COGNITIVE PROCESSING THERAPY FOR ACUTE STRESS DISORDER

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**This manual is adapted, with permission from
Resick, P. A., Monson, C. M., & Chard, K. M. (2007). Cognitive processing therapy: Veteran/military version. Washington, DC: Department of Veterans' Affairs.**

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How to Use This Manual

Parts I and II

This version of the therapist's manual for Cognitive Processing Therapy (CPT) has been organized to maximize the ease with which therapists prepare for and conduct CPT with clients suffering from Acute Stress Disorder (ASD) following sexual assault. This manual has been adapted, with permission from the veteran/military version by P.A. Resick, C.M. Monson and K.M. Chard (2007) for use in a research trial examining the effectiveness of an abbreviated, 6-session CPT protocol for ASD.

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

Part II includes instructions on each of the 6 sessions. Each session opens with a summary that briefly outlines the format of the session and gives recommended times for each segment of the session. Each segment is then reviewed in detail, with goals, rationale, and sample dialogue. Call-outs are located throughout this section in the right margins of the text to allow therapists to quickly locate specific topics. Sample session progress notes follow the close of each session to facilitate tracking of therapist/client progress. Relevant client handouts also follow each session; please refer to the notes in Appendix A and B for additional information on handouts.

Appendices

Appendix A: Therapist Materials and Handouts includes clean, single-sided, reproducible copies of all client handouts. Six copies of all worksheets are included. Practice assignment instructions and a list of the accompanying handouts for the client's reference separate the session handouts. Additionally, example worksheets on sexual assault trauma are included in this section.

In addition, included are the materials that are not directly related to session handouts or practice assignments for the clients. These items include: the CPT contract, session practice assignment reviews, the PCL and WAI for sessions 2, 4 and 6.

Appendix B: Literature on CPT provides references to publications on CPT.

Table of Contents

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

Theory Behind CPT 1
ASD/PTSD as Disorder of Non-Recovery 3
Pre-Therapy Issues 4
1. Who Is Appropriate for CPT? 4
2. When Should the CPT Protocol Begin? 5
3. Treatment Contracting for CPT 6
Overview of CPT Sessions 7
Socratic Questioning Within CPT 8
1. Clarification 9
2. Probing Assumptions 10
3. Probing Reasons and Evidence 10
4. Questioning Viewpoints and Perspectives 10
5. Analyzing Implications and Consequences 10
6. Questions About the Question 10
Issues in Conducting CPT 11
1. Comorbidity 12
2. Avoidance 17
3. Needs of Clients 17
4. ASD/PTSD-Related Disability Status 17
5. Religion and Morality 18
6. Sexual Trauma in the Workplace 20
7. Ongoing Symptom Assessments Using PTSD and Depression Scales 22

| Part 2: | CPT for ASD: Session by Session 23

Session 1: Introduction and Education 24
Session 2: The Meaning of the Event 54
Session 3: Identification of Thoughts and Feelings 78
Session 4: Remembering the Traumatic Event 101
Session 5: Second Trauma Account 126
Session 6: Challenging Questions 141

| Appendix A: | Therapist Materials and Client Handouts

| Appendix B: | Literature on CPT

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

Cognitive Processing Therapy (CPT) in its original form is a 12 session therapy that has been found effective for the treatment posttraumatic stress disorder (PTSD) following traumatic events (Monson et al., 2006; Resick et al., 2002; 2008; Resick & Schnicke, 1992, 1993[1]). Pilot work indicates that an abbreviated version of CPT conducted over 6-sessions has utility in treating Acute Stress Disorder (ASD[2]). The research on CPT originally focused on rape victims, however the therapy has been successfully used with a range of other traumatic events, including military-related traumas. This manual focuses on the use of CPT for the treatment of acute stress disorder (ASD) following sexual assault. It is a modified version of the 12-session therapy for the treatment of PTSD in veterans and incorporates suggestions from almost two decades of clinical experience with the therapy. Although this manual is for use in a research treatment trial for ASD, it also contains more general information about the use of CPT in a non-research context.

Theory Behind CPT

- Theory behind CPT

CPT is based on a social cognitive theory of traumatic stress disorders such as Acute Stress Disorder (ASD) and Post-Traumatic Stress Disorder (PTSD). Specifically, CPT focuses on how the traumatic event is construed and coped with by a person who is trying to regain a sense of mastery and control in his or her life. The purpose of this manual is to address the treatment of ASD with CPT. However, throughout the following introduction to CPT generic reference is made to the post-traumatic stress reactions that can develop following more than 1 month since the traumatic event (PTSD). Given that the presence of ASD is highly predictive of the later development of PTSD, the

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[1] Monson, C. M., Schnurr, P. P., Resick, P. A., Friedman, M. J., Young-Xu, Y., & Stevens, S. P. (2006). Cognitive processing therapy for veterans with military-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 74, 898–907*; Resick, P. A., Nishith, P., Weaver, T. L., Astin, M. C., & Feuer, C. A. (2002). A comparison of cognitive processing therapy, prolonged exposure and a waiting condition for the treatment of posttraumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology, 70*, 867–879; Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology, 60*(5), 748–756; Resick, P. A., & Schnicke, M. K. (1993). *Cognitive processing therapy for rape victims: A treatment manual.* Newbury Park, CA: Sage Publications; Resick, P. A., Galovski, T. E., Uhlmansiek, M., Scher, C. D., Clum, G.A., Young-Xu, Y. (2008). A randomized clinical trial to dismantle components of cognitive processing therapy for posttraumatic stress disorder in female victims of interpersonal violence. *Journal of Consulting and Clinical Psychology, 76(2*), 243-258.

[2] Nixon, R. D. V. (2007). Using Cognitive Processing Therapy for Assault Victims With Acute Stress Disorder. In D. A. Einstein (Ed.), *Innovations and Advances in Cognitive Behaviour Therapy* (pp. 185-196). Sydney Australia: Australian Academic Press.

treatment of ASD will have considerable impact on the prevention of chronic post-trauma reactions (Brewin et al., 1999; Bryant & Harvey, 1998[3]).

- Emotional processing theory of PTSD

In addition to social cognitive theory, another major theory explaining PTSD is Lang's[4] (1977) information processing theory, which was extended to PTSD by Foa, Steketee, and Rothbaum[5] (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, clients 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. Consequently, therapeutic intervention with CPT during the acute stage of trauma reactions and ASD symptoms is likely to prevent the later development of PTSD.

- Social cognitive theories

Although social cognitive theories are not incompatible with information/emotional processing theories, these theories focus beyond the development of a fear network to other pertinent affective responses such as horror, anger, sadness, humiliation, or guilt. Some emotions such as fear, anger, or sadness may emanate directly from the trauma (primary emotions) because the event is interpreted as dangerous, abusive, and/or resulting in losses. It is possible that secondary, or manufactured, emotions can also result from faulty interpretations made by the client. For example, if someone is intentionally attacked by another person, the danger of the situation would lead to a fight-flight-freeze response, and the attending emotions might be anger or fear (primary). However, if in the aftermath, the person blamed herself[6] for the attack, the person might experience shame. These manufactured emotions would have resulted from thoughts and interpretations about the event rather than the event itself. As long as the individual keeps

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[3] Brewin, C.R et al., (1999). Acute stress disorder and posttraumatic stress disorder in victims of violent crime. *American Journal of Psychiatry, 156*, 360-366; Bryant, R.A., & Harvey, A.G (1998). Relationship of acute stress disorder and posttraumatic stress disorders following mild traumatic brain injury. *American Journal of Psychiatry, 155*, 625-629.

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

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

[6] Throughout this manual, we will refer to a single client using the pronouns "he" and "she" alternately, rather than saying "she/he" or "him/her."

saying that the event was her fault, she will keep producing shame (hence, manufactured).

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

In a social-cognitive model, affective expression is needed, not for habituation, but in order for the affective elements of the stored trauma memory to be changed. It is assumed that the natural affect, once accessed, will dissipate rather quickly and will no longer be stored with the trauma memory. Also, the work of accommodating the memory and beliefs can begin. Once faulty beliefs about the event (self-blame, guilt) and overgeneralized 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 clients about this process is described in Session 1 along with a handout in the client materials section.

ASD and PTSD as Disorders of Non-Recovery

- ASD and PTSD symptoms

ASD type symptoms are extremely common immediately following very serious traumatic stressors, and the presence of ASD is highly predictive of the later occurrence of PTSD (Brewin et al., 1999: Bryant & Harvey, 1998). ASD is diagnosed in the first month following exposure to significant trauma, such as physical and sexual assault. In addition, because we know that recovery takes a few months under normal circumstances, it may be best to think about diagnosable ASD and 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 client believes that she will be overwhelmed by the amount of affect that will emerge if she stops avoiding and numbing herself. Perhaps she was taught as a child that emotions are bad, and that she should "just get over it." In another case, a client 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 client may have seen something so horrifying that every time she falls asleep and dreams about it, she wakes up in a cold sweat. In order to sleep, she drinks heavily. Another client 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 all these cases, thoughts or avoidance behaviors are interfering with emotional processing and cognitive restructuring. There are as many individual examples of things that can block a smooth recovery as there are individuals with ASD and PTSD.

Pre-Therapy Issues

1. Who Is Appropriate for CPT?

- Who is appropriate for CPT?

