Musik in bayern
ISSN: 0937-583x Volume 88, Issue 09 (July -2023)
https://musikinbayern.com DOI https://doi.org/10.15463/gfbm-mib-2023-341

The Effect of Cognitive Behavioral Therapy in Treating Post-Traumatic Stress Disorder among Martyrs' Families

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To Cite this Article
Noor abdalkareem Radhi, Prof.Mansour bayrami, Prof. touraj hashemi, Ph.D. Jalil Babapour, Ph. D Abbas Bakhshipour , **The Effect of Cognitive Behavioral Therapy in Treating Post-Traumatic Stress Disorder among Martyrs' Families** ” *Musik In Bayern, Vol. 88, Issue 09,-June 2023, pp123-142*

Article Info
Received: 25-06-2023 Revised: 23-06-2023 Accepted: 10-07-2023 Published: 18-07-2023

Abstract

In the present study, the aim of the researcher was to investigate the effect of cognitive behavioral therapy in treating post-traumatic stress disorder among martyrs' families. The statistical population of the present study consists of family members of martyrs in Iraq who are diagnosed with post-traumatic stress disorder by doctors. The sampling method in this research was be a multi-stage cluster. Finally, 60 people were selected as the sample size in this study. Then these 60 people presented in two groups of 30 people in the form of experimental and control groups in the research. First, pre-test (PTSD questionnaire) was administered among both groups, then the experimental group passed the cognitive behavioral therapy. After that, post-test was taken from both groups (again the same questionnaires), and finally the significance of the difference between the two groups was measured. As it was observed in the previous chapter, those martyrs’ families who were

instructed by cognitive behavior therapy outperformed in PTSD than those didn't receive any therapy. Such a result can be justified by considering some outstanding characteristics about the nature of cognitive behavior therapy and its effectiveness in PTSD contexts.

Keywords: Cognitive Behavioral Therapy, Post-Traumatic Stress Disorder

Introduction

One of the consequences of any war is the occurrence of physical and psychological problems that arise for people who have been directly or indirectly involved in the war. Physical problems usually lead to disability, but psychological damage will plague the victims for a long time, even after the war. The injured person is not only mentally disturbed, but also the family environment is endangered by his influence. War is considered as one of the factors influencing the prevalence, onset and course of mental and behavioral disorders. Therefore, in this study, the purpose is to investigate the effect of cognitive behavioral therapy in treating post-traumatic stress disorder among martyrs' families. In this regard, in the first chapter of the research, researcher tried to examine the issues, problems and challenges in this field, and in the next section, the importance and significance of research are mentioned. The purposes are then explained. In the following, research hypotheses will be presented. Finally the researcher defined the keywords of the research from a conceptual and operational perspectives.

Life is usually associated with stress and strain. From birth to death, a person experiences many positive and negative stresses that usually affect his life, both quantitatively and qualitatively. Physiologists consider stress to be a physical response to environmental changes. Psychologists consider stress as the result of various social and psychological situations that have the ability to cause behavioral and psychological disorders in individuals (Gächter, Savage, & Torgler, 2011). Throughout history, man has always witnessed wars. Numerous analyzes have been made about the cause of the war, but the occurrence of the phenomenon of war is an undeniable fact. Wars have always been a source of stress and have caused mental disorders and illnesses, but these disorders and illnesses have clearly received more scientific attention since the second half of the nineteenth century. War as a severe stressor is an event that has been imposed on us

throughout history. However, defending Islamic values and the territorial integrity of the country is an inevitable religious and national duty. But we should never neglect its negative consequences, including the irreparable damage caused by the martyrdom, injury, disability and loss of many of the best people in society. One of these negative consequences is its psychological effects on the families of martyrs, veterans and martyrs (Hassanzadeh, 2017). Stress has become commonplace in the daily lives of these families. Some days are more intense and some days are very weak. If we know how to deal with it, we can easily minimize the role of this anomaly in their lives Post-traumatic stress disorder is a disorder that develops in a minority of people after exposure to stress. Risk factors for post-traumatic stress disorder are many, and that war trauma is an important risk factor for the development of this disorder in later life and can have a profound impact on growth and physical and mental health. (Gerson & Rapaport, 2013). These injuries include a wide range of life-threatening experiences, medical injuries, trauma, and the death of loved ones (Gerson & Rapaport, 2013; Alisic, Zalta, Van Wessel et al., 2014).

