Cognitive Processing Therapy
Veteran/Military Version:

THERAPIST'S MANUAL

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How to Use This Manual

Parts I, II, and III

The Veteran/military version of the therapist's manual for Cognitive Processing Therapy (CPT) has been organized to maximize the ease with which therapists prepare for and conduct CPT.

Part I includes background information on CPT and other common issues related to PTSD that may arise during the therapy. We recommend that therapists read the entire manual before meeting with patients.

Part II includes instructions on each of the 12 sessions. Each session opens with a summary that briefly outlines the format of the session and gives recommended times for each segment of the session. Each segment is then reviewed in detail, with goals, rationale, and sample dialogue. Call-outs are located throughout this section in the right margins of the text to allow therapists to quickly locate specific topics. Sample session progress notes follow the close of each session to facilitate tracking of therapist/patient progress. Relevant patient handouts also follow each session; please refer to the Materials Manual for additional information on handouts.

Part III offers information on alternatives to conducting CPT, including variations of CPT and adaptations of CPT for group administration.

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| Part 1: | Introduction to Cognitive Processing Therapy (CPT)

Cognitive Processing Therapy (CPT) is a 12-session therapy that has been found effective for posttraumatic stress disorder (PTSD) and other corollary symptoms following traumatic events (Monson et al., 2006; Resick et al., 2002; Resick & Schnicke, 1992, 1993[1]). Although the research on CPT focused on rape victims originally, we have used the therapy successfully with a range of other traumatic events, including military-related traumas. This revision of the manual is in response to requests for a treatment manual that focuses exclusively on military trauma. The manual has been updated to reflect changes in the therapy over time, particularly with an increase in the amount of practice that is assigned and with some of the handouts. It also includes suggestions from almost two decades of clinical experience with the therapy.

Theory Behind CPT

- Theory behind CPT

CPT is based on a social cognitive theory of PTSD that focuses on how the traumatic event is construed and coped with by a person who is trying to regain a sense of mastery and control in his or her life. The other major theory explaining PTSD is Lang's[2] (1977) information processing theory, which was extended to PTSD by Foa, Steketee, and Rothbaum[3] (1989) in their emotional processing theory of PTSD. In this theory, PTSD is believed to emerge due to the development of a fear network in memory that elicits escape and avoidance behavior. Mental fear structures include stimuli, responses, and meaning elements. Anything associated with the trauma may elicit the fear structure or schema and subsequent avoidance behavior. The fear network in people with PTSD is thought to be stable and broadly generalized so that it is easily accessed. When the fear network is activated by reminders of the trauma, the information in the network enters consciousness (intrusive symptoms). Attempts to avoid this

- Emotional processing theory of PTSD

[1] Monson, C. M., Schnurr, P. P., Resick, P. A., Friedman, M. J., Young-Xu, Y., & Stevens, S. P. (2006). Cognitive processing therapy for Veterans with military-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 74, 898–907*; Resick, P. A., Nishith, P., Weaver, T. L., Astin, M. C., & Feuer, C. A. (2002). A comparison of cognitive processing therapy, prolonged exposure and a waiting condition for the treatment of posttraumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology, 70*, 867–879; Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology, 60*(5), 748–756; Resick, P. A., & Schnicke, M. K. (1993). *Cognitive processing therapy for rape victims: A treatment manual.* Newbury Park, CA: Sage Publications.

[2] Lang, P. J. (1977). Imagery in therapy: An information processing analysis of fear. *Behavior Therapy, 8*, 862–886.

[3] Foa, E. B., Steketee, G. S., & Rothbaum, B. O. (1989). Behavioral/cognitive conceptualizations of posttraumatic stress disorder. *Behavior Therapy, 20*, 155–176.

activation result in the avoidance symptoms of PTSD. According to emotional processing theory, repetitive exposure to the traumatic memory in a safe environment will result in habituation of the fear and subsequent change in the fear structure. As emotion decreases, patients with PTSD will begin to modify their meaning elements spontaneously and will change their self-statements and reduce their generalization. Repeated exposures to the traumatic memory are thought to result in habituation or a change in the information about the event, and subsequently, the fear structure.

- Social cognitive theories

Although social cognitive theories are not incompatible with information/emotional processing theories, these theories focus beyond the development of a fear network to other pertinent affective responses such as horror, anger, sadness, humiliation, or guilt. Some emotions such as fear, anger, or sadness may emanate directly from the trauma (primary emotions) because the event is interpreted as dangerous, abusive, and/or resulting in losses. It is possible that secondary, or manufactured, emotions can also result from faulty interpretations made by the patient. For example, if someone is intentionally attacked by another person, the danger of the situation would lead to a fight-flight-freeze response, and the attending emotions might be anger or fear (primary). However, if in the aftermath, the person blamed himself[4] for the attack, the person might experience shame. These manufactured emotions would have resulted from thoughts and interpretations about the event rather than the event itself. As long as the individual keeps saying that the event was his fault, he will keep producing shame (hence, manufactured).

Social-cognitive theories focus more on the *content* of cognitions and the effect that distorted cognitions have on emotional responses and behavior. In order to reconcile information about the traumatic event with prior schemas, people tend to do one or more of three things: assimilate, accommodate, or over-accommodate. Assimilation is altering the incoming information to match prior beliefs (*"Because a bad thing happened to me, I must have been punished for something I did"*). Accommodation is altering beliefs enough to incorporate the new information (*"Although I didn't use good judgment in that situation, most of the time I make good decisions"*). Over-accommodation is altering one's beliefs about oneself and the world to the extreme in order to feel safer and more in control ("*I can't ever trust my judgment again*"). Obviously, therapists are working toward accommodation, a balance in beliefs that takes into account the reality of the traumatic event without going overboard.

In a social-cognitive model, affective expression is needed, not for habituation, but in order for the affective elements of the stored trauma memory to be changed. It is assumed that the natural affect, once accessed, will dissipate rather quickly and will no longer be stored with the trauma memory. Also, the work of

[4] Throughout this manual, we will refer to a single patient using the pronouns "he" and "she" alternately, rather than saying "she/he" or "him/her." The term "service member" will also be used as a generic term rather than marine, sailor, airman, etc., and will be used interchangeably with Veteran.

accommodating the memory and beliefs can begin. Once faulty beliefs about the event (self-blame, guilt) and over-generalized beliefs about oneself and the world (e.g., safety, trust, control, esteem, intimacy) are challenged, then the secondary emotions will also decrease along with the intrusive reminders. The explanation that CPT therapists give to patients about this process is described in Session 1 along with a handout in the patient materials section.

PTSD as Disorder of Non-Recovery

- PTSD symptoms

Because we know that PTSD symptoms are nearly universal immediately following very serious traumatic stressors and that recovery takes a few months under normal circumstances, it may be best to think about diagnosable PTSD as a disruption or stalling out of a normal recovery process, rather than the development of a unique psychopathology. The therapist needs to determine what has interfered with normal recovery. In one case, it may be that the patient believes that he will be overwhelmed by the amount of affect that will emerge if he stops avoiding and numbing himself. Perhaps he was taught as a child that emotions are bad, that "real men" don't have feelings, and that he should "just get over it." In another case, a patient may have refused to talk about what happened with anyone because she blames herself for "letting" the event happen and she is so shamed and humiliated that she is convinced that others will blame her, too. In a third case, a patient may have seen something so horrifying that every time he falls asleep and dreams about it, he wakes up in a cold sweat. In order to sleep, he drinks heavily. Another patient is so convinced that she will be victimized again that she refuses to go out any more and has greatly restricted her activities and relationships. In still another case, in which other people were killed, a patient experiences survivor guilt and obsesses over why he was spared when others were killed. He feels unworthy and experiences guilt whenever he laughs or finds himself enjoying something. In all these cases, thoughts or avoidance behaviors are interfering with emotional processing and cognitive restructuring. There are as many individual examples of things that can block a smooth recovery as there are individuals with PTSD.

Pre-Therapy Issues

1. Who Is Appropriate for CPT?

- Who is appropriate for CPT?

CPT was developed and tested with people with a wide range of comorbid disorders and extensive trauma histories. In research settings, we have implemented the protocol with people who were from 3 months to 60 years post-trauma (worst trauma), although we have used it clinically for more recent traumas. We have implemented the protocol successfully with people who had no more than a fourth-grade education and as little as an IQ of 75 (although in both cases, we needed to modify the worksheets somewhat). In research protocols, people have met full criteria for a PTSD diagnosis, but there is no reason that it could not be implemented with someone who is subthreshold for diagnosis. However, if the person does not have PTSD at all and has some other diagnosis

(e.g., depression only, anxiety disorder), one should implement treatment protocols for those disorders (i.e., just because someone has experienced a traumatic event does not mean that she has PTSD). Clinical considerations as to whether CPT is appropriate can follow the exclusion criteria we have used for clinical trials except for those that were for purely methodological reasons (e.g., stable psychopharmacological regimen). First and foremost, if someone is a danger to self or others, treatment of PTSD is not the most immediate treatment goal. Likewise, if someone is in imminent danger, such as those who are being stalked or are in an actively abusive relationship, then the first order of business is safety planning. In contrast, just because someone might be redeployed to a combat zone does not mean that he could not be treated successfully before redeployment. The potential for trauma in the future is something we all live with, so the possibility of future violence or trauma should not stop treatment now. In fact, successful treatment of PTSD may actually reduce risk for future PTSD.

If someone cannot engage in treatment for his PTSD because he is so dissociative or has such severe panic attacks that he cannot discuss the trauma at all, then other therapy may need to precede CPT (e.g., grounding techniques, panic control treatment). Depression is the most common comorbidity and is not a rule-out unless the person cannot engage in therapy at all due to the severity of the depression. We have implemented the CPT protocol with those who are abusing substances, but typically not in an outpatient setting if they are substance dependent. However, once someone has stabilized after detoxification, he may be able to engage in CPT. These decisions need to be made on a case-by-case basis in consultation with the patient. The motivation of the patient to reduce her PTSD symptoms may be the most important consideration in whether to proceed with the protocol. Coping skills development is not a part of the protocol, but a therapist may choose to train her patients in affect tolerance skills if she determines that the patients' skills in this area are so poor that they will act out and engage in self-harm behavior when thinking or talking about the traumatic event. In these cases, the therapist may also consider implementing the CPT-C (without the written trauma account component) rather than CPT (discussed later in Part III of this manual).

2. When Should the CPT Protocol Begin?

- When should the CPT protocol begin?

We are frequently asked if it is important to develop a relationship with the patient before beginning any trauma work. Our answer is no, this is not necessary. In fact, if a therapist waits for weeks or months to begin trauma work in the absence of any of the contraindications listed above, the patient may receive the message that the therapist thinks that she is not ready or able to handle trauma-focused therapy. This reluctance on the part of the therapist may collude with the patient's natural desire to avoid this work (as part of her PTSD avoidance coping). The therapeutic relationship develops quickly within the protocol when the therapist is using a Socratic style of interacting, because the therapist is demonstrating to the patient her deep interest in understanding exactly how the patient thinks and feels through these questions. Also, if additional time is taken

that is not CPT-focused, there is a risk of developing a manner of interacting that will have to be reshaped in order to deliver the manualized therapy (see below regarding CPT with established patient).

- Starting the CPT protocol with a new patient

New Patient. We recommend that with a new patient, the therapist begins the CPT protocol within one to three sessions of assessment and information gathering. Once the therapist determines that the patient indeed has PTSD, is interested in treatment for these symptoms, and that other symptoms and life events are not interfering with treatment, the therapist can introduce the protocol and the contract for CPT (see the Therapist Materials section of the Materials Manual).

- Starting the CPT protocol with an established patient

Established Patient. It is somewhat more difficult to transition from another form of therapy with an established patient to CPT than it is to introduce the protocol to a new patient. We believe that the best method of introducing CPT is to transparently discuss the possibility of this change with the patient. If a therapist has been seeing a patient for months or years and there has been no significant improvement in some time, this provides a good opportunity to reassess where the patient is with regard to symptoms and to suggest a new approach. The therapist can tell the patient that he has received new training on a protocol that has now been found to be effective with Veterans with PTSD. It is quite acceptable to tell the patient that you have received new training. The patient should be happy that you are staying current with the latest procedures (as you would with your doctors). The therapist should explain how this therapy protocol is different in both style and content from the therapy they have received up to this point. If the therapist has not been using a cognitive-behavioral approach, using practice assignments, following a specific agenda during sessions, or focusing on a specific traumatic event, this change can be quite dramatic. However, in conducting supervision with VA therapists who have transitioned their patients to CPT, there has rarely been a problem as long as the therapist explains the rationale for the change and how the therapy would differ. The onus is very much on the therapist to establish and follow the new therapy process because, in our experience, patients with PTSD are happy to revert to a non-trauma-focused therapy.

If changing formats within the context of a long-term therapy relationship appears too daunting, another approach is to switch patients with another therapist who is also learning CPT. The therapists can explain to the patients that they recommend this change to another format of therapy in order for the patient to obtain the most recent advances in the treatment of PTSD and that a fresh start with another therapist might prove to be easier for both parties. Honesty in this matter is the best approach.

3. Treatment Contracting for CPT

Regardless of whether someone is a new or an established patient, before starting the protocol, the therapist should explain what is expected of both patient and

therapist. This therapy protocol is typically conducted in 12 sessions, which could be administered once or twice a week. The therapy will focus to begin with the worst traumatic event, although it can move to other events after Session 5. The patient will be expected to attend all sessions regularly (once a month is not sufficient) and to complete the practice assignments. The therapist will agree to adhere to the protocol and focus on the PTSD for this period of time. It is helpful for the therapist to explain that her job will also be to recognize and discourage the patient's avoidance behaviors that have maintained the PTSD.

In the Therapist Materials section of the Materials Manual there is a patient contract that can be used to demark the work that will be done and to engage the patient in the process.

Overview of CPT Sessions

- Overview of CPT sessions

The contents of each session are described in Part 2 along with issues that therapists are likely to encounter. The therapy begins with an education component about PTSD, and the patient is asked to write an Impact Statement in order for the patient and therapist to begin to identify problem areas in thinking about the event (i.e., "stuck points"). The patient is then taught to identify and label thoughts and feelings and to recognize the relationship between them. The next two sessions focus on generating a trauma account of the worst traumatic incident, which is read to the therapist in session. During these first five sessions, the therapist uses Socratic questioning to begin to challenge distorted cognitions, particularly those associated with assimilation, such as self-blame, hindsight bias, and other guilt cognitions. Thereafter, the sessions focus on teaching the patient cognitive therapy skills and finally focus on specific topics that are likely to have been disrupted by the traumatic event: safety, trust, power/control, esteem, and intimacy.

After the individual CPT protocol is described in detail, there are subsequent sections on using the protocol without the written trauma account component, a section on delivering CPT in a group format, and a section on treatment issues with comorbid disorders.

- Order of sessions

It is strongly recommended that the protocol be implemented in the order presented here. The skills and exercises are designed to build on one another, and even the modules in the last five sessions follow in the hierarchical order in which they are likely to emerge with patients. However, when implemented in individual therapy, the last five sessions may be modified depending on the particular issues that a patient reports. For example, if a patient has severe safety issues but no issues with esteem or intimacy, then the therapist may want to skip the later two modules and focus more time on safety. Conversely, if someone has no safety or control issues but is primarily troubled with self-trust and self-esteem issues, then the therapist may want to spend more time on those modules. However, even if a patient has not mentioned an issue within a particular domain of functioning (safety, trust, power/control, esteem, intimacy), it may be helpful for her to read

the module and complete worksheets on any stuck points that become apparent. It is not unusual for the modules to reveal issues that had not been identified earlier in therapy.

- Format of each session

The usual format for sessions is to begin with review of the practice assignments using the Practice Assignment Review, located in the Therapist Materials section of the Materials Manual, followed by the content of each specific session. The Practice Assignment Review helps facilitate the patient's compliance with out-of-session practice assignments because of the therapist specifically inquiring about these assignments at the beginning of therapy sessions (starting with Session 2). Review of this form at the beginning of the sessions also decreases the likelihood of getting off protocol due to an immediate focus on the assignments. During the last 5 or so minutes of the session, the assignment for the next week is introduced and is accompanied by the necessary explanation, definition(s), and handouts. It is not recommended that the therapist start a general discussion at the beginning of the session but should begin immediately with the practice assignment that was assigned. If the patient wishes to speak about other topics, we either use the topic to teach the new skills we are introducing (e.g., put the content on an A-B-C Worksheet) or we save time at the end for these other topics, reinforcing the trauma work with discussion of the topic. If the therapist allows the patient to direct the therapy away from the protocol, avoidance will be reinforced, along with disruption in the flow of the therapy. In addition, placing the practice assignments last in the session will send a message to the patient that the practice assignments are not very important and may lead to less treatment adherence on the part of the patient. Among the most difficult skills for the therapist to master, especially if he or she has been trained in more nondirective therapies, is how to be empathic but firm in maintaining the protocol. If a patient does not bring in his practice assignment one session, it does not mean that the therapy is delayed for a week. The therapist has the patient do the assignment orally (or they complete a worksheet together) in the session and reassigns the uncompleted assignment along with the next assignment.

Socratic Questioning Within CPT

- Socratic questioning

There are several styles of cognitive therapy within the general class of cognitive therapies. CPT is designed to bring patients into their own awareness of the inconsistent and/or dysfunctional thoughts maintaining their PTSD. Accordingly, a cornerstone part of the practice of CPT is Socratic questioning. Throughout the course of treatment, therapists should be consistently using Socratic questioning to induce change, with the goal of teaching patients to question their own thoughts and beliefs. Because the method is so integral to CPT, we have included more general information here about what Socratic questioning is, and types and examples of Socratic questions that can be posed.

Socratic questioning originated from the early Greek philosopher/teacher Socrates. He believed that humans had innate knowledge and that this knowledge could be revealed by another person asking specific questions. He also contended

that humans who came into knowledge, versus being told, were more likely to retain the information and build on that knowledge to acquire more knowledge. Socratic questioning is routinely used in American law schools, in some forms of cognitive therapy, and specifically in CPT.

Socrates was convinced that thoughtful questioning enabled the logical self-examination of ideas and facilitated the determination of the validity of those ideas. As described in the writings of Plato, a student of Socrates, the teacher feigns ignorance (à la "Columbo" in the modern ages) about a given subject in order to acquire another person's fullest possible knowledge of the topic. With the capacity to recognize contradictions, Socrates assumed that incomplete or inaccurate ideas would be corrected during the process of disciplined questioning and hence would lead to progressively greater truth and accuracy.

Applied to CPT, the purpose of Socratic questioning is to challenge the accuracy of patients' thinking in a way that will help alleviate their psychological distress. As the therapy unfolds, the patient is taught how to use Socratic questioning on himself. Socratic questioning involves subtle methods. Therapists who are accustomed to delivering overtly directive psychotherapy may find it disconcerting at first to ask more questions and make fewer interpretive statements. Therapists who are accustomed to nondirective psychotherapy may initially be concerned that they are being coercive or too directive with the patient. Through Socratic questioning, the patient is empowered to take more credit than the therapist for change that occurs. We have found that this strategy fosters less dependence on the therapist and encourages patients to take more responsibility for their treatment. Further, the goal of Socratic questioning is never for the therapist to "win" an argument or to convince the patient to take the therapist's side. Instead, patients are allowed to fully explore their rationale for their thoughts in a safe environment. Used alone and in conjunction with the worksheets, Socratic questioning will help patients examine their problematic thinking that has been created or reinforced as a result of the traumatic event(s).

Socratic questioning consists of six main categories: clarification, probing assumptions, probing reasons and evidence, questioning viewpoints or perspectives, probing implications and consequences, and questions about questions (Paul, 2006). The categories build on one another, but it is also possible to shift from one category to another throughout a therapy session. Below are sample questions that can be used in sessions to help patients examine their beliefs.

1. Clarification

- Clarification questions

Patients often accept their automatic thought about an event as the only option. Clarification questions help patients examine their beliefs or assumptions at a deeper level, which can help to elicit more possible reactions from which to choose. These questions often fall into the "tell me more" category and are typified by the following:

- *What do you mean when you say…?*
- *How do you understand this?*
- *Why do you say that?*
- *What exactly does this mean?*
- *What do we already know about this?*
- *Can you give me an example?*
- *Are you saying…or…?*
- *Can you say that another way?*

2. Probing Assumptions

- Probing assumptions

Probing questions challenge the patient's presuppositions and unquestioned beliefs on which her argument is founded. Often patients have never questioned the "why" or "how" of their beliefs, and once the beliefs are held up to further inspection, the patient can see the tenuous bedrock that the beliefs are built on.

- *How did you come to this conclusion?*
- *What else could we assume?*
- *Is this thought based on certain assumptions?*
- *How did you choose those assumptions?*
- *How did you come up with these assumptions that…?*
- *How can you verify or disprove that assumption?*
- *What would happen if…?*
- *Do you agree or disagree with…?*
- *If this happened to a friend/sibling, would you have the same thoughts about them?*

3. Probing Reasons and Evidence

- Probing reasons and evidence

Probing reasons and evidence is a similar process to probing assumptions. When the therapist helps patients look at the actual evidence behind their beliefs, they often find that the rationale in support of their arguments is rudimentary at best.

- *How do you know this?*
- *Show me…?*
- *Can you give me an example of that?*
- *What do you think causes…?*
- *Are these the only explanations?*
- *Are these reasons good enough?*
- *How might it be refuted in court?*
- *Would these reasons stand up in a reputable newspaper?*
- *Why is…happening?*
- *Why?*
- *What evidence is there to support what you are saying?*
- *Has anyone in your life expressed a different opinion?*
- *Would _____ stand up in a court of law as evidence?*

4. Questioning Viewpoints and Perspectives

- Questioning viewpoints and perspectives

Often the patient has never considered other viewpoints but instead adopted a perspective that fits his needs for safety and control most readily. By questioning alternative viewpoints or perspectives, the therapist is in effect "challenging" the position. This will help the patient see that that there are other, equally valid, viewpoints that still allow the patient to feel appropriately safe and in control.

- *What alternative ways of looking at this are there?*
- *What does it do for you to continue to think this way?*
- *Who benefits from this?*
- *What is the difference between…and…?*
- *Why is it better than…?*
- *What are the strengths and weaknesses of…?*
- *How are…and…similar?*
- *What would…say about it?*
- *What if you compared…and…?*
- *How could you look at this another way?*

5. Analyzing Implications and Consequences

- Analyzing implications and consequences

Often patients are not aware that the beliefs that they hold lead to predictable and often unpleasant logical implications. When therapists help patients examine the potential outcomes to see if they make sense, or are even desirable, patients may realize that their entrenched beliefs are creating a large part of their distress.

- *Then what would happen?*
- *What are the consequences of that assumption?*
- *How could…be used to…?*
- *What are the implications of…?*
- *How does…affect…?*
- *How does…fit with what we learned in session before?*
- *Why is…important?*
- *What can we assume will happen?*
- *What would it mean if you gave up that belief?*

6. Questions About the Question

- Questions about the question

Patients may sometimes "challenge the therapist" or push therapist-patient boundaries by directly inquiring whether the therapist has experienced a specific traumatic event. For example, patients may ask the therapist directly, *"Have you ever been to war?"* or *"Have you ever been raped?"* In this often difficult situation, therapists may rely both on their good clinical judgment, as well as CPT-specific skills, to inquire why the patient might be interested in this information. It is up to each therapist's discretion about how much information s/he is willing to disclose. It is also important to consider, as always, the effect

that any disclosure would have on the patient and to use that information to guide your response.

We believe that it might be most useful at these points in therapy to gently *question the question*. By putting the focus back on the patient and his intentions, the patient can more thoroughly examine his reasons for asking these types of questions. It might be that the patient is attempting to find out whether the therapist can truly understand what he went through, or he may be avoiding discussing his own experience in detail by putting the focus on the therapist. Here are some possible ways to address these types of questions if they arise:

- *Are you wondering whether I will be able to handle hearing about your experience?*
- *Why is this information important to you? What would it mean to you if I did or did not share your experience?*
- *What would my answer either way mean to you?*
- *Are you concerned that I don't understand? Please tell me what you think I am missing. I would like to understand what the experience was like for you.*

Issues in Conducting CPT

- Therapist-patient agreement on therapy goals

Many therapists were never trained to conduct manualized psychotherapies and may feel uncomfortable with both the concept and the execution. It is important that the patient and therapist agree on the goal for the therapy (trauma work for PTSD and related symptoms) so that the goals do not drift or switch from session to session. Without a firm commitment to the treatment goals, when the therapy is "off track," the therapist may not know whether to get back on the protocol or to let it slide. As other topics arise, the therapist sometimes isn't sure whether, or how, to incorporate them into the sessions. A few words on these topics are appropriate here. Once therapists have conducted protocol therapy a few times, they usually find that they become more efficient and effective therapists. They learn to guide the therapy without tangents or delays. They find they can develop rapport with patients through the use of Socratic questions because the patients are explaining to the therapist exactly how they feel and think and the therapist expresses interest and understanding with these questions. There is usually enough time in the session to cover the material for the session and still have time for some other topics, such as things that came up that week or other current issues related to their PTSD (childrearing, job concerns, marital issues, etc.). However, if those are major issues, then the therapist will need to prioritize the order. It is inadvisable to try to deal with several types of therapy for different problems simultaneously.

1. Comorbidity

- Comorbidity

Although PTSD has very high rates of comorbidity (other disorders along with the PTSD), normally, comorbid depression, anxiety, and dissociation remit along

with PTSD. Therefore, we believe there is rarely a need to deal with other symptoms independently of the PTSD protocol.

Major depressive disorder, which occurs in approximately half of people with PTSD and substance abuse, the rates of which vary depending on the population being studied, are both commonly comorbid with PTSD. Anxiety disorders and personality disorders are also fairly common. Additionally, health problems are associated with PTSD. Fortunately, except for patients with substance dependence, CPT has been tested on patients with a range of disorders in addition to PTSD. Thus far, we have found that those with major depressive disorder improve as much as those without the disorder, although they may begin and end with higher levels of depressive symptoms. Patient-reported health symptoms improve significantly, and measures of anxiety and dissociation also improve over the course of treatment. Other complex symptoms such as an impaired sense of self and tension-reduction behaviors (e.g., self-harming behaviors and acting out) improve markedly with treatment. Nevertheless, there are considerations that should be mentioned with regard to comorbid disorders. Discussing all possible comorbid disorders is beyond the scope of this manual, so we have picked a few of the more common disorders for your consideration.

- Substance use disorders

Substance dependence should be treated before addressing PTSD, but substance-abusing patients may be treated with CPT if there is a specific contract for not drinking abusively during the therapy, and if there is a specific focus on the suspected role of abusive drinking as avoidance coping. Further, it may be possible to implement CPT immediately following substance abuse treatment. In fact, if the Veteran is following an inpatient admission for detoxification with a residential program, there may be a unique window of opportunity to treat PTSD. It is not unusual for intrusive recollections of traumatic events, particularly nightmares and flashbacks, to emerge after someone has stopped drinking or using drugs. The substance use may have served as a method to avoid these memories and to suppress unwanted emotions. So, after detoxification, these PTSD symptoms may reassert themselves. If the patient is motivated to work on his PTSD, or if the therapist can use the increase in symptoms as a motivator, there may be an opportunity to improve those PTSD symptoms before the patient can fall back into his usual coping method and relapse. At this point, based on clinical experience rather than research, our best predictor of success with CPT with this population is motivation to change. The therapist should ask in a very straightforward fashion whether the patient wants to improve his PTSD symptoms enough to refrain from alcohol or drugs for treatment to commence. Some patients have been able to tolerate CPT, including the account writing, fairly soon after stopping their substance abuse, while others announce that they will relapse if they talk about the trauma even years after sobriety. We take these patients at their word. If someone promises to relapse, we do not implement the protocol, but let them know that it is available when they are ready. Those who proceed with treatment need to understand how their substance abuse has served as avoidance, and the therapist should check in frequently about urges to drink or use. If such urges occur during treatment, they can, in fact, indicate particular

stuck points or important emotions that should be processed. CPT without the trauma account (CPT-C, discussed later in this manual in Part 3: Alternatives and Considerations in Conducting CPT) can also be implemented if the therapist and patient determine that the patient is, in fact, too fragile to handle writing about the trauma memory (i.e., reluctance is not due to the more common stuck points about emotions). Typically we have the patients focus on specific child, family, and marital issues after completing the course of PTSD treatment. Sometimes those problems remit when the patient no longer has PTSD interfering with functioning.

- MDD

Major depressive disorder (MDD) is the most common comorbid disorder with PTSD. Being depressed is not a rule-out for PTSD treatment. In fact, PTSD treatment should successfully address MDD that is often secondary to the PTSD. All treatment outcome studies on PTSD have found substantial and lasting improvement in depressive symptoms along with PTSD improvement. There are only a few caveats to consider. Although medication instability is a typical exclusion criterion for psychosocial treatment outcome studies for pragmatic purposes (i.e., is change attributable to the intervention or the medication?), medication changes can also complicate clinical practice. A clinician may be tempted to throw every possible intervention at the patient at once, expecting to achieve the quickest possible results. However, if a patient is beginning or increasing a medication while starting psychotherapy, neither the patient nor the clinician will know what was effective. Why does this matter? When the patient begins to feel better, she may attribute the change to the medication, even if it is not the case, and not attribute the change to her own efforts. She may even stop complying with psychotherapy. Also, if the medication was the locus of the change, the prescribing physician needs to know what the minimally effective dose of the medication is without the confusion of the common occurrence of increasing symptoms during the trauma account or decreasing symptoms after the trauma accounts or cognitive therapy. The prescribing physician and therapist need to coordinate their efforts to minimize this confusion.

- Psychotherapy and medication

We have occasionally seen patients who were so heavily and multiply medicated that they were unable to engage in treatment or access appropriate emotions. We have also occasionally seen unmedicated patients whose depression was so severe they could not muster the energy to attend treatment or comply with assignments. Either extreme is a problem that must be rectified before appropriate psychotherapy can be implemented. It is important to stress that we are not suggesting that all patients with PTSD, with or without MDD, should be on medications. Rather, we suggest that, if a patient can tolerate her distress for a few more weeks while CPT begins, there may not be a need for medications at all. In addition, many of the young returning service members may not want to begin a regimen of psychotropic medications. There is very little research on the combination or sequencing of medication and psychotherapy to guide us at this point. Good communication between providers can assist with decision making on the appropriateness and sequencing of medication.

As with depression and substance abuse, the concern with other anxiety disorders is whether they are so disabling that they interfere with PTSD treatment. If obsessive-compulsive disorder (OCD), panic disorder, or agoraphobia is so severe that the patient cannot engage in PTSD treatment, then the other disorder should be treated first. If the other anxiety disorder appears to be trauma-related (i.e., the onset, precipitants, and anxious content appear conceptually related to traumatic events) and the person can attend treatment, then it is quite possible that successful treatment of PTSD will improve the comorbid anxiety condition(s) as well. Any therapist who works with PTSD patients in VA will have heard stories of patients who secure their home perimeter every evening before bedtime, sometimes for hours. These superstitious safety behaviors may rise to the level of OCD. When we have treated patients with PTSD and OCD, we have started with the PTSD to see if the OCD symptoms would improve. There is no reason at this point to expect that PTSD symptoms will improve with successful OCD treatment. These OCD types of behaviors can be considered right along with safety issues in Sessions 7 and 8, with the goal of getting the patients to test out their overestimated level of danger (P: *"If I don't secure the perimeter this amount, my house will be attacked."* T: *"Do your neighbors and the people on the next block march with rifles? Have they been attacked? Has there ever been a time when you couldn't do it?"*). Once the flashbacks, nightmares, and triggered false alarms are reduced, it is easier to explain the principles of behavioral exposure and response prevention along with the cognitive work. Later in the protocol, the therapist could assign the patient to do an experiment to test his assumptions. Although this is not a typical component of CPT, a behavioral experiment might be very helpful with comorbid anxiety disorders. OCD symptoms may also be addressed while working on issues of control. The person with OCD has the temporary illusion of control when engaging in the ritual that is intended to reduce his anxiety. Aside from the fact that the rituals (cleaning, checking, etc.) soon come to control the person rather than the other way around, the therapist can help the patient to accept that he can't have control over future events (see Session 10) and that the rituals don't prevent future events from occurring and may be totally irrelevant.

- OCD

Panic disorder is commonly comorbid with PTSD. Our research with CPT indicates an improvement in panic symptoms without any particular extra intervention. However, there are some people who are so crippled by their panic disorder that they cannot tolerate discussing the traumatic event without having panic attacks. In this case, the therapist may want to consider treating the panic disorder first with a cognitive-behavioral treatment such as panic control treatment (Craske, Barlow, & Meadows, 2000[5]) or simultaneously with CPT

- Panic disorders

[5] Craske, M. G., Barlow, D. H., & Meadows, E. A. (2000). *Mastery of your anxiety and panic: Therapist guide for anxiety, panic, and agoraphobia (MAP-3)*. San Antonio, TX: Graywind/Psychological Corporation.

(Falsetti et al., 2001[6]). Falsetti and her colleagues developed a protocol that combines CPT with panic control treatment.

- Personality disorder

The challenge with personality disorders in PTSD treatment is how to stay on track with the protocol and not get derailed by side issues. In other words, the therapist does not attempt to treat the personality disorder but treats the PTSD in spite of the personality disorder. The therapist needs to keep in mind that the patient has been coping with his life circumstances for a long time, albeit ineffectively, and that getting pulled off onto the "crisis of the week" can serve as an avoidance function to doing the trauma work. If one can conceptualize personality disorders as over-generalized patterns of responding across a range of situations, then it is quite easy to see how someone with a long history of trauma, or coping with his trauma, might develop avoidant personality, dependent personality, and so forth. These beliefs and behavioral patterns served a functional purpose, at least at some point in the person's life. It is now dysfunctional because these patterns are so over-generalized (and probably obsolete). Within the cognitive framework, these over-generalized assumptions and beliefs become reified to the schema level and become automatic filters through which all experiences pass. Any experiences that do not conform to the over-riding schema are either distorted (assimilated) to fit the construct or ignored. Those experiences that appear to confirm the over-riding schema are used as proof and lead to further over-accommodation. It is difficult to challenge a large schema such as *"everyone will abandon me"* or *"I can't take care of myself,"* so the therapist should continually bring these global ideas down to very specific events, thoughts, and emotions and then challenge the evidence on those specific events with Challenging Beliefs Worksheets. When the same assumptions emerge across many worksheets, the therapist can say, *"I am detecting a theme here. Across these six worksheets it always comes back to the thought that people are trying to harm you* (or whatever the schema is). *You have said this to yourself so often and across so many situations that you have come to believe it is carved in stone as TRUTH. And we are going to have to chip away at that belief just like you would have to chip away at stone to get it to change—in this case, one worksheet at a time. Now I see that each time you have done a Challenging Beliefs Worksheet that you were able to challenge the thought that someone was intentionally trying to harm you. How many experiences will you need to have, how much evidence will you need to move to the thought that <u>some</u> people are not trying to harm you? And how would that feel if you believed that?"*

- Dissociation and amnesia

While dissociative disorders are relatively rare, dissociative responses are fairly common in traumatized individuals. In fact, peritraumatic dissociation, dissociation during or immediately after the traumatic event, is one of the most robust predictors of PTSD. Dissociation can become conditioned, just like the

[6] Falsetti, S. A., Resnick, H. S., Davis, J., & Gallagher, N. G. (2001). Treatment of posttraumatic stress disorder with comorbid panic attacks: Combining cognitive processing therapy with panic control treatment techniques. *Group Dynamics, 5*(4), 252–260.

fight-flight response, to previously neutral cues. If the patient dissociates whenever she is reminded of the trauma, such dissociation may interfere with the tasks required during therapy. There are several solutions to this problem. One is that the therapist can work with the patient in advance to refrain from dissociating, through grounding techniques (e.g., cueing to date, time, location, safety; touching a predetermined object as a reminder). The therapist needs to provide a rationale for the patient to learn not to dissociate when stressed. There are two good rationales. One is that dissociation actually puts the Veteran at greater risk, in that if she were really in danger, she would have fewer options for extricating herself from the situation. Another rationale for learning not to dissociate is that dissociation is an emergency response, like the fight-flight response, that shuts down immune and other normal functioning. Having this emergency response occur frequently, dysregulates the person's immune functioning. PTSD has been associated with greater health problems, and people who dissociate frequently are often observed to have higher rates of many physical disorders and diseases.

Another option is to use the CPT protocol but have the patient write the account using techniques to minimize dissociation. One strategy that we have used successfully is to have the patient set a kitchen timer for 5 minutes and start writing. The bell serves to interrupt dissociation, orienting the patient back to the present. The kitchen timer can then be set for 6 minutes, with the patient returning to reading or writing the account. The timer can be set for progressively longer periods to provide graded habituation and stronger grounding skills.

In summary, therapists should not be daunted by comorbid disorders accompanying PTSD or assume that CPT cannot be implemented with patients who have extensive trauma histories. CPT was developed and has been tested with patients who almost all had complex trauma histories and various comorbidities. The decision the clinician must make is whether the comorbid disorder is so severe that it will preclude the patient's participation in PTSD treatment. In that case, the therapist may want to treat the comorbid disorder before, or simultaneously, with CPT. There are evidence-based cognitive-behavioral therapies for most comorbid conditions that clinicians will encounter. For the most part, however, the treatment of PTSD will improve the comorbid symptoms and may even eliminate the necessity of further treatment for those symptoms.