CPT was developed and tested with people with a wide range of comorbid disorders and extensive trauma histories. In research settings, the protocol has been implemented with people who were from 3 months to 60 years post-trauma (worst trauma), although we have used it clinically for more recent traumas. It has been implemented successfully with people who had no more than a fourth-grade education and as little as an IQ of 75 (although in both cases, the worksheets were modified somewhat). In many research protocols, people have met full criteria for a PTSD diagnosis, but there is no reason that it could not be implemented with someone who is subthreshold for diagnosis. Recent research protocols have implemented CPT with people who have met the full criteria for an ASD diagnosis (Nixon, 2007[7]) and there is strong evidence for the use of other cognitive behavioural protocols for ASD (Bryant R.A. et al. 1998a; 2003[8]). However, if the person does not have ASD/PTSD at all and has some other diagnosis (e.g., depression only, another anxiety disorder), one should implement treatment protocols for those disorders (i.e., just because someone has experienced a traumatic event does not mean that she has ASD/PTSD). Clinical considerations as to whether CPT is appropriate can follow the exclusion criteria we have used for clinical trials except for those that were for purely methodological reasons (e.g., stable psychopharmacological regimen). First and foremost, if someone is a danger to self or others, treatment of ASD/PTSD is not the most immediate treatment goal. Likewise, if someone is in imminent danger, such as those who are being stalked or are in an actively abusive relationship, then the first order of business is safety planning. In contrast, just because someone might be redeployed to a combat zone does not mean that he could not be treated successfully before redeployment. The potential for trauma in the future is something we all live with, so the possibility of future violence or trauma should not stop treatment now. In fact, successful treatment of ASD/PTSD may actually reduce risk for future PTSD.

If someone cannot engage in treatment for his ASD/PTSD because he is so dissociative or has such severe panic attacks that he cannot discuss the trauma at all, then other therapy may need to precede CPT (e.g., grounding techniques, panic control treatment). Depression is the most common comorbidity and is not a rule-out unless the person cannot engage in therapy at

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[7] Nixon, R. D. V. (2007). Using Cognitive Processing Therapy for Assault Victims With Acute Stress Disorder. In D. A. Einstein (Ed.), *Innovations and Advances in Cognitive Behaviour Therapy* (pp. 185-196). Sydney Australia: Australian Academic Press.

[8] Bryant, R. A. et al. (1998a). Treatments of acute stress disorder: A comparison of cognitive behaviour therapy and supportive counseling. *Journal of Consulting and Clinical Psychology, 66,* 826-866. Bryant, R. A. et al. (2003). Treating acute stress disorders following mild traumatic brain injury *American Journal of Psychiatry, 160,* 585-587.

all due to the severity of the depression. We have implemented the CPT protocol with those who are abusing substances, but typically not in an outclient setting if they are substance dependent. However, once someone has stabilized after detoxification, he may be able to engage in CPT. These decisions need to be made on a case-by-case basis in consultation with the client. The motivation of the client to reduce their ASD/PTSD symptoms may be the most important consideration in whether to proceed with the protocol. Coping skills development is not a part of the protocol, but a therapist may choose to train her clients in affect tolerance skills if she determines that the clients' skills in this area are so poor that they will act out and engage in self-harm behavior when thinking or talking about the traumatic event. In these cases, the therapist may also consider implementing the CPT-C (without the written exposure component) rather than CPT (for more information see original manual).

2. When Should the CPT Protocol Begin?

- When should the CPT protocol begin?

For the treatment of ASD, it is usual to commence the CPT protocol two weeks after the event. The two week time period allows for the normal trauma response to begin to settle and social supports to emerge. However, if a person strongly feels they need help and they have clinically significant symptoms, then beginning treatment is appropriate. In addition, the commencement of trauma focused treatment is to be distinguished from debriefing. The treatment of ASD involves different goals, theoretical premises, populations and strategies compared to debriefing (Bryant et al. 2000[9]). In particular, debriefing commences within 24 to 72 hours post trauma, whereas ASD treatment typically commences after the immediate aftermath of the trauma has settled.

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

- Starting the CPT protocol with a new client

New Client. We recommend that with a new client, the therapist begins the CPT protocol within one to three sessions of assessment and information gathering. Once the therapist determines that the client indeed has

[9] Bryant, R.A., & Harvey, A.G. (2000). *Acute stress disorder: A handbook of theory, assessment, and treatment.* Washington, DC: American Psychological Association.

ASD/PTSD, is interested in treatment for these symptoms, and that other symptoms and life events are not interfering with treatment, the therapist can introduce the protocol and the contract for CPT (see handout in Appendix A: Therapist Materials).

- Starting the CPT protocol with an established client

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

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

3. Treatment Contracting for CPT for ASD

Regardless of whether someone is a new or an established client, before starting the protocol, the therapist should explain what is expected of both client and therapist. This therapy protocol is typically conducted in 6 sessions, administered once a week. The therapy will focus on the worst, most recent, traumatic event. The client will be expected to attend all sessions regularly (once or twice a month is not sufficient) and to complete the practice assignments. The therapist will agree to adhere to the protocol and focus on the ASD for this period of time. It is helpful for the therapist to explain that her job will also be to recognize and discourage the client’s avoidance

behaviors that will maintain symptoms and increase the likelihood of the later occurrence of PTSD.

In Appendix A: Therapist Materials, there is a client contract that can be used to demark the work that will be done and to engage the client in the process.

Overview of CPT Sessions[10]

- Overview of CPT sessions

The contents of each session are described in Part 2 along with issues that therapists are likely to encounter. The therapy begins with an education component about ASD/PTSD, and the client is asked to write an Impact Statement in order for the client and therapist to begin to identify problem areas in thinking about the event (i.e., "stuck points"). The client is then taught to identify and label thoughts and feelings and to recognize the relationship between them. The next two sessions focus on generating a written account of the worst traumatic incident, which is read to the therapist in session. During the early sessions, the therapist uses Socratic questioning to begin to challenge unhelpful cognitions, particularly those associated with assimilation, such as self-blame, hindsight bias, and other guilt cognitions. Thereafter, the sessions focus on teaching the client 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 outside of the current research context (e.g., without the written trauma account component), and a section on treatment issues with comorbid disorders.

- Order of sessions

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

- Format of each session

The usual format for sessions is to begin with review of the practice assignments using the Practice Assignment Review, located in Appendix A: Therapist Materials, followed by the content of each specific session. The

[10] The manual session guidelines refer to the 6-session protocol for individuals with ASD. For clients with chronic PTSD, the original 12-session CPT protocol should be followed.

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

Socratic Questioning Within CPT

- Socratic questioning

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

Socratic questioning originated from the early Greek philosopher/teacher Socrates. He believed that humans had innate knowledge and that this knowledge could be revealed by another person asking specific questions. He also contended that humans who came into knowledge, versus being told, were more likely to retain the information and build on that knowledge to acquire more knowledge. Socratic questioning is routinely used in American law schools, in some forms of cognitive therapy, and specifically in CPT. Socrates was convinced that thoughtful questioning enabled the logical self-examination of ideas and facilitated the determination of the validity of those ideas. As described in the writings of Plato, a student of Socrates, the teacher feigns ignorance (à la "Columbo" in the modern ages) about a given subject in order to acquire another person's fullest possible knowledge of the topic. With

the capacity to recognize contradictions, Socrates assumed that incomplete or inaccurate ideas would be corrected during the process of disciplined questioning and hence would lead to progressively greater truth and accuracy.

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

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

1. Clarification

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

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

- Clarification questions

2. Probing Assumptions

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

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

- Probing assumptions

3. Probing Reasons and Evidence

- Probing reasons and evidence

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

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

4. Questioning Viewpoints and Perspectives

- Questioning viewpoints and perspectives

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

- *What alternative ways of looking at this are there?*
- *What does it do for you to continue to think this way?*
- *Who benefits from this?*

- *What is the difference between…and…?*
- *Why is it better than…?*
- *What are the strengths and weaknesses of…?*
- *How are…and…similar?*
- *What would…say about it?*
- *What if you compared…and…?*
- *How could you look at this another way?*

5. Analyzing Implications and Consequences

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

- Analyzing implications and consequences

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

6. Questions About the Question

Often therapists become flustered when clients ask direct questions or make direct statements toward the therapist that may even appear to be "challenging the therapist" or an attempt to violate therapist-client boundaries. For example, *"have you ever been assaulted?"* or *"have you ever been raped?"* At these points in therapy it can be very helpful to *question the question*. By putting the focus back on the client and his intentions, the dialogue is often de-escalated and this can allow the client to more thoroughly examine his motives for asking in the first place.

- Questions about the question

- *What is the point of asking that question?*
- *Why do you think you asked this question?*
- *What does that mean?*
- *What would getting an answer either way mean to you?*
- *Are you concerned that I don't understand? Please tell me what you think I am missing. I would like to understand what the experience was like for you.*

Issues in Conducting CPT

Many therapists were never trained to conduct manual based psychotherapies and may feel uncomfortable with both the concept and the execution. It is important that the client and therapist agree on the goal for the therapy (trauma work for ASD and related symptoms) so that the goals do not drift or switch

- Therapist-client agreement on therapy goals

from session to session. Without a firm commitment to the treatment goals, when the therapy is “off track,” the therapist may not know whether to get back on the protocol or to let it slide. As other topics arise, the therapist sometimes isn’t sure whether, or how, to incorporate them into the sessions. A few words on these topics are appropriate here. Once therapists have conducted protocol therapy a few times, they usually find that they become more efficient and effective therapists. They learn to guide the therapy without tangents or delays. They find they can develop rapport with clients through the use of Socratic questions because the clients are explaining to the therapist exactly how they feel and think and the therapist expresses interest and understanding with these questions. There is usually enough time in the session to cover the material for the session and still have time for some other topics, such as things that came up that week or other current issues related to their ASD/PTSD (childrearing, job concerns, marital issues, etc.). However, if those are major issues, then the therapist will need to prioritize the order. It is inadvisable to try to deal with several types of therapy for different problems simultaneously.