This disorder often occurs in the families of martyrs with a high rate of behavioralemotional problems. In any society, people may develop behavioral problems associated with post-traumatic stress disorder to experience various traumas such as domestic violence, car accidents, parental death, etc. (Alisik et al., 2014). The results of separate studies indicate the effectiveness of trauma-focused cognitive-behavioral therapy on reducing the severity of symptoms in individuals. Also in another study, Thornbach and Müller (2015) showed that cognitive behavior therapy has an important role in regulating emotion and reducing internal and external problems of school-age people. New developments in the field of cognitivebehavioral therapy have been very promising. Given the number of people involved and the lack of resources in any disaster large or small that increases the risk of posttraumatic stress disorder, the need for short-term, pragmatic and easy-to-implement interventions is needed (Zang, Hunt & Cox, 2013).

The term and construct of PTSD initially emerged into the diagnostic canon of the American Psychiatric Association, DSM-5 in 1980 under the nosologic classification scheme in a response to Vietnam War veterans (Friedman, 2007). The concept was initially controversial as the significant change brought about by the

concept was the stipulation that the etiological agent was outside the individual (a traumatic event) rather than an inherent individual weakness (a traumatic neurosis) (Friedman, 2007). This introduction of a uniform criteria for psychiatric disorders related to trauma changed the social and research landscape. The legitimization of PTSD in DSM-5 led to a new generation of treatment studies as the new disorder
achieved widespread interest (Jones & Wessely 2005).
Some individuals are exposed to trauma through their professions, such as combat veterans, ambulance personnel, police officers, firefighters and journalists. These individuals have been found to have differing lifetime prevalence rates of PTSD. For instance in terms of armed forces, The National Center for PTSD proposes that the lifetime prevalence of PTSD among male combat veterans is very high at approximately 39 %, with the prevalence rates ranging from 6-12 % in Afghanistanand 12-20 % in Iraq (Gradus, 2007)
Rates of PTSD for this group range between 5 to 16.3 % (Del Ben, Scotti
Chen & Fortson, 2006) and risk factors include witnessing death of a child (Haslam & Mallon, 2003), being of a younger age, second emergency job, greater frequency of life stressors, previous psychological treatment and high aggressiveness and low self-efficacy (measured during training) (Del Ben et al., 2006).
A cognitive-behavioral account of psychiatric disorders is based on learning theory and/or cognitive/information processing theory. Following is a brief description ofkey assumptions. From a learning theory perspective, CMDs can largely be
understood from classical and operant principles. Stimuli functions (from an
unconditioned stimulus) can transfer to other stimuli (a conditioned stimulus) due to paring (Dixon & Rehfeldt, 2018).These perseverative cognitions (worry and rumination) can impede psychophysiological unwinding and prolong the effect of stressors. In other words,lack of psychological detachment from stressors is an important contributor to incomplete recovery and perseverative cognitions have been found predictive of exhaustion and fatigue. From a behavioral perspective, worry and rumination can be viewed as verbal behaviors, maintained by both negative and positive reinforcement (being

associated with inactivity it reduces exposure to the actual problems at hand, and it might be intermittently followed by a feeling of things making sense) (Vandevala. Et al., 2017).
Finally, sleep is central to recovery, a fundamental source of deactivation and psychophysiological unwinding. Low sleep quality (particularly nonrestorative
sleep and trouble falling asleep) have been found associated with poor recovery,
which in turn relates to level of exhaustion. Also, insufficient sleep may predict
future exhaustion, and sleep disturbance is a common feature in exhaustion disorder. Thus, sleep disturbance seems to be an important factor in both the development and maintenance of exhaustion. Importantly, a factor contributing to sleep disturbance in stress is perseverative cognitions (Ebert, Berking, & Thiart, 2015).
Several models that detail key cognitive and behavioral factors central in the
maintenance of social anxiety disorder (SAD) exist (Sonnenschein, Sorbi, van
Doornen, Schaufeli, Maas, 2007)
Cognitive restructuring is a treatment component that aims to (a) identify key
maladaptive beliefs and thoughts central to emotional distress, and (b) evaluate and
challenge them to generate more adaptive and functional thinking patterns. Its
proposed mechanism of change is that changes in biased information processing and negative thinking is responsible for reductions in emotional symptoms. In other words, cognitive reappraisal is the core process believed to be affected by this
strategy, and subsequently have impact on symptoms (Craske, Treanor, Conway,
Zbozinek, & Vervliet, 2014). Or c behavioral activation + work to modify automatic thoughts + focus on core schemas (Jacobson, Dobson, & Truax, 1996).
showed there was no difference between treatments in outcomes (depressive
symptoms and diagnostic status), and importantly, they all produced similar changes in maladaptive cognitions. As suggested in a review evaluating mechanisms of change in treatment of depression, cognitive changes seem to mediate therapeutic improvement, but changes in cognition might not be specific to cognitive interventions. Thus, what might intuitively seem to be related (cognitive restructuring and cognitive change), could in fact also involve other causal routes

