

Cognitive Processing Therapy Veteran/Military Version

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Cognitive Processing Therapy: Veteran/Military Version

Part 1

Introduction to Cognitive Processing Therapy

Cognitive Processing Therapy (CPT) is a 12-session therapy that has been found effective for both PTSD and other corollary symptoms following traumatic events (Monson et al, 2006; Resick et al, 2002; Resick & Schnicke, 1992, 1993¹). 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.

Also included in this manual is a module for traumatic bereavement. This module is not included as one of the 12 sessions but could be added to the therapy. We recommend that the session be added early in therapy, perhaps as the second session along with the educational component on posttraumatic stress disorder. Although we expect PTSD to remit as a result of treatment, we do not necessarily expect bereavement to remit. Grief is a normal reaction to loss and is not a disorder. Bereavement may have a long and varied course. The goal of dealing with grief issues within CPT is not to shorten the natural course of adjustment, but to remove blocks and barriers (distorted cognitions, assumptions, expectations) that are interfering with normal bereavement. Therefore, the focus is on normal grief, myths about bereavement, and stuck points that therapists may need to focus on in this domain. If the bereavement session is added to CPT, then the assignment to write an impact statement would be delayed one session (see Session 1) for those who have PTSD due to a traumatic death. Another possibility is to have the patients write two impact statements for those who both lost a loved one and have PTSD related to something that happened to them directly. One statement would be about what it means that the traumatic event happened to them. The other statement would be about what it means that the loved one has died.

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

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 & 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*, 748-756.

Resick, P. A., & Schnicke, M. K. (1993). *Cognitive processing therapy for rape victims: A treatment manual*. Newbury Park, CA: Sage Publications.

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 considering 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 would be inadvisable to try to deal with several types of therapy for different problems simultaneously.

Normally, comorbid depression, anxiety, and dissociation remit along with PTSD, so we rarely believe there is a need to deal with other symptoms independently of the PTSD protocol. Substance dependence should be treated prior to 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 (for more information on comorbidity see Section 3). 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. Other considerations regarding comorbidity are found later in the manual.

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 their issues into the skills that are being taught (i.e., A-B-C sheets, Challenging Questions, Patterns of Problematic Thinking, 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.

Returning OEF/OIF veterans may have different needs than older veterans. 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 numbed) 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.

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 (if comorbid depression is a problem) once a week. Most often there is a large drop in symptoms when the assimilation about the trauma is resolving. Typically this occurs around the 5th or 6th session with the written exposure 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.

Theory

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/her life. The other major theory explaining PTSD is Lang's² (1977) information processing theory, which was extended to PTSD by Foa, Steketee, and Rothbaum³ (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 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.

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 response and the attending emotions might be anger or fear (primary). However, if in the aftermath, the person blamed himself or herself for the attack, the person might experience shame or embarrassment. These manufactured emotions would have

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.

resulted from thoughts and interpretations about the event, rather than the event itself. As long as the individual keeps saying that the event was their fault, they keep producing shame (hence, manufactured).

Social-cognitive theories focus more on the *content* of cognitions and the effect that distorted cognitions have upon emotional responses and behavior. In order to reconcile the 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 ones 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 accommodating the memory and beliefs can begin. Once faulty beliefs regarding 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.

Because we know that PTSD symptoms are nearly universal immediately following a serious traumatic stressor 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 saw 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 has started drinking 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 of 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.

Overview

The contents of each session are described 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. Then the next two sessions focus on generating a written account of the worst traumatic incident, which is read to the therapist in session. During the first five sessions, the therapist uses Socratic questioning to begin to challenge distorted cognitions, particularly those associated with assimilation like 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 exposure component, a section on delivering CPT in a group format and a section on treatment issues with comorbid disorders,

It is strongly recommended that the protocol be implemented in the order presented here. The skills and exercises are designed to build upon 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 used individually, the last five sessions may be modified depending upon 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 had no safety or control issues but was 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 him 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.

The usual format for sessions is to begin with review of the practice assignments, followed by the content of each specific session. During the last 15 minutes of the session, the assignment for the next week is introduced and is accompanied by the necessary explanation, definition(s), and handout. 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 sheet) 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, the 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 s/he has been trained in more non-directive

therapies, is how to be empathic but firm in maintaining the protocol. If a patient does not bring in his/her 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.

Part 2

Cognitive Processing Therapy: 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 prior to 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, as well as to conduct repeated assessments during therapy to monitor the course of treatment.

Session 1: Introduction and Education Phase

Therapist Overview

Overall, there are several goals for the first session: 1) build rapport with the patient, 2) to educate the patient regarding symptoms of posttraumatic stress disorder and depression, 3) to provide a rationale for treatment based on a cognitive conceptualization of PTSD, 4) to lay out the course of treatment, and 5) to elicit treatment compliance.

It is necessary to address compliance early in the course of therapy because avoidance behavior (half of the symptoms of PTSD) can interfere with successful treatment. 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 attempt to set the expectation that therapy benefit is dependent on the amount of effort they invest through practice assignment compliance and practice with new skills. It may be helpful to remind the patient that what he⁴ 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.

⁴ Because of the awkwardness of the English language and the desire to refer to a single patient, the pronouns "he" and "she" will be used alternately, rather than saying "she/he", "him/her" throughout the manual. The term soldier will also be used as a generic term rather than soldier, marine, sailor, airman etc., and will be used interchangeably with veteran.

Patients sometimes arrive with a press to speak about their story. 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 regarding 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 post-traumatic stress disorder. The symptoms of PTSD fall into three 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 thoughts, which are memories that suddenly pop into your mind. You might have the intrusive thoughts 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?..."

"A second set of symptoms concern arousal⁵. 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, 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?..."

"The third cluster of symptoms is avoidance of reminders of the event. A natural reaction to intrusive reminders 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

⁵ 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, and avoidance. This way the explanation for the symptoms follows logically from their description.

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. Sometimes people have trouble remembering all or part of the event. Sometimes people feel numb and cut-off from the world around them. This feeling of detachment or numbness is another form of avoidance. Sometimes it is described as feeling as though you are watching life from behind glass. Which things or thoughts do you avoid or run away from?... Have you felt numb or shut off from your emotions?... Have you found yourself feeling disconnected from other people?

2. Trauma Recovery and Fight-Flight Response

“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’”.

*There are some different reasons why you may be having trouble recovering. First, there may be an automatic component during the event that you should consider as you evaluate how you responded during the event. 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. In order 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?

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

"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.

One common belief that many people get 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.

*"When an unexpected event occurs that doesn't fit your beliefs, there are different ways that you may try to make it fit. 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.*

*"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.

4. Types of Emotions

“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 on 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 to it. However, it will burn out if it is not continually fed. The 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.

In order 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

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, they 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 this event. If the patient is resistant to writing an account about the worst event, the therapist needs to do some cognitive therapy during session two and have the patient complete some A-B-C sheets 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 affect-charged event by providing a timeframe in the request.

“In order 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 the most traumatic event...”

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 reexperiencing 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. 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

"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 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 handout on stuck points and the Stuck Point Log). We will keep a Stuck Point Log in your folder so 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."

Anticipating Avoidance and Increasing 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 they have been doing. It is very important that the patient understand what the therapy consists of and why it will work. They 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.

The therapist should describe the course of therapy (and the nature of the trauma account in sessions four and five) 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 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 is, 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 this event happened to you, and 2) how has it changed or strengthened your views about yourself, other people and the world in general?”

In order 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.”

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 them that you are not grading their work or interested in their 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 into a tape recorder.

Practice assignment:

Please write at least one page on *why* this traumatic event occurred. You are *not* 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.

Traumatic Bereavement Session (Session 2 if applicable)

The goals for this session are to 1) determine the impact of the traumatic event on beliefs about self and others, 2) begin to normalize the grief process and differentiate it from PTSD symptoms, 3) identify stuck points that may interfere with the normal course of bereavement, and 4) begin to assist the patient in viewing her relationship with the person who died as altered, but not finished.

If this session is added, then the therapist will have the patient read the Impact Statement first before turning to the topic of grief. Please see the regular session two, next, for comments regarding avoidance and what to do if the patient did not complete the assignment. After discussing the Impact Statement and identifying stuck points that are evident, the therapist will begin an education portion on the topic of normal bereavement and will look for stuck points that may interfere with normal grief reactions. To facilitate this process, some information is provided below to assist the therapist to think about traumatic versus normal bereavement issues, and to provide some education to the patient regarding the course of bereavement as varying and multidimensional. It is important for the therapist to refrain from pathologizing the grief process and to begin to differentiate grief from PTSD or depression.

Therapist overview: Traumatic bereavement

PTSD can interfere with the normal course of bereavement. It is also possible that unresolved grief can further complicate recovery from PTSD. Although witnessing or being injured during an event in which a loved one/friend was killed is more obviously associated with PTSD, therapists need to consider a PTSD diagnosis among those who were not present at the traumatic death of a loved one. In civilian life, the sudden, unexpected and perhaps violent death of a significant other is so shocking, horrifying, and schema-discrepant that family and friends of the victim may have trouble taking in the fact that the person has been killed. During war, soldiers may accept the possibility that they or others may be killed, on an abstract level, but losing friends, seeing children die, or having deaths occur in unexpected places (when one thought he was safe), can also be shocking and hard to accept. Acceptance may be particularly difficult for parents who lose children because of the expectation that their children will survive them. And like other trauma survivors who actively avoid accepting the reality of the situation, traumatic-death surviving family and friends may engage in self-blame as an attempt to undo the event (e.g., “*If only I hadn’t done X, he wouldn’t have been there at the time*”). Unlike other trauma victims, traumatic death survivors may believe that to accept the trauma and begin to move on with their lives means they have betrayed the other person, that the other person isn’t being properly honored.

Flashbacks, intrusive thoughts, and other intrusive reminders can recur even if someone was not present at the death of their significant other. People may flash on or have strong emotional or physiological reactions when reminded of being informed of the death. For example, some people have strong reactions when the telephone or doorbell rings. They immediately flash back to being told. Some people have strong reactions to temporal cues such as a specific time of day, dusk, a certain month, or other anniversaries of the death. They may react to climactic cues such as temperature, humidity, smells or other seasonal reminders.

Holidays or other personal days of celebration (birthdays, anniversaries) can be particularly difficult and can trigger trauma cues (as well as positive memories).

It is not unusual for people to have images of or ruminate about (with accompanying affect and physiological responses) what they imagine happened to their loved one/friend. Some people feel compelled to put themselves into the shoes of the person who died in an attempt to be closer with them. They try to imagine what the other person experienced, what they must have been feeling or thinking, and wonder if they suffered or were in pain for a long time before they died. These images can serve as intrusive reminders of PTSD (Criterion B).

Often with PTSD induced by traumatic bereavement, we do not see effortful avoidance with regard to the person who died. To the contrary, some people intentionally ruminate and are afraid to let go of the images, even very distressing images, because to let go is, in their minds, to lose their loved one. Effortful avoidance is more likely to be of the trauma cues listed above. Numbing is common.

When some people are killed during a traumatic event, those who survive, whether they are friends, family, or strangers, may well have survivor guilt. When people experience traumatic events, they often ask the question, “*Why me?*” because of their just world belief. A corollary of this belief is asking “*Why not me?*” when surrounding others are killed. People with survivor guilt feel that they do not have the right to go on when others are not, or believe that they are less deserving of happiness (or even of living) than the person or people who died. They try to determine why they survived and cannot find an acceptable explanation.

An issue that may need to be addressed with military and veteran populations is not just witnessing or hearing about the death of someone the patient cared about, but also issues that arise from having killed themselves. Soldiers may find themselves forced to engage in behavior that is against their personal moral code, or in conflict with the circumstances under which they believed that they would be killing others. In our experience, situations in which civilians, and especially children, are killed are especially traumatic for veterans and servicemen (e.g., children with backpack bombs, children put in front of transportation convoys). Grieving and assumptions about one’s actions during war can be very complicated because of the nature of war itself. Veterans and military personnel may blame themselves, the combatants, the government that put them in the position they found themselves, or the behavior and perceived failures of command or fellow soldiers. The combination of anger and guilt can complicate and prolong the grief response.

The goal of CPT for bereavement is to help patients determine and eliminate any stuck points, problematic cognitions that are blocking their recovery, and to help them eventually focus on the person’s life, not just the way in which he or she died.

First the therapist can start with bereavement issues...

“Prior to this death, what has been your experience with the death of loved ones?”

If the patient has never experienced the death of a loved one, then ask *“What were your expectations about death of loved ones? Had you ever thought about it? Or was it a topic that you avoided thinking about?”*

Once the therapist understands what the patient understood about death and the grief process prior to the traumatic death, s/he can then ask..

“How is this situation different than what you had experienced before (or imagined)?”

“What have other people been telling you about grief and mourning?”

“What suggestions have people been making?”

Give the patient(s) the Myths of Mourning handout. Discuss each of the statements with the patient to determine which, if any, statements the patient has been subscribing. Along with debunking some common myths, the therapist uses this session to help the patient understand the normal process of bereavement, to see how the traumatic bereavement relates to symptoms of PTSD, and to begin to identify distorted cognitions, conflicts between prior beliefs and the traumatic event.

Education on Normal Bereavement

Bereavement affects different aspects of one’s life. People have emotional, spiritual, and physical reactions. They also have to adjust their roles with regard to other people, the community more generally, and with regard to tasks and behaviors. While some grief reactions may feel like and share some characteristics with other psychological reactions such as depression, it is important for the therapist not to pathologize grief. Bereavement is not the result of personality traits, but is the normal and time-limited reaction to loss. Mourning is not the same as depression and does not respond to anti-depressants.

