

# Applying Trauma-Focused Cognitive Behavioral Therapy Following a Dog Attack. A Case Report

## Aplicando terapia cognitivo-conductual focalizada en el trauma tras un ataque de un perro. Un caso de estudio

Matias Emilio Salgado  
Tornu Hospital, Argentina

**Abstract: Background:** Cognitive-behavioral therapy is the most effective psychological treatment for posttraumatic stress disorders (PTSD). This paper reports treatment of a 45-year-old woman with PTSD following a dog attack. Trauma-focused cognitive-behavioral therapy (TF-CBT) was applied by a therapist with little experience in PTSD. The study objective is to explore the clinical value of TF-CBT when delivered by a novel therapist. **Method:** Several scales were used to measure treatment efficacy. **Results:** TF-CBT delivered by a novel therapist supervised by experts was a satisfactory treatment for the patient, who showed a clinically significant change. **Conclusions:** This case illustrates the potential efficacy of TF-CBT delivered by a novel therapist in PTSD.

*Keywords:* posttraumatic stress disorder, cognitive-behavioral therapy, cognitive therapy, PTSD, trauma.

**Resumen: Antecedentes:** Los tratamientos psicológicos más efectivos para el Trastorno de Estrés Postraumático (TEPT) son cognitivo-conductuales. Este trabajo presenta el tratamiento de una mujer de 45 años con TEPT desarrollado luego de un ataque de un perro, en el que se aplicó un tratamiento cognitivo-conductual focalizado en el trauma (TCC-FT) por un terapeuta novel. **Metodo:** Para medir la eficacia del tratamiento se utilizaron distintas escalas. **Resultados:** La TCC-FT llevada adelante por un terapeuta novel bajo supervisión de expertos fue un tratamiento satisfactorio para la paciente quien presentó cambio clínicamente significativo. **Conclusiones:** Este caso ilustra la potencial eficacia de la TCC-FT para el tratamiento del TEPT, cuando es llevado adelante por terapeutas noveles.

*Palabras clave:* trastorno de estrés postraumático, terapia cognitivo-conductual, terapia cognitiva, TEPT, trauma.

---

La correspondencia sobre este artículo debe enviarse al autor al e-mail: [salgadamatias@psi.uba.ar](mailto:salgadamatias@psi.uba.ar)

 Este es un artículo Open Access bajo la licencia CC BY-NC-ND.

The most effective psychological treatments for Posttraumatic Stress Disorder (PTSD) are cognitive-behavioral (Foa, Keane, & Friedman, 2000; Foa, Hambree & Rothbaum, 2007; National Institute for Health and Clinical Excellence (NICE), 2005). The main components of the treatment are psychoeducation, exposure, cognitive restructuring, and anxiety management (Harvey, Bryant, & Tarrier, 2003). Although there are different versions of this particular type of treatment, its effectiveness relies on the “emotional processing” of the memory and the habituation to the associated anxiety (Grey, 2007b). Different cognitive-behavioral models for PTSD have similarities but have also differing emphasis (Grey, 2007a). The Ehlers and Clark’s (2000) model is strongly based on the developments of other experienced researchers and clinicians. It was designed to explain the persistency of PTSD and to provide clear guidelines for trauma-focused cognitive-behavioral treatment (TF-CBT) differing from older CBT approaches by intentionally structuring the reliving aspects of therapy to facilitate reappraisals of the experience (Harvey, Bryant, & Tarrier, 2003).

Ehlers and Clark (2000) suggest that persistent PTSD occurs when a person processes the traumatic experience in a way that produces *a sense of a serious current threat*. The three mechanisms that activate and maintain this are: 1) the fragmented and relatively not well integrated trauma memories; 2) negative appraisals of the trauma and/or its sequelae; 3) coping strategies that do not allow changes in these two areas (e.g. avoiding thoughts and feelings, places or reminders of the trauma, and suppressing intrusive thoughts and memories) (Grey, 2007a, Grey 2007b). Therefore, Ehlers & Clark (2000) and Clark & Ehlers (2004) suggest that goals of treatment are: 1) to reduce the re-experiencing by elaboration of the trauma memory and discrimination of triggers; 2) to modify excessively negative appraisals; 3) to drop dysfunctional behavioral and cognitive strategies.

There is a wide range of interventions that can be applied to achieve these changes. The initial interventions include: performing an extensive and detailed clinical assessment, providing verbal and written information about PTSD which may help validating the patient’s experience and normalizing symptoms, discussing the role of thought suppression (for example performing the “White Bear” experiment during session). Also, rationale for treatment is provided and tailored to patient’s symptoms aiming at explaining the role of: differences in memory, negative appraisals and unhelpful coping strategies. In order to make this particular discussion easier for patients the use of metaphors is recommended. As an example, the “Conveyor belt” metaphor is provided below:

Therapist: Processing the memory is like going down a conveyor belt before being stored away with normal memories in a filing cabinet. You can have more control over those memories in the filing cabinet and you can bring them out whenever you want to. At the moment every time the memory comes back onto the conveyor belt, when it pops into your mind, you just push it off not allowing it to be fully processed. (Grey, 2007b, p.191).

