provide background and rationale for treatment
  - Review common postdisaster problems
  - Review empirical support for the treatment of postdisaster problems
- Briefly describe the treatment
- Discuss CR for disaster-related distress

Common postdisaster psychological problems

Percent of samples (N=225) in which shown outcomes were assessed and observed



Norris et al. 2002

Who is at-risk for postdisaster adjustment problems?

- Some of the strongest risk factors include:
  - More severe exposure
  - Female gender
  - Middle age
  - Ethnic minority group membership
  - Secondary stress
  - Prior psychiatric problems
  - Weak or deteriorating psychosocial resources

Norris et al. 2002

Creation of NCPTSD post-disaster distress manual

- Identified effective interventions for the range of problems most common after disasters
  - PTSD
  - Depression
  - Other anxiety disorders
- Selected core elements from empirically supported treatments that were found across disorders

CBT for PTSD

- Consensus guidelines support CBT for PTSD:
- Components of CBT associated with largest effects are exposure and cognitive restructuring (CR).
- Several studies have compared the effects of CR to exposure with most finding comparable benefit (e.g., Resick et al., 2002).
- However, in one five-year follow-up study comparing the two, participants receiving CR were less likely to meet criteria for PTSD and showed fewer PTSD symptoms than participants receiving exposure (Tarrier & Sommerfield, 2004).

CBT for Depression & Anxiety

- CBT is one of the most well supported treatments for depressive and anxiety disorders
- Depression:
  - Meta-analyses show cognitive therapy superior to waitlist, antidepressants, and miscellaneous therapies and equal to behavior therapy in its effects (Dobson, 1989; Gloaguen et al. 1998)
- Anxiety:
  - Cognitive restructuring is major component of empirically supported treatments for GAD and panic (for reviews see: Borkovec & Whisman, 1996; Craske, Meadows, & Barlow, 1994; Newman & Borkovec, 1995)

Core Components of CBT

CBT typically includes some combination of the following:

1) Psychoeducation
2) Anxiety Management Techniques
   - e.g. breathing retraining
3) Cognitive Restructuring
4) Exposure
   - Imaginal or in vivo (typically only for PTSD)

Psychoeducation

- Provide information about a person's symptoms
- Help normalize the reaction
- Establish rapport
- Provide rationale for treatment; instill sense of hopefulness

Anxiety Management/Coping Skills

- AMTs are coping strategies for dealing with anxiety
- Typical components:
  - breathing retraining
  - progressive muscle relaxation
  - positive self-statements
  - Relaxation training

Cognitive Restructuring

- Technique designed to teach clients that there is a connection between thoughts and feelings.
- Explain that the thoughts people have are often automatic and that they come from previous (often traumatic) experiences.
- Teach clients a strategy for challenging those thoughts and either generating new more adaptive thoughts and/or an action plan for dealing with the upsetting situation.

Exposure

- A set of techniques designed to promote confrontation with feared objects, situations, memories and images and reduce anxiety. Clients relive memories (imaginal) and confront avoided situations (in vivo).
- Goal: Habituation or desensitization to trauma stimuli and memories. Clients learn that they do not have to be afraid of their memories or their feelings.

Exposure

- Imaginal
  - Detailed account of the trauma in present tense as if it were re-occurring - Includes sensory details, thoughts, and feelings.
  - Exposure to a limited number of scenes.
  - Often have client listen to tape of exposure for homework
  - Repeated in session until SUDS decreases by 50%
  - Can have client write scene
- In Vivo
  - Create a hierarchy
  - Expose self to feared situations or places that are being avoided. Can be done with a coach.

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Overview of Intervention

Overview of intervention

- A 10 session manualized intervention to treat a range of postdisaster distress
- Designed to be one part of larger disaster mental health system response
- To be implemented no sooner than 60 days postdisaster
- For individuals showing more than transient stress response
- Intermediate step between crisis counseling and longer term mental health treatment

Notes about Manualized Treatments

- Ensures that core skills are taught
- Should be individually tailored for client's presenting problems, but core skills and principles will remain the same across clients
- Cannot be implemented effectively in the absence of therapeutic alliance, rapport, trust
- Does not need to usurp therapist's personality!
- Requires you to be intimately familiar with the material in order to integrate with your own therapeutic style
- Allows for studies on treatment outcome by providing uniformity of approach

Familiarizing Yourself with the Manual

- 10 Self-Contained Sessions
- Up to 5 practice sessions
- Appendices contain:
  - Copies of all handouts (in case client forgets workbook)
  - Worksheet on common challenges in using CR
  - Sample transcripts

Session Structure

- Each session has consistent structure. It is important to set tone/structure from beginning:
  - BRIEF check-in
  - Review/troubleshooting of prior week's homework
  - Didactic material
  - Brief review of session and assigning of next week's homework (practice)

Three Components

- Psychoeducation
  - Taught in Session 1
- Anxiety management/Coping
  - Taught in Session 2
- Cognitive Restructuring (CR)
  - Taught in Sessions 3 and 4
  - Practiced in Sessions 5-9

Why No Exposure?