In the past it was possible to tell that someone was grieving for a period of time because of clothing indicative of mourning and institutionalized rules about mourning such as wearing black for a year, wearing certain jewelry or armbands, limiting social engagements and so forth. These practices provided more community support because the person who was grieving was clearly identifiable and there was an expectation that bereavement should take an extended period of time. On the other hand, the rigid rules about length of mourning were not flexible enough to accommodate different patterns of grief. Some people may not have needed a year in order to begin to reestablish their lives (some may have needed longer). In modern times, there is no way to identify whether someone is in mourning, so the community quickly returns to usual routines and expects the bereaved person to do so as well. While community support is often very active initially, people often return to their own lives after a few months, leaving the bereaved adrift to adjust to their changes in roles and tasks. After a few months grieving people may start receiving comments by others that they should move on with their lives and to put the traumatic event and the loved one behind them (people with PTSD hear this all the time even without a traumatic death). People may need assistance in tolerating the predominant community standards that do not reflect the reality of the mourning timeline for them.

In the early stages of bereavement, people need information and support in coping emotionally. Later, if the person who died is a family member, they need to focus more on

instrumental tasks. Some tasks, like dealing with insurance companies and changing names on titles are directly due to the death of the family member. Other tasks represent a realignment of typical chores (e.g., now the patient needs to pay bills or cook, when before the other partner took responsibility for those tasks). Each of these instrumental adjustments, if successfully negotiated, will help the bereaved person accept the reality of the situation and assist in a greater sense of control. As the tasks and roles are realigned, then the person also moves to reconnect with his community, reestablish and adjust relationships with their friends and relatives and finally to rebuild his assumptive world. This latter task includes adjusting his beliefs about himself and the world, with regard to the loved one's death. As elsewhere in CPT, the therapist is looking for accommodation rather than assimilation or over-accommodation, balance in beliefs rather than extreme statements.

Sometimes the bereavement process for military personnel becomes more acute once they leave the military. While in the military, other people in that environment may have been able to provide support and understanding of the losses that a soldier experienced. Upon returning to the civilian world, however, people in the environment may not be able to understand or appreciate the loss of comrades, or may even be unsympathetic because of different viewpoints on the war. Although our society appears to be doing a better job separating the war from the warrior in the recent OEF/OIF conflict, this is not universally true and there are many Vietnam veterans who carry the scars of verbal abuse upon returning to the US after their tours of duty in Vietnam. They may not have been given the opportunity to grieve the loss of their friends and fellow soldiers or may be stuck in a cycle of grieving that has not remitted.

The following are excerpts from a bereavement Impact Statement. The statement was four hand-written pages. It illustrates the effects the murder of a granddaughter had on a patient.

I think at first I needed to be strong from my son. As long as I could do that, I did not have to face the finality of death. This is still so hard for me to say. To think of _____ in the past tense still causes me to have a panicky feeling. I cannot describe how much I love her or how much I miss her.

I thought I would always be the same me. But now I realize I will never be the same. At first I kept trying to be the same self- Tried so hard that I would get these panic attacks, so I just tried not to think about it.

I feel like this big cloud has settled over me and sometimes it suffocates me. I would like to just pull the covers over my head and not take them off for a long time. But I know I can't, especially for my son. He says he would like to go into a closet and not come out.

I talked today with my Pastor about my feelings, how I feel so frozen inside, that I cannot pray and do not feel spiritual at all. It makes me feel so empty. I miss the fellowship I had with my God. I do want to have that again.

Some people say I need to try to forgive – I can't and I don't want to – at least not now... I really don't want to be angry – this is not me. But right now I'm so angry.

While the example above illustrates assimilation through non-acceptance and avoidance, the next excerpts from a different patient whose friend was killed and illustrates both assimilation and over-accommodation.

I always believed that I could protect _____ from anything or anyone. I feel like a failure. I failed him. I should have been watching his back then no one would have been able to shoot him in his back. I could have administered CPR and helped to breathe in him the breath of life. He would have calmed down and fought harder if I had been there... Who knew? But I failed him and I don't have any other chance to make it up to him.

This world is a cruel world where no one seems to care about anyone outside of their own family... I trust no one outside of the family and I really am no longer close to my family. I no longer use the word "friend" because it no longer serves a purpose in my life. I feel abandoned by certain people in my family. They are already ready for me to move on. Isn't that crazy?!

It may be helpful for a patient to realize that his relationship with the deceased has changed rather than ended. The patient can still have a relationship with the deceased even though the relationship is not reciprocal. As part of the Impact Statement on the death of the significant other, the patient is asked, *"How has the event affected your relationship with the deceased?"*

One of the problems that can occur early in the grieving process (and stall out in some cases) is the tendency to over-idealize the person who has died. It is difficult for the bereaved person to move on, reestablish connections with others, and alter her relationship with the deceased if the person who died is not the person who lived before. The loved ones may experience more survivor guilt or hindsight bias if they believe that the person who died was perfect or that it is bad/wrong to remember any flaws or foibles. The therapist needs to tread lightly on this topic, perhaps pursuing it later in therapy, although it can be broached gently at this time. The therapist, in hearing an over-idealized description of the deceased can say:

"He sounds like an angel. I'd like to have a better picture of the whole man that you knew. Tell me a little about his eccentricities or habits".

The goal here is to help the patient to grieve for the person who really lived with an integrated and balanced view.

In some cases, over-idealization may be a particular problem because the idealized image of the deceased is embraced by a whole community. In the aftermath of the World Trade Center attack, firefighters, police, and other rescue workers who died have been rightly hailed as heroes. Heroes are people who risk themselves to help others in spite of their fear or flaws, not because they were fearless and flawless. It may be particularly difficult for family members if their memories of the person clash with the public image. If a couple was having marital problems, or the partner was having an extra-marital affair, was abusive, or alcoholic, the surviving partner would not know how to reconcile this information with the accolades and images of the partner as a saint. Even to remember small flaws would seem like a betrayal of the person who died. And yet, the surviving partner and family members have these memories as well and struggle to deal with them. Some people attempt to suppress or ignore inconsistent information. If they are successful in avoiding, there is a greater likelihood of more prolonged bereavement than for those who can put the person's life into an accurate perspective.

Pertinent to situations like the attack on September 11, 2001, and war, is the issue in which the body of the deceased is never found. It may be more difficult in these cases for the surviving family and friends to accept that the person is actually dead. When there is no concrete proof that the person died, assimilation and denial are more likely. The survivors may have continuing fantasies that there has been some mistake, that the loved one has been wandering around with amnesia or injured and unable to contact them. They may have extended periods during which acceptance of the reality of the situation is postponed.

Finally, when a group of people experience the same event and then support each other in the aftermath, they can help each other progress through the various stages of grief. However, there are two risks. One is that the members of the group will be recovering at different rates, leading to misunderstandings or some people being held back from their natural rate. A worse outcome is that the group becomes stuck together and stop recovering altogether. They develop an us-against-them mentality in which they come to believe that no one can understand what they have experienced and that they can never recover. If someone who seeks therapy is enrolled in a long-term support group (either formally or informally) in which this has occurred, it will be somewhat more difficult for the therapist to intervene with over-generalized beliefs because they are held by a group of people, lending credence to them. The therapist will need to remind the patients during cognitive therapy that other people saying things does not constitute evidence for a belief.

The following is a list of possible stuck points that the therapist may encounter while working on bereavement issues. This list is, of course, not exhaustive, but merely suggestive.

- 1) *"I have no right to feel happiness when ____ has died and can no longer be happy"* (Survivor guilt).
- 2) *"I could have prevented this, if only ____"* (Distorted sense of power).
- 3) *"If only I had _____, this would not (might not) have happened"* (Distorted sense of responsibility- hindsight bias).
- 4) *"This can't be happening. He/she will show up at some time"* (Denial in many of its forms).
- 5) *"This can't be happening to me"* (Personal non-acceptance).
- 6) *"Others may eventually pull out of this grief, but not me. My relationships are of a different quality"* (Uniqueness).
- 7) *"I can never be happy with someone else ever again"* (Distorted consequences).
- 8) *"My life is over"*.

Practice assignment:

Please write at least a page on what it means to you that _____ was killed. As in the last assignment, focus on meanings regarding safety, trust, power/control, esteem and intimacy. Also write about how the death has affected your memory of _____, your relationship with _____, and how you perceive you are adjusting to the loss.

Session 2: The Meaning of the Event (if no bereavement, session 3 if bereavement)

The goals of the second session are: 1) to review the cognitive-behavioral formulation of PTSD and depression, 2) to begin to determine the patient's stuck points and formulate why the patient has not recovered naturally from the event (Impact Statement), and 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 their 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.

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, overgeneralized 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 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.

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 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.

The therapist should use the framework of the Impact Statement to help the patient begin to recognize which of their statements reflect assimilation and over-accommodation. For example, in response to a patient's statement regarding thinking of ways he could have handled the traumatic situation differently, the therapist might say, "*It sounds like 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, 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*", "*I can never feel close to anyone again*". The therapist can mildly point out that 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 the victim of several adult assaults. Although he is clearly blaming himself for the events (assimilation), he is intimidated by other people and has overgeneralized danger in the world. His problems with self-esteem are also evident.

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 patients’ 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 between 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.

“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- mad, sad, glad, and scared. These four 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 mad and scared different for you?”...

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. The patient is then asked what she would feel, and then what she just said to herself (e.g., *"I'm hurt. She must not like me."*). *"I wonder if someone else might have different thoughts about her behavior?"* If the patient is unable to generate other 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 talk about 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?"..

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 between 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 they have 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 what was going to happen and exactly when it was going to happen, and knew exactly who 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 and 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 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*”.

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 a 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 responds, “*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.

Several A-B-C sheets 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 sheet. The patient and therapist should fill out one sheet together during the session. As the sample, 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 sheets that have some relevance to the patient’s presentation should also be given to him.

“These practice sheets 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 (Col. A). Then try to recognize what you were saying to yourself (Col. B). Try to fill out these sheets 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 sheet about the traumatic event”.

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

Practice assignment:

Please complete the ABC sheets to become aware of the connection between events, your thoughts, feelings, and behavior. Complete at least one sheet each day. Remember to fill out the form as soon after an event as possible. Complete at least one sheet about the worst traumatic event. Also, please use the Identifying Emotions handout to help you determine what emotions you are feeling.

Session 3: Identification of Thoughts and Feelings

The goals of Session 3 are to: 1) assist the patient in labeling thoughts and emotions in response to events; 2) introduce the idea that changing thoughts can change the intensity or type of emotions that are experienced; 3) begin challenging the patient's self-blame and guilt with regard to the traumatic event through Socratic questions, and 4) assign the patient to write a detailed account of the traumatic incident. (**NOTE:** If the therapist is using the CPT protocol without the written accounts, then the assignment will be to do the A-B-C sheets again until the next session).

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. Otherwise, the therapist should begin by going over the A-B-C sheets completed for practice. In looking over the sheets 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 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 results in depression, terror, or other desperate emotions.

Frequently, patients label thoughts as feelings. For example, one patient brought in an A-B-C sheet which 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 four basic emotions for the patient and asked her which of the four 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 or herself. It is quite acceptable, and in fact better, for the therapist to correct him or herself 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.”).

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

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.*

As another example, consider this patient's problem with survivor guilt. The following dialog occurred during a discussion of the patient's A-B-C sheet on which he had written that when he thinks about leaving the hospital, he feels anxiety and general distress. He wrote in the thoughts (B) column "*I don't know why I'm alive.*" This patient had survived a combat involving crossfire in which others died. He sustained a head injury for which he spent more than two weeks inpatient at an Army hospital.