The elaboration of the trauma memory can be achieved by applying prolonged exposure, also known as “Reliving”. Complementary approaches for processing trauma memories are: constructing a written account of the trauma, *in vivo* exposure, and working on the discrimination of triggers. Patients usually feel that their trauma memories pop in their minds “out of the blue”, which is why it is recommended to question carefully to identify triggers. The work on triggers discrimination can increase the patient’s sense of control over the re-experiencing symptoms. Moreover, it is helpful to include interventions focused on the recovery of patient’s life areas that have changed after the traumatic event such as relationships with friends and family, work, exercise, and leisure activities. These interventions known as “Reclaiming your life” help patients recover the activities they used to enjoy and valued, hence, to “feel themselves again”. Also, in order to continue and consolidate improvement, and to prevent future relapse, during the last sessions the patient is asked to create their own “Blueprint” of the treatment. With the Blueprint patients can summarize how the problem was developed, what was maintaining it, what they had learnt during treatment that helped to cope with it, how they plan to build on what was learnt, and what they would manage differently in the future if they had to face a new difficult situation.

In terms of therapy context, TF-CBT requires the therapist to provide a safe environment, both emphatically (e.g. establishing a positive therapeutic alliance) and practically (e.g. facilitating an appropriate room with a “sense of safety”, and having available time). At the same time the therapist should be comfortable listening to details of the particular traumatic event the patient had experienced. After initial assessment patients are

offered between 10 and 12 weekly 90-minute sessions. Every session is audio-taped, and patients listen to them during the week to consolidate session's work. Also, monitoring patients progress is an important aspect of treatment, so the patient is asked to complete specific questionnaires on a weekly basis in order to evaluate improvement and treatment results. More details of the treatment procedures can be found in: Elhers & Clark (2000), Clark & Ehlers (2004), Ehlers, Clark, Hackmann, McManus, & Fennell, (2005), Ehlers et al. (2010), and Grey (2007a, 2007b).

The available literature regarding how therapist experience interacts with symptom severity in predicting client outcomes is highly equivocal (Mason, Grey, & Veale, 2016). Some studies support the hypothesis that the therapist expertise is an important outcome variable in psychotherapy. However, other studies show that expertise may not predict treatment outcome (Eells, Lombart, Kendjelic, Turner, & Lucas, 2005). This contradictory information leaves unclear whether trainees could manage the complexity of PTSD and its treatment, or else, if these cases have to be allocated to more experienced therapists in order to achieve clinically significant outcomes.

### Aims of this study

The aim of the present study case was to explore and present the clinical usefulness of TF-CBT for treating PTSD when delivered by a therapist with little experience. Particular attention was given to how the treatment was developed together with the patient's cognitive, emotional and behavioral responses.

## Case Report

### Subject: "Kate" (Name changed to preserve identity)

Kate is a 45-year-old, female, white-British, sales assistant on sick-leave, cohabitating with a partner, mother of two sons and has a granddaughter. Kate developed PTSD after a being attacked by two dogs, one of which bit her leg causing severe injury and loss of function. She was referred by her GP. A Telephone Triage three weeks after the attack evaluated the possibility of developing PTSD and referred her for "High intensity CBT".

### Kate's account of the traumatic event

"As I walked out of the house I could hear dogs barking. As I was walking along I got to the house on the end and outside the gate there were two dogs. They started to bark and snarl at me. I felt very frightened and scared. I carried on walking up the stairs. They were still barking. As I got to the top of the stairs I looked over my shoulder and they were running after me. I thought to myself "Oh no! They are going to attack me!" The biggest one opened his mouth and bit the bottom of my leg. All I could see was his big white fang teeth. Once the dog has bitten me they both ran back down the stairs into the garden. I was on the floor holding my leg. There was blood all over my hands. I was screaming. I was scared. I thought I was going to die, there was no-one around to help me. I was all alone" (Summary of the written narrative for session 9).

### Assessment

The initial PTSD-focused standard structured assessment at the clinic was delivered by a senior therapist, and included the Psychiatric Diagnostic Screening Questionnaire (PDSQ) and the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II). The PSDQ is a self-report instrument designed

to screen for the DSM-IV (APA, 1994) Axis I disorders (Zimmerman & Sheeran, 2003). The SCID-II is a semi-structured interview for making the major Axis II DSM-IV diagnoses (First, Gibbon, Spitzer, Williams & Benjamin, 1997).

The severity of the trauma and its sequels were assessed meeting criterion for “moderate” PTSD. The main symptoms were: intrusive distressing memories and images; flashbacks; nightmares; sleeping problems; hyper-vigilance; persistent avoidance of dogs; thought suppression; low mood, “feeling useless, angry and irritable”; had given up usual activities.

The event had happened three months before. Kate did not lose consciousness at any time and there was no memory loss; was not under the effect of alcohol or any drugs; had not received previous treatment; and reported neither history of trauma nor of childhood abuse. Although she had symptoms of anxiety and depression as a result of the PTSD, Kate did not meet diagnostic criteria for other current co morbid Axis I disorders, or personality disorders, substance abuse or history of substance dependence. Kate didn't have current suicidal ideation neither reported past suicide attempts. Kate had no indication of psychotropic medication. The patient gave her consent to present this case study.