2. Avoidance

- Discourage patient avoidance

Most Veterans present for PTSD treatment many years after the traumatic event. They are usually not in crisis and are able to handle their day-to-day lives (at whatever level they are functioning) without constant intervention. Much of the disruption in the flow of therapy for PTSD comes from avoidance attempts on the part of the patient. We point out avoidance whenever we see it (e.g., changing the subject, showing up late for sessions) and remind the patient that avoidance maintains PTSD symptoms. If the patient wants to discuss other issues, we save

time at the end of the session or attempt to incorporate her issues into the skills that are being taught (i.e., A-B-C Worksheets, Challenging Questions Worksheets, Patterns of Problematic Thinking Worksheets, Challenging Beliefs Worksheets). If the patient does not bring in practice assignments, we do not delay the session but conduct the work in session and then reassign the practice assignment along with the next assignment.

3. Needs of Returning OIF/OEF Veterans

- OIF/OEF Veterans

Returning Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) military personnel and Veterans may have different needs than Veterans from other wars/conflicts. They may prefer two sessions a week so that they can get therapy finished quickly. They may request early morning or evening appointments to accommodate their jobs. They may want their PTSD treatment augmented with couples counseling. They may appear a bit more "raw" than the very chronic Vietnam Veterans that most VA clinicians are accustomed to working with. The more accessible emotions are actually an advantage in processing the traumatic events and in motivating change, but therapists who have worked with only very chronic (and emotionally numb) Veterans may become alarmed when they first work with these patients. They may think that strong emotions or dissociation should be stabilized or medicated first. However, CPT was developed and tested first with rape victims who may also be very acute and very emotional. As long as patients are willing to engage in therapy and can contract against self-harm and acting out, there is no reason to assume that they need to wait for treatment.

4. PTSD-Related Disability Status

- PTSD-related disability status

Therapists often express concern about the patient's disability status and what will happen to her disability status and entitlements if the PTSD is effectively treated. For OIF/OEF Veterans, the goal is to have them return to gainful employment and not be on disability for their PTSD. At the beginning of treatment with these patients, they may not be able to conceptualize sleeping through the night again, not being disrupted by flashbacks, or having the concentration to hold down a job. The therapist needs to impart a clear message that these symptoms can improve, to instill some hope in the patient. However, specific career or job planning might be postponed until later in therapy to see how much symptom remission has been achieved. If the Veteran sustained head injuries during his deployment, it may not be clear how much of the symptom picture is due to PTSD and how much is due to brain injury until the PTSD symptoms are resolved.

Older Veterans (and their therapists) are sometimes reluctant to engage in an efficacious treatment for fear of losing benefits and not being able to support themselves. We highly encourage clinicians to seek out specific information from their Veterans Benefits Administration (VBA) staff about the likelihood that Veterans will have their disability rating reevaluated. In our experience, there is

much lore around VBA taking away Veterans' benefits. In our discussion with VBA staff, they have indicated that they are so burdened with claims that they do not have time to review older cases *unless* the Veteran is seeking an increase in his disability or there is some concrete evidence that the Veteran is making money through employment and he is not supposed to be able to be employed. There may be an infamous case in your VA in which entitlements were taken away or decreased, but it is important to assess more accurately with the Veteran the probability of such a situation occurring.

PTSD-related disability seems to present as the biggest challenge if a patient is actively seeking a disability rating or increase in her existing rating. We encourage clinicians to be up-front with patients about the timing of CPT in relation to their pursuit of service-connected benefits. If they are actively trying to prove that they have symptoms of PTSD, it is logically not the time to engage in a therapy that is shown to decrease symptoms. It is far better to prevent the Veteran from having a failed therapy experience by delaying a course of CPT than it is to proceed with a course that was doomed from the outset. There are many disabled and nondisabled Veterans with PTSD who are not seeking a change in their rating who are better positioned to take advantage of the benefits of CPT. Veterans in the claims process may want to seek a supportive therapy or non-trauma-focused intervention while awaiting the outcome of their claims.

If someone is rated with a permanent 100% service-connected PTSD disability, the Veteran has every right to benefit from symptom reduction to improve the quality of her life. If the Veteran is not considered permanently and 100% disabled by her PTSD, then the therapist should ask the patient to consider the costs and benefits of symptom reduction and quality of life if her PTSD improved, and the probability that her service-connected entitlement would even change as a result of an improvement in her PTSD. Therapists should remember that there is the option of diagnosing with PTSD, In Partial Remission, in their progress note documentation.

In some cases, disability status is actually a stuck point that needs to be challenged because it has an alternative function (*"If I am not a disabled Veteran, who am I?" "If I stop receiving the benefits, that means the government thinks what happened to me was not important"*).

5. Religion and Morality

- Issues of religion and morality

There are several ways in which religion and morality more generally intersect with PTSD. It is not uncommon for there to be disruptions in religious beliefs (*"How could God let this happen?" "Is God punishing me?"*) or stuck points that are produced by the conflict between the traumatic event and prior religious beliefs. This may be directly entangled in the "just world belief" (*"Why me?" "Why not me?" "Why did my friend/family die?"*), which is taught directly by some religions but could have been inferred by the patient and not actually part of the religion. It could be in the context of a violation of one's moral or ethical code

(*"I murdered people while in Iraq").* It could also entail other people trying to get the patient to forgive himself or forgive a perpetrator.

You should not avoid these topics, because they may prove to be at the heart of your patient's PTSD. Even if you have a different set of religious beliefs (or are agnostic or atheist), it is not a good reason to avoid these topics. You need to wade into cross-cultural beliefs as part of your work, and religion is an important part of your patient's culture. The just world belief is probably the most common assumption that is taught, not just by religions but also by parents and teachers. People like to believe that if they follow the rules that good things will happen and that if someone breaks the rules that they will be punished. People fail to learn this as a probability statement (*"If I follow the rules, it decreases my risk of something bad happening"*), which would be more realistic. If people hold strongly to the just world belief, then they may engage in backward reasoning. This would lead them to the conclusion that if something bad happened to them, they are being punished. However, if they can't figure out what they did wrong, they will end up railing at the unfairness of the situation or of God. No religion guarantees that good behavior will *always* be rewarded and bad behavior punished (here on earth), so if your patient says this, then he may have either distorted his religion or was taught this by a mistaken parent or religious leader. Like any profession, there is variability on how educated or adherent a religious leader is to the tenets of the religion. Please make sure you differentiate the religion itself from an individual practitioner when you discuss these issues. You may be able to check with the tenets of the religion through a Web search or by talking to clergy at your VA or your own place of worship.

When someone doesn't understand how God could let an event happen that involves another person (rape, assault, combat), the concept of *free will* may be very helpful. Most Western religions adhere to the concept of free will, of choice to behave or misbehave (or what are heaven and hell for?). If God gives an individual free will to make choices, then it does not follow that He would take away the free will of another person in order to punish the patient. That person also had free will to fire the gun or rape, etc. Free will implies that God does not step in and stop the behavior of others any more than He forces the patient to behave or misbehave. Furthermore, even when there is not another person's behavior and choice involved, it does not take a great deal of inspection of the world to find evidence that God is not using natural events, accidents, or illnesses only to punish bad people. When we see these events happening to infants, children, or people we know to be wonderful, caring individuals, the only thing that we can fall back on at that point is that "God works in mysterious ways." However, it could also be the case that God does not intervene in day-to-day lives and that the concept of God should be used for comfort, community, and moral guidance.

If a patient believes that lives are predetermined and that he has no free will, then you may wonder why he has PTSD. What is the conflict? Is he having trouble accepting his fate? Or is it just a matter of not being able to process emotions?

You should ask the patient how he came to understand what happened to him, and what images or thoughts he keeps coming back to.

- "Why me?"

The question that may logically follow *"Why me?"* is *"Why not you?"* If someone wonders why she was spared (language that implies intent) when others were killed, the same line of questioning can proceed. Is there logic to war, to who dies or who lives? Because someone is a good person, did that make her more immune to being killed in war? Unfortunately, the military, as well as religions, may reinforce the notion that if something bad happened, someone made a mistake. In the military, after events transpire, service members may be subject to debriefings to determine "what went wrong." While it is understandable that military leaders are attempting to reduce risk in the future, they are also planting the message that someone made mistakes for the outcome to be as it was (as opposed to the possibility that an ambush worked or that the combatants were outmanned in a particular situation).

- Self- or other-forgiveness

The concepts of self- or other-forgiveness are sometimes brought up in therapy. If these issues are comfortable concepts for a patient, she probably would not bring them up for discussion. Instead, they are typically mentioned because there is some discomfort with or conflict over the subjects. As noted above, with regard to self-forgiveness, it is very important for you to first challenge the specifics of the event to see if your patient has anything to forgive herself for. Because it is almost axiomatic that people will blame themselves for traumatic events, it does not mean that they intended the outcome. Therefore, blame and guilt may be misplaced. If someone is the victim of a crime, she is just that, a victim. There is nothing she could have done that would justify what happened to her. Because a woman feels dirty or violated does not mean that she did anything wrong that needs forgiveness. This would be an example of emotional reasoning. Killing someone in war is not the same as murdering someone. The person may have had no other options than what occurred at the time, so the Socratic questioning needs to establish intent, available options at the time, etc. One should only discuss self-forgiveness when it has been established that the patient had intended harm against an innocent person, that he had other available options at the time and willfully chose this course of action. Killing a civilian by accident (e.g., someone caught in the crossfire) in a war is just that, an accident. Committing an atrocity (raping women or children, torturing people) is clearly intended harm. Guilt is an appropriate response to committing an atrocity or a crime. A patient may well need to accept what he has done, be repentant, and seek out self-forgiveness, or if religious, forgiveness within the church or other place of worship. Even then you should work with your patient to contextualize who he was then with what his values are now to help him realize that he is not the same as when the event occurred. Once all this has been thoroughly processed and digested, some form of restitution or community service may assist the patient in moving beyond his permanent, self-inflicted sentence.

Forgiving others is sometimes brought into the session when the concept is premature or forced by others. If a patient has just accepted that the event was not

her fault (e.g., sexual abuse or assault), she may be just recognizing that the other person intended the harm and is to blame for the event. To foreclose on the righteous anger before letting it run its course may bring comfort to a family, but it is the same type of PTSD symptom that has been occurring already, avoiding affect. You can ask the patient if the perpetrator has asked for forgiveness. Most churches or other places of worship do not confer forgiveness on the unrepentant. If the perpetrator has not asked for forgiveness, there is no need for the patient to forgive. Even if the perpetrator of the traumatic event has asked for forgiveness, the patient is not obligated to give it. Understanding why someone did something is not the same as excusing him. The patient could refer the perpetrator to the church, or other places of worship, to ask forgiveness of God. The purpose of the patient granting forgiveness should not be for someone else to pretend that all is well, but only for giving the patient some peace of mind. If forgiveness is being forced by others, it will only bring frustration and guilt.

6. Military Sexual Trauma (MST)

- Military sexual trauma (MST)

Although there are many different types of traumatic experiences, each unique in its own way, experiences of sexual trauma often raise special issues for patients and clinicians. This is particularly true when the trauma is what the VA terms "military sexual trauma"; that is, sexual assault or repeated, threatening acts of sexual harassment that occurred while the Veteran was in the military. Sexual assault is any sort of sexual activity between at least two people in which someone is involved against his or her will. Physical force may or may not be used. The sexual activity involved can include many different experiences such as unwanted touching, grabbing, oral sex, anal sex, sexual penetration with an object, and/or sexual intercourse. Sexual harassment that falls into the category of MST involves repeated, unsolicited, and threatening verbal or physical contact of a sexual nature. Examples of this include threats of retaliation for not being sexually cooperative or implied faster promotions or better treatment in exchange for being sexually cooperative.

A number of studies have shown that MST experiences are extremely prevalent among Veterans; rates are typically even higher among Veterans using VA healthcare. Although sexual trauma occurs more frequently among women than among men, the disproportionate ratio of men to women in the military means that as a clinician working with Veterans, you are about equally likely to encounter men with experiences of MST as you are to encounter women with experiences of MST. In general, rape is the trauma most likely to be associated with PTSD, meaning that you may treat sexual trauma quite frequently in your CPT work.

While there is little empirical data comparing experiences of military sexual trauma with experiences of sexual harassment and assault that occur outside of military service, there are aspects of MST that may make these experiences qualitatively different for victims. For example, because sexual trauma associated with military service most often occurs in a setting where the victim lives and

works, many victims must continue to interact and work closely with their perpetrators on an ongoing basis after the trauma. This often increases their sense of helplessness and powerlessness and may leave them at risk for additional victimization. Given the "total" nature of the military environment, this victimization may take a variety of forms. Victims may need to rely on their perpetrators (or associates of their perpetrator) to authorize medical and psychological care or provide for other basic needs. There may also be career-related consequences for victims in that perpetrators are frequently peers or supervisors with the power to influence work evaluations and decisions about promotions. Even if this is not the case, victims may face the difficult choice of either continuing military careers in which they are forced to have frequent contact with their perpetrators or sacrificing career goals in order to protect themselves from future victimization or retraumatization.

Most military groups are characterized by high unit cohesion, particularly during combat. Although this level of solidarity is typically a positive aspect of military service, the dynamic it creates may amplify the difficulties of responding to sexual harassment and assault in this environment. For example, the high value placed on organizational cohesion may make it taboo to divulge any negative information about a fellow soldier. As a result, many victims are reluctant to report sexual trauma and may struggle to identify even to themselves that what occurred was an assault. Those who choose to report to those in authority often feel that they are not believed or, even worse, find themselves blamed for what happened. They may be encouraged to keep silent and their reports may be ignored. Having this type of invalidating experience often has a significant negative impact on the victim's posttrauma adjustment.

- MST and CPT

How might these factors impact your CPT work with Veterans? First, trust (both of oneself and others) may be a particularly potent issue given that perpetrators are most often someone the victim knows and may have been someone with whom the victim was quite close. Because of this relationship, victims may have stuck points related to the idea that the sexual assault or harassment was consensual, or at least condoned on their part; it will be important for you to remind them of the coercive aspects of the context surrounding the trauma. As with sexual trauma occurring outside the military, the stigma associated with sexual trauma may mean that you encounter a great number of stuck points related to self-blame and esteem. Men in particular may express concerns about their sexuality, sexual identity, or their masculinity. It may be hard for them to reconcile what happened with societal beliefs about men being strong and powerful—acknowledging their vulnerability is at odds with how they have been taught to think about themselves as men. In addition, individuals who have been sexually traumatized are at particularly high risk of experiencing subsequent sexual victimization. When this happens, victims may find themselves stuck on issues related to agency (power and control) and self-worth.

- Sexual arousal during MST

Another issue to consider is that because sexual arousal typically occurs in pleasurable settings, most people assume that sexual arousal equates with

enjoyment. Victims of sexual assault may erroneously conclude that, because they may have experienced arousal or even orgasm, that they must have enjoyed the experience, that they are perverted, or that their bodies betrayed them. All these conclusions are incorrect. It is quite possible to be stimulated and experience fear, horror, or anger instead of pleasure. Soldiers have reported experiencing erections or even orgasm in combat. That doesn't mean that they were experiencing enjoyment or found the experience to be sensual. It does mean that they experienced a cascade of hormones throughout their bodies that happened to include those that stimulate sexual arousal.

Patients are often reluctant to bring up this topic in therapy. They may feel deep shame that they experienced sexual arousal in a situation in which they believe it to be inappropriate and may view it as some type of personal failing. The therapist can help alleviate this guilt and shame through education and should bring up the topic in a low-key and routine way if the patient does not broach the topic. One of the simplest ways to help the patient to think differently about it is to remind the patient that sexual arousal is not a voluntary response any more than being tickled is. In fact, tickling is a good analogy to use. Someone can be tickled against his will, be laughing, and hate it at the same time. When nerve endings are stimulated, there is no conscious choice about whether those nerve endings should react. If the patient is helped to see that his or her reactions were the normal outcome of stimulation and not some moral choice, he or she should experience relief and the lessening of guilt or shame. Please refer to the Patient Workbook for examples of an A-B-C Worksheet, Challenging Questions Worksheet, and Challenging Beliefs Worksheet on MST.

- Example worksheets on MST located in Materials Manual

7. Ongoing Symptom Assessment Using PTSD and Depression Scales

- Using PTSD & depression scales

It is recommended that the patient be assessed, not just before and after treatment but during treatment as well. We typically give patients a brief PTSD scale and a depression scale, such as the Beck Depression Inventory[7] or the Patient Health Questionnaire (PHQ-9)[8] (if comorbid depression is a problem), once a week. The PCL-5 monthly version is administered once before the first session and evaluates the patient's symptoms **during the past month**. Subsequent administrations of the PCL-5 evaluate the patient's symptoms **during the prior week** and are administered weekly. We recommend that the weekly versions of the PCL-5 be given to the patient while he is waiting for the start of the session. Most often there is a large drop in symptoms when the assimilation about the trauma is resolving. Typically this occurs around the fifth or sixth session with the trauma account and cognitive therapy focusing on the traumatic event itself. Occasionally this takes longer, but with frequent assessment, the therapist can monitor the progress and see when the shift occurs. When there is not a reduction in scores by halfway through therapy, the therapist should discuss this with the patient to make

[7] Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 141*, 1311.
[8] Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*, 606–613.

sure that the patient is completing the assessment accurately, and, if so, the therapist should explore with the patient where they are still stuck (e.g., continued avoidance, certain stuck points, previously undisclosed trauma details). Both the monthly and weekly versions of the PCL-5 are located in the Therapist Materials section of the Materials Manual.

8. Traumatic Brain Injury and Modified CPT Sheets

- TBI and Modified CPT Sheets

Many Veterans come in for mental health care having experienced a traumatic brain injury (TBI) in addition to the events that led to the PTSD. Research on evidence-based treatments suggests that the treatment manuals for PTSD can be implemented with a majority of TBI patients (other than the most severe) as they are currently written, with a significant improvement in PTSD and related symptoms. In addition, CPT includes approved modified sheets for individuals that have cognitive deficits that impact their ability to complete the worksheets in their current formats. The modified worksheets include the ABC sheet, the Challenging Questions Worksheet, and the Challenging Beliefs Worksheet, which are included in the Materials Manual. In therapy with someone who has cognitive limitations, we encourage therapists to continue to move through the forms in the basic manual until the Veteran begins to struggle with even basic comprehension of the current exercise. At that point, the clinician can revert to the simplified version of the worksheet that the Veteran could not complete in a reasonable manner. **NOTE**: Some confusion is often to be expected and typically lessens with practice at home and in the office. The rest of therapy would rely on these simplified worksheets that can be used in groups or individually and in CPT or CPT-C.

9. Supplementary Help Sheets

- Supplementary Help Sheets

The Stuck Point Help Sheet is designed as an additional resource for therapists to share with CPT patients to help them understand and identify stuck points. This may be given to the patient in the first or second session or later on if they continue to struggle with the concept of stuck points.

The Stuck Point Help Sheet for Therapists is a guide for therapists to further explain stuck point concepts (it is not intended to be given to patients). It includes examples of stuck points, sample dialogue for explaining stuck points, and important reminders about identifying and structuring stuck points.

Supplementary materials are included in the CPT Materials Manual.

| Part 2: | CPT: Session by Session

It is presumed that the therapist will have conducted some form of assessment of the patient's traumatic event and persistent symptoms and specifically contracted to do a course of CPT before undertaking the first session. At least a brief assessment of PTSD and depressive symptoms should be conducted. There are several brief PTSD checklists and depression scales that can be used to assess pretreatment symptoms and to conduct repeated assessments during therapy to monitor progress across treatment. The PCL-5 is included in this manual.

The contents of the following pages contain summaries, guided explanations of the session, sample session notes, and accompanying handouts for the therapist's reference. Please refer to the Alternatives and Considerations in Conducting CPT section for an outline of CPT without the Trauma Account (CPT-C). Reproducible copies of the patient handouts can be found in the CPT Materials Manual.

The individual sessions are:

Session 1: Introduction and Education
Session 2: The Meaning of the Event
Session 3: Identification of Thoughts and Feelings
Session 4: Remembering the Traumatic Event
Session 5: Identification of Stuck Points
Session 6: Challenging Questions
Session 7: Patterns of Problematic Thinking
Session 8: Safety Issues
Session 9: Trust Issues
Session 10: Power/Control Issues
Session 11: Esteem Issues
Session 12: Intimacy Issues and Meaning of the Event

Session 1: Introduction and Education

Summary of Session 1 – Introduction and Education Phase

Administer the PCL-5 (monthly version) before the start of this session, collect, and store.

1. Set agenda (5 minutes)

2. Therapist explanations to patient (10 minutes)

- PTSD Symptoms: 4 Clusters (Handout)
  - Reexperiencing: thoughts, dreams, flashbacks, psych, physio
  - Arousal: sleep, irritability/anger, concentration, hypervigilance, startle
  - Alterations in mood and cognition: guilt, anger, self-blame
  - Avoidance: thoughts, places/activities/people,

  Many other forms of avoidance: alcohol, staying as busy as possible, physical symptoms, avoiding therapy or practice assignments.
- Trauma Recovery and Fight-Flight Response
  - Fight/flight, freeze
  - Paired with cues: sight, sound, smell, etc.
- Cognitive Theory
  - Belief structure: categories—just world, good things to good people, etc.
  - Change memories to fit beliefs (assimilation)
  - Change beliefs about the world (accommodation/over-accommodation)
- Types of Emotions
  - Two types of emotions that follow trauma: natural and manufactured

3. Brief review of most traumatic event (5 minutes)

4. Therapy rationale—stuck points (10 minutes)

- Goals of Treatment
  - To recognize and modify old thoughts and feelings that may be unhelpful
  - To accept the reality of the event
  - To change beliefs enough to accept it without going overboard
  - To feel your emotions about the event
- Review Stuck Point Handout

5. Anticipating avoidance and increasing compliance (5 minutes)

6. Overview of treatment—structured (5 minutes)

- 12 Sessions, 50 mins.–1 hour each:
  1. Introduction
  2. Meaning of the Event
  3. Identifying Thoughts and Feelings
  4. Remembering the Event
  5. Identifying "Stuck Points"
  6. Challenging Questions
  7. Problematic Thinking
  8. Safety
  9. Trust
  10. Power and Control
  11. Esteem
  12. Intimacy and Meaning
- Note importance of compliance with attendance and practice assignments

7. Assign practice and problem solve re: completion (5 minutes)

- First Impact Statement

8. Check-in re: patient's reactions to session (5 minutes)

Session 1: Introduction and Education Phase

The goals of Session 1 are:

- Session 1 goals

1. To build rapport with the patient.
2. To educate the patient about symptoms of PTSD and depression.
3. To provide a rationale for treatment based on a cognitive conceptualization of PTSD.
4. To lay out the course of treatment.
5. To elicit treatment compliance.

- Compliance & avoidance

It is necessary to address treatment compliance early in the course of therapy because avoidance behavior (half the symptoms of PTSD) can interfere with successful outcomes. We are concerned with two forms of compliance: attendance and completion of out-of-session practice assignments. It is strongly recommended that patients attend all sessions and complete all assignments in order to benefit fully from therapy. We set the expectation that therapy benefit is dependent on the amount of effort patients invest through practice assignment compliance and practice with new skills. It may be helpful to remind the patient that what he has been doing has not been working and that it will be important to tackle issues head-on rather than continue to avoid. Avoidance of affective experience and expression should also be addressed.

In this session, patients are also given the opportunity to ask any questions they may have about the therapy. Sometimes patients' stuck points become evident in the questions and concerns they express during this first session. And finally, as with all therapies, rapport building is crucial for effective therapy. The patient needs to feel understood and listened to, otherwise she may not return.

- Trauma disclosure

Patients sometimes arrive with a pressing need to speak about their trauma. However, the therapist should prevent the patient from engaging in an extended exposure session at the first session. Intense affect and graphic details of an event, disclosed before any type of rapport or trust has been established, may well lead to premature termination from therapy. The patient is likely to assume that the therapist holds the same opinions about his guilt, shame, or worthlessness that he, the patient, holds, and may be afraid to return to therapy after such a disclosure.

Other patients will be very reluctant to discuss the traumatic event and will be quite relieved that they do not have to describe it in detail during the first session. In these cases, the therapist may have to draw out even a brief description of the event. Dissociation when attempting to think about or talk about the event is common. An initial assessment session grants the patient and therapist the opportunity to get acquainted before the therapy begins and allows the therapist to provide the patient with a description of what the therapy will entail. In this first session, it is important that the therapist remind the patient that CPT is a very structured form of therapy and that the first session is a bit different from the

others because the therapist will do more talking. The therapist begins with a description of the symptoms of PTSD and a cognitive formulation of them.

Therapist Explanations to Patient

1. PTSD Symptoms

In going over the results of your testing, we found that you are suffering from posttraumatic stress disorder. The symptoms of PTSD fall into four clusters. The first cluster is the re-experiencing of the event in some way. This includes nightmares about the event or other scary dreams; flashbacks, when you act or feel as if the incident is recurring; intrusive memories that suddenly pop into your mind. You might have the intrusive memories when there is something in the environment to remind you of the event (including anniversaries of the event) or even when there is nothing there to remind you of it. Common times to have these memories are when you are falling asleep, when you relax, or when you are bored. These symptoms are all normal following such a traumatic event. You are not going crazy. Can you give me examples of these experiences in your own life since the event?

- PTSD symptoms–criterion B

A second set of symptoms concerns arousal.[9] *As might be expected, when reminded of the event, you are likely to experience very strong emotions. Along with these feelings are physical reactions. Indicators of arousal symptoms include problems falling or staying asleep, irritability or outbursts of anger, reckless or self-destructive behavior, difficulty concentrating, startle reactions like jumping at noises or if someone walks up behind you, always feeling on guard or looking over your shoulder even when there is no reason to. Which of these do you experience?*

- PTSD symptoms–criterion E

A third set of symptoms involves changes in your mood and the way you think about things as a result of the trauma. You might find that your mood is persistently negative, and that you often experience emotions such as guilt, shame, anger, fear, and sadness. Sometimes people lose interest in activities, find it hard to experience positive emotions, and feel cut-off from the world around them. In terms of how your thinking might have been impacted, you may find that you think about yourself, others, and the world differently, perhaps in an overly negative way. After experiencing a trauma, many people blame themselves or other people for not being able to prevent the trauma from happening. Sometimes people have trouble

- PTSD symptoms–criterion D

[9] Although avoidance is listed second in the DSM, it makes more sense to present the symptoms to patients in their most likely order: intrusion, arousal, emotions and cognitions, then avoidance. This way the explanations for the symptoms follow logically from their descriptions.

remembering all or part of the event. Have you felt numb or shut off from positive emotions? What emotions do you most often experience? Have you found yourself feeling disconnected from other people? Do you find that you blame yourself or other people for the trauma happening?

The fourth set of symptoms is avoidance of reminders of the event. A natural reaction to intrusive memories and strong emotional reactions is the urge to push these thoughts and feelings away. You might avoid places or people who remind you of the event. Some people avoid watching certain television programs or turn off the TV. Some people avoid reading the newspaper or watching the news. You might avoid thinking about the event and letting yourself feel your feelings about the event. There might be certain sights, sounds, or smells that you find yourself avoiding or escaping from because they remind you of the event. Which things or thoughts do you avoid or run away from?

- PTSD symptoms–criterion C

2. Trauma Recovery and Fight-Flight-Freeze Response

- Trauma recovery

Many people are exposed to traumatic events. In the time immediately following a trauma, most people will have the symptoms of PTSD that we just talked about. However, over time, for many people, those symptoms naturally decrease, and they are not diagnosed with PTSD. In other words, they naturally recover from the traumatic event. There are some people who do not recover and are later diagnosed with PTSD. Based on that, it is helpful to think of PTSD as a problem in recovery. Something got in the way of you having that natural process of recovery, and our work together is to determine what got in the way and to change it so that you can recover from what happened. We will be working to get you "unstuck."

- Fight-flight-freeze reactions

There are some different reasons why you may be having trouble recovering. First, there is an automatic component during the event that you should consider as you evaluate how you responded during the time. When people face serious, possibly life-threatening events, they are likely to experience a very strong physical reaction called the ***fight-flight reaction****. More recently we have learned that there is a third possibility, the* ***freeze response****. In the fight-flight reaction, your body is trying to get you ready to fight or flee danger. The goal here is to get all the blood and oxygen out to your hands, feet, and big muscle groups like your thighs and forearms so that you can run or fight. To do that quickly, the blood leaves your stomach or your head. You might feel like you have been kicked in the gut or are going to faint. Your body stops fighting off diseases and digesting food. You are not thinking about your philosophy of life and may*

have trouble thinking at all. The same thing happens with the freeze response, but in this case your body is trying to reduce both physical and emotional pain. You may have stopped feeling pain or had the sense that the event was happening to someone else as if it were a movie. You might have been completely shut down emotionally or even had shifts in perception like you are out of your body or that time has slowed down.

If you have been thinking now of other things that you could have done then, you might need to consider what your state of mind was during the event. Did you have all possible options available to you? Did you know then what you know now? Do you have different skills now than you did then?

- Classical conditioning processes

Second, the fight-flight response that you were experiencing during the traumatic event can get quickly paired with cues, or things in the environment, that didn't have any particular meaning before. Then later, when you encounter those cues, you are likely to have another fight-flight reaction. Your nervous system senses the cue, which could be a sight, a sound, smell, or even a time, and then your body reacts as though you are in danger again. These reactions will fade over time if you don't avoid those cues. However, if you avoid reminder cues, your body won't learn that these are not, in fact, good danger cues. They don't tell you very accurately whether you are actually in danger so you may have false alarms going off frequently. After a while you won't trust your own senses or judgment about what is and isn't dangerous, and too many situations seem dangerous that are not.

You may start to have thoughts about the dangerousness of the world, particular places, or situations that are based on your reactions rather than the actual realistic danger of those situations. This leads us to examine how your thoughts may affect your reactions. Besides thoughts about dangerousness, many different types of beliefs about ourselves and the world can be affected by traumatic events.

3. Cognitive Theory

- Cognitive theory

As you were growing up you learned about the world and organized it into categories or beliefs. For example, when you were small, you learned that a thing with a back, seat and four legs is a chair. In the beginning you just called all of them "chair." You may have even called a couch a chair or a stool a chair because they had a back, seat, and four legs. Later, as you got older, through experience, you learned more complex categories, so you may have learned dining room chair, rocking chair, recliner, or folding chair. We develop

many categories of ideas and beliefs about others, the world, and ourselves, as well as for objects.

- Just world belief

One common belief that many people learn while growing up is that "good things happen to good people and bad things happen to bad people." This is called the "just world belief." You may have learned this through your religion, your parents, your teachers, or you may have picked it up as a way to make the world seem safer and more predictable. It makes more sense when you are young. For example, parents wouldn't want to say, "If you do something you're not supposed to, you may or may not get in trouble." However, as we grow up, we realize that the world is more complex than that, just like how we learn that there are all different types of chairs. If you have ever had things go bad and you said "Why me?" then you have a just world belief. You also subscribe to the just world belief if you wondered "Why not me?" when others were hurt or killed.

- Assimilation

When an unexpected event occurs that doesn't fit your beliefs, there are different ways that you may try to make it fit with your existing beliefs. One way that you may have tried to make the event and your beliefs fit is by changing your memories or interpretation of the event to fit with your pre-existing beliefs ***(assimilation)****. Examples of changing your interpretations/memories of the event are to blame yourself for not preventing the event (or protecting loved ones), to have trouble accepting that the event happened, to 'forget' that it happened, or to forget the most horrifying parts. Changing the event may seem easier than changing your entire set of beliefs about the world, how people behave, or your beliefs about your safety.*

- Over-accommodation

It is possible that instead of changing the event, you may change your beliefs to accept what happened ***(accommodation)****. This is one of our goals for therapy. Unfortunately, some people go overboard and change their beliefs too much, which may result in a reluctance to become intimate or develop trust, and increased fear* ***(over-accommodation)****. Examples that reflect an extreme change in beliefs include thinking that no one can be trusted or that the world is completely dangerous.*

For some people who have had previous negative experiences in their life, traumatic events can seem to reinforce or confirm these previously held beliefs. For example, prior to having experienced a trauma you might have believed that others can't be trusted or that the world is generally unsafe. The traumatic event comes along and seems to confirm those beliefs. Or, maybe you were told that everything was your fault growing up, so when a bad thing happens, it seems to confirm that once again, you are at fault.

Our goals for therapy are: 1) to help you accept the reality of the event, 2) to feel your emotions about it, and 3) to help you develop balanced and realistic beliefs about the event, yourself, and others.

When explaining cognitive theory to the patient, it is recommended that the therapist explain the concepts in patient-accessible language and not use the words, "assimilation" and "over-accommodation."

4. Types of Emotions

- Natural vs. manufactured feelings

There are two kinds of emotions that follow traumatic events. The first type is the feelings that follow naturally from the event and that would be universal: fear when in real danger, anger when being intentionally harmed, joy or happiness with positive events, or sadness with losses. These natural emotions have a natural course. They will not continue forever unless there is something that you do to feed them. It is important to feel these emotions that you may not have allowed yourself to experience about the event and let them run their natural course.

The second type of emotions, manufactured feelings, result not directly in response to the event but based on how you interpret the event. If you have thoughts such as "I should have rescued other people" or "I must be a failure that I can't get over it," then you will be feeling angry at yourself or shame. These emotions are not based on the facts of the event but on your interpretations. The more that you continue to think about the event in these ways, the more and more of the manufactured feelings you are going to have. The upside of the fact that you are producing these feelings is that if you change your thoughts and interpretations, you will change your feelings. Think of your emotions as a fire in a fireplace. The fire has energy and heat to it, just like your emotions. However, it will burn out if it is not continually fed. Self-blame or guilty thoughts can continue to feed the emotional fire indefinitely. Take away the fuel of your thoughts, and the fire burns out quickly.

For you to recover from your traumatic event(s), we will be working together for you to express and accept your natural emotions and to adjust the manufactured feelings."

Brief Review of Most Traumatic Event

- Honing in on the traumatic event

In this first session, the therapist and patient work together to define the most traumatic event that they will work on first. The patient then provides a brief account of the traumatic event. It is important the therapist keep the patient contained and not conduct an exposure to the traumatic material. Most Veterans have a "public version" of the incident that they can use that does not elicit much

affect. However, if the patient starts to become distressed or dissociates, the therapist should ask questions and keep the patient grounded in the present. If needed, the therapist can stop the patient's description. The therapist only needs enough of the details to begin to hypothesize what problematic interpretations and cognitions might need to be explored.

We begin with the worst incident because there is more likely to be generalization of new, more balanced cognitions from the worst event to less severe events than the other way around. Also, if the patient begins with a less severe event because she believes she cannot handle the worst event, she will still believe that after working on the less distressing event. If the patient is resistant to writing an account about the worst event, the therapist needs to do some cognitive therapy during Session 2 and have the patient complete some A-B-C Worksheets on her thoughts and feelings about working on the worst event (see Sessions 2 and 3). It is helpful to provide an expectation that the patient provide a brief, less affectively charged event by providing a time frame in the request.

> *For me to have a clearer picture of what we will be working on first, could you please give me a brief description, about five minutes, of your most traumatic event….*

- Dealing with multiple traumatic events

If the patient responds that he has multiple traumatic events that disturb him, making it difficult or impossible to choose the "most" traumatic event, first validate the fact that he may have multiple distressing events. Then, focus on ascertaining which one seems to be causing the most PTSD symptoms by inquiring about the content of his re-experiencing symptoms. The therapist can ask, *"What do you think about or have flashbacks about the most?"* It may also be helpful to probe about his behavioral avoidance symptoms to determine the event that should be addressed first. It is important to pick one specific traumatic event that will serve as the initial focus of treatment. It may become clear later on that the "most" traumatic event is something different, perhaps because the patient had avoided disclosing it initially or had downplayed the level of distress it caused. If the therapist discovers that there is a different event that is most distressing, the focus can switch. Depending on when in therapy this happens, the patient may be asked to write an additional account (See session 4), but the focus will be on finding the assimilated stuck points related to this other event. Remind the patient that work on the chosen event will very likely impact the other events, and, if not, there will be opportunities to work on the other events.

Therapy Rationale—Stuck Points

- Introducing stuck points

> *So, one goal of therapy will be to help you recognize and modify what you are saying to yourself—in other words, your thoughts and interpretations about the event, which may have become automatic. These distorted beliefs may become so automatic that you aren't even aware that you have them. Even though you may not be aware of what you are saying to yourself, your beliefs and self-statements*

affect your mood and your behavior. Often, people aren't aware that they are having thoughts about whatever they are experiencing. For example, on the way here today, you were probably wondering what this therapy would be like or what I would be asking you to talk about. Do you remember what you were thinking about before the session?

I will be helping you to identify what your automatic thoughts are and how they influence what you feel. I will also teach you ways to challenge and change what you are saying to yourself and what you believe about yourself and the event. Some of your beliefs about the event will be more balanced than others. You'll remember that we discussed at the beginning of this session about how some people get stuck in their recovery process. We will be focusing on changing the beliefs that are interfering with your recovery or keeping you stuck. We call these problematic beliefs "stuck points." (The patient is given the Stuck Points Handout.) *We will keep a Stuck Point Log in your folder so that as we identify problematic ideas, we can write them down. Then when we move to different worksheets you will have this list to draw on.*

- **Give patient Stuck Points Handout**

Anticipating Avoidance and Increasing Compliance

- Increasing patient compliance

The patient has been avoiding thinking about the event, thereby escaping and avoiding strong and unpleasant emotions. The therapist must develop a strong and compelling rationale for therapy in order for the patient to be motivated to do something completely antithetical to what she has been doing. It is very important that the patient understand what the therapy consists of and why it will work. She should have ample opportunity to ask questions and express concerns. The therapist needs to express confidence, warmth, and support.