- T: *Could you say more about feeling guilty?*
- P: *It's just that I don't know why I'm here. God gave me a second chance, but I don't feel I deserve it. I should've died like the rest.*
- T: *Are you saying you feel guilty for surviving?*
- P: *Yeah, I do. I guess so.*
- T: *What are you guilty of? Guilt implies some wrongdoing. What did you do wrong?*
- P: *I know to you it seems ridiculous, but I just feel that way. I feel guilty. If I hadn't taken the elevator to escape, I wouldn't have gotten hurt so bad and I could have helped others get out. [The patient had sustained burns from volatile liquids that funneled down elevator shafts burning him severely as he exited the elevator on the bottom floor of his building.]*
- T: *How could you have seen or predicted that you would get hurt and become immobilized by taking the elevator? How could you have guessed which escape route would be the best when everything was suddenly in chaos?*
- P: *Well, everyone knows you're not supposed to take the elevator when there's a building fire!*
- T: *Sure, but something must have made you think the elevator was the best way out. Under those circumstances, you made the best decision you could.*
- P: *Yeah, but I didn't even take anyone with me! And because I went that way, I got hurt and I couldn't help others and most of the rest of the people I worked with on that floor died!*
- T: *Let's look at what the situation was like when you decided to run the way you did. What was happening?*
- P: *Lights were out. Sprinklers were spraying water everywhere. There was smoke. People were screaming or shouting. I just headed as best I could for a way out. I moved towards where the elevators were, for some reason not the stairs.*

- T: *How often had you taken the stairs from your floor before? Did you know the way to the stairs?*
- P: *Well, no not really. I'd never taken the stairs.*
- T: *Why did you go toward the elevator?*
- P: *It was automatic. And for some reason, they were running. I just got in.*
- T: *How much time did you have to think about that, to weigh your options?*
- P: *Think?! There wasn't really time to think. I don't know, maybe seconds, but things were bad up there. The elevator popped open. I just got on, not thinking, I suppose, and punched the down button. I don't know where anybody else was! [begins to cry]*
- T: *[waits a moment to let patient cry a little and regain some composure] That's painful to remember. I'm sorry. Let's continue because I think it will help. So, you had a couple of seconds to make a decision. Tell me about your decision making process at that moment.*
- P: *I just told you! No time! I just got in and went down! It was like I didn't even think! Suddenly I was on the elevator. It opened. I got on.*
- T: *So, it was automatic?*
- P: *But I shouldn't have done it. I should have helped others.*
- T: *What would you say if a friend of yours escaped a burning building but others didn't? Would you blame him for not helping others get out? Would you assume he even had the chance or could help others?*
- P: *If a friend? ... Like who? A friend? Well, I wouldn't automatically blame a friend for something. I guess not.*
- T: *Why not?*
- P: *Well, I'd be glad my friend got out all right. I guess I'd assume he'd done all he could.*
- T: *How did he do all he could do? How would you come to that conclusion?*
- P: *Well, it was a burning building right? Like mine. I'd just naturally assume he would've done all he could to help others, but maybe the situation was out of hand and all he could do was save himself.*
- T: *What do you mean by that?*
- P: *Well, he couldn't do anything. He might not even have noticed where others were to save them.*
- T: *Even if he might have tried, it doesn't mean he would've been successful. Why do you give your friend the benefit of the doubt and not yourself?*
- P: *I never really quite thought of it that way. You know, it's easier to not be hard on a friend. I would be glad he was alive. A friend, you know.*
- T: *So, again, why give the benefit of the doubt? What about you? Wasn't the situation you just described really the situation you had in your building after the explosion?*
- P: *It was. Yeah, I guess it was. [sits quietly, looks down]*
- T: *[after waiting a few moments in silence] What are you thinking?*
- P: *I couldn't do anything. [starts to cry]*

The preceding dialog demonstrates the therapist's attempt to begin to challenge the patient's feelings of survivor guilt by helping the patient more realistically assess the circumstances surrounding the trauma and his escape. Erroneous retrospective thinking and not accepting one's helplessness during traumatizing events together lead some survivors to feel guilty and sure their actions during the event were somehow flawed or inadequate. It is clear this survivor has issues or "stuck points" around guilt and self-blame, especially in the disclosure that

he would readily accept a friend's survival story uncritically, but not his own. This issue will be addressed in sessions to come in several ways. Written accounts will bring more light to the circumstances this survivor endured during the event, anchoring him better in fact rather than preferred fictions of the trauma. Challenging Questions, Patterns of Problematic Thinking and Challenging Beliefs Worksheets will help the patient to identify and question his own tendencies to blame himself or to engage in hindsight bias about this traumatic experience.

The out-of-session practice assignment for the next week is to write a detailed account of the chosen index trauma. 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 written 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, 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 hand-written and not typed. As mentioned previous, there is evidence that writing the account is more evocative. Typing the account lends more objectivity and tendencies 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. 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 feelings about the event, your feelings will become less intense and less overwhelming.”*

There are two purposes for the writing assignments. The first purpose is to serve as an exposure technique. Writing about the event in great detail assists in calling up the complete memory about 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 then can be stored without such intense emotions encoded with it. (Unlike theories that suggest the repeated prolonged exposures are necessary for habituation, we have found that the primary natural emotions dissipate quickly and do not need extended exposure work). The second purpose is for the therapist and patient together to begin to search for stuck points.

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 sheets every day.

Session 4: Remembering the Traumatic Event

The goals of Session 4 are to: 1) have the patient read his account, with affective expression; 2) identify the patient's stuck points regarding the event; 3) begin challenging self-blame and other assimilation with Socratic question; and 4) reassign the account with more details and anything that was left out.

The therapist should begin the session by having the patient read the written 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 about- talking to the patient, saying the patient's name, handing her a tissue, asking questions, to contain the affect.

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?*" If they have not been identified thus far, 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 in 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 point at which he perceived a loss of control over the situation.

Depending upon the length and complexity of the event, the average written account is about eight hand-written pages. However, some particularly short events may not require as much. 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.

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.

If the patient reads or recounts the event without any emotion, the therapist should stop the patient 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.

Sometimes, the patient is not avoiding affect, but is experiencing the emotions that were experienced at the time. If the patient dissociated, she may dissociate again as she recalls her memories of the event. If patients were nauseous, 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.

Finally, the therapist should ask the patient about stuck points that may not be in her written account (i.e., what she thought she should have done). Often, patients have regrets afterward because they feel 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 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.

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, 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 him 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.

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 worst option). Part of the context would also include the age of the person at the time of the event (and developmental level) 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 they think 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 regarding the context of killing.

- 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, at least in part, 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, never mind the outcome?*

P: *No. 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 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 exacerbate his defensiveness or possibly contribute to dropout from the therapy.

If the patient's index event was child physical or sexual abuse, he or she may be particularly confused by the concept of punishment. They 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 them as people, but is only about the abuser and his or her choices. 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 he/she was the occasion for the assault (they were 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 he or she is to blame for the event, the therapist can ask if the patient intended for this to happen. When he/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.*

Responsibility and 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 between 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 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 we put ourselves 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: *Hmmmm.....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 awhile 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 Tom 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, pointing out acts of heroism or courage can be powerful interventions with veterans and soldiers.

A comment on *perpetration*. Aside from acts of war and killing in that context, it is possible that a patient will describe an event in which they 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 their 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 war and not since (or not for years), the therapist may need to help the patient to contextualize and differentiate who they were then, from who they are 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.

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.

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, ⁶1990a). 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 his/her own assumptions and thoughts to make sure they are not becoming unbalanced. The principles behind CPT apply to therapists as well as patients.

For the practice assignment, the therapist asks the patient to write the whole incident 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 as well as more of his thoughts and feelings during the incident. The therapist should add that this week, 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 proceedings, medical treatment, funerals, or rejection from loved ones compound the trauma and should be considered part of the event, for all practical purposes. Memories of these events and

⁶ 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*(1), 131-149.

concomitant stuck points should be included in the writing assignments and discussions. If the patient is experiencing different thoughts and feelings than with 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)*”.

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

Practice assignment:

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 session.

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

Session 5: Identification of Stuck Points

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

The therapist should begin the session by going over the new version of the incident. 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).

The therapist should continue to use Socratic questions, particularly the questions listed on the Challenging Questions sheet 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 their component of the event) was not preventable and hence, they are 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 word. 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 word blame or fault is not appropriate or accurate.

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 to 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.

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 sheets.

Practice assignment:

Please choose one stuck point each day and answer the questions on the Challenging Questions sheet with regard to each of these stuck points. Write your answers on a separate piece of paper so that you can keep the list of questions for future reference

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.

Session 6: Challenging Questions

The goals of Session 6 are to: 1) review the Challenging Questions sheets, 2) assist the patient in answering questions he had difficulties answering; 3) continue cognitive therapy regarding stuck points the patient is trying to challenge, and 4) introduce and assign the Patterns of Problematic Thinking worksheet. Unless the patient has a strong need for the therapist to hear a new account, the writing and reading of a second incident 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 regarding 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 sheets 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.

The session begins with the practice assignments and reviewing the patient's answers to the Challenging Questions. 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.

Occasionally, a patient will lose track of the fact that they are trying to answer one question and 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 an example sheet is 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 it 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.

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, and poor self-esteem or suspicion of others.

After discussing the questions, Patterns of Problematic Thinking are introduced. This worksheet is different from the Challenging Questions sheet 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 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.

For the practice assignment, the patient should consider her stuck points, and find examples for each relevant thinking pattern. As he experiences events in the following days, he should notice and record any of the patterns he identifies. He should be asked to look for specific ways in which his 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 an example sheet with examples along with blank sheets for them to complete.

Practice assignment:

Consider the stuck points you have identified thus far and find examples for each of the problematic thinking patterns listed on the sheet. 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.

Session 7: Patterns of Problematic Thinking

The goals of this session are to: 1) review the Patterns of Problematic Thinking sheet; 2) help the patient determine if she has particularly strong tendencies toward any of the counterproductive patterns; 3) introduce the Challenging Beliefs Worksheet that will be used throughout the remainder of therapy; and 4) introduce the Safety module handout. (**NOTE:** If the therapist is using CPT without written 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).

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 is the case, resulting in alienation from others. Emotional reasoning regarding 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 he must have done something wrong.

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 person starts to say, “*Some people cannot be trusted*”, the accompanying emotions are less intense than to say “all”. (See examples next two pages.)

At this point the therapist should introduce the Challenging Beliefs Worksheet (adapted from Beck & Emery⁷, 1985, p. 205). The introduction of this worksheet is very important in the patient not being overwhelmed by the seeming complexity of it. The worksheet brings together all of 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 sheet 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 problematic thinking patterns sheet 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.

⁷ Beck, A.T., & Emery, G. (1985). Anxiety disorders and phobias: A cognitive perspective. New York: Basic Books, Inc.

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 prior to 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 them 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 sheet 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 sheets as events occur to which he has emotional reactions during the week for practice.

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

"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?..."

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 regarding 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). Overgeneralized fears lead some veterans 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 of these cases, the patients declared that

because during the war you couldn't tell friend from foe, they had learned to be leery of most people they encountered who reminded them in any way of their enemy. 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 may 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 of 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 the higher risks elsewhere.

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/he can help the patient to see that he doesn't have to behave as if it is a high frequency event. The therapist can also point out that the patient is jumping to conclusions without supporting evidence.

The patient should be given the Safety module to remind her of these issues. The modules on safety and other issues were based on the work of McCann & Pearlman⁸ (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 which have been distressing.

⁸ McCann, I. L., & Pearlman, L. A. (1990b). *Psychological trauma and the adult survivor: Theory, therapy and transformation*. New York: Brunner/Mazel.

Practice assignment:

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 issues with self- or other-safety, 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.

Session 8: Safety Issues

Session 8 goals are to: 1) go over the Challenging Beliefs Worksheets with the patient and assist the veteran as needed to complete the worksheets; 2) review the Safety module and focus on self- or other-safety issues for which the patient should complete worksheets; 3) introduce the Trust module and the concepts of self- and other- trust.

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 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.

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 veteran 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 had an elevator as well as at work. He estimated that he rode 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).

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 at other times 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 “Questions to ask yourself” they wrote “*Confusing a low probability for a high probability event.*” Under the “Patterns of Problematic Thinking” column they wrote “*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 re-read the worksheet regularly so that the reasoning becomes comfortable.

Another patient, an Iraq veteran, who struggled with his first challenging beliefs worksheet, believed that, even though he had been back in the US for six months, he was at the same level of danger that he was in Beirut. He insisted that because there might be some people in the US who could plan another attack, he was in just as much danger. He could not see the difference between the ideas “something could happen” from “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. He was able to acknowledge that the two statements felt somewhat different and that *could* was different than *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.

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 veteran thought he or she could trust, sometimes veterans feel betrayed by the people they turned to for help or support during or after the event. For example, if a veteran thought that someone let him down during battle, he might decide right then and there not to trust anybody. Sometimes veterans 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 veterans' emotions and they withdraw or try to minimize the event or the impact. Such a withdrawal may be viewed as a rejection by veterans, 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 they have had all of the emotions that they 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.

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.

Session 9: Trust Issues

Goals for session 9 are to: 1) review the worksheets on self- and other-trust; 2) review other worksheets on patient stuck points; and 3) introduce the module and concepts regarding power and control. Competence issues may also factor into this section although they may also pertain to esteem.

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 who 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).

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, that 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 loan \$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?*

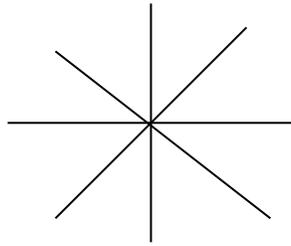
P: *Yeah, but if I started out by trusting everyone, then I might get hurt.*

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 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 veteran 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*").

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 their behaviors in the middle of an emergency will be (or what the outcome would have been if they did 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 he will end up feeling isolated and alienated from people who could provide genuine support and intimacy.

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 veterans 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.

Session 10: Power/Control Issues

Session 10 goals are to: 1) review the patient's Challenging Beliefs Worksheets on control and power; 2) introduce the Esteem module for challenging self- and other-esteem issues; 3) assign the patient to practice giving and receiving compliments; and 4) assign the patient to do at least one nice thing for him/herself every day.

The session should begin with a discussion of the patient's attempts to change cognitions regarding 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 soldier through his day focusing on all of 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, what to wear, and to eat, 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, they never would have remembered the decisions that they made that day. Only because the outcome was so catastrophic do people go back and try to question all of 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 felt that such efforts would be futile. She felt stuck in a job that was unsatisfying and 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.*"

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 also to remember that while fear is associated with the fight-flight response, so is anger. Environment cues may trigger anger that is 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 training to turn off the “battle mind” when the soldier returns home.

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 towards), 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 of 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. A certain amount of 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 soldier, but they should not have an equal share of the blame and anger.

One veteran 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.

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 prior to the event should be explored.

