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Treating Trauma From the Top Down

A Cognitive Path to Healing

By Kate Chard

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Forty years ago, it might've been hard to envision how mainstream the term trauma *would become. But now—given wars, political strife, racial tensions, socioeconomic disparities, the rise of the digital world and the 24-hour news cycle, and now a global pandemic—we're bombarded by traumas big and small. Ask your average person walking down the street—or your average therapist, for that matter—if society experiences more trauma today than ever before, and you're likely to get a few head nods.*

So it's no surprise that the perception of more trauma has brought with it more interventions for treating it—some informed by very different schools of thought. Does trauma live in the body, brain, mind, or some combination? Can we "spot" it in our clients? And what about interventions that seemingly have little to do with therapy, like exercise, martial arts, or equine therapy? When it comes to designating best practices for treating trauma, where does the field stand?

Enter Kate Chard, researcher, author, and professor of clinical psychiatry and behavioral neuroscience at the University of Cincinnati, as well as Director of the UC Health Stress Center. Over the course of her work, she's confronted many of these same questions. And in a field seemingly dominated by approaches that have become known as "bottom up," she's come to an alternative conclusion about what it takes to treat trauma effectively: focus on the client's automatic thoughts.

We sat down with Chard to hear more about today's trauma-treatment research, what it takes to engage clients and inspire hope, and why the answers to some of our biggest questions about trauma treatment might be right in front of us.

Many therapists now accept the notion that trauma lives in the body. Does your research support that?

The body's reactions to trauma are very real, because, as we know from numerous studies, PTSD affects the amygdala and the prefrontal cortex. In fact, we often refer to it as an amygdala hijacking when someone goes into fight, flight, freeze with no threat present. Trauma survivors often talk about having cold hands and feet, because blood flow to our hands and feet decrease during fight, flight, freeze. There are also the bodily reactions of increased heart rate, muscle tension, hyperventilation, and so on.

When you look at brain activity in someone with PTSD, you see a great deal of neuronal activity in the amygdala, whereas in a treated brain, you see a directional shift, with the prefrontal cortex sending calming messages to the amygdala. So we know that certain treatments cause a decrease in amygdala activation. Someone can learn to hear a sound downstairs and, rather than get activated, think, "No one's down there; that's just the dog knocking the trash can over."

That said, while we all recognize the body's reactivity in PTSD, studies across the board have found that body-centered treatments, like equine therapy, yoga, mindfulness, and Taekwondo, don't actually make people better. That's not to say people shouldn't engage in these activities if it calms or distracts them, but we shouldn't assume that if one person likes running or tai chi, that it will help someone else. Clients should be encouraged to engage in various types of exercise and self-care, but physical activity must be an addition to therapy, not a replacement for it.

So what's the role of the body in therapy? It's not that the body is holding the traumatic memory; it's that the amygdala is activating it within the body. When we work to stop the amygdala from activating from PTSD, the body also stops reacting to the trigger. I had a client say after five sessions, "My hands aren't cold anymore."

And I said, "Well, your amygdala isn't firing the same way it was."

So, yes, we have to attend to our bodies, but the focus has to be on calming the amygdala. With CPT, clients are prompted to write an impact statement wherein they reflect on how the traumatic event affected them, and then they work with the therapist to identify stuck points, or beliefs that have prevented them from

recovering. The clinician uses Socratic dialogue to help them identify disruptive thoughts and determine if there are ways to make them more realistic and flexible. In other words, CPT is effective because it works on activating the executive-functioning part of the brain, which controls cognitions, which then helps quiet the amygdala when it's activated.

How did you get involved in the development of CPT?

Originally, even as early as eighth grade, I wanted to treat kids with trauma histories. But when I entered graduate school, planning to be trained in the best treatments for child trauma, I discovered that very few studies in the '80s focused on treating PTSD symptoms in children or adults. There were a couple of small studies on rape and a couple of studies on combat, but there wasn't a single study that had been conducted on PTSD outcomes in adult survivors of childhood abuse, not one.

I was so impassioned by my desire to find treatments for these clients that I called every one of the leading experts in trauma who'd published a study on interpersonal violence. I asked them, "If you were going to treat an adult survivor of child sexual abuse, what would you do? Would you use your protocol? Would you change it?" I had wonderful conversations with these researchers, but I was left with the realization that no one had an adequate answer for me.

That left me with burning questions. If child-abuse PTSD cases are among the most important to treat because they're often labeled the most difficult, why hasn't a single study looked for a way to help this population? What's the best care for people with extensive child and often additional adult trauma? I became a researcher because I didn't have an answer to those questions.