I cannot emphasize enough how important it is that you not avoid, which is what you usually have done to try to cope since the event. This will be your biggest (and probably scariest) hurdle. I cannot help you feel your feelings, or challenge your thoughts if you don't come to therapy or if you avoid completing your practice assignments. If you find yourself wanting to avoid, remind yourself that you are still struggling with the event because you have avoided dealing with it head-on.

Overview of Treatment

The therapist should describe the course of therapy (and the nature of the trauma account in Sessions 4 and 5) and the importance of doing practice assignments.

There are 168 hours in a week. We cannot expect you to change your symptoms and the way you have been coping in one or two hours of

therapy a week if you are continuing to practice your old ways of thinking the other 166 hours a week. It will be important for you to take what you are learning and apply it to your everyday life. Your therapy needs to be where your life and PTSD are, not just in this little room.

First Impact Statement

For the next session, I want you to start working on how you think about and explain the traumatic event. I also want you to pay attention to how the traumatic event impacted on your views of yourself, other people, and the world. I want you to write at least one page on 1) why you think this event happened to you, and 2) how has changed or strengthened your views about yourself, other people, and the world in general?

For this assignment to be most helpful to you, I strongly suggest you try to start this assignment soon, so that you have enough time to write thoughtfully. Pick a time and place where you have as much privacy as possible, so you can feel any feelings that arise as you complete the assignment.

- Writing the Impact Statement
- **Give patient practice assignment sheet**

The patient is given a practice assignment sheet. If at all possible, the patient should handwrite the Impact Statement. Some patients will want to type on the computer. Research suggests that word processing can impede engagement with the assignment (e.g., too focused on grammar or spelling). Therefore, encourage that this and other assignments be handwritten. It is often helpful to remind the patient that you are not grading his work or interested in his grammar, etc. Rather, you're interested in the content and feelings. If the patient has problems with literacy or physical disabilities that make it difficult or impossible to write, the therapist might suggest that he record his thoughts on a tape recorder.

Practice Assignment

- **Assign Session 1 practice assignment**

Please write at least one page on why you think this traumatic event occurred. You are <u>not</u> being asked to write specifics about the traumatic event. Write about what you have been thinking about the cause of the worst event.

Also, consider the effects this traumatic event has had on your beliefs about yourself, others, and the world in the following areas: safety, trust, power/control, esteem, and intimacy. Bring this with you to the next session.

Also, please read over the handout I have given you on stuck points so that you understand the concept we are talking about.

Check-in re: Patient's Reactions to Session

Finish the session by asking about the patient's reactions to the session and whether he has any questions about the content or the practice assignment. Remember to normalize any emotions and praise the patient for taking this important step toward recovery.

Sample Session 1 Progress Note

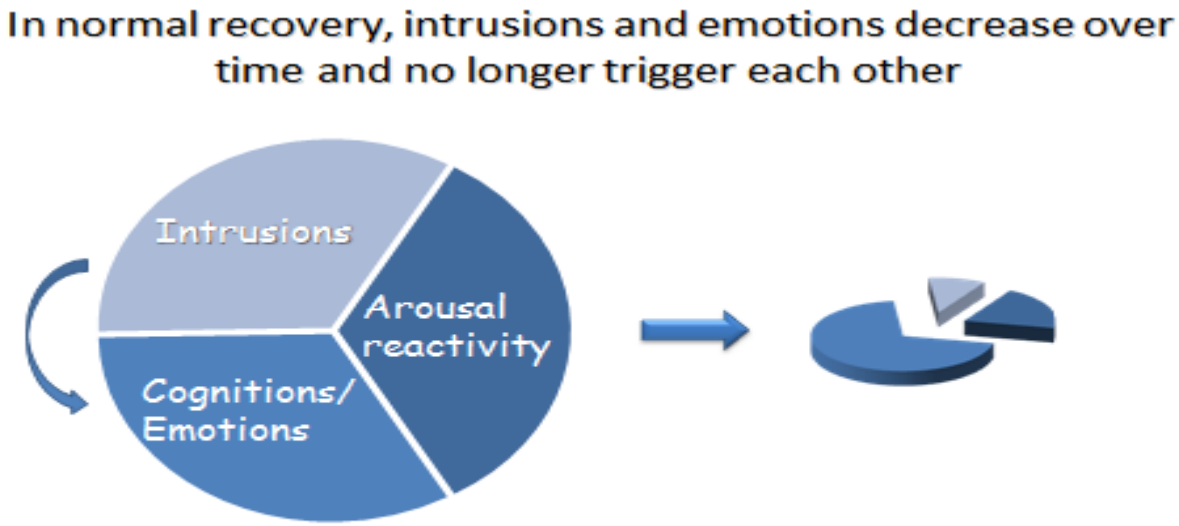
Contact: 50-minute psychotherapy session

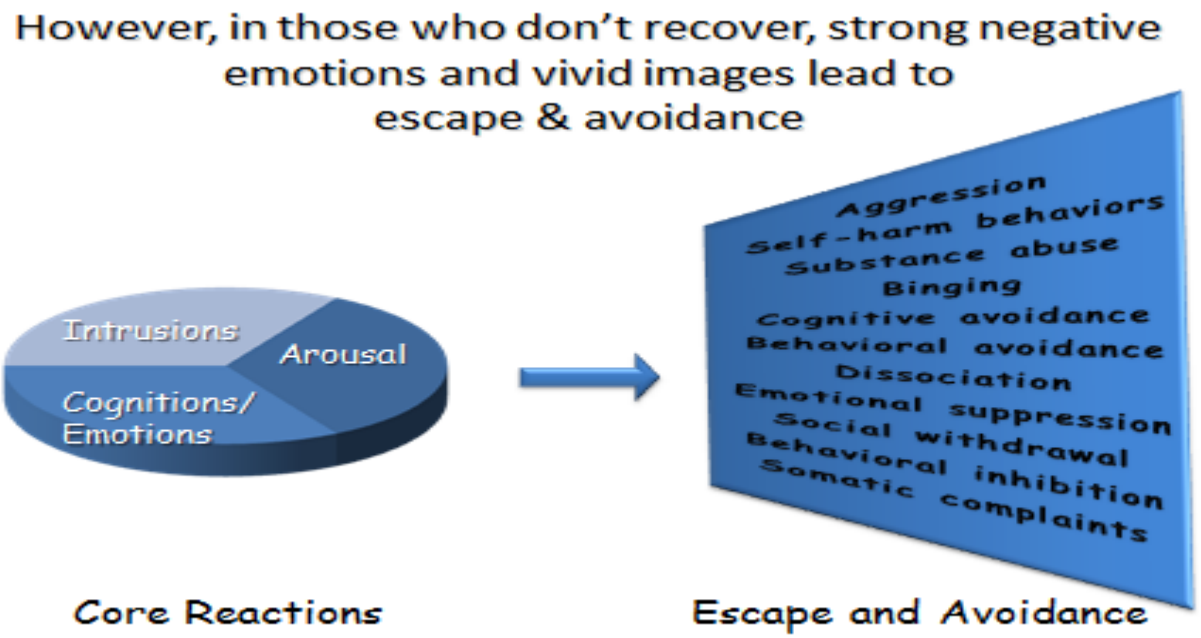
Content: The patient completed the first session of CPT for PTSD. An overview of PTSD symptoms and a cognitive explanation of the development and maintenance of PTSD was presented. A related rationale for treatment was provided, including the use of cognitive restructuring to alleviate stuck points that prevent the patient from more fully emotionally processing the traumatic event(s). The patient provided a brief description of his most traumatic event.

The patient was given a practice assignment to write a one-page Impact Statement describing the impact of his traumatic experiences on his thoughts and beliefs about himself, others, and the world.

Plan: Continued CPT for PTSD

Recovery or Non-recovery from PTSD Symptoms Following Traumatic Events





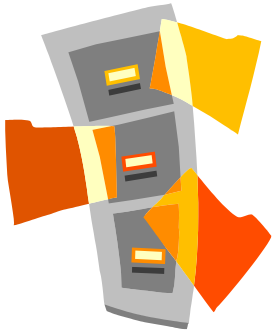
The avoidance prevents the processing of the trauma that is needed for recovery and works only temporarily

Stuck Points—What Are They?

Throughout the rest of therapy we will be talking about stuck points and helping you to identify what yours are. Basically, stuck points are conflicting beliefs or strong negative beliefs that create unpleasant emotions and problematic or unhealthy behavior. Stuck points can be formed in a couple of different ways:

1. Stuck points may be conflicts between prior beliefs and beliefs after a traumatic experience.

STUCK



<u>Prior Belief</u>
I am able to protect myself in dangerous situations.

<u>Harmed During Military Service</u>
I was harmed during my military service, and I am to blame.

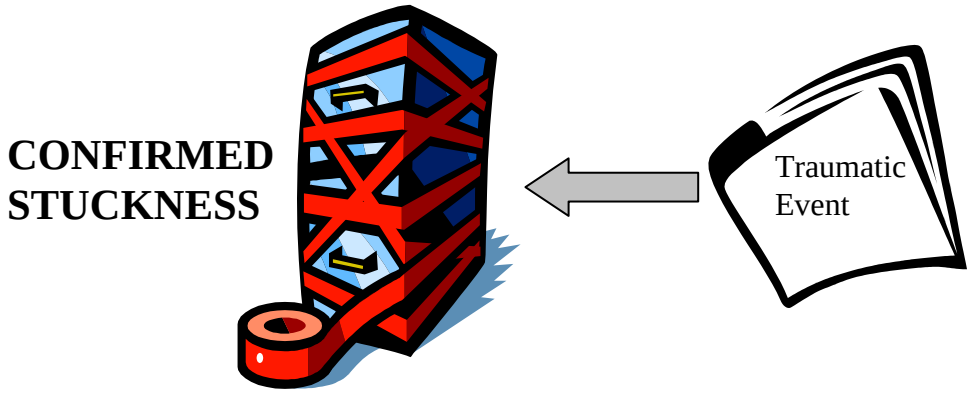
<u>Results</u>

- If you cannot change your previous beliefs to accept what happened to you (i.e., it is possible that I cannot protect myself in all situations), you may find yourself saying, "I deserved it because of my actions or inactions. I am responsible for what happened."
- If you are questioning your role in the situation, you may be making sense of it by saying, "I misinterpreted what happened…I didn't make myself clear…I acted inappropriately…I must be crazy, or I must have done something to have caused it…"
- If you are stuck here, it may take some time until you are able to get your feelings out about the trauma.

<u>Goal</u>

- To help you change the prior belief to "You may *not* be able to protect yourself in all situations." When you are able to do this, you are able to accept that it happened and move on from there.

2. Stuck points may also be formed if you have prior negative beliefs that seem to be confirmed or are reinforced by the event.



Prior Belief
Authority is not to be trusted.

Harmed During Military Service
I was harmed during my military service, and because of leadership.

Results

- If you see the trauma as further proof that authority (i.e., leadership) is not to be trusted, you believe this even more strongly.
- If you are stuck here, you may have strong emotional reactions that interfere with your ability to have successful relationships with authority. It may feel "safe" for you to assume all authority is untrustworthy, but this belief may keep you distressed, negatively impact your relationships, and possibly lead to legal, work, and social problems.

Goal

- To help you modify your beliefs so they are not so extreme. For example, "*Some* authority figures can be trusted in *some* ways and to *some* extent."

Session 2: The Meaning of the Event

Summary of Session 2: The Meaning of the Event

1. Administer PCL-5 (in waiting room if possible), collect, and store. Complete Practice Assignment Review and set agenda. (5 minutes)

2. Have patient read Impact Statement—begin to look for stuck points (5 minutes)
- If practice not written, have patient describe meaning of event orally and reassign.
- Add stuck points to the log

3. Discuss meaning of Impact Statement with patient (10 minutes)
- Begin to identify stuck points
- Review major issues to be focused on in treatment
- Identify **Assimilation** (changing memories to fit beliefs)
  - **Over-accommodation** (going overboard on changing beliefs as a result of memories)
  - **Accommodation** (changing beliefs about the world and events…this is desirable)

4. Review concepts (5 minutes)
- PTSD symptoms, info processing theory, treatment rationale, stuck points

5. Help identify and see connections among events, thoughts, and feelings (10 minutes)
- Six basic emotions: angry, disgusted, ashamed, sad, scared, happy
- Combined: jealous = mad + scared
- Varying intensity: irritated/angry/enraged
- Secondary emotions: guilt, shame.
- Patient examples of own feelings, including physical sensations
- Interpretation of events/self-talk affecting feelings (snubbed on street), alternatives
- Go back to Impact Statement for personal application

6. Introduce A-B-C Worksheets and fill one out together (5 minutes)

7. Assign practice and problem solve re: completion (5 minutes)

- A-B-C Worksheets to become aware of connection among events, thoughts, feelings, and behavior
- At least one A-B-C Worksheet each day (as soon after an event as possible)
- At least one worksheet directly about the worst traumatic event
- Add to Stuck Point Log

8. Check-in re: patient's reactions to session (5 minutes)

Session 2: The Meaning of the Event

The goals of Session 2 are:

1. To begin to determine the patient's stuck points and formulate why the patient has not recovered naturally from the event (Impact Statement).
2. To review the cognitive-behavioral formulation of PTSD and depression.
3. To begin helping the patient to identify and see the connection among events, thoughts, and emotions. The primary vehicle for understanding the patient's understanding of her own trauma and its effects is through the Impact Statement. Review of the effects of the trauma on one's life can also be used to enhance motivation for change.

- Session 2 goals

Patient Reading of the Impact Statement

The therapist should begin the session by asking how the practice assignment went and asking the patient to read it to the therapist. In listening to the Impact Statement, the therapist should be attuned to stuck points that are interfering with acceptance of the event (assimilation) and extreme, over-generalized beliefs (over-accommodation). If the patient did not do her practice assignment, the therapist should discuss the importance of completing practice assignments, review the problem of avoidance in the maintenance of the symptoms, and then ask the patient if she thought about the meaning of the event. **We never reinforce avoidance.** If a patient does not do her practice assignment or "forgets to bring it in," we proceed with the assignment orally during the session. The patient should read this and all other assignments out loud. If the therapist were to read it, the patient could tune out. It is another attempt at avoidance. The assignment to write the Impact Statement should be reassigned if it was not completed out of session, but the therapist should proceed with the next assignment as well.

- Reviewing the Impact Statement

The purpose of the Impact Statement is to have the patient examine the effect that the event has had on his life in several different areas. When reading the essays, it will be important for the therapist to determine whether or not this goal has been achieved. After listening to the Impact Statement, the therapist should praise the patient and review with the patient the major issues that emerged that will be focused on during treatment. The therapist should normalize the impact of the event but also begin to instill the idea that there may be other ways to interpret the event or begin to move beyond it.

Meaning of the Impact Statement

The therapist should use the framework of the Impact Statement to help the patient begin to recognize which of her statements reflect assimilation and over-accommodation. Please note that it is not necessary to use these terms. For example, in response to a patient's statement on thinking of ways she could have handled the traumatic situation differently, the therapist might say, *"It sounds like*

- Using the Impact Statement to address assimilation and over-accommo-dation

you wish that you could have had more options at the time. It's hard to accept the outcome, isn't it?" Engaging in hindsight bias, self-blame, and denial of various sorts are all examples of assimilation or trying to alter the event to fit prior beliefs. Examples of over-accommodation would be *"We are in grave danger all the time," "I can't trust my own judgment,"* and *"I can never feel close to anyone again."* The therapist can mildly point out those extreme statements, while intended to make the patient feel safer and more in control, have a heavy price and ultimately do not work.

The following is an example of an Impact Statement written by a 34-year-old man who had been sexually abused as a child and is the victim of several adult assaults. Although he is clearly blaming himself for the events (assimilation), he is intimidated by other people and has over-generalized danger in the world. His problems with self-esteem are also evident.

- Example of Impact Statement

> *The overall feeling of what it means to have been assaulted is the feeling that I must be bad or a bad person for something like this to have occurred. I feel it will or could happen again at any time. I feel only safe at home. The world scares me and I think it unsafe. I feel all people are more powerful than I, and am scared by most people. I view myself as ugly and stupid. I can't let people get real close to me. I have a hard time communicating with people of authority, so plainly I haven't been able to work. My fiancée and I rarely have sex and sometimes just a hug revolts me and scares me. I feel if I spend too much time out in the world an event like my past will take place. I feel hatred and anger towards myself for letting these things happen. I feel guilty that I've caused problems with my family (parents divorced). I feel dirty most of the time and believe that's how others view me. I don't trust others when they make promises. I find it hard to accept that these events have happened to me.*

Along with helping to begin identifying stuck points, problematic thoughts, beliefs, assumptions, and conflicts that will need to be attended to in therapy, the initial Impact Statement can also be used to help increase the patient's motivation to change. In the process of examining all the ways that the traumatic event has affected the patient's beliefs about self and others, it may be possible for the therapist to help the patient see that the cost of avoiding is very high and that it is worth it to risk remembering the trauma and feeling the painful emotions. After the therapist and patient have discussed the Impact Statement, the therapist begins to help the patient to identify and label thoughts and emotions; to learn to see the connection among events, thoughts, and feelings; and to be introduced to the idea that changing thoughts can change the level and type of emotion experienced. The therapist first gives the patient the Identifying Emotions Handout as they discuss types and intensity of emotions.

- **Give patient Identifying Emotions Handout**

> *Today we are going to work on identifying what different feelings are, and we will be looking at the connection between your thoughts*

and feelings. Let's start with some basic emotions—angry, disgusted, ashamed, sad, scared, or happy. These basic emotions can be combined to create other emotions like jealousy (mad + scared) or can vary in intensity (for example, irritated, angry, or enraged). Can you give me an example of something that makes you mad? When do you feel sad? How about happy? What frightens you? How do you feel physically when you are feeling angry? How do you feel physically when you are feeling scared? How are angry and scared different for you? What does shame or embarrassment feel like?

Build Stuck Point Log

- Build Stuck Point Log

The therapist and the patient should begin to construct the Stuck Point Log together. Stuck points are added to the log in session based on the discussion of the Impact Statement. If patients have listed stuck points that are not challengeable (e.g. feelings, questions, compound statements) the therapist should ask questions that will help to hone the patient in on a workable stuck point (e.g., what is the thought behind this feeling, is this true, or can you put this in an if/then statement?).

Connections Among Events, Thoughts, and Feelings

- Interpretation of events

The therapist then describes how interpretations of events and self-statements can affect feelings. The therapist can use as an example an acquaintance walking down the street and not saying hello to the patient, or an alternative is if someone says he will call and then doesn't. The patient is then asked what she would feel and next what she just said to herself (e.g., "*I'm hurt. She must not like me*" or "*I wonder if someone else might have different thoughts about her behavior?")*. If the patient is unable to generate alternative statements, the therapist should present several other possible self-statements (*"She must not have her glasses on," "I wonder if she is ill?" "She didn't see me,"* or *"What a rude person!"*). Then the therapist can ask the patient what she would feel if she said any of the other statements. It can then be pointed out how different self-statements elicit different emotional reactions.

Now, let's go back to the Impact Statement you wrote. What kinds of things did you write about when thinking about what it means to you that _____ happened to you? What feelings did you have as you wrote it?

- Connection of thoughts, feelings, and behavior

If the patient does not recognize his feelings or their connection to beliefs, help the patient tie his thoughts to his feelings and behavior. "*How do these thoughts influence your mood? How do they affect your behavior?*" The therapist should make sure the patient sees the connection among his thoughts, feelings, and behaviors. Sometimes a simple "why" question can help elicit the patient's thinking.

T: *Why were you angry?*
P: *Because I should have known better.*
T: *So your thought was, "I should have known that this was going to happen"?*
P: *Yes.*
T: *And your anger was directed toward yourself?* (Always remember to ask about the direction of anger.)

This exchange also allows the therapist to begin some gentle Socratic challenges to assess how flexible the patient's thinking is, and whether the patient has made some simple blind assumptions ("*I just should have known"*) or whether she has developed complex and convoluted thought patterns.

T: *I don't understand; how could you have known that this was going to happen?*
P: *I had a strange feeling that morning, like something was going to happen.*
T: *Have you ever had those kinds of feelings when nothing happened?*
P: *Yes, but it was very strong. I should have done something.*
T: *Did your feeling tell you what was going to happen or when it was going to happen?*
P: *No.*
T: *Then what could you have done?*
P: *I don't know. I just should have done something.*
T: *Were you certain about your feeling? You said that sometimes you have had feelings and then nothing happened.*
P: *No, I wasn't positive.*
T: *So, you didn't quite trust those feelings and wouldn't have known what to do even if you were sure?*
P: *No, but I still feel guilty that I should have done something.*
T: *Let's pretend for a second that you had a clear vision of exactly <u>what</u> was going to happen and exactly <u>when</u> it was going to happen, and knew exactly <u>who</u> to call to warn. What do you think their reaction would have been?*
P: *They wouldn't have believed me. They would have thought I was just some crank.*
T: *And then how would you feel?*
P: *Well, I wouldn't feel guilty or angry at myself; I would be angry at them and frustrated at not being able to do anything.*
T: *Yes, it's frustrating not being able to do anything to stop an event that is out of your control, isn't it?*
P: *Yes, I hate it.*
T: *It is very difficult to accept that some events can be out of our control. But it is not really your fault that it happened, is it?*
P: *No, I suppose not.*

If the patient begins to argue with the therapist or dig in her heels over her beliefs, the therapist should back off immediately and just say something like, *"Well, I can see that this is an important topic that we will need to work on later in therapy,"* or just *"We'll get back to this topic later."*

- Dealing with an argumentative patient

Although some patients will have very convoluted thinking that justifies their problematic cognitions, often a therapist will find almost no answers in response to Socratic questions. For example, in response to questioning the statement *"I let it happen"* with *"How did you let it happen?"* the patient may just say, *"I don't know; I didn't prevent it."* The therapist then would ask, *"How could you have prevented it?"* and the patient may respond, *"I don't know, I just should have."* In these cases, the patient has just made a blind assumption. He drew a conclusion that he should have prevented it, believed it without question, and never examined it any further. The patient then responds as if the statement were true, just because he said so. If the patient becomes uncomfortable because he doesn't have answers to the questions, the therapist can gently reassure him that they will work on this later in therapy.

Introduction to A-B-C Worksheets

Several A-B-C Worksheets are given to the patient (enough for one each day until the next session). The therapist points out the different columns and how to fill them in. More than one event can be written on each worksheet. The patient and therapist should fill out one worksheet together during the session. As an example, an event the patient has already brought into therapy or some event that occurred within the past few days should be used. Example A-B-C Worksheets that have some relevance to the patient's presentation should also be given to him.

- **Give patient blank and example A-B-C Worksheets**

> *These practice worksheets will help you to see the connection between your thoughts and feelings following events. Anything that happens to you or you think about can be the event to look at. You may be more aware of your feelings than your thoughts at first. If that is the case, go ahead and fill out Column C first. Then go back and decide what the event was (Column A). Then try to recognize what you were saying to yourself (Column B). Try to fill out these worksheets as soon after the events as possible. If you wait until the end of the day (or week) you are less likely to remember what you were saying to yourself. Also, the events you record don't have to be negative events. You also have thoughts and feelings about pleasant and neutral events. However, I want you to do at least one A-B-C Worksheet about the traumatic event.*

- Introducing A-B-C Worksheets

At the bottom of the A-B-C Worksheets are two questions that introduce the notion of alternative interpretations of events. The primary focus of the A-B-C Worksheets should be on the patient identifying the link between thoughts and feelings before moving on to challenging cognitions. Thus, the therapist should

use her judgment about introducing these questions in this session to the patient based on the patient's grasp of the basic cognitive-behavioral process. If the patient fills out the session spontaneously with an appraisal that the thought is not realistic, this may be an indicator that he is already beginning to challenge his own thoughts. If he insists that the extreme thought is realistic, then the therapist also has important information about the patient's rigidity. The two questions at the bottom can also be used in addition to the rest of the form as an alternative to the Challenging Beliefs Worksheet if that form proves to be too difficult for the patient due to low intelligence or literacy issues (see Session 7).

NOTE: If you opt to use Session 2a, review the first impact statement and finish any material that has not been finished in the previous sessions. Then introduce the idea that grief and PTSD are somewhat different and can complicate the recovery from the traumatic event. Grieving the loss of other people may entail different stuck points than those involved with the PTSD that the patient experienced directly. The patient may have trouble with the concept that they still have a relationship with the person who has died (i.e., they relate to them in making decisions and reacting to life's events and they have to accept that the person has died). Assign the second impact statement instead of the A-B-C worksheets for the next session.

Practice Assignment for Session 2

- **Assign Session 2 practice assignment**

Please complete the A-B-C Worksheets to become aware of the connection between events, your thoughts, feelings, and behavior. Complete at least one worksheet each day. Remember to fill out the form as soon after an event as possible and if you identify any new stuck points add them to your log. Complete at least one worksheet about the worst traumatic event. Also, please use the Identifying Emotions Handout to help you determine what emotions you are feeling.

Sample Session 2 Progress Note

Contact: 50-minute psychotherapy session

Content: This was the second session of CPT for PTSD. The patient did (not) complete the practice related to writing an Impact Statement describing the impact of his traumatic experiences on his thoughts and beliefs about himself, others, and the world. We discussed the assignment in session, with an emphasis on identifying stuck points in his thinking that interfere with recovery. These stuck points were added to the log. The relationships amongst thoughts, feelings, and behaviors were reviewed, and an example from his discussion about the impact of his trauma on his life was used to illustrate the cognitive model. The patient agreed to complete A-B-C Worksheets daily to monitor his thoughts, feelings, and behaviors until the next session.

Plan: Continued CPT for PTSD

Initial of Patient Last Name: _____ Last 4 digits of SSN: _____
Therapist Initials: _____ Date: _____ Session: _____

Format of CPT: Individual ❒ Group ❒ CPT-C ❒ CPT ❒

PCL-5: WEEKLY

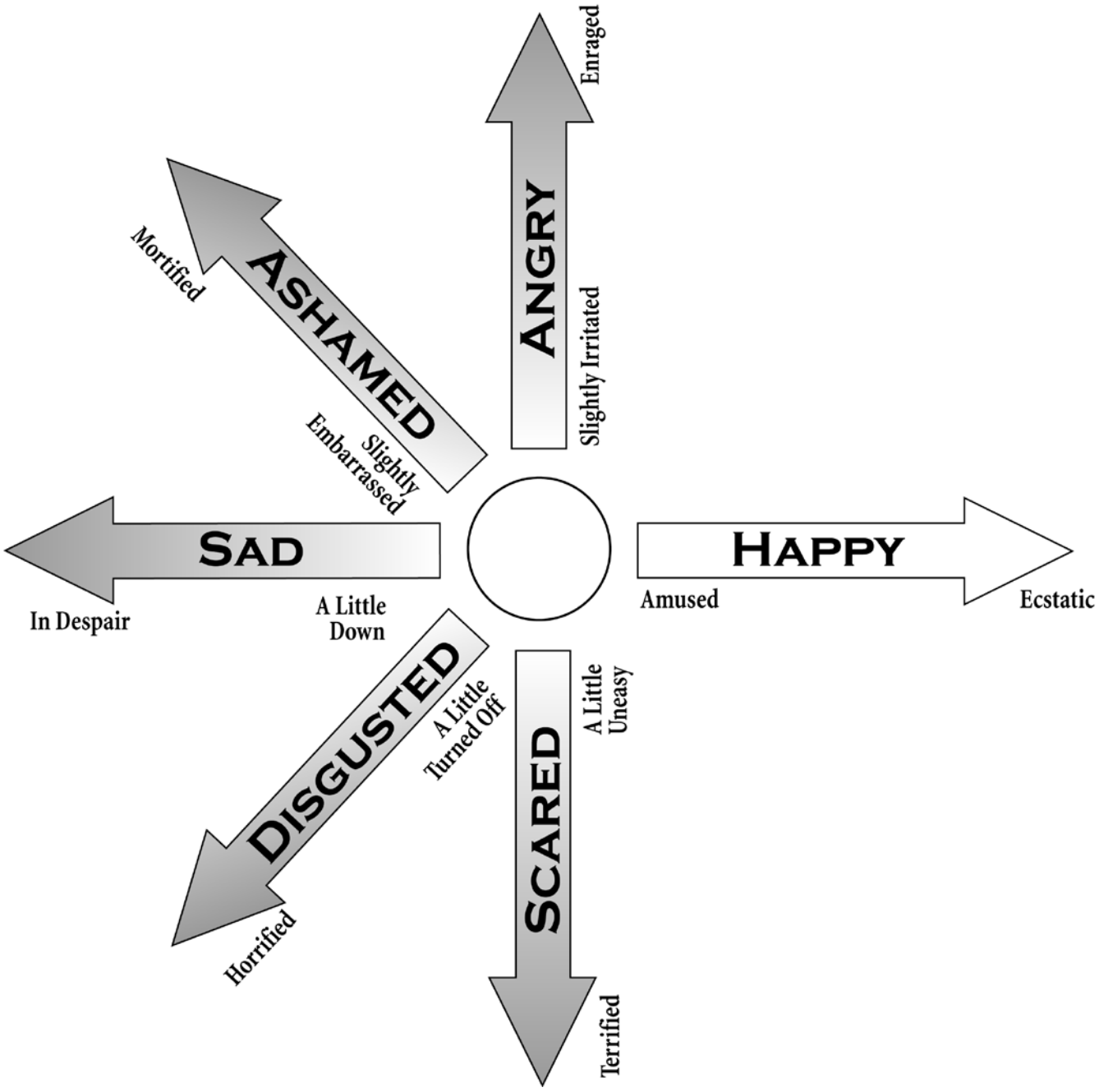
Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past week.

In the past week, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD

Stuck Point Log

Identifying Emotions Handout



A-B-C Worksheet

Date: _____ Patient: _____

ACTIVATING EVENT **A** "Something happens."	**BELIEF/STUCK POINT** **B** "I tell myself something."	**CONSEQUENCE** **C** "I feel something."

Are my thoughts above in "B" *realistic*?

_____

What can you tell yourself on such occasions in the future?

_____

_____

_____

A-B-C Worksheet

Date: _____ Patient: _____

ACTIVATING EVENT **A** "Something happens."	**BELIEF/STUCK POINT** **B** "I tell myself something."	**CONSEQUENCE** **C** "I feel something."
"I shot a Vietnamese woman while in combat."	***"I am a bad person because I killed a helpless civilian."***	***"I feel guilty and angry with myself."***

Are my thoughts above in "B" *realistic*? ***"No. One mistake does not make me a bad person. People make mistakes, and high stress situations, like combat zones, increase the probability of such mistakes."***

What can you tell yourself on such occasions in the future? ***"I may have made mistakes in my life, but that does not make me a bad person. I may have done things that I regret, but I have also done good things in my life."***

A-B-C Worksheet

Date: _____ Patient: _____

ACTIVATING EVENT **A** "Something happens."	**BELIEF/STUCK POINT** **B** "I tell myself something."	**CONSEQUENCE** **C** "I feel something."
"My commanding officer making orders that got us into crossfire."	***"People in authority cannot be trusted. He put us in harm's way to protect himself."***	***"I feel fearful and distrusting. I avoid people in authority, or argue with them about their decisions when I have to interact with them."***

Are my thoughts above in "B" *realistic*? ***"No. Not all authority figures are necessarily like my commanding officer."***

What can you tell yourself on such occasions in the future? ***"People in authority are individuals, and they do not all share the same strengths and weaknesses."***

A-B-C Worksheet

Date: _____ Patient: _____

ACTIVATING EVENT **A** "Something happens."	**BELIEF/STUCK POINT** **B** "I tell myself something."	**CONSEQUENCE** **C** "I feel something."
"I build a porch and the railing comes loose."	***"I can never do anything right."***	***"I get angry and kick the railing. I also feel down and sad because I can't do anything right."***

Are my thoughts above in "B" *realistic*? ***"No. It wouldn't hold up in a court of law, because I do SOME things right."***

What can you tell yourself on such occasions in the future? ***"There are some things that I do all right. It is not true that I 'never' do anything right***

Session 3: Identification of Thoughts and Feelings

Summary of Session 3: Identification of Thoughts and Feelings

1. Administer PCL-5 (in waiting room if possible), collect, and store. Complete Session 3 Practice Assignment Review and set agenda. (5 minutes)

2. Review A-B-C Worksheets, further differentiating between thoughts and feelings (15 minutes)

- Label thoughts vs. emotions
- Recognize changing thoughts can change intensity of type of feelings
  - Begin challenging self-blame and guilt
- Point out mismatches:
  - Dominant emotion(s)? - Emotions follow thoughts?
  - Dominant thought(s)? - Thoughts and emotional intensity match?
- Look for stuck points, add them to the log, and use Socratic questioning to help patient identify alternative hypotheses

3. Discuss the A-B-C Worksheet related to trauma (10 minutes)

- Review orally if patient did not complete
- Challenge the stuck point of self-blame using Socratic questioning

4. Introduce the Trauma Account (10 minutes)

- How to write the Trauma Account
- Cognitive therapy for any concerns about the Trauma Account
  - Complete an A-B-C Worksheet about the assignment

5. Assign practice and problem solve re: completion (5 minutes)

- Full Trauma Account with sensory details
- Daily reading of the full Trauma Account
- Daily completion of A-B-C Worksheets
- Problem-solving re: practice completion is very important. Refer to rationale if necessary.

6. Check-in re: patient's reactions to session (5 minutes)

Session 3: Identification of Thoughts and Feelings

The goals of Session 3 are:

1. To assist the patient in labeling thoughts and emotions in response to events.
2. To introduce the idea that changing thoughts can change the intensity or type of emotions that are experienced.
3. To continue to identify stuck points and add them to the log.
4. To begin challenging the patient's self-blame and guilt with regard to the traumatic event through Socratic questions.
5. To assign the patient to write a detailed account of the traumatic incident.

- Session 3 goals

NOTE: If the therapist is using the CPT protocol without the trauma accounts, then the assignment will be to do the A-B-C Worksheets again until the next session.

Review of A-B-C Worksheets

Homework Noncompliance—If the patient did not write the initial Impact Statement for the last session, this session should begin with having the patient read the Impact Statement and noticing any changes or additions since the last session. If the patient fails to bring in the Impact Statement again or the A-B-C Worksheets, the therapist should have a serious discussion about the patient's motivation for treatment at this time. If the patient continues to be noncompliant with the assignments, therapy should not proceed without a commitment from the patient. The therapist should consider whether some other form of treatment is needed first (e.g., Dialectical Behavior Therapy (DBT), skills, substance abuse treatment, panic disorder treatment) before PTSD treatment can commence. It is preferable to ask the patient to return to treatment when he can devote himself to the work than to have him fail to recover due to noncompliance. If the latter is the case, it will be more difficult to implement the protocol at a later time (*"That therapy didn't work; I'm a failure"*). Remind the patient that avoidance behavior is a symptom, not an effective method of coping. If the patient recommits to treatment, have him bring in both the Impact Statement and A-B-C- Worksheets, but hold off on the trauma account assignment to determine if he is going to follow through. The therapist should begin by going over the A-B-C Worksheets completed for practice. In looking over the worksheets that the patient has completed since the previous session, the therapist should look for several patterns first. Is there a particular dominant emotion that repeatedly occurs (e.g., anger at self)? Is there a particular thought that recurs across situations that might indicate a greater schema distortion (*"I can't do anything right"*—incompetence)? Do the emotions follow logically from the thoughts that are expressed? Is there a match between the thoughts and the degree of the emotions (small event, disproportionately large feelings)?

After looking over the entries generally, the therapist assists the patient in sorting through the individual items that were problematic for the patient. Frequently

- Mismatch between thoughts and emotions

mismatches occur between thoughts and either type or degree of emotion because the thought that was listed was not actually the last thought in a chain of thoughts and emotions. The therapist can point out the discrepancy mildly and ask what thought goes with the level or type of emotion that was expressed. There may, in fact, have been a series of thoughts and incremental emotions that lead to the final stronger emotion. Tracking through the sequence can be helpful for patients to see how increasingly extreme statements result in depression, terror, or other desperate emotions.

- Thoughts vs. feelings

Frequently, patients label thoughts as feelings. For example, one patient brought in an A-B-C Worksheet that said *"Get yelled at before I even have my coffee"* at "A," *"I try so hard but never get rewarded"* at "B," and *"I feel like I'm fighting an unsuccessful battle"* at "C." The therapist again labeled the basic emotions for the patient and asked her which of the feelings fit the statement best. She said, *"sad and angry."* The therapist pointed out that what she had listed at "C" was actually another thought that could be listed at "B." The patient was able to understand the distinction between thoughts and feelings. The therapist also pointed out that just using the words *"I feel..."* in front of a thought does not make that thought a feeling. Patients are encouraged to use the words *"I think that ..."* or *"I believe…"* for thoughts and to reserve *"I feel…"* for emotions.

NOTE: This misuse of the word "feel" is so common that the therapist may also catch himself. It is quite acceptable, and in fact better, for the therapist to correct himself during the session if it occurs, thus normalizing how our spoken language can be misapplied.