## Formulation

Kate was exposed to a traumatic situation where two dogs attacked her, one of which bit her leg causing severe injury and loss of function. At the moment of the attack she thought her life was threatened and that the dogs were going to bite her to death. After the attack she suffered symptoms such as repeated and unwanted re-experience of the event, hyperarousal and avoidance of stimuli (including thoughts) which served her as reminders of the attack. Although these are normal symptoms in the aftermath of a traumatic event (Ehlers & Clark, 2000), in Kate's case they became PTSD as she could not recover from them by herself in the following months. Her symptoms became persistent as Kate had processed the traumatic event in a way that led to a sense of *serious current threat*. First, due to the high levels of arousal she had at the time of the traumatic event, her trauma memory had been poorly integrated with other autobiographical memories, and they were being triggered by a wide range of low-level cues (e.g. dog images on TV). It seemed there was not a “time code” on her memory (Grey, 2007b) that could tell Kate that the attack had occurred in the past and therefore that she was no longer in danger. On the other hand, Kate's persistent sense of current threat arose not only from the nature of the trauma memory but also from her negative interpretations of the symptoms experienced (e.g. “I'm useless”), the event itself (e.g. “It is so unfair, I was just going to work”), and its sequelae (e.g. “I think I won't be able to walk properly again”). Moreover, these negative cognitive appraisals and the nature of the trauma memory were being maintained by a variety of cognitive and behavioral strategies, such as avoiding thoughts (e.g. thoughts related to details of the attack), feelings (e.g. emotions triggered by the image of the attack), places (e.g. the place of the attack, parks and her partner's mother place -who had two dogs), other reminders of the event (e.g. going up the stairs where she was attacked), suppression of intrusive memories (e.g. pushing out of her mind the image of the dog's teeth), rumination about certain aspects of the event (e.g. playing over what the owner of the dog told her “The door was locked”), rumination about certain aspects of the sequelae (e.g. if she would be able to recover properly), and other avoidant strategies (e.g. not going out of her place, and closing doors and windows).

The cognitive model for PTSD (Ehlers, & Clark, 2000) understands that individuals are processing the trauma and its sequelae in a way which poses a threat to self. Therefore, the aim of Kate's treatment was to help her process the trauma so she could see it as a time-limited, past event which did not necessarily have global threatening implications for her future. The goals of the treatment were to work on reducing re-experiencing by the elaboration of her trauma memory and discrimination of triggers, to help her identify and modify excessively negative appraisals of the traumatic event and its sequelae, and to drop dysfunctional behavioral and cognitive strategies that had the effect of maintaining the disorder.

## Treatment

Current CT-PTSD treatment was based on Ehlers and Clark's (2000) treatment model and was focused on the PTSD. It started 11 weeks after the attack and was conducted in English in individual sessions. Patient received 12 weekly sessions of 90 minutes. All sessions were audio taped so the patient listened to them between sessions. The therapist kept detailed notes and filmed each session using videos in supervision. The therapist was a male, 33-year-old Clinical Psychologist in training from Argentina on placement at an outpatient clinic specializing in the treatment of anxiety disorders for adults located in London, UK. The therapist had had 3 years of experience in CBT treating patients from a wide range of disorders but had treated only one TF-CBT case before. During the time of current treatment, he participated in two two-day workshops on CT-PTSD and received close individual supervision from a senior clinician trained on TF-CBT on a weekly basis.

## Measures

Self-reports of symptom severity were taken before initial assessment, and before each session (1-3 hours earlier or one day before the session) with different scales respectively.

**Severity of PTSD symptoms.** The primary outcome measure was the change in PTSD symptoms. The patient completed: 1) The Posttraumatic Diagnostic Scale (PDS) (Foa, Cashman, Jaycox, & Perry, 1997). The PDS asks patients to rate how often they were distressed by each of the PTSD symptoms specified in DSM-IV ranging from never to 5 times per week or more/almost always. The sum score of the PDS measures the overall severity of PTSD symptoms (Ehlers et al. 2013). 2) The Impact of event scale revised (IES-R), a 22-item self-report measure that assesses subjective distress caused by traumatic events. Items correspond directly to 14 of the 17 DSM-IV symptoms of PTSD and the patients have to indicate how much they were distressed or bothered during the past seven days by each "difficulty" listed (Weiss & Marmar, 1996). 3) The Posttraumatic Cognitions Inventory (PTCI) is a 33-item self-report measure of negative and dysfunctional posttraumatic cognitions (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999).

**Depression and anxiety.** Symptoms of depression and anxiety were secondary outcome measures. The patient completed: 1) The Beck Anxiety Inventory (BAI) (Beck & Steer, 1993a) and the Beck Depression Inventory (BDI) (Beck & Steer, 1993b), both standard 21-item self-report measures with high reliability and validity (Ehlers et al., 2013). 2) The Patient Health Questionnaire (PHQ-9), a self-administered version of the PRIME-MD depression module which scores each of the 9 DSM-IV depression criteria (Kroenke, Spitzer & Williams, 2001). 4) The Generalized Anxiety Disorder Scale (GAD-7) a self-report anxiety questionnaire that proved valid in primary care (Löwe et al., 2008).