- Imaginal exposure techniques designed for full-blown PTSD
  - Not as much evidence supports use of exposure for sub-threshold PTSD
- Exposure may not work as well as cognitive restructuring on guilt (better for fear/anxiety).
- Exposure not appropriate for other disaster related disorders such as depression.
- Current treatment draws on principles of exposure and encourages the blocking of avoidance behaviors in regard to trauma memories and reminders. This is incorporated into psychoeducation, coping, and CR modules.

Psychoeducation

- Emphasized in 1st sessions, but woven throughout treatment
- Goals are normalization, establishment of rapport, information gathering in regard to client's problems in functioning
- Therapist can tailor to client's specific presentation.

Education Topics

- PTSD
- Common Reactions (anxiety, sadness, guilt/shame, anger)
- Depression
- Anxiety
- Substance abuse
- Grief/bereavement
- Sleep problems/nightmares
- Problems with functioning (work, relationships, physical)

Anxiety Management/Coping

- Coping skills interwoven throughout intervention, but are formally introduced in Session 2
- Three skills:
  - Breathing Retraining - to counter the physical symptoms of anxiety.
  - Pleasant Activities Scheduling - to help more depressed and/or isolated individuals engage in more positive activities.
  - Coping Skills Training - to increase awareness of alternative, more positive, coping strategies.

Cognitive Restructuring

- Introduced in sessions 3 and 4; practiced through remainder of the treatment
- "Backbone" of treatment
- Clients taught connection between problematic thinking and feeling patterns
- Ultimate goal is to change problematic feelings/behaviors by putting thoughts into more realistic/balanced perspective.
- Can be used for wide variety of problematic cognitive, emotional, and behavioral patterns

CBT for Postdisaster Distress: Psychoeducation

Overview of Intervention

- Goal: To put the client at ease by letting them know what to expect in the upcoming sessions and to build client's confidence that the treatment will work for them.
- Explain the focus of the intervention is on decreasing common symptoms and increasing functioning.
- Review the 3 components of the treatment
- Clarify that you will not be asking clients to relive events or spend a lot of time re-telling them

Trauma Information

- Goal: To learn what the client experienced during the hurricane and establish treatment goals.
- You must balance your desire to know more with the time constraints of the manual. You will learn more about symptoms in the next section.
- Clients should not be pushed too hard at this point to tell their story.
- As you conduct interview, pay attention to areas that you think will be most clinically relevant. This will help you later in deciding how much time to spend on each section of psychoeducation.

Education

- Goal: To understand client's sx and to educate client about common postdisaster reactions.
- Intended to be an interactive dialogue between you and the client.
- Strike a balance between covering the didactic material, developing rapport with the client, and gaining further information about their symptoms.
- Spend more time on sections that you feel are primary for the client.
- Remind clients that everything you are covering is in their workbooks.

Posttraumatic Stress Symptoms

- Reexperiencing:
  - Intrusive thoughts, nightmares, flashbacks, upset at reminders
- Avoidance:
  - Avoidance of people, places, situations or thoughts that remind you of the trauma
- Numbing:
  - Restricted range of affect, lack of interest, estrangement, sense of foreshortened future
- Arousal:
  - Trouble concentrating, difficulty sleeping, hypervigilance, startle, irritability.

Common Reactions

- Fear and Anxiety
  - Adaptive response after trauma. Hard wired (fight/flight)
  - False alarms
- Anger
  - Also part of fight or flight
  - Anger can be directed at self or others
- Sadness
  - Often related to actual loss, but can be about loss of trust, hope, innocence, safety, etc.
- Guilt & Shame
  - Shame= feeling associated with unworthy or indecent conduct or circumstances
  - Guilt-=a feeling of responsibility or remorse for some offense, crime, wrong, etc., whether real or imagined.

Depression

- Can occur because of actual loss or because of loss of sense of safety, trust, innocence.
- Symptoms covered: decreased interest, change in weight/appetite, sleep, agitation/lethargy, fatigue, worthlessness, trouble concentrating, suicidal thoughts.

Anxiety

- New material on worry, panic attacks, and phobias.

Substance Abuse

- Research shows that most people will develop a new substance problem following a disaster. However, people who have had problems in the past will have a tendency to relapse.
- Substances are often used as a way to self-medicate or escape but there is a boomerang effect. That is, may work in short run but in the long run it makes symptoms worse.

Grief/Bereavement

- This is not an intervention specifically for grief. However, it should still be helpful in managing symptoms of grief.
- Review the stages of grief

Sleep Problems and Nightmares

- There are many sleep problems that are common such as trouble falling asleep, waking up frequently, sleeping too much, nightmares, and fear of going to sleep because of nightmares.
- The sleep tips are good and should be reviewed with any client having sleep problems.