It is important for the therapist to praise the efforts of the patient and help with corrections in a low-key manner, particularly if the patient has lots of issues with negative self-evaluation (e.g., *"O.K., let's move this thought over to the "B" column. Now what feeling goes with that thought? Just one word"*).

- Stuck point log

Remember to add new stuck points to the log.

Review of A-B-C Worksheet Related to Trauma

When going over the worksheet about the traumatic event, the therapist again has an opportunity to begin cognitive challenges with Socratic questions. Consider the following bereavement issue:

- Example of Socratic questioning

P: *In the "A" column, I wrote "I didn't think about Jack all day when I was at work." My thoughts were "How could I betray him like this? I am worthless." In the "C" column I wrote "shame, angry, and I cancelled my plans for the evening."*
T: *Who were you angry at?*
P: *Myself.*
T: *I'm not sure I understand. How is that a betrayal of Jack?*
P: *I don't know - it just is.*

T: (Therapist waits silently)
P: *Well, it just doesn't seem fair for me to go on with my life, when he can't go on with his.*
T: *But how is that a betrayal? The word "betrayal" makes it sound like you are saying that you were being disloyal or treacherous. Is that what you mean?*
P: *Well, not treacherous, but yes, disloyal.*
T: *Before he died, did you ever have a workday when you didn't think about him all day?*
P: *Sure. Lots of times.*
T: *Were you being disloyal then? Were you betraying him by being busy at work and concentrating on what you were being paid to do?*
P: *Well, no, but that was different. He was alive then. I assumed that I would see him again at the end of the day.*
T: *You said that it wasn't fair for you to go on when he couldn't. If you go on with your work and life and don't think about him all the time, how will you have been disloyal? Why is it different now?*
P: (Tearfully) *I'm afraid that if I am not thinking about him, that it means that I am forgetting him.*
T: (After a long pause to allow the patient to cry) *When he was alive and you didn't think about him all day, did you forget him? Could you have thought about him if you wanted to?*
P: *Of course.*
T: *And even though you know you are not going to see him at the end of the day, you could decide to think about him? You can remember him if you want to?*
P: *I suppose so. I'm just afraid to let go. It's almost like if I don't think about him all the time, he really is gone.*
T: *So, you are saying that it is still very difficult to accept that he has died.*
P: *Yes.*
(Another pause)
T: *Since he died, have you learned anything new about Jack? Did anyone tell you any stories that you haven't heard before?*
P: *Yes, lots of his relatives told me stories about when Jack was a child, and people at work have told me about things he did for people there that he never told me.*
T: *So, in some ways, even though he is gone, you are still learning about him and who he was.*
P: *That's true.*
T: *And have your feelings for Jack continued?*
P: *Yes, in some ways, they have increased. I heard so many nice things that people said he had said and done. He was very unselfish and never even mentioned these things to me. I'm very proud of him.*

T: *So, rather than forgetting him, your relationship with him has continued and your positive feelings have increased. That doesn't sound like you are betraying him. Also, being an unselfish person, Jack would not expect you to stop living your life because he had died, would he?*

P: *No, he wouldn't. It just didn't feel right to me. I just don't know how I am supposed to think or be.*

T: *There isn't a right way or wrong way to grieve. In spite of some stereotypes, people deal with the death of a loved one all sorts of different ways with all sorts of different feelings over different periods of time. You won't be very fair to yourself if you hold up some standard and decide that you are doing this wrong somehow.*

Introduction to the Trauma Account

- Writing the Trauma Account

The out-of-session practice assignment for the next week is to write a detailed account of the chosen index trauma. The therapist should ask whether the index trauma selected at Session 1 remains the event that causes the most distress. If there is a different trauma that is more distressing, the trauma account may be written on the newly identified event. The patient is asked to write down exactly what happened with as many details as possible. He should be encouraged to include sensory detail (sights, sounds, smells, etc.) and his thoughts and feelings during the event. To encourage a more in-depth account, set the expectation that the average handwritten trauma account is about eight pages long. If the patient is unable to complete the assignment, he should be encouraged to write as much of it as he can. He may need to write on several occasions to complete the assignment. If he is unable to complete the assignment in one sitting or becomes emotional and needs to stop for a few minutes, he should draw a line at the point he stopped. The therapist may be able to determine some of the stuck points by examining the points at which he quit writing. The patient should be instructed to read the account to himself every day until the next session. (Once the account is written, reading the account should only take a few minutes a day.) Encourage the patient to pick a time when he has privacy and can cry and feel other emotions without being interrupted or embarrassed. Be direct about discouraging completing practice assignments at work, during lunch, or in a public place. For those with substance abuse issues, directly indicate that they should not write the account while using substances. Identify this as avoidance behavior. Also, the account should be handwritten and not typed. As mentioned previously, there is evidence that writing the account is more evocative. Typing the account lends more objectivity and tends to focus on grammar rather than the emotional engagement that is desired.

The therapist should add,

Don't be surprised if you feel your reactions almost as strongly as you did at the time of the incident. However, you need to remind

yourself that this is a memory and that you are not actually in danger as you recall that event. Your feelings have been stored in your memory intact. If you have not dealt with this event, your feelings and the details of the event are quite vivid when you finally confront the memory in its entirety. People tend to remember traumatic events in much greater detail than everyday events. Over time, if you continue to allow yourself to feel your emotions about the event, your feelings will become less intense and less overwhelming.

- Purposes of writing the full Trauma Account

There are two purposes for the writing assignments. First, writing about the event in great detail assists in calling up the complete memory of the event, including the natural emotions that have been encoded with the memory. Retrieving the natural emotions allows them to be fully expressed and dissipated. The memory can then be stored without such intense emotions encoded with it. (We have found that the primary natural emotions dissipate quickly and do not need extended exposure work, unlike theories that suggest the repeated prolonged exposures are necessary for habituation.) The second purpose is for the therapist and patient together to begin to search for stuck points.

After the therapist introduces the trauma account assignment, it is suggested that the therapist and patient complete an A-B-C Worksheet to examine the patient's thoughts about the assignment. In the A column, the activating event would be "*assignment to write trauma account.*" The therapist and patient then work through the worksheet to identify thoughts that may serve as a barrier to assignment completion.

Practice Assignment

- **Assign Session 3 practice assignment**

Please begin this assignment as soon as possible. Write a full account of the traumatic event and include as many sensory details (sights, sounds, smells, etc.) as possible. Also, include as many of your thoughts and feelings that you recall having during the event. Pick a time and place to write so you have privacy and enough time. Do not stop yourself from feeling your emotions. If you need to stop writing at some point, please draw a line on the paper where you stop. Begin writing again when you can, and continue to write the account even if it takes several occasions.

Read the whole account to yourself every day until the next session. Allow yourself to feel your feelings. Bring your account to the next session.

Also, continue to work with the A-B-C Worksheets every day and when you find stuck points continue adding them to your log.

Sample Session 3 Progress Note

Contact: 50-minute psychotherapy session

Content: This was the third session of CPT for PTSD. He did (not) complete A-B-C Worksheets daily, identifying his thoughts, feelings, and behaviors. These worksheets were used to further illustrate the relationships among thoughts, feelings, and behaviors to daily events. Additional stuck points were added to the log. Some initial challenging of dysfunctional thoughts was introduced. The session concluded with the assignment to write about the most traumatic event the patient has experienced and to include as many sensory and emotional details as possible. Daily monitoring of thoughts, feelings, and behaviors continues.

Plan: Continued CPT

Initial of Patient Last Name: _____ Last 4 digits of SSN: _____
Therapist Initials: _____ Date: _____ Session: _____

Format of CPT: Individual ❒ Group ❒ CPT-C ❒ CPT ❒

PCL-5: WEEKLY

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past week.

In the past week, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD

A-B-C Worksheet

Date: _____ Patient: _____

ACTIVATING EVENT **A** "Something happens."	**BELIEF/STUCK POINT** **B** "I tell myself something."	**CONSEQUENCE** **C** "I feel something."

Are my thoughts above in "B" *realistic*?

_____

What can you tell yourself on such occasions in the future?

_____

_____

_____

Session 4: Remembering the Traumatic Event

Summary of Session 4: Remembering the Traumatic Event

1. **Administer PCL-5 (in waiting room if possible), collect, and store. Complete Session 4 Practice Assignment Review and set agenda.** (5 minutes)

2. **Have patient read full Trauma Account aloud with affective expression** (10 minutes)
   - Goals of Written Trauma Account:
     - Affective Expression—Holding back feelings? Why? (soda bottle analogy)
     - Identify Stuck Points—Over-accommodation?
     - Challenge Self-Blame—Assimilation?
   - Remain quiet during reading (except to stop and ask to restart if no emotions are expressed)
   - Ask about feelings during writing and reading
   - Ask about areas where it seemed something was avoided
   - If Trauma Account was not written, discuss reasons and then have patient recount the trauma during the session and reassign the writing

3. **Identify stuck points** (10 minutes)
   - Use patient's expression of affect or lack thereof to identify stuck points
   - Ask to read again if initially read without affective expression or if clarification is needed
   - Listen for stuck points in the content and add them to the log
   - Note the places the patient had to stop writing and ask about emotions, look for stuck points

4. **Challenge patient's stuck points related to self-blame and other assimilation using Socratic questioning** (10 minutes)
   - e.g., What else might you have done? And what might have happened then?
   - Discuss hindsight bias

5. **Explain difference between responsibility and blame** (5 minutes)

6. **Assign practice and problem solve re: completion** (5 minutes)
   - Rewriting of the full Trauma Account
   - Daily reading of the full Trauma Account
   - Daily completion of the A-B-C Worksheets
   - Problem-solving re: practice completion (this is extremely important if practice not completed this session)

7. **Check-in re: patient's reactions to session** (5 minutes)

Session 4: Remembering the Traumatic Event

The goals of Session 4 are:

1. To have the patient read his account, with affective expression.
2. To identify the patient's stuck points for the event and add to the log.
3. To begin challenging self-blame and other assimilation with Socratic questions.
4. To reassign the account with more details and anything that was left out.

- Session 4 goals

Patient Reading of Full Trauma Account With Affective Expression

- Patient reading of full trauma account

The therapist should begin the session by having the patient read the trauma account. If the patient did not do the assignment, the therapist should first ask her why she did not complete it. Discuss the problem of avoidance and how it prevents recovery. Then ask the patient to describe the event as if she had written it. Be sure to help the patient to identify her thoughts and feelings as she recounts the event, but do not have the patient write it during session. If the patient has brought the trauma account, having the patient, rather than the therapist, read the account assists in engagement with the memory and reduces the likelihood of dissociation or other emotional disengagement from the account. If the patient expresses emotions, the therapist should remain still and not interfere with the expression of affect. Comforting words or even handing the patient a tissue can actually interfere with expression of affect because the patient is brought back to the present. Patients are usually trying so hard not to experience their emotions that just about anything the therapist does can disrupt the process. Therapists who are new to trauma therapy are often concerned that patients will experience an overwhelming amount of affect. Patients are also frequently concerned about the extent of emotions they have been avoiding. However, we have not found that to be the case in the vast majority of cases and are usually very pleased with even a small expression of affect. In those rare cases in which the therapist is concerned about the extent of emotion that the patient is expressing, the therapist can begin to do those very things mentioned above—talking to the patient, saying the patient's name, handing her a tissue, asking questions—to contain the affect.

- Therapist behavior during reading

It is important that the therapist allows and encourages the patient to express his emotions about the event and help him to identify both his thoughts and feelings. The patient should be encouraged to discuss his feelings and thoughts while doing the assignment, as well as during the incident. *"What was the most frightening part for you?" "Is there some aspect of the incident that you shy away from recalling?"* This exercise may help the patient and therapist to identify his stuck points. The therapist should notice the points at which the patient stopped writing and ask if these were particularly difficult points of his memory, and why. *"What were you feeling at the time that you quit writing?"* Often these points are particularly anxiety-provoking because they were the most life-threatening to the patient or the moment at which he perceived a loss of control over the situation.

- Therapist guidance during reading

Depending on the length and complexity of the event, the average trauma account is about eight handwritten pages. However, some particularly short events may not require as many. Others are so long and complex that several writing sessions may be needed to complete the account. Some patients will write extensively about irrelevant details and then gloss over the most crucial and traumatic elements. The therapist needs to listen carefully, not just to what the patient reads but also to what he leaves out. If the therapist realizes or suspects that an important aspect of the account has been avoided, the patient should be asked for more detail about that portion of the experience after he has finished reading the whole account.

- Length and content of Trauma Account

If the patient reads or recounts the event without any emotion, the therapist should stop the patient early in the account and ask him if he is holding back his feelings, and why. The therapist may need to discuss the issue of loss of control and the patient's fear of being overwhelmed by his emotions (*"I will go crazy, forever"*). The analogy we typically use is one of a bottle of soda that has been shaken. When the cap comes off, there is a rush, but it is temporary and eventually the soda flattens. If the patient were to quickly put the cap back on, the soda would retain its fizz. The soda, under pressure, had energy to it but can't keep producing that energy when the cap is left off. Natural emotions can be viewed the same way. The patient feels the strength of the emotions but keeps the lid on them, thinking that they will continue indefinitely. At this point, the therapist can ask the patient to recall times when he has experienced feelings such as sadness or anger and what happened after he allowed himself to feel his emotions. It can also be helpful for the therapist to remind him that the actual event is over and that he is no longer in imminent danger. The strong feelings are of a memory. After addressing this issue, the therapist should resume with the account and ask the patient what he was feeling at the time. Again, when a patient begins to experience emotions, it is important that the therapist sits quietly and does not disrupt the emotions, minimize them, or interfere in any way.

- Soda bottle analogy of emotions
- Let the patient feel full emotions

Sometimes, the patient is not avoiding affect but is experiencing the emotions just as they were experienced at the time. If the patient dissociated, she may dissociate again as she recalls her memories of the event. If patients were nauseated, they may feel the same way as they recall the event in detail the first time. Typically the emotions change after the first account and the patient begins to experience more current emotions, not just those that were encoded at the time of the event.

Identification of Stuck Points

Finally, the therapist should ask the patient about stuck points that may not be in her trauma account (i.e., what she thought she should have done). **Remember to add any new stuck points to the log**. Often, patients have regrets afterward because they believe they should have prevented an event, did not fight hard enough, or did or didn't do something that affected others. Sometimes stuck points emerge because other people respond to hearing about the event by

- Stuck points from Trauma Account

second-guessing the Veteran's behavior. The therapist may have to discuss 20/20 hindsight (hindsight bias) and how easy it is to say how you should have behaved after something occurs. This can be a particularly difficult stuck point if the other person's comment mirrors what the patient previously believed about how she would act in such a situation. No one knows how she will respond in a particular situation. Sometimes patients jump to the faulty conclusion that if they had acted differently in some way, the event would have turned out differently. Of course, people's fantasies usually result in a good outcome. They don't consider more negative outcomes. In this vein, Socratic questioning about the range of possible outcomes with alternative courses of action is very helpful.

Stuck Points Specifically Related to Self-Blame and Other Assimilation Using Socratic Questioning

- Self-blame

Self-blame is often encountered early in therapy as the patient recalls the event. This form of assimilation occurs because the patient is looking for ways in which he could have prevented or stopped the particular outcome that occurred. Even following disasters that are clearly outside of a patient's control, self-blame and guilt are common. People imagine ways they could have changed personal outcomes; they have regrets about not saving others; they feel guilty about things they did or did not do, and about feelings they did or did not feel during or after the event. This "if only" type thinking serves as assimilation in that it is an attempt to undo the event in retrospect. It usually never occurs to the patient that the "if only" might not have worked. Some people get caught up in assumptions about how one should react or how long it should take to recover, and then feel guilty that they are not doing it right. Some people even feel guilty because they are coping well when others around them are not.

- Contextualization of traumatic event

It is important for the therapist to help the patient contextualize the traumatic event. For example, if a Veteran blames himself for killing someone in Vietnam and has flashbacks of seeing that person's face, he may not be fully appreciating the context of the situation. Going through the account will help the patient see that he was in a war, that the other person was shooting at him, and that he had no other good option at the time (or perhaps a worse option). Part of the context would also include the age of the person (and developmental level) at the time of the event and his beliefs about war and the military at the time. He may also have been sleep-deprived or hungry, or terrorized and dissociative at the time. It is important for the patient to understand that actions he thinks of later, but not at the time of the event, were not options. The therapist's job is to guide the patient, through the use of Socratic questions, to realize that events can occur in spite of one's best efforts. The best-made plans do not always result in positive outcomes. The following is an example of Socratic questioning early in therapy about the context of killing.

- Example of Socratic questioning

T: *Earlier you mentioned that you were feeling angry about the reports from Abu Ghraib. Can you tell me what makes you angry?*

P: *I can't believe that they would do that to those prisoners.*
T: *What specifically upsets you about Abu Ghraib?*
P: *Haven't you heard the reports? I can't believe that they would humiliate and hurt them like that. Once again, the U.S. military's use of force is unacceptable.*
T: *Do you think your use of force as a member of the U.S. military was unacceptable?*
P: *Yes. I murdered innocent civilians. I am no different than those military people at Abu Ghraib. In fact, I'm worse because I murdered them.*
T: *Murder. That's a strong word.*
P: *Yah?*
T: *From what you've told me, it seems like you killed some people who may or may not have been "innocent." Your shooting occurred in a very specific place and time, and under certain circumstances.*
P: *Yes, they died at my hands.*
T: *Yes, they died, and it seems because of your shooting. Does that make you a murderer?*
P: *Innocent people died and I pulled the trigger. I murdered them. That's worse than what happened at Abu Ghraib.*
T: (Quietly) *Really, you think it is worse?*
P: *Yes. In one case, people died, and in another they didn't. Both are bad, and both were caused by soldiers, but I killed people and they didn't.*
T: *The outcomes are different. I'm curious if how it happened matters?*
P: *Huh?*
T: *Does it matter what the soldiers' intentions were in those situations?*
P: *No. I don't get what you're saying. The bottom line is killing versus no killing.*
T: (Realizing that there was minimal flexibility in the patient's thinking at this point) *I agree that there is no changing the fact that people died, and that your shooting had something to do with that. However, I think we might disagree on the use of the term "murder." It is clear that their deaths have been a very difficult thing for you to accept, and that you are trying to make sense of that. The sense that you appear to have made of their deaths is that you are a "murderer." I think this is a good example of one of those stuck points that has prevented you from recovering from this traumatic event. We'll definitely be spending more time together on understanding your role in their deaths. I'm not sure "murder" is the right word to describe what happened.*

In addition to testing the patient's cognitive flexibility, the therapist also wanted to plant the seeds of a different interpretation of the event. She was careful not to push too far, and she retreated when it was clear that he was not amenable to an alternative interpretation. He was already defensive and somewhat angry, and she did not want to exacerbate his defensiveness or possibly contribute to dropout from the therapy.

- Child physical or sexual abuse

If the patient's index event was child physical or sexual abuse, he may be particularly confused by the concept of punishment. He may assume that the event occurred as some form of punishment, an idea that may have been reinforced by the abuser. Later traumas are then also assumed to be some form of punishment. Because the patients cannot figure out what they did wrong or what they could have done that deserved such severe punishment, they may have concluded that it must have been because they were bad people to begin with. The ultimate goal for the therapist is to help the patient to see that abuse has nothing to do with him as a person, but is only about the abuser and his or her choices.

- Rape

Because rape is a very personal event, patients who have experienced it may also believe that it means something about them as people. Again, the therapist will need to guide the patient to see that she was the occasion for the assault (she was convenient or had higher risk factors such as small size or alcohol use) but not the *cause* of the event. The perpetrator is entirely responsible and to blame for the event, and no risk factor can force someone to commit an assault. In fact, some risk factors would result in protective behavior in good people (e.g., intoxication, small size). Blame and fault are words that should only be used when intent was present (i.e., when the patient says she is to blame for the event, the therapist can ask if the patient intended for this to happen. When she says no, the therapist can explain that blame and fault only apply to intentional acts.)

P: *It is my fault that the sergeant raped me. I should have been able to stop it.*
T: *How could you have stopped it?*
P: *I was trained in close combat.*
T: *When did you recognize that you were in danger?*
P: *We were talking and then he closed the door, walked over and pushed me down.*
T: *And is this the type of situation you had been trained to handle?*
P: *No. They were training us for situations with strangers, with the enemy. I never expected to be assaulted by my sergeant.*
T: *So you were surprised by him. Were you confused as to what was going on?*
P: *Yes, very.*
T: *So there was a period of time that you didn't know what was going on and what to do?*
P: *Yes. I just froze for a minute. I said "no" several times but he didn't stop. I remember pushing at him but I remember thinking, "If I fight him, he could kill me."*

T: *Was he bigger than you? Stronger than you?*
P: *Yes. And when he was on top of me, I couldn't move. I couldn't breathe.*
T: *So how could you have stopped it?*
P: *I guess I couldn't have. But, I just keep thinking I should have.*
T: *But that thought doesn't get you anywhere does it? He had surprise on his side, your training didn't include fighting off someone you knew, who was your superior, was bigger, stronger, and had the power to ruin your career. You know, I wonder if you are confusing "I should have" with "I wish I could have."*
P: *I do wish I could have stopped it.*
T: *I wish it hadn't happened either. You didn't deserve to have it happen. And from everything you have told me, I am not hearing any way you could have stopped it. How does it feel to say "I wish I could have stopped it" instead of "I should have stopped it"?*
P: *You know, it does feel different. When I say "I should have," I feel guilty. When I say, "I wish," I just feel a little sad.*

Difference Between Responsibility and Blame

- Responsibility vs. blame

In this stage of CPT focused on addressing assimilation, it is important for the therapist to educate the patient about the distinction between blame and responsibility. Responsibility relates to one's actions in a situation that contributes to a certain outcome. A combination of responsibility and intentionality is what determines blame. If there is no intention to do harm, then blame is not appropriate. People are capable of making distinctions in levels of blame and responsibility. An example of that is the distinction that people can make among an accident (no responsibility, no intentionality), negligent manslaughter (responsibility, but no intentionality), and murder (responsibility and intention to kill).

The following is Socratic questioning about intentionality and responsibility as it relates to the prior example of killing in a combat situation.

T: *I think it is worthwhile for us to discuss the differences between blame and responsibility. Let's start with responsibility. From your account, it sounds like you were responsible for the shooting. It sounds like there were other people who may have been responsible, too, given that you were not the only person who shot at that time. The bottom line is that responsibility is about your behavior causing a certain outcome. Blame has to do with your intentionality. It has to do with your motivations at the time. In this case, did you go into the situation motivated and intending to kill?*
P: *No, but the outcome was that they were murdered.*

T: *Some died. From what you've shared, if you put yourself back into the situation at the time, it was not your intention at all for them to die. Your, and others', intentions were to get the people out of the area. To secure and protect the area. Your intention at the time did not seem to be to kill people. In fact, wasn't your intention quite the opposite?*
P: *Yes.* (Begins to cry)
T: (Pause until his crying subsides somewhat) *Your intention was not to kill civilians at all. Thus, the word blame is not appropriate. Your intention was not at all to have to shoot them.*
P: *But why do I feel like I am to blame?*
T: *That's a good question. What's your best guess about why that is?*
P: (Still crying) *If someone dies, someone should take responsibility.*
T: *Do you think it is possible to take responsibility without being to blame? What would be a better word for a situation that you had a part in, but you didn't intend for it to happen? If someone shot someone but didn't intend to do that, what would we call that?*
P: *An accident, I guess.*
T: *That's right. In fact, what would we call shooting someone when you were trying to protect something or someone?*
P: *Self-defense.*
T: *Yes—very good. Weren't you responsible for securing the area?*
P: *Yah.*
T: *So, if you were responsible for guarding and securing that area, and they didn't heed your warnings, wouldn't that have put the area at risk?*
P: *Yes, but they were civilians… not insurgents.*
T: *How do you know that?*
P: (Pause) *I don't.*
T: *We actually don't know what their intention was, do we? They didn't heed the several warnings, right?*
P: *Yes.* (Pause)
T: *We don't know, and won't know, bottom line. However, what we do know is what you knew at the time. What you knew at the time is that they had not heeded the warnings, that you were responsible for securing the area, and that you took action when you needed to take action to protect the area. Thinking about those facts of what happened and what you knew at the time, how do you feel?*
P: *Hmm… I guess I'd feel less guilty.*
T: *You'd feel less guilty, or you feel less guilty?*
P: *When I think through it, I do feel less guilty.*
T: *There may be points when you start feeling guiltier again. It will be important for you to hold onto the facts of what happened,*

versus going to your automatic interpretation that you've had for a while now. Is there any part of it that makes you proud?

P: *Proud?*

T: *Yes. It seems like you did exactly what you were supposed to do in a stressful situation. Didn't you show courage under fire?*

P: *It's hard for me to consider my killing to be courageous.*

T: *Sure. You haven't been thinking about it in this way before. It is something to consider*.

The therapist's Socratic questioning was designed to help the patient consider the entire context in which he was operating when he killed civilians, or possibly insurgents. She also began to plant seeds that he not only did nothing wrong, but did what he was supposed to do to protect the area. Whenever possible, point out acts of heroism or courage as powerful interventions with patients.

A Comment on Perpetration

- Perpetration

Aside from acts of war and killing in that context, it is possible that a patient will describe an event in which she did commit what might be considered murder (in war, the intentional killing of an unarmed and nonthreatening person) or a sexual assault. The therapist first needs to ask questions to determine if a patient's self-blame is a form of assimilation described earlier. If it was indeed intended and unprovoked harm against an innocent person, the therapist should ascertain if this is behavior that has continued since the person left the military or if it only occurred in the context of war. If the former, then the therapy needs to shift focus to assess whether someone is currently in danger (and possible Tarasoff warnings), and more generally to cease the behavior. In this case, it may be necessary to stop the CPT protocol to focus on the more basic safety of others. If it is the latter case, that the behavior occurred during the combat and not since, the therapist may need to help the patient to contextualize and differentiate who she was then from who she is now. Too often people fall prey to the fundamental attribution error and do not fully appreciate the contextual factors that determine behavior. They make characterological attributions that may not be accurate based on a review of their behavior.

- Safety of others

Ultimately, the therapist must make a clear statement that the patient was not to blame for things he had no control over and did not cause, but does have responsibility for intended acts. The therapist and patient can discuss what values the patient has now and strive for self-forgiveness in those situations for which he has responsibility. He may also want to engage in some type of remediation to society if it is not possible to do something for the victim.

Vicarious Traumatization

- Therapist reactions to trauma

As a side note, therapists reading or hearing graphic accounts may experience vicarious traumatization and may need to process their own reactions to hearing

these accounts (McCann & Pearlman, [10]1990a). If a therapist becomes uncomfortable listening to a patient's account of the event, it is possible that the therapist may send subtle signals (and in cases we have heard about, not so subtle signals) to the patient that the therapist can't handle the event either. For example, immediately handing the patient a tissue tells the patient to pull herself together (and dry up). Shutting the patient down is a fatal error on the part of the therapist. In order for the patient to be able to accept and integrate the event and tolerate her emotions, the therapist must also be able to do so. Therapists are particularly at risk if they are doing a great deal of trauma work. In these circumstances, the therapist should make sure to get supervision and support in order to continue the work effectively and not suffer unduly. The therapist should also check her own assumptions and thoughts to make sure they are not becoming unbalanced. The principles behind CPT apply to therapists as well as patients.

- Supervision

Practice Assignment

For the practice assignment, the therapist asks the patient to write the whole account again at least one more time. If the patient has been unable to complete the assignment the first time, he should be encouraged to write more than last time. Often, the first version reads like a police report with nothing but the facts. The patient should be encouraged to add more sensory details and more of his thoughts and feelings during the incident. The therapist should add that this time, the patient is also requested to write his current thoughts and feelings, what he is thinking and feeling as he is writing the account, in parentheses (e.g., *"I'm feeling very angry"*). Also, the trauma may encompass much more than the narrow circumstance of the event. Police or military procedures, medical treatment, funerals, or rejection from loved ones may compound the trauma and should be considered part of the event, for all practical purposes. Memories of these events and concomitant stuck points should be included in the writing assignments and discussions. If the patient is experiencing different thoughts and feelings from those in the first account, then he can write his current thoughts or feelings in the margins or in parentheses, e.g., *"At that moment I was absolutely terrified (now I am feeling angry)."*

- Second Trauma Account

The patient should be reminded to read over the new account every day until the next session.

The patient should also be asked if they have a different traumatic event that continues to cause distress. If they do, in addition to the re-write of the first trauma account, the therapist may assign the patient to write an account of the different trauma. The goal of this additional trauma account is to help identify assimilated stuck points that relate to the other event.

- Optional Additional Trauma Account

[10] McCann, I. L., & Pearlman, L. A. (1990a). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*(l), 131–149.

Write the whole incident again as soon as possible. If you were unable to complete the assignment the first time, please write more than last time. Add more sensory details, as well as your thoughts and feelings during the incident. Also, this time write your current thoughts and feelings in parentheses (e.g., "I'm feeling very angry"). Remember to read over the new account every day before the next session.

Also, continue to work with the A-B-C Worksheets every day.

- **Assign Session 4 practice assignment**

Sample Session 4 Progress Note

Contact: 50-minute psychotherapy session

Content: This was the fourth session of CPT for PTSD. The patient completed his practice assignments related to writing a detailed account of his most traumatic event and daily monitoring of thoughts, feelings, and behaviors. The patient was distressed in this session when discussing his thoughts and feelings about the traumatic event but was able to tolerate these emotions. The goal of this intervention is to increase his access to and expression of these feelings and to allow the natural resolution of them. The therapist used cognitive therapy strategies to challenge the patient's dysfunctional interpretations about the event. The session concluded with practice to write again about the most traumatic event the patient has experienced and to further elaborate on the sensory and emotional details. He agreed to include his thoughts and feelings while writing the account and to read the account daily.

Plan: Continued CPT

Initial of Patient Last Name: _____ Last 4 digits of SSN: _____
Therapist Initials: _____ Date: _____ Session: _____

Format of CPT: Individual ❒ Group ❒ CPT-C ❒ CPT ❒

PCL-5: WEEKLY

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past week.

In the past week, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

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A-B-C Worksheet

Date: _____ Patient: _____

ACTIVATING EVENT **A** "Something happens."	**BELIEF/STUCK POINT** **B** "I tell myself something."	**CONSEQUENCE** **C** "I feel something."

Are my thoughts above in "B" *realistic*?

_____

What can you tell yourself on such occasions in the future?

_____

_____

_____

Session 5: Second Trauma Account

Summary of Session 5: Second Trauma Account

1. **Administer PCL-5 (in waiting room if possible), collect, and store. Complete Session 5 Practice Assignment Review and set agenda.** (5 minutes)

2. **Read second Trauma Account aloud; help to identify differences between the first and second accounts** (15 minutes)
   - Goals: New Additions (or Deletions)?
     - Progress of affective expression and self-blame/guilt?
     - Continue cognitive therapy on stuck points
     - Introduce Challenging Questions
   - Discuss: Feelings of when it happened and now
     - Differences and similarities: at time of event, now
     - Feelings after writing it the second time vs. the first time—less intense?

3. **Engage patient in challenging assumptions and conclusions that the patient had made after processing affect, with particular focus on self-blame** (10 minutes)
   - Use some of the challenging questions to help introduce the next worksheet, The Challenging Questions Worksheet, to continue cognitive therapy on stuck points regarding the worst traumatic event.
   - Help patient reduce use of word **blame**, which implies intentionality

4. **Introduce Challenging Questions Worksheet to help patient challenge stuck points** (10 minutes)
   - Go through blank question worksheet
   - Go through example worksheets
   - Choose a stuck point of the patient's to begin addressing with these questions (a focus on assimilation is helpful at this point in the therapy)

5. **Assign practice and problem solve re: completion** (5 minutes)
   - One stuck point a day, using the Challenging Questions Worksheet
   - Continue to work on trauma account(s) if not finished, and read over daily

6. **Check-in re: patient's reactions to session** (5 minutes)

Session 5: Second Trauma Account

The goals of Session 5 are:

- Session 5 goals

1. To have the patient read and discuss the newest version of the Trauma Account.
2. To discuss the new additions (or deletions).
3. To check the progress of affective expression and self-blame/guilt and other forms of assimilation.
4. To continue cognitive therapy on stuck points for the event.
5. To introduce the Challenging Questions Worksheets so that the patient will begin to use Socratic questions himself.
6. To assign Challenging Questions Worksheets and an account for another traumatic event if needed.

Patient Reading of the Second Trauma Account With a Focus on the Differences Between the First and Second Accounts

- Reading of the second Trauma Account

The therapist should begin the session by going over the new version of the account. The patient is helped to analyze her feelings then and now. The patient should discuss the differences and similarities between how she felt at the time of the event and how she felt as she wrote about it. The patient should be asked how she felt after writing and reading about the event a second time as compared to the first time. It is likely that the intensity of emotions will be less the second time if she allowed herself to feel her emotions the first time. The therapist should point out the difference as an example of how the feelings will become less intense over time (or temporarily increased if she managed to avoid her feelings during the first writing assignment).

Challenging Assumptions and Conclusions With a Focus on Self-Blame

- Examining various forms of assimilation

The therapist should continue to use Socratic questions, particularly the questions listed on the Challenging Questions Worksheet in order to continue to help the patient to examine assimilation, self-blame, and other forms of hindsight bias. By including questions that the patient will be introduced to, he will begin to become acquainted with the concepts. Hopefully, by the time the patient has completed two accounts and has put the event back into context, much of the self-blame will have diminished. As with Sessions 3 and 4, it is important for the therapist to keep in mind that often the self-blame and assimilation occur because the patient is not remembering how he was thinking, feeling, or coping during the event. The patient may assume that he had or should have had skills or knowledge that he did not have and then judge himself harshly for not behaving differently. Typically, when the therapist can put the patient back in the full context of the situation, the patient can then see that the event (or his component of the event) was not preventable and hence, he is not to blame.

The therapist can help the patient reduce her use of the words "blame" or "fault" by catching it whenever the patient uses the words. Once the therapist and patient have established that the patient did not intend the outcome and could not prevent the event from occurring, then it is important to change the language that is used to describe the event. As discussed in Session 4, "blame" implies intentionality. If the patient agrees that she did not intend the outcome, then the words blame or fault are not appropriate or accurate.

Introduction to the Challenging Questions Worksheet

The list of challenging questions is introduced during this session. The list can be used to question and confront maladaptive self-statements and stuck points. In order to help patients comprehend the assignment, we have created a handout of a sample that walks the patient through the assignment step by step with a stuck point. The therapist should reiterate that stuck points are conflicts between old beliefs and the reality of the event, or negative beliefs that were seemingly confirmed by the event. In either case, the beliefs don't work because they lead to self-blame, guilt, anger at self and others, etc. The therapist can choose a statement the patient has made during the session and use the questions to begin confronting the validity of the belief. At this stage of therapy, it is particularly valuable to focus attention on stuck points indicating assimilation and self-blame. Until the patient can accept that she was not to blame or accept the reality of the outcomes, it will be difficult to work on other issues. If there is time in the session, it is helpful for the patient and therapist to complete one sheet together. It should be pointed out that not all questions will be relevant to every thought.

- **Give patient Challenging Questions Worksheet**

To increase out-of-session assignment compliance, it is also helpful to determine several stuck points that the patient can address with the Challenging Questions Worksheets. It is often necessary to resolve trauma related, assimilated stuck points (e.g. "It was my fault", " I could have prevented X from happening"), before you can challenge over-accommodated beliefs (e.g. "I am bad", "The world is unsafe") so you should focus the client on addressing an unresolved assimilated stuck points first.

- **Focus on assimilated stuck points first**

Practice Assignment

Please choose one stuck point each day and answer the questions on the Challenging Questions Worksheet with regard to each of these stuck points. There are extra copies of the Challenging Questions Worksheets provided, so you can work on multiple stuck points.

If you have not finished your accounts of the traumatic event(s), please continue to work on them. Read them over before the next session and bring all of your worksheets and trauma accounts to the next session.

- **Assign Session 5 practice assignment**

Sample Session 5 Progress Note

Contact: 50-minute psychotherapy session

Content: This was the fifth session of CPT for PTSD. The patient completed his practice assignment related to rewriting his traumatic event, including further elaboration and inclusion of his current thoughts and feelings. He was able to experience the associated emotions, and his distress related to them was decreased compared to the last session. Cognitions about self-blame/guilt were specifically targeted for cognitive restructuring. In addition, "challenging questions" were introduced to the patient to aid his own challenge of dysfunction and erroneous beliefs. The notion of stuck points (i.e., thoughts that lead to unpleasant emotions that do not dissipate relatively quickly) was reviewed, and the patient agreed to identify one stuck point each day to challenge with the aid of the Challenging Questions Worksheet.

Plan: Continued CPT

Initial of Patient Last Name: _____ Last 4 digits of SSN: _____
Therapist Initials: _____ Date: _____ Session: _____

Format of CPT: Individual ❒ Group ❒ CPT-C ❒ CPT ❒

PCL-5: WEEKLY

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past week.