Significance of the Study

In any society, people's health is of special importance and paying attention to their mental health helps them to be mentally and physically healthy and to play their social role better. On the other hand, stress is an integral part of our lives and considering the rate of traumatic events such as war; Stress-related diseases also show an increasing rate. Post-traumatic stress disorder is a complex and chronic disorder that causes significant problems and disruptions in social and educational functioning and can have a profound impact on the growth of individuals (Gerson & Rapaport, 2013).

Purposes of the Study

Main objective: investigation the effect of cognitive behavior therapy on the treatment of post-traumatic stress disorder in the families of martyrs Sub-objectives:

1) Investigation The effect of cognitive behavioral therapy on the penetrating memories in the families of martyrs
2) Investigation The effect of cognitive behavioral therapy on the problem of interpersonal communication in the families of martyrs
3) Investigation The effect of cognitive behavior therapy on the inability to control emotions in the families of martyrs
4) Investigation The effect of cognitive behavioral therapy on the lack of depression in the families of martyrs

Research Questions

Main question: Does cognitive behavior therapy have any statistically effect on the treatment of post-traumatic stress disorder in the families of martyrs? Sub-questions:

1) Does cognitive behavioral therapy have any statistically effect any statistically effect on penetrating memories in the families of martyrs?

2) Does cognitive behavior therapy have any statistically effect on the problem of interpersonal communication in the families of martyrs?

3) Does cognitive behavior therapy have any statistically effect on the inability to control emotions in the families of martyrs?

4) Does cognitive behavioral therapy have any statistically effect on the lack of depression in the families of martyrs?

Research Hypotheses

Main Hypothesis: Cognitive behavior therapy has a positive effect on the treatment of post-traumatic stress disorder in the families of martyrs

Sub-hypotheses:

1) Cognitive behavior therapy has a positive effect on the penetrating memories in the families of martyrs
2) Cognitive behavior therapy has a positive effect on the problem of interpersonal communication in the families of martyrs
3) Cognitive behavior therapy has a positive effect on the inability to control emotions in the families of martyrs
4) Cognitive behavioral therapy has a positive effect on the lack of depression in the families of martyrs

Method

The method of conducting research is one of the major factors that affect the research and the results and often depends on the purpose of the research, the nature of the subject, the implementation possibilities of the research and the hypotheses developed. The present study is applied in terms of purpose and is considered as a quasi-experimental research in terms of path. The quasi-experimental research design is usually used in situations where it is not possible to control all the relevant variables in the study. In this method, the researcher, aware of all the limitations, tries to bring it closer to the experimental research. In this method, before applying the variables, both experimental and control groups are tested and their status is clarified. The experimental group is then affected by the independent variable. Then the test is performed from both groups and the results of the two tests are compared with each other. If there is a significant difference, the researcher

can ensure the effectiveness of the independent variable (Sohrabi, 2013). This type of research work is applied, because this research uses the cognitive context and information provided through basic research to meet human needs and improve and optimize

tools, methods, objects and patterns to develop welfare and comfort and upgrade the surface. The present study is a quasi-experimental with pre-test and post-test.

Based on this, the researcher first randomly selected the experimental and control groups, and evaluated the PTSD variable (as a pre-test) between them. The experimental group then underwent cognitive behavioral therapy for three months (once per week). The control group did not have any specific treatment during this period. At the end of the course, the PTSD questionnaire was distributed again in both experimental and control groups and this variable was re-evaluated. Thus, by observing possible differences in responses, the effect of cognitive behavioral therapy on PTSD of the martyrs' families was investigated.