## Summary of treatment and sessions' content

**Session 1.** Kate comes with her mother. She uses an orthopedic boot and walks with difficulty. Kate has a collaborative approach. Current symptoms and problems: "I can't go out from home; I'm hypervigilant; alert of noises; on guard all the time; I have nightmares of the event; I avoid situations as I'm afraid of being attacked again; I'm upset and irritable; I feel useless". Patient shares the traumatic event in the way she finds comfortable: very quickly and not emotionally engaged. Goals: "To stop having fear of dogs, to be able to go to work and to go out by myself". PTSD Normalization of symptoms. Initial identification of the maintaining factors. Worst things after the trauma: "Feeling useless; not going out from home; being angry". Main intrusive thought: "The moment when the dog is biting me". Cognitive-behavioral strategies: avoiding dogs and parks, overprotecting her granddaughter on the street, looking all the windows, being hypervigilant of dogs and people, staying at home, staying up late as being afraid of having nightmares, washing up or trying to push her thoughts out of her head every time a memory pops into her mind. Appraisals: the world is a dangerous place, the people can attack me. Main beliefs: "I'm going to be bitten again; someone is going to attack me". Initial shared case formulation.

Thought suppression experiment and “letting memories come and go” instruction. Reclaiming your life (RYL): identification of areas to be reclaimed and initial steps: “going shopping again”. The rationale for trauma memory works with the “conveyor belt” metaphor. General information about PTSD. Homework.

**Session 2.** “Irritable and upset; anxious, afraid of being attacked; depressed because I can’t get back to work, I feel useless, weak”, flashbacks and nightmares of “The dog biting me”, been avoiding dogs and open spaces. Went shopping but “My mother was some meters behind me”. Continue rationale for trauma memory work. Imaginal reliving. Kate cannot fully engage emotionally so the relieving was repeated. Identification of hotspots: “Surgeon tells me I needed skin grafts; when I saw my leg for the first time; when I was lying on the floor; when the dogs where biting me; when the policemen were bandaging up my leg” (see example in table 1). Identification of thoughts, and associated meanings and emotions. Homework: Kate suggests not locking the windows during the morning and afternoon. RYL: going shopping on her own.

**Session 3.** Further imaginal reliving: cannot get fully emotionally engaged. Identification of hotspots and associated meanings and emotions. RYL: continue going shopping on her own, not checking for dogs once inside the shop, going out with friends. At the very end of the session she asks whether she can show photos of her leg. Showing them: “I feel relief, and anger with the owner of the dogs”. She feels she usually needs to show them: “Because people think it was just a dog bite”.

**Session 4.** Kate went shopping by herself: “Made me feel happy because I can rely more on myself”, also “I’m happy because I was able to visit my friends”. On the other hand, “My leg is healing, I’m not using the boot anymore”. Further imaginal reliving of hotspots in a guided way as the patient finds it helpful to be fully emotionally engaged. Cognitive restructuring updating the associated meanings with the new information. Updating trauma memory with new information (example on Table 1). Homework: continue going shopping on her own without checking for dogs. In terms of the photos she had showed: make sequence adding a last photo of herself at the end in order to make an “integrated” series. RYL: continue visiting friends and travelling by bus on her own.

**Table 1. Example of hotspots with associated cognitions, emotions and update**

Situation	Cognition	Emotion	Update
	I can do nothing. How much further is it gonna go?	Fear	I can move my leg They didn’t kill me. I’m alive
Dogs are biting me	The other one is gonna join in.	Fear	Only one dog bit me. The other one didn’t join in.
	Please just go away!	Fear	The dogs left
	If they come back they can do anything to me.	Fear	The dogs didn’t come back
	I hope someone come and help me.	Fear	Nine police men came running to help me

**Session 5.** Sleeping better, and the intrusive thoughts “Are slowly disappearing”. Further discussion of meanings of hotspots, identification of updating information, and imaginal reliving of hotspots with update. RYL: meeting friends from work, going out and taking the bus, and going to the shop on her own.

**Session 6.** The Doctor discharged her, expected would be walking normally in 18 months. Further reliving of the whole event and memory updating. Patient concludes: “Now it is much easier for me to tell what has happened compared to the first time, I can say it freely without being afraid of saying it. It is easier for me to connect with my feelings”. Homework: written narrative of the trauma. RYL.

**Session 7.** “I feel more normal, happier; more confident; sleeping much better”. Visited some friends: “I feel more alive”, and went to the seaside with her partner. Intrusive thoughts are “less and less frequent”. She is

angry with the owner of the dogs: “because I feel he got away with it”. Work on maintaining behaviors: behavioral experiment in session (going to the supermarket). She concluded: “I was attacked once in 45 years, there could be another 45 years... It’s really unlikely it’s going to happen again”. Homework: “Going for a coffee with a friend”, “buying some shoes”.

**Session 8.** Intrusive thoughts and “checking for dogs” have decreased. She went shopping for shoes but “didn’t enjoy it much because I lost interest and got bored”. Work on discrimination of triggers and finding the differences between “now and then”. Maintaining behaviors: stopped seeing family if they had dogs. Behavioral experiment in session to drop safety behaviors, hypervigilance and to work on trigger discrimination: going to the park. Kate believed 100% she would be attacked by a dog. After the experiment she concluded: “I have to be close to dogs to overcome this fear, otherwise I will be forever checking and asking someone to come with me. Not all the dogs are the same as the one who attacked me. Is not that every of them want to bite people”. The patient identified faces of dogs as triggers of the image the dog biting her. Further working on triggers helped Kate to identify that looking from the top of the stairs where she was attacked triggered the image of her lying on the floor. Site visit plan. Homework: Visiting family with dogs, spotting the differences every time she sees a dog’s face. As her written narrative did not include much emotional detail she agreed to write a new account.

