



## Shorter communication

## Cognitive behavioral therapy for PTSD and somatization: An open trial



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## ABSTRACT

No treatment, to date, has been developed to improve both posttraumatic stress disorder (PTSD) and medically unexplained physical symptoms (MUPS), despite mounting evidence of high comorbidity between PTSD and MUPS. This study assessed the feasibility, acceptability, and treatment outcomes of an adapted cognitive behavioral therapy for PTSD and *abridged somatization* in a sample of eight participants. Fifteen percent of completers did not meet PTSD criteria after treatment completion and 62.5% improved their somatic symptoms. There was a significant difference between pre- and post-treatment depression symptoms, as well as in psychological and physical functioning measures. Results indicated a small to moderate effect size ( $d = 0.27$ – $0.78$ ) in PTSD severity scores, and moderate to large effect size in depression symptoms and psychosocial and physical functioning variables ( $d = 0.39$ – $1.12$ ). Preliminary evidence of acceptability indicates that the current CBT intervention may be suitable for Latinos individuals with PTSD and MUPS.

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## Introduction

There is mounting evidence that patients with posttraumatic stress disorder (PTSD) report higher rates of somatic symptoms than those without PTSD (Gillock, Zayfert, Hegel, & Ferguson, 2005; Shalev, Bleich, & Ursano, 1990) independent of comorbid anxiety and depression (Van Ommeren et al., 2002). Typically, somatic symptoms such as headaches, fatigue, shortness of breath, nausea, or musculoskeletal symptoms tend to become chronic and disabling, and lead to excessive medical treatment seeking (Wessely, Nimnuan, & Sharpe, 1999). A prospective, longitudinal study revealed that a chronic course of PTSD was significantly associated with higher rates of new onset of somatoform disorders (Perkonig et al., 2005). Another large longitudinal study (Andreski, Chilcoat, & Breslau, 1998) found that patients with PTSD were twice as likely as those with other disorders (e.g. anxiety and/or substance use disorders) to have somatic symptoms.

Many PTSD symptoms overlap with MUPS (Briere et al., 2002; Gupta, 2006). MUPS such as nausea, diarrhea, vomiting, dizziness, shortness of breath, tingling sensations, and voice loss, can be

considered physiological reactivity to cues related to trauma (Gupta, 2006). There is also evidence that PTSD has a significant negative impact on psychosocial functioning (Kessler, 2000; Sareen et al., 2007). For example, data from the Canadian Community Health Survey (Sareen et al., 2007) showed that people with PTSD were more likely to have a lower quality of life, more days of disability due to mental health, and were more likely to report suicide attempts than people without PTSD, after adjusting for demographic variables and other mental disorders. Similarly, patients with somatization have a marked degree of impaired functioning (Gureje, Simon, Ustun, & Goldberg, 1997).

Latino/as are the largest ethnic minority group in the United States comprising 16.3% of the population (U.S. Census Bureau, 2011); by the year 2050, they are projected to become one fourth of the US population. Yet, it is well documented that Latinos and other ethnic minority groups have less access to mental health services than do White/Caucasian Americans (W/C; Bernal & Scharro del Rio, 2001; Services, 1999; U.S. Department of Health and Human Services, 1999). Proposed reasons for mental health care disparities are multiple and complex, ranging from structural and organizational variables (e.g. availability of Spanish-speaking personnel), to clients' characteristics (e.g. beliefs and attitudes about mental illness and treatment) (Bernal & Saenz-Santiago, 2006). At the same time, there is evidence that Latinos are more likely to develop PTSD than other ethnic groups (Galea et al., 2004; Marshall, Schell, & Miles, 2009; Ortega & Rosenheck, 2000; Ritscher,

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Struening, Hellman, & Guardino, 2002). The 1996 National Anxiety Disorders Screening Day (NADSD) study revealed that Latinos, along with other minority ethnic groups were more likely to endorse PTSD symptoms than W/C counterparts (Ritsher et al., 2002). Another study with Vietnam War veterans found that Latinos had significantly more severe PTSD symptoms and a higher probability of experiencing PTSD than W/C veterans (Ortega & Rosenheck, 2000). Latinos also report higher rates of somatic or physical symptoms than other ethnic groups (Escobar, Gomez, & Tuason, 1983; Pina, Silverman, & Silverman, 2004; Pole, Best, Metzler, & Marmar, 2005). For example, a World Health Organization study in 14 countries revealed that somatization disorder was over 10 times more prevalent in South American countries than in non-Hispanic regions (Gureje et al., 1997). Another study suggests that among different ethnic groups of immigrants attending primary care clinics in the U.S., South/Central Americans had significantly higher somatization scores than the other groups (Aragona et al., 2005). It has been suggested that the high rates of somatization in Latinos is associated to stigma against emotional expression as a sign of mental illness (Escobar, Rubio Stipek, Canino, & Karno, 1989). However, there is a dearth of research available as Latinos have been understudied in mental health research given the poor participation in treatment outcome studies (Miranda, Azocar, Organista, Munoz, & Lieberman, 1996).