Participants

The statistical population is all the elements and individuals that have one or more attributes in common in a certain geographical scale. The smaller the statistical population, the more accurately it can be studied than a larger statistical population (Sohrabi, 2013). The statistical population of the present study consists of all family members of martyrs in Iraq. The sample consists of who are diagnosed with post-traumatic stress disorder by doctors. The sampling method in this research was be a multi-stage cluster. Finally, 60 people were selected as the sample size in this study. Then these 60 people presented in two groups of 30 people in the form of experimental and control groups in the research. The participants of the study were married all, and they were older than 40 years old. Additionally, the participants were at an average level in terms of social well-being.

Results

Table 4.1. *Descriptive Statistics for the Pretest*

Musik in bayern
ISSN: 0937-583x Volume 88, Issue 09 (July -2023)
https://musikinbayern.com DOI https://doi.org/10.15463/gfbm-mib-2023-341

Group	N	Mean	Std. Deviation	Min	Max
Experimental	30	121.65	1.040	103	162
Control	30	116.35	2.231	99	157
Total	60	119	2.580	99	162

Their scores on the pre-test were compared with each other using the one-way ANOVA. The results of the used one-way ANOVA and the descriptive statistics for the argumentative writing performance of all the two selected groups are presented in the following tables:

Table 4.2. *ANOVA for the Pretest*

	df	*F*	*Sig.*
Between Groups	2	0.94	.000
Within Groups	57		
Total	59		

As it can be seen, the obtained value for F between is 2 and for F within 57; therefore, the case for denominator is 0.94. Because such a value is less than the critical value for F (2, 57), it can claimed that the differences between the PTSD of all the two groups on the pre-test were not statistically significant. In fact, all the groups belonged to the same population at the beginning of the study and before starting the treatments for each group. The average of experimental group was 121.65, and control group was 116.35. Therefore, there were differences between averages of the groups.

The research questions of the current study are:

1) Does cognitive behavioral therapy have any statistically effect any statistically effect on penetrating memories in the families of martyrs?

2) Does cognitive behavior therapy have any statistically effect on the problem of interpersonal communication in the families of martyrs?

3) Does cognitive behavior therapy have any statistically effect on the inability to control emotions in the families of martyrs?

4) Does cognitive behavioral therapy have any statistically effect on the lack of depression in the families of martyrs?

In order to answer the research questions, the PTSD performances of the two groups on the post-test were compared with each other. The descriptive statistics for performances of all of the two groups have been given in the table 4.5.

Table 4.3. *Descriptive Statistics for the Performance of All Groups in the Posttest*

	N	Mean	Std. Deviation	Minimum	Maximum
experimental	30	93.90	.912	81	103
control	30	117.40	2.437	99	155
Total	60	105.65	2.213	99	155

As it can be seen, there were differences between the mean scores of experimental and control groups. The mean scores were as:

M1 = 93.90, M2 =117.40. In fact, M2 > M1.

As it can be seen in the table 4.5, the more PTSD scores (based on the mean) were for the group 2 that is the control group, in which cognitive behavioral therapy was not used. And the least performance in area of PTSD was for experimental group, in which cognitive behavioral therapy was used. In order to make sure if such differences were significant or not, the one-way ANOVA was used. The results of the applied one-way ANOVA are given in the table 4.4.

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Table 4.4. *ANOVA for the Posttest*

	df	*F*	*Sig.*
Between Groups	2	9.219	.000
Within Groups	57		
Total	59		

The obtained value for $F_{(2, 57)}$ = 9.219. Because this value is greater than the critical value (F = 3.09) for F with these degrees of freedom, this conclusion can be drawn that the differences between the mean scores for the two groups of the study on the post-test were statistically significant. Accordingly, it is revealed that cognitive behavioral therapy has statistically effect on PTSD in the families of martyrs.