1. Comorbidity

- Comorbidity

At present, there is evidence that even early in an acute response there is some comorbidity with ASD (other disorders along with the ASD: Shalev, et al., 1996[11]). For example, posttrauma ASD clients report more panic attacks and symptoms than non ASD clients (Nixon et al., 2003[12]). However, if a significant comorbid problem exists with ASD, the comorbid disorder is often pre-existing. The following recommendations and comorbid disorders are more likely to be present in PTSD, such as comorbid depression, anxiety, and dissociation. In spite of this, the comorbidity normally remits along with PTSD. Therefore, we believe there is rarely a need to deal with other symptoms independently of the PTSD protocol.

Major depressive disorder, which occurs in approximately half of people with PTSD and substance abuse, the rates of which vary depending on the population being studied, are both commonly comorbid with PTSD. Anxiety disorders and personality disorders are also fairly common. Additionally, health problems are associated with PTSD. Fortunately, except for clients with substance dependence, CPT has been tested on clients 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. Client-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

[11] Shalev, A., Peri, T., Canetti, L., & Schreiber, S., (1996). Predictors of PTSD in Injured Trauma Survivors: A Prospective Study. *American Journal of Psychiatry, 153,* 219-225.
[12] Nixon, R.D.V. & Bryant, R.A. (2003). Peritraumatic and persistent panic attacks in acute stress disorder. *Behaviour Research and Therapy, 41* 1237-1242.

is beyond the scope of this manual, so we have picked a few of the more common disorders for your consideration.

Substance dependence should be treated before addressing PTSD with CPT, but substance-abusing clients may be treated with CPT if there is a specific contract for not drinking abusively during the therapy, and if there is a specific focus on the suspected role of abusive drinking as avoidance coping. Further, it may be possible to implement CPT immediately following substance abuse treatment.

- Substance use disorders

In fact, if the client is following an in a client 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 client 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 client can fall back into his usual coping method and relapse. At this point, based on clinical experience rather than research, our best predictor of success with CPT with this population is motivation to change. The therapist should ask in a very straightforward fashion whether the client wants to improve his PTSD symptoms enough to refrain from alcohol or drugs for treatment to commence. Some clients 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 clients at their word. If someone promises to relapse, we do not implement the protocol, but let them know that it is available when they are ready. Those who proceed with treatment need to understand how their substance abuse has served as avoidance, and the therapist should check in frequently about urges to drink or use. If such urges occur during treatment, they can, in fact, indicate particular stuck points or important emotions that should be processed. CPT without the written account (CPT-C: for more information refer to original manual) can also be implemented if the therapist and client determine that the client is, in fact, too fragile to handle writing about the trauma memory (i.e., reluctance is not due to the more common stuck points about emotions). Typically we have the clients focus on specific child, family, and marital issues after completing the course of PTSD treatment. Sometimes those problems remit when the client no longer has PTSD interfering with functioning.

- MDD

Major depressive disorder (MDD) is the most common comorbid disorder with PTSD. Being depressed is not a rule-out for PTSD treatment. In fact, PTSD treatment should successfully address MDD that is often secondary to the PTSD. All treatment outcome studies on PTSD have found substantial and lasting improvement in depressive symptoms along with PTSD improvement. There are only a few caveats to consider. Although medication instability is a typical exclusion criterion for psychosocial treatment outcome studies for pragmatic purposes (i.e., is change attributable to the intervention or the medication?), medication changes can also complicate clinical practice. A clinician may be tempted to throw every possible intervention at the client at once, expecting to achieve the quickest possible results. However, if a client is

beginning or increasing a medication while starting psychotherapy, neither the client nor the clinician will know what was effective. Why does this matter? When the client begins to feel better, she may attribute the change to the medication, even if it is not the case, and not attribute the change to her own efforts. She may even stop complying with psychotherapy. Also, if the medication was the locus of the change, the prescribing physician needs to know what the minimally effective dose of the medication is without the confusion of the common occurrence of increasing symptoms during the 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.

- Psychotherapy and medication

We have occasionally seen clients 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 clients whose depression was so severe they could not muster the energy to attend treatment or comply with assignments. Either extreme is a problem that must be rectified before appropriate psychotherapy can be implemented. It is important to stress that we are not suggesting that all clients with PTSD, with or without MDD, should be on medications. Rather, we suggest that, if a client 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 clients 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 other anxiety disorders is whether they are so disabling that they interfere with PTSD treatment. If obsessive-compulsive disorder (OCD), panic disorder, or agoraphobia is so severe that the client 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 clients will have heard stories of clients who secure their home perimeter every evening before bedtime, sometimes for hours. These superstitious safety behaviors may rise to the level of OCD. When we have treated clients with PTSD and OCD, we have started with the PTSD to see if the OCD symptoms would improve. There is no reason at this point to expect that PTSD symptoms will improve with successful OCD treatment. These OCD types of behaviors can be considered right along with safety issues in Sessions 3 and 4, with the goal of getting the clients to test out their overestimated level of danger. 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 client to do an experiment to test his assumptions. Although this is not a typical component of CPT, a behavioral experiment might be very helpful with comorbid anxiety disorders. OCD symptoms may also be addressed while working on issues of control. The person with OCD

has the temporary illusion of control when engaging in the ritual that is intended to reduce his anxiety. Aside from the fact that the rituals (cleaning, checking, etc.) soon come to control the person rather than the other way around, the therapist can help the client to accept that he can't have control over future events (see Session 6) and that the rituals don't prevent future events from occurring and may be totally irrelevant.

- Panic disorders

Panic disorder is commonly comorbid with PTSD and has been observed in (Nixon et al. 2003[13]). Our research with CPT indicates an improvement in panic symptoms without any particular extra intervention. However, there are some people who are so crippled by their panic disorder that they cannot tolerate discussing the traumatic event without having panic attacks. In this case, the therapist may want to consider treating the panic disorder first with a cognitive-behavioral treatment such as panic control treatment (Craske, Barlow, & Meadows, 2000[14]) or simultaneously with CPT (Falsetti et al., 2001[15]). Falsetti and her colleagues developed a protocol that combines CPT with panic control treatment.

- Personality disorder

The challenge with personality disorders in PTSD treatment is how to stay on track with the protocol and not get derailed by side issues. In other words, the therapist does not attempt to treat the personality disorder but treats the PTSD in spite of the personality disorder. The therapist needs to keep in mind that the client has been coping with his life circumstances for a long time, albeit ineffectively, and that getting pulled off onto the "crisis of the week" can serve as an avoidance function to doing the trauma work. If one can conceptualize personality disorders as overgeneralized patterns of responding across a range of situations, then it is quite easy to see how someone with a long history of trauma, or coping with his trauma, might develop avoidant personality, dependent personality, and so forth. These beliefs and behavioral patterns served a functional purpose, at least at some point in the person's life. It is now dysfunctional because these patterns are so overgeneralized (and probably obsolete). Within the cognitive framework, these overgeneralized assumptions and beliefs become reified to the schema level and become automatic filters through which all experiences pass. Any experiences that do not conform to the over-riding schema are either distorted (assimilated) to fit the construct or ignored. Those experiences that appear to confirm the over-riding schema are used as proof and lead to further over-accommodation. It is difficult to challenge a large schema such as *"everyone will abandon me"* or *"I can't take care of myself,"* so the therapist should continually bring these global ideas down to very specific events, thoughts, and emotions and then challenge the evidence on those specific events with Challenging Beliefs Worksheets. When the same assumptions emerge across many worksheets, the

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[13] Nixon, R.D.V. & Bryant, R.A. (2003). Peritraumatic and persistent panic attacks in acute stress disorder. *Behaviour Research and Therapy, 41* 1237-1242.
[14] Craske, M. G., Barlow, D. H., & Meadows, E. A. (2000). *Mastery of your anxiety and panic: Therapist guide for anxiety, panic, and agoraphobia (MAP-3)*. San Antonio, TX: Graywind/Psychological Corporation.
[15] 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.

therapist can say, *"I am detecting a theme here. Across these six worksheets it always comes back to the thought that people are trying to harm you* (or whatever the schema is). *You have said this to yourself so often and across so many situations that you have come to believe it is carved in stone as TRUTH. And we are going to have to chip away at that belief just like you would have to chip away at stone to get it to change—in this case, one worksheet at a time. Now I see that each time you have done a Challenging Beliefs Worksheet that you were able to challenge the thought that someone was intentionally trying to harm you. How many experiences will you need to have, how much evidence will you need to move to the thought that 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, peritraumatic dissociation, dissociation during or immediately after the traumatic event, is one of the most robust predictors of PTSD. Dissociation can become conditioned, just like the fight-flight response, to previously neutral cues. If the client 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 client 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 client to learn not to dissociate when stressed. There are two good rationales. One is that dissociation actually puts the client at greater risk, in that if she were really in danger, she would have fewer options for extricating herself from the situation. Another rationale for learning not to dissociate is that dissociation is an emergency response, like the fight-flight response, that shuts down immune and other normal functioning. Having this emergency response occur frequently, dysregulates the person's immune functioning. PTSD has been associated with greater health problems, and people who dissociate frequently are often observed to have higher rates of many physical disorders and diseases.