In the past week, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	**0**	**1**	**2**	**3**	**4**
2. Repeated, disturbing dreams of the stressful experience?	**0**	**1**	**2**	**3**	**4**
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	**0**	**1**	**2**	**3**	**4**
4. Feeling very upset when something reminded you of the stressful experience?	**0**	**1**	**2**	**3**	**4**
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	**0**	**1**	**2**	**3**	**4**
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	**0**	**1**	**2**	**3**	**4**
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	**0**	**1**	**2**	**3**	**4**
8. Trouble remembering important parts of the stressful experience?	**0**	**1**	**2**	**3**	**4**
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	**0**	**1**	**2**	**3**	**4**
10. Blaming yourself or someone else for the stressful experience or what happened after it?	**0**	**1**	**2**	**3**	**4**
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	**0**	**1**	**2**	**3**	**4**
12. Loss of interest in activities that you used to enjoy?	**0**	**1**	**2**	**3**	**4**
13. Feeling distant or cut off from other people?	**0**	**1**	**2**	**3**	**4**
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	**0**	**1**	**2**	**3**	**4**
15. Irritable behavior, angry outbursts, or acting aggressively?	**0**	**1**	**2**	**3**	**4**
16. Taking too many risks or doing things that could cause you harm?	**0**	**1**	**2**	**3**	**4**
17. Being "superalert" or watchful or on guard?	**0**	**1**	**2**	**3**	**4**
18. Feeling jumpy or easily startled?	**0**	**1**	**2**	**3**	**4**
19. Having difficulty concentrating?	**0**	**1**	**2**	**3**	**4**
20. Trouble falling or staying asleep?	**0**	**1**	**2**	**3**	**4**

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Challenging Questions Worksheet

Below is a list of questions to be used in helping you challenge your maladaptive or problematic beliefs/stuck points. Not all questions will be appropriate for the belief/stuck point you choose to challenge. Answer as many questions as you can for the belief/stuck point you have chosen to challenge below.

Belief/Stuck Point:_____

1. What is the evidence for and against this stuck point?
   FOR:

   AGAINST:

2. Is your stuck point a habit or based on facts?

3. In what ways is your stuck point not including all of the information?

4. Does your stuck point include all-or-none terms?

5. Does the stuck point include words or phrases that are extreme or exaggerated (i.e., always, forever, never, need, should, must, can't, and every time)?

6. In what way is your stuck point focused on just one piece of the story?

7. Where did this stuck point come from? Is this a dependable source of information on this stuck point?

8. How is your stuck point confusing something that is possible with something that is likely?

9. In what ways is your stuck point based on feelings rather than facts?

10. In what ways is this stuck point focused on unrelated parts of the story?

Challenging Questions Worksheet

Below is a list of questions to be used in helping you challenge your maladaptive or problematic beliefs/stuck points. Not all questions will be appropriate for the belief/stuck point you choose to challenge. Answer as many questions as you can for the belief/stuck point you have chosen to challenge below.

Belief/Stuck Point: *I let the accident happen.*

1. What is the evidence for and against this stuck point?
   FOR: *I stood by and watched the accident happen.*
   AGAINST: *1. I wasn't the one who was assigned the duty*
   2. It wasn't my watch.
   3. Others were there too—they did nothing.

2. Is your stuck point a habit or based on facts?
   We are what we speak and since I've spoken it for 39 years, I take it as a fact – but I suppose it is a habit. It's hard to change my belief after I've spoken it for so long.

3. In what ways is your stuck point not including all of the information?
   I wasn't on duty, it wasn't in my power to do anything to prevent it.

4. Does your stuck point include all-or-none terms?
   The fact that this happened and I could have prevented it is either black or white. I erred and a person paid the ultimate price. It was either stop him or let him go.

5. Does the stuck point include words or phrases that are extreme or exaggerated (i.e., always, forever, never, need, should, must, can't, and every time)?
   Yes; I can't believe I let this tragedy happen! Disappointment, hurt, mental angst, permanent, death, lost forever.

6. In what way is your stuck point focused on just one piece of the story?
   I guess I'm looking at the bad—totally. I'm taking full responsibility for it without any thought given to the circumstance of others being there.

7. Where did this stuck point come from? Is this a dependable source of information on this stuck point?
   It came from me, I witnessed the accident and wish I could have stopped it.

8. How is your stuck point confusing something that is possible with something that is likely?
   It is possible I let it happen, but there were other things that also contributed.

9. In what ways is your stuck point based on feelings rather than facts?
   Feelings - I feel guilty, so I must have let it happen. I wish it didn't happen.

10. In what ways is this stuck point focused on unrelated parts of the story?
    I have focused on what I didn't do, but I didn't focus on what I was able to do and the other people there.

Challenging Questions Worksheet

Below is a list of questions to be used in helping you challenge your maladaptive or problematic beliefs/stuck points. Not all questions will be appropriate for the belief/stuck point you choose to challenge. Answer as many questions as you can for the belief/stuck point you have chosen to challenge below.

Belief/Stuck Point: *I take antidepressants, so I must be screwed.*

1. What is the evidence for and against this stuck point?
   FOR: *Other people's opinions*

   AGAINST: *I feel better when I take them. It gives me time to make better decisions.*

2. Is your stuck point a habit or based on facts?
   Habit—I listen to press/others and it seems like the whole world is on Prozac.

3. In what ways is your stuck point not including all of the information?
   I'm not considering how helpful the medications are.

4. Does your stuck point include all-or-none terms?
   I tell myself if I don't take it today then I'll lose it.

5. Does the stuck point include words or phrases that are extreme or exaggerated (i.e., always, forever, never, need, should, must, can't, and every time)?
   I use words like "screwed up."

6. In what way is your stuck point focused on just one piece of the story?
   N/A

7. Where did this stuck point come from? Is this a dependable source of information on this stuck point?
   It's my belief. Professionals feel I need it. Other people tell me it's not worth a shit.

8. How is your stuck point confusing something that is possible with something that is likely?
   I suppose it is not likely that I am screwed. The medications do help. I may not always need them.

9. In what ways is your stuck point based on feelings rather than facts?
   Feelings, focused on how I feel when I hear others talk about medications.

10. In what ways is this stuck point focused on unrelated parts of the story?
    It really helps me. The person putting the medication down probably needs medication, too.

Challenging Questions Worksheet

Below is a list of questions to be used in helping you challenge your maladaptive or problematic beliefs/stuck points. Not all questions will be appropriate for the belief/stuck point you choose to challenge. Answer as many questions as you can for the belief/stuck point you have chosen to challenge below.

Belief/Stuck Point: *I am responsible for my mom's death.*

1. What is the evidence for and against this stuck point?
   FOR: *There is what I believe is circumstantial evidence.*
   AGAINST: *There is no concrete evidence to this belief.*

2. Is your stuck point a habit or based on facts?
   It has become a habit.

3. In what ways is your stuck point not including all of the information?
   I blame myself and don't give my mom the responsibility for the actions she took.

4. Does your stuck point include all-or-none terms?
   Of course it was all or none; I felt responsible, guilty to the core. But now, I am processing the events, and it's not all my fault.

5. Does the stuck point include words or phrases that are extreme or exaggerated (i.e., always, forever, never, need, should, must, can't, and every time)?
   I am responsible. It's all my fault. I should have handled that night differently.

6. In what way is your stuck point focused on just one piece of the story?
   I am leaving out the fact that my mom died from her actions.

7. Where did this stuck point come from? Is this a dependable source of information on this stuck point?
   I still feel as though I had some part of it.

8. How is your stuck point confusing something that is possible with something that is likely?
   My mom was not an emotionally stable woman, it is not likely that I was entirely responsible for her death.

9. In what ways is your stuck point based on feelings rather than facts?
   It is based on feelings I feel guilty, so then I have assumed I must be responsible.

10. In what ways is this stuck point focused on unrelated parts of the story?
    Yes, I am focused more on me than her role.

Session 6: Challenging Questions

Summary of Session 6: Challenging Questions

1. Administer PCL-5 (in waiting room if possible), collect, and store. Complete Session 6 Practice Assignment Review and set agenda. (5 minutes)

2. Review Challenging Questions Worksheet (10 minutes)

- Assist patient in answering questions they had difficulty answering
- Assist patient to analyze and confront stuck points (hindsight bias)
- Begin shifting focus to over-accommodation, as the self-blame resolves
- Re-read Trauma Account (this applies only if account needed to be reassigned and it is clinically important to read it in session)

3. Continue cognitive therapy for stuck points (10 minutes)

4. Introduce Patterns of Problematic Thinking Worksheet (15 minutes)

- Go over blank handout
- Go over example
- Questions to consider or address:
  - Does the patient have tendency toward particular patterns of problematic thinking?
  - Describe how these patterns become automatic, creating negative feelings (use example) or causing people to engage in self-defeating behavior (use example)
  - What other events in your life has this kind of thinking affected?
  - Over-accommodation?
- Help patient generate more possible examples of problematic thinking patterns, trauma and non-trauma-related, using the Patterns of Problematic Thinking Worksheet
- Shift to patient taking over Socratic questioning of self; be supportive/consultative

5. Assign practice and problem solve re: completion (5 minutes)

- Identify stuck points and find examples for each Patterns of Problematic Thinking Worksheet. Notice and write down new examples experienced each day. Look for patterns. Look for ways your reactions to events have been affected by your past bad experiences and the habitual patterns that have developed after them.
- Continue reading Trauma Accounts if you still have strong emotions about them.
- If patient had difficulty with Challenging Questions
- Worksheets, assign another one as well as the Patterns of Problematic Thinking.

6. Check-in re: patient's reactions to session (5 minutes)

Session 6: Challenging Questions

The goals of Session 6 are:

1. To review the Challenging Questions Worksheets.
2. To assist the patient in answering questions he had difficulties answering.
3. To continue cognitive therapy for stuck points the patient is trying to challenge.
4. To introduce and assign the Patterns of Problematic Thinking Worksheet.

- Session 6 goals

Unless the patient has a strong need for the therapist to hear a new account, the writing and reading of other trauma accounts can be done outside the session. However, the therapist will want to check on progress and ask the patient to report on stuck points that need to be resolved.

If the patient's scores on the PTSD scale being used have not dropped by this point in treatment, this may indicate that the core conflict about the event has still not been resolved. The therapist should continue to spend the bulk of the session working on the index trauma with the Challenging Questions Worksheets and Socratic questioning. At this point, the therapist should go over the PTSD scale used to assess outcomes to see which symptoms are still most problematic. If the patient is still avoiding thinking about or feeling emotions about a portion of the event, having him write a more detailed account of that portion or confirming that he is reading the account outside of session on a regular basis is indicated. If the patient reports continued nightmares or flashbacks, the therapist should check on the content. The content might give clues as to the part of the event in which the patient is still stuck. On the other hand, if there has been a significant drop in PTSD scores, then the therapist may turn attention to over-accommodated beliefs in the present and future.

- Review of PTSD symptom outcomes

Review of the Challenging Questions Worksheet

The session begins with the practice assignments and reviewing the patient's answers to the Challenging Questions Worksheet. The therapist assists the patient to analyze and confront her stuck points. For the most part, patients do an excellent job answering the questions. The most common problem we encounter is that patients will try to use another thought as evidence supporting their problematic belief. For example, in challenging the stuck point *"I should have behaved differently during the event,"* a patient says the evidence for the statement is *"I should have prevented the event."* The second statement is not evidence for the first. The therapist can help define evidence as actions that would "hold up in court," in other words, observable actions that reasonable people could agree on. In this case, the only evidence that might support the statement would have to be some proof of negligence or intentional harmful behavior.

- Using Challenging Questions to confront stuck points

Occasionally, a patient will lose sight of the fact that he is trying to answer one question and will wander around using the Challenging Questions to challenge

completely different thoughts instead of one thought. Other times a patient may pick a stuck point that is too vague and be unable to answer the questions. These problems can be avoided if example worksheets are given to the patient and if the therapist and patient pick out several well-specified stuck points to work on. At this stage of therapy, the most likely stuck points revolve around self-blame and hindsight bias as to how the event could have been handled differently. In the case of traumas including deaths of others around the patient, survivor guilt is also likely. The therapist should make sure that underlying attributions, expectations, and other conflicting cognitions have been identified. The relevance of some of the questions that the patient was unable to recognize should be pointed out.

- Focusing on one stuck point

At this point in therapy there should also be a shift in the therapist's behavior. Up until now, the therapist has been asking the Socratic questions to guide the patient to question her assumptions. With the introduction of the Challenging Questions, patients begin to ask and answer those questions for themselves. The therapist begins to take on a more consultative and supportive role. The interchange can be more interactive and the therapist may be able to suggest other possible answers to the questions. The therapist will only need to return to Socratic questions when the patient is stuck.

The first five or six sessions of therapy focus on encouraging natural affect to run its course and to modify maladaptive cognitions about the event through the therapist's Socratic questioning. Once assimilation (evidenced by self-blame, if-only statements, and denial or functional amnesia) has been resolved, attention turns to over-accommodation. Because of the patient's interpretation about the causes of the event, he then draws conclusions about himself and the world in order to feel safer and in more control, as if he could prevent other negative events from happening. For example, people who have been assaulted by someone they know are likely to experience disruptions in trust. They may also develop over-generalized problems with trust if their loved ones let them down in the aftermath of the event. If a patient decides he had poor judgment that allowed the event to happen, he won't trust his judgment in other situations. If someone concludes that authorities were responsible for the event, he will have distrust and disregard for authorities. Such over-generalized, over-accommodated beliefs are an attempt to feel safer but result in disrupted relationships, fearful behavior, poor self-esteem, or suspicion of others

- Addressing over-accommodation

Introduction to Patterns of Problematic Thinking

After discussing the questions, Patterns of Problematic Thinking are introduced. This worksheet is different from the Challenging Questions Worksheet in that it is focused on patterns of thinking and not a specific belief. Rather than focusing on a single thought or belief, the patient is asked to notice whether he has tendencies toward particular counterproductive thinking patterns. The therapist should describe how these patterns become automatic, creating negative feelings and causing people to engage in self-defeating behavior (e.g., avoiding relationships

- **Give patient Patterns of Problematic Thinking Worksheet**

because of the conclusion that no one can be trusted). The therapist should use examples from prior sessions or attempt to have the patient give an example from a recent event.

Introduction Practice Assignment

For the practice assignment, the patient should consider her stuck points and find examples for each relevant thinking pattern. As she experiences events in the following days, she should notice and record any patterns she identifies. She should be asked to look for specific ways in which her reactions to the event may have been affected by these habitual patterns. Some of these thinking patterns may have predated the event, or they could have developed in response to it. In order for patients to understand these problematic thinking patterns better, we give them a worksheet with examples along with blank worksheets for them to complete. If the patient had difficulty with the Challenging Questions Worksheet, assign another one in addition to the Patterns of Problematic Thinking Worksheet.

- **Assign Session 6 practice assignment**

> *Consider the stuck points you have identified thus far and find examples for each of the problematic thinking patterns listed on the worksheet in your day to day life (or over the course of the next week). Look for specific ways in which your reactions to the traumatic event may have been affected by these habitual patterns. Continue reading your accounts if you still have strong emotions about them.*

Sample Session 6 Progress Note

Contact: 50-minute psychotherapy session

Content: This was the sixth session of CPT for PTSD. The patient completed his practice assignment related to challenging stuck points daily with aid of the Challenging Questions Worksheet. Stuck points related to self-blame and hindsight bias were particularly targeted. Patterns of problematic thinking contributing to stuck points continue to be targeted for restructuring. The patient has developed a greater ability to challenge his dysfunctional and erroneous beliefs associated with his stuck points. Patterns of problematic thinking (e.g., minimization/exaggeration, all-or-none thinking) were introduced, and examples from the patient's thinking about his traumatic event and life in general were used to illustrate these patterns. He agreed to identify examples of each problematic thinking pattern before the next session.

Plan: Continued CPT

Initial of Patient Last Name: _____ Last 4 digits of SSN: _____
Therapist Initials: _____ Date: _____ Session: _____

Format of CPT: Individual ❒ Group ❒ CPT-C ❒ CPT ❒

PCL-5: WEEKLY

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past week.

In the past week, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	**0**	**1**	**2**	**3**	**4**
2. Repeated, disturbing dreams of the stressful experience?	**0**	**1**	**2**	**3**	**4**
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	**0**	**1**	**2**	**3**	**4**
4. Feeling very upset when something reminded you of the stressful experience?	**0**	**1**	**2**	**3**	**4**
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	**0**	**1**	**2**	**3**	**4**
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	**0**	**1**	**2**	**3**	**4**
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	**0**	**1**	**2**	**3**	**4**
8. Trouble remembering important parts of the stressful experience?	**0**	**1**	**2**	**3**	**4**
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	**0**	**1**	**2**	**3**	**4**
10. Blaming yourself or someone else for the stressful experience or what happened after it?	**0**	**1**	**2**	**3**	**4**
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	**0**	**1**	**2**	**3**	**4**
12. Loss of interest in activities that you used to enjoy?	**0**	**1**	**2**	**3**	**4**
13. Feeling distant or cut off from other people?	**0**	**1**	**2**	**3**	**4**
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	**0**	**1**	**2**	**3**	**4**
15. Irritable behavior, angry outbursts, or acting aggressively?	**0**	**1**	**2**	**3**	**4**
16. Taking too many risks or doing things that could cause you harm?	**0**	**1**	**2**	**3**	**4**
17. Being "superalert" or watchful or on guard?	**0**	**1**	**2**	**3**	**4**
18. Feeling jumpy or easily startled?	**0**	**1**	**2**	**3**	**4**
19. Having difficulty concentrating?	**0**	**1**	**2**	**3**	**4**
20. Trouble falling or staying asleep?	**0**	**1**	**2**	**3**	**4**

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD.

Patterns of Problematic Thinking Worksheet

Listed below are several types of patterns of problematic thinking that people use in different life situations. These patterns often become automatic, habitual thoughts that cause us to engage in self-defeating behavior. Considering your own stuck points, find examples for each of these patterns. Write in the stuck point under the appropriate pattern and describe how it fits that pattern. Think about how that pattern affects you.

1. **Jumping to conclusions** or predicting the future?

2. **Exaggerating or minimizing** a situation (blowing things way out of proportion or shrinking their importance inappropriately).

3. **Ignoring important parts** of a situation.

4. **Oversimplifying** things as good/bad or right/wrong.

5. **Over-generalizing** from a single incident (a negative event is seen as a never-ending pattern).

6. **Mind reading** (you assume people are thinking negatively of you when there is no definite evidence for this).

7. **Emotional reasoning** (using your emotions as proof, e.g. "I feel fear so I must be in danger")

Patterns of Problematic Thinking Worksheet

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1. **Jumping to conclusions** or predicting the future?
   (Sexual assault victim/combat veteran) If a male is alone with a child, then the man will hurt the child.

2. **Exaggerating or minimizing** a situation (blowing things way out of proportion or shrinking their importance inappropriately).
   I saw a dead body and riots but I didn't get hurt and others saw worse so my reaction to the situation was wrong. I am weak.

3. **Ignoring important parts** of a situation.
   I keep forgetting the fact that the perpetrator had a knife, which is important information about how much control I had.

4. **Oversimplifying** things as good/bad or right/wrong.
   It was wrong for me to run from the dead body or hide while in Cuba.

5. **Over-generalizing** from a single incident (a negative event is seen as a never-ending pattern).
   I was raped by my grandfather, so when I see old men that look like him, I think they must be like him.

6. **Mind reading** (you assume people are thinking negatively of you when there is no definite evidence for this).
   My dad yells now, so I assume he must be angry. But it's not true a lot of the times, as he yells sometimes because he is deaf in one ear and going deaf in another. He yells because he doesn't know he is yelling.

7. **Emotional reasoning** (using your emotions as proof, e.g. "I feel fear so I must be in danger")
   I cried and felt guilty when dad yelled at me when I got hurt, so I must have done something wrong.

Patterns of Problematic Thinking Worksheet

Listed below are several types of patterns of problematic thinking that people use in different life situations. These patterns often become automatic, habitual thoughts that cause us to engage in self-defeating behavior. Considering your own stuck points, find examples for each of these patterns. Write in the stuck point under the appropriate pattern and describe how it fits that pattern. Think about how that pattern affects you.

1. **Jumping to conclusions** or predicting the future?
   (Combat veteran) I did a bad job. I didn't save my friend and other people also got killed in the battle. But, I did the best I could, and there was no way I could have saved everyone—that's not realistic. I contributed to the fight, and in doing so I may have saved some of my friends' lives. I saved myself too. I guess that's not evidence for doing a "bad" job. I guess that's evidence for <u>doing</u> my job, doing a <u>good</u> job.
2. **Exaggerating or minimizing** a situation (blowing things way out of proportion or shrinking their importance inappropriately).
   I used to say that if I had not been asleep the ambush would not have happened and no one would have died. I would say now that I have minimized the severity and unpredictability of war.
3. **Ignoring important parts** of a situation.
   I have always felt guilty because I killed people. I have felt bad about myself and have put myself down for years. It didn't occur to me to think about the reality of the situation; it was war. I had to kill. That is the nature of war. I may not agree with the war now, or believe in war, but the fact is that it was war and to survive I had to shoot. It was my duty to shoot back and defend our regiment. In feeling guilty and assuming I was bad, I was disregarding an important factor of the situation—I was disregarding the fact that it was a war.
4. **Oversimplifying** things as good/bad or right/wrong.
   Not everyone is good or bad. I may have done some things in my life that were not that good, but that does not make me a bad person.
5. **Over-generalizing** from a single incident (a negative event is seen as a never-ending pattern).
   That ambush was just one event in the entire war, and one event in my life. Just because that was an awful event doesn't mean that I can't handle things. It doesn't mean I do everything wrong.
6. **Mind reading** (you assume people are thinking negatively of you when there is no definite evidence for this).
   I have always assumed everyone thought I had let them down. I assumed they thought that I had blown it and allowed the ambush to happen. But now I realize I only imagined that—I didn't really know what they were thinking. Since then I have written to some of the guys and none of them ever thought it was my fault. Boy, I guess I was mind reading.
7. **Emotional reasoning** (using your emotions as proof, e.g. "I feel fear so I must be in danger")
   Since I have always felt guilty I assumed I was guilty. But feeling something is very different from what is really true. I felt guilty because people got hurt, but that doesn't mean it was my fault they got hurt.

Session 7: Patterns of Problematic Thinking

Summary of Session 7: Patterns of Problematic Thinking

1. Administer PCL-5 (in waiting room if possible), collect, and store. Complete Session 7 Practice Assignment Review and set agenda. (5 minutes)

2. Review Patterns of Problematic Thinking Worksheet to address trauma-related stuck points (10 minutes)

- Questions to consider or address:
  - Does patient have strong tendencies toward particular patterns?
  - Discuss how these patterns may have affected his reactions to the trauma
  - Replace with other, more adaptive, cognitions

3. Introduce Challenging Beliefs Worksheet with a trauma example (15 minutes)

- Point out that much of this is repeated from previous worksheets
  - Rate strength of belief (0%–100%)
  - Rate strength of emotion (0%–100%)
  - Use Challenging Questions Worksheet
  - Use Patterns of Problematic Thinking Worksheet
  - Generate new, balanced, evidence-based statement

4. Introduce first of five problem areas: Safety issues related to <u>self</u> and <u>others</u> (10 minutes)

- Five themes: safety, trust, power/control, esteem, intimacy
- Prior/after: How did trauma affect beliefs about _____ for self? For others?
- If stuck point → worksheet
- Need to recognize how beliefs influence behavior/avoidance
- Help the patient begin to introduce more moderate self-statements
- Practice Challenging Beliefs Worksheet by introducing one on a safety-related stuck point (which may be completed for practice)

5. Assign practice and problem solve re: completion (5 minutes)

- Daily identification of stuck points—one relating to safety and confront them using the Challenging Beliefs Worksheet. Look for specific ways that your reactions to the traumatic event may have been affected by these habitual patterns. Try to use this for a recent distressing event, too.
- Have the patient continue reading Trauma Accounts if he still has strong emotions about them.

6. Check-in re: patient's reactions to session (5 minutes)

Session 7: Patterns of Problematic Thinking

The goals of Session 7 are:

1. To review the Patterns of Problematic Thinking Worksheet.
2. To help the patient determine if she has particularly strong tendencies toward any counterproductive patterns.
3. To introduce the Challenging Beliefs Worksheet that will be used throughout the remainder of therapy.
4. To introduce the Safety Module Handout.

- Session 7 goals

NOTE: If the therapist is using CPT without trauma accounts, this session will be divided and the Safety Module will be introduced at the next session. This session will introduce the Challenging Beliefs Worksheet, and the patient will work from his stuck point log.

Review of Patterns of Problematic Thinking to Address Trauma-Related Stuck Points

The session should begin with review of the practice assignment on Patterns of Problematic Thinking. The therapist helps the patient to confront the automatic self-statements and replace them with other more adaptive cognitions. The therapist should discuss with the patient how these patterns may have affected his reactions to the traumatic event(s). There are a number of problematic thinking patterns that are seen frequently with this population. For example, a patient who habitually jumps to the conclusion that negative outcomes are his fault may increase the likelihood of self-blame after the event. Mind reading is very common. The patient assumes that other people think and feel the same way she does and reacts as if this were the case, resulting in alienation from others. Emotional reasoning about safety and guilt are frequently observed. Because a patient feels fear, she then assumes that she is in danger. If a person feels shame or guilt, he may assume that means this is proof he must have done something wrong.

- Reviewing Patterns of Problematic Thinking

Over-generalizing from a single incident and extreme black-and-white thinking are also very common. Even if he does not believe it completely to begin with, convincing a patient to modify his language use can have an immediate effect on the severity of secondary (manufactured) emotions. Once the therapist can get a foot in the door with the fact that perhaps some people (even one person) can be trusted in some way, then the therapist can continue to remind the patient that "all" is not accurate. Once the patient starts to say, *"Some people cannot be trusted,"* the accompanying emotions are less intense than to say *"all."* (See examples next two pages.)

- Minimizing over-generalization

Introduction to the Challenging Beliefs Worksheet with a Trauma Example

- **Give patient Challenging Beliefs Worksheet**

At this point the therapist should introduce the Challenging Beliefs Worksheet (adapted from Beck & Emery[11], 1985, p. 205). The introduction of this worksheet is very important so the patient is not overwhelmed by the seeming complexity of it. The worksheet brings together all the skills taught in the worksheets used thus far in the therapy and introduces the notion of alternative thoughts and feelings. The Challenging Beliefs Worksheet will be used throughout the rest of the sessions. The A-B-C Worksheet is incorporated into the two columns on the left. However, at this point the patient is asked to rate the extent to which she believes her statements (0%–100%) and how strong her emotions are (0%–100%). In order to challenge the belief, the patient begins by examining the challenging questions and answering the most pertinent ones. Next, she looks over the Patterns of Problematic Thinking Worksheet to see if she has been engaging in one of the counterproductive thinking patterns. Then, for the first time, the patient is asked to generate another statement that is more balanced and evidence-based.

- Developing balanced beliefs

It is important at this point to emphasize that the goal of therapy is not necessarily to return people to their prior beliefs. If someone had extreme beliefs before the event, the goal would be to develop more balanced, adaptive beliefs. For example, if someone used to believe that she could trust everyone, it would not be very realistic and might be high risk to return to that belief. Or if someone believed that it is always important to shut down one's emotions, we would not want to return him to that belief. People with a long history of trauma, particularly beginning in childhood, are prone to extreme beliefs that can become very entrenched.

The practice assignment will be to analyze stuck points or other trauma reactions and to confront and change problematic cognitions with the Challenging Beliefs Worksheet. As an example, a stuck point that was identified from the initial Impact Statement assignment or from preceding sessions should be used. The therapist and patient should fill out one worksheet together in session. The therapist should help the patient choose at least one stuck point to work on every day over the next week, but should also encourage him to use the worksheets as events occur during the week for practice.

Introduction to Safety Issues Related to Self and Others

- Introducing safety

The therapist should then introduce the first of five specific topics that will be discussed over the next five sessions.

[11] Beck, A. T., & Emery, G. (1985). *Anxiety disorders and phobias: A cognitive perspective.* New York: Basic Books, Inc.

For the next five sessions we will begin considering specific themes which may be areas of beliefs in your life that were affected by the traumatic event. At each session I will be asking you to consider what your beliefs were prior to the event and to consider how the [index event] has affected them. If we decide together that any of these themes represent stuck points for you, I will be asking you to complete worksheets on them in order for you to begin changing what you are saying to yourself. The five general themes are safety, trust, power and control, esteem, and intimacy. Each of these themes can be considered from two directions, how you view yourself and how you view others.

The first topic we will discuss is safety. If prior to the [event] you thought you were quite safe (that others were not dangerous) and that you could protect yourself, these beliefs are likely to have been disrupted by the event. On the other hand, if you had prior experiences that left you thinking others were dangerous or likely to harm you, or believing that you were unable to protect yourself, then the event would serve to confirm or strengthen those beliefs. When you were growing up did you have any experiences that left you believing you were unsafe or at risk? Were you sheltered? Did you believe you were invulnerable to traumatic events?

- Over-generalized fear & safety

After the patient describes her prior beliefs, the therapist should help her to determine whether her prior beliefs were disrupted or reinforced by the traumatic event. The therapist and patient should determine whether she continues to have negative beliefs about the relative safety of others or her ability to protect herself from harm. They should discuss how negative beliefs can elicit anxiety reactions (e.g., *"Something bad will happen to me if I go out alone in my car"*). The patient will need to recognize how these beliefs and emotions affect her behavior (avoidance). Over-generalized fears lead some patients to avoid entire groups of people who were associated with a particular conflict. A Vietnam Veteran reported that he was always uncomfortable around Asian people, while an Iraq Veteran said he was always on guard when near someone who looks Middle Eastern. In both cases, the patients declared that because you couldn't tell friend from foe during the war, they had learned to be leery of most people they encountered who reminded them in any way of their experiences. In the beginning of therapy, they saw no difference between low-probability and high-probability events and believed that they were at equal risk in Iraq and their hometown. Any possibility of harm was too much to tolerate. The therapist challenged them by asking how many times they had been shot at since being home. When the Veteran announced that he was safe because he secured his perimeter every night and patrolled much of the evening, the therapist asked how often the neighbors and people on the next block were attacked in their own homes and mildly wondered if the patient had any evidence that he was in danger other than his own fear (emotional reasoning).

The therapist may need to help the patient to differentiate prudent safety practices from fear-based avoidance either at the end of this session or during the next session. The patient can reduce the probability of being a victim through increased safety practices (e.g., locking doors, but not repeatedly checking them) without feeling fearful and panicky or engaging in excessive avoidance behavior. However, some events are so unpredictable and unavoidable that there is no way to decrease risk (e.g., the World Trade Center attack). Generalized fear is not going to prevent traumatic events and will only serve to prevent recovery. Along these lines, some patients have focused so much attention on some factor associated with the trauma that they focus all their safety planning on that factor to the exclusion of other higher-risk sources of danger. For example, one patient was attacked in her own home. For years afterward she spent a great deal of time and money on alarm systems and safety measures in her home. On the other hand, she was going out to bars and getting drunk with friends on a regular basis. She was even the victim of a "date-rape drug" slipped into one of her drinks. Still, she focused only on the likelihood of being attacked in her home while ignoring higher risks elsewhere.

- Removing generalized fear

The therapist should help the patient recognize his self-statements and begin to introduce alternative, more moderate, less fear-producing self-statements (e.g., replace *"I'm sure it's going to happen again"* with *"It's unlikely to happen again"*). Sometimes patients believe that if the event happens once, it will happen again. The therapist may need to give the patient some probability statistics and remind him that this event was not a daily, weekly, or even yearly event for him. It is, in fact, a low-probability event. Although the therapist cannot promise that it will not occur again, she can help the patient to see that he doesn't have to behave as if it were a high-frequency event. The therapist can also point out that the patient is jumping to conclusions without supporting evidence.

Practice Assignment

The patient should be given the Safety Module to remind her of these issues. The modules on safety and other issues are based on the work of McCann & Pearlman[12] (1990a). If self-safety or other-safety issues are evident in the patient's statements or behavior, she should complete at least one worksheet on safety before the next session. Otherwise, the patient should be encouraged to complete worksheets on other identified stuck points and recent trauma-related events that have been distressing.

- **Give patient Safety Module**

> *Use the Challenging Beliefs Worksheets to analyze and confront at least one of your stuck points each day. Please read over the module on safety and think about how your prior beliefs were affected by the [event]. If you have safety issues related to yourself or others,*

- **Assign Session 7 practice assignment**

[12] McCann, I. L., & Pearlman, L. A. (1990b). *Psychological trauma and the adult survivor: Theory, therapy and transformation*. Philadelphia: Brunner/Mazel.

complete at least one worksheet to confront those beliefs. Use the remaining sheets for other stuck points or for distressing events that have occurred recently.

Sample Session 7 Progress Note

Contact: 50-minute psychotherapy session

Content: This was the seventh session of CPT for PTSD. The patient completed his practice assignment related to identifying patterns of problematic thinking. The Challenging Beliefs Worksheet was introduced as a method of self-guided cognitive restructuring. An example stuck point was used to illustrate the use of the worksheet. He is increasingly able to challenge his own maladaptive thinking. The five themes targeted in the remainder of the treatment were introduced, with a focus on safety for exploration in the next session. The patient agreed to complete a Challenging Beliefs Worksheet each day about stuck points before the next session and to read the materials related to safety stuck points.

Plan: Continued CPT

Initial of Patient Last Name: _____ Last 4 digits of SSN: _____
Therapist Initials: _____ Date: _____ Session: _____

Format of CPT: Individual ❒ Group ❒ CPT-C ❒ CPT ❒

PCL-5: WEEKLY

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past week.

In the past week, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD

Challenging Beliefs Worksheet

A. Situation	B. Thought/Stuck Point	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
Describe the event, thought or belief leading to the unpleasant emotion(s).	Write thought/stuck point related to Column A. Rate belief in each thought/stuck point below from 0-100% (How much do you believe this thought?)	Use **Challenging Questions** to examine your automatic thought from Column B. Consider if the thought is balanced and factual or extreme.	Use the **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
		Evidence For? Evidence Against? Habit or fact? Not including all information? All or none? Extreme or exaggerated? Focused on just one piece? Source dependable? Confusing possible with likely? Based on feelings or facts? Focused on unrelated parts?	Jumping to conclusions: Exaggerating or minimizing: Ignoring important parts: Oversimplifying: Over-generalizing: Mind reading: Emotional reasoning:	**G. Re-rate Old Thought/ Stuck Point** Re-rate how much you now believe the thought/stuck point in Column B from 0-100% **H. Emotion(s)** Now what do you feel? 0-100%
	C. Emotion(s) Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100%			

Challenging Beliefs Worksheet

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I have to ride on a plane.	*Air travel is dangerous.—75%* **C. Emotion(s)** Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100% *Afraid—100%* *Helpless—75%* *Anxious—75%*	Evidence For? *People have been killed.* Evidence Against? *Airport security has been increased.* Habit or fact? Not including all information? *The fact that planes fly every day and nothing happens to them.* All or none? Extreme or exaggerated? *Yes. I am exaggerating the risk.* Focused on just one piece? Source dependable? Confusing possible with likely? *Yes, I have been saying that it is likely that the plane will crash.* Based on feelings or facts? *I am letting myself believe this because I feel scared and not because it is realistic.* Focused on unrelated parts?	Jumping to conclusions: Exaggerating or minimizing: Ignoring important parts: Oversimplifying: Over-generalizing: Mind reading: Emotional reasoning: *I feel very small…that I will be hurt or killed flying—95%*	*The chances are very small that I will be killed or hurt while flying.—95%* *Even if the plane blew up, I could not do anything about it.—80%* **G. Re-rate Old Thought/ Stuck Point** Re-rate how much you now believe the thought/stuck point in Column B from 0-100% *15%* **H. Emotion(s)** Now what do you feel? 0-100% *Afraid—40%* *Helpless—5%* *Anxious—10%*

Challenging Beliefs Worksheet

A. Situation	B. Thought/Stuck Point	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
Describe the event, thought or belief leading to the unpleasant emotion(s).	Write thought/stuck point related to Column A. Rate belief in each thought/stuck point below from 0-100% (How much do you believe this thought?)	Use **Challenging Questions** to examine your automatic thought from Column B. Consider if the thought is balanced and factual or extreme.	Use the **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
I led my company into an ambush, and many of my men were killed.	*I should have prevented it—it is my fault that people were killed—100%* **C. Emotion(s)** Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100% *Guilt—100%* *Helpless—100%* *Anxious—75%*	Evidence For? *People were killed.* Evidence Against? *There was no way to know that there was going to be an ambush—that's the nature of an ambush. To think I should have known it was coming is to ignore the fact that it was an ambush.* Habit or fact? Not including all information? All or none? *No one else would have led their company into an ambush.* Extreme or exaggerated? Focused on just one piece? Source dependable? Confusing possible with likely? Based on feelings or facts? Focused on unrelated parts?	Jumping to conclusions: Exaggerating or minimizing: Ignoring important parts: *I haven't been paying attention to the fact that it was an ambush. There was no way I could have known.* Oversimplifying: Over-generalizing: Mind reading: Emotional reasoning: *Because I feel guilty, I AM guilty.*	*There was no way to see it coming at the time.—85%* *I did the best I could given the circumstances.—90%* *It's not my fault that people were killed in the ambush.—75%* **G. Re-rate Old Thought/ Stuck Point** Re-rate how much you now believe the thought/stuck point in Column B from 0-100% *10%* **H. Emotion(s)** Now what do you feel? 0-100% *Guilt—40%* *Helpless—80%* *Anxious—40%*

Challenging Beliefs Worksheet

A. Situation	B. Thought/Stuck Point	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
Describe the event, thought or belief leading to the unpleasant emotion(s).	Write thought/stuck point related to Column A. Rate belief in each thought/stuck point below from 0-100% (How much do you believe this thought?)	Use **Challenging Questions** to examine your automatic thought from Column B. Consider if the thought is balanced and factual or extreme.	Use the **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
I am putting off doing my therapy practice assignment.	*If I let myself feel angry, I'll be out of control.– 50%* **C. Emotion(s)** Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100% *Angry – 50%* *Fear – 95%*	Evidence For? *I have acted aggressively in the past when I felt angry.* Evidence Against? *I have never been really destructive when I was angry. It is my choice how I act when I feel angry, I can always take a break or leave the situation.* Habit or fact? *Habit* Not including all information? All or none? Extreme or exaggerated? *It is exaggerated to say that I would be out of control, I have some control.* Focused on just one piece? Source dependable? Confusing possible with likely? Based on feelings or facts? Focused on unrelated parts?	Jumping to conclusions: *I am jumping to conclusions to assume that I will have no control if I feel my feelings* Exaggerating or minimizing: *I am equating anger with rage instead of what it is—unpleasant.* Ignoring important parts: *I am disregarding the times I have felt angry and maintained control.* Oversimplifying: Over-generalizing: Mind reading: Emotional reasoning:	*Anger can be expressed without aggression. – 60%* *Anger is an emotion like sadness. I let myself feel that and still maintain control over my behaviors. – 60%* **G. Re-rate Old Thought/ Stuck Point** Re-rate how much you now believe the thought/stuck point in Column B from 0-100% *20%* **H. Emotion(s)** Now what do you feel? 0-100% *Angry – 30%* *Fear – 35%*

Challenging Beliefs Worksheet

A. Situation	B. Thought/Stuck Point	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
Describe the event, thought or belief leading to the unpleasant emotion(s).	Write thought/stuck point related to Column A. Rate belief in each thought/stuck point below from 0-100% (How much do you believe this thought?)	Use **Challenging Questions** to examine your automatic thought from Column B. Consider if the thought is balanced and factual or extreme.	Use the **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
A friend wants to set me up for a date with someone she knows.	*I can't get involved with anyone because since this assault I am too afraid to let anyone close enough to see how restricted my life has become.—75%* **C. Emotion(s)** Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100% *Fear—50%* *Sadness—80%* *Anger—50%*	Evidence For? *One person I told about the assault while we were dating was very supportive at the time, but became more and more distant after that and finally stopped calling altogether.* Evidence Against? *My friends and family have been supportive.* Habit or fact? Not including all information? All or none? *Most healthy people would not run from a relationship.* Extreme or exaggerated? Focused on just one piece? Source dependable? *Coming from past negative experience and from an unhealthy person.* Confusing possible with likely? Based on feelings or facts? Focused on unrelated parts?	Jumping to conclusions: Exaggerating or minimizing: *Because 1 date may have had problems, doesn't mean others will.* Ignoring important aspects: *That person was not healthy or secure.* Oversimplifying: *If I tell someone who can't deal with it, it is not necessarily bad because I could find out something important about the relationship.* Over-generalizing: Mind reading: Emotional reasoning:	*A date could tell me they don't want anything to do with me because I am dealing with having been assaulted.—60%* **G. Re-rate Old Thought/ Stuck Point** Re-rate how much you now believe the thought/stuck point in Column B from 0-100% *50%* **H. Emotion(s)** Now what do you feel? 0-100% *Fear—25%* *Sadness—40%* *Anger—10%*

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<tr><td rowspan="2">My mom letting her boyfriend beat me for something I didn’t do when I was younger.</td><td>She never stood up for me or listened to my side of the story.—90%

C. Emotion(s)

Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100%

Angry (at her)—100%</td><td>Evidence For? There were so many occasions when he would come home drunk and beat me for just lying in my bed. My step-brothers got away with a lot and I took the blame.

