POSTTRAUMATIC STRESS DISORDER (PTSD)

BEHAVIORAL DEFINITIONS

1. Has been exposed to a traumatic event involving actual or perceived threat of death or serious injury.
2. Reports response of intense fear, helplessness, or horror to the traumatic event.
3. Experiences disturbing and persistent thoughts, images, and/or perceptions of the traumatic event.
4. Experiences frequent nightmares.
5. Describes a reliving of the event, particularly through dissociative flashbacks.
6. Displays significant psychological and/or physiological distress resulting from internal and external clues that are reminiscent of the traumatic event.
7. Intentionally avoids thoughts, feelings, or discussions related to the traumatic event.
8. Intentionally avoids activities, places, people, or objects (e.g., up-armored vehicles) that evoke memories of the event.
9. Displays a significant decline in interest and engagement in activities.
10. Experiences disturbances in sleep.
11. Reports difficulty concentrating as well as feelings of guilt.
12. Reports hypervigilance
13. Demonstrates an exagger0061ted startle response.
14. Symptoms present more than one month.
15. Impairment in social, occupational, or other areas of functioning.

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LONG-TERM GOALS

1. Eliminate or reduce the negative impact trauma related symptoms have on social, occupational, and family functioning.
2. Returns to the level of psychological functioning prior to exposure to the traumatic event.
3. No longer experiences intrusive event recollections, avoidance of event reminders, intense arousal, or disinterest in activities or relationships.
4. Thinks about or openly discusses the traumatic event with others without experiencing psychological or physiological distress.
5. No longer avoids persons, places, activities, and objects that are reminiscent of the traumatic event.

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SHORT-TERM OBJECTIVES

1. Describe in as much detail as comfort allows the nature and history of the PTSD symptoms. (1, 2)

THERAPEUTIC INTERVENTIONS

1. Establish rapport with the client toward building a therapeutic alliance.
2. Gently and sensitively explore the client's recollection of the facts of the traumatic incident and his/her cognitive and emotional reactions at the time; assess frequency, intensity, duration, and history of the client's PTSD symptoms and their impact on functioning (see "How the Trauma Affects Me" in the *Adult Psychotherapy*

Homework Planner by Jongsma); supplement with semi-structured assessment instrument if desired (see *The Anxiety Disorders Interview Schedule–Adult Version*).

2. Cooperate with psychological testing. (3)

3. Administer or refer the client for administration of psychological testing or objective measures of the PTSD symptoms and/or other comorbidity (e.g., *Minnesota Multiphasic Personality Inventory–2*; *Impact of Events Scale-Revised; PTSD Symptom Scale; Posttraumatic Stress Diagnostic Scale*); discuss results with the client; readminister as indicated to assess treatment progress).

3. Acknowledge any substance use. (4, 5)

4. Assess the client for the presence and degree of substance abuse or dependence.

5. Refer the client for a more comprehensive substance use evaluation and treatment.

4. Verbalize any symptoms of depression, including any suicidal thoughts. (6)

6. Assess the client's depth of depression and suicide potential and treat appropriately, taking the necessary safety precautions as indicated (see the Suicidal Ideation chapter in this *Planner*).

5. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (7, 8, 9, 10)

7. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to

address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).

8. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if appropriate (e.g., increased suicide risk when comorbid depression is evident).

9. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

10. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

6. Cooperate with a psychiatric evaluation to assess for the need for psychotropic medication. (11, 12)

11. Assess the client's need for medication (e.g., selective serotonin reuptake inhibitors) and arrange for prescription, if appropriate.

12. Monitor and evaluate the client's psychotropic medication prescription compliance and the effectiveness of the medication on his/her level of functioning.

7. Verbalize an accurate understanding of PTSD and how it develops. (13)

13. Discuss how PTSD results from exposure to trauma; results in intrusive recollection, unwarranted fears, anxiety, and a vulnerability to other negative emotions such as shame, anger, and guilt; and results in avoidance of thoughts, feelings, and activities associated with the trauma.