**Session 9.** Site visit. Meet the patient at her place and continue planning the visit to the place of the attack that was meters away from there. As a behavioral experiment, her predictions about what would happen are noted. At the site, Kate reconstructs what has happened in each point of the road she had walked that day. She is very anxious as it is the first time she comes back to the place of the attack. Discrimination of triggers and spotting the differences between “now and then”. She delivers a new version of the written narrative with emotional details (part copied at the beginning of this case report). RYL: “No worries week: to do whatever you want to do instead of what the PTSD is telling you to do”. She would try coming next session on her own. Homework: Behavioral experiments during the week at the site of the event.

**Session 10.** The patient comes on her own (and will continue to do so from this session on). Further work on cognitive restructuring, discrimination of triggers, and changing maintaining behaviors/cognitive strategies. Imagery rescripting for the images of possible new attacks that usually pops into her mind before going out, and with the images of the attack. Homework: new behavioral experiments to do between sessions. Start a “Blueprint” draft.

**Session 11.** Patient has “Bad news”: police told her that most probably the dogs’ owner will be judged “Non guilty” and she would be called to declare. She is upset: “The owner of the dogs will laugh at me; he will humiliate me”. She is afraid the judge: “May think I’m a liar”. Cognitive restructuring over these assumptions. Further imagery rescripting so that the patient could practice and apply it in an active fashion any time she needs it. Continue with the Blueprint draft. Homework: finish blueprint. RYL.

**Session 12.** Although the dogs’ owner has been judged “not guilty” the patient is calm. In terms of going to testify she says: “It will be what it has to be”. Work on different ways to deal if there is a negative outcome at the trial. The patient is “checking for dogs” even less frequently and is walking through the stairs where she was attacked on a daily basis. Review the progress in updating memories, discriminations of triggers, appraisals, and maintaining behaviors/cognitive strategies. Work on keeping on “getting well” and manage any future relapse using what was learnt through the treatment, the recordings of the sessions, her blueprint, and any behavioral experiment that helps. Agree homework. RYL. Patient feedback: “The treatment has been very useful in general, and in particular the work with the memories of the attack. The treatment helped me to move on and to push myself to get better otherwise I wouldn’t be ok... it helped me to get my life back”.

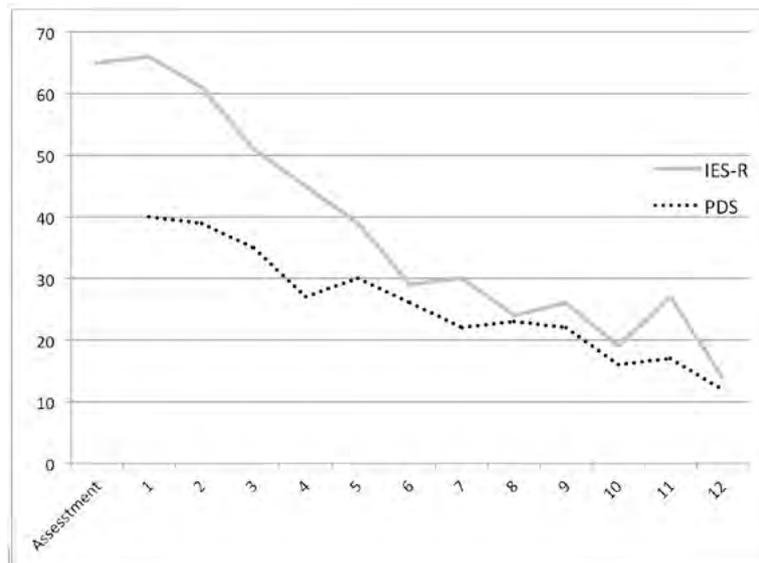
## Results

During the 12 sessions, treatment progress was evaluated with: PDS, IES-R, PHQ-9 & GAD-7. Before sessions “1”, “6” and “12” the PTCI, BDI and BAI were also included as it is shown in Table 2. There was no dropout, and perfect attendance.

### Improvement in PTSD symptoms.

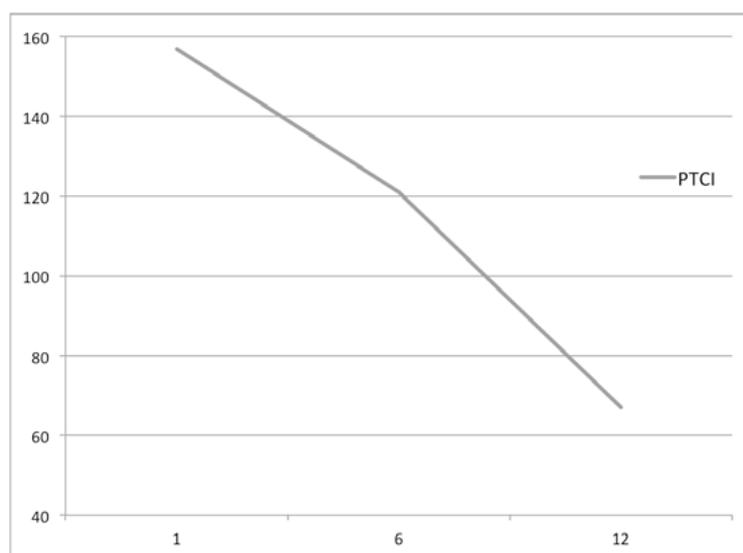
Table 2 shows PTSD symptom scores (IES-R, PDS and PTCI) from each session (including IES-R score at assessment). The patient presented reliable improvement (Improving Access to Psychological Therapies, 2014; Foa & Rothbaum, 1998; Foa et al. 1999; Ehlers et al. 2013) and clinically significant treatment response as defined in Jacobson and Truax (1991) given the scales results over the cut-offs between clinical and nonclinical presentations established by Foa et al. (1999), Ehring, Kleim, Clark, Foa & Ehlers (2007), and Beck et al. (2008) (see also Fig. 1).