Another option for problematic dissociation is to use the CPT-C protocol. A third option is to use the CPT protocol but have the client write the account using techniques to minimize dissociation. One strategy that we have used successfully is to have the client set a kitchen timer for 5 minutes and start writing. The bell serves to interrupt dissociation, orienting the client back to the present. The kitchen timer can then be set for 6 minutes, with the client 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 clients who have extensive trauma histories. CPT was developed and has been tested with clients 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 client's participation in PTSD treatment. In that case, the therapist may want to treat the comorbid disorder before, or simultaneously, with CPT. There are evidence-based cognitive-

behavioral therapies for most comorbid conditions that clinicians will encounter. For the most part, however, the treatment of PTSD will improve the comorbid symptoms and may even eliminate the necessity of further treatment for those symptoms.

2. Avoidance

- Deter client avoidance

Clients with ASD present within 4 weeks of the traumatic event, whereas clients may present with PTSD 3 months to many years after the traumatic event. Whilst clients with ASD may be extremely emotional due to the recovery due to the recovery of the trauma, and clients with PTSD may be 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 ASD and PTSD comes from avoidance attempts on the part of the client. We point out avoidance whenever we see it (e.g., changing the subject, showing up late for sessions) and remind the client that avoidance maintains symptoms. If the client wants to discuss other issues, we save time at the end of the session or attempt to incorporate her issues into the skills that are being taught (i.e., A-B-C Worksheets, Challenging Questions Worksheets, Patterns of Problematic Thinking Worksheets, Challenging Beliefs Worksheets). If the client does not bring in practice assignments, we do not delay the session but conduct the work in session and then reassign the practice assignment along with the next assignment.

3. Needs of Clients

- Needs of Clients

Individuals with ASD or PTSD may have specific needs, such as the need to ‘get on’ with life and maintain everyday functioning, that if not addressed may block the progression of therapy. For example, some individuals 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 treatment augmented with couples counseling. Some clients may appear a bit more “raw” than the very chronic clients, which may lead to some therapists and clients to 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 clients are willing to engage in therapy and can contract against self-harm and acting out, there is no reason to assume that they need to wait for treatment.

4. PTSD-Related Disability/Compensation Claims

- PTSD-related disability status

In some client groups, there may be PTSD related disability and compensation claims that create concern for the therapist and clients about what will happen to claims if PTSD is effectively treated. Compensation claims are more likely to be present in client groups of motor vehicle trauma, physical assault or veterans.

PTSD-related disability and/or compensation claims seem to present as the biggest challenge if a client is actively seeking a disability rating or compensation. We encourage clinicians to be up-front with clients about the

timing of CPT in relation to their pursuit of service-connected benefits. If they are actively trying to prove that they have symptoms of PTSD, it is logically not the time to engage in a therapy that is shown to decrease symptoms. It is far better to prevent the client from having a failed therapy experience by delaying a course of CPT than it is to proceed with a course that was doomed from the outset. Clients in the claims process may want to seek a supportive therapy or non-trauma-focused intervention while awaiting the outcome of their claims.

Alternatively, there are clients where the goal of therapy is to have the client return to gainful employment and not be on disability for their PTSD. The client then has the ability to benefit form symptom reduction to improve the quality of life experienced. At the beginning of treatment with these clients, they may not be able to conceptualize sleeping through the night again, not being disrupted by flashbacks, or having the concentration to hold down a job. The therapist needs to impart a clear message that these symptoms can improve, to instill some hope in the client. However, specific career or job planning might be postponed until later in therapy to see how much symptom remission has been achieved. For example, if the client sustained head injuries during his motor vehicle trauma, it may not be clear how much of the symptom picture is due to PTSD and how much is due to brain injury until the PTSD symptoms are resolved.

5. Religion and Morality

- Issues of religion and morality

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

You should not avoid these topics, because they may prove to be at the heart of your client's ASD/PTSD. Even if you have a different set of religious beliefs (or are agnostic or atheist), it is not a good reason to avoid these topics. You need to wade into cross-cultural beliefs as part of your work, and religion is an important part of your client's culture. The just world belief is probably the most common assumption that is taught, not just by religions but also by parents and teachers. People like to believe that if they follow the rules that good things will happen and that if someone breaks the rules that they will be punished. People fail to learn this as a probability statement (*"If I follow the rules, it decreases my risk of something bad happening"*), which would be more realistic. If people hold strongly to the just world belief, then they may engage in backward reasoning. This would lead them to the conclusion that if something bad happened to them, they are being punished. However, if they can't figure out what they did wrong, they will end up railing at the unfairness of the situation or of God. No religion guarantees that good behavior will

always be rewarded and bad behavior punished (here on earth), so if your client says this, then he may have either distorted his religion or was taught this by a mistaken parent or religious leader. Like any profession, there is variability on how educated or adherent a religious leader is to the tenets of the religion. Please make sure you differentiate the religion itself from an individual practitioner when you discuss these issues. You may be able to check with the tenets of the religion through a Web search or by talking to clergy or your own place of worship.

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

If a client believes that lives are predetermined and that he has no free will, then you may wonder why he has PTSD. What is the conflict? Is he having trouble accepting his fate? Or is it just a matter of not being able to process emotions? You should ask the client how he came to understand what happened to him, and what images or thoughts he keeps coming back to.

- "Why me?"

The question that may logically follow *"Why me?"* is *"Why not you?"* For example, if someone wonders why something has happened, why she was spared (language that implies intent) when others were killed, the same line of questioning can proceed. Is there logic to war, to who dies or who lives? Because someone is a good person, did that make her more immune to being killed in war? Unfortunately, many religions, parents, or world views may reinforce the notion that if something bad happened, someone made a mistake or they are a bad person. Specifically, many people have a belief that "good things happen to good people and bad things happen to bad people." This is called the "just world belief."

- Self- or other-forgiveness

The concepts of self- or other-forgiveness are sometimes brought up in therapy. If these issues are comfortable concepts for a client, she probably would not bring them up for discussion. Instead, they are typically mentioned because there is some discomfort with or conflict over the subjects. As noted above, with regard to self-forgiveness, it is very important for you to first challenge the specifics of the event to see if your client has anything to forgive herself for. Because it is almost axiomatic that people will blame themselves

for traumatic events, it does not mean that they intended the outcome. Therefore, blame and guilt may be misplaced. If someone is the victim of a crime, she is just that, a victim. There is nothing she could have done that would justify what happened to her. Because a woman feels dirty or violated does not mean that she did anything wrong that needs forgiveness. This would be an example of emotional reasoning. Killing someone in war is not the same as murdering someone. The person may have had no other options than what occurred at the time, so the Socratic questioning needs to establish intent, available options at the time, etc. One should only discuss self-forgiveness when it has been established that the client had intended harm against an innocent person, that he had other available options at the time and willfully chose this course of action. Committing an atrocity (raping women or children, torturing people) is clearly intended harm. Guilt is an appropriate response to committing an atrocity or a crime. A client may well need to accept what he has done, be repentant, and seek out self-forgiveness, or if religious, forgiveness within the church or other place of worship. Even then you should work with your client to contextualize who he was then with what his values are now to help him realize that he is not the same as when the event occurred. Once all this has been thoroughly processed and digested, some form of restitution or community service may assist the client in moving beyond his permanent, self-inflicted sentence.

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

6. Sexual Trauma in the Workplace (ST)

- Sexual trauma (ST)

Although there are many different types of traumatic experiences, each unique in its own way, experiences of sexual trauma often raise special issues for clients and clinicians. This is particularly true when the trauma is sexual assault or repeated, threatening acts of sexual harassment that occur in the workplace. Sexual assault is any sort of sexual activity between at least two people in which someone is involved against his or her will. Physical force may or may not be used. The sexual activity involved can include many different experiences such as unwanted touching, grabbing, oral sex, anal sex, sexual penetration with an object, and/or sexual intercourse. Sexual

harassment that involves repeated, unsolicited, and threatening verbal or physical contact of a sexual nature. Examples of this include threats of retaliation for not being sexually cooperative or implied faster promotions or better treatment in exchange for being sexually cooperative.

Many victims of sexual trauma are reluctant to report and may struggle to identify even to themselves that what occurred was an assault. Those who choose to report to those in authority often feel that they are not believed or, even worse, find themselves blamed for what happened. They may be encouraged to keep silent and their reports may be ignored. Having this type of invalidating experience often has a significant negative impact on the victim's posttrauma adjustment.

- ST and CPT

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

- Sexual arousal during ST

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

Clients are often reluctant to bring up this topic in therapy. They may feel deep shame that they experienced sexual arousal in a situation in which they believe it to be inappropriate and may view it as some type of personal failing. The therapist can help alleviate this guilt and shame through education and should bring up the topic in a low-key and routine way if the client does not broach the topic. One of the simplest ways to help the client to think differently about it is to remind the client that sexual arousal is not a voluntary response any more than being tickled is. In fact, tickling is a good analogy to

use. Someone can be tickled against his will, be laughing, and hate it at the same time. When nerve endings are stimulated, there is no conscious choice about whether those nerve endings should react. If the client is helped to see that his or her reactions were the normal outcome of stimulation and not some moral choice, he or she should experience relief and the lessening of guilt or shame. Please refer to Appendix A: Client Handouts for examples of an A-B-C Worksheet, Challenging Questions Worksheet, and Challenging Beliefs Worksheet on ST.