For practice, the patient completes Challenging Beliefs Worksheets on stuck points regarding self- and other-esteem drawing from the Esteem module. In addition, the patient is assigned to practice giving and receiving compliments during the week and to do at least one nice thing for himself 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 they are 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 in that those with PTSD tend to isolate themselves. Pleasant events scheduling can also be helpful for those with depression and may assist with relapse prevention.

Practice assignment:

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.

Session 11: Esteem Issues

The goals of session 11 are to: 1) review the compliments and nice things that the patient has done for himself; 2) review the Challenging Beliefs Worksheets regarding esteem and other topics; 3) introduce the concepts of self- and other- intimacy; 4) assign Challenging Beliefs Worksheets on intimacy; and 5) assign a new Impact Statement.

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 seem 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, and practice giving and receiving compliments on a daily basis 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.

The patient and therapist then discuss the Challenging Beliefs Worksheets regarding 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 veteran 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 regarding the event, all eat away at one's global perception of self-esteem. In the case of interpersonal crimes (such as MST), 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.

It is sometimes helpful to address issues regarding 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 upon herself.

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 over-generalize their disregard for the perpetrator of a traumatic event to an entire group (e.g. Asians, Iraqis). In these cases where the veteran 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.

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 on a daily basis. Like crime, natural disasters, wars, plane crashes, terrorist activities and other devastating events 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 veterans 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 veteran may express great disdain for everyone from that country, even those people who have lived in the US for generations.

Another topic that emerges frequently with veterans 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 veterans with PTSD use their outrage at the government as an avoidance strategy. Instead of focusing on specific traumatic events, some veterans with PTSD will immediately try to move the focus to politics and the government (avoidance by rhetoric). 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. If the patient has been using a dislike of the government as an avoidance of more personal experiences, this topic will need to be broached very early in therapy. However, it could re-emerge with the topic of esteem and can be challenged again.

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. 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 they were 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 again here. Again, the patient should use the Challenging Beliefs Worksheets to confront maladaptive self-statements and to generate more comforting statements.

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 their current thoughts, and not how they may have thought in the past.

Practice assignment:

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.*

Session 12: Intimacy Issues and Meaning of the Event

The goals for the last session are to: 1) 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) have the patient read the new Impact Statement; 3) read the first Impact Statement and compare the two statements; 4) review the course of treatment; 5) identify goals for the future; and 6) remind patients that they are taking over as the therapist now and should continue to practice the skills they have learned during treatment.

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 regarding 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 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 compulsive spending or gambling, or are so dependent upon others that they do not believe that they can take care of themselves. 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. Rather than grabbing for food, cigarettes, alcohol, or a credit card, we encourage patients to grab a worksheet instead, and 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 prior to attempting to work on the traumatic memory. 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.

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 100%-service-connected 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, and that the rest of their age mates are asking themselves the same questions. What will I do when I retire? How will I spend my time? Who will be in my life? The therapist should help the veteran to see that these are normal questions, and instead of fearing the future, they now have the opportunity to explore and decide how they want to spend their 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 their options.

Younger veterans 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 they might have considered.

With regard to intimacy of 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 veterans avoid developing new relationships. As a result, many of these people feel isolated and alone during their recovery from the traumatic event.

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 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 for the purpose.

The therapist and patient should go over the new Impact Statement regarding the meaning of the event. The patient should first read his new Impact Statement to the therapist. This is an example final Impact Statement written by 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. About safety, I 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 seem 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 the 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 of time. 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.

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 in continuing 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.

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, that 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 work with their worksheets. They should be encouraged to experience their natural emotions and check their thought to make sure they are not extreme.

A Note on Aftercare

We recommend that after completing the protocol, whether conducted weekly or twice a week, that 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 their 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.

One VA program we know of has instituted an aftercare program for veterans who have completed CPT. It is a group that meets monthly. They 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 veterans may attend for one session or a number depending upon what they are working on. The facilitator of the group has reported to us that it has been very helpful in maintaining gains and giving the veterans a place to continue to work on stuck points without needing to return to a more formal therapy.

Part 3

Alternatives and Considerations in Conducting Cognitive Processing Therapy

Cognitive Processing Therapy without the Written Account

Recently, Resick and colleagues completed a dismantling study of CPT (Resick, et al, 2005⁹). In that study we compared the full 12-session CPT (CPT+) protocol with its constituent parts: CPT without the written exposure (CPT-) and written exposure without the cognitive therapy (WE). In that study we found that all three conditions were the same by post-treatment but that the trajectory of change was different. Throughout the course of therapy, the CPT- group was showing significantly faster improvement than the WE condition, which only caught up at the end. CPT- also showed faster improvements than CPT+ until the two written exposure sessions had been completed. CPT+ fell between the other two groups after that. The CPT- group also had only a 15% drop-out rate compared to 26% each for the other two conditions.

Because these results need to be replicated, and because the first study with veterans used the full CPT protocol (Monson et al, 2006), we have included the full protocol here for training and implementation. However, these recent results do indicate that CPT- is a good alternative for those veterans for whom the written account is problematic. It also provides a good solution to the dilemma of how to handle the written accounts in group treatment. For whom is the written exposure 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-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 written account. However, one might consider using CPT- 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 found the account to be a beneficial component. If the patient will quit treatment rather than do the account, CPT- should be used. In giving people a choice of which version of the protocol to use, we have found some veterans will choose the CPT+ protocol.

The CPT- 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 written account is an assignment that tends to elicit stronger emotions, the therapist using the CPT- protocol needs to make a specific effort to draw out natural emotions and particularly to help the patient notice the differences in emotions when they change their self-dialogue. Also, the therapist cannot wait until the account is read to determine what the patient's stuck points are. The therapist may need to do more Socratic questioning to bring out enough details about the traumatic event to challenge the stuck points adequately.

⁹ Resick, P.A., Galovski, T., Phipps, K., Uhlmansiek, M., Ansel, J., & Griffin, M. (2005, November). *A dismantling study of the components of cognitive processing therapy*. In symposium (Nixon, R.D.V., Chair) "Innovative use of cognitive processing therapy for treating PTSD," presented at the 39th annual meeting of the Association for Behavioral and Cognitive Therapies, Washington, DC.

The CPT 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 much information in the original protocol. The first change is at Session 4. Instead of assigning the written exposure or moving straight to challenging questions, we added another week of A-B-C sheets. In the CPT+ protocol, patients are asked to continue working on A-B-C sheets while they write their accounts. We believe that one week of doing the worksheets is often not sufficient, especially if the veteran 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 regarding the worst traumatic event, and focus on assimilation regarding that event before the patient is asked to begin doing it himself.

The second change is to divide session 7 of the CPT+ protocol (in CPT- 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- 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 written account. The safety module and the topic of over-accommodated safety is introduced in the next session (Session 7). From session 7 on, the protocols are identical. The outline for CPT- is as follows:

Cognitive Processing Therapy Minus Written Exposure (CPT-)

Session 1: Symptoms of PTSD; explanation of symptoms (cognitive theory); description of therapy. Practice assignment: Patient is instructed to write impact statement.

Session 2: Patient reads impact statement. Therapist and patient discuss meaning of trauma. Begin to identify stuck points and problematic areas. Review of symptoms of PTSD and theory. Introduction of A-B-C sheets with explanation of relationship between thoughts feelings and behavior.

Session 3: Review of A-B-C practice assignment. Discussion of stuck points; assimilation and self-blame. Review the event with regard to any acceptance or self-blame issues. Begin Socratic questioning regarding stuck points. Reassign A-B-C sheets.

Session 4: Review A-B-C practice assignment. Help patient challenge self-blame or assimilation with Socratic questions. Introduce challenging questions sheet to challenge single beliefs regarding the trauma. Use challenging questions with regard to self-blame or assimilation (undoing) issues in particular.

Session 5: Review challenging questions sheets. Introduce Patterns of Problematic Thinking worksheet. Have patient continue to use both challenging questions practice assignment as well as Patterns of Problematic Thinking sheet. Make sure patient understand 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 sheet to challenge their cognitions regarding the trauma(s). Practice assignment: Use the worksheets everyday on typical events and complete several on the trauma, particularly to challenge self-blame and undoing cognitions.

Session 7: Review challenging beliefs worksheets. Introduce the topic of safety. Discussion how previous beliefs regarding 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 worksheets on safety.

Session 8: Review safety worksheets and help patient to challenge problematic beliefs they were unable to complete successfully on their own. Introduce topic of trust. Pick out any stuck points on self-trust or other trust. Practice assignment. Read trust module and complete worksheets on trust.

Session 9: Review trust worksheets. Introduce topics of control/power/competence. Discuss how prior beliefs were affected by the trauma. Practice assignment: Control module and worksheets.

Session 10: Review control/power worksheets. Introduce topic of esteem (self-esteem and regard for others). Have patient complete common assumptions sheet regarding competence and esteem. Pick out frequent problematic assumptions. Practice assignment: Module and worksheets on esteem as well as assignments regarding giving and receiving compliments and doing nice things for self.

Session 11: Review all of the practice assignment. Discuss reactions to two behavioral assignments. Introduce final topic: intimacy. Practice assignment: continue giving and receiving compliments, read module and complete worksheets on stuck points regarding intimacy. Final assignment: rewrite the impact statement.

Session 12: Go over all of the practice assignment. Have patient read the 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 regarding compliments and doing nice things for self.

Grief and bereavement session

Adding the bereavement session may be very helpful for individuals or groups who have experienced losses as part of their military service. The therapist should consider using this module if grief is entangled in PTSD, and stuck points regarding the loss of the significant other or issues regarding the grief process itself are interfering with either the grief process or PTSD recovery. If someone is appropriately grieving the loss of comrades the therapist should just encourage that process and focus on other events that are most closely associated with PTSD. An assessment of nightmares, flashbacks, and intrusive images should indicate whether the PTSD is

surrounding this death or whether the PTSD lies elsewhere. We recommend that if these issues become apparent during the initial interviews with the patient, that the most logical place to insert the bereavement session including the second impact statement is right after the session 2. However, if stuck points regarding grief and bereavement emerge later in therapy, it is possible to add this session other places. It is also possible to add the impact statement assignment without adding a session, especially if this occurs to one person in a group format CPT. We did not renumber all of the sessions of the “classic CPT” but the therapist should just pick back up where he/she stopped to insert this session.

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. 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). Regardless of the population served or the setting where it is applied, there are some general issues that therapists should be aware of prior to using CPT in a group format.

1. Differences Between Group and Individual CPT

The content of CPT is very similar, whether conducted with a group of patients or a single patient. The greatest difference is in the implementation of the written account (if it is included in the protocol). Patients in individual therapy are given an opportunity to re-experience their emotions in a one-on-one setting during sessions (in addition to experiencing the same in between sessions). In groups, we typically do not allow members to read their accounts out loud during therapy sessions. While processing one's own event is important, hearing the graphic details of another person's experience may produce secondary traumatization in someone already suffering from PTSD.

Instead, during the session, the therapist(s) explore the reactions the patients had while writing about the event to determine whether they in fact recalled all of the memory and experienced their emotions. Group participants are asked whether they included sensory details, thoughts and feelings in their account, experienced strong emotions, or recalled new memories. If group members were unable to express their emotions fully, they are encouraged to take steps to increase the likelihood of successfully completing the assignment. The discussion about the writing assignment also focuses on stuck points that were identified and evidence from the event that may refute those distorted beliefs and interpretations.

Following this discussion, the therapist collects the written accounts to read between sessions. While reading the accounts, the therapist searches for stuck points, which are usually indicated by points at which the patient stopped writing and drew a line, or parts of the event the patient skips, glosses over, or reports amnesia. The therapist makes note of whether the account has been written like a police report (without accompanying thoughts and feelings) or whether the full memory has been retrieved and activated. Encouragement, praise, and possible stuck points are recorded on the accounts before being returned.

There are several alternative models for handling the written account that have been used clinically in VA settings, although there is no research to support one model over another. One alternative model for the group format is to conduct individual sessions with the patients to give them an opportunity to read their accounts to a therapist and to provide the therapist the opportunity for in-depth cognitive therapy around major stuck points that emerge. Some VA programs, particularly smaller residential programs have had the combat veterans read their accounts to the group. They have added a couple of sessions in order to accommodate everyone. Finally, another option is to delete the account writing completely and conduct the protocol without the two written account sessions (see previous section for more information on CPT-)

If a patient in individual therapy misses a session, it can be rescheduled or delayed until the next scheduled appointment. However, the same opportunity is not possible with groups. Instead, if a patient misses a group session, she/he is contacted by telephone. If the next practice assignment can be given over the phone, then the therapist does so and asks the patient how the last assignment went. Another purpose for the telephone call is to discuss why the patient missed the session and to discuss the likely problem of avoidance. If necessary, the therapist invites the patient to arrive early for the next session so the last session can be reviewed and the practice assignment given. At the beginning of the next session, the other members of the group can also give the patient who missed a session a synopsis of what occurred the previous week. This approach has the advantage of solidifying the group members' knowledge as well.

Thus far, we have not had a problem with patients missing more than a few sessions. If someone were to miss many sessions and had not been doing the practice assignments, we would discuss the problem with the patient to try to determine if s/he needed individual therapy or whether the patient was unwilling to change avoidance patterns at this time. We would encourage the patient to begin therapy again when ready to confront these issues. We would also offer other referrals.

Although we discourage patients from receiving therapy for the trauma from other therapists while in treatment with us, CPT groups have sometimes been considered adjunctive therapy for patients who are already receiving individual therapy elsewhere. Typically, they are working on other issues with their individual therapist and have come to us because their therapist was not dealing with their trauma issues. We believe that receiving simultaneous trauma-focused therapy with both group and individual therapists can be very confusing for the patient, especially if the individual therapist assumes a different theoretical orientation.