8. Verbalize an understanding of the treatment rationale for PTSD. (14, 15)

14. Educate the client about how effective treatments for PTSD help address the cognitive, emotional, and behavioral consequences of PTSD using cognitive and behavioral therapy approaches.

15. Assign the client to read psychoeducational chapters of books or treatment manuals on PTSD that explain its features and development (e.g., *Overcoming Posttraumatic Stress Disorder* by Smyth; *Reclaiming Your Life from a Traumatic Experience* by Rothbaum, Foa, and Hembree).

9. Learn and implement calming skills. (16)

16. Teach the client calming skills (e.g., breathing retraining, relaxation, calming self-talk) to use in and between sessions when feeling overly distressed.

10. Participate in Cognitive Processing Therapy to process the trauma and reduce its impact. (17, 18, 19, 20)

17. Use a Cognitive Processing Therapy approach beginning with assigning the client to write a description of the meaning of the traumatic event (i.e., the impact

statement); ask the client to read and discuss the impact statement (see *Posttraumatic Stress Disorder* by Resick, Monson, and Rizvi; *Cognitive Processing Therapy for Rape Victims* by Resick and Schnicke). EBT

18. Teach the client the relationship between thoughts, behaviors, and emotions associated with the trauma. EBT

19. Ask the client to write a detailed description of the traumatic event and read the statement in session (or assign "Share the Painful Memory" in the *Adult Psychotherapy Homework Planner* by Jongsma); use cognitive therapy techniques to question biased thoughts and beliefs and explore unbiased alternatives; repeat this process until a shift from biased to unbiased thinking is evident. EBT

20. Ask the client to rewrite a description of the event, but now reflecting new thoughts and beliefs; discuss this restructured version of the event reinforcing the new beliefs; assess and address themes common to PTSD (e.g., safety, trust, power, control, esteem, and intimacy). EBT

EBT 11. Participate in Cognitive Therapy to help identify, challenge, and replace biased, negative, and self-defeating thoughts resulting from the trauma. (21, 22, 23)

21. Using Cognitive Therapy techniques, explore the client's self-talk and beliefs about self, others, and the future that are a consequence of the trauma (e.g., themes of safety, trust, power, control, esteem, and intimacy); identify and challenge biases; assist him/her in generating appraisals that correct for the

biases; test biased and alternatives predictions through behavioral experiments. ▽

22. Assign the client to keep a daily log of automatic thoughts (e.g., "Negative Thoughts Trigger Negative Feelings" in the *Adult Psychotherapy Homework Planner* by Jongsma); process the journal material to challenge distorted thinking patterns with reality-based thoughts and to generate predictions for behavioral experiments. ▽

23. Assign the client a homework exercise in which he/she identifies fearful self-talk; tests, through behavioral experiments, the predictions from these dysfunctional thoughts; and creates reality-based alternatives. Review and reinforce success while problem-solving obstacles toward sustaining positive change (see *Overcoming Posttraumatic Stress Disorder* by Smyth). ▽

▽ 12. Participate in Prolonged Exposure Therapy to reduce fear and avoidance associated with the trauma. (24, 25, 26, 27, 28)

24. Direct and assist the client in constructing a fear and avoidance hierarchy of trauma-related stimuli. ▽

25. Utilize in vivo exposure in which the client gradually exposes himself/herself to objects, situations, places negatively associated with the trauma. ▽

26. Assign the client a homework exercise in which he/she does an exposure exercise and records responses (see "Gradually Reducing Your Phobic Fear" in the *Adult Psychotherapy Homework Planner* by Jongsma

or *Overcoming Posttraumatic Stress Disorder* by Smyth); review and reinforce progress, problem-solve obstacles. EBT

27. Utilize imaginal exposure to process memories of the trauma, at a client-chosen level of detail, for an extended period of time (e.g., 90 minutes); repeat in future sessions until distress reduces and stabilizes (see *Prolonged Exposure Therapy for PTSD* by Foa, Hembree, and Rothbaum; or *Posttraumatic Stress Disorder* by Resick, Monson, and Rizvi). EBT

