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Preliminary study of a new integrative approach in treating post-traumatic stress disorder: SEE FAR CBT

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ABSTRACT

SEE FAR CBT is a suggested new protocol for the treatment of anxiety disorders and post-traumatic stress disorder (PTSD) using creative form treatment based on empowerment through fantastic reality. The model emphasizes the role of fantastic reality and the use of imaginal re-narration of the traumatic event with the use of cards as a means of externalization or distancing. The treatment protocol incorporates methods of somatic memory reduction as well as CBT elements. The main objective of this study was to introduce the model and test the therapeutic efficacy of this new integrative therapeutic approach by comparing it to a well-established treatment approach; eye movement desensitization and reprocessing (EMDR). Adult PTSD patients, divided into EMDR ($n = 12$) and SEE FAR CBT ($n = 9$) groups, were assessed for traumatic symptoms at three time intervals (pre-treatment, post-treatment and 1-year follow-up). Both EMDR and SEE FAR CBT were associated with effective alleviation of traumatic symptoms, showing statistically significant decreases in their trauma symptoms over time but not differing in treatment efficacy during any of the assessment times. With some methodological limitations, results suggest further inquiry of the proposed model in clinical and experimental settings.

Introduction

During the 20th century major developments in the field of psycho-trauma (Vitzthum, Mache, Joachim, Quarcoo, & Groneberg, 2009) have enabled effective treatment for post-traumatic stress disorder (PTSD) (APA, 2000). We find that the two most effective treatments cited in the literature are prolonged exposure (PE), and eye movement desensitization and reprocessing (EMDR) (Seidler & Wagner, 2006). The need to develop another new protocol arises for several reasons: first, prior findings demonstrate that there are key brain structures and pathways associated with retaining the traumatic incident process (Gilboa et al., 2004; Hendler et al., 2003; Lanius et al., 2004; LeDoux, 1996). Thus, the reactivation of these pathways via 'imaginal exposure' techniques (Foa, Doron, & Yadin, 2006; Hembree, Rauch, & Foa, 2003) is paramount and is part of the healing process. However, neither PE nor EMDR explicitly refers to the process of imagination nor do they employ its curative effect (Spates, Koch, Cusack, Pagoto, & Waller, 2009). Second, in PE, clients are asked to vividly re-experience their traumatic story. This might lead to over-engagement and prevent habituation (Hembree et al., 2003). Moreover, it might elicit dissociative responses, causing the patients to experience invasive feelings of agitation, react fearfully, and avoidance can be manifested, (Lanius & Hopper, 2008; Rauch & Foa, 2006). Thus, there must be a "safer" way to access and activate the traumatic episodic memory, while regulating emotional engagement. Third, owing to their hypervigilant and avoidant state, a PTSD victim's interest in significant activities and the ability to play are diminished, resulting in an on-guard "not to remember" condition (Lahad & Doron, 2009,2010; Solomon & Mikulincer, 2006). Hence, there is a fundamental need to gradually regain one's will and desire to play through exploration. Fourth, this is a novel attempt to test the efficacy of an arts form PTSD treatment protocol compared to an EBT (evidence based treatment) protocol such as EMDR. As Johnson, Lahad, and Gray (2009) state: "The creative arts therapies have been utilized with all types of trauma, though there are no data to indicate whether their efficacy varies according to type of traumatic event, single versus repeated traumatization, or age of traumatization. . . no estimates are available with specifically PTSD populations, nor have any meta-analyses been completed on the other creative arts therapy modalities" (p. 484).

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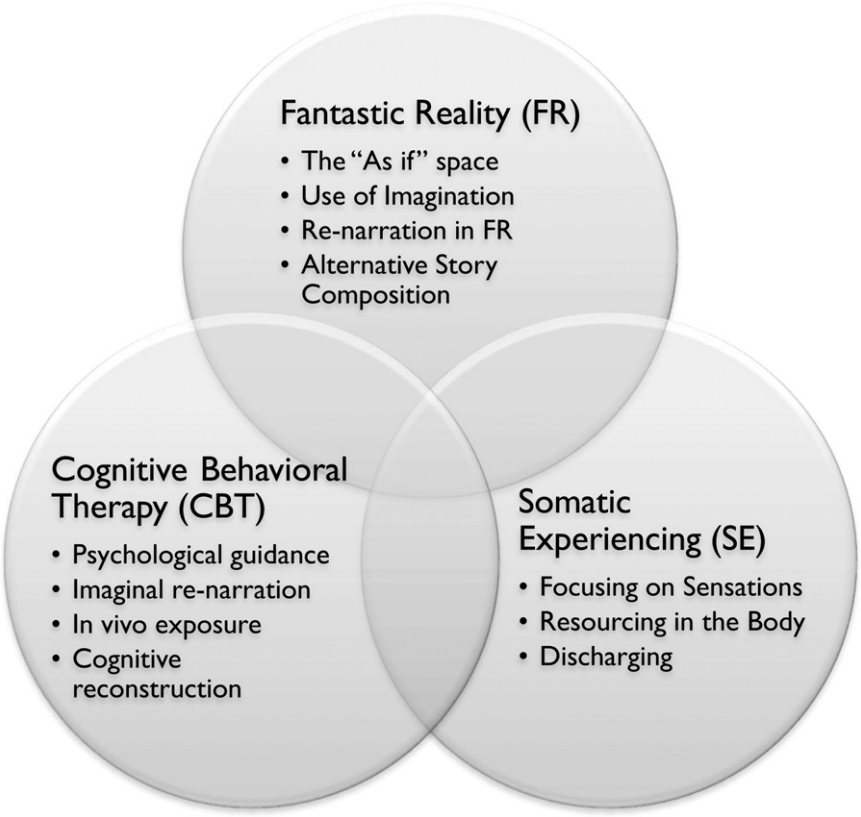