Around the same time, I discovered Aaron Beck and CBT, and his ideas made sense to me on a fundamental level. I even learned that Marcus Aurelius, the Roman emperor, often quoted the writings of Epictetus, the freed slave, who was essentially giving CBT advice when he stated, "People are not disturbed by things, but by the views they take of them." So basically, it's not what happens to you, but how you react to it that matters. This fits with our knowledge that 70 percent of people who experience traumatic events don't go on to develop PTSD.

By the early '90s, Patricia Resick had completed her study of CPT for rape victims.

She was using cognitive behavioral treatment at a time when everything in much of trauma treatment was based in either supportive talk therapy or exposure treatments. This piqued my interest because she was providing clients with a solid skill set to alleviate their symptoms and giving them tools they could use in their lives.

When the mental health agency where I worked as a graduate student asked her to train the staff in her treatment for rape, I sat there thinking, *How could we change this manual to fit child sexual-abuse survivors?* Three months later, CPT for child sexual abuse was created.

Over time, CPT has evolved, and research has shown that when the focus of treatment is on changing cognitions—not on retelling the story of the traumatic event—symptoms improve faster. By focusing on cognition, we can help clients examine why they believe the event happened and what impact it's had on their life. We provide tools and a safe place for clients to examine their beliefs and determine if they're based on the facts of what happened or if they're skewed due to the PTSD.

For example, a client may say, "The rape is my fault because I went out that night," blaming themselves instead of blaming the rapist, and as a result, they may not trust themselves to make choices that will keep them safe. The CPT therapist helps the client realize their decisions didn't cause the rape, and they can indeed trust their decision-making. This process helps reduce their symptoms of depression, blame, guilt, and shame.

It's so important to recognize that our clients want to have hope that they can get better. When we introduce cognitive skill building early, we find that hope improves, and then clients are less likely to drop out. We know that hope has to improve before PTSD can decrease. So a huge part of our treatment has to be building hope.

CPT's movement away from expectation that all clients have to tell their trauma narratives was a turning point in the field because we clinicians had spent so many years believing that we absolutely had to hear the story in order to validate clients and help them process the memory. What we really needed was to validate how they're feeling and how they think about themselves and the world—not what happened. In addition, CPT works with PTSD from a wide variety of traumas; it's

effective with different cultures and has been translated into 10 languages.

> *"...when clients aren't pressed to tell their trauma narratives, the dropout rate is lower and you can heal from your PTSD faster."*

It's easy to forget that trauma treatment is relatively new. What are some things you were taught about trauma early in your career that turned out to be wrong?

When I entered the field, in the '80 and early '90s, there were many myths about trauma that prevented us from providing the best possible treatment. One big myth comprised two interrelated ideas: that trauma victims had to be treated in a group setting, and that they had to share their stories. Many people in community clinics and veteran hospitals were running away from treatment because they didn't want to hear other people's stories or share their own.

At the same time, for clinicians, there was an emphasis on making people stay with their memories, cry, and process the trauma. If someone told a story without showing emotion, you were supposed to have them tell the story a second or third time, and that was supposed to provide catharsis. We've had generations of clients saying, "I can't do therapy if I have to tell you what happened: it's too shameful, too horrible. And I just don't want to go through it." We essentially told them, "When you're ready to stop being 'avoidant,' come in for therapy." But they couldn't, so they were never treated.

The second big myth, in direct opposition to the first, was that you shouldn't have a client tell you about their trauma because they'll get too distressed and hurt themself, or someone else, and end up in the hospital. So, if someone started getting distressed by any traumatic material, you were supposed to pull back immediately. That whole idea was terrible because it cosigns the client's notion that their trauma is so horrible or shameful that even a clinician can't handle hearing about it.

Now the trauma field has moved to more middle ground. We've moved away from the idea that clients are too fragile for their own traumatic material, and the idea

that they need to be re-exposed to it. Today, our models are much more guided by client choice than therapist choice. We discovered that you never need to tell your story to be treated for trauma. In fact, several studies have shown that when clients aren't pressed to tell their trauma narratives, the dropout rate is lower and you can heal from your PTSD faster. I call it the great sigh of relief in the field of PTSD.

Meanwhile, over the last 30 years, there's been a proliferation of different treatment models. Prolonged exposure therapy and some of the newer written narrative therapies are wonderful treatments, if the client chooses to be in them. The problem was that for a long time, the only options were to be in prolonged exposure or talk therapy. That's a really tough choice for clients, especially sexual-trauma survivors, who may not feel safe or comfortable going into detail about their traumas. Plus, several studies have shown that while talk therapy can help reduce some symptoms, the improvement isn't as large or as lasting as evidence-based treatments.