**Figure 1.** Improvement in PTSD symptoms I.



IES- R = Impact of event scale revised; PDS = Posttraumatic Diagnostic Scale.

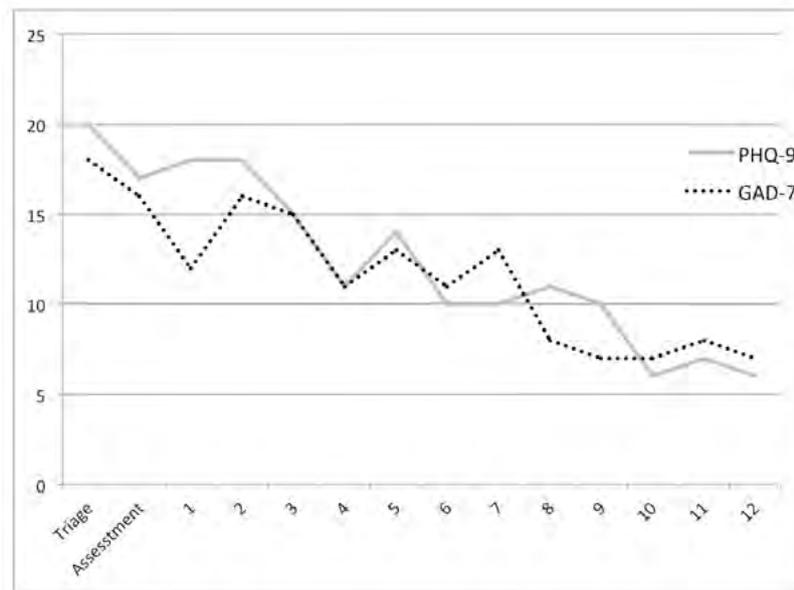
**Figure 2.** Improvement in PTSD symptoms II.



PTCI = Posttraumatic Cognitions Inventory.

Improvement in other symptoms.

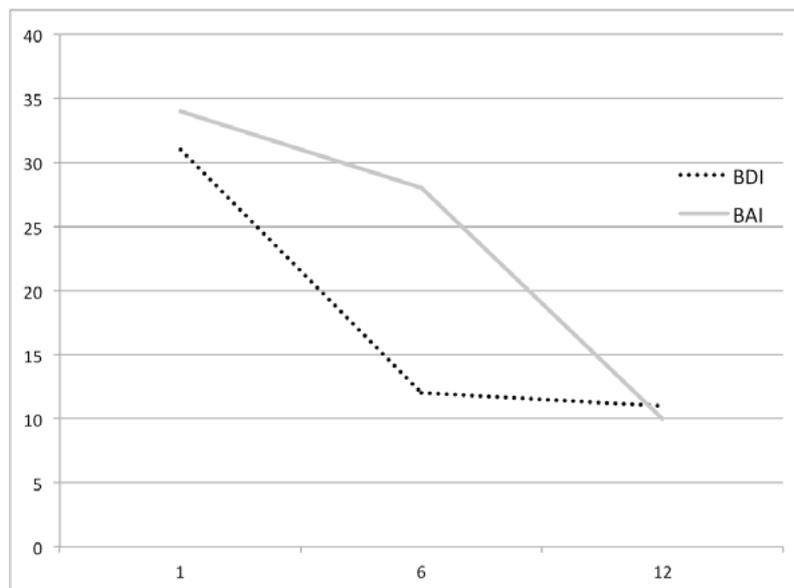
Figure 3. Improvement in Depressive and Anxiety Symptoms I.



PHQ-9 = Patient Health Questionnaire; GAD-7 = General Anxiety.

Table 2 shows the changes in depressive (BDI and PHQ-9) and anxiety (BAI and GAD-7) symptoms with treatment. The patient presented reliable improvement (Improving Access to Psychological Therapies, 2014; Busch et al., 2013; Gillis, Hagga, & Ford, 1995; Beck & Steer, 1993a).

Figure 4. Improvement in Depressive and Anxiety Symptoms II.



BDI = Beck Depression Inventory; BAI = Beck Anxiety Inventory.