Fig. 1. SEE FAR CBT model.

The objective of this study is to introduce a new integrative model for treating PTSD, and test its therapeutic efficacy in a clinical setting.

SEE FAR CBT

The proposed treatment model is based on the concepts outlined in Johnson et al. (2009) chapter in the book *Effective Treatments for PTSD – Practice Guidelines from the International Society for Traumatic Stress Studies*, in which they suggested the similarities of the creative therapy techniques and several known techniques for the treatment of psycho-trauma (i.e., psycho-education, exposure, cognitive restructuring, re-narration, somatic reactions). However, they also indicated that, to date, despite the use of potentially effective methods, the creative therapies have not been examined in a quasi-experimental design. SEE FAR CBT is an attempt to test the hypothesis that a creative conceptualization integrated into a treatment protocol that emphasizes the creative process can be effective in the treatment of PTSD. Thus, SEE FAR CBT has modified and adapted elements from several approaches to treatment of psycho-trauma that have proven successful in changing and bettering the situation of trauma victims (Leith, Vanslyke, & Allen, 2009; Mendis, Mello, Ventura, Passarela, & Mari, 2008; Parker, Doctor, & Selvam, 2008). The combined effective trauma treating methods in the model involve: (a) aspects of somatic experience (SE) (Levine & Frederick, 1997), (b) fantastic reality (FR) (Lahad, 2000, 2005), and (c) cognitive behavioral therapy (CBT) (Foa, Keane, Friedman, & Cohen, 2009) (see Fig. 1).

SE is a method focusing on the "body memory" (Rothschild, 2000; Van der Kolk, Van der Hart, & Marmar, 1996), the physiological memory (which is embedded in the limbic system). The basis of this therapeutic process rests on the ability of the subjective physical sensation to be reported by the patient through focusing on good sensations and emotional resources (i.e., bodily grounded sensations), as well as on bad sensations (i.e., the implicit traumatic memory), for physiological energy discharge and better self-regulation of the body experience and state.

FR is a theoretical construct suggested by Lahad (2000, 2005), Lahad and Doron (2009,2010) to describe the ability of people facing traumatic situations to transcend into a fantastic space where they feel safe and secure and where they can deal with and change the unchangeable. Lahad's concept is based on several theoretical ideas: (1) Winnicott's concept of potential space (Winnicott, 1971), interpreted by Ogden (1985) as the "intermediate area of experiencing that lies between fantasy and reality" (p. 129); (2) Jennings' approach to dramatic space (Jennings, 1994), described by Chesner (1994) as the place where "the context of illusion and play give permission for more freedom of exploration and expression" (p. 116); and (3) Landy's ideas of aesthetic distancing (Landy, 1996), summarized by Jenkyns (2001) as "the state when the individual, while in act of dramatic engagement, is in a state of emotional balance" (p. 70). What is common to all these approaches is that they use play and playfulness as part of the healing process (Jennings, 1994; Landy, 1996; Winnicott, 1971). In practice, FR is introduced by the use of metaphoric therapeutic cards (TC) (see Ayalon, 2007) to represent both "a pleasant/safe place" (i.e., a subjective feeling of comfort and security) and the re-narrating process of the traumatic story. The use of cards as an "externalization" of the otherwise internally haunting images or as "distancing" (Landy, 1996; White & Epston, 1990), allows the clients to take the position of the observer in their own drama, thus giving them a sense of control and manageability over the incident. Moreover FR allows the client to make use of the "as if space", a space where all the IFs are possible and where the impossible becomes possible. This practice reintroduces the client to his/her ability to play and to experience empowerment.

Table 1
SEE FAR CBT[a] components and terminology.