Evidence Against? She didn’t let him beat me twice. But that was because the evidence was overwhelming it wasn’t me.

Habit or fact? Pretty close to fact, but it was not “never.”

Not including all information?

All or none? Most healthy people would not run from a relationship.

Extreme or exaggerated?

Focused on just one piece? She didn’t know what to do without someone supporting us financially.

Source dependable?

Confusing possible with likely?

Based on feelings or facts? I guess both.

Focused on unrelated parts? No</td><td>Jumping to conclusions:

Exaggerating or minimizing: Maybe a little, but I’ve been told to suck it up my whole life and she really didn’t stick up for me most of the time.

Ignoring important aspects: My mom was so focused on herself and getting money for us that she couldn’t or wouldn’t see she was not taking care of me.

Oversimplifying: Maybe, but I have a point!

Over-generalizing: Maybe she didn’t know what to do (food and a house vs. sticking up for me).

Mind reading: Maybe she did hear me but didn’t know what to say.

Emotional reasoning: I know I felt ignored.</td><td>It sucks that we had to be in that situation and she couldn’t pay more attention to me.—100%

G. Re-rate Old Thought/ Stuck Point

Re-rate how much you now believe the thought/stuck point in Column B from 0-100%

90%

H. Emotion(s)

Now what do you feel? 0-100%

Sad (for me)—60%</td></tr>
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<tr><td rowspan="2">My Lt. sent us down a road that he knew was filled with insurgents. Four friends were killed because of him.</td><td>He got them killed. –100%

C. Emotion(s)

Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100%

Angry—100%</td><td>Evidence For? They are dead!

Evidence Against? None.

Habit or fact? He didn’t actually kill them.

Not including all information? Insurgents killed them.

All or none? Yes.

Extreme or exaggerated? I guess. The order didn’t seem to make sense though—why did we have to go then? And, there was a pretty good chance we all could have made it.

Focused on just one piece? I guess I don’t know if he had pressure (orders) to send us there right then.

Source dependable?

Confusing possible with likely? Based on feelings or facts? Outrage at not understanding why he made that call.

Focused on unrelated parts? No</td><td>Jumping to conclusions: I guess I don’t know what he was thinking when he ordered us there.

Exaggerating or minimizing: Yes.

Ignoring important parts: I don’t know why he made that call.

Oversimplifying: We had made the run before there even though it was really dangerous.

Over-generalizing:

Mind reading:

Emotional reasoning: I was angry and blamed him.</td><td>I hate that my friends died and although it didn’t seem critical to make that run, I don’t know what the Lt. was thinking or responding to.

It was really risky, but we had made it safely 4 times previously.—90%

G. Re-rate Old Thought/ Stuck Point

Re-rate how much you now believe the thought/stuck point in Column B from 0-100%

40%

H. Emotion(s)

Now what do you feel? 0-100%

Relieved, not as angry—60%</td></tr>
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<tr><td rowspan="2">My boss said that I did a good job.</td><td>She liked my work!—80%

C. Emotion(s)

Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100%

Happy—75%</td><td>Evidence For? She said she liked it and she has criticized my work in the past, so she’s not just always being nice.

Evidence Against? None.

Habit or fact? Fact.

Not including all information?

All or none? Maybe she liked more than she disliked, but on the whole I think she liked it.

Extreme or exaggerated? I don’t think so.

Focused on just one piece? No.

Source dependable? It was her.

Confusing possible with likely?

Based on feelings or facts? Facts.

Focused on unrelated parts? None.</td><td>Jumping to conclusions: No.

Exaggerating or minimizing: I don’t think so.

Ignoring important parts: She was smiling when she said it, so no.

Oversimplifying:

Over-generalizing:

Mind reading: She actually said she liked my work.

Emotional reasoning: I sort of think I didn’t do as good of a job as I had wished, so I don’t feel great about my job. I can see that I think that based on my feelings rather than what she actually said.</td><td>She liked my work—90%

G. Re-rate Old Thought/ Stuck Point

Re-rate how much you now believe the thought/stuck point in Column B from 0-100%

90%

H. Emotion(s)

Now what do you feel? 0-100%

Happy—90%</td></tr>
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Safety Issues Module

Beliefs Related to SELF: The belief that you can protect yourself from harm and have some control over events.

Prior Experience

Negative	Positive
If you are repeatedly exposed to dangerous and uncontrollable life situations, you may develop negative beliefs about your ability to protect yourself from harm. The traumatic event serves to confirm those beliefs.	If you have positive prior experiences, you may develop the belief that you have control over most events and can protect yourself from harm. The traumatic event causes disruption in this belief.

Symptoms Associated With Negative Self-Safety Beliefs
➢ Chronic and persistent anxiety ➢ Intrusive thoughts about themes of danger ➢ Irritability ➢ Startled responses or physical arousal ➢ Intense fears related to future victimization

Resolution

If you previously believed that…	Possible self-statements may be…
"It can't happen to me," you will need to resolve the conflict between this belief and the victimization experience.	"It is unlikely to happen again, but the possibility exists."
"I can control what happens to me and can protect myself from any harm," you will need to resolve the conflict between prior beliefs and the victimization experience.	"I do not have control over everything that happens to me, but I can take precautions to reduce the possibility of future traumatic events."
You had no control over events and could not protect yourself, the traumatic event will confirm these beliefs. New beliefs must be developed that mirror reality and serve to increase your beliefs about your control and ability to protect yourself.	"I do have some control over events and I can take steps to protect myself from harm. I cannot control the behavior of other people, but I can take steps to reduce the possibility that I will be in a situation where my control is taken from me."

Beliefs Related to OTHERS: The belief about the dangerousness of other people and expectancies about the intent of others to cause harm, injury, or loss.

Prior Experience

Negative	Positive
If you experienced people as dangerous in early life or you believed it as a cultural norm, the traumatic event will seem to confirm these beliefs.	If you experienced people as safe in early life, you may expect others to keep you safe and not cause harm, injury, or loss. The traumatic event causes a disruption in this belief.

Symptoms Associated With Negative Others-Safety Beliefs
➢ Avoidant or phobic responses ➢ Social withdrawal

Resolution

If you previously believed that…	Possible self-statements may be…
"Others are out to harm me and can be expected to cause harm, injury, or loss," you will need to adopt new beliefs in order to be able to continue to feel comfortable with people you know and to be able to enter into new relationships with others.	"There are some people out there who are dangerous, but not everyone is out to harm me in some way."
"I will not be hurt by others," you will need to resolve the conflict between this belief and the victimization.	"There may be some people who will harm others, but it is unrealistic to expect that everyone I meet will want to harm me."

Session 8: Safety Issues

Summary of Session 8: Safety Issues

1. Administer PCL-5 (in waiting room if possible), collect, and store. Complete Session 8 Practice Assignment Review and set agenda. (5 minutes)

2. Review the Challenging Beliefs Worksheet to address safety stuck points (10 minutes)

- Help the patient to complete practice, if necessary
- Discuss success or problems in changing cognitions
- Help the patient confront problematic cognitions that he was unable to modify by himself

3. Help patient confront problematic cognitions and generate alternative beliefs using the Challenging Beliefs Worksheet (15 minutes)

- Review Safety Module; focus on patient's self- or other- safety issues
- Probability: Low vs. high = reality vs. fear
- Calculate %'s

4. Introduce second of five problem areas: Trust issues related to <u>self</u> and <u>others</u> (10 minutes)

- Self-trust = belief one can trust or rely on one's own perceptions and judgment
- After trauma, many begin to second-guess own judgment about
  - Being there in the first place: *"Did I do something to 'ask for it'?"*
  - Own behavior during event: *"Why didn't I ____ when it was happening?"*
  - Ability to judge character: *"I should have known _____ about him."*
- Trust in others is also frequently disrupted after a trauma
  - Betrayal if perpetrator was trusted
  - Betrayal if others don't give belief or support
  - Rejection if others can't tolerate what happened and withdraw
- Compare trust in self/others before/after
- Go over module

5. Assign practice and problem solve re: completion (5 minutes)

- Patient to challenge stuck points with the Challenging Beliefs Worksheet, with one relating to trust and confront them using the Challenging Beliefs Worksheet daily.
- Have the patient continue reading Trauma Accounts if he still has strong emotions about them.

6. Check-in re: patient's reactions to session (5 minutes)

Session 8: Safety Issues

The goals of Session 8 are:

1. To go over the Challenging Beliefs Worksheets with the patient and assist the Veteran as needed to complete the worksheets.
2. To review the Safety Module and focus on self- or other-safety issues for which the patient should complete worksheets.
3. To introduce the Trust Module and the concepts of self- and other- trust.

- Session 8 goals

Review of the Challenging Beliefs Worksheet to Address Safety Stuck Points

The therapist should begin the session by going over the worksheets and discussing the patient's success or problems in changing cognitions (and subsequent emotions). The therapist and patient should use the Challenging Questions to help the patient confront problematic cognitions that he was unable to modify himself. As an example, one patient was in an elevator that fell 20 floors and then stopped just as it reached the bottom. Aside from having nightmares and flashbacks, he found himself unable to get back into an elevator again. His thought was *"Elevators are unsafe"* and *"The next time I am going to die."* On the worksheet, the patient stated that the evidence was correct that elevators were unsafe and that he knew he would die the next time because he survived this time. He did not see that he was exaggerating or drawing conclusions when evidence is lacking, nor did he report engaging in emotional reasoning. At the end of the worksheet, his ratings did not change.

- Review Challenging Beliefs Worksheets

Confronting Problematic Cognitions and Generating Alternative Beliefs Using the Challenging Beliefs Worksheet

Unfortunately, the above example is sometimes typical of the forms filled out for the first time by patients. The patients are sometimes so entrenched in their beliefs that they can't look at them any other way. For this patient (and for many with safety issues) the therapist began to focus on the probability of being in an elevator crash again. The therapist needs to remind the patient that, although most people experience a serious traumatic event during their life, in day-to-day living, traumatic events are very low probability. Yet, he continues to behave as if the probability were extremely high. For example, in the case above, the therapist asked the patient how often he rode in elevators before. The patient informed the therapist that his apartment and work place both had elevators, and he estimated that he had ridden in elevators six to eight times a day for the past 20 years. The therapist asked him if he had been in an elevator crash before and when the patient said *"no"*, he was asked if he knew anyone who had ever been in a crash (also *"no"*).

- Probability estimates

At that point the therapist pulled out a calculator and said:

That's about 58,000 times over the last 20 years. For you, that means that if everything stayed the same and these events occurred at the same rate, and you began using elevators again, you might have a 1 in 58,000 chance of being in a crash and a 57,999 out of 58,000 chance of not being in an elevator crash over the next 20 years. Does it make sense to you that you walk around being terrified all of the time and avoid places where you might need to use an elevator? Do you want those few terrifying moments to own the rest of your life and to dictate what you can and cannot do?

The therapist also pointed out that the patient probably had a greater chance of being in a car accident, yet he didn't avoid driving and was not in perpetual fear of an accident. The patient agreed with the statements and began to rethink his beliefs. The patient and therapist completed the worksheet a second time. Under the column "Challenging Questions" they noted *"Confusing a low probability for a high probability event."* Under the "Patterns of Problematic Thinking" column they circled *"Jumping to conclusions, either/or thinking, and emotional reasoning."* He then re-rated his fear as 40%. The next week he reported that he had gone on an elevator for a few floors and was not as frightened. The idea that the next time would result in death was also challenged successfully. Once a patient has a worksheet that successfully challenges a stuck point, the patient should be encouraged to reread the worksheet regularly so that the reasoning becomes comfortable.

- Example of an Iraq Veteran

Another patient, an Iraq Veteran, who struggled with his first Challenging Beliefs Worksheet, believed that, even though he had been back in the United States for 6 months, he was at the same level of danger that he had been in Baghdad. He insisted that because there might be some people in the United States who could plan another attack, he was in just as much danger. He could not see the difference between the ideas *"something could happen"* and *"something will happen."* His high level of fear led him to emotional reasoning and to the assumption that he was in danger. The therapist asked him how many times he was shot at in Iraq, and he said "*many."* Then the therapist asked him how many times he had been shot at before going over there or since returning (*"none"*). When the therapist asked him how he concluded he was in equal danger, his response was *"but it could happen."* The therapist agreed with that statement but not the assumption that it *will* happen and had him notice how he felt when he said it *could* happen versus that it *will* happen. The patient was able to acknowledge that the two statements felt somewhat different and that *could* was different from *will* in terms of probability (100% for the latter and something less for the former). The therapist assigned him to work on this with more Challenging Beliefs Worksheets.

Introduction to Trust Issues Related to Self and Others

- Introducing Trust

During the remainder of the session the therapist should introduce and discuss the theme of trust (self-trust and trust of others):

Self-trust is concerned with the belief that one can trust or rely upon one's own perceptions or judgments. After traumatic events, many people begin to second-guess themselves and to question their own judgment about being in the situation that led to the event, their behaviors during the event, or about their ability to judge character if, in the case of an assault, the perpetrator was an acquaintance. Trust in others is also frequently disrupted following traumatic events. Aside from the obvious sense of betrayal that occurs when a trauma is caused intentionally by someone the patient thought he or she could trust, sometimes patients feel betrayed by the people they turned to for help or support during or after the event. For example, if a patient thought that someone let him down during battle, he might decide right then and there not to trust anybody. Sometimes patients carry that belief for decades without actually knowing whether the other person or group in fact betrayed them or whether there might be an alternative explanation for their behavior.

Sometimes people cannot cope with the patients' emotions and they withdraw or try to minimize the event or the impact. Such a withdrawal may be viewed as a rejection by patients, and they come to believe that the other person cannot be trusted to be supportive. Sometimes when more than one member of a family is affected by a traumatic event, such as the traumatic death of a loved one, family members are out of sync with each other. One person wants to talk and needs comfort just as another closes off because she has had all of the emotions that she could handle for a while. Without clear communication, the cycling of grief and withdrawal can be misunderstood as lack of support and can result in problematic interpretations of the situation.

Prior to the event, how did you feel about your own judgment? Did you trust other people? In what ways? How did your prior life experiences affect your feelings of trust? How did the _____ affect your feelings of trust in yourself or others?

The therapist and patient should briefly go over the Trust Module. For practice, the patient should analyze and confront themes of safety and trust using the worksheets.

- **Give patient Trust Module**

Practice Assignment

Please read the Trust Module and think about your beliefs prior to experiencing [event] as well as how the event changed or reinforced those beliefs. Use the Challenging Beliefs Worksheets to continue analyzing your stuck points. Focus some attention on issues of self- or other-trust, as well as safety, if these remain important stuck points for you.

- **Assign Session 8 practice assignment**

Sample Session 8 Progress Note

Contact: 50-minute psychotherapy session

Content: This was the eighth session of CPT for PTSD. The patient completed his practice assignment related to daily completion of the Challenging Beliefs Worksheet. Examples from these worksheets were reviewed to offer further cognitive restructuring and to fine-tune completion of the worksheets. Safety-related stuck points were specifically targeted. Stuck points related to trust were introduced, and he agreed to read materials related to this theme. The patient also agreed to complete a Challenging Beliefs Worksheet each day about stuck points before the next session.

Plan: Continued CPT

Initial of Patient Last Name: _____ Last 4 digits of SSN: _____
Therapist Initials: _____ Date: _____ Session: _____

Format of CPT: Individual ❒ Group ❒ CPT-C ❒ CPT ❒

PCL-5: WEEKLY

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past week.

In the past week, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD

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		Evidence For? Evidence Against? Habit or fact? Not including all information? All or none? Extreme or exaggerated? Focused on just one piece? Source dependable? Confusing possible with likely? Based on feelings or facts? Focused on unrelated parts?	Jumping to conclusions: Exaggerating or minimizing: Ignoring important parts: Oversimplifying: Over-generalizing: Mind reading: Emotional reasoning:	**G. Re-rate Old Thought/ Stuck Point** Re-rate how much you now believe the thought/stuck point in Column B from 0-100% **H. Emotion(s)** Now what do you feel? 0-100%
	C. Emotion(s) Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100%			

Trust Issues Module

Beliefs Related to SELF: The belief that one can trust or rely on one's own perceptions or judgments. This belief is an important part of self-concept and serves an important self-protection function.

Prior Experience

Negative	Positive
If you had prior experiences where you were blamed for negative events, you may develop negative beliefs about your ability to make decisions or judgments about situations or people. The traumatic event serves to confirm these beliefs.	If you had prior experiences that led you to believe that you had great judgment, the traumatic event may disrupt this belief.

Symptoms Associated With Negative Self-Trust Beliefs
➢ Feelings of self-betrayal ➢ Anxiety ➢ Confusion ➢ Over-caution ➢ Inability to make decisions ➢ Self-doubt and excessive self-criticism

Resolution

If you previously believed that…	A possible self-statement may be…
You could not rely on your own perceptions or judgments, the traumatic event may have reinforced your belief that "I cannot trust my judgment" or "I have bad judgment." In order to come to understand that the traumatic event was not your fault and that your judgments did not cause the traumatic event, you need to adopt more adaptive beliefs.	"I can still trust my good judgment even though it's not perfect." "Even if I misjudged this person or situation, I realize that I cannot always realistically predict what others will do or whether a situation may turn out as I expect it to."
… you had perfect judgment, the traumatic event may shatter this belief. New beliefs need to reflect the possibility that you can make mistakes but still have good judgment.	"No one has perfect judgment. I did the best I could in an unpredictable situation, and I can still trust my ability to make decisions even though it's not perfect."

Beliefs Related to OTHERS: Trust is the belief that the promises of other people or groups can be relied on with regard to future behavior. One of the earliest tasks of childhood development is trust versus mistrust. A person needs to learn a healthy balance of trust and mistrust and when each is appropriate.

Prior Experience

Negative	Positive
If you were betrayed in early life, you may have developed the generalized belief that "no one can be trusted." The traumatic event serves to confirm this belief, especially if you were hurt by an acquaintance.	If you had particularly good experiences growing up, you may have developed the belief that "All people can be trusted." The traumatic event shatters this belief.

Posttraumatic Event Experience

If the people you knew and trusted were blaming, distant, or unsupportive after the traumatic event, your belief in their trustworthiness may have been shattered.

Symptoms Associated With Negative Others-Trust Beliefs
➢ Pervasive sense of disillusionment and disappointment in others ➢ Fear of betrayal or abandonment ➢ Anger and rage at betrayers ➢ If repeatedly betrayed, negative beliefs may become so rigid that even people who are trustworthy may be viewed with suspicion ➢ Fear of close relationships, particularly when trust is beginning to develop, active anxiety and fear of being betrayed ➢ Fleeing from relationships

Resolution

If you previously believed that…	Possible self-statements may be…
If you grew up believing that "no one can be trusted," which was confirmed by the traumatic event, you need to adopt new beliefs that will allow you to enter into new relationships with others instead of withdrawing because you believe others to be untrustworthy.	"Although I may find some people to be untrustworthy, I cannot assume that everyone is that way." "Trust is not an all-or-none concept. Some may be more trustworthy than others." "Trusting another involves some risk, but I can protect myself by developing trust slowly and including what I learn about that person as I get to know him or her."
"Everyone can be trusted," the traumatic event will shatter this belief. In order to avoid becoming suspicious of the trustworthiness of others, including those you used to trust, you will need to understand trust is not either/or.	"I may not be able to trust everyone, but that doesn't mean I have to stop trusting the people I used to trust."
If your beliefs about the trustworthiness of your support system were shattered, it will be necessary to address general issues before you assume that you can no longer trust the support system. Of central importance is to consider their reaction and the reasons why they may have reacted in an unsupportive fashion. Many people simply do not know how to respond and may be reacting out of ignorance. Some respond out of fear or denial because what has happened to you makes them feel vulnerable and may shatter their own beliefs. Practicing how to ask for what you need from them may be a step in assessing their trustworthiness.	
If your attempts to discuss the traumatic event with them leaves you feeling unsupported, you may use self-statements such as "There may be some people I cannot trust talking with about the traumatic event, but they can be trusted to support me in other areas." If that person continues to blame you and make negative judgments about you, you may decide that this person is no longer trustworthy. It's unfortunate, but sometimes you find out that some people you thought of as friends do not turn out to be true friends after a trauma. However, you may also be pleasantly surprised to find that some people have better reactions than you expected.	

Session 9: Trust Issues

Summary of Session 9: Trust Issues

1. Administer PCL-5 (in waiting room if possible), collect, and store. Complete Session 9 Practice Assignment Review and set agenda. (5 minutes)

2. Review Challenging Beliefs Worksheet to challenge trauma-related trust stuck points and generate alternative beliefs (10 minutes)

3. Discuss judgment issues that may arise from stuck points related to trust (15 minutes)

- Trust falls on a continuum, not "all or none"
- Different kinds of trust: with money vs. with a secret
- "Star" diagram
- Discuss patient's social support systems (family and friends): may be protecting themselves from emotions/helplessness/vulnerability, inadequacy/ignorance—not rejection

4. Introduce third of five problem areas: Power/control issues related to <u>self</u> and <u>others</u> (10 minutes)

- Self-power (self-efficacy)
- People naturally expect they can solve problems and meet new challenges
- Traumatized people often try to control everything–to stay safe
- Lack of TOTAL CONTROL may feel like NO CONTROL
- Power over others:
  - Need to control may spill into relationships, ruining old ones and preventing new ones

5. Assign practice and problem solve re: completion (5 minutes)

- Identify stuck points, one relating to Power/Control (and Safety or Trust as needed), and confront them using the Challenging Beliefs Worksheet.
- Have the patient continue reading Trauma Accounts if he still has strong emotions about them.

6. Check-in re: patient's reactions to session (5 minutes)

Session 9: Trust Issues

The goals of Session 9 are:

- Session 9 goals

1. To review the worksheets on self- and other-trust.
2. To review other worksheets on patient stuck points.
3. To introduce the module and concepts about power and control.

Review of Challenging Beliefs Worksheet to Challenge Trauma-Related Trust Stuck Points and Generate Alternative Beliefs

As with the other sessions, the therapist should begin by going over the practice assignments and discussing the patient's success or difficulties in changing cognitions. Although trust is often an issue for patients with PTSD generally, it is particularly an issue for those who were victimized by acquaintances (for example, in military sexual trauma situations). They often think that they should have been able to tell that this person might harm them and, as a result, they begin to question their judgment in whom they can or cannot trust. Looking back at the event, many people look for clues and indicators that may have indicated that this event was going to happen. They judge themselves as having failed at preventing what they determined to be a preventable event (or at least the outcome was preventable for them, as in the case of a disaster).

Discussion of Judgment Issues Arising From Stuck Points Related to Trust

- Explaining trust

Self-distrust may even generalize to other areas of functioning, and the patient may have difficulty making everyday decisions. Rather than falling on a continuum, trust becomes an either/or concept in which people tend not to be trusted unless there is overwhelming evidence to the contrary. As a result, they tend to avoid becoming involved in or withdraw from relationships.

The therapist needs to present the idea that trust falls on a continuum and is multi-dimensional. Sometimes people decide that because someone can't be trusted in one way, they can't be trusted in any other way.

T: *Along with different levels of trust, there are also different kinds of trust. Have you ever met anyone that you would trust to $20 but wouldn't want to trust with a secret?*
P: *Yes.*
T: *I can imagine someone that I would trust with my life, but I wouldn't expect him to remember to return $20.*
P: *I know someone like that.*
T: *I know someone else that I would not trust with my opinion about the weather. He'd figure out some way to insult me. However, it takes time to determine in which ways you can and cannot trust someone.*

P: *That's why I think it is safer just to distrust everyone to begin with.*

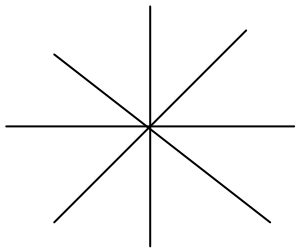
T: *The problem with that is that people are always trying to dig out of a deep hole with you then. When is it enough? And weren't you saying that you were feeling very alone and wish you had more friends?*

P: *Yeah, but if I started out by trusting everyone, then I might get hurt.*

T: *True. I agree that starting out by assuming that everyone is trustworthy would be risky. How about starting out somewhere other than the two extremes?*

P: *What do you mean?*

T: *Well, what if we called the middle point between total trust and total distrust "0", meaning no information? And rather than a single line with a middle point like a seesaw, we could think of it as having lines coming out in many directions.* (Therapist draws lines on paper for the patient to see.)



So you could have a line for trusting with a secret, and another line for trusting with money, and still another line for not using your weaknesses to hurt you, and so forth. Then as you get information about the person, they could move further out on the lines. If they all head in the positive direction then this is someone you can trust more in many ways. If some lines are going one way and others are going the other, then perhaps you just wouldn't tell them your deepest secrets or loan them your life savings, but you might be able to still have them in your life. You would just know what their limitations are. Someone who always scores on the negative side is someone you want to stay away from.

P: *That makes sense. But, it's scary to think that I would be giving someone a chance to hurt me.*

T: *Well, you don't start with the big stuff. You start with small things and see how they handle them. You also listen to what other people say about the person and what their experiences are. They can provide information too.*

With regard to trusting family and friends, it may be helpful for the therapist to explain why other people sometimes react negatively to the patient—as a defense

- Trust & others' reactions

against their own feelings of helplessness and vulnerability, or their own need to retain the just-world belief. Sometimes other people react negatively or withdraw because they just don't know how to react or what to say, and the patient interprets their reactions as rejection. Sometimes the patient cannot even recognize that family members are also hurting and upset because of what happened to him. It is not unusual for a patient to say, *"But why would they be upset? It happened to me."* The therapist can discuss with the patient how to ask for the support he needs from others (e.g., *"I don't need advice; I just need you to listen and understand what I am going through"*).

- Self-trust

With regard to self-trust, it is important for the therapist to point out that it is probable that other people would not have picked up on cues that the event was going to occur either, and that no one can know for sure what the outcome of her behaviors will be in the middle of an emergency (or what the outcome would have been if she had done something else). In addition, while 20/20 hindsight may be more accurate, no one has perfect judgment about how other people are going to behave in the future. However, in being overly suspicious of everyone, the patient may lose many people who are, in fact, trustworthy. In the end, she will end up feeling isolated and alienated from people who could provide genuine support and intimacy.

Introduction to Power/Control Issues Related to Self and Others

- **Give patient Power/ Control Handout**

The theme of power and control is introduced next as the topic for the next session. The patient is given the Power/Control Module to read and work with for the next session. Self-power (self-efficacy) refers to a person's expectations that she can solve problems and meet new challenges. Because the event was out of their control, traumatized people often attempt complete control over other situations and their emotions. These people may adopt the unrealistic belief that they *must* control everything or they will be completely out of control. Again, there is a tendency to engage in either/or thinking. Conversely, if someone over-generalizes and believes she has no control over anything, she may refuse to make any decisions or be proactive with her life because she believes that nothing will work out anyway. Like trust, control is also multidimensional, so it is appropriate for the therapist to say, *"Control with regard to what? Your emotions? Your spending? Your nervous habits?"* It is not uncommon for patients with PTSD to believe that if they don't clamp down on their emotions that they will go to the other extreme and lose control completely.

Power with regard to others involves the belief that one can or cannot control future outcomes in interpersonal relationships. People who have been the victim of interpersonal violence, particularly by acquaintances, attempt to have complete control in any new relationships they may develop after the trauma and have difficulty allowing the other member to have any control. As a result, previously existing relationships may become disrupted, or they may have great difficulty establishing new relationships, and possibly avoid the situation all together. This

issue is usually closely tied to trust of others and should be explored for stuck points.

The therapist should describe how prior experience affects these beliefs and how traumatic events can confirm negative or disrupt positive beliefs. For practice, the patient should continue using worksheets to analyze and confront these beliefs.

Practice Assignment

Use the Challenging Beliefs Worksheets to continue to address your stuck points. After reading the Power/Control Module and thinking about it, complete worksheets on this topic.

- **Assign Session 9 practice assignment**

Sample Session 9 Progress Note

Contact: 50-minute psychotherapy session

Content: This was the ninth session of CPT for PTSD. The patient completed his practice assignment related to daily completion of the Challenging Beliefs Worksheet. Examples from these worksheets were reviewed to offer further cognitive restructuring and to fine-tune completion of the worksheets. Trust-related stuck points were specifically targeted. Stuck points related to power/control were introduced, and he agreed to read materials related to this theme. The patient also agreed to complete a Challenging Beliefs Worksheet each day about stuck points before the next session.

Plan: Continued CPT

Initial of Patient Last Name: _____ Last 4 digits of SSN: _____
Therapist Initials: _____ Date: _____ Session: _____

Format of CPT: Individual ❒ Group ❒ CPT-C ❒ CPT ❒

PCL-5: WEEKLY

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past week.

In the past week, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD

Challenging Beliefs Worksheet

<table>
<tr><th>A. Situation</th><th>B. Thought/Stuck Point</th><th>D. Challenging Thoughts</th><th>E. Problematic Patterns</th><th>F. Alternative Thought(s)</th></tr>
<tr><td>Describe the event, thought or belief leading to the unpleasant emotion(s).</td><td>Write thought/stuck point related to Column A. Rate belief in each thought/stuck point below from 0-100% (How much do you believe this thought?)</td><td>Use Challenging Questions to examine your automatic thought from Column B.

Consider if the thought is balanced and factual or extreme.</td><td>Use the Patterns of Problematic Thinking Worksheet to decide if this is one of your problematic patterns of thinking.</td><td>What else can I say instead of Column B? How else can I interpret the event instead of Column B?

Rate belief in alternative thought(s) from 0-100%</td></tr>
<tr><td rowspan="2"></td><td rowspan="2">C. Emotion(s)

Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100%</td><td rowspan="2">Evidence For?

Evidence Against?

Habit or fact?

Not including all information?

All or none?

Extreme or exaggerated?

Focused on just one piece?

Source dependable?

Confusing possible with likely?

Based on feelings or facts?

Focused on unrelated parts?</td><td rowspan="2">Jumping to conclusions:

Exaggerating or minimizing:

Ignoring important parts:

Oversimplifying:

Over-generalizing:

Mind reading:

Emotional reasoning:</td><td>G. Re-rate Old Thought/ Stuck Point

Re-rate how much you now believe the thought/stuck point in Column B from 0-100%

H. Emotion(s)

Now what do you feel? 0-100%</td></tr>
</table>

Power/Control Issues Module

Beliefs Related to SELF: The belief/expectation that you can solve problems and meet challenges. Power is associated with your capacity for self-growth.

Prior Experience

Negative	Positive
If you grew up experiencing inescapable, negative events, you may develop the belief that you cannot control events or solve problems even if they are controllable/solvable. This is called learned helplessness. Later traumatic events may seem to confirm prior beliefs about helplessness.	If you grew up believing that you had control over events and could solve problems (possibly unrealistically positive beliefs), the traumatic event may disrupt those beliefs.

Symptoms Associated With Negative Self-Power/Control Beliefs
➢ Numbing of feelings ➢ Avoidance of emotions ➢ Chronic passivity ➢ Hopelessness and depression ➢ Self-destructive patterns ➢ Outrage when faced with events that are out of your control or people who do not behave as you would like

Resolution

If you previously believed that…	A possible self-statement may be…
Over-control—It is important to understand that no one can have complete control over his emotions or behavior at all times. While you may be able to influence external events, it is impossible to control all external events or the behavior of other people. Neither of these facts is a sign of weakness, but only an understanding that you are human and can admit that you are not in control of everything that happens to you or your reactions.	"I do not have total control over my reactions, other people, or events at all times. I am not powerless, however, to have some control over my reactions to events or to influence the behavior of others or the outcome of some events."

Helplessness or powerlessness—To regain a sense of control and decrease the accompanying symptoms of depression and loss of self-esteem that often go along with believing you are helpless, you will need to reconsider the ability to control events.	"I cannot control all events outside of myself, but I do have some control over what happens to me and my reactions to events."

Beliefs Related to OTHERS: The belief that you can control future outcomes in interpersonal relationships or that you have some power, even in relation to powerful others.

Prior Experience

Negative	Positive
If you had prior experiences with others that led you to believe that you had no control in your relationships with others, or that you had no power in relation to powerful others, the traumatic event will seem to confirm those beliefs.	If you had prior positive experiences in your relationships with others and in relation to powerful others, you may have come to believe that you could influence others. The traumatic event may shatter this belief because you were unable to exert enough control, despite your best efforts, to prevent the event.

Symptoms Associated With Negative Others-Power/Control Beliefs
➢ Passivity ➢ Submissiveness ➢ Lack of assertiveness that can generalize to all relationships ➢ Inability to maintain relationships because you do not allow the person to exert any control in the relationships (including becoming enraged if the other person tries to exert even a minimal amount of control)

Resolution

If you previously believed that…	Possible self-statements may be…
Powerlessness—For you to avoid being abused in relationships because you do not exert any control, you will need to learn adaptive, balanced beliefs about your influence on other people.	"Even though I cannot always get everything I want in a relationship, I do have the ability to influence others by standing up for my rights to ask for what I want."
Over-control—It is important to realize that healthy relationships involve sharing power and control. Relationships in which one person has all the power tend to be abusive (even if you are the one with all the power).	"Even though I may not get everything I want or need out of a relationship, I can assert myself and ask for it. A good relationship is one in which power is balanced between both people. If I am not allowed any control, I can exert my control in this relationship by ending it, if necessary."