## Overall improvement.

Direct work on the trauma memory helped to process the event better and to update several beliefs the patient had at the moment of the attack. Identifying patterns of thought suppression and in vivo exposure to avoided situations helped to reduce her sense of current threat. The patient engaged well with all aspects of therapy being motivated to do the necessary tasks during and between sessions. At the end of therapy, she no longer met diagnostic criteria for PTSD, no longer had to work to suppress memories, felt more confident outdoors and was getting on with her life. The patient still had some difficulties being close to big dogs, going to parks and with walking pass the place where she was attacked, but in general was more able to recognize this, deal with it more skillfully, and had planed to continue doing things to improve her reactions. She was feeling motivated about returning to work. She had also been going out more often and more easily, and had started to do the things she used to do before the attack. She feels less angry with the owner of the dogs but this was not widely addressed during treatment. There was not follow up session as arranged with the patient and supervisor due to the fact that the therapist ended his placement and moved to a different country. Nevertheless, the patient had been offered a follow up session with the case supervisor if she considered it necessary, but given the good results obtained the patient decided not to have it, did not request it later on (although it was available), and did not start any other mental health treatment so far (12 months).

## Discussion

The result of the present case study is in line with previous studies in which TF-CBT has been proven to be a useful approach for PTSD (Ehlers et al. 2013, Grey 2007a). This study supports the effectiveness of TF-CBT for PTSD in clinical practice. It shows that this treatment can be successfully implemented by a novel therapist with previous experience in CBT but short experience in TF-CBT. The patient tolerated the treatment and engaged well with all aspects of therapy. There was no dropout and perfect attendance. She was very motivated to do the necessary tasks during and between sessions.

At the beginning of the therapy, the patient was suffering from PTSD following a dog assault which left her with significant leg injuries. The therapy included direct work on the trauma memory in order to help the better processing of the event and to update several beliefs that the patient had at the moment of the attack. The therapy also involved identifying patterns of thought suppression, in vivo exposure to avoided situations, and included work with the *sense of threat* experienced outdoors.

The improvement in PTSD symptoms was large as showing clinically significant change throughout different scales. Also reliable improvement was shown in anxiety and depressive symptoms. At the end of the therapy, the patient no longer met the diagnostic criteria for PTSD. She no longer had to work to suppress memories, felt more confident outdoors and was getting on with her life.

The patient still had some difficulties with being close to big dogs, going to parks and with walking pass the place where she was attacked, but in general was more able to recognize this, deal with it more skillfully, and had plan to continue doing things to improve her reactions. Kate was feeling motivated about returning to work. She has also been going out more often and more easily, and had started to do the things she used to do before the attack.

## Conclusions

The study had several limitations. First, there were no data regarding PTSD at triage and only a short group of measures from assessment. However, the high level of change from the current baseline can actually show the effectiveness of the treatment. Second, the patient had only one recent trauma which could be understood as one of the best scenarios in terms of possible treatment outcomes. However, as shown in Table

3 the severity of the patient's PTSD, anxiety and depressive symptoms were high and the patient no longer reached PTSD criteria at the end of treatment. Third, there was no follow up due to practical reasons (the therapist ending his placement and moving to a different country) leaving the stability of treatment effects uncertain. However, the possibility of a follow up session with the case supervisor had been offered to the patient, which never requested afterwards. Nevertheless, it is important to discuss with patients the need and usefulness of follow up, maintenance, and booster sessions.

**Declaration of Conflicting Interests:** The author declares no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Funding:** The author received no financial support for the research, authorship, and/or publication of this article

## References

- American Psychiatric Association. APA. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed. revised). Washington, D.C., USA: Author.
- Beck, A. T., & Steer, R. A. (1993a). *Beck Anxiety Inventory - Manual*. San Antonio, TX, USA: The Psychological Corporation.
- Beck, A. T., & Steer, R. A. (1993b). *Beck Depression Inventory - Manual*. San Antonio, TX, USA: The Psychological Corporation.
- Beck, G., Grant, D., Read, J., Clapp, J., Coffey, S., Miller, L., & Palyo, S. (2008). The Impact of Event Scale –Revised: Psychometric properties in a sample of motor vehicle accident survivors. *Journal of Anxiety Disorders*, 22(2), 187–198.
- Busch, A., Whited, M., Appelhans, B., Schneider, K., Waring, M., DeBiasse, M., ... Pagoto, S. (2013). Reliable change in depression during behavioral weight loss treatment among women with major depression. *Obesity (Silver Spring, Md.)*, 21(3), E211-E228. doi: <https://doi.org/10.1002/oby.20113>
- Clark, D. M., & Ehlers, A. (2004). Posttraumatic stress disorder: from cognitive theory to therapy. In: R. L. Leahy (Ed.), *Contemporary Cognitive Therapy: Theory, research and practice* (pp. 141-160). New York, USA: Guilford Press.
- Eells, T. D., Lombart, K. G., Kendjelic, E. M., Turner, L. C., & Lucas, C. P. (2005). The quality of psychotherapy case formulations: a comparison of expert, experienced, and novice cognitive-behavioral and psychodynamic therapists. *Journal of Consulting and Clinical Psychology*, 73, 579-589.
- Ehlers, A., & Clark, D. M. (2000). A cognitive model of post-traumatic stress disorder. *Behavior Research and Therapy*, 38, 319–345.
- Ehlers, A., Clark, D. M., Hackmann, A., Grey, N., Wild, J., & Liness, S. (2010). Intensive Cognitive Therapy for PTSD: a feasibility study. *Behavioural and Cognitive Psychotherapy*, 38, 383-398. <https://doi.org/10.1017/S1352465810000214>
- Ehlers, A., Clark, D. M., Hackmann, A., McManus, F., & Fennell, M. (2005). Cognitive therapy for PTSD: Development and evaluation. *Behaviour Research and Therapy*, 43, 413–431.
- Ehlers, A., Grey, N., Wild, J., Stott, R., Liness, S., Deale, A., ... Clark, D. M. (2013). Implementation of Cognitive Therapy for PTSD in routine clinical care: Effectiveness and moderators of outcome in a consecutive sample. *Behavior Research and Therapy*, 51, 742-752.
- Ehring, T., Kleim, B., Clark, D., M., Foa, E., B., & Ehlers, A. (2007). Screening for posttraumatic stress disorder: what combination of symptoms predicts best? *Journal of Nervous and Mental Disorders*, 195(12), 1004-1012.
- First, M., Gibbon, M., Spitzer, R., Williams, J., & Benjamin, L. (1997). *Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II)*. Washington, D.C., USA: American Psychiatric Press, Inc.

