In the immediate aftermath of traumatic events, many people experience symptoms of posttraumatic stress disorder (PTSD). The majority of these people will recover in the following months, but a significant subgroup develops chronic PTSD. Factors explaining the maintenance of the disorder are at the core of Ehlers and Clark’s (2000) cognitive model of chronic PTSD. The model specifies three maintaining mechanisms. First, people with chronic PTSD show excessively negative appraisals (“added meanings”) of the trauma and / or its sequelae that lead to a sense of current threat. Second, the nature of the trauma memory explains the occurrence of reexperiencing symptoms. Third, the patients’ appraisals motivate a series of dysfunctional behaviours and cognitive strategies (such as thought suppression, rumination, safety-seeking behaviours) that are intended to reduce the sense of current threat, but maintain the problem by preventing change in the appraisals and trauma memory, and / or lead to increases in symptoms.

The maintaining mechanisms specified in the model have found empirical support in a range of experimental and prospective longitudinal studies (e.g., Ehlers, Mayou, & Bryant, 1998; Dunmore, Clark, & Ehlers, 2001; Halligan et al., 2003; Michael, Ehlers, & Halligan, 2005).

On the basis of the model, we have developed a new version of CBT for PTSD that has three goals. First, the idiosyncratic negative appraisals of the trauma and / or its sequelae are identified and changed. Therapeutic techniques include imaginal reliving of the event and the writing of a trauma narrative to identify hot spots and associated meanings, Socratic questioning, and behavioural experiments. Second, the trauma memory is elaborated. “Added meanings” of the trauma are updated with information that corrects impressions and predictions, using a range of techniques such as updated trauma narratives, imaginal reliving including updated meanings, in vivo reconstruction of the event, and imagery modification. Patients learn to discriminate triggers of reexperiencing symptoms from the stimuli that were present during the trauma. Third, the patient is encouraged to drop maintaining behaviours and cognitive strategies. Results from two randomised controlled trials and an audit of a NHS clinic indicate that the treatment is highly effective. The treatment is highly acceptable to patients, possibly because on average only 90 minutes of reliving were needed. We have recently successfully a 1-week intensive version of the treatment that appears to be as effective as the standard programme using weekly sessions (Ehlers et al., 2003; Ehlers, Clark, Hackmann, McManus, & Fennell, 2005; Gillespie, Duffy, Hackmann, & Clark, 2002).
References