Session 10: Power/Control Issues

Summary of Session 10: Power/Control Issues

1. Administer PCL-5 (in waiting room if possible), collect, and store. Complete Session 10 Practice Assignment Review and set agenda. (5 minutes)

2. Discuss connection. Set agenda between power/control and self-blame, and help challenge related problematic cognitions using the Challenging Beliefs Worksheet (10 minutes)

- Help patient gain a *balanced* view of power/control
  - No such thing as total control, but not completely helpless either
- Address anger issues:
  - Over-arousal, lack of sleep, increased startled reactions
  - "Stuffed" when unable to express at time of event
  - Anger vs. aggression (not the same thing)—can come out on family
  - Anger at self for "should have dones"
  - Innocence/responsibility/intentionality
  - Is described by others as a "control freak"

3. Review ways of giving and taking power using the handout (10 minutes)

4. Introduce fourth of five problem areas: Esteem issues related to <u>self</u> and <u>others</u> (15 minutes)

- Review Esteem Module; self and others
- Explore patient's self-esteem before event

5. Assign practice and problem solve re: completion (5 minutes)

- Identify stuck points daily, one relating to esteem issues, and confront them using the Challenging Beliefs Worksheet
- Practice giving and receiving compliments daily
- Do at least one nice thing for self each day
- Have the patient continue reading Trauma Accounts if he still has strong emotions about them.

6. Check-in re: patient's reactions to session (5 minutes)

Session 10: Power/Control Issues

The goals of Session 10 are:

1. To review the patient's Challenging Beliefs Worksheets on control and power.
2. To introduce the Esteem Module for challenging self- and other-esteem issues.
3. To assign the patient to practice giving and receiving compliments.
4. To assign the patient to do at least one nice thing for herself every day (pleasant events scheduling).

- Session 10 goals

Connection Between Power/Control and Self-Blame

- Helping the patient gain a balanced view

The session should begin with a discussion of the patient's attempts to change cognitions about control/power. The therapist needs to help the patient regain a balanced view of power and control. Realistically, no one has complete control over all events that occur to them, or the behavior of other people. On the other hand, people are not completely helpless. They can influence the course of events, and they can control their own reactions to those events. If a patient believes that he has no control over his life, the therapist may walk the service member through his day focusing on all the decisions he made, or assign him to monitor decisions for an entire day. Usually, by the time the patient completes the assignment, he realizes how many hundreds of decisions are made in a day, from what time to get up, to what to wear and to eat, to what route to take to work, etc. Patients very often blame some small everyday decision for putting them in the location and circumstances of the traumatic event. The therapist can remind the patient that if the traumatic event had not happened, he never would have remembered the decisions that he made that day. Only because the outcome was so catastrophic do people go back and try to question all the decisions they made that day, and mentally try to undo those decisions.

For example, one patient had come to believe that she was helpless and incompetent in many areas of her life because of her helplessness during the traumatic event. As a result of feeling incompetent, she did not assert herself when she had the opportunity. She believed that such efforts would be futile. She was stuck in a job that was unsatisfying and felt helpless to influence her employer's unreasonable demands. When the therapist began to help her look at her options, she began to see she wasn't totally helpless. As she began to apply and get interviews for other jobs, she felt more comfortable asserting herself with her boss. Although she eventually left that job for a better one, her last months on the first job were more satisfying, and she was able to see that she could effect change in other people.

Another patient believed that he was completely in or completely out of control. His automatic thought was *"If I'm not in control, who is? I can't decide anything if I'm not in control, and I don't have a choice in the matter if someone else is controlling the situation."* Periodically, in reaction to the tight control over his emotions and attempts to control everything and everyone else, he would totally

lose control by getting drunk to the point of unconsciousness. In this case, it was necessary for the therapist to help the patient view control as falling on a continuum. The patient's alternative thought was *"I don't have to have total control over everything to have control over most of my decisions."*

- Addressing control issues

Control issues are evident in people who exhibit compulsive behavior such as checking and rechecking, compulsive neatness, binging and purging, etc. These patients need to understand how their behavior, an attempt to control their emotions, serves as an escape or avoidance. In fact, as compulsions increase over time, the patient is eventually controlled by them rather than the other way around. Reframing the behavior as out of control may help the patient to shift his thinking about the effectiveness of the compulsive behavior. Response prevention of the behavior and tolerance of affect are the means of treatment, perhaps after completing the CPT protocol if the behavior continues to be a significant problem.

- Addressing anger issues

The topic of anger frequently emerges in treatment with Veterans. Some anger is related to the hyperarousal symptoms of PTSD such as irritability from physiological arousal, lack of sleep, and frequent startle reactions. It is important to also remember that while fear is associated with the fight-flight response, so is anger. Environmental cues may trigger anger associated with the fight response that did not stop when the imminent danger stopped. In fact, military training encourages the fight and anger response. Unfortunately, there is no equivalent time in training to turn off the "battle mind" when the service member returns home.

- Anger vs. aggression

While some Veterans and many crime victims report that they did not experience anger during the event, many people find feelings of anger emerge in the aftermath. However, because the person or persons who harmed them may not be available for them to express their anger (or are too dangerous to express anger toward), the anger is sometimes left without a target and is experienced as helpless anger. Some victims turn their anger on those who are close by, family and friends. Many people have never been taught to discriminate between anger and aggression and believe that aggression is the appropriate outlet for anger.

Anger directed at self often emerges, as traumatized people dwell on all the things they "should" have done to prevent the event or defend themselves. Many people entering therapy are angry at themselves for this reason. Once they are able to see that a change in their behavior may not have prevented the event, they may direct their anger outward at anyone they perceive to have taken away their control and created feelings of helplessness. Anger may also be directed at society, at government, or at other individuals who may be held responsible for not preventing the event in some way. As in the case of guilt, it may be necessary for the therapist to help the patient discriminate innocence, responsibility, and intentionality. Only the intentional perpetrator of events should be blamed. Others may be responsible for setting the stage or inadvertently increasing the risk to the service member, but they should not have an equal share of the blame and anger.

One patient in therapy expressed anger at himself because he felt he was not competent to deal with the event. In this case, his stuck point was that he *should* have been able to recover from this event quickly and by himself. He began to question his competence in many areas of his life. In this case, the therapist needed to remind the patient that most people have difficulties following severe traumas and that some events in life are too big to be handled all alone.

Ways of Giving and Taking Power

Hand the patient the Ways of Giving and Taking Power Handout.

- Ways of giving and taking power

> *"There are many ways people give and take their power. You can do this appropriately or inappropriately and this sheet gives us some examples. For example, if you tell your partner you will not have sex unless he/she does XYZ, you are taking power in a negative way. Or, if you base your actions or behaviors solely on the reactions you expect from others, you are giving your power away. If, on the other hand, you do something (or do not do something) because you want to and it makes you feel good, you are taking your power appropriately.*
>
> *"Can you give me an example of things that you do that fit in each of the categories below? Are these behaviors that you would like to change? What stuck points keep your from making the changes you would like to make?"*

Introduction to Esteem Issues Related to Self and Others

The remainder of the session should focus on the theme of esteem. The therapist briefly goes over the Esteem Module with the patient and describes how self-esteem and esteem toward others can be disrupted by traumatic events. The patient's self-esteem before the event should be explored.

- Introducing Esteem

Practice Assignment

For practice, drawing from the Esteem Module, the patient completes Challenging Beliefs Worksheets on stuck points for self- and other-esteem. In addition, the patient is assigned to practice giving and receiving compliments during the week and to do at least one nice thing for herself each day without any conditions or strings attached (e.g., exercise, read a magazine, call a friend to chat). These assignments are given to help the patient become comfortable with the idea that she is worthy of compliments and pleasant events without having to earn them or disown them. The assignments are also intended to help the patient connect socially with others because those with PTSD tend to isolate themselves. Pleasant events scheduling can also be helpful for those with depression and may assist with relapse prevention.

- **Give patient Esteem handout**

After reading the Esteem Module, use the worksheets to confront stuck points regarding self- and other-esteem.

In addition to the worksheets, practice giving and receiving compliments during the week and do at least one nice thing for yourself each day (without having to earn it). Write down on this sheet what you did for yourself and who you complimented.

- **Assign Session 10 practice assignment**

Sample Session 10 Progress Note

Contact: 50-minute psychotherapy session

Content: This was the 10th session of CPT for PTSD. The patient completed his practice assignment related to daily completion of the Challenging Beliefs Worksheet. Examples from these worksheets were reviewed to offer further cognitive restructuring and to fine-tune completion of the worksheets. Power-/control-related stuck points were specifically targeted. Stuck points related to esteem were introduced, and he agreed to read materials related to this theme. The patient also agreed to complete a Challenging Beliefs Worksheet about stuck points and give or receive a compliment each day before the next session. He also agreed to do one nice thing for himself daily.

Plan: Continued CPT

Initial of Patient Last Name: _____ Last 4 digits of SSN: _____
Therapist Initials: _____ Date: _____ Session: _____

Format of CPT: Individual ❒ Group ❒ CPT-C ❒ CPT ❒

PCL-5: WEEKLY

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past week.

In the past week, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD

Challenging Beliefs Worksheet

A. Situation	B. Thought/Stuck Point	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
Describe the event, thought or belief leading to the unpleasant emotion(s).	Write thought/stuck point related to Column A. Rate belief in each thought/stuck point below from 0-100% (How much do you believe this thought?)	Use **Challenging Questions** to examine your automatic thought from Column B. Consider if the thought is balanced and factual or extreme.	Use the **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
		Evidence For? Evidence Against? Habit or fact? Not including all information? All or none? Extreme or exaggerated? Focused on just one piece? Source dependable? Confusing possible with likely? Based on feelings or facts? Focused on unrelated parts?	Jumping to conclusions: Exaggerating or minimizing: Ignoring important parts: Oversimplifying: Over-generalizing: Mind reading: Emotional reasoning:	**G. Re-rate Old Thought/ Stuck Point** Re-rate how much you now believe the thought/stuck point in Column B from 0-100% **H. Emotion(s)** Now what do you feel? 0-100%
	C. Emotion(s) Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100%			

Ways of Giving and Taking Power

	GIVING POWER	TAKING POWER
POSITIVE	• Being altruistic (helping others without expecting anything in return) • Helping others in need or crisis • Sharing yourself with another person as part of the give and take in relationships **Example**: You are on your way to the store when a friend asks for a ride to the doctor, and you decide to take her.	• Being assertive • Setting limits and boundaries with others • Being honest with yourself and others **Example**: Telling someone you cannot help her now, but you schedule a time to meet later when it fits into your schedule.
NEGATIVE	• Basing your actions or behaviors solely on the reactions you expect from others • Always placing the needs of others above your own • Allowing others to easily access your "buttons" to get you emotionally upset **Example**: Having a strong negative reaction to someone who is clearly manipulating you to feel that way.	• Giving ultimatums • Testing limits • Intentionally upsetting others for personal gain • Behaving aggressively **Example**: Telling your partner you will not have sex with him until he does what you want.

Esteem Issues Module

Beliefs Related to SELF: Self-esteem is the belief in your own worth, which is a basic human need. Being understood, respected, and taken seriously is basic to the development of self-esteem.

Prior Experience

Negative	Positive
If you had prior experiences that represented a violation of your own sense of self, you are likely to develop negative beliefs about your self-worth. The traumatic event may seem to confirm these beliefs. Prior life experiences that are associated with negative beliefs about the self are likely to be caused by: - Believing other people's negative attitude about you - An absence of empathy and responsiveness by others - The experience of being devalued, criticized, or blamed by others - The belief that you had violated your own ideals or values	If you had prior experiences that served to enhance your beliefs about your self-worth, then the traumatic event may disrupt those beliefs (your self-esteem).

Examples of Negative Self-Esteem (Self-Worth) Beliefs
➢ I am bad, destructive, or evil ➢ I am responsible for bad, destructive, or evil acts ➢ I am basically damaged or flawed ➢ I am worthless and deserving of unhappiness and suffering

Symptoms Associated With Negative Self-Esteem (Self-Worth) Beliefs
➢ Depression ➢ Guilt ➢ Shame ➢ Possible self-destructive behavior

Resolution

If you previously believed that…	A possible self-statement may be…
You were worthless (or any of the beliefs listed above) because of prior experiences, the traumatic event may seem to confirm this belief. This can also occur if you received poor social support after the event. In order to improve your self-esteem and reduce the symptoms that often go along with it, you will need to reevaluate your beliefs about your self-worth and be able to replace maladaptive beliefs with more realistic, positive ones.	"Sometimes bad things happen to good people. Just because someone says something bad about me, that does not make it true. No one deserves this, and that includes me. Even if I have made mistakes in the past, that does not make me a bad person deserving of unhappiness or suffering (including the traumatic event)."
If you had positive beliefs about your self-worth before the traumatic event, you may have believed that "nothing bad will happen to me because I am a good person." The event may disrupt such beliefs, and you may think you are a bad person because this event happened, or look for reasons why it happened or what you did to deserve it (i.e., "Maybe I was being punished for something I had done or because I am a bad person.") In order to regain your prior positive beliefs about your self-worth, you will need to make some adjustments so that your sense of worth is not disrupted every time something unexpected and bad happens to you. When you can accept that bad things might happen to you (as they happen to everybody from time to time), you let go of blaming yourself for events that you did not cause.	"Sometimes bad things happen to good people. If something bad happens to me, it is not necessarily because I did something to cause it or because I deserved it. Sometimes there is not a good explanation for why bad things happen."

Beliefs Related to OTHERS: These are beliefs about how much you value other people. In addition, a realistic view of others is important to psychological health. In less psychologically healthy people, these beliefs are stereotyped, rigid, and relatively unchanged by new information.

Prior Experience

Negative	Positive
If you had many bad experiences with people in the past or had difficulty taking in new information about people you knew (particularly negative information), you may have found yourself surprised, hurt, and betrayed. You may have concluded that other people are not good or not to be respected. You may have generalized this belief to everyone (even those who are basically good and to be respected). The traumatic event may seem to confirm these beliefs about people.	If your prior experiences with people had been positive, and if negative events in the world did not seem to apply to your life, the event was probably a belief-shattering event. Prior beliefs in the basic goodness of other people may be particularly disrupted if people, who were assumed to be supportive, were not there for you after the event.

Examples of Negative Others-Esteem Beliefs
➢ The belief that people are basically uncaring, indifferent, and only out for themselves ➢ The belief that people are bad, evil, or malicious ➢ The belief that the entire human race is bad, evil, or malicious

Symptoms Associated With Negative Others-Esteem Beliefs
➢ Chronic anger ➢ Contempt ➢ Bitterness ➢ Cynicism ➢ Disbelief when treated with genuine caring compassion ("What do they really want?") ➢ Isolation or withdrawal from others ➢ Antisocial behavior justified by the belief that people are only out for themselves

Resolution

	Possible self-statements may be…
It will be important for you to reconsider the automatic assumption that people are no good, and consider how that belief has affected your behavior and social life in general.	
When you first meet someone, it is important that you do not form snap judgments because these tend to be based on stereotypes, which are not generally true for the majority of people you will meet. It is all right to adopt a "wait and see" attitude, which allows you flexibility in developing your perceptions about the other person and does not penalize the person whom you are trying to get to know.	
If, over time, this person makes you uncomfortable, or does things that you do not approve of, you are free to stop trying to develop the relationship and end it. Be aware, however, that all people make mistakes, and consider your ground rules for friendships or intimate relationships. If you confront the person with something that makes you uncomfortable, you can use that person's reaction to your request in making a decision about what you want from that person in the future (i.e., if the person is apologetic and makes a genuine effort to avoid making the same mistake, then you might want to continue getting to know this person. If the person is insensitive to your request or belittles you in some other way, then you may want to get out of this relationship.) The important point is, like trust, you need time to get to know people and form an opinion of them. It is important that you adopt a view of others that is balanced and allows for changes.	"Although there are people I do not respect and do not wish to know, I cannot assume this about everyone I meet. I may come to this conclusion later, but it will be after I have learned more about this person."
If those you expected support from let you down, don't drop these people altogether at first. Talk to them about how you feel and what you want from them. Use their reactions to your request as a way of evaluating where you want these relationships to go.	"People sometimes make mistakes. I will try to find out whether they understand it was a mistake or whether it reflects a negative characteristic of that person, which may end the relationship for me if it is something I cannot accept."

Session 11: Esteem Issues

Summary of Session 11: Esteem Issues

1. Administer PCL-5 (in waiting room if possible), collect, and store. Complete Session 11 Practice Assignment Review and set agenda. (5 minutes)

2. Discuss patient's reactions to giving and receiving compliments and engaging in a pleasant activity (5 minutes)

- Reinforce—How did it go?
- Compliments/Pleasant Activities
  - What happened?
  - Able to hear for self?
  - Recipients pleased?
  - Continue to talk?
  - Like it?
  - Feel you deserved it?
  - Feel guilty?
  - Encourage *more* and enjoy!

3. Help patient identify esteem issues and assumptions, and challenge them using Challenging Beliefs Worksheet (20 minutes)

- Does patient believe she is *permanently* damaged as a result of the trauma?
- Perfectionist? Does patient believe she made a mistake?
- Esteem for others—over-generalize disregard to whole groups?

4. Introduce fifth of five problem areas: Intimacy issues related to self and others (10 minutes)

- How have relationships been affected by the trauma?
- Self-intimacy—ability to calm and soothe oneself?
- How were these both *before* and *after*?
- Any problems: e.g., food? alcohol? spending?

5. Assign practice and problem solve re: completion (5 minutes)

- Patient should identify stuck points, one of which relates to Intimacy issues, and confront them using the Challenging Beliefs Worksheet
- Write Impact Statement (discuss the purpose of this)
- Continue to give and receive compliments
- Continue to do at least one nice thing for self each day
- Have the patient continue reading Trauma Accounts if he still has strong emotions about them.

6. Check-in re: patient's reactions to session (5 minutes)

Session 11: Esteem Issues

The goals of Session 11 are:

1. To review the compliments and nice things that the patient has done for himself.
2. To review the Challenging Beliefs Worksheets on esteem and other topics.
3. To introduce the concepts of self- and other-intimacy.
4. To assign Challenging Beliefs Worksheets on intimacy.
5. To assign a new Impact Statement.

- Session 11 goals

Giving and Receiving Compliments

The therapist should reinforce the patient's efforts to give and receive compliments and to do nice things for herself. Was she able to hear the compliment without immediately rejecting it? (T: *"Just say thank you and think about what they said."*) What happened when she gave compliments? Did the recipients seemed pleased? Did they continue to talk with the patient? The patient is asked how she felt when doing nice things for herself (e.g., did she feel that she did not deserve it? or feel guilty?). She should be encouraged to continue to do nice things for herself, practice giving and receiving compliments daily, and to allow herself to enjoy them. The therapist can help the patient to generate some self-esteem-enhancing self-statements if she tends to make disparaging comments about herself.

- Giving and receiving compliments

Identifying Esteem Issues and Assumptions

The patient and therapist then discuss the Challenging Beliefs Worksheets on esteem. A very common stuck point on the topic of self-esteem is that the patient is now damaged in some way because of the event. Because he has been suffering from flashbacks, nightmares, startle reactions, etc., the patient may have concluded that he is crazy or is permanently damaged. Perceiving oneself as damaged, believing that one has poor judgment, or believing that others blame him for things he did or did not do about the event all eat away at one's global perception of self-esteem. In the case of interpersonal crimes (such as military sexual trauma) the victim may also conclude that there must have been something wrong with him to begin with to have been targeted. If the patient makes global negative comments about himself, the therapist can begin by pinning down what the patient is being self-critical about. Like trust, esteem is a global construct that is multidimensional.

- Identifying self-esteem issues & assumptions

It is sometimes helpful to address issues about perfectionism here. Patients often have poor opinions of themselves because they so harshly judge themselves whenever they make a mistake. This overgeneralization follows logically from the patient's belief that she made mistakes before, during, or after the traumatic event. It may be helpful for the therapist to remind the patient about the basic unfairness she is practicing with herself.

- Addressing perfectionism

T: *What would you think of a teacher who said, "If you don't get 100% correct, you will earn an F in the course?"*
P: *I would say that is unfair.*
T: *Right. That way there would be two grades, A for perfect, F for everything else. Normally an A, an outstanding grade, goes to those people who score 90% or better. That gives people up to 10% mistakes and still be considered outstanding. 80% would be above average and 70% would be average. So let's grade yesterday. You say it was a bad day and that you really screwed up when you didn't handle that phone call at work as well as you would have liked. It sounds like you gave yourself an F.*
P: *I did.*
T: *So how many things did you do yesterday? How many decisions did you make? What percentage correct did you have for the day?*
P: *Well, when you put it that way… I guess I did fine. But lots of the things I did yesterday don't matter as much as the mistake I made at work.*
T: *Sure. Not everything has equal importance. At school, some of your projects earned more points than others, too. Was it the most important activity of the day?*
P: *Yes, I think so.*
T: *Was it the most important event or activity of the week?*
P: *No. Two days before, I turned in a big report to my boss that I had worked on for weeks. She was very pleased with what I had done.*
T: *So, if you give yourself a grade only for the day, it would carry more points, but if you gave yourself a grade for the entire week, it would not be very important?*
P: *No, I would give myself an A for the week.*
T: *Thinking of it that way, do your emotions feel a bit less than when you first said that you were a failure and couldn't do anything right?*
P: (Laughs) *Yeah. It is such a bad habit to make those extreme statements.*
T: *And to believe them when you say them.*
P: *Yes, at the time, it feels right and true.*
T: *Sure. It feels right because it is what you have been practicing for a long time. It is a habit rather than a fact. Just because it feels right doesn't make it true.*

With regard to esteem for others, it is not uncommon for patients to overgeneralize their disregard for the perpetrator of a traumatic event to an entire group (e.g., Asians or Iraqis). In these cases when the patient maligns all humanity or some subgroup of the population, it is important for the therapist to help him move off of the extreme and down the continuum. The patient will need

to look for and acknowledge the exceptions to his over-generalized schema in order to accommodate the schema more realistically.

- Addressing selective attention

Another way in which beliefs about the "goodness/badness" of humans is affected following traumatic events is through selective attention. For example, before being criminally victimized, many people pay little attention to reports about crime in the media. After being victimized, they begin to notice how often the topic emerges on the news, programs on television, or in magazines. Because they are now attending to crime, it appears to them that crime is everywhere and that all people are bad. They forget that these events are being reported because they are "news" and that most people are not victimizing or being victimized daily. Like crime, other devastating events such as natural disasters, wars, plane crashes, and terrorist activities may not elicit much attention until they strike near home. Then these events suddenly become very real and very personal. And the victims often over-generalize blame of others (as well as themselves) in order to regain a sense of control. It is not at all unusual for patients with PTSD to over-generalize to the entire population of the country that was at war and assume that everyone in that country has identical attitudes about Americans and the war. The patient may express great disdain for everyone from that country, even those people who have lived in the United States for generations.

- Addressing an over-accommodated viewpoint of the government

Another topic that emerges frequently with patients as an other-esteem issue is an over-accommodated viewpoint of the "government." Just like the words "trust" or "control," "government" is an overly general term. In fact, some patients with PTSD use their outrage at the government as an avoidance strategy. Instead of focusing on specific traumatic events, some patients with PTSD will immediately try to move the focus to politics and the government (avoidance by rhetoric or diatribe). It is important for the therapist early in therapy to bring the focus of the discussion back to the index event and not allow the patient to dominate the session with ranting. And just as the therapist may ask, *"trust with regard to what?"* he or she can also ask, *"What do you mean by government? Do you mean the federal government? Which administration or which branch of government? Do you mean state or local government? Are they all the same? When you say that the government is no good, does that mean that when you call 911 no one answers the phone?"* As with other overly vague terms, it is important for the patient to move off of the extreme and see the different types and categories that he might in fact judge in a more graded fashion. Although this issue might emerge early in therapy, it could reemerge with the topic of esteem and can be challenged again.

Intimacy Issues Related to Self and Others

- Introducing Intimacy

The topic of intimacy is introduced toward the end of the session, and the therapist and patient briefly discuss how relationships may have been affected by the event. Intimacy with others (or lack of intimacy) will be easier to identify than self-intimacy. However, it is important that there is a focus on nonsexual intimacy as well as sexual intimacy. Self-intimacy is the ability to soothe and calm oneself

and to be alone without feeling lonely or empty. Self-intimacy moves beyond self-esteem and includes a strong sense of self-efficacy and comfort with one's own company. The patient is encouraged to recognize how intimacy with self and others was before the event and how it was affected by the event. The therapist and patient should discuss any problems with inappropriate external attempts to self-soothe (e.g., alcohol, food, spending, etc.) that were likely discussed earlier in the therapy but should be reinforced here. Again, the patient should use the Challenging Beliefs Worksheets to confront maladaptive self-statements and to generate more comforting statements.

- **Give patient Intimacy handout**

Practice Assignment

Finally, in order to assess how the patient's beliefs have changed since the start of treatment, the patient is asked to write a new Impact Statement reflecting what it *now* means to her that the event(s) happened, and what her current beliefs are in relation to the five topics of safety, trust, power/control, esteem, and intimacy. It is important to stress that the patient should write about her current thoughts and not how she may have thought in the past.

Use the Intimacy Module and Challenging Beliefs Worksheets to confront stuck points regarding self- and other-intimacy. Continue completing worksheets on previous topics that are still problematic.

*Please write at least one page on what you think **now** about why this traumatic event(s) occurred. Also, consider what you believe now about yourself, others, and the world in the following areas: safety, trust, power/control, esteem, and intimacy.*

- **Assign Session 11 practice assignment**

Sample Session 11 Progress Note

Contact: 50-minute psychotherapy session

Content: This was the 11th session of CPT for PTSD. The patient completed his practice assignment related to completing the Challenging Beliefs Worksheet daily, giving/receiving a compliment each day, and doing something nice for himself each day. Examples from the worksheets were reviewed to offer further cognitive restructuring and to fine-tune completion of the worksheets. Esteem-related stuck points were specifically targeted. Stuck points related to intimacy were introduced, and he agreed to read materials related to this theme. The patient also agreed to complete a Challenging Beliefs Worksheet about stuck points each day and to write another Impact Statement describing his current thoughts and beliefs about himself, others, and the world related to his traumatic experiences.

Plan: Conclusion of CPT at next session

Initial of Patient Last Name: _____ Last 4 digits of SSN: _____
Therapist Initials: _____ Date: _____ Session: _____

Format of CPT: Individual ❒ Group ❒ CPT-C ❒ CPT ❒

PCL-5: WEEKLY

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past week.

In the past week, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD

Challenging Beliefs Worksheet

A. Situation	B. Thought/Stuck Point	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
Describe the event, thought or belief leading to the unpleasant emotion(s).	Write thought/stuck point related to Column A. Rate belief in each thought/stuck point below from 0-100% (How much do you believe this thought?)	Use **Challenging Questions** to examine your automatic thought from Column B. Consider if the thought is balanced and factual or extreme.	Use the **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
		Evidence For? Evidence Against? Habit or fact? Not including all information? All or none? Extreme or exaggerated? Focused on just one piece? Source dependable? Confusing possible with likely? Based on feelings or facts? Focused on unrelated parts?	Jumping to conclusions: Exaggerating or minimizing: Ignoring important parts: Oversimplifying: Over-generalizing: Mind reading: Emotional reasoning:	**G. Re-rate Old Thought/ Stuck Point** Re-rate how much you now believe the thought/stuck point in Column B from 0-100% **H. Emotion(s)** Now what do you feel? 0-100%
	C. Emotion(s) Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100%			

Intimacy Issues Module

Beliefs Related to SELF: An important function for stability is the ability to soothe and calm oneself. This self-intimacy is reflected in the ability to be alone without feeling lonely or empty. When a trauma occurs, people react differently depending on their expectancy of how well they will cope.

Prior Experience

Negative	Positive
If you had prior experiences (or poor role models) that led you to believe that you are unable to cope with negative life events, you may have reacted to the traumatic event with negative beliefs that you were unable to soothe, comfort, or nurture yourself.	A person with stable and positive self-intimacy may experience the traumatic event as less traumatic because of the expectancy and ability of drawing support from internal resources. However, if the event is in conflict with earlier self-intimacy beliefs, the person may feel overwhelmed or flooded by anxiety.

Symptoms Associated With Negative Self-Intimacy Beliefs
➢ Inability to comfort and soothe self ➢ Fear of being alone ➢ Experience of inner emptiness or deadness ➢ Periods of great anxiety or panic if reminded of trauma when alone ➢ May look to external sources of comfort—food, drugs, alcohol, medications, spending money, or sex ➢ Needy or demanding relationships

Resolution

New beliefs	A possible self-statement may be…
Understanding the typical reactions to trauma may help you feel less panicky about what you are experiencing. Most people cannot recover from such a major traumatic event without the support of others. External sources of comfort, such as alcohol or food, are just crutches that, instead of helping you to recover, may in fact prolong your reactions. They may comfort you in the short run because you use them to avoid and suppress your feelings. The feelings do not go away, however, and you then have to deal with the consequences of the excess food, spending, alcohol, etc., which compound the problem.	"I will not suffer forever. I can soothe myself and use the skills I have learned to cope with these negative feelings. I may need help in dealing with my reactions, but that is normal. Even though my feelings are quite strong and unpleasant to experience, I know they are temporary and will fade over time. The skills and abilities I am developing now will help me to cope better with other stressful situations in the future."

Beliefs Related to OTHERS: The longing for intimacy, connection, and closeness is one of the most basic human needs. The capacity to be intimately connected with other people is fragile. It can easily be damaged or destroyed through insensitive, hurtful, or unempathic responses from others.

Prior Experience

Negative	Positive
Negative beliefs may result from traumatic loss of intimate connections. The event may seem to confirm your belief in your inability to be close to another person.	If you previously had satisfying intimate relationships with others, you may find that the event (especially if committed by an acquaintance) may leave you believing that you could never be intimate with anyone again.

Posttraumatic Experience
You may also experience a disruption in your belief about your ability to be intimate with others if you were blamed or rejected by those who you thought would be supportive.

Symptoms Associated With Negative Others-Esteem Beliefs
➢ Pervasive loneliness ➢ Emptiness or isolation ➢ Failure to experience connectedness with others even in relationships that are genuinely loving and intimate

Resolution

New beliefs	Possible self-statements about [ ] may be…
For you to again have intimate relationships with others, you will need to adopt new, more adaptive beliefs about intimacy. Intimate relationships take time to develop and involve effort from both people. You are not solely responsible for the failure of prior relationships. The development of relationships involves risk taking, and it is possible that you may be hurt again. Staying away from relationships for this reason alone, however, is likely to leave you feeling empty and alone.	[New relationships] "Even though a former relationship did not work out, it does not mean that I cannot have satisfying intimate relationships in the future. I cannot continue to believe and behave as though everyone will betray me. I will need to take risks in developing relationships in the future, but if I take it slow, I will have a better chance of telling whether this person can be trusted."
Attempt to resolve your issues with the people who let you down and hurt you by asking them for what you need and letting them know how you feel about what they said or did. If they are unable to adjust to your requests and are unable to give you what you need, you may decide that you can no longer be close to those people. You may find, however, that they responded as they did out of ignorance or fear. As a result of your efforts, communication may improve and you may end up feeling closer to them than you did before the traumatic event.	[Existing relationships] "I can still be close to people, but I may not be able (or want) to be intimate with everyone I meet. I may lose prior or future intimate relationships with others who cannot meet me half-way, but this is not my fault or due to the fact that I did not try."

Session 12: Intimacy Issues and Meaning of the Event

Summary of Session 12: Intimacy Issues and Meaning of the Event

1. Administer PCL-5 (in waiting room if possible), collect, and store. Complete Session 12 Practice Assignment Review and set agenda. (5 minutes)

2. Help patient identify intimacy issue, assumptions, and any remaining stuck points, and challenge them using Challenging Beliefs Worksheet (15 minutes)

- Focus on development and maintenance of *relationships*
- Be watchful for deficits in self-soothing (Food? Alcohol? Spending?)
- Intimacy
  - Interpersonal Intimacy—withdrawal from others
  - Sexual Intimacy—physical cueing

3. Patient to read Impact Statement(s) (15 minutes)

- Patient to read final Impact Statement and go over its meaning
- Therapist to read original Impact Statement
- Compare the two
- Note how beliefs have changed by work in therapy in only a short period
- Reinforce patient's progress as a result of the work done
- Any remaining distortions or problematic beliefs?

4. Involve patient in reviewing the course of treatment and patient's progress (10 minutes)

- Review concepts and skills
- Patient to reflect on own good work, progress, and changes made
- Patient to take credit for facing and dealing with difficult and traumatic event
- Continuing success depends on patient's continuing practice of skills learned

5. Help patient identify goals for the future and delineate strategies for meeting them (5 minutes)

- Also remind patient that he is taking over as therapist now and should continue to use the skills that he has learned

Session 12: Intimacy Issues and Meaning of the Event

The goals of Session 12 are:

- Session 12 goals

1. To review Challenging Beliefs Worksheets on intimacy and work on resolving any stuck points that might interfere with the development or maintenance of relationships with self and others.
2. To have the patient read the final Impact Statement.
3. To read the first Impact Statement and compare the two statements.
4. To review the course of treatment.
5. To identify goals for the future.
6. To remind patients that they are taking over as the therapist now and should continue to practice the skills they have learned during treatment.

Identifying Intimacy Issues and Assumptions

The final session begins with a review of Challenging Beliefs Worksheets on intimacy. The purpose of the session is to help the patient to identify the patient's stuck points for intimacy. The goal for the patient is to work on these stuck points over time with the new skills she has learned in therapy.

- Self-intimacy

Self-intimacy is the ability of someone to engage in coping, self-control, and appropriate self-soothing without relying heavily on external methods of soothing. Problems with self-intimacy are evident if the patient has been abusing substances, including food, or compulsively spending or gambling, or is so dependent on others that she does not believe that she can take care of herself. When given the assignment to write about the traumatic events, one patient announced that she would have to eat a gallon of ice cream and smoke two packs of cigarettes to get through it. This was a good clue to the therapist that she had issues about self-comforting. Over the course of the therapy and particularly during these last two sessions, this issue was addressed. These issues about self-soothing are often related to control issues, so the issue of substance abuse is frequently addressed earlier in treatment as well. We encourage patients to grab a worksheet rather than grabbing for food, cigarettes, alcohol, or a credit card; to think through what they were saying to themselves; and to calm themselves with more appropriate self-statements and behaviors. However, if the patient has serious problems with substances, those problems should be treated before or simultaneously with CPT. Normally we do not start CPT unless the patients promise to refrain from using their problematic substances while they are in treatment. Then, although we may plant seeds and weave these issues into treatment earlier as appropriate, we do not focus on self-intimacy as a theme until late in therapy as we work on relapse prevention.

- Nonsexual intimacy with others

With regard to intimacy with others, two types of intimacy are often issues: closeness with family/friends and sexual intimacy. Many people with PTSD withdraw from people who could be supportive and avoid being close to others, as a way of protecting themselves from possible rejection, blame, or further harm.

Frequently, relationships dissolve and traumatized patients avoid developing new relationships. As a result, many of these people feel isolated and alone during their recovery from the traumatic event.

- Sexual intimacy

Sexual intimacy can be a particular problem with victims of sexual assault, although sexual functioning can be interrupted as well, in response to other kinds of trauma. Symptoms of PTSD and depression can interfere with normal sexual functioning, particularly sexual desire. However, to sexual assault victims, sexual behavior becomes particularly threatening because the act of being sexual has become a cue associated with the assault, and because of the level of trust and vulnerability that is necessary for sexual intimacy. The patients' withdrawal from others, however, is in direct conflict with their need for comfort and support from others. These intimacy issues are often interwoven with trust issues that may still be unresolved and deserve continued attention from the patient. Although CPT is not intended as a sex therapy, this cognitive therapy can be useful in identifying and correcting problematic cognitions that may interfere with sexual functioning. However, more serious dysfunctions should be treated with other therapy protocols designed specifically for the purpose.

Patient Reading of the New Impact Statement

- New Impact Statement

The therapist and patient should go over the new Impact Statement about the meaning of the event. The patient should first read his new Impact Statement to the therapist. Below is an example of a new Impact Statement written by "Chazz," an Iraq Veteran who had been forced to shoot at a car that did not heed warnings to stop at a checkpoint. A woman and child died in the event.

> *There is no doubt that this traumatic event has deeply impacted me. My thoughts about myself, others, and the world were changed, and changed again. When I started therapy, I believed that I was a murderer. I blamed myself completely. Now, I believe that I shot a family, but I did not murder them. I realize that I had to do what I did at the time, and that others around me also chose to shoot because we had to. I will never know what that man or maybe even family was trying to do by going through that checkpoint, but I know now that I had no choice but to shoot to stop them. Regarding safety, I used to think that there were people that were out to get me, but now I realize that the probability of that is slim. Now I worry about the stuff that everyone worries about like crazy drivers, illness, or some accident. I also used to worry that I was going to go off and hurt my family. I don't believe that I will do that because I've never done that before and basically this trauma messed with my head about how likely I would be to hurt someone unless I had to. I'm trusting myself more in terms of the decisions I make, and I have some more faith and trust in my government now that I realize that I really needed to shoot in that situation. I think I may always struggle with wanting to have power and control over things, but I'm working*

on not having control over everything. The fact is that I don't have control, even though I like to think that I do. My self-esteem is improving. I have to remember that not every bad thing that happens is my fault and that I deserve to be happy even if I don't fully believe it yet. One of the biggest things that seems to be changing is that I'm enjoying being close to my wife and my new daughter. I used to avoid my wife because I thought I didn't deserve to be happy and that I might hurt her and my daughter. Slowly I'm realizing that it is not very likely that I'll hurt them, or at least mean to hurt them. My wife seems much happier now. I want to hold onto this time in my life, and provide a good life for my daughter and wife. I'm happy to know that my daughter is not going to know someone who thought that snipers were out to get him, anxious, and avoiding everything. It sounds silly, but I'm kind of glad that I went through this, because I think I'm going to be better because of it.