2. Choosing a format

If both group and individual therapy are available, we typically allow the patient to choose which type of treatment they would like to participate in; but we are aware this is not possible in all settings. Nevertheless, group therapy, either alone or as an adjunct with individual therapy, can facilitate cognitive and emotional growth by having the individual process his or her experiences with other group members who share similar experiences. Additional advantages of using a group format include cost effectiveness, social support, normalization, universality, and patient's challenging each other's problematic cognitions and behaviors, thereby enhancing skill development (e.g. positive coping skills). Through the group experience, veterans can see that

they are not "nuts" and realize that their symptoms and behaviors are much like other veterans who experienced similar events.

In spite of its unique benefits, there are some challenges inherent to group CPT. The most significant challenges are pragmatic issues, such as recruiting enough patients, giving each individual enough time, and managing group members who dominate time or members with severe personality disorders. For these reasons, some clinicians choose to offer CPT in a combined group and individual format, where practice assignments are assigned in the group but reviewed in individual sessions. The group can then be used to process member's reactions to their completed practice assignments, and to provide further practice of worksheets. If it is not feasible to offer individual sessions throughout the duration of the group, the therapist may choose to conduct individual therapy sessions only during the account writing and introduction of the Challenging Questions worksheet sessions. These sessions require the most one on one time with the therapist and allow the patients to feel safe in knowing that they will only share their traumatic material with one person. Patients in a group format may be less willing to ask questions when they are confused so if an individual format is not available the therapist will have to be more proactive to make sure that everyone understands the concepts and practice assignments. If group CPT is conducted without concurrent CPT individual therapy, the leaders should insure that all group members are able to complete the practice assignments with little outside assistance, and are truly motivated for change.

3. Logistical Issues

The groups we have conducted have been closed, meaning that once a group has started no new members may join. The closed format is, of course, necessary because CPT was developed as a progressive therapy in which skills are taught in a particular order and build upon one another. While individual therapy sessions typically last 50-60 minutes, group sessions run 90 minutes to allow the members adequate time to discuss their particular issues. Ideally, groups should have between 5 and 9 members (although we know of some very talented therapists who can manage 10-12). We have found that five members is minimal (five rather than four to avoid the pairing effect that can happen with four), because if one or two people miss a session then the group ceases to be a group and becomes individual therapy with several patients in attendance. With more than eight or nine, the group may feel too large, especially for one therapist; there may not be enough time for the individual members to get their needs met; and the large size may inhibit individual disclosures.

Although it is possible for one therapist to run a group, we recommend two co-therapists. We have found that using co-therapists is more effective than a single leader for many reasons. First, co-therapists allow one person to watch the group interaction while another therapist is leading a discussion. These observations can then be brought to the group for their reactions. In addition, if a group member becomes overly emotional one of the group therapists can attend to his needs while the other leader can continue to run group. On a practical note, there is a significant amount of practice assignments in CPT and one therapist might find it difficult to review all of the assignments by the next session. Finally, two therapists allow for coverage during vacations, sick days, and unplanned emergencies that might occur.

When performing group therapy, one must address several issues that may not be as pertinent when conducting individual therapy. The first is what day/time will the group be conducted. Although seemingly a small issue, timing of the group must be considered by the therapist, because patients may not realize how emotional they will become during the group. Thus, going straight to work right afterward may not be advisable. In addition, many patients are unable to take off enough time from work to attend several sessions of therapy, or they may be unable to obtain child care during the work day, therefore making evening groups a necessity.

Another logistical issue concerns the types of traumas that will be included in the group. While there are some advantages to running a group with members who all share the same type of trauma, it is possible to combine different types because there is no in-depth discussion of the trauma in the groups. This is especially useful in smaller clinics where it is difficult to enroll an entire group of people with the same trauma at the same time. Group members should be informed of this format prior to their agreeing to participate in the group and any concerns or questions should be discussed at this time as well. It is also possible to conduct a group that combines men and women if the participants are initially and carefully screened to make sure this would not be a significant trigger for any of the members. If both genders are to be included, it may be more helpful to have all of the same type of traumas to assist with the normalizing process.

4. Therapists' Role in Group Treatment

During group CPT, the therapists' primary roles are to structure the group sessions, challenge problematic cognitions, process the practice assignments from the prior session, and educate group members on the next assignment. Keeping group members "on task" can be one of the more difficult challenges encountered by the therapist. For example, given that avoidance is one criterion for PTSD (and represents half of the symptoms needed for diagnosis), it is common for the group participants to try and avoid the session material or experience their thoughts and feelings about the trauma. This is especially true during the initial sessions when the patients are still becoming comfortable with one another, and during the trauma writing phase of treatment if this component is included. Avoidance should be normalized at all times and not labeled as resistance or denial, which can often feel like blaming to the patient. The therapist can work on the patient's avoidance by telling patients some of the symptoms of avoidance ahead of time and by asking the patient to examine their fears that may be underlying their avoidance.

To keep the group on track, the therapist should provide structure for each session by setting an agenda at each session and letting the participants know what will be covered during that session. The agenda should include a brief check-in to see how everyone is doing and to establish if anyone has a pressing issue that needs to be discussed in group that day. This should be followed by a review of the practice assignment from the prior session, and then followed by an introduction to the practice assignment for the following week. For some of the more complex practice assignments, the leaders should leave 25-30 minutes to go over the assignment and to create example(s) with the group.

If the group loses focus during the session, one strategy to get the group back on track is to ask the patient who is digressing to make the connection between what they are saying and the topic that the group was originally discussing. If the patient appears to be avoiding the topic at

hand, the therapist may want to use gentle confrontation, noting that the topic appears difficult for the patient or that he seems to be having a difficult time staying with his feelings about the topic. These reactions can then be normalized by the rest of the group by having the therapist ask if anyone else ever wanted to avoid a topic or stop feeling their feelings in group. This technique will build a bond between the patients and will allow the therapist to address the underlying fears that are causing the patient to avoid.

Perhaps one of the most obvious concerns is what to do about missed sessions. We inform patients prior to starting the group that it is very important that they do not miss any sessions and to not enroll in the group if they have something that will interfere with the group times over the course of the therapy. At the same time, we acknowledge that there are unforeseen circumstances that will keep a patient from attending a group. If the group is conducted in conjunction with individual therapy, the individual session for the missed week can be extended to 90 minutes to cover what was missed in group. If the group does not have adjunctive individual therapy, the group therapist can meet individually with the patient during the week or, if necessary, just prior to the next group session. If none of these options can be arranged, the group members can give an overview of what was covered in group the prior week. Given that many people now have computers and email, especially younger veterans, it may be possible to email the practice assignment to the group participant who has missed so that she can bring it to the next session.

5. Practice Assignment Completion

The ability to monitor practice assignment completion is one of the most challenging issues when conducting CPT groups. If CPT patients are not asked to read their traumatic accounts with the rest of the group or are not required to share their worksheets with the group the therapist may not know until after the session whether the participants completed the assignment at all or if there was a conceptual problem with the assignment. By refraining from talking about the traumatic material in group, therapists do not have to be as concerned about secondary traumatization among group members. But at the same time, therapists cannot be as certain that the patients have completed their practice assignments. In individual CPT, patients who do not write their trauma account or do their practice assignment sheets are asked to verbally complete them in session to acclimate them to the process. Because the use of this technique is more challenging in group CPT, it can be more difficult to convince patients that they can and should complete their practice assignment. Although the group members and group leaders will be aware that a patient's practice assignment is not complete, this pressure is often not enough to prevent some patients from having difficulty completing their assignments. However, one of the advantages of group treatment is that the recalcitrant patient may be able to see other group members, who are doing their practice assignments, getting better. This might motivate them to comply better.

There are several reasons why patients may not complete their practice assignment, and they are typically related to some type of avoidance. Some patients avoid material because of the emotionally-laden nature of the assignment and the individual is afraid of being overwhelmed or even destroyed by their thoughts, feelings, and memories. Patients will often state that they are scared they will "go crazy", "cry forever", "become uncontrollably angry" or that they may not be able to come back from the memory. These beliefs can be identified as a stuck point that will

need to be challenged before the individual can benefit from CPT. In addition, the group can help to normalize these reactions and create a safe place for the patient to talk about his fears of doing trauma-focused therapy. We have found that this encouragement is often enough to motivate patients to do their assignments, although if the issue is more deep-seated, it may be difficult to address in group and an individual discussion with the leader may need to take place to establish the reasons why the patient does not want to complete the practice assignment.

Group members can also have difficulty completing their practice assignment because they fear that writing down the events, thoughts, and feelings regarding the trauma will make the memory too “real” and thus too difficult to manage. If the patients have difficulty labeling the event as traumatic, they may instead minimize the impact of the event or inaccurately interpret the details of the trauma (e.g. blaming themselves for a rape).

It is important to challenge these cognitions, perhaps by pointing out that their traumatic reactions (as reported on the pre-treatment assessments) provide evidence that a trauma did indeed occur and their reaction to the event(s) are disrupting their life. It may also be helpful to ask the patients why they have come to the group. Their answers can point out the contradictions that they are expressing; on the one hand they are misinterpreting (or minimizing) the details of the trauma while on the other hand they acknowledge their distress and are seeking help. It is helpful for therapists to inform patients at the beginning of therapy that they will likely have the urge to avoid their practice assignment or coming to group sessions. This will facilitate the normalization process and will often make the patient more open to discussing their ambivalence or concerns about completing the therapy with the group and/or the leaders.

One technique that we have found to be particularly useful in helping patients complete their practice assignment is a group phone list. All members who are willing to participate have their name placed on the list. For practice assignments, the group members are asked to call the person below them on the list before the next session. The following week they call the person two below them on the list, and so on, until finally everyone has called everyone else on the list. The patients are instructed that they should not talk about their trauma histories on the phone, nor should they meet one another in person unless everyone in the whole group is invited.

A second technique that we have found helpful in encouraging trauma writing is “contract phone calls”. The patient states when he is going to try and complete his practice assignment, and the length of time he will need to do the assignment. The therapist then agrees to call the patient for a “check-in” phone call right after this time frame to ensure that he is ok and to normalize any reactions the patient is having. This also allows the patient to feel safe that, if he is having strong emotional reactions, there will be someone available to help him process his experience.

6. Managing Individual Personalities and Group Conflict

As with any group treatment, it can be difficult to manage the variety of personalities that come together in a CPT group. This makes it very important that staff complete a thorough screening of patients prior to admitting them to a group. Therapists may want to ask patients questions such as why they want to join the group, what they hope to get out of the group, and what their past group experiences have been like. In the CPT groups that we have conducted, we

have not needed to exclude patients based on their personality disorders, but we acknowledge that some patients can have more disruptive personality traits that may need to be addressed in individual therapy or personality disorder groups prior to enrollment in a CPT group. These may include an extreme sense of entitlement, excessive levels of dependence on others, or over-identification with the "sick PTSD veteran" role. Unless the pathology is very severe, we have successfully treated borderline, histrionic, narcissistic and antisocial personality disordered patients using group CPT.

One area that is often concerning to new CPT therapists is the amount of affect that may be generated in group CPT. As with individual CPT, we know that many of the patients will get worse before they get better, and part of that worsening is the need to process the trauma with full affect. We have found that many veterans, regardless of gender, have often not been given an opportunity to express their feelings either in their daily lives or in their past therapy experiences. Veterans often report that they believe no one will understand them, and if they let out their emotions they will destroy themselves and/or the people around them. Thus, patients need to be encouraged to share their feelings in group without fear of recrimination. Group leaders have the responsibility of guiding the patients through their feelings and showing them that their emotions are acceptable and manageable. Acceptance of and encouragement to show affect in an appropriate fashion often diffuses excessive emotional responses and disruptive group behaviors.

Two other areas that need to be monitored in a group are overly dominant patients and excessively shy patients. Dominant patients may tend to answer first, make absolute statements (e.g., "no one but another veteran can understand a veteran"), story tell, or challenge the leader's role. These behaviors will often silence many of the group members (particularly the shyer members) and may create hidden animosities in the group that affect future dynamics. In addition, members who are already struggling with feelings of avoidance will see this as a sufficient reason why they do not need to participate. The first step for the therapists is to identify the dominant and the shy patients as early as possible. The therapists can then begin to loosely monitor and control the amount of time each patient has to talk. One technique that may be effective is to propose to the members that those who are quick to respond should count to 10 before giving an answer, thus giving patients who are slower to respond an opportunity to voice their thoughts or feelings. Another option is to ask that once a person has participated three times they wait until someone else has spoken on a topic before they add to the discussion. By making these suggestions to the group as a whole, the therapists will not single out a particular patient or making some patients feel embarrassed.

If there is a particular patient who is very shy or less expressive, the therapist should determine whether this is due to a personality trait, a reaction to the trauma, or a form of avoidance. It may be helpful to call on that patient and ask her if she has anything to add to the discussion that day. It may also be helpful to ask the whole group for their reaction to a group topic and then check-in with all group members before moving on to the next topic. If it is not possible to draw a silent member into the discussion or to lessen a monopolizing patient's behavior, it may be necessary to individually talk to the patient before or after the next group session.