Problems with Functioning

- Some clients will have an easier time reporting functioning problems rather than symptoms. However, if through discussions of functioning it is clear that you missed important symptoms, it is fine to go back and review symptoms.
- Relationship problems:
  - separation/divorce
  - parenting problems
  - lack of social support
  - additional burdens if lost spouse or support person

Problems with Functioning Continued

- Work Problems
  - Job loss
  - Lack of interest/dissatisfaction
  - Being late
  - Impaired concentration
  - Financial problems

Problems with Functioning Continued

- Physical Problems
  - Illness
  - Exacerbation of preexisting conditions
  - Appetite change
  - Weight change

Case Formulation

- Goal: To develop a case conceptualization of how the disaster is currently impacting the client and to make the client feel that you have an understanding of their disaster-related problems and how to help them.
- This is important for 2 reasons:
  - 1. It demonstrates to clients that they have been heard.
  - 2. It provides clients with an explanation of how all of their symptoms and problems fit together.
- Summarize main areas of symptomatology and explain how you will teach them skills for dealing with these symptoms.

Challenging Cognitions

- Goal: To teach clients the 5 Steps of CR
- Bridge between Problematic Thinking Styles and 5 Steps:

  "So, what do we do about these unhelpful beliefs that make us feel lousy? Well, we want to evaluate whether what we think makes sense. If we decide that our thoughts aren't accurate, we can change them. If we change them, we may feel better. If we decide that the thoughts are accurate, then we develop a plan for coping with the situation. This process is called Cognitive Restructuring or CR."

The 5 Steps

- Step 1: Upsetting Situation
- Step 2: Feelings
- Step 3: Thoughts
- Step 4: Challenge your Thought
- Step 5: Making a Decision

Step 1: Upsetting Situation

- Have client briefly write down (or describe to you) the upsetting situation

Step 2: Feeling

- Have the client circle one of the 4 negative feeling states: fear/anxiety, sadness/depression, guilt/shame, and anger.
- If clients say it is more than one feeling do a separate sheet for each.
- Sometimes clients will be resistant to picking one of these. They might want to identify a different feeling, for example, jealousy. However, in most cases these other feelings are made up of the 4 primary ones. Thus jealousy can be thought of as a combination of anger and fear. So, have client challenge anger and then fear.

Step 3: Thought

- Have clients write down the one thought that is leading to the distress. If they have trouble use the Thoughts and Feelings Handout.
- Try and keep thoughts closely related to the situation. For example, rather than the thought "I am no good," use the thought "I am no good because I yelled at my kids." It will be much easier in the next step to challenge the latter step.
- See if clients can identify a Problematic Thinking Style and have them circle it below. This is a good sign, suggesting that they know their thinking is extreme.

Step 4: Challenge Your Thought

- First, have clients come up with all the evidence they can to support their thought. Do not worry about the quality of the evidence
- Next, have the client come up with as much evidence as they can against the thought. Explain to them that they should act as both prosecutor and defendant. They should present both sides of the evidence to the judge. It is best if clients can come up with evidence on their own. Ask questions to help them generate evidence. You can also use the Questions to Ask When I am Challenging Thoughts Handout.

Step 5: Making a Decision

- Once the client has generated the evidence, you ask the client if the evidence mostly supports the thought or mostly does not support the thought.
- If evidence does NOT support the thought: develop a new thought that is supported by the evidence. Might also develop action plan (more on this later).
- If evidence DOES support thought: develop an action plan for coping in the situation

Action Plan I

- Must develop an action plan if the evidence DOES support the thought. In this case, be creative. Use problem solving skills, coping skills, and other therapeutic techniques to help client manage upsetting feelings in a specific situation.
- Example: Client challenges the thought that her boyfriend broke up with her because she is too needy after 9/11 and determines that it is supported by the evidence. Action Plan might involve: getting into therapy, finding other support people, and developing a plan for what to do when upset rather than just calling boyfriend.

Action Plan II

- Might want to develop an action plan even if thought is NOT supported by the evidence.
- Example: Client challenges the thought that tall buildings are unsafe and replaces it with the new thought "just because I feel afraid does not mean I am in danger." However, the client still feels afraid. The action plan might involve doing breathing retraining while in the building, bringing a friend with them, as well as replacing the old thought with the new one.

CR do's and dont's

- Do complete a CR sheet each time you start.
- Do help client generate evidence against their thought.
- Do help client try and develop a more balanced thought.
- Don't let time run out so that CR left undone.
- Don't get into a power struggle with client.
- Don't allow client to quit before they develop an alternative thought. Have them come up with one even if they don't believe it.

When to Terminate?

1. Client can generate evidence against the thought.
2. Client can use CR in the moment.
3. Client can do CR "in their head."
4. Client has dealt with core thoughts.
5. Client reporting a decrease in postdisaster symptoms either by self report or by an assessment measure.