As one-way ANOVA showed that differences between the performances of the twt groups on the post-test were significant, then our concern would be to identify where these differences exactly lied. In other words, which group performed differently from other two groups? In order to answer this question, the Scheffe test as a post hoc test was run to see where the differences exactly were. Multiple comparisons which have been made using Scheffe test as a robust Post Hoc Test are presented in table 4.5

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Table 4.5. Multiple Comparisons (scheffe) of posttests of three classes

ISSN: 0937-583x Volume 88, Issue 09 (July -2023)
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(I) reduction	(J) reduction	Mean Difference (I-J)	Sig.	95% Confidence Interval	
				Lower Bound	Upper Bound
1 (penetrating memories)	2	2.650*	.000	1.09	4.21
1 (interpersonal communication)	2	1.500	.041	-.06	3.16
1 (inability to control emotions)	2	3.650*	.000	1.39	5.25
1 (lack of depression)	2	2.700*	.000	1.22	4.31
2 (penetrating memories)	1	-2.650	.000	-.06	-3.01
2 (interpersonal communication)	1	-1.500	.041	1.05	-2.02
2 (inability to control emotions)	1	-3.650*	.000	-4.21	-1.09
2 (lack of depression)	1	-2.700	.000	-3.06	-.06

*. The mean difference is significant at the 0.05 level.

As it can be observed in the above table, the differences between the mean scores for comparison of the control and the experimental groups was significant. Accordingly, it can be concluded that students in control group had higher score on post-test (PTSD) compared with those subjects in experimental group who were instructed by cognitive behavior therapy.

Assessing research hypotheses

It should be noted that the hypotheses are tested on the basis of the One-way ANOVA:

First hypothesis: In line with the first hypothesis of the research, it is noteworthy that before the experiment, no significant difference was observed between the control and experimental groups in the category of penetrating memories. After testing and implementing the cognitive behavior therapy, the experimental group's scores were statistically significant lower than other group, therefore it was concluded that, cognitive behavior therapy has a positive effect on the penetrating memories in the families of martyrs. By comparing the research findings with other researchers, it can be concluded that these findings are consistent with the results of Mayayi,

Yousefi, Yousefi (2015). The human brain is the most complex object known in the universe. Perhaps the most important element of the brain is that it is malleable, which means it can always change based on the information it perceives. Since birth, our brains are establishing pathways first created by reflexes and eventually reinforced by experiences, memories, and learning. Yet, the pace at which it develops and its ability to change does slow down as we become adults. Well to put it simply, cognitive behavioral therapy strives to restructure the brain by establishing new neural pathways via neutral thinking. For example, a depressed or anxious brain has typically been reinforcing negative thought pathways over some amount of time. In many cases, these well-established pathways influence the brain's willingness to process negative information more easily than positive information, often resulting in what are known as cognitive distortions, or skewed thought patterns.

Second hypothesis: In line with the second hypothesis of the research, it is noteworthy that before the experiment, no significant difference was observed between the control and experimental groups in the category of interpersonal communication. After testing and implementing the cognitive behavior therapy, the experimental group's scores were statistically significant lower than other group, therefore it was concluded that, cognitive behavior therapy has a positive effect on the problem of interpersonal communication in the families of martyrs. By comparing the research findings with other researchers, it can be concluded that these findings are consistent with the results of Hassanzadeh (2017) and Mayayi, Yousefi, Yousefi (2015). CBT focuses on reviewing and reworking unhelpful thinking styles and behavioral habits. For this reason it is one of the most useful ways of disentangling unsuccessful communicational strategies and therefore, of altering and improving communication styles. This can require addressing some of the 'beliefs' you hold about relationships, you in relationship, what makes us vulnerable and how we can be understood by people who matter to us. Cognitive behavioral therapy can be helpful in communication styles. Communication within relationships can be particularly problematic within our closest relationships – it can be much easier to communicate clearly and successfully with people who are more distant. For many people it's much easier to

communicate clearly with work colleagues or with friends than it is with partners or family members. This may be because it is harder to say what we mean, what we want or don't want, to people who matter to us the most. There is also the possibility that we assume that we know what people close to us are going to say, or going to think, rather than listening to what they do say ('mind-reading' is a common - and not very useful - unhelpful thinking pattern in relationships).

Third hypothesis: In line with the third hypothesis of the research, it is noteworthy that before the experiment, no significant difference was observed between the control and experimental groups in the category of inability to control emotions. After testing and implementing the cognitive behavior therapy, the experimental group's scores were statistically significant lower than other group, therefore it was concluded that, cognitive behavior therapy has a positive effect on the inability to control emotions in the families of martyrs. By comparing the research findings with other researchers, it can be concluded that these findings are consistent with the results of Rajabi (2016) and Mayayi, Yousefi, Yousefi (2015). Unlike more complex or traditional forms of talk-therapy, cognitive behavioral therapy simplifies the process of understanding and changing emotional processes. According to CBT, there are just a few powerful components of emotion to understand and work with. In fact, emotion is a primary variable in the cognitive model. The cognitive therapist facilitates identification of troubling emotions, helps the patient explore the origins of the emotion (automatic thoughts), and collaboratively generates alternative

perspectives. Cognitive therapy supervisor's help trainees learn to identify their own automatic thoughts and emotions and teach them how to use this information productively in therapy.