There are times when certain patients will not get along with other patients. This may happen for a variety of reasons including traumatic memory triggers, misunderstandings, etc., which can result in one member feeling ostracized by other group members. The excluded group member may be interrupted by other members when they begin to speak, or group members may sigh or roll their eyes when the ostracized member speaks. We have found this phenomenon to be very common in the VA when members think another member is only coming to the group to obtain compensation. For this reason it is important to let patients know ahead of time that the CPT group should not be used as a way to obtain compensation and patients with this sole goal should be referred elsewhere.

7. Patient Issues

Veterans Administration hospitals and Veterans Centers have been using group formats for years, thus many veterans will be very familiar with a group format. Nevertheless, previous iterations of group therapy often involved long-term supportive psychotherapy or "rap" groups that may have led to veterans simply "telling war stories." While this type of group can be helpful and normalizing for some veterans, other veterans may feel triggered by this type of content. Patients may try to tell war stories during the group or engage in one-up-man-ship story-telling in order to feel accepted by the group. Unfortunately, the fear that CPT will involve more "war stories" will make many veterans cautious about attending a CPT group, so leaders should be quick to establish ground rules for the group that does not allow for war stories that do not have a very explicit connection to the topic at hand. In addition, staff should make sure that before the group starts they describe the CPT group format and how it is similar or dissimilar to some of the groups the patient may have been involved in before coming to CPT.

Two other topics that veterans often bring up in group are their feelings about the government, VA, military and compensation seeking. Both of these topics can be very important to the veteran initiating the conversation, but they can also be very distracting and inhibiting of group process. Often veterans have very strong opinions about the VA, the government or the military, especially if they feel they have been mistreated in some way by the organization. This in turn can lead to very impassioned speeches on the topic, which in fact can serve an avoidance function (avoidance by rhetoric). These diatribes can be divisive in the group if other members do not feel the same way. In addition, many of the younger veterans are pro-government, military and VA, and they are silenced when they hear the stories from the older veterans. One way for group leaders to address this is ask that patients limit their "political" discussion on these fronts as these discussions have not been found to have long term therapeutic benefits in "rap groups" that have existed for years in the VA. Another technique can be to point out the problematic thinking in over-generalizing from a few "bad" people they have encountered to all people in that organization, which allows the group as a whole to address this issue as a stuck point.

The second topic that can be very disruptive for a group is compensation. While most veterans are honest and ethical in the portrayal of their symptoms, we have found that a few veterans are not as truthful. Sometimes patients will tell us privately when they feel that someone in the group is not there for the right reason (i.e., to get relief from their symptoms). This "malingerer" patient will often engage in combat story-telling, will hyper-focus on their symptoms, will often try to portray their trauma or symptoms as the worst in the group, and they

may turn the dialog to compensation and service connection exams frequently. This patient is very different from the patient who honestly wants to get better, but fears losing compensation before they are ready or able to provide for themselves. We have often found that these patients tend to drop out of treatment or become more motivated to get better when the treatment discussion stays focused on stuck points.

Considerations on Comorbidity

PTSD has very high rates of comorbidity (other disorders along with the PTSD). The most common comorbidity is major depressive disorder, which occurs in approximately half of people with PTSD. Another common comorbidity is substance abuse, the rates of which vary, depending upon the subculture being studied. Anxiety disorders and personality disorders are all fairly common. Health problems are also associated with PTSD. Fortunately, except for 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 disorder for your consideration.

Substance Abuse

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 onto 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- can also be implemented if the therapist and patient determine

that the patient is, in fact, too fragile to handle exposure to the trauma memory (*i.e.*, reluctance is not due to the more common stuck points about emotions).

Major Depressive Disorder

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 (is change attributable to the intervention or the medication?), these 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 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 written exposure or decreasing symptoms after the written accounts or cognitive therapy. The prescribing physician and therapist need to coordinate their efforts to minimize this confusion.

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 who could not attend therapy or complete their practice assignments because their 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 soldiers 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.

Anxiety Disorders

As with depression and substance abuse, the concern with anxiety disorders is whether they are so disabling that they interfere with PTSD treatment. If 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 obsessive-compulsive disorder (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 at 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 their 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.

Panic disorder is commonly comorbid with PTSD, and more so under the DSM-IV decision rules than under the previous DSM-III-R, which disallowed the diagnosis in the presence of other Axis I disorders. Our research with CPT indicates an improvement in panic disorder 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, 2000¹⁰) or simultaneously with CPT (Falsetti et al, 2001¹¹). Falsetti and her colleagues developed a protocol that combines CPT with the panic control treatment.

Personality Disorders

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 their 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 avoid 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

¹⁰ Craske, M.G., Barlow, D. H., & Meadows, E. A. (2000). *Mastery of your anxiety and panic: Therapist guide for anxiety, panics, and agoraphobia (MAP-3)*. San Antonio, TX: Graywind/Psychological Corporation.

¹¹ 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.

functional purpose, at least at some point in the person's life. It is now dysfunctional because these patterns are so overgeneralized (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 continuously 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 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 some 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, peri-traumatic dissociation, dissociation during or immediately after the traumatic event, is one of the better predictors of PTSD. Dissociation can become conditioned, just like the 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 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 for problematic dissociation is to use the CPT- protocol. A third 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 five minutes and start writing. The bell serves to interrupt dissociating, orienting the patient back to the present. The kitchen timer can then be set for six 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 prior to, 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.

Section 4
Patient Materials

Copy of PCL plus scoring instructions (WE NEED TO GET EDC THIS)

Session 1: Introduction and Education Phase

Post-trauma Reactions

Stuck Points handout

Stuck Point Log

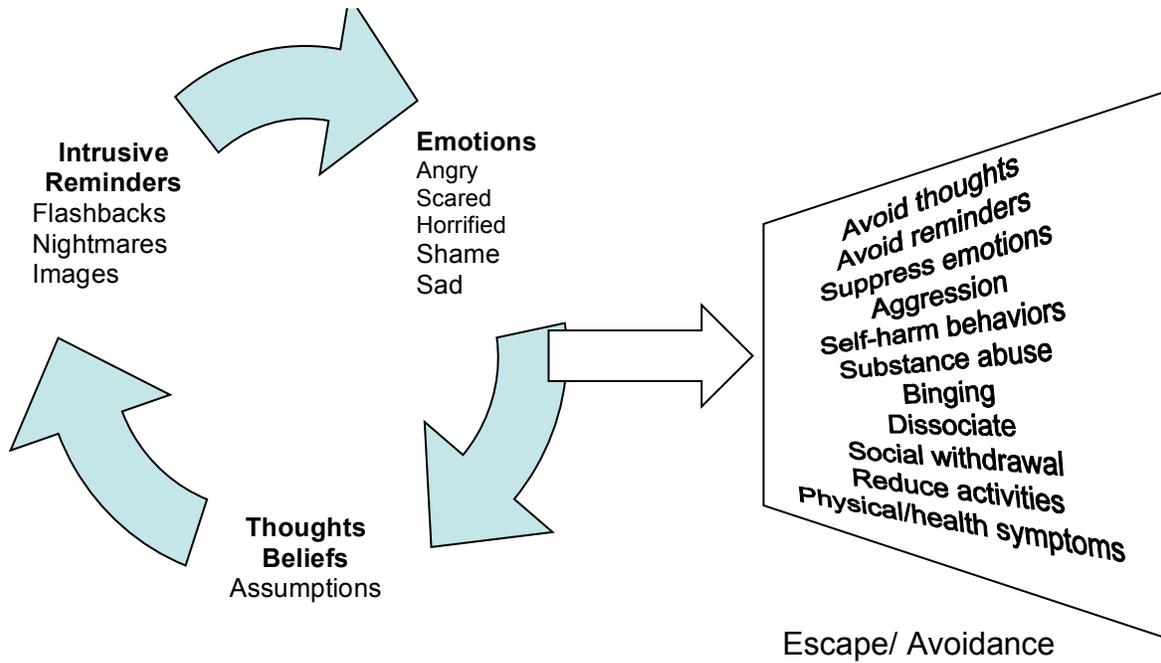
Practice Assignment

Practice assignment:

Please write at least one page on *why* this traumatic event occurred. You are *not* 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.

Post-Trauma Reactions that Lead to PTSD



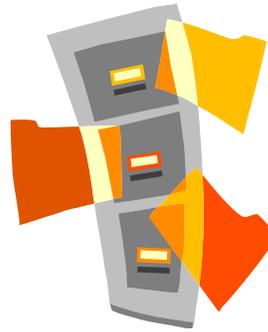
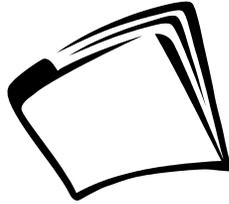
STUCK

Stuck Points - What Are They?

Traumatic
Event

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.**



Prior Belief

I am able to protect myself in dangerous situations, and I am to blame.

Harmed During Military Service

I was harmed during my military service,

Results

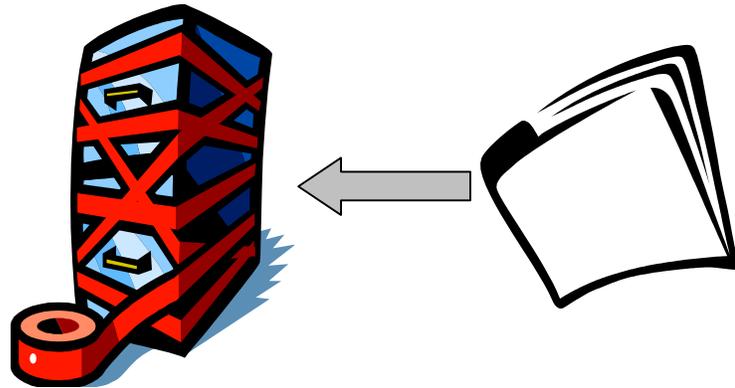
- If you cannot change your previous beliefs to accept what happened to you (*i.e.*, it is possible that I cannot protect myself in all situations), you may find yourself saying "I deserved it because of my actions or inactions. I am responsible for what happened."
- If you are questioning your role 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.

Goal

- 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.

CONFIRMED

2. **STUCKNESS** also be formed if you have prior negative beliefs that are confirmed or reinforced by the event.

Prior Belief

Authority is not to be trusted.

Attack

You are harmed during your military service.

Results

- If you see the trauma as further proof that authority (i.e., federal government) 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" to 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

Emotions Handout (To be drawn by EDC)

A-B-C Worksheet (make enough copies for one a day until the next session)

Sample worksheets

Practice Assignment

Practice assignment:

Please complete the ABC sheets to become aware of the connection between events, your thoughts, feelings, and behavior. Complete at least one sheet each day. Remember to fill out the form as soon after an event as possible. Complete at least one sheet about the worst traumatic event. Also, please use the Identifying Emotions handout to help you determine what emotions you are feeling.

A-B-C Sheet

Date: _____ Client : _____

ACTIVATING EVENT**A**

“Something happens”

BELIEF**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?

Alternative Session 2: Traumatic Bereavement Session

Myths of mourning

Practice Assignment (second impact statement)

Then back to the materials from regular session 2

Practice assignment:

Please write at least a page on what it means to you that _____ was killed. As in the last assignment, focus on meanings regarding safety, trust, power/control, esteem and intimacy. Also write about how the death has affected your memory of _____, your relationship with _____, and how you perceive you are adjusting to the loss.

Myths of Mourning

Grief and mourning decline in a steadily decreasing fashion over time.

All losses prompt the same type of mourning.

Bereaved individuals need only express their feelings in order to resolve their mourning.

To be healthy after the death of a loved one, the mourner must put that person out of mind.

Grief will affect the mourner psychologically but will not interfere in other ways.

Intensity and length of mourning are a testimony to love for the deceased.

When one mourns a death, one mourns only the loss of that person and nothing else.

Losing someone to a sudden unexpected death is the same as losing someone to an anticipated death.

Mourning is over in a year.

Time heals all wounds.

From Therese A. Rando, *Treatment of Complicated Mourning* (1993), Research Press, Champaign, IL p. 27-28.

Session 3: Identification of Thoughts and Feelings (4 if bereavement session added...)
Practice Assignment plus enough A-B-C sheets until the next session

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 sheets every day

Session 4: Remembering the Traumatic Event

Practice Assignment plus enough A-B-C sheets until the next session

Practice assignment:

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 session.

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

Session 5: Identification of Stuck Points

Challenging Questions Sheet (enough copies until next session)

Challenging Questions samples

Practice Assignment

Practice assignment:

Please choose one stuck point each day and answer the questions on the Challenging Questions sheet with regard to each of these stuck points. Write your answers on a separate piece of paper so that you can keep the list of questions for future reference

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.

Challenging Questions Sheet

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

Belief: _____

1. What is the evidence for and against this idea?

FOR:

AGAINST:

2. Is your belief a habit or based on facts?

3. Are your interpretations of the situation too far removed from reality to be accurate?

4. Are you thinking in all-or-none terms?

5. Are you using words or phrases that are extreme or exaggerated? (i.e., always, forever, never, need, should, must, can't and every time)

6. Are you taking the situation out of context and only focusing on one aspect of the event?

7. Is the source of information reliable?

8. Are you confusing a low probability with a high probability?

9. Are your judgments based on feelings rather than facts?

10. Are you focused on irrelevant factors?

Session 6: Challenging Questions

Patterns of Problematic Thinking worksheets (copy enough until next session)

Sample worksheets

Practice Assignment

Practice assignment:

Consider the stuck points you have identified thus far and find examples for each of the problematic thinking patterns listed on the sheet. 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.