- Example worksheets are located in Appendix A

7. Ongoing Symptom Assessment Using ASD, PTSD and Depression Scales

- Using ASD/ PTSD & depression scales

There are various measures that can be used to assess the frequency and intensity of ASD and PTSD symptoms that clients experience. It is recommended that the client be assessed, not just before and after treatment but during treatment as well. Typically clients are given a brief PTSD scale and a depression scale, such as the Beck Depression Inventory (BDI)[16] (if comorbid depression is a problem), in weeks 2, 4 and 6 of therapy. Other measures that may be used at pre-treatment assessments as well as during treatment are the Posttraumatic diagnostic Scale (PDS: Foa et al., 1997), the Depression, Anxiety and Stress Scale (DASS: Lovibond & Lovibond, 1995) and the Acute Stress disorder Scale (ASDS: Bryant et al., 2000[17]). For example, CPT for PTSD across 12 sessions involves the administration of the PCL-S monthly version once before the first session and evaluates the client's symptoms **during the past month**. Subsequent administrations of the PCL-S evaluate the client's symptoms **during the prior week** and are administered weekly. When measuring symptoms, most often there is a large drop in symptoms when the assimilation about the trauma is resolving. Typically this occurs around the third or fourth session (of 6 sessions) with the written account and cognitive therapy focusing on the traumatic event itself. Occasionally this takes longer, but with frequent assessment, the therapist can monitor the progress and see when the shift occurs. For the current use of this manual in the treatment of ASD with CPT, the pre-treatment, within treatment (sessions 2, 4 and 6) and posttreatment versions of the PCL will be used and are located in Appendix A: Therapist Materials and Client Handouts

[16] Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 141*, 1311.

[17] Bryant , R.A. et al. (2000). Acute stress disorder scale: A self-report measure of acute stress disorder. *Psychological Assessment, 12*, 61-68; Foa, E.B., et al. (1997). The validation of a self-report measure of posttraumatic stress disorder: the Posttraumatic Diagnostic Scale. *Psychological assessment, 9*, 445-451; Lovibond, S.H, & Lovibond, P.F. (1995). *Manual for the Depression Anxiety Stress Scales,* (2nd ed). Sydney Psychology Foundation.

| Part 2: | CPT: Session by Session

It is presumed that the therapist will have conducted some form of assessment of the client's traumatic event and persistent symptoms and specifically contracted to do a course of CPT before undertaking the first session. At least a brief assessment of ASD/PTSD and depressive symptoms should be conducted. There are several brief checklists and depression scales that can be used to assess pretreatment symptoms and to conduct repeated assessments during therapy to monitor progress across treatment. Included in this manual are the PCL and WAI scales for use in sessions 2, 4 and 6.

The contents of the following pages contain summaries, guided explanations of the session, sample session notes, and accompanying handouts for the therapist's reference. Reproducible copies of the client handouts can be found in Appendix A Therapist's Materials and Client Handouts.

The individual sessions are:

Session 1	Introduction/Education and Introducing Thoughts, Feelings & Stuck Points
Session 2:	The Meaning of the Event, Thoughts & Feelings, Challenging Beliefs
Session 3:	Meaning of the Event, Problematic Thinking Patterns & Introducing Safety & Trust Issues
Session 4	Reviewing Safety & Trust Issues & Introducing Power/control & Esteem Issues
Session 5:	Reviewing Power/Control Issues & Introducing Intimacy Issues
Session 6:	Reviewing Intimacy Issues, Identifying remaining Stuck Points & Future Directions

Session 1: Introduction and Education
Thoughts, Feelings & Stuck Points

Summary of Session 1 – Introduction and Education Phase

1. **Set agenda** (5 minutes)

2. **Therapist explanations to client** (15 minutes)
   - ➢ ASD Symptoms: 4 Clusters (Handout)
     - Dissociation: detachment, numbness to surroundings and emotions
     - 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. Many other forms of avoidance: alcohol, staying as busy as possible, physical symptoms, avoiding therapy or practice assignments.
   - ➢ Trauma Recovery and Fight-Flight Response
     - Fight/flight, freeze
     - Paired with cues: sight, sound, smell, etc.
   - ➢ Cognitive Theory
     - Belief structure: categories—just world, good things to good people, etc.
     - Change memories to fit beliefs (assimilation)
     - Change beliefs about the world (accommodation/over-accommodation)
   - ➢ Types of Emotions
     - Two types of emotions that follow trauma: natural and manufactured

Optional: Brief review of most traumatic event if therapist did not undertake initial assessment (5 minutes)

3. **Therapy rationale—stuck points** (10 minutes)
   - ➢ Goals of Treatment
     - To recognize and modify old thoughts and feelings that may be unhelpful
     - To accept the reality of the event
     - To change beliefs enough to accept it without going overboard
     - To feel your emotions about the event
   - ➢ Review Stuck Point Handout

4. **Overview of treatment—structured** (5 minutes)
   - ➢ 6 Sessions, 90 mins–2 hours each:
     - 1- Introduction
     - 2- Meaning of the Event, Thoughts & Feelings, Challenging Beliefs
     - 3- Remembering the event, Problematic Thinking Patterns
     - 4- Safety & Trust Issues
     - 5- Power/control & Esteem Issues
     - 6- Intimacy Issues, Stuck Points & Future Directions

5. **Anticipating avoidance and increasing compliance (5 minutes)**
   - ➢ Administer Therapy Expectancy Questionnaire:

6. **Help identify and see connections among events, thoughts, and feelings** (10 minutes)
   - ➢ Six basic emotions: angry, disgusted, ashamed, sad, scared, happy
   - ➢ Combined: jealous = mad + scared
   - ➢ Varying intensity: irritated/angry/enraged
   - ➢ Secondary emotions: guilt, shame.

- Patient examples of own feelings, including physical sensations
- Interpretation of events/self-talk affecting feelings (snubbed on street), alternatives

7. Introduce A-B-C Worksheets and fill one out together (5 minutes)
- A-B-C Worksheets to become aware of connection among events, thoughts, feelings, and behavior

8. Introduce Challenging Questions Worksheet to help client challenge stuck points (15 minutes)
- Go through blank question worksheet
- Go through example worksheet
- Choose a stuck point of the client's to begin addressing with these questions (a focus on assimilation is helpful at this point in the therapy)

9. Assign practice assignment and problem solve re: completion (5 minutes)
- First Impact Statement
- ABC sheet
  - At least one A-B-C Worksheet each day (as soon after an event as possible)
  - At least one worksheet directly about the worst traumatic event
- Challenging one stuck point a day using challenging questions

10. Check-in re: client's reactions to session (5 minutes)

Session 1: Introduction and Education Phase

The goals of Session 1 are:

1. To build rapport with the client.
2. To educate the client about symptoms of ASD.
3. To provide a rationale for treatment based on a cognitive conceptualization of ASD/PTSD.
4. To lay out the course of treatment
5. To elicit treatment compliance.
6. To introduce the idea that changing thoughts can change the intensity or type of emotions that are experienced.
7. Introduce stuck points

- Session 1 goals

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

- Compliance & avoidance

In this session, clients are also given the opportunity to ask any questions they may have about the therapy. Sometimes clients' 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 client needs to feel understood and listened to, otherwise she may not return.

Clients sometimes arrive with a pressing need to speak about their trauma. However, the therapist should prevent the client 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 client is likely to assume that the therapist holds the same opinions about his guilt, shame, or worthlessness that he, the client, holds, and may be afraid to return to therapy after such a disclosure.

- Trauma disclosure

Other clients 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 client and therapist the opportunity to get acquainted before the therapy begins and allows the therapist to provide the client with a description of what the therapy will entail. In this first session, it is important that the therapist remind the

client 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 Client

1. ASD Symptoms

"In going over the results of your testing, we found that you are suffering from acute stress disorder. The symptoms of ASD fall into four clusters. The first cluster is the dissociation or distance from your surroundings and emotions. This includes a feeling of numbness, detachment or absence of being emotionally responsive and feeling less aware of your surroundings. You might feel distant from your normal self or as though you were looking at yourself from the outside. Along with these feelings, you may have noticed that you are unable to recall some important aspect of the event. Which of these do you experience? Have you felt like things around you seem unreal?"

- ASD symptoms–criterion B

"The second cluster is the reexperiencing of the event in some way. This includes nightmares about the event or other scary dreams; flashbacks, when you act or feel as if the incident is recurring; intrusive memories that suddenly pop into your mind. You might have the intrusive memories when there is something in the environment to remind you of the event (including anniversaries of the event) or even when there is nothing there to remind you of it. Common times to have these memories are when you are falling asleep, when you relax, or when you are bored. These symptoms are all normal following such a traumatic event. You are not going crazy. Can you give me examples of these experiences in your own life since the event?"

- ASD symptoms–criterion C

"A third set of symptoms concern arousal.[18] *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?"*

- ASD symptoms–criterion E

"The fourth cluster of symptoms is avoidance of reminders of the event. A natural reaction to intrusive memories and strong emotional reactions is the urge to push these thoughts and

- ASD symptoms–criterion D

[18] Although avoidance is listed fourth in the DSM, it makes more sense to present the symptoms to clients in their most likely order: detachment, intrusion, arousal, and avoidance. This way the explanation for the symptoms follows logically from their description.

feelings away. You might avoid places or people who remind you of the event. Some people avoid watching certain television programs or turn off the TV. Some people avoid reading the newspaper or watching the news. You might avoid thinking about the event and letting yourself feel your feelings about the event. There might be certain sights, sounds, or smells that you find yourself avoiding or escaping from because they remind you of the event. 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-Freeze Response

- Trauma recovery

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

- Fight-flight-freeze reactions

"There are some different reasons why you may be having trouble recovering. First, there is an automatic component during the event that you should consider as you evaluate how you responded during the time. When people face serious, possibly life-threatening events, they are likely to experience a very strong physical reaction called the ***fight-flight reaction****. More recently we have learned that there is a third possibility, the* ***freeze response****. In the fight-flight reaction, your body is trying to get you ready to fight or flee danger. The goal here is to get all the blood and oxygen out to your hands, feet, and big muscle groups like your thighs and forearms so that you can run or fight. 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?"