28. Assign the client a homework exercise in which he or she does self-directed exposure to the memory of the trauma. EBT

EBT 13. Learn and implement personal skills to manage challenging situations related to trauma. (29)

29. Use techniques from Stress Inoculation Training (e.g., covert modeling [i.e., imagining the successful use of the strategies], role-play, practice, and generalization training) to teach the client tailored skills (e.g., calming and coping skills) for managing fears, overcoming avoidance, and increasing present-day adaptation (see *Clinical Handbook/Practical Therapist Manual for Assessing and Treating Adults with Posttraumatic Stress Disorder (PTSD)* by Meichenbaum). EBT

EBT 14. Learn and implement guided self-dialogue to manage thoughts, feelings, and urges brought on by encounters with trauma-related situations. (30)

30. Teach the client a guided self-dialogue procedure in which he/she learns to recognize maladaptive self-talk, challenges its biases, copes with engendered feelings, overcomes avoidance, and reinforces his/her accomplishments; review and

reinforce progress, problem-solve obstacles.

15. Participate in Eye Movement Desensitization and Reprocessing (EMDR) to reduce emotional distress related to traumatic thoughts, feelings, and images. (31)

16. Participate in Acceptance and Commitment Therapy (ACT) to reduce the impact of the traumatic event. (32, 33, 34, 35)

31. Utilize Eye Movement Desensitization and Reprocessing (EMDR) to reduce the client's emotional reactivity to the traumatic event and reduce PTSD symptoms.

32. Use an ACT approach to PTSD to help the client experience and accept the presence of troubling thoughts and images without being overly impacted by them, and committing his/her time and efforts to activities that are consistent with identified, personally meaningful values (see *Acceptance and Commitment Therapy for Anxiety Disorders* by Eifert, Forsyth, and Hayes).

33. Teach mindfulness meditation to help the client recognize the negative thought processes associated with PTSD and change his/her relationship with these thoughts by accepting thoughts, images, and impulses that are reality-based while noticing, but not reacting to, non-reality-based mental phenomena (see *Guided Mindfulness Meditation* [Audio CD] by Zabat-Zinn).

34. Assign the client homework in which he/she practices lessons from mindfulness meditation and ACT in order to consolidate the approach into everyday life.

35. Assign the client reading consistent with the mindfulness and ACT approach to supplement work done in session (see *Finding Life Beyond*

Trauma: Using Acceptance and Commitment Therapy to Heal from Post-Traumatic Stress and Trauma-Related Problems by Follette and Pistorello).

17. Acknowledge the need to implement anger control techniques; learn and implement anger management techniques. (36, 37)

36. Assess the client for instances of poor anger management that have led to threats or actual violence that caused damage to property and/or injury to people (or assign "Anger Journal" in the *Adult Psychotherapy Homework Planner* by Jongsma).

37. Teach the client anger management techniques (see the Anger Control Problems chapter in this *Planner*).

18. Learn and implement approaches for addressing shame and self-disparagement. (38)

38. Use a Compassionate Mind Training to help the client identify and change self-attacking and personal shaming resulting from the trauma (see *Focused Therapies and Compassionate Mind Training for Shame and Self-Attacking* by Gilbert and Irons).

19. Implement a regular exercise regimen as a stress release technique. (39, 40)

39. Develop and encourage a routine of physical exercise for the client.

40. Recommend that the client read and implement programs from *Exercising Your Way to Better Mental Health* by Leith.

20. Sleep without being disturbed by dreams of the trauma. (41)

41. Monitor the client's sleep pattern (or assign "Sleep Pattern Record" in the *Adult Psychotherapy Homework Planner* by Jongsma) and encourage use of relaxation, positive imagery, and sleep hygiene as aids to sleep (see the Sleep Disturbance chapter in this *Planner*).

21. Participate in conjoint and/or family therapy sessions. (42)

42. Conduct family and conjoint sessions to facilitate healing of hurt caused by the client's symptoms of PTSD.

22. Participate in group therapy sessions focused on PTSD. (43)

43. Refer the client to or conduct group therapy sessions emphasizing the sharing of traumatic events and their effects with other PTSD survivors.