Session 7: Patterns of Problematic Thinking

Challenging Beliefs Worksheets (copy enough until next session)

Sample copies of completed worksheets

Safety Module

Practice Assignment

Practice assignment:

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 issues with self- or other-safety, 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.

Challenging Beliefs Worksheet

A. Situation	B. Thoughts	D. Challenging Thoughts	E. Problematic patterns	F. Alternative Thought
Describe the event, thought or belief leading to the unpleasant emotion(s).	Write thought(s) related to Column A. Rate belief in each thought below from 0-100% (How much do you believe this thought?)	Use Challenging Questions to examine your automatic thoughts from Column B. Is the thought balanced and factual or extreme?	Use the Problematic Thinking Patterns sheet 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?	Jumping to conclusions	
		Habit or Fact?	Exaggerating or minimizing	
		Interpretations not accurate?		
		All or none?	Disregarding important aspects	G. Re-rate old thoughts
	C. Emotion(s)	Extreme or exaggerated?	Oversimplifying	Re-rate how much you now believe the thought in Column B from 0-100%
	Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100%	Out of context?	Overgeneralizing	
		Source unreliable?		H. Emotion(s)
		Low versus high probability?	Mind reading	Now what do you feel? 0-100%
		Based on feelings or facts?	Emotional reasoning	
		Irrelevant factors?		

Safety Issues

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

- **Prior Experience**

Negative - 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.

Positive - 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
- Startle responses or physical arousal
- Intense fears related to future victimization

- **Resolution**

- *If you previously believed that “It can’t happen to me”, you will need to resolve the conflict between this belief and the victimization experience.*

- *Possible self-statement may be “It is unlikely to happen again, but the possibility exists”.*

- If you previously believed that “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.

- Possible self-statement may be “I do not have control over everything that happens to me, but I can take precautions to reduce the possibility of future victimization”.

-If you previously believed that 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 belief about your control and ability to protect yourself.

- A self-statement may be “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 - If you experienced people as dangerous in early life or you believed it as a cultural norm, the traumatic event will confirm these beliefs.

Positive – If you experienced people as safe in early life, you may expect others to keep you safe and not caused harm, injury, or loss by them. The traumatic event causes a disruption in this belief.

- **Symptoms Associated with Negative Other-Safety Beliefs**

- Avoidant or phobic responses

- Social withdrawal

- **Resolution**

- If you previously believed “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 for you to be able to continue to feel comfortable with people you know and to be able to enter into new relationships with others.

- Possible self-statement may be “There are some people out there who are dangerous, but not everyone is out to harm me in some way”.

- If you previously believed that “I will not be hurt by others”, you will need to resolve the conflict between this belief and the victimization.

- Possible self-statement may be “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

Challenging Beliefs Worksheets (copy enough until next session)

Trust Module

Practice Assignment

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.

Trust Issues

Beliefs Related to Self - The belief that one can trust or rely upon 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 - 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.
 - Positive - 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 Post-Assault Negative Self-Beliefs**
 - Feelings of self-betrayal
 - Anxiety
 - Confusion
 - Overcautious
 - Inability to make decisions
 - Self-doubt and excessive self-criticism
- **Resolution**
 - If you previously believed 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. Possible self-statements may be:
 - 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.
 - If you previously believed that 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. Possible self-statement may be “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 upon, 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 - 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 the assailant was an acquaintance.

- *Positive - 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.*

- **Post-traumatic 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 Other-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.
 - Close relationships, particularly when trust is beginning to develop, activate anxiety and fear of being betrayed.
 - Fleeing from relationships.

- **Resolution**

- If you had the prior belief that “No one can be trusted,” which was confirmed by the traumatic event, you need to adopt new beliefs which will allow you to enter into new relationships with others instead of withdrawing because you believe others to be untrustworthy.

- Possible self-statements might be “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/her.”

– If you grew up believing that “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.

- Possible self-statement may be “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 to take 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 judgment 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 victimization. However, you may also be pleasantly surprised to find that some people have better reactions than you expected.

Session 9: Trust Issues

Challenging Beliefs Worksheets (copy enough until next session)

Power/Control Module

Practice Assignment

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.

Power and Control Issues

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 - 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 confirm prior beliefs about helplessness.
 - Positive - 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.
 - Negative beliefs resulting from trauma - Negative beliefs are manifested as unrealistically high or unrealistically low expectancies for personal power.
 - a. The belief that one must be in control of oneself, one's emotions, and one's actions at all times and that any sign of vulnerability represents a sign of weakness and powerlessness.
 - b. The belief that one is helpless to control forces both within and outside of the self.

- Symptoms Associated with Overcontrol or Helplessness
 - 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
 - Overcontrol – It is important to understand that no one can have complete control over their 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 are signs of weakness, but only an understanding that you are human and can admit that you are not in total control of everything that happens to you or your reactions.
 - A possible self-statement may be “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 - In order 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 of events.

- A possible self-statement could be, “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 - 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.

–Positive - 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.

- **Resulting Negative Beliefs** - Negative beliefs about power involve the belief that one must be in control of all relationships or, in contrast, that one has no power and is at the mercy of others. If negative helpless beliefs become fixed, the person is vulnerable to future exploitation or victimization.

- **Symptoms of Faulty Power Beliefs**

–Passivity

–Submissiveness

–Lack of assertiveness that can generalize to all relationships

–Inability to maintain relationships because you do not allow the other person to exert any control in the relationship (including becoming enraged if the other person tries to exert even a minimal amount of control)

- **Resolution**

– Powerlessness - In order 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.

- Possible self-statement could be “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 right to ask for what I want.”

- Overcontrol - 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).
- Possible self-statements are “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

Challenging Beliefs Worksheets (copy enough until next session)

Esteem Module

Practice Assignment

Practice assignment:

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.

Esteem Issues

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 - If you had prior experiences that represented a violation of your sense of self, you are likely to develop negative beliefs about your self-worth. The traumatic event may confirm these beliefs. Prior life experiences which 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 have violated your own ideals or values.

- Positive - 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 Beliefs about Self-worth:**

- 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 Related to Negative Beliefs**

- Depression
 - Guilt
 - Shame
 - Possible self-destructive behavior

- **Resolution**

- If you had prior experiences that left you believing that you were worthless (or any of the beliefs listed above), 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 begin to replace maladaptive beliefs with more realistic, positive ones.

- Possible self-statements include "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 begin to 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.

- Possible self-statements include "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 no good explanation for why bad things happen."

Beliefs Related to Others - These are beliefs about other people that match accurately the reality of the other person and which are reshaped as new information is received. A realistic view of other people is important to psychological health. In less psychologically healthy people, these images are stereotyped, rigid, and relatively unchanged by new information.

- **Prior Experience**

- Negative - If you have 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.

- Positive - 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 Other-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 Resulting from Negative 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

- 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 alright 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 someone and form an opinion of them. It is important that you adopt a view of others that is balanced and allows for changes.

- Possible self-statement is "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 all together 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 the relationship to go.

- Possible self-statement includes, "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

Challenging Beliefs Worksheets (copy enough until next session)

Intimacy Module

Practice Assignment

Practice assignment:

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.*

Intimacy Issues

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 regarding how well they will cope.

- **Prior Experience**

- Negative - If you had prior experiences (or poor role models) which lead 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.

- Positive - 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 so severe that a person is unable to soothe themselves, then the event is in conflict with earlier self-intimacy beliefs. The person may feel overwhelmed or flooded by anxiety.

- **Symptoms of Negative 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**

- 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 compounds the problem.

- Possible self-statements include: “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 - Negative beliefs may result from traumatic loss of intimate connections. The event may confirm your belief in your inability to be close to another person.

- Positive - 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.

- **Post-traumatic 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 Resulting from Negative Beliefs**

- Pervasive loneliness

- Emptiness or isolation

- Person may fail to experience connectedness with others even in relationships that are genuinely loving and intimate

- **Resolution**

- In order 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.

- Possible self-statements regarding new relationships include “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 from 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.

- Possible self-statements regarding existing relationships include “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

Give clean copies of worksheets to take with them

Assign continued use of worksheets

Section 5**Adjunct Therapist Materials**

A. Therapy contract

B. Brief Summary of CPT for review before sessions (Cliff's notes).

C. Sample progress notes

COGNITIVE PROCESSING THERAPY FOR POSTTRAUMATIC STRESS DISORDER

What is Cognitive Processing Therapy?

Cognitive Processing Therapy (CPT) is a cognitive-behavioral treatment for Posttraumatic Stress Disorder (PTSD) and related problems.

What are the goals of CPT?

The overall goals of CPT are to improve your PTSD symptoms, as well as associated symptoms such as depression, anxiety, guilt, and shame. It also aims to improve your day-to-day living.

What does CPT consist of?

CPT consists of 12 individual (one-on-one) therapy sessions. Each session lasts 50-60 minutes. In these sessions, you will learn about the symptoms of PTSD, and why we believe that some people develop it.

You and your therapist will also identify and explore how your trauma(s) have changed your thoughts and beliefs, and how some of these ways of thinking may keep you “stuck” in your symptoms. CPT does not involve repeatedly reviewing the details of your trauma(s). However, you will be asked to write about your experiences in order to understand how they have affected your thoughts, feelings, and behaviors.

What is expected of me in CPT?

Perhaps the most important expectation of CPT is for you to make a commitment to come to sessions.

In addition, after each session you will be given practice assignments to complete outside of the sessions. These assignments are designed to more rapidly improve your PTSD symptoms outside of the treatment sessions. You are also encouraged to ask any questions that you might have at any point in doing CPT.

Your Commitment:

Your decision to do CPT is voluntary. Therefore, you may choose to stop the treatment at any time. Should this happen, you will be asked to come in for one final session to discuss your concerns prior to terminating. Other types of PTSD treatment will be offered to you.

With my signature, I am indicating that I have reviewed these materials and received information about CPT for PTSD. I commit optimistically to myself, to this treatment, and the goals listed above. I will receive a copy of this agreement.

Veteran Signature

Date

Clinician Signature

Date

B. Brief Summary of CPT (“Cliff’s notes” for review)

Session 1: Introduction and Education

1) Set Agenda (5 minutes)

2) Provide Education on PTSD (10 minutes)

3 Symptom Clusters:

Reexperiencing: thoughts, dreams, flashbacks, psych, physio

Arousal: sleep, irritability/anger, concentration, hypervigilance, startle

Avoidance: thoughts, places/activities/people, facts, no interest, detached, no feelings, no future

3) Explain Symptoms – Theory (15 minutes)

Difficult to recover – automatic reactions → SURVIVAL

Fight/Flight, Freeze

Feelings get turned off, but still paired with cues: sight, sound, smell, etc.

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)

Two types of emotions that follow trauma: Natural and Manufactured

4) 5-Minute Account of the Trauma (worst one-identified in pre-tx CAPS) (5 minutes)

5) Treatment Rationale (10 minutes)

Goals of Treatment

To recognize and modify old thoughts and feelings that may be wrong

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 Handout on Stuck Points

6) Provide Overview of Treatment -- Structured (5 minutes)

12 Sessions, 50 min - 1 hour each:

- | | |
|---------------------------------------|---------------------------|
| 1 - Introduction | 7 - Problematic Thinking |
| 2 - Meaning of the Event | 8 - Safety |
| 3 - Identifying Thoughts and Feelings | 9 - Trust |
| 4 - Remembering the Event | 10 - Power and Control |
| 5 - Identifying “Stuck Points” | 11 - Esteem |
| 6 - Challenging Questions | 12 - Intimacy and Meaning |

Note Importance of compliance with attendance and practice assignments

7) Assign Practice: Write Impact Statement (5 minutes)

Problem-solve Re: Practice Completion

8) Check-in Re: Patient's Reactions to Session (5 minutes)

Session 2: The Meaning of the Event

1) Set Agenda and Review Practice using the CPT Practice Review Form (5 minutes)

2) Review Concepts (10 minutes)

PTSD Symptoms, Info Processing Theory, Tx Rationale, Stuck Points

3) Have Patient Read Impact Statement - (Begin to look for Stuck Points) (10 minutes)

If practice not written, have patient describe meaning of event orally and reassign.

4) 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 & events...this is desirable)

5) Help Identify & See Connections among Events, Thoughts, and Feelings (15 minutes)

Introduce **ABC Sheet** to help Patient with this

-Four Basic Emotions: mad, sad, glad, scared

-Combined: jealous = mad + scared

-Varying Intensity: irritated/angry/enraged

-Patient examples of own feelings, incl physical sensations

-Interpretation of events/self-talk affecting feelings(snubbed on street), alternatives

-Go back to Impact Statement for personal application

-Fill out one ABC Sheet together

6) Assign Practice (5 minutes)

Complete **ABC Sheets** to become aware of connection between events, thoughts, feelings, and behavior:

-Please complete at least one **ABC Sheet** each day, with examples, past or current, related to trauma.

-Remember to fill out as soon after an event as possible.

-Complete at least one sheet about the traumatic event.

-Bring this with you to the next session.

Problem-solve Re: Practice Completion

7) Check-in Re: Patient's Reactions to Session (5 minutes)

Session 3: Identification of Thoughts and Feelings

1) Set Agenda and Review Practice using the CPT Practice Review Form (5 minutes)

2) Review ABC sheets, further differentiating between thoughts and feelings (25 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 & emotional intensity match?

Look for stuck points & use Socratic questioning to help patient identify alternative hypotheses

3) Discuss the ABC sheet related to trauma (orally if patient did not complete) (15 minutes)

Challenge the stuck point of self-blame using Socratic questioning.