- Classical conditioning processes

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

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

3. Cognitive Theory

- Cognitive theory

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

- Just world belief

"One common belief that many people learn while growing up is that 'good things happen to good people and bad things happen to bad people.' This is called the 'just world belief.' You may

have learned this through your religion, your parents, your teachers, or you may have picked it up as a way to make the world seem safer and more predictable. It makes more sense when you are young. For example, parents wouldn't want to say, 'If you do something you're not supposed to, you may or may not get in trouble.' However, as we grow up, we realize that the world is more complex than that, just like how we learn that there are all different types of chairs. If you have ever had things go bad and you said 'Why me?' then you have a just world belief .What did you believe about rape before it happened to you?"

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

- Assimilation

"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."*

- Over-accommo-dation

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

"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."

- Natural vs. manufactured feelings

Brief Review of Most Traumatic Event

In this first session, the therapist and client work together to define the most traumatic event that they will work on first. For ASD clients (rather than PTSD), it is assumed this will be the most recent trauma. The client then provides a brief account of the traumatic event. It is important the therapist keep the client contained and not conduct an exposure to the traumatic material. However, if the client starts to become distressed or dissociates, the therapist should ask questions and keep the client grounded in the present. If needed, the therapist can stop the client's description. The therapist only needs enough of the details to begin to hypothesize what problematic interpretations and cognitions might need to be explored.

- Honing in on the traumatic event

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 client begins with a less severe event because she believes she cannot handle the worst event, she will still believe that after working on the less distressing event. If the client is resistant to writing an account about the worst event, the therapist needs to do

some cognitive therapy during the session and have the client complete some A-B-C Worksheets on her thoughts and feelings about working on the worst event. It is helpful to provide an expectation that the client provide a brief, less affectively charged event by providing a time frame 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 your most traumatic event…"*

- Dealing with multiple traumatic events

If the client 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 ASD 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 client that work on the chosen event will very likely impact the other events, and if not, there will be opportunities to work on the other events.

Therapy Rationale—Stuck Points

- Introducing stuck points

> *"So, one goal of therapy will be to help you recognize and modify what you are saying to yourself—in other words, your thoughts and interpretations about the event, which may have become automatic. These distorted beliefs may become so automatic that you aren't even aware that you have them. Even though you may not be aware of what you are saying to yourself, your beliefs and self-statements affect your mood and your behavior. Often, people aren't aware that they are having thoughts about whatever they are experiencing. For example, on the way here today, you were probably wondering what this therapy would be like or what I would be asking you to talk about. Do you remember what you were thinking about before the session?*

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

- **Give client Stuck Points Handout & Stuck Point Log**

Overview of Treatment

The therapist should describe the course of therapy (and the nature of the Trauma Account in Sessions 3 and 4) and the importance of doing practice assignments.

> *"There are 168 hours in a week. We cannot expect you to change your symptoms and the way you have been coping in one or two hours of therapy a week if you are continuing to practice your old ways of thinking the other 166 hours a week. It will be important for you to take what you are learning and apply it to your everyday life. Your therapy needs to be where your life and traumatic stress reactions are, not just in this little room."*

> "*Today we are going to work on identifying what different feelings are, and we will be looking at the connection between your thoughts and feelings. Let's start with some basic emotions—angry, disgusted, ashamed, sad, scared, or happy. These basic emotions can be combined to create other emotions like jealousy (mad + scared) or can vary in intensity (for example, irritated, angry, or enraged). Can you give me an example of something that makes you mad? When do you feel sad? How about happy? What frightens you? How do you feel physically when you are feeling angry? How do you feel physically when you are feeling scared? How are angry and scared different for you? What does shame or embarrassment feel like?"*

- **Give client Identifying Emotions Handout**

Connections Among Events, Thoughts, and Feelings

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 client, or an alternative is if someone says he will call and then doesn't. The client is then asked what she would feel and next what she just said to herself (e.g., "*I'm hurt. She must not like me*" or "*I wonder if someone else might have different thoughts about her behavior?")*. If the client is unable to generate alternative statements, the therapist should present several other possible self-statements (*"She must not have her glasses on," "I wonder if she is ill?" "She didn't see me,"* or *"What a rude person!"*). Then the therapist can ask the client 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.

- Interpretation of events

If the client does not recognize his feelings or their connection to beliefs, help the client 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 client sees the connection among his thoughts, feelings, and behaviors. Sometimes a simple "why" question can help elicit the client's thinking.

- Connection of thoughts, feelings, and behavior

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 client's thinking is, and whether the client has made some simple blind assumptions ("*I just should have known"*) or whether she has developed complex and convoluted thought patterns.

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

- Dealing with an argumentative client

If the client 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 clients will have very convoluted thinking that justifies their problematic cognitions, often a therapist will find almost no answers in response to Socratic questions. For example, in response to questioning the statement *"I let it happen"* with *"How did you let it happen?"* the client 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 client may respond, *"I don't know, I just should have."* In these cases, the client 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 client then responds as if the statement were true, just because he said so. If the client becomes uncomfortable because he doesn't have answers to the questions, the therapist can gently reassure him that they will work on this later in therapy.

Introduction to A-B-C Worksheets

- Introducing A-B-C Worksheets

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

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

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

At the bottom of the A-B-C Worksheets are two questions that introduce the notion of alternative interpretations of events. The primary focus of the A-B-C Worksheets should be on the client identifying the link between thoughts and feelings before moving on to challenging cognitions. Thus, the therapist should use her judgment about introducing these questions in this session to the client based on the client's grasp of the basic cognitive-behavioral process. If the client 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 client'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 client due to low intelligence or literacy issues (see Session 2).

Introduction to the Challenging Questions Worksheet

The list of challenging questions is introduced during this session. The list can be used to question and confront maladaptive self-statements and stuck points. In order to help clients comprehend the assignment, we have created a handout of a sample that walks the client 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 client 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 client can accept that she was not to blame or accept the reality of the outcomes, it will be difficult to work on other issues. If there is time in the session, it is helpful for the client and therapist to complete one sheet together. It should be pointed out that not all questions will be relevant to every thought.

- **Give client Challenging Questions Worksheet**

To increase out-of-session assignment compliance, it is also helpful to determine several stuck points that the client can address with the Challenging Questions Worksheets.

First Impact Statement

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

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

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

or impossible to write, the therapist might suggest that he record his thoughts on a tape recorder.

Anticipating Avoidance and Increasing Compliance

The client 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 client to be motivated to do something completely antithetical to what she has been doing. It is very important that the client understand what the therapy consists of and why it will work. She should have ample opportunity to ask questions and express concerns. The therapist needs to express confidence, warmth, and support.

- Increasing client compliance

> *"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."*

Practice Assignment 1

- **Assign Session 1 practice assignment 1**

> *"Please write at least one page on why you think 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."*

Practice Assignment 2

- **Assign Session 1 practice assignment 2**

> *"Please complete the A-B-C Worksheets to become aware of the connection between events, your thoughts, feelings, and behavior. Complete at least one worksheet each day. Remember to fill out the form as soon after an event as possible. Complete at least one worksheet about the worst traumatic event. Also, please use the Identifying Emotions Handout to help you determine what emotions you are feeling. Bring these sheets to the next session."*

Practice Assignment 3

- **Assign Session 1 practice assignment 3**

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

Check-in re: Client's Reactions to Session

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

Sample Session 1 Progress Note

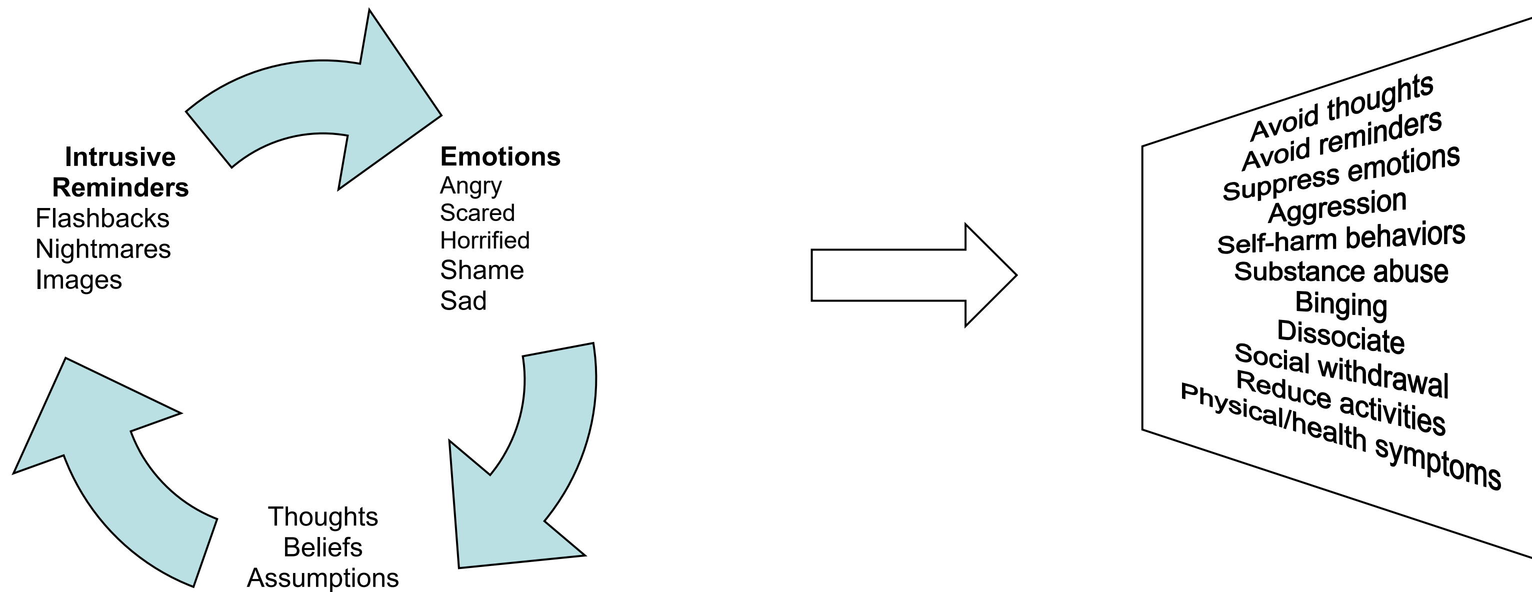
Contact: 90-minute psychotherapy session