Fourth hypothesis: In line with the fourth hypothesis of the research, it is noteworthy that before the experiment, no significant difference was observed between the control and experimental groups in the category of lack of depression. After testing and implementing the cognitive behavior therapy, the experimental group's scores were statistically

significant lower than other group, therefore it was concluded that, cognitive behavior therapy has a positive effect on the lack of depression in the families of martyrs. By comparing the research findings with other researchers, it can be concluded that these findings are consistent with the results of Li, Li, Jiang and Xu (2020). CBT teaches you to become aware of and adjust negative patterns, which can help you reframe your thinking during moments of heightened anxiety or panic. It can also provide new coping skills, like meditation or journaling, for those struggling with a substance use disorder or depression. With cognitive therapy, a person learns to recognize and correct negative automatic thoughts. Over time, the depressed person will be able to discover and correct deeply held but false beliefs that contribute to the depression.

Main hypothesis: In line with the main hypothesis of the research, it is noteworthy that before the experiment, no significant difference was observed between the control and experimental groups in the PTSD. After testing and implementing the cognitive behavior therapy, the experimental group’s scores were statistically significant lower than other group, therefore it was concluded that, cognitive behavior therapy has a positive effect on the PTSD in the families of martyrs. By comparing the research findings with other researchers, it can be concluded that these findings are consistent with the results of Li, Li, Jiang and Xu (2020), Rajabi

(2016) and Mayayi, Yousefi, Yousefi (2015). CBT is one of the most widely practised therapeutic approaches in psychology. CBT reduces depressive symptoms by identifying inaccurate and maladaptive cognitions, testing the cognitions against reality, and modifying the dysfunctional thoughts, emotions and behaviours through different strategies accordingly. The standard techniques of CBT which are utilised in treating depression are divided into two parts. The cognitive techniques include cognition identification, thought recording, cognition restructuring, thought testing and distraction strategy training. The behavioral techniques consist of goal setting, activity scheduling, relaxation training and relapse prevention. CBT is a more short-term approach than psychoanalysis and psychodynamic therapies. Other types of therapies may require several years for discovery and treatment. CBT often requires only up to 20 sessions, according to the National Health

Services, but you can continue seeing your therapist for as long as you need. Every situation is unique, so how long you pursue treatment is up to you and your therapist. CBT sessions provide opportunities to identify current life situations that may be causing or contributing to your mental health conditions, like anxiety or depression. CBT allows you and your therapist to identify patterns of thinking or distorted perceptions that are no longer serving you. This is different from psychoanalysis. This type of therapy involves working backward through your life history to discover an unconscious source of the problems you're facing.

These may include: all-or-nothing thinking: viewing the world in absolute, black-and-white terms; disqualifying the positive: rejecting positive experiences by insisting they "don't count" for some reason; automatic negative reactions: having habitual, scolding thoughts; magnifying or minimizing the importance of an event: making a bigger deal about a specific event or moment; overgeneralization: drawing overly broad conclusions from a single event; personalization: taking things too

personally or feeling actions are specifically directed at you; mental filter: picking out a single negative detail and dwelling on it exclusively so that the vision of reality becomes darkened.

Empirical Suggestions

You might decide on your own that you want to try cognitive behavioral therapy. Or a doctor or someone else may suggest therapy to you. Here's how to get started:

 Find a therapist. You can get a referral from a doctor, health insurance plan, friend or other trusted source. Many employers offer counseling services or referrals through employee assistance programs (EAPs). Or you can find a therapist on your own — for instance, through a local or state psychological association or by searching the internet.

 Understand the costs. If you have health insurance, find out what coverage it offers for psychotherapy. Some health plans cover only a certain number of therapy sessions a year. Also, talk to your therapist about fees and payment options.

 Review your concerns. Before your first appointment, think about what issues you'd like to work on. While you can also sort this out with your therapist, having some sense in advance may provide a starting point.

Before seeing a psychotherapist, check his or her.

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