Considering the high comorbidity of PTSD and somatic symptoms, the overlap of symptoms, the high rates of these symptoms in Latino populations, the poor participation of Latinos in treatment trials, and the devastating effects of these disorders, there is no doubt that a treatment targeting both disorders is sorely needed. Furthermore, a meta-analysis of psychotherapy for PTSD (Bradley, Greene, Russ, Dutra, & Westen, 2005) acknowledged that available treatments do not consider the comorbidities of patients who suffer from trauma and suggest the inclusion of augmented treatment strategies in randomized clinical trials (RCTs). Hence, the current study presents a protocol to treat both PTSD and *abridged somatization* based on two existing treatment manuals, Cognitive Restructuring for PTSD (Marks, Lovell, & Noshirvani, 1998) and Cognitive Behavioral Therapy (CBT) for Somatization Disorders (Woolfolk & Allen, 2006).

Cognitive restructuring, based on the cognitive model of emotional disorders (Beck, Emery, & Greenberg, 2005) is the fundamental principle of cognitive-based interventions to treat PTSD symptoms and MUPS. Specifically, individuals with both disorders tend to show distorted cognitions about their symptoms and are unaware of the role of their thinking in maintaining their disorders. These individuals negatively appraise the emotions and actions associated with traumatic events (Ehlers & Clark, 2000), as well as the physical symptoms they experience (Salkovskis, Hawton, Salkovskis, Kirk, & Clark, 1989). In regard to PTSD, there is empirical evidence suggesting that dysfunctional thoughts predict PTSD severity after controlling for frequency of thought intrusions and the use of avoidance strategies (Steil & Ehlers, 2000).

A CBT manualized treatment for MUPS has been developed by Allen and colleagues (Woolfolk & Allen, 2006). In their study examining the efficacy of this intervention, participants were randomly assigned to either: (1) a 10-session CBT in addition to a psychiatric consultation intervention, or (2) standard medical care coupled with physician's correspondence recommending limiting additional medical procedures beyond scheduled appointments. Patients treated in the CBT and psychiatric consultation condition were significantly more likely to be rated as at least "very much improved" on the Clinical Global Impressions Scale (CGI-SD) than patients treated with only augmented standard medical care (40% [ $n = 17$ ] vs. 5% [ $n = 2$ ]), 15 months after baseline. The CBT intervention was associated with greater improvements in self-reported

functioning and somatic symptoms and a greater decrease in health care costs. An effectiveness study (Escobar et al., 2007) that included mostly Latino patients (68%), using the same intervention in a primary care setting showed similar results.

Given these findings, the goal of this open trial (OT) study was to report preliminary evidence of the feasibility and acceptability of an adapted and integrated protocol to treat co-morbid PTSD and MUPS, and to estimate effect sizes to inform a future RCT.

## Methods

### Participants

Participants were recruited in South Florida from outpatient clinics at a major regional hospital, a local community agency providing services to victims of domestic violence, and through advertisements in free local newspapers. Recruitment materials included questions such as, "Have you lived through a frightening, distressing experience in your life?, do you have multiple physical symptoms?" Inclusion criteria were: 1) Current diagnosis of PTSD as defined by the Diagnostic Statistical Manual-IV-Text Revised; 2) MUPS as defined by the "Abridged somatization" criteria (Escobar, Waitzkin, Silver, Gara, & Holman, 1998) that requires at least 6 MUPS for females and 4 for males out of the 35 DSM-IV-TR somatic symptoms; 3) Aged between 18 and 65; 4) English and/or Spanish speaking; and 5) Self-identified as Latina/o. Exclusion criteria included: 1) Current substance dependence; 2) psychotic symptoms within the month preceding baseline; 3) suicidality or homicidality requiring hospitalization within the 6 months preceding baseline; 4) any severe cognitive impairment or history of serious organic mental disorder; 5) an unstable major medical condition; 6) a medication regimen for physical symptoms that had not been stable for at least 3 months prior to baseline; 7) current pregnancy or expecting to become pregnant close to baseline; 8) concurrent psychotherapy provided by a mental health professional at the time of recruitment, and 9) endorsement of ongoing domestic or intimate partner violence.

### Treatment description

The treatment included 10–14 sessions of a CBT intervention for both PTSD and somatization delivered at a community clinic in a southeastern university campus. Data was collected from 2009 to 2011. Therapy was provided by the first, third and fourth authors. The treatment was delivered in a module format to maximize its flexibility. In this way the intervention was tailored to each patient taking into consideration their own therapy goals, treatment needs, severity of symptoms, specific environmental stressors, and individual and cultural beliefs about trauma and symptoms. The first module comprised Cognitive Restructuring and its various therapeutic strategies (e.g. thought records, downward arrow technique, and behavioral experiments) (Beck et al., 2005), which were used to address dysfunctional beliefs associated with MUPS and PTSD symptoms. The second module included Relaxation Training (RT), which was used to reduce physiological arousal and hypersensitivity to bodily sensations that are common in patients with somatic complaints (Barsky, 1992). RT included diaphragmatic breathing and autogenic relaxation. The third module was Activity Regulation (AR) (i.e., activity scheduling and pacing), which mainly targeted management of physical symptoms. Specifically, AR focuses on the tendency of these participants to withdraw from activities because they believe it will cause injury or exacerbate current physical symptoms (Katon et al., 1991). AR also helps reduce avoidant behaviors in participants with PTSD due to their fear of interacting with others and also directly targets their restricted

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