Content: The client completed the first session of CPT for ASD. An overview of ASD symptoms and a cognitive explanation of the development and maintenance of ASD were presented. A related rationale for treatment was provided, including the use of cognitive restructuring to alleviate stuck points that prevent the client from more fully emotionally processing the traumatic event(s). The client provided a brief description of his most traumatic event. The relationships amongst thoughts, feelings, and behaviors were reviewed, and an example from his discussion about the impact of his trauma on his life was used to illustrate the cognitive model. The patient agreed to complete A-B-C Worksheets daily and the Challenging Questions Worksheets to monitor his thoughts, feelings, and behaviors until the next session.

The client 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 ASD

Posttrauma Reactions That Lead to ASD and PTSD

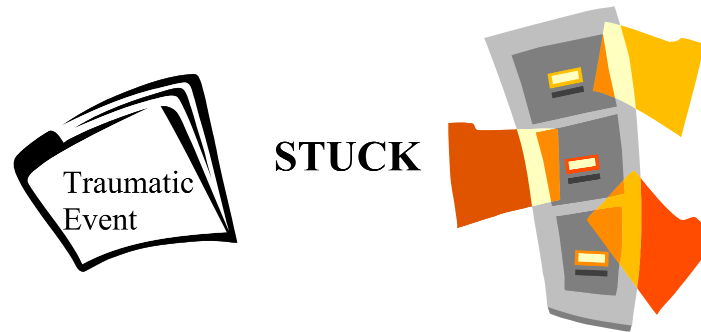


Escape/Avoidance

Stuck Points—What Are They?

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

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



Prior Belief
You can't be raped by someone you know

Rape
You are raped by someone you know.

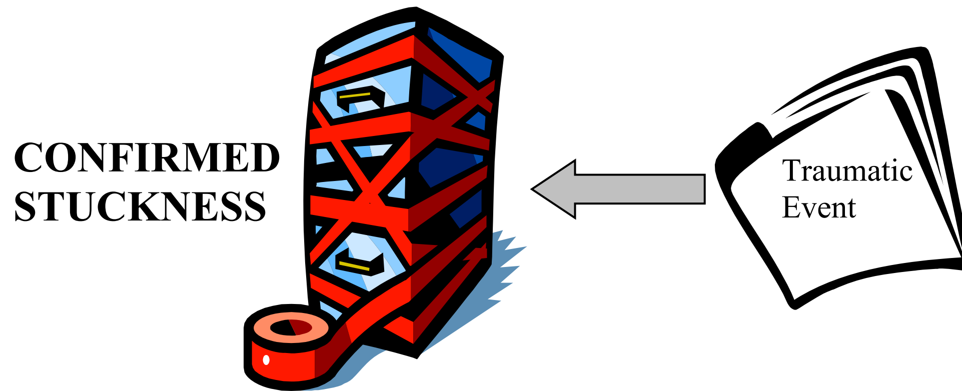
Results

- If you cannot change your previous beliefs to accept what happened to you (i.e. you can be raped by someone you know), you may find yourself asking "Was it really a rape?"
- If you are asking yourself if it was really a rape, you may be making sense of the rape by saying "I must have misinterpreted what happened…I didn't make myself clear…I must be crazy or I must have done something to mislead him…"
- 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 *can* be raped by someone you know". When you are able to do this, you are able to label the event as a rape (accept that it happened), and move on from there

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



<u>Prior Belief</u>
Men are no good.

<u>Rape</u>
You are raped by a man

<u>Results</u>

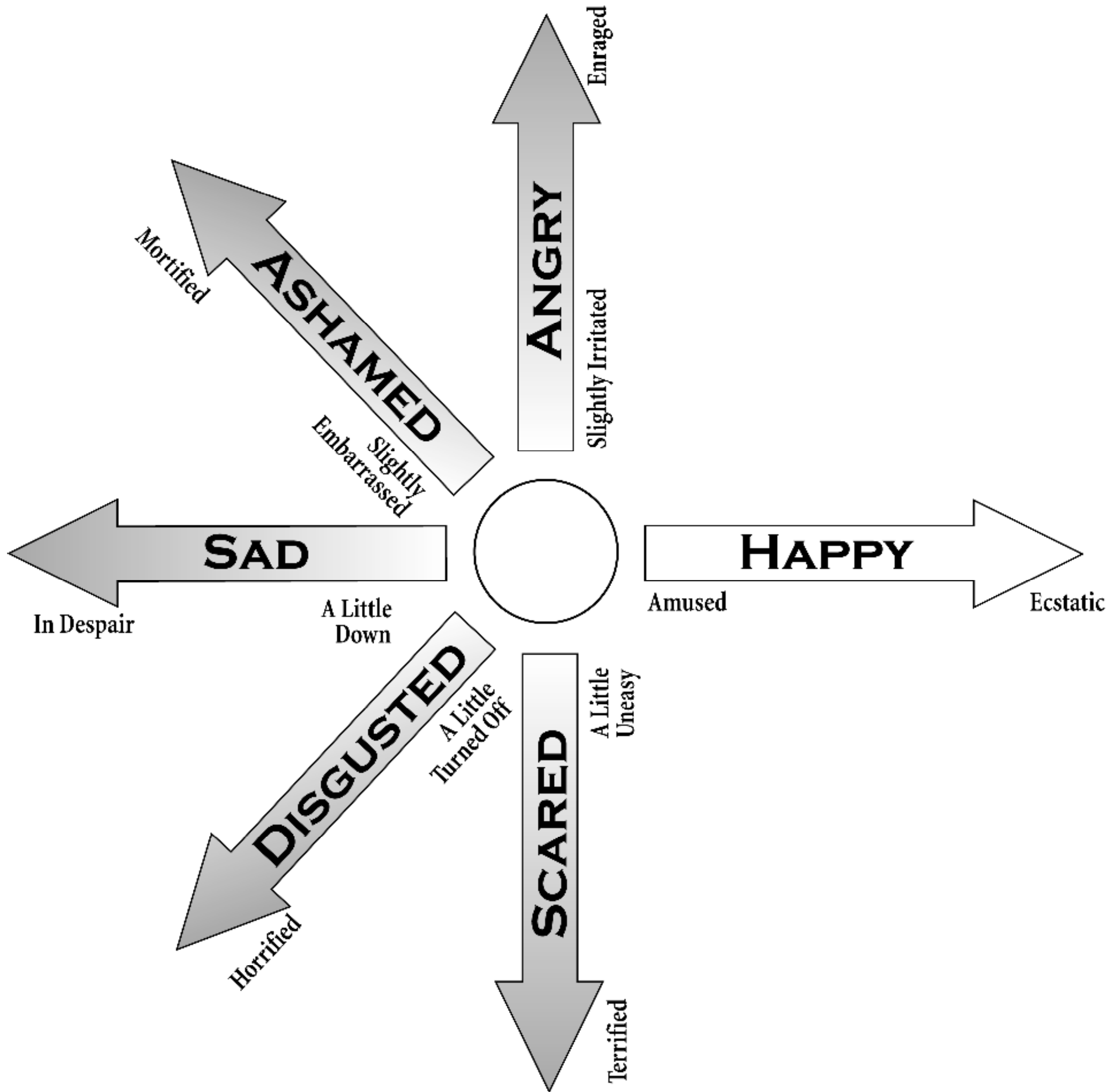
- If you see the rape as further proof that men are "no good", then you will believe this very strongly.
- If you are stuck here, you may have strong emotional reactions that interfere with your ability and desire to have relationships with men. This may feel "safe" to you, but unless this is how you wish to live the rest of your life, this belief may keep you distressed, negatively impact your relationships, and possibly lead to legal, work, and social problems, it deserves some attention.

<u>Goal</u>

- To help you modify your beliefs so they are not so extreme. For example, "*Some* men are no good, but this is not true of all men."

Stuck Point Log

Identifying Emotions Handout



Initial of Client Last Name: _____________ Client ID: ___________________
Therapist Initials: ______________________ Date: ____________ Session: ___________

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

Therapeutic Outcome Questionnaire – Session 1

INSTRUCTIONS: Please circle one number for each question which best represents your feelings about the treatment program. Please then place the completed questionnaire in the envelope provided and seal.