Component	Source approach	Therapeutic purpose
Psycho-education	CBT, SE	Normalizing patients behavioral reactions, enhancing sense of control, strengthening therapist–patient relationship and trust
In vivo exposure	CBT	Live exposure to situations, places, and avoided behavior results in learning control over anxiety
Desensitization	CBT	Gradual habituation to the aversive stimuli (memory or behavior), which results in emotional extenuation and adaptation
Relaxation techniques	CBT, SE, SIT	Prevents hyper-ventilation states and increases control in the level of the anxiety
Resourcing	SE	Bringing to consciousness positive and pleasant as well as negative experiences, and being alert to the physiological sensations – as therapeutic tool for emotional and bodily discharge
Safe place	SE, FR, NLP	Creates a sense of security and control, along with the experience of confidence and dominance
Metaphoric therapeutic cards	FR	Symbolic and associative cards which enable access to deep feelings and assist in narrating the experience by distancing from it
Exposure in FR	FR, CBT	Recollection and reprocessing of the traumatic memory via re-narrating the subjective story with therapeutic cards aiming to reconstruct and conceptualize the fragmented memory in a coherent narrative
"As if space"	FR	Theoretical space elicited by the cards, which enables imaginative play and cognitive flexibility, thus providing an opportunity to modify the traumatic memory without changing the outcome
Pendulation	SE, EMDR	Discharging mechanism of the stressful/traumatic memory, by movement between resourced areas in the body, or between different therapeutic cards

Note: CBT, Cognitive behavioral therapy; SE, somatic experiencing; FR, fantastic reality; SIT, stress inoculation techniques; NLP, neuro-linguistic programming; EMDR, eye movement and desensitization reprocessing.

[a] Description of technique' components is elaborated in Lahad and Doron (2010), as well is available on video at http://www.counpsych.net/nato.html.

The cognitive behavioral components of SEE FAR CBT, influenced by PE and other cognitive behavioral therapies (Ellis & MacLaren, 1998; Foa et al., 2006, 2009) adopt the following five aspects: the impact of repeating the story on the desensitization or habituation processes, the power of verbalizing the story and making it an accessible coherent story that can be referred to as past, the need to experience *in vivo* gradual exposure as part of the training so that non-threatening, non-dangerous avoidance behavior will be diminished and thus give the client a sense of control and a sense of coherence, the use of a reflective-learning experience discussion at the end of each session, and the on-going psycho-education approach, in which the patient is made aware of each step in the process thereby becoming a partner in the quest from hurt to healing. It should be noted that in its clinical practice, SEE FAR CBT protocol does not apply each one of the treatment protocols separately, but integrates the elements that have been found to be clinically effective, derived from those treatments into a new treatment protocol (see Table 1 for summary of SEE FAR CBT components).

Method

Participants

In order to conduct this study, data of 106 (young and adult) patients were obtained from a psycho-trauma treatment unit of the Community Stress Prevention Center (CSPC) in northern Israel. All participants were self-referred and came from urban and communal populations located in an area exposed to hostilities for 33 days during the Second Lebanon War in the summer of 2006. Administration of the treatment took place 3 months to 1 year following the incident. Participants underwent diverse treatment approaches; SEE FAR CBT ($n = 43$), EMDR ($n = 57$), and combined EMDR and SEE FAR CBT, or other types of therapies (psycho-educational, etc.) ($n = 6$). However, since this study is concerned with the effectiveness of SEE FAR CBT treatment in comparison to EMDR over three points in time only, participants who received other therapies and did not manage to complete the three measures of traumatic symptoms were not included in the final analysis. Aiming to test young adult and adult populations, participants younger than 18 years old were not approached. Participants scoring below the established threshold for clinical PTSD (Ehlers, Clark, Hackmann, McManus, & Fennell, 2005) were also excluded. Eventually, the analyzed data for this study were taken from 21 ($n = 21$) participants from the treatment groups, EMDR ($n = 12$, 67% females) and *SEE FAR CBT* ($n = 9$, 79% females) who gave their consent to participate in the study in a telephone interview. The mean age of the sample was 49.14 ($SD = 18.16$, range = 21–78) and the median number of treatment appointments was 6 (range = 1–16). Groups did not differ either in age, $t(19) = -1.41$, *ns*, or in the number of treatment sessions, $t(19) = -.79$, *ns*. Participants also did not differ in the types of their trauma, χ^2 (2, $n = 21$) = 1.60, *ns.* 67% of EMDR and 89% of SEE FAR CBT participants were referred to therapy because of their war experiences.

Measures

The Post-traumatic Diagnostic Scale (Foa, Cashman, Jaycox, & Perry, 1997) is a self-report measure used to assess trauma exposure and PTSD severity, and to provide a brief but reliable self-report measure of post-traumatic stress disorder (PTSD) for use in both clinical and research settings. Using an event checklist and specific criteria queries, the PDS assesses if the experience meets the DSM-IV Criterion A for a traumatic event (Foa et al., 1997). PDS assesses PTSD symptoms associated with the event, yielding subscale mean scores for intrusion, avoidance, and arousal clusters and a total severity score. Overall PTSD severity is indexed by the sum of the 17 item scores. The frequency of each item is rated on four-point scale (0 = *not at all or only one time;* 3 = *five or more times a week or almost always*), and therefore the sum can range from 0 to 51. Since the subscales in PDS were not identical to the number of items each in subscale, the mean score (ranging from 0 to 3) was set to represent the severity score of the specific subscale. A clinical threshold was set according to prior papers which reported a below total PDS score of 14 (Coffey, Gudmundsdottir, Beck, Palyo, & Miller, 2006; Ehlers et al., 2005). In addition, suggested cut offs for symptom severity rating were suggested to be: 1–10 mild, 11–20 moderate, 21–35 moderate to severe and above 36 as severe (McCarthy, 2008). Current analysis yielded high and stable test–retest reliability for total PDS scores ($\alpha = .87$ and $\alpha = .91$, respectively), resembling prior reported psychometric properties of the PDS. In addition, the PDS has good internal consistency and correlates well with other measures of PTSD symptoms (McCarthy, 2008).

Table 2
SEE FAR CBT stages of therapy.

Stage	Description
1	A detailed intake interview combined with an assessment and diagnosis of PTSD
2	Psycho-education – an explanation of the essence of PTSD, including a discussion about common responses; a survey of the different approaches to therapy: SE, *in vivo* exposure, re-narration in the FR and cognitive processing
3	A mutual decision that therapy is necessary
4	Clarifying the objectives of the therapy
5	Relaxation, creating a safe place in various ways (the imagination, cards, etc.) and anchoring the sensations in the body
6	Examining avoidances and building an *in vivo* exposure hierarchy, practicing *in vivo* exposure, desensitization, practicing exposure in the FR
7	Re-narration in the fantastic reality using cards; practicing *in vivo* exposure
8	Processing "hot spots" (i.e., high levels in the subjective units of distress) that surfaced in the re-narration in the FR using cards; practicing *in vivo* exposure
9	Summary and evaluation of results

Procedure

All participants underwent an intake procedure by two staff members of the clinic, who assigned them, on the basis of a free spot, to different therapists. Participants were blind to the future selected treatment type that would be used during sessions. Of the 22 clinic therapists, eight were experts in both EMDR and SEE FAR CBT protocols. Two were trained clinical psychologists, three were clinical social workers and three were creative arts therapists with a mean number of 5 years training and approximately 8 years of practice in treating trauma and anxiety related disorders. A written informed consent was obtained from participants before assessing post-traumatic symptoms. The PDS was administered to the patient by the therapist at first session (pre-treatment), last (post-treatment) session, and after a 1-year follow-up. No assessment of co-morbid axis I or II disorders was made. The EMDR group received full EMDR treatment according to the official protocol (see Spates et al., 2009), by professionally trained therapists. Correspondingly, the other group received a full SEE FAR CBT protocol for post-traumatic stress disorder treatment. Following therapy, participants did not receive additional treatment. CSPC maintains an ethics committee which approved this study and determined that despite the original consent, a verbal consent would be obtained by phone during the 1-year telephone follow-up.

SEE FAR CBT protocol (Lahad & Doron, 2007, 2009)

Therapy consists of several stages (described in Table 2) and clients receive two weekly 90 min sessions. This is the "gold standard" in the treatment of psycho-trauma and enables efficient and gradual work during the different stages, especially during the FR desensitization process and the FR re-narration sessions. Thus, in order to establish engagement on the one hand, and to offer a sufficient "recovery" phase for the client, on the other, a greater amount of time is available. Transition from stage to stage is not constrained by the number of specific sessions and is a function of the gradual personal process (i.e., practicing re-narration in fantastic reality without sufficient desensitization practice or lacking sufficient knowledge of the possible physiological reactions would not be effective).

Following the initial stages of intake and PTSD diagnosis, followed by psycho-education and setting of therapy objectives, which are similar to most therapies (Foa et al., 2009), the client studies how to reduce arousal and how to control fearful reactions so that a sense of safety is gained. Next, the client practices SE modalities (i.e., focusing, resourcing), and is given an explanation about the importance of discharge of blocked physical energy due to the trauma. The client is introduced to the power of FR and externalization through a process of creating an external safe space using therapeutic cards (see Fig. 2). The establishment of association between the image and the experience of relaxation and pleasantness assists the client during the therapy whenever anxiety prevails and the need for stress reduction arises, through focusing on the card, returning to the external, internalized safe space and then, returning to the therapeutic process.

A CBT process includes making an avoidance list, an *in vivo* exposure list and a plan. *In vivo* exposure is regularly practiced and monitored until the end of the treatment. During the next stage, the client is encouraged to confront an unpleasant/difficult discomfort inducing memory in order to practice desensitization and control physiological arousal. Using the safe place card on one side and a symbolic representation of a distressful (non-traumatic) memory on another card, the client goes through a process of "pendulation" between the cards until anxiety habituation is established. In addition, the client is invited to mobilize fantastic reality (or playfulness and empowerment) adding a third card that "may protect" the quality of the safe space as a calm and reassuring one. This new card, placed between the safe space card and the unpleasant card, is referred to as a "protective card". It is fascinating to see how this 'card' moderates the arousal. During the last part of the therapeutic process, the client practices re-narration of the trau-

Fig. 2. Stage 5: Creating safe place through therapeutic cards with extension in drawing (21.0 cm × 29.7 cm).

Fig. 3. Stage 7: Re-narration in the fantastic reality using COPE, SAGA and HABITAT therapeutic cards (available from: http://www.oh-cards.com/index.html).

matic experience in the fantastic reality, using therapeutic cards (see Fig. 3).

During the re-narrations, the clients choose several cards representing the traumatic event and are encouraged to observe the cards, and they are asked to narrate the story over again. In the sequel, clients are asked to choose and remove the cards they "wish to" exclude, or to reorder the sequence of cards, and retell the story. This helps them to experiment with possibilities, "play" with alternatives and gain control over their story. Last, they are instructed to add new "as if" cards to the array. These cards should represent things or people of whom, if the clients had had them during the incident, they could have assisted the clients without changing the consequences. Exposure in FR and re-narration help the therapist indicate where the client is "stuck", where she or he froze and which parts are very painful (memories which are subjectively highly distressing), and then reprocess and re-narrate them with the client using cards. At the end of each exposure session, the clients return to their anchored 'safe place-card' and they are asked what they have learned during the process. At the end of the treatment the therapist and the client summarize, evaluate and discuss the therapeutic process.

Hypothesis. Whilst the literature reveals a vast amount of research regarding EMDR, SEE FAR CBT has not yet been tested enough and requires consistent inquiry in order to estimate its effectiveness. Moreover, this study is vanguard in empirically examining the influence of this new treatment approach on PTSD symptoms. We hypothesized that both treatment groups (EMDR and SEE FAR CBT) would show a significant decrease in PDS subscales and total severity scores below clinical levels from pre- to post-test conditions.

Results

The PDS total severity scores were analyzed in a 3×2 factorial analysis of variance (ANOVA) repeated measures with time (pre-treatment vs. post-treatment vs. follow-up) as a within-subject factor and condition (EMDR vs. SEE FAR CBT) as a between subjects factor. Table 3 shows descriptive statistics of main and interaction effects, and Fig. 4 illustrates these effects.

The ANOVA yielded a significant time main effect, $F(2,38) = 46.05$, $p < .001$, $\eta_p^2 = 0.71$, but no significant effects of condition, $F(1,19) = .24$, *ns*, and interaction of time over condition $F(2,38) = 0.21$, *ns*. Application of ANOVA on intrusion, avoidance, and arousal scores yielded significant time main effects, $F(1,19) = 25.27$, $p < .001$, $\eta_p^2 = 0.57$, $F(1,19) = 27.27$, $p < .001$, $\eta_p^2 = 0.59$ and $F(1, 19) = 30.71$, $p < .001$, $\eta_p^2 = 0.62$ (respectively), but no significant effect of condition, $F(1,19) = .55$, *ns*, $F(1,19) = .07$, *ns*, and $F(1,19) = .21$, *ns* (respectively), and no interaction effect of time over condition, $F(2,38) = 0.40$, *ns*, $F(2,38) = 1.15$, *ns*, and $F(2,38) = 0.01$, *ns*, (respectively).

Table 3
Means, standard deviations and repeated measures analyses of variance (ANOVA) of PTSD total severity and subscale measures.

Measurement	Condition	Pre-treatment	Post-treatment	Follow-up	ANOVA repeated measures		
		M (*SD*)	*M* (*SD*)	*M* (*SD*)	Time $F_{2,38}$	Condition $F_{1,19}$	Time × condition $F_{2,38}$
PDS[a] total	EMDR	30.25 (7.97)	13.75 (7.56)	14.83 (8.34)	37.64*	.79	.18
	SEE FAR CBT	29.56 (8.80)	12.78 (10.88)	11.78 (10.58)			
Intrusion	EMDR	1.92 (0.61)	1.02 (0.76)	1.00 (0.64)	25.27*	.55	.41
	SEE FAR CBT	1.92 (0.53)	0.72 (0.46)	0.83 (0.78)			
Avoidance	EMDR	1.46 (0.59)	0.54 (0.36)	0.89 (0.52)	27.27*	.07	1.15
	SEE FAR CBT	1.51 (0.78)	0.61 (0.65)	0.60 (0.69)			
Arousal	EMDR	2.06 (0.75)	1.06 (0.57)	0.81 (0.47)	30.71*	.21	.01
	SEE FAR CBT	1.94 (0.53)	0.97 (0.96)	0.71 (0.61)			

* $p < .001$ (two-tailed).
[a] PDS, Post-traumatic stress Diagnostic Scale. EMDR, eye movement desensitization and reprocessing ($n = 12$); SEE FAR CBT, somatic experiencing–fantastic reality–cognitive behavioral therapy ($n = 9$).

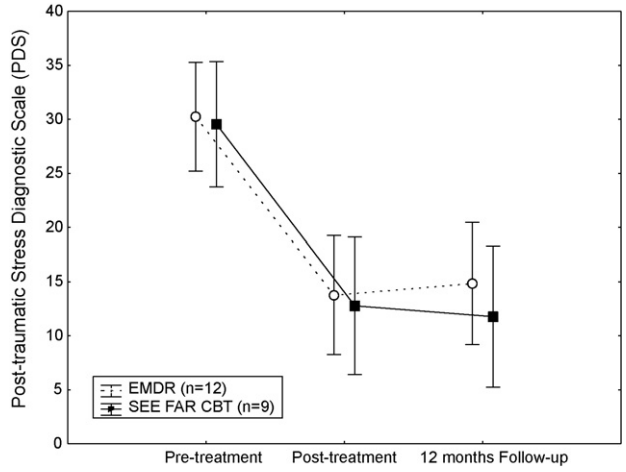

Fig. 4. Comparison of EMDR vs. SEE FAR CBT PTSD scores over assessment points ($n = 21$).

Post hoc comparisons using the Tukey HSD indicated statistically significant ($p < 0.05$) decreases in PDS total and subscale scores from pre-treatment to post-treatment, and from pre-treatment to follow-up for EMDR and SEE FAR CBT, but not significant differences from post-treatment to follow-up for either group. In addition, it showed no difference in PTSD symptoms between therapies at any given assessment point.

At post-treatment, eight (78%) of SEE FAR CBT patients, as opposed to five (42%) of EMDR patients, reported subclinical PTSD, $\chi^2(1, n = 21) = 2.74$, *ns*. At the 1-year follow-up, six (56%) of SEE FAR CBT reported subclinical PTSD scores, while 42% of EMDR patients reported subclinical scores, $\chi^2(1, n = 21) = 0.40$, *ns*. However, eight (89%) of SEE FAR CBT and nine (75%) of EMDR patients were found to exhibit mild to moderate severity of PTSD symptoms at 1-year follow-up, $\chi^2(3, n = 21) = 3.76$, *ns*.

Discussion

The current study aimed to introduce a novel therapeutic approach combining a creative method with cognitive behavioral therapy for treating PTSD, and to test its efficacy in alleviating PTSD symptoms. In accordance with the first hypothesis, significant reduction in PDS subscales and overall severity scores were found in both EMDR and SEE FAR CBT participants. The current results replicate prior research findings for EMDR effectiveness in treating post-traumatic symptoms (Davidson & Parker, 2001), and for the first time shed empirical light on SEE FAR CBT's effective capabilities in reduction of PTSD symptoms. Bisson et al.'s (2007) systematic review and meta-analysis of psychological treatments for chronic post-traumatic stress disorder suggests that "trials of psychological treatments are required, including further comparison studies of one type of psychological treatment against another" (Bisson et al., 2007, p. 102). In order to utilize these recommendations SEE FAR CBT was compared to a well-established psychotherapy, EMDR, which has repeatedly shown its effectiveness in improving trauma-related symptoms (Davidson & Parker, 2001). Since interaction effects of time over condition, and condition main effect were not found to be significant, indicating no supremacy for either treatment, we might estimate SEE FAR CBT's role as a short and long term PTSD symptom alleviator.

Results of past comparative studies reveal no significant change from baseline to post-treatment when comparing EMDR to other therapies, like cognitive restructuring, PE, and trauma-focused cognitive behavioral therapy (TFCBT) (Bisson et al., 2007; Power et al., 2002). Nevertheless, the results indicate non-significant increased drift in PTSD symptoms on follow-up measurements among EMDR patients (Rothbaum, Astin and Marsteller, 2005). The current study showed similar patterns among EMDR patients, but not among SEE FAR CBT patients. Current results suggest that SEE FAR CBT is an effective approach in treating PTSD cluster symptoms for adults, maintaining its effect for a 1-year follow-up period. Prior findings of comparative and controlled trials show that EMDR has been found slightly more effective than other therapies (such as exposure, PE, relaxation) (Spates et al., 2009), while other studies have shown opposite results in which EMDR was slightly inferior to other therapies (Rothbaum, Astin, & Marsteller, 2005; Taylor et al., 2003). In the present study, descriptively, SEE FAR CBT showed greater reduction of overall post-traumatic symptoms over a 1-year period but, as mentioned, this difference was not found statistically significant. Although not reaching statistical significance, it is worth considering the role of SEE FAR CBT in maintaining low avoidance symptoms in comparison to EMDR. We suggest that the lower avoidance symptoms may be due to SEE FAR CBT's extensive focus on the cognitive behavioral approach emphasizing *in vivo* exposure, habituation of fearful responses to trauma-relevant stimuli and correction of erroneous probability estimates of danger (Foa et al., 2009). Nevertheless, the descriptive increased reduction in intrusion symptoms over time among SEE FAR CBT participants might suggest the hypnotic function of repeated stimulation of the visual cortex during exposure, which will be discussed later.

Symptom focused cognitive therapy is undoubtedly effective in treatment of patients suffering from post-trauma. Its effectiveness is claimed to result from the use of cognitive models of memory affecting frontal areas of the brain, and the effect of exposure (Foa et al., 2009). Cognitive behavioral models for treatment of post-trauma disorders show the importance of chronological re-narration and resuming daily tasks in reality. They also prove the importance of discussion and of the patient giving significance to the event in terms of his understanding and knowledge at the time that the traumatic event took place or thereafter. However, for the purpose of creating a solid narrative, all of the effective methods use imagination (without discussing the effectiveness of this mechanism). Imaginal exposure and re-narration are used in both PE and EMDR when the client imagines (brings forth in his mind's eye) the event. SEE FAR CBT suggests a different focus for its effectiveness and thus a different model of treatment which puts much more emphasis on three specific elements: the visual stimuli supposedly activating the visual cortex, the observing position known as aesthetic distancing, and the ability to introduce positive wishful, empowering elements conceptualized as fantastic reality.

Evidence from neuroscience studies suggests that during repeated trauma-related imagery tasks, PTSD participants exhibit many more nonverbal patterns of memory retrieval, characterized by a right-lateralized pattern of activation, including paralimbic and visual areas (Lanius et al., 2004). We suggest that by asking the client to consciously choose images on cards that represent the traumatic incident (a subjective choice of images, colors, and shapes) and arranging these cards in a sequence, we offer better access to the "situationally accessible memory" (SAM) memory system, hypothesized by Brewin, Dalgleish, and Joseph (1996) in their dual representation theory. To initiate the intrusive images and physiological responses among PTSD clients, the image-based SAM system contains lower level perceptual processing of the traumatic scene, such as smells and sights which were not stored in the "verbally accessible memory" (VAM). Memories in the SAM are not represented within a complete personal context comprising past, present, and future, and must be processed in order to be recorded in the VAM system. Thus, the repeated recollection of the event coupled with the illustrations activates the visual cortex and establishes a connection with the prefrontal cortical areas while being assisted by the narration which follows it.

Although substantial research recognizes the predictive role of dissociation in subsequent development of PTSD (Briere, Scott, & Weathers, 2005), and specifically of the peri-traumatic dissociation (Ozer, Best, Lipsey, & Weiss, 2003), dissociative mechanisms are also mentioned in the literature as a psychological coping apparatus which enables the individual to escape the overwhelming traumatic incident, when actual physical escape is not available (Van der Kolk et al., 1996; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Some research even indicates the mitigating role of certain distinct dissociative experiences, when facing a life threatening situation, such as near death experiences (NDE), on subsequent development of PTSD symptoms (Greyson, 2001). More recently, Kaplansky's (2009) study of NDE versus PTSD subjects can be seen as an illustration of the power of imagination as protective factor when facing traumatic situations. She compared PTSD patients and NDErs both exposed to war and terror incidents and found that people who had had NDE, a form of transcendence into fantastic reality otherwise known as peri-traumatic dissociation (Greyson, 2001), did not suffer from PTSD nor anxiety nor pathological dissociation as measured by the Dissociative Experiences Scale (Kaplansky, 2009). When comparing the type of NDE between PTSD and the NDE non-PTSD group, she found that whereas they both experienced all the types of NDE (i.e., out of body, floating, tunnel and light, meeting spiritual figures, and life in front of my eyes), the PTSD group experienced the "life in front of my eyes" cluster far more than the NDE non-PTSD group (70% compared to 7%, respectively). In other words whereas the non-PTSD NDE's dissociation was mostly fantastic the PTSD dissociation confronted them with their coming mortality, anxiety, remorse and the pain of parting from their loved ones. Kaplansky (2009) suggests that those people who developed PTSD had only a partial dissociation experience, that is partial awareness of their coming death or extreme terror combined with some dissociative/NDE experience, not allowing them, hypothetically, fully transcend into fantastic reality, whereas the NDE subjects had been able to transcend into fantastic reality and hardly had any "life as a movie" phenomena thus suggesting they experienced full and protective dissociation.

Based on this study, we wish to propose that the dissociative flashbacks of patients with PTSD may be the client's brain attempts to complete the originally disrupted course of full transcendence into fantastic reality. A mechanism that with the slightest reminder provokes anxiety and fear and stops the process of full recollection. Our suggestion is that all exposure therapy is basically allowing this transcendence into fantastic reality by asking the client to *imagine* the incident *as if* it happens now. Moreover, the uniqueness of the SEE FAR CBT protocol is the introduction of possibilities into otherwise "frozen" memory by suggesting to the client the possibility to remove unpleasant cards and retell the story or the instruction to experiment with the "as if or if only" cards of what could have helped without changing the outcome. This process empowers the client to withstand the impossible story with some inner real or imaginative resources. We suggest that the observation of the visual sequence creates a competing positive visual stimulus that directly affects the visual cortex and the memory systems and eventually is encoded as a modified "memory" to the traumatic one, or at least a more flexible succession of the event. While previously exhibiting very high levels of hypnotizability as compared to subjects with different psychological disorders and control group (Spiegel, Hunt, & Dondershine, 1988), taking into account the close link between the ability to be hypnotized and the tendency to fantasize (Wilson & Barber, 1983; Lynn & Ruhe, 1988), we propose that PTSD patients may be "experts" in fantasy and imagination, and that despite the fact that the use of imagination is expressed in a negative way (i.e., flashbacks), it is still possible to use the fantasy to create alternatives to their traumatic story.

The observer position is unique to this treatment. In none of the other effective psycho-trauma protocols does the client observe his/her traumatic story as a distant, observable story. It is the distancing within the art form which both contains the experience and allows it to be seen from many perspectives. In aesthetic distancing "the 'in-between' or 'liminal' state allows the individual to look at the situation through identification and distancing at the same time" (Tselikas-Portman, 1999, p. 9). Aesthetic distance, according to Landy (1996) is the midpoint that is a balance of affect and cognition; "an ideal state in which one is able to think feelingly and feel without the fear of being overwhelmed with passion" (p. 48). The positive impact of being an "audience in your own drama/trauma" has been described by Greenberger (2005) in her research on Holocaust survivors. The effect of aesthetic distance (Landy, 1996), that is, of observing one's own traumatic story as it unfolds through projective/associative cards, plus the ability to remove unpleasant parts and reintroduce wishful elements might create an empowering effect, and thus change the helpless position of the PTSD client. We suggest that the fact that the client slowly learns to play using the cards and fantastic reality, the rigid haunting memories and especially the intrusive ones reduce their power over him/her. The new concept of fantastic reality being the "as if" place where all "ifs" are possible offers an imaginary space complete with aesthetic distancing which creates a safe and secure place for the traumatized clients to re-experience and master their pain through metaphoric milieus. Another potential explanation of the effectiveness of the story being laid out before the client's eyes is the concept of externalization. Externalization's key purpose in narrative therapy is to separate the person from the problem thereby permitting the problem to be viewed from a variety of perspectives and contexts. This fosters client mastery over the problem. The externalization process is embedded within the deconstruction of dominant narratives in clients' lives that support and maintain their problems and the elicitation of subjugated narratives and unique outcomes that form preferred narratives in which the problem has no place (Freedman & Combs, 1996; Parry & Doan, 1994; White & Epston, 1990). Thus, by externalizing the traumatic story and introducing new possibilities, we manage to reduce its horrifying meaning and possibly reduce symptoms. In addition, some of these therapeutic elements were previously successfully used by Grunet, Weis, Smucker, and Christianson (2007) in their research on the imagery re-scripting and reprocessing technique. Hence, we may assume that SEE FAR CBT is recommended for both; non-fear and anxiety PTSD as well as to anger shame and guilt clients as suggested by Grunet et al. (2007). As for clients' tendency to dissociate, as well as control panic attack during the process by using the 'safe place 'card as a grounding and focusing outside method. Unlike the other methods we can also trace where the client has 'left' us (dissociate) as we follow his recount as he observe the cards in front of him. As the card is concrete evidence of where the client got "stuck" or disconnected. Pointing at that image and asking the client to look at it and continue, allows us to bring the client back on the track of retelling.

Limitations

The current study's relatively small sample size might make the generalization of the results to a broader population of psychotrauma patients difficult. However, considering this study to be preliminary, and comparing the study's sample size to some other pioneering and comparative study samples found in the literature usually consisting of no more than 15 patients per comparison or treatment group (Foa, Rothbaum, Riggs, & Murdock, 1991; Ironson, Freund, Strauss, & Williams, 2002; Shapiro, 1989), we use similar sample sizes. As mentioned, the study sample was taken from a very specific population, those exposed to and mentally afflicted by

war. Involuntarily excluding crime, motor vehicle accidents, occupational injuries, rape, assault and natural disaster victims from the study might be a weakness that should be considered in the future. An additional major limitation of this study concerns the randomization of the participants into treatment groups. Being chosen for treatment groups by the existence of a free spot might have created a bias and influenced the final outcomes. Although randomization is significant and a standard requirement in clinical studies (Foa et al., 2009), previous comparative studies have not always applied this method of selection in its conventional way (Cahill, Rothbaum, Resick, & Follette, 2009; Pitman et al., 1996; Sherman, 1998; Simon, 2000). Lack of initial information on existent pharmacological treatment or co-morbid disorders might limit the extent to which we can conclude and draw a clear and complete picture of treatment's efficacy. Finally, assessment of psychopathology using a single self-reported measure for PTSD might limit the efficacy of the model in the alleviation of other symptoms (i.e., depression, anxiety, somatic complains, etc.). Nevertheless, the first EMDR paper, presented by Shapiro (1989) used a single SUDs measure to report reduction in anxiety following treatment.

Future recommendation

As results were exploratory only, significant future investigation of this integrative model is warranted which should be interpreted with great caution. Using an extended battery of self-report scales, randomized group assignment, control group and enlarged sample size would assist in genuine evaluation of the model. Expanding the implementation of the model to wider age ranges (especially children and adolescents), adapting the treatment protocol cross-culturally, and empirically monitoring these developments should be considered of high importance. SEE FAR CBT is a novel attempt to combine creative methods with a CBT, which emphasizes the role of imaginal re-narration of the traumatic event with the use of cards as a means of externalization. Thus, it is important to systematically compare TFCBT methods such as PE with SEE FAR CBT to determine the relative role of the application of therapeutic cards on dissociative symptoms and PTSD intrusive symptoms. Later on, a randomized controlled design, accounting for possible individual differences in imaginative capacity or involvement should be carried out. In addition, in the future, it would be significant to explore the immediate neural correlates of the traumatic story re-narration, and the long lasting anatomical and functional changes in the brain due to such therapeutic intervention.

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