- Foa, E., Ehlers, A., Clark, D. M., Tolin, D., & Orsillo, S. (1999). The Posttraumatic Cognitions Inventory (PTCI): Development and validation. *Psychological Assessment, 11*, 303-331.
- Foa, E., & Rothbaum, B. (1998). *Treating the trauma of rape: Cognitive behavioral therapy for PTSD*. New York, USA: Guilford Press.
- Foa, E., Hembree, E., & Rothbaum, B. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences therapist guide*. Oxford University Press; USA.
- Foa, E., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of posttraumatic stress disorder: the Posttraumatic Diagnostic Scale. *Psychological Assessment, 9*, 445-451. <https://doi.org/10.1037/1040-3590.9.4.445>
- Foa, E., Keane, T., & Friedman, M. (2000). *Effective Treatments for Posttraumatic Stress Disorder: Practice Guidelines from the International Society for Traumatic Stress Studies*. New York, USA: Guilford Press.
- Gillis, M., Haaga, D., & Ford, G. (1995). Normative values for the Beck Anxiety Inventory, Fear Questionnaire, Penn State Worry Questionnaire, and Social Phobia and Anxiety Inventory. *Psychological Assessment, 7*, 450-455.
- Grey, N. (2007a). Post-traumatic stress disorder. Investigation. In S. J. E. Lindsay & G. E. Powell (Eds), *The Handbook of clinical Adult Psychology* (3rd ed., pp. 164-185). London, UK: Routledge.
- Grey, N. (2007b). Post-traumatic stress disorder. Treatment. In S. J. E. Lindsay & G. E. Powell (Eds), *The Handbook of clinical Adult Psychology* (3rd ed., pp. 186-205). London, UK: Routledge.
- Harvey, A. G., Bryant, R. A., & Tarrier, N. (2003). Cognitive behaviour therapy for posttraumatic stress disorder. *Clinical Psychology Review, 23*, 501-522.
- Jacobson, N. S., & Truax, P. (1991). Clinical Significance: A Statistical Approach to Defining Meaningful Change in Psychotherapy Research. *Journal of Consulting and Clinical Psychology, 59*(1), 12-19.
- Improving Access to Psychological Therapies (2014). Measuring Improvement and Recovery. Adult Services. Version 2. Retrieved from <http://www.iapt.nhs.uk/silo/files/measuring-recovery-2014.pdf>
- Kroenke, K., Spitzer, R. & Williams, J. (2001). The PHQ-9. Validity of a Brief Depression Severity Measure. *Journal of General Internal Medicine, 16*, 606-613. <https://doi.org/10.1046/j.1525-1497.2001.016009606.x>
- Löwe, B., Decker, O., Müller, S., Brähler, E., Schellberg, D., Herzog, W., & Herzberg, P. (2008). Validation and standardization of the Generalized Anxiety Disorder Screener (GAD-7) in the general population. *Medical Care, 46*(3), 266-274. <https://doi.org/10.1097/MLR.0b013e318160d093>
- Mason, L., Grey, N., & Veale, D. (2016). My therapist is a Student? The Impact of Therapist Experience and Client Severity on Cognitive Behavioural Therapy Outcomes for People with Anxiety Disorders. *Behavioural and Cognitive Psychotherapy, 44*(2), 193-202.
- National Institute for Health and Clinical Excellence (NICE), (2005). *Post-traumatic Stress Disorder (PTSD): The Management of PTSD in Adults and Children in Primary and Secondary Care*. NICE clinical guideline 26. London: Gaskell and the British Psychology Society. Available at <http://guidance.nice.org.uk/CG26> [NICE guideline]
- Weiss, D., & Marmar, C. (1996). The Impact of Event Scale - Revised. In J. Wilson & T. M. Keane (Eds.). *Assessing psychological trauma and PTSD* (pp. 399-411). New York, USA: Guilford.
- Zimmerman, M., & Sheeran, T. (2003). Screening for principal versus comorbid conditions in psychiatric outpatients with the Psychiatric Diagnostic Screening Questionnaire. *Psychological Assessment, 15*(1), 110-114. <http://dx.doi.org/10.1037/1040-3590.15.1.110>

Artículo recibido: 27/01/2016

Revisión recibida: 11/06/2016

Artículo aceptado: 23/06/2016