1	2	3	4	5	6	7	8	9
Not at All		**Very Little**		**Somewhat**		**Moderately**		**Extremely**

How logical does this type of treatment seem to you?	1	2	3	4	5	6	7	8	9
How confident are you that this treatment will be successful in reducing your trauma-related symptoms?	1	2	3	4	5	6	7	8	9
How confident are you that this treatment will be successful in reducing your other personal problems?	1	2	3	4	5	6	7	8	9
How confident would you be in recommending this treatment to a friend with similar problems?	1	2	3	4	5	6	7	8	9

A-B-C Worksheet

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?

____

____

____

A-B-C Worksheet

Date: ___________ **Client:** ____________________________

ACTIVATING EVENT **A** "Something happens"	**BELIEF** **B** "I tell myself something"	**CONSEQUENCE** **C** "I feel something"
I want to read my favourite book ***The man that wrote the book looks just like the man that raped me***	***Do I want to pick this book up?*** ***The individual who wrote the book and the man who did the rape are two different people.***	***Cautious and scared*** ***Still feel upset***

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

What can you tell yourself on such occasions in the future? ***Remind myself that the author of my favourite book did not hurt me. It is ok/safe to read book.***

Challenging Questions Worksheet

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?

Challenging Questions Worksheet

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: *I chose to take a poorly lit short cut home. It was my fault, I should have known better, I let it happen.*

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

   FOR: *I should have gone a safer way. I deserve what I got. Everyone knows that dark areas are where street crimes happen.*

   AGAINST: *I had no prior reason to take a different way home or to believe that anyone would follow me. Just because I took a short cut doesn't mean that the perpetrator had the right to attack me. When I took the shortcut, I had no idea what would happen to me. When I took the shortcut, all I knew was that I would get home faster.*

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

   Here you need to think about whether you have just said this so many times to yourself that it seems like fact or whether it is indeed a fact. A fact is an observable (to others also) provable action or thing.

   Yes, I guess just because I took a short cut doesn't automatically mean that I caused the assault. Maybe because I used to believe this was true of others, I just applied it to myself as if it were fact. Yes, the fact is that the assault was not my fault.

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

   Here you are being asked whether you are distorting what happened in some way, for some reason.

   Maybe I am blaming myself more because I am afraid of expressing my anger outwardly or toward the attacker .I tend to turn things around so it's my fault in general, and it's likely that this is another example of doing that. I feel as if I have more control over preventing a future assault if I blame something I did in particular than if I blame someone else.
   Reality is: It was my attacker's fault. The perpetrator assaulted me. I did not want this to happen nor did I ask for it.

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

   This also refers to thinking of things as either-or, black-white, right-wrong, good-bad. This belief is more often associated with extreme ways of viewing something with no-in-betweens, no grays, no middle ground.

   Yes, looking back I realise that while taking the short cut may have been higher risk than I knew at the time, it is not something that necessarily or always leads to an assault.

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)?**

Yes, I think I should have known I would be assaulted if I took the short cut. But I don't know how this is possible. If I had known it would happen, I would not have gone that way.

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

In other words, are you making some judgement without considering the entire context (the whole assault scenario, including what you felt like and thought at the time of the assault and just before)?

Yes, I am taking my going the short way home out of the context of what I expected that night. It was dark out and I thought it best to get home as quickly as possible. Another part of this whole scenario is that I've taken that short cut many times and nothing has ever happened to me.

7. Is the source of information reliable?

This question is asking you who the source of the information is and whether they are reliable. This applies best with beliefs originating from what the attacker may have said to you or from blaming comments from other people around you.

No, my father was angry because it happened and lashed out by blaming me. He is not a reliable source of information when he is angry. Other people need to believe that they can avoid an attack for their own peace of mind, but they can't; therefore, they are not reliable in their judgement of this event.

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

This question is meant to help you determine whether the probability is as high as you think or really much lower.

Since the assault I have been acting as if being attacked is a certainty instead of a possibility. When I say "I should have known better" that implies that the crime was a certainty.

It did happen so I know that it is possible, but I have taken that short cut many times, so I also know it wasn't high probability.

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

What you want to think about here is whether your stuck point is based on actual fact or your feelings.

Yes, I feel guilty because I think I should have known what would happen, but this is a feeling, and there are no facts to support that it was my fault.

10. Are you focused on irrelevant factors

This question is asking you whether or not factors involved in your stuck point (for example, behaviours engaged in, and so on) are relevant to the resulting belief.

Yes, I am focusing on something I did that is in no way connected to the assault, that is, taking a short cut (my action did not cause the assault – THE ATTACKER DID!!!!)

Challenging Questions Worksheet

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: *Since I went with him voluntarily, it is my fault that I was raped – I should have known better.*

1. **What is the evidence for and against this idea?**
   FOR: *I went, so I deserve whatever happened that night* (you can even challenge this too!).
   AGAINST: *Just because I went with him it doesn't mean I agreed to have sex with him. Just because I agreed to go with him doesn't mean he had the right to rape me. When I went with him I had not idea what he would do to me. When I went with him all I knew what that he was a nice person. Going with him didn't mean I caused the rape. It is impossible to identify a rapist – I could not have known.*

2. **Is your belief a habit or based on facts?**
   Here you need to think about whether you have just said this so many times to yourself that it seems like fact or whether it is indeed a fact. A fact is an observable (to others also) provable action or thing.

   Yes, I guess just because I went with him voluntarily doesn't automatically mean that I caused the rape. Maybe because I used to believe this was true of others, I just applied it to myself as if it were fact.

3. **Are your interpretations of the situation too far removed from reality to be accurate?**
   Here you are being asked whether you are distorting what happened in some way, for some reason.

   Maybe I am blaming myself more because I am afraid of expressing my anger outwardly or toward the rapist. I tend to turn things around so it's my fault in general, and it's likely that this is another example of doing that. I feel as if I have more control over preventing a future rape if I blame something I did in particular than if I blame someone else. It feels as if I had more control during the rape I blame myself – I hate to admit that I was totally helpless and out of control of the situation. Reality is: It was his fault. He raped me. I did not want this to happen nor did I ask for this to happen. No one deserves to be raped, and no behaviours can cause a rape.

4. **Are you thinking in all-or-none terms?**
   This also refers to thinking of things as either-or, black-white, right-wrong, good-bad. This belief is more often associated with extreme ways of viewing something with no-in-betweens, no grays, no middle ground.

   This does not apply to this stuck point.

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)?**

Yes, I think I should have known he would rape me. But I don't know how this is possible. If I had known he would do this, I would not have gone voluntarily.

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

In other words, are you making some judgement without considering the entire context (the whole assault scenario, including what you felt like and thought at the time of the assault and just before)?

Yes, I am taking my voluntarily going with him out of the context of what I expected that night- we were supposed to go out on a date, so it is the norm that a woman will voluntarily leave with a man when they go out. Another part of this whole scenario is that he gave me signals that he was a nice guy, and had never in the past done anything that would have made me suspicious about him , therefore is makes a lot of sense that I went out with him voluntarily. This does not mean I caused the rape or acted in a way tat anyone would no have done.

7. Is the source of information reliable?

This question is asking you who the source of the information is and whether they are reliable. This applies best with beliefs originating from what the attacker may have said to you or from blaming comments from other people around you.

Maybe not. So many of my girlfriends and family members have asked my why I went with him – this reinforced my belief that I should have somehow known, since other people implied I should have. Other people need to believed that they can identify a rapist for their own peace of mind, but they can't; therefore, they are not reliable in their judgement of this event.

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

This question is meant to help you determine whether the probability is as high as you think or really much lower.

This does not apply to this stuck point.

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

What you want to think about here is whether your stuck point is based on actual fact or your feelings.

Yes, I feel guilty because I think I should have known what would happen, but this is a feeling, and there are no facts to support that it was my fault. I could not have known this was going to happen. If I can believe this, I will no longer feel the guilt and blame myself.

10. Are you focused on irrelevant factors

This question is asking you whether or not factors involved in your stuck point (for example, behaviours engaged in, and so on) are relevant to the resulting belief.

Yes, I am focusing on something I did that is in no way connected to the rape - that is, going with him (what I did) did not cause the rape – HE DID!

Session 2: The Meaning of the Event
Thoughts & Feelings
Challenging Beliefs

Summary of Session 2: The Meaning of the Event

Administer PCL and WAI (in waiting room if possible), collect, and store.

1. Complete Session 2 Practice Assignment Review and set agenda. (5 minutes)

2. Have client read Impact Statement—begin to look for stuck points (5 minutes)

- If practice not written, have client describe meaning of event orally and reassign.
- Collect Impact Statement from client

3. Discuss meaning of Impact Statement with client (10 minutes)

- Begin to identify stuck points
- Review major issues to be focused on in treatment
- Identify **Assimilation** (changing memories to fit beliefs)
  - **- Overaccommodation** (going overboard on changing beliefs as a result of memories)
  - **- Accommodation** (changing beliefs about the world and events…this is desirable)

4. Review concepts (5 minutes)

- ASD symptoms, info processing theory, treatment rationale, stuck points

5. Review A-B-C Worksheets, further differentiating between thoughts and feelings (5 minutes)

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

6. Discuss the A-B-C Worksheet related to trauma (5 minutes)

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

7. Review the Challenging questions Sheet (10 minutes)

- Assist patient in answering questions they had difficulty