4) Assign Practice (10 minutes)

-Write account of trauma, with sensory details, and read over daily

-Complete ABC Sheets daily

Problem-solve Re: Practice Completion (this is very important...refer to rationale if necessary)

5) Check-in Re: Patient's Reactions to Session (5 minutes)

Session 4: Remembering the Trauma

1) Set Agenda and Review Practice using the CPT Practice Review Form (5 minutes)

2) Have Patient Read Trauma Account Aloud with Affective Expression (15 minutes)

Goals of Exposure:

Affective Expression – Holding back feelings? Why? (Soda bottle)

Identify Stuck Points – Over-accommodation?

Challenge Self-Blame – Assimilation?

Remain quiet during reading (except to stop & 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 not written, discuss reasons & then have patient recount the trauma during the session & reassign the writing.

3) Identify Stuck Points and indicators of over-accommodation (20 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
 Note the places the patient had to stop writing & 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) Assign Practice (5 minutes)

-Rewrite Trauma Account, not as a police report, but in more detail, including all the sensory aspects and even more thoughts (self-talk) and feelings, including feelings from the time itself and feelings you may be having now as you write this (put current feelings in parentheses). READ OVER EVERYDAY. (Add other events too?)

-Complete ABC Sheets daily

Problem-solve Re: Practice Completion (this is extremely important if practice not completed this session)

6) Check-in Re: Patient's Reactions to Session (5 minutes)

Session 5: Identification of Stuck Points

1) Set Agenda and Review Practice using the CPT Practice Review Form (5 minutes)

2) Read 2nd Trauma Account aloud; help to identify differences between 1st and 2nd

Goals:

New Additions (or Deletions)?

Progress of Affective Expression and Self-Blame/Guilt?

Continue Cognitive Therapy on Stuck Points

Introduce Challenging Questions

- Feelings: when it happened? now?
- Differences and similarities: at time of event, now
- Feelings: after writing second time vs first time **less intense?**

3) Involve patient to challenge assumptions and conclusions that the patient had made after processing affect, with particular focus on SELF-BLAME

- Therapist to use some of the challenging questions, as a way of introducing
- Help Patient reduce use of word **blame**, which implies intentionality

4) Introduce Challenging Questions Sheet to help patient challenge Stuck Points (Handout)

Provide Handouts

Go through blank question sheet

Go through example sheet

Choose a stuck point of the patient's to begin addressing with these questions (again, a focus on self-blame is helpful at this point in the therapy)

5) Assign Practice (5 minutes)

Challenge at least one Stuck Point a day, using the Challenging Questions Sheet. Write answers on a separate piece of paper so that you can keep the list of questions for future reference.

(Continue to work on Trauma Account(s) if not finished, and read over daily.)

Problem-solve Re: Practice Completion

6) Check-in Re: Patient's Reactions to Session (5 minutes)

Session 6: Challenging Questions:

1) Set Agenda and Review Practice using the CPT Practice Review Form (5 minutes)

2) Review Challenging Questions Sheet to address Stuck Point of Self-Blame (15 minutes)

Assist Patient in answering questions they had difficulty answering
Assist Patient to analyze and confront Stuck Points (Hindsight Bias)

(Re-read Trauma Account? (this applies only if account needed to be reassigned & it is clinically important to read it in session))

3) Continue Cognitive Therapy Regarding Stuck Points

Begin shifting focus to over-accommodation as self-blame will likely be starting to resolve.

4) Introduce Patterns of Problematic Thinking Sheet (15 minutes)

Handouts

Go over blank handout

Go over example

Does Patient have tendency toward particular patterns of problematic thinking?

Describe how these patterns become automatic

creating negative feelings(Get Patient example)

causing people to engage in self-defeating behavior(Get Patient 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 Sheet

Shift to Patient taking over Socratic questioning of self. Be supportive/consultative.

5) Assign Practice (5 minutes)

Identify Stuck Points and find examples for each Pattern of Problematic Thinking Sheet.

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 developed after them.

(Continue reading trauma accounts if you still have strong emotions about them.)

Problem-solve Re: Practice Completion

6) Check-in Re: Patient's Reactions to Session (5 minutes)

Session 7: Patterns of Problematic Thinking

1) Set Agenda and Review Practice using the CPT Practice Review Form (5 minutes)

2) Review Patterns of Problematic Thinking to address trauma-related Stuck Points (10 minutes)

-Does Patient have strong tendencies toward particular patterns?

-Discuss how these patterns may have affected his reactions to the Event

-Replace with other, more adaptive, cognitions

3) Introduce Challenging Beliefs Worksheet with a trauma example (25 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 sheet
- Use Patterns of Problematic Thinking sheet
- Generate NEW, balanced, evidence-based statement

4) Introduce first of 5 problem areas: Safety issues related to Self and Others (10 minutes)

Handout

- 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 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 (5 minutes)

Patient to identify Stuck Points each day, 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.

(Continue reading trauma accounts if you still have strong emotions about them.)

Problem-solve Re: Practice Completion

6) Check-in Re: Patient's Reactions to Session (5 minutes)

Session 8: Safety Issues

1) Set Agenda and Review Practice using the CPT Practice Review Form (5 minutes)

2) Review the Challenging Beliefs Worksheet to address Safety Stuck Points (15 minutes)

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

3) Help patient confront problematic cognitions using the Challenging Beliefs Worksheet and generate alternative beliefs (20 minutes)

- Review Safety module; focus on Patient's self- or other- Safety issues
- Probability: Low vs high = reality vs fear
- Calculate #'s?

4) Introduce 2nd of 5 problem areas: Trust issues related to Self and Others (10 minutes)

Handout

-Self-Trust = belief one can trust or rely on one's own perceptions and judgment

-After Trauma, many begin to 2nd 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 (5 minutes)

Patient to identify Stuck Points, one relating to TRUST (& Safety?), and confront them using the Challenging Beliefs Worksheet daily.
 (Continue reading trauma accounts if you still have strong emotions about them.)

Problem-solve Re: Practice Completion

6) Check-in Re: Patient's Reactions to Session (5 minutes)

Session 9: Trust Issues

1) Set Agenda and Review Practice using the CPT Practice Review Form (5 minutes)

2) Review Challenging Beliefs Worksheet to challenge trauma-related Trust Stuck Points and generate alternative beliefs (15 minutes)

3) Discuss judgment issues that may arise from Stuck Points related to Trust (20 minutes)

- Trust falls on a continuum, not All or None
- Different Kinds of trust: w/ money vs w/ secret
- "Star" diagram:
- Discuss patient's social support systems: Family & Friends: Protecting Selves from emotions/helplessness/vulnerability, inadequacy/ignorance – Not rejection

4) Introduce 3rd of 5 problem areas: Power/Control issues related to Self and Others (10 minutes)

*****Handout*****

- 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 (5 minutes)

Identify Stuck Points, one relating to POWER/CONTROL (& Safety or Trust as needed), and confront them using the Challenging Beliefs Worksheet.

(Continue reading trauma accounts if you still have strong emotions about them.)

Problem-solve Re: Practice Completion

6) Check-in Re: Patient's Reactions to Session (5 minutes)

Session 10: Power/Control Issues:

1) Set Agenda and Review Practice using the CPT Practice Review Form (5 minutes)

2) Discuss connection between POWER/CONTROL and Self-Blame & Help challenge related Problematic Cognitions using the Challenging Beliefs Worksheet (25 minutes)

-Help Patient gain balanced view of Power & Control

No such thing as total control, not completely helpless either

-Anger?: -over-arousal, lack of sleep, increased startle

-“stuffed” when unable to express at time of event

-anger vs aggression – not the same - can come out on family

-anger at self = for “should have done’s”

-innocence / responsibility / intentionality

3) Introduce 4th of 5 problem areas: Esteem issues related to Self and Others (10 minutes)

Handout

-Review ESTEEM Module; self and others

-Explore Patient's Self-Esteem before Event

4) Assign Practice (5 minutes)

Patient to: -Identify Stuck Points daily, one relating to ESTEEM issues, and confront them using the Challenging Beliefs Worksheet;

-Practice giving and receiving compliments daily; and

-Do at least one nice thing for self each day.

(Continue reading trauma accounts if you still have strong emotions about them.)

Problem-solve Re: Practice Completion

6) Check-in Re: Patient's Reactions to Session (5 minutes)

Session 11: Esteem Issues:

1) Set Agenda and Review Practice using the CPT Practice Review Form (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?

ComplimentsPleasant Activities

- | | |
|-------------------------|-----------------------------------|
| -What happened? | -Like it? |
| -Able to hear for self? | -Feel you deserved it? |
| -Recipients pleased? | -Feel guilty? |
| -Continue to talk? | -Encourage <u>more</u> and Enjoy! |

3) Help Patient identify ESTEEM issues and assumptions, and challenge them using Challenging Beliefs Worksheet (25 minutes)

- Does Patient believe they are permanently damaged as a result of the Trauma?
- Perfectionist? --> --> Does Patient believe they made a mistake?
- Esteem for Others – over-generalize disregard to whole groups?

4) Introduce 5th of 5 problem areas: Intimacy issues related to Self & Others (10 minutes)

Handout

- 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 (10 minutes)

- Patient to: -Identify Stuck Points, one of which relates to INTIMACY issues, and confront them using the Challenging Beliefs Worksheet;
- Rewrite Impact Statement (discuss the purpose of this);
- Continue to give and receive compliments; and
- Continue to do at least one nice thing for self each day.

(Continue reading trauma accounts if you still have strong emotions about them.)

Problem-solve Re: Practice Completion

6) Check-in Re: Patient's Reactions to Session (5 minutes)

Session 12: Intimacy Issues:

1) Set Agenda and Review Practice using the CPT Practice Review Form (5 minutes)

2) Help patient identify Intimacy issues and assumptions as well as any remaining stuck points, and challenge them using Challenging Beliefs Worksheet (25 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)

- Patient to read rewritten 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 for only short period of time
- 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

- 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

6) Remind Patient that they are taking over as Therapist now and should continue to use the skills that they've learned

SAMPLE SESSION NOTES

SESSION #1

Contact: 60-minute psychotherapy session.

Content: The patient completed the first session of Cognitive Processing Therapy (CPT) for PTSD. An overview of PTSD symptoms, as well as 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 events. 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.

SESSION #2

Contact: 60-minute psychotherapy session.

Content: This was the second session of Cognitive Processing Therapy (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. 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" sheets daily to monitor his thoughts, feelings, and behaviors until the next session.

Plan: Continued CPT for PTSD

SESSION #3

Contact: 60-minute psychotherapy session.

Content: This was the third session of Cognitive Processing Therapy (CPT) for PTSD. He did (not) complete "A-B-C" sheets daily, identifying his thoughts, feelings, and behaviors. These sheets were used to further illustrate the relationships among thoughts, feelings, and behaviors to daily events. Some initial challenging of dysfunctional thoughts was introduced. The session concluded with practice 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.

SESSION #4

Contact: 60-minute psychotherapy session.

Content: This was the fourth session of Cognitive Processing Therapy (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 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 on a daily basis.

Plan: Continued CPT.

SESSION #5

Contact: 60-minute psychotherapy session.

Content: This was the fifth session of Cognitive Processing Therapy (CPT) for PTSD. The patient completed his practice assignment related to re-writing his traumatic event, including further elaboration and inclusion of his current thoughts/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., conflicts between existing beliefs and traumatic events, or beliefs that were confirmed as a result of the traumatic events) was reviewed, and the patient agreed to identify one stuck point each day to challenge with the aid of the “challenging questions sheet.”

Plan: Continued CPT.

SESSION #6

Contact: 60-minute psychotherapy session.

Content: This was the sixth session of Cognitive Processing Therapy (CPT) for PTSD. The patient completed his practice assignment related to challenging stuck points on a daily basis with aid of the “challenging questions sheet.” 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 of the problematic thinking patterns prior to the next session.

Plan: Mid-tx assessment prior to next session. Continued CPT.

SESSION #7

Contact: 60-minute psychotherapy session.

Content: This was the seventh session of Cognitive Processing Therapy (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 prior to next session, and to read the materials related to safety stuck points.

Plan: Continued CPT.

SESSION #8

Contact: 60-minute psychotherapy session.

Content: This was the eighth session of Cognitive Processing Therapy (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 prior to next session.

Plan: Continued CPT.

SESSION #9

Contact: 60-minute psychotherapy session.

Content: This was the ninth session of Cognitive Processing Therapy (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 prior to next session.

Plan: Continued CPT.

SESSION #10

Contact: 60-minute psychotherapy session.

Content: This was the tenth session of Cognitive Processing Therapy (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 prior to next session. He also agreed to do one nice thing for himself daily.

Plan: Continued CPT.

SESSION #11

Contact: 60-minute psychotherapy session.

Content: This was the eleventh session of Cognitive Processing Therapy (CPT) for PTSD. The patient completed his practice assignment related to daily completion of the “Challenging Beliefs” worksheet, 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.

SESSION #12

Contact: 60-minute psychotherapy session.

Content: This was the twelfth and final session of Cognitive Processing Therapy (CPT) for PTSD. The patient completed his practice assignment related to daily completion of the “Challenging Beliefs” worksheet, and writing another “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 lead 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 with his referring clinician experiences (e.g., what worked, how he might use the skills in future therapy).

Plan: Conclusion of CPT. Post-treatment and one-month follow-up assessments scheduled.

Section 6
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