23. Verbalize an understanding of relapse prevention. (44, 45, 46)

44. Provide the client with a rationale for relapse prevention that discusses the risk and introduces strategies for preventing it.

45. Discuss with the client the distinction between a lapse and relapse, associating a lapse with a temporary setback and relapse with a return to a sustained pattern of thinking, feeling, and behaving that is characteristic of PTSD.

46. Identify and rehearse with the client the management of future situations or circumstances in which lapses could occur.

24. Learn and implement strategies to prevent relapse of PTSD. (47, 48, 49)

47. Instruct the client to routinely use strategies learned in therapy (e.g., continued everyday exposure, cognitive restructuring, problem-solving), building them into his/her life as much as possible.

48. Develop a "coping card" or other reminder on which coping strategies and other important information can be recorded (e.g., steps in problem-solving, positive coping statements, reminders that were helpful to the client during therapy).

49. Schedule periodic maintenance or "booster" sessions to help the client maintain therapeutic gains and problem-solve challenges.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	309.81	Posttraumatic Stress Disorder
	300.14	Dissociative Identity Disorder
	300.6	Depersonalization Disorder
	300.15	Dissociative Disorder NOS
	995.54	Physical Abuse of Child, Victim
	995.81	Physical Abuse of Adult, Victim
	995.53	Sexual Abuse of Child, Victim
	995.83	Sexual Abuse of Adult, Victim
	308.3	Acute Stress Disorder
	304.80	Polysubstance Dependence
	305.00	Alcohol Abuse
	303.90	Alcohol Dependence
	304.30	Cannabis Dependence
	304.20	Cocaine Dependence
	304.00	Opioid Dependence
	296.xx	Major Depressive Disorder
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Axis II:	301.83	Borderline Personality Disorder
	301.9	Personality Disorder NOS
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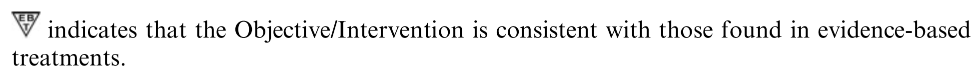
Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
309.81	F43.10	Posttraumatic Stress Disorder
300.14	F44.81	Dissociative Identity Disorder
300.6	F48.1	Depersonalization/Derealization Disorder
300.15	F44.89	Other Specified Dissociative Disorder
300.15	F44.9	Unspecified Dissociative Disorder
995.54	T74.12XA	Child Physical Abuse, Confirmed, Initial Encounter
995.54	T74.12XD	Child Physical Abuse, Confirmed, Subsequent Encounter
995.81	T74.11XA	Spouse or Partner Violence, Physical, Confirmed, Initial Encounter
995.81	T74.11XD	Spouse or Partner Violence, Physical, Confirmed, Subsequent Encounter
995.53	T74.22XA	Child Sexual Abuse, Confirmed, Initial Encounter
995.53	T74.22XD	Child Sexual Abuse, Confirmed, Subsequent Encounter
995.83	T74.21XA	Spouse or Partner Violence, Sexual, Confirmed, Initial Encounter
995.83	T74.21XD	Spouse or Partner Violence, Sexual, Confirmed, Subsequent Encounter
995.83	T74.21XA	Adult Sexual Abuse by Nonspouse or Nonpartner, Confirmed, Initial Encounter
995.83	T74.21XD	Adult Sexual Abuse by Nonspouse or Nonpartner, Confirmed, Subsequent Encounter
308.3	F43.0	Acute Stress Disorder
305.00	F10.10	Alcohol Use Disorder, Mild
303.90	F10.20	Alcohol Use Disorder, Moderate or Severe
304.30	F12.20	Cannabis Use Disorder, Moderate or Severe
304.20	F14.20	Cocaine Use Disorder, Moderate or Severe
304.00	F11.20	Opioid Use Disorder, Moderate or Severe
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
301.83	F60.3	Borderline Personality Disorder
301.9	F60.9	Unspecified Personality Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.


indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.