We now hear clinicians saying that they're trained in multiple distinct trauma therapies that the client can choose from, and follow each one step by step, instead of saying they're eclectic and just mixing interventions here and there. Borrowing different aspects of different models hasn't been shown to work as well with PTSD.

A third myth about trauma—which I believed and perpetuated as much as anyone—is that you can't receive treatment for PTSD while you're being traumatized. There was a prominent idea that trauma treatment should begin after the traumatic events. For years, we told domestic violence victims, "I'll do safety planning and supportive therapy with you, but you have to get out before I can treat your trauma."

During the wars in Iraq and Afghanistan in the 2000s, the U.S. government identified the need to provide evidence-based treatments for service members while they were still deployed. My colleagues and I flew to bases all over the world to train therapists to do CPT with these people. We asked ourselves, why can't we treat people who are still in domestic violence situations, or even first responders who may experience traumas on every shift? Thankfully, many clinicians rapidly adopted this change, and you can now see PTSD interventions offered to clients in all sorts of key areas, including prisons and high-crime neighborhoods. Our work helped

debunk that myth and show that we can help people who are still living in traumatic situations.

What do you say to the idea that a manualized therapy breaks therapeutic rapport and can dehumanize the client?

Many therapists rightfully worry about the importance of the therapeutic relationship, as well as providing a safe place for the client to explore their traumatic material. I think that concern has translated into the myth that a clinician needs to spend two, three, four, five sessions creating an alliance. In fact, we've found in multiple types of studies and in clinics that delaying therapy in this way increases avoidance, the likelihood of dropout, and suicidal ideation, as the client feels no hope because they're not learning a technique to help manage their symptoms.

When therapists first meet our clients, we can increase that immediate rapport building by being genuine and kind and instilling a sense of hope that treatment will help them get better. What we've shown in studies is the first session of therapy is the biggest predictor of outcome. Being able to be our authentic self, right away, even while we're delivering a manualized treatment, is what's most important.

Where's the field going next with trauma treatment?

I'm always thinking about what's going to move the field in a way that helps the most people, so no one has to sit in therapy for 30 years waiting to get better. There isn't a one-size-fits-all model, but there are four evidence-based trauma treatments out there for clients to choose from: exposure-based, cognitive-processing, EMDR, and present-centered therapy.

While we've identified key treatments that give people options, there's still much for us to learn. For example, there's no data to show that people with complex PTSD need treatment different from that given to other people with trauma. And there's still disagreement about what constitutes complex PTSD.

One exciting development is around the seemingly tried-and-true idea that we should be doing therapy once a week. Several research studies and clinical settings have seen more success with what's called "massed" treatment—several sessions a week or even daily for a few weeks, rather than a weekly session for 10 to 15 weeks.

This treatment schedule has lower dropout rates and can potentially provide even greater improvement than traditional treatment schedules.

There's also the need to think more about what different subtypes of trauma exist. For years, we've grouped people with very different kinds of traumatic experiences and symptoms presentations in the same category of PTSD. I'm interested in looking more closely at how different kinds of traumas affect the brain differently and if there are subtypes of PTSD. There's been so much thinking about fear-based trauma, but what about guilt- and shame-based trauma? When an abuser says to a child, "You're my special little one," there may not be fear in that sexual contact, but later, there may be shame and guilt. I think we need to distinguish between those groups to refine treatment models.

Also, we've collected biological data and EEG brainwave data on 500 people—both active duty and veterans, with and without PTSD—to identify subtypes through biological tests and traditional assessments. For many people, it would be helpful to have a blood test for PTSD, so that they wouldn't be required to tell their story in order to be diagnosed. I expect in the next 10 years, we'll have a blood test for PTSD markers.

When we take a step back, this is an exciting time because people are becoming advocates for their mental health care, and they're becoming more educated and thoughtful about the kind of treatment they want.

It's great that so much information is so readily available on the internet, but I worry that people will share inaccuracies and myths about treatment or PTSD. For instance, many clients used to believe that you can't recover from PTSD—which is not at all factual. If you can get access to treatment, you can get better. You can reactivate your prefrontal cortex, stop the amygdala hijacking, and get back the life you deserve.

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Kathleen M. Chard, PhD, *is a codeveloper of CPT and director of the Trauma Recovery Center at the Cincinnati VA Medical Center. She's the coauthor of* Cognitive Processing Therapy for PTSD: A Comprehensive Model *and author of* CPT for Sexual Abuse Treatment Manual.