The therapist subsequently reads to the patient his original Impact Statement that the therapist kept from the second session (or subsequent session if not brought to the second session) so that the patient can see how much change has taken place in a rather short period. Usually, there is a remarkable change in the second Impact Statement from the first, and a typical patient remark is *"Did I really think that?"* The patient should be encouraged to examine how his beliefs have changed as a result of the work he has done in therapy. The therapist should also look for any remaining distortions or problematic beliefs that may need further intervention.

Review of the Course of Treatment and Patient Progress

- Reviewing concepts with patient

The rest of the session is saved for review of all the concepts and skills that have been introduced over the course of therapy. The patient is reminded that her success in recovering will depend on her persistence to practice her new skills and resistance to returning to old avoidance patterns or problematic thinking patterns. Any remaining stuck points should be identified and strategies for confronting them should be reiterated. Patients are asked to reflect on the progress and changes they have made during the course of therapy and are encouraged to take credit for facing and dealing with a very difficult and traumatic event.

Patient Goals for the Future

- Goals for the future

Goals for the future are discussed. Patients with traumatic bereavement issues would not be expected to be over their grief but should be encouraged to allow themselves to continue with the process as they work to rebuild their lives. Patients should be reminded that if they encounter a reminder and have a flashback, nightmare, or sudden memory they had not accessed before, it doesn't mean that they are relapsing. In response to any of these intrusive experiences, the patient should be encouraged to write an account if needed or to utilize with his

worksheets. He should be encouraged to experience his natural emotions and to check his thoughts to make sure they are not extreme.

A topic that sometimes emerges among people who have had PTSD for decades is a question about who they are or will be without their PTSD. If someone has carried a diagnosis for many years and has organized his life around avoidance and managing flashbacks and other symptoms, he may wonder who he is now. For some disabled Vietnam Veterans, we have introduced the concept of "PTSD Retirement." We remind patients that people change their roles, and to some extent their identity, at different points in their lives, including retirement, and many of their age mates are asking themselves the same questions, because of retirement from work. What will I do when I retire? How will I spend my time? Who will be in my life? The therapist should help the patient to see that these are normal questions, and instead of fearing the future, he now has the opportunity to explore and decide how he wants to spend his time. Many older adults are changing careers or working part time. They adopt new leisure activities or do volunteer work. They spend time with grandchildren. The therapist should guide the patient to see these changes in a positive light and should encourage him to explore his options.

- PTSD in younger patients

Younger patients are also going through important developmental milestones in terms of jobs and careers, as well as relationships and family. The reduction of PTSD symptoms can help these patients get back on their developmental trajectory, and this process should be normalized. Those who have experienced permanent injuries will need some assistance in considering alternative jobs than those they might have considered.

A Note on Aftercare

- Aftercare

We recommend that after completing the protocol, whether conducted weekly or twice a week, the therapist set up a follow-up appointment for a month or two into the future. The patient should be encouraged to continue to use her Challenging Beliefs Worksheets on any remaining stuck points. The follow-up session should include the same assessment measures that were used during treatment and can be used to get the patient back on track or to reinforce gains. This practice is also helpful in instilling with patients the notion of episodes of care. They are encouraged to work as their own cognitive therapist on their stuck points and daily events that arise, and then present for treatment when they have difficulty resolving a stuck point or recent event. A specific goal-oriented piece of work can be done, and then they are encouraged to continue using the skills they develop in the therapy episodes.

Several VA programs we know of have instituted aftercare programs for patients who have completed CPT. It is a group that meets monthly. Patients bring in topics they would like to discuss and use the worksheets and modules to challenge stuck points. It has been set up as a drop-in group in which the patients may attend for one session or a number depending on what they are working on.

The facilitators of these groups have reported to us that the groups have been very helpful in maintaining gains and giving the patients a place to continue to work on stuck points without needing to return to a more formal therapy.

Sample Session 12 Progress Note

Contact: 50-minute psychotherapy session

Content: This was the 12th and final session of CPT for PTSD. The patient completed his practice assignment related to completing the Challenging Beliefs Worksheet daily and writing a final Impact Statement. Examples from the worksheets were reviewed for further cognitive restructuring, especially aimed at the development and maintenance of relationships. The first and final Impact Statements were compared, which led to discussion about the course of therapy. Goals for the future were established, and the patient was encouraged to continue using his developed skills and to share his treatment experiences with his referring clinician (e.g., what worked, how he might use the skills in future therapy).

Plan: Conclusion of CPT. Follow-up appointment scheduled for 1 month from date.

Initial of Patient Last Name: _____ Last 4 digits of SSN: _____
Therapist Initials: _____ Date: _____ Session: _____

Format of CPT: Individual ❒ Group ❒ CPT-C ❒ CPT ❒

PCL-5: WEEKLY

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past week.

In the past week, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD

Patterns of Problematic Thinking Worksheet

Listed below are several types of patterns of problematic thinking that people use in different life situations. These patterns often become automatic, habitual thoughts that cause us to engage in self-defeating behavior. Considering your own stuck points, find examples for each of these patterns. Write in the stuck point under the appropriate pattern and describe how it fits that pattern. Think about how that pattern affects you.

1. **Jumping to conclusions** or predicting the future?

2. **Exaggerating or minimizing** a situation (blowing things way out of proportion or shrinking their importance inappropriately).

3. **Ignoring important parts** of a situation.

4. **Oversimplifying** things as good/bad or right/wrong.

5. **Over-generalizing** from a single incident (a negative event is seen as a never-ending pattern).

6. **Mind reading** (you assume people are thinking negatively of you when there is no definite evidence for this).

7. **Emotional reasoning** (using your emotions as proof, e.g. "I feel fear so I must be in danger")

Challenging Questions Worksheet

Below is a list of questions to be used in helping you challenge your maladaptive or problematic beliefs/stuck points. Not all questions will be appropriate for the belief/stuck point you choose to challenge. Answer as many questions as you can for the belief/stuck point you have chosen to challenge below.

Belief/Stuck Point:_____

1. What is the evidence for and against this stuck point?
   FOR:

   AGAINST:

2. Is your stuck point a habit or based on facts?

3. In what ways is your stuck point not including all of the information?

4. Does your stuck point include all-or-none terms?

5. Does the stuck point include words or phrases that are extreme or exaggerated (i.e., always, forever, never, need, should, must, can't, and every time)?

6. In what way is your stuck point focused on just one piece of the story?

7. Where did this stuck point come from? Is this a dependable source of information on this stuck point?

8. How is your stuck point confusing something that is possible with something that is likely?

9. In what ways is your stuck point based on feelings rather than facts?

10. In what ways is this stuck point focused on unrelated parts of the story?

Challenging Beliefs Worksheet

A. Situation	B. Thought/Stuck Point	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
Describe the event, thought or belief leading to the unpleasant emotion(s).	Write thought/stuck point related to Column A. Rate belief in each thought/stuck point below from 0-100% (How much do you believe this thought?)	Use **Challenging Questions** to examine your automatic thought from Column B. Consider if the thought is balanced and factual or extreme.	Use the **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
	C. Emotion(s) Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100%	Evidence For? Evidence Against? Habit or fact? Not including all information? All or none? Extreme or exaggerated? Focused on just one piece? Source dependable? Confusing possible with likely? Based on feelings or facts? Focused on unrelated parts?	Jumping to conclusions: Exaggerating or minimizing: Ignoring important parts: Oversimplifying: Over-generalizing: Mind reading: Emotional reasoning:	**G. Re-rate Old Thought/ Stuck Point** Re-rate how much you now believe the thought/stuck point in Column B from 0-100% **H. Emotion(s)** Now what do you feel? 0-100%

| Part 3: | Alternatives and Considerations in Conducting CPT

CPT Without the Trauma Account (CPT-C)

- CPT, CPT-C, CPT-W

Recently, Resick and colleagues completed a dismantling study of CPT (Resick et al., 2008). In that study we compared the full 12-session CPT protocol with its constituent parts: CPT without the written trauma account (CPT-C) and the written trauma account without the cognitive therapy (CPT-W). We found that all three conditions were the same by post-treatment, but the trajectory of change was different. Throughout the course of therapy, the CPT-C group showed significantly faster improvement than the CPT-W condition, which only caught up at the end. CPT-C also showed faster improvements than CPT until the two trauma account sessions were completed. CPT fell between the other two groups after that. The CPT-C group also had only a 15% drop-out rate compared to 26% each for the other two conditions.

Because the studies with Veterans have used the full CPT Protocol (Monson et al., 2006; Forbes et al., 2012; Suris et al., 2013), we have included the full protocol here for training and implementation. However, recent results indicate that CPT-C is a good alternative for those Veterans for whom the trauma account is problematic. It also provides a good solution to the dilemma of how to handle the trauma accounts in group treatment. For whom is the trauma account problematic? In our studies of CPT, we have never excluded people with personality disorders or other comorbidities as long as the person was lucid, not engaging in any self- or other-harm behaviors, or under current risk by others (e.g., domestic violence or stalking). Therefore, CPT was tested with people who had a range of disorders who did not worsen with the administration of the trauma account. However, one might consider using CPT-C if a patient is so avoidant that he already has one foot out the door. Some patients arrive in therapy announcing that they cannot or will not talk about the traumatic event. Most of the time we have been able to do cognitive therapy around these stuck points, and they find the account to be a beneficial component. If the patient will quit treatment rather than do the account, CPT-C should be used. We recommend giving Veterans the choice between CPT and CPT-C, because it can serve to enhance motivation. In giving people a choice of which version of the protocol to use, we have found some Veterans will choose the CPT protocol.

- CPT-C

The CPT-C protocol does not ignore the processing of emotions. Patients are encouraged to both feel and label their natural event-related emotions and to challenge those that are secondary to appraisals and thoughts (manufactured). However, because the trauma account is an assignment that tends to elicit stronger emotions, the therapist using the CPT-C protocol needs to make a specific effort to draw out natural emotions and to help the patient notice the differences in emotions when she changes her self-dialogue. Also, the therapist cannot wait until the account is read to determine the patient's stuck points. The

therapist may need to do more Socratic questioning to bring out enough details about the traumatic event to challenge the stuck points adequately.

The CPT-C protocol is still 12 sessions. Rather than shortening the therapy (which would be possible), we took advantage of the opportunity to reinforce new skills and divide up two sessions with as much information as in the original protocol. The first change is at Session 3. Instead of assigning the trauma account or moving straight to challenging questions, we continue to focus solely on A-B-C Worksheets. In the CPT protocol, patients are asked to continue working on A-B-C Worksheets *and* write their accounts. We believe that 1 week of doing the worksheets is often not sufficient, especially if the patient has difficulty identifying his thoughts or labeling his emotions. Therefore, an additional week of practice is very beneficial before the challenging questions are introduced. This also gives the therapist an additional session to challenge the patient's stuck points about the worst traumatic event, and focus on assimilation regarding that event before the patient is asked to begin doing it himself.

The next change occurs at Session 4. Instead of reassigning the written account, patients are asked to complete Challenging Questions Worksheets on a daily basis with a focus on assimilation. In Session 5 the next worksheet, Patterns of Problematic Thinking, is introduced.

The last major change involves dividing Session 7 of the CPT protocol (in CPT-C Session 6), in which the Challenging Beliefs Worksheet and Safety Module are both introduced after going over the Patterns of Problematic Thinking assignment. In the CPT-C protocol, the Challenging Beliefs Worksheet is introduced, but not the Safety Module. Again, this gives the therapist another opportunity to elicit assimilated beliefs about the worst trauma that might have emerged more naturally with the trauma account. The Safety Module and the topic of over-accommodated safety are introduced in the next session (Session 7). From Session 8 on, the protocols are identical. The outline for CPT-C is as follows:

CPT Without the Trauma Account (CPT-C) Outline

- Outline of CPT-C

Session 1: Symptoms of PTSD, explanation of symptoms (cognitive theory), description of therapy. Practice assignment: Write Impact Statement.

Session 2: Patient reads Impact Statement. Therapist and patient discuss meaning of trauma. Begin to identify stuck points and add to Stuck Point Log. Review symptoms of PTSD and theory. Introduction of A-B-C Worksheets with explanation of relationship among thoughts, feelings, and behavior. Practice assignment: Complete 1 A-B-C sheet each day including at least one on the worst trauma.

Session 3: Review A-B-C practice assignment. Discuss stuck points with a focus on assimilation. Review the event with regard to any acceptance or blame issues.

Begin Socratic questioning regarding stuck points. Practice assignment: Reassign A-B-C Worksheets.

Session 4: Review A-B-C practice assignment and challenge assimilation with Socratic questions. Introduce Challenging Questions Worksheet to challenge specific assimilated beliefs regarding the trauma. Practice assignment: Challenge one stuck point per day using the Challenging Questions Worksheet (focus on assimilation/blame).

Session 5: Review Challenging Questions Worksheets. Introduce Patterns of Problematic Thinking Worksheet. Practice assignment: Complete Patterns of Problematic Thinking Worksheet on a daily basis. Continue using Challenging Questions as needed. Make sure patient understands the importance of balance in beliefs rather than extreme, either/or thinking.

Session 6: Review practice assignment. Determine patterns of problematic thinking. Introduce Challenging Beliefs Worksheet. Teach patient to use the new worksheet to challenge cognitions about the trauma(s). Practice assignment: Complete Challenging Beliefs Worksheets daily on the trauma, as well as, everyday events.

Session 7: Review Challenging Beliefs Worksheets. Introduce Safety Module. Discuss how previous beliefs about safety might have been disrupted or seemingly confirmed by the index event. Use Challenging Beliefs Worksheet to challenge safety beliefs. Practice assignment: Read Safety Module and complete Challenging Beliefs Worksheets on safety.

Session 8: Review Challenging Beliefs Worksheets and help patients to challenge problematic beliefs they were unable to complete successfully on their own. Introduce Trust Module. Pick out any stuck points on self-trust or other-trust. Practice assignment: Read Trust Module and complete Challenging Beliefs Worksheets on trust.

Session 9: Review Challenging Beliefs Worksheets. Introduce Power/Control Module. Discuss how prior beliefs were affected by the trauma. Practice assignment: Read Power/Control Module and complete Challenging Beliefs Worksheets on power/control. Continue to challenge other stuck points on a daily basis using the Challenging Beliefs Worksheets.

Session 10: Review Challenging Beliefs Worksheets. Introduce module on Esteem (self-esteem and regard for others). Practice assignment: Read module and complete Challenging Beliefs Worksheets on esteem, as well as assignments regarding giving and receiving compliments and doing nice things for self. Continue to challenge other stuck points on a daily basis using the Challenging Beliefs Worksheets.

Session 11: Review Challenging Beliefs Worksheets. Discuss reactions to two behavioral assignments. Introduce final module on Intimacy. Practice assignment: Continue giving and receiving compliments, read Intimacy Module, and complete Challenging Beliefs Worksheets on stuck points regarding intimacy. Final assignment: Write final Impact Statement. Continue to challenge other stuck points on a daily basis using the Challenging Beliefs Worksheets.

Session 12: Go over all the Challenging Beliefs Worksheets. Have patient read the final Impact Statement. Read the first Impact Statement and compare the differences. Discuss any intimacy stuck points. Review the entire therapy and identify any remaining issues the patient may need to continue to work on. Encourage the patient to continue with behavioral assignments on compliments and doing nice things for self. Remind patient that he is taking over as therapist now and should continue to use skills he has learned.

Group CPT Administration

- Group CPT administration

CPT has been shown to be effective in a group format, either alone or in combination with individual therapy. Group CPT has been used to treat PTSD successfully in a variety of patient populations, including rape victims, childhood sexual abuse survivors, combat Veterans, and military sexual trauma victims. The format also has been used in residential treatment programs in conjunction with other treatments (such as coping-skills building, Dialectical Behavior Therapy, and Acceptance and Commitment Therapy to name a few). Please see the CPT Group Manual for details on conducting CPT in a group.

Appendix A: Glossary of CPT Terms

Accommodation: The goal of CPT is to encourage accommodation, which involves accepting that the traumatic event occurred and discovering ways to successfully integrate the experience into the individual's life (e.g., "In spite of this bad event happening to me, I am a good person."). Accommodation reflects balanced thinking.

Assimilation: Information about an event is absorbed without changing prior beliefs. The incoming information may be altered to match prior beliefs in order to reconcile information about the traumatic event with prior schemas. Assimilation frequently serves as a process of engaging in undoing or self-blame for the trauma (e.g., ""If only I had…", "I should have stopped it" "It wasn't really abuse").

CPT: A 12-session trauma-focused, manualized therapy based on the social cognitive theory of PTSD that focuses on how the traumatic event is construed and coped with by a person who is trying to regain a sense of mastery and control in his or her life. CPT has been found effective for posttraumatic stress disorder (PTSD) and other corollary symptoms following traumatic events.

CPT SharePoint website: A part of an interactive community of websites for VHA employees on the VA *intra*net providing CPT materials and resources including consultation opportunities. Information on cognitive processing therapy in general and the CPT Implementation Program can be found on the CPT SharePoint intranet. https://vaww.portal.va.gov/sites/cpt_community/default.aspx

CPT-C: 12-session cognitive-only CPT (without the written trauma account). The CPT-C modification is indicated for certain patients (e.g., patients who refuse to write an account, have impending redeployment, have less overall time available, or have no or limited recollection of the event). CPT-C can also be indicated when therapists want to allot more time for the patient to develop cognitive skills. CPT-C remains trauma-focused and does not ignore the processing of emotions.

Emotional processing theory: A theory of PTSD developed by Foa, Steketee, and Rothbaum (1989) derived from information processing theory (Lang, 1977). In this theory, PTSD is believed to emerge due to the development of a fear network in memory that elicits escape and avoidance behavior. Mental fear structures include stimuli, responses, and meaning elements. Anything associated with the trauma may elicit the fear structure or schema and subsequent avoidance behavior. Prolonged exposure therapy for PTSD is based on emotional processing theory.

Fight-flight-freeze reactions: Natural and automatic, fear/flee/freeze or anger/aggression reactions that occur when faced with a traumatic situation.

Grounding techniques: Techniques such as cueing to date, time, location, or safety; or touching a predetermined object used when patients are dissociative to help orient back to the present.

Hindsight bias, 20/20 hindsight: An example of a distorted cognition associated with assimilation. A person with hindsight bias may believe that he/she knew an outcome in advance (e.g., "If only I had _____, this would not (might not) have happened." "I knew that I shouldn't trust him").

Impact statement: A written description of how the patients' worst trauma has affected their life including a discussion of the patients' beliefs about the cause of the event and of each of the following five primary themes that are be addressed in CPT: safety, trust, power/control, esteem, and intimacy. The impact statement is given as a practice assignment in session 1 and again in session 11.

Index trauma: The trauma chosen for the written trauma account by the patient and therapist. The index trauma is generally the worst trauma. One of the major benefits of selecting the worst trauma is that there is more likely to be generalization of new, more balanced cognitions from worst event to less severe event than the other way around. Additionally, the worst trauma account may yield the most relevant stuck points and can reinforce a sense of mastery for the patient.

Just world belief: The belief that the world is an orderly, predictable, and fair place, where people get what they deserve (i.e. good things happen to good people, bad things happen to bad people). This is a cognitive distortion theorized to impact trauma recovery and is addressed in CPT.

Military sexual trauma (MST): Sexual assault or repeated, unsolicited, threatening acts of sexual harassment that occurred while the Veteran was in the military.

Natural emotions vs. manufactured emotions: Natural emotions are emotions that follow directly after an event and would be universally experienced, i.e. a hard-wired response, such as fear when in danger, or sadness in response to loss. Manufactured emotions are feelings experienced not directly from an event but instead based on an interpretation of an event (e.g., guilt, shame).

Over-accommodation: Altering one's beliefs about oneself and the world to the extreme to feel safer and more in control in order to reconcile information about the traumatic event with prior schemas. Over-accommodation typically involves generalizing trauma-based reactions to non-traumatic situations (e.g., "I can never trust anyone again."). These beliefs often fit into the themes that constitute the final five sessions of CPT.

PCL-5 (PTSD Checklist): The PCL-5 is a 20-item self-report measure of the 20 DSM-5 symptoms of PTSD. Respondents rate how much they were bothered by that problem in the past week or month.

Posttraumatic stress disorder (PTSD): Psychological disorder defined in the DSM-5 as an intense reaction after exposure to a traumatic event. Symptoms are broken down into 4 distinct clusters:

- *Re-experiencing*: Intrusive thoughts, dreams, or flashbacks of the trauma; also includes psychological and physiological distress to reminders of trauma.
- *Avoidance*: Avoidance of trauma-related thoughts and feelings, avoidance of external reminders of the trauma.
- *Negative alterations in cognitions and mood*: Persistent negative beliefs about oneself or the world, persistent distorted blame of self or others for causing the traumatic event, trauma-related emotions (e.g., guilt, fear, shame).
- *Hyperarousal*: General increase in arousal including difficulties sleeping or concentrating, exaggerated startle response, hypervigilance, angry outbursts, and reckless behavior.

Prolonged Exposure (PE): An empirically supported cognitive behavioral therapy that treats PTSD across a variety of settings and trauma populations. The main therapeutic components are direct ("in vivo") and imaginal exposure to the traumatic event. Unlike CPT, cognitive restructuring is not a main or required component of PE. PE construes PTSD as a disorder induced by an overactive fear network which elicits avoidance and prevents full emotional processing of the trauma. The goal of PE is to facilitate emotional processing through activating and then modifying this fear network through exposure exercises.

Social cognitive theory: A theory that postulates that the way in which an individual cognitively processes a traumatic event impacts his/her emotions. According to this theory, recovery from PTSD relies on the activation, and subsequent correction, of faulty cognitions and their related emotions. Full cognitive processing of the trauma will alleviate negative emotions associated with the trauma and reduce symptomatology.

Socratic questioning: A cognitive therapy technique in which the therapist asks leading questions to assist the patient in challenging the accuracy of his/her thinking and rectifying inaccurate thought patterns in a way that alleviates psychological distress.
Six categories of Socratic questioning:

- *Clarification* - "Tell me more" questions which help patients examine their beliefs/assumptions on a deeper level and provide information necessary for the therapist to fully understand the situation.
- *Probing assumptions* – "Why" and "How" questions designed to challenge patients' presuppositions and unquestioned beliefs.
- *Probing reasons and evidence* – Questions that assist patients in looking at the actual evidence behind their beliefs. This is a similar process to probing assumptions.
- *Questioning viewpoints and perspectives* – Challenging patients' position through asking questions about alternative viewpoints and perspectives.
- *Analyzing implications and consequences* – Questions that help the patient examine the potential outcomes of his/her beliefs to see if they are desirable or even make sense.

- *Questions about the question* – A technique of responding when the therapist is directly questioned by the patient. Instead of providing an answer to the question, the therapist responds with another question that returns the focus back on the patient.

Stuck points: Patients' problem-areas in thinking that interfere with the recovery process and that are keeping them "stuck." Stuck points can include both assimilated and over-accommodated beliefs. Stuck points are continually identified throughout CPT and become primary targets for practice assignments and in-session work.

Survivor Guilt: A manufactured emotion associated with surviving a traumatic event that others, often loved ones, did not survive. Survivor guilt is also applicable to situations in which an individual did not suffer as serious injuries/consequences from a trauma as others, often associated with feelings of worthlessness. The "why not me?" question is the flip side of the question "Why me?" and implies a belief in a just world.

PTSD as a disorder of non-recovery: A perspective of PTSD as a "stalling-out" of the normal trauma-recovery process rather than the development of a unique psychopathology. This perspective is based on the evidence that PTSD symptoms are nearly universally observed immediately following serious traumatic stressors, with most individuals achieving recovery over the course of several months. Those who remain symptomatic after several months are considered to have stagnated in this normal recovery process and can be diagnosed with PTSD.

Traumatic bereavement: Bereavement in response to a traumatic death; the trauma component adds unique issues to the typical course of bereavement. Additionally, PTSD may interfere with the normal bereavement process, and bereavement may interfere with PTSD treatment. It may be helpful to identify stuck points related to traumatic loss and cognitive adjustment to life without the deceased individual(s).

Vicarious traumatization: A reaction that occurs when an individual begins experiencing PTSD-like symptoms, questioning his/her own vulnerabilities, and /or feeling fear/concern for his/her own safety in response to hearing a detailed or graphic account of another's trauma history. Vicarious traumatization is often observed in mental health professionals who treat trauma patients, emphasizing the importance of self-awareness and self-care when working with trauma populations.

5 CPT Themes: Five general themes of over-accommodation specifically are addressed in the last 5 sessions of the CPT protocol. Each session includes psychoeducation, where a theme is discussed in relation to self and others, and a theme-related practice assignment. Specific theme-related stuck points are identified and targeted for practice assignment and in-session work.

- *Safety* – Beliefs regarding one's own ability to control events and protect self/others from harm and the dangerousness/harmful intentions of others.
- *Trust* – Adopting a healthy balance of trust and mistrust. This includes both trust of one's own perceptions/judgments and the reliability of other's promises, intentions, and behavior.

- *Power/Control* – Beliefs of one's own capability to meet challenges as well as the ability to maintain power and control outcomes in the context of interpersonal relationships. This also includes the extent to which others have control over one's life.
- *Esteem* – Perspectives of self-worth and the worth of others. This includes personal needs of being understood and respected as well as fostering realistic views, and challenging rigid/stereotypical views, of others.
- *Intimacy* – Fostering of self-intimacy (the ability to soothe oneself and be alone without feeling lonely or empty) and ability to connect with others. This also focuses on the innate human desire for closeness with others.

Appendix B: Literature on CPT

Ahrens, J., & Rexford, L. (2002). Cognitive processing therapy for incarcerated adolescents with PTSD. *Journal of Aggression, Maltreatment and Trauma, 6,* 201– 216.

Alvarez, J., McLean, C. Harris, A. H. S., Rosen, C. S., Ruzek, J. I., & Kimerling, R. (2011). The comparative effectiveness of cognitive processing therapy for male Veterans treated in a VHA posttraumatic stress disorder residential rehabilitation program. *Journal of Consulting and Clinical Psychology, 79,* 590–599.

Bass, J. K., Annan, J., McIvor Murray, S., Kaysen, D., Griffiths, S., Cetinoglu, T., … Bolton, P.A. (2013) Controlled trial of psychotherapy for Congolese survivors of sexual violence. *New England Journal of Medicine, 368,* 2182–2191.

Chard, K. M. (2005). An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse. *Journal of Consulting and Clinical Psychology, 73,* 965–971.

Chard, K. M., Resick, P. A., & Wertz, J. J. (1999). Group treatment of sexual assault survivors. In B. H. Young & D. D. Blake (Eds.), *Group treatments for post-traumatic stress disorders: Conceptualization, themes, and processes* (pp. 35–50). Philadelphia: Brunner/Mazel.

Chard, K. M., Ricksecker, E. G., Healy, E. T., Karlin, B. E., & Resick, P. A. (2012). Dissemination and experience with cognitive processing therapy. *Journal of Rehabilitation Research & Development, 49,* 667–678.

Chard, K.M., Schumm, J.A., McIlvain, S. M., Bailey, G.W., & Parkinson, R. B. (2011). Exploring the efficacy of a residential treatment program incorporating cognitive processing therapy – cognitive for Veterans with PTSD and traumatic brain injury. *Journal of Traumatic Stress, 24,* 347–351.

Chard, K.M., Schumm, J.A., Owens, G.P., & Cottingham, S.M. (2010). A comparison of OEF and OIF Veterans and Vietnam Veterans receiving cognitive processing therapy. *Journal of Traumatic Stress. 23,* 25–32.

Chard, K. M., Weaver, T. L., & Resick, P. A. (1997). Adapting cognitive processing therapy for child sexual abuse survivors. *Cognitive and Behavioral Practice, 4,* 31–52.

Clarke, S.B., Rizvi, S.L., & Resick, P.A. (2008). Borderline personality characteristics and treatment outcome in cognitive-behavioral treatments for PTSD in female rape victims. *Behavior Therapy, 39,* 72–78.

Difede, J., & Eskra, D. (2002). Cognitive processing therapy for PTSD in a survivor of the World Trade Center bombing: A case study. *Journal of Trauma Practice, 1,* 155–165.

Ellis, L. F., Black, L. D., & Resick, P. A. (1992). Cognitive-behavioral treatment approaches for victims of crime. In P. A. Keller & S. R. Heyman (Eds.), *Innovations in clinical practice: A source book* (pp. 11, 23–38). Sarasota, FL: Professional Resource Exchange.

Falsetti, S. A., Resnick, H. S., Davis, J., & Gallagher, N. G. (2001). Treatment of posttraumatic stress disorder with comorbid panic attacks: Combining cognitive processing therapy with panic control treatment techniques. *Group Dynamics, 5*(4), 252–260.

Falsetti, S. A., Resnick, H. S., & Lawyer, S. R. (2006). Combining cognitive processing therapy with panic exposure and management techniques. In L. A. Schein, H. I. Spitz, G. M. Burlingame, P. R. Muskin, & S. Vargo (Eds.) *Psychological effects of catastrophic disasters: Group approaches to treatment* (pp. 629–668). New York: Haworth Press.

Forbes, D., Lloyd, D., Nixon, R. D. V., Elliott, P., Varker, T., Perry, D., … Creamer, M. (2012). A multisite randomized controlled effectiveness trial of cognitive processing therapy for military-related posttraumatic stress disorder. *Journal of Anxiety Disorders, 26,* 442–52.

Galovski, T. E., Blain, L. M., Mott, J. M., Elwood, L., & Houle, T. (2012). Manualized therapy for PTSD: Flexing the structure of cognitive processing therapy. *Journal of Consulting and Clinical Psychology, 80,* 968–981.

Galovski, T. E., Monson, C., Bruce, S. E., & Resick, P. A. (2009). Does cognitive-behavioral therapy for PTSD improve perceived health and sleep impairment? *Journal of Traumatic Stress, 22*, 197–204.

Galovski, T. E. & Resick, P. A. (2005). Cognitive processing therapy and the treatment of posttraumatic stress disorder. In A. Freeman (Ed.) *International Encyclopedia of Cognitive Behavior Therapy*. Kluwer Academic/ Plenum Publishers.

Galovski, T. E. & Resick, P. A. (2008). Cognitive processing therapy for posttraumatic stress disorder secondary to a motor vehicle accident: A single-subject report. *Cognitive and Behavioral Practice, 15,* 287–295.

Gilman, R., Schumm, J. A., Chard, K. M. (2012). Hope as a change mechanism in the treatment of posttraumatic stress disorder. *Psychological Trauma: Theory, Practice and Research, 4*, 270–277.

Hall, C. A., & Henderson, C. M. (1996). Cognitive processing therapy for chronic PTSD from childhood sexual abuse: A case study. *Counseling Psychology Quarterly, 9*(4), 359–371.

House, A. S. (2006). Increasing the usability of cognitive processing therapy for survivors of child sexual abuse. *Journal of Child Sexual Abuse, 15,* 87–103.

Kaysen, D., Lostutter, T. W., & Goines, M. A. (2005). Cognitive processing therapy for acute stress disorder resulting from an anti-gay assault. *Cognitive and Behavioral Practice, 12*, 278–289.

Kaysen, D., Schumm, J., Pedersen, E. R., Seim, R. W., Bedard-Gilligan, M., & Chard, K. (2014). Cognitive processing therapy for Veterans with comorbid PTSD and alcohol use disorders. *Addictive Behaviors, 39,* 420–427.

Kelly, K. A., Rizvi, S. L., Monson, C. M., & Resick, P.A. (2009). The impact of sudden gains in cognitive behavioral therapy for posttraumatic stress disorder. *Journal of Traumatic Stress, 22*, 287–293.

Liverant, G. I., Suvak, M. K., Pineles, S. L., & Resick, P. A. (2012). Changes in posttraumatic stress disorder and depressive symptoms during cognitive processing therapy: Evidence for concurrent change. *Journal of Consulting and Clinical Psychology, 80,* 957–967.

Messman-Moore, T. L., & Resick, P. A. (2002). Brief treatment of complicated PTSD and peritraumatic responses in a client with repeated sexual victimization. *Cognitive and Behavioral Practice, 9,* 89–99.

Monson, C. M., Price, J. L., & Ranslow, E. (2005, October). Treating combat PTSD through cognitive processing therapy. *Federal Practitioner,* 75–83.

Monson, C. M., Schnurr, P. P., Resick, P. A., Friedman, M. J., Young-Xu, Y., & Stevens, S. P. (2006). Cognitive processing therapy for Veterans with military-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 74,* 898–907.

Nishith, P., Nixon, R. D. V., & Resick, P. A. (2005). Resolution of trauma-related guilt following treatment of PTSD in female rape victims: A result of cognitive therapy targeting comorbid depression? *Journal of Affective Disorders, 86,* 259–265.

Nishith, P., Resick, P. A., & Griffin, M. G. (2002). Pattern of change in prolonged exposure and cognitive processing therapy for female rape victims with posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 70,* 880–886.

Owens, G. P., Pike, J. L., & Chard, K. M. (2001). Treatment effects of cognitive processing therapy on cognitive distortions of female child sexual abuse survivors. *Behavior Therapy, 32*(3), 413–424.

Petrak, J. (1996). Current trends in the psychological assessment and treatment of victims of sexual violence. *Sexual and Marital Therapy, 11*, 37–45.

Resick, P. A. (1992). Cognitive treatment of crime-related post-traumatic stress disorder. In R. D. Peters, R. J. McMahon, & V. L. Quinsey (Eds.), *Aggression and violence throughout the life span* (pp. 171–191). Newbury Park, CA: Sage Publications.

Resick, P. A. (2001). Cognitive therapy for posttraumatic stress disorder. Journal of Cognitive Psychotherapy, 15(4), 321–329.

Resick, P.A., Galovski, T.A., Uhlmansiek, M. O., Scher, C.D., Clum, G. A., & Young-Xu, Y. (2008). A randomized clinical trial to dismantle components of cognitive processing therapy for posttraumatic stress disorder in female victims of interpersonal violence. *Journal of Consulting and Clinical Psychology, 76,* 243–258.

Resick, P.A., Monson, C.M., & Rizvi, S.L. (2007). Posttraumatic stress disorder. In D.H. Barlow (Ed.), *Clinical handbook of psychological disorders (4th ed.)*: *A step-by-step treatment manual* (pp. 65–122). New York: Guilford Press.

Resick, P. A., Nishith, P., & Griffin, M. G. (2003). How well does cognitive-behavioral therapy treat symptoms of complex PTSD? An examination of child sexual abuse survivors within a clinical trial. CNS Spectrums, 8, 340–355.

Resick, P. A., Nishith, P., Weaver, T. L., Astin, M. C., & Feuer, C. A. (2002). A comparison of cognitive processing therapy, prolonged exposure and a waiting condition for the treatment of posttraumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology, 70*, 867–879.

Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology*, *60*(5), 748–756.

Resick, P. A., & Schnicke, M. K. (1993). *Cognitive processing therapy for rape victims: A treatment manual.* Newbury Park, CA: Sage Publications.

Resick, P. A., Williams, L. F., Suvak, M. K., Monson, C. M., & Gradus, J. L. (2012). Long-term outcomes of cognitive–behavioral treatments for posttraumatic stress disorder among female rape survivors. *Journal of Consulting and Clinical Psychology, 80,* 201–210.

Resick, P. A., Suvak, M. K., Johnides, B. D., Mitchell, K. S., & Iverson, K. M. (2012). The impact of dissociation on PTSD treatment with cognitive processing therapy. *Depression and Anxiety, 29,* 718–730.

Rizvi, S. L., Vogt, D., & Resick, P. A. (2009). Cognitive and affective predictors of treatment outcome in cognitive processing therapy and prolonged exposure for posttraumatic stress disorder. *Behaviour Research and Therapy, 47,* 737–743.

Schulz, P. M., Huber, L. C. & Resick, P. A (2006). Practical adaptations of cognitive processing therapy for treating PTSD with Bosnian refugees: General implications for adapting practice to a multicultural clientele. *Cognitive and Behavioral Practice, 13,* 310–321.

Schulz, P. M., Resick, P. A., Huber, L. C., & Griffin, M. G. (2006). The effectiveness of cognitive processing therapy for PTSD with refugees in a community setting. *Cognitive and Behavioral Practice, 13,* 322–321.

Sobel, A. A., Resick, P. A., & Rabalais, A. E. (2009). The effect of cognitive processing therapy on cognitions: Impact statement coding. *Journal of Traumatic Stress. 22,* 205–211.

Surís, A., Link-Malcolm, J., Chard, K., Ahn, C. & North, C. (2013). A randomized clinical trial of cognitive processing therapy for Veterans with PTSD related to military sexual trauma. *Journal of Traumatic Stress, 26,* 28–37.

Walter, K. H., Bolte, T. A., Owens, G. P., & Chard, K. M. (2012). The impact of personality disorders on treatment outcome for Veterans in a posttraumatic stress disorder residential treatment program. *Cognitive Therapy and Research, 36,* 576–584.

Walter, K. H., Keifer, S. L., & Chard, K. M. (2012). Relationship between posttraumatic stress disorder and postconcussive symptom improvement after completion of a posttraumatic stress disorder/traumatic brain injury residential treatment program. *Rehabilitation Psychology, 57,* 13–17.

Westwell, C. A. (1998). Cognitive processing therapy in the treatment of marital rape. *Psychotherapy in Private Practice, 17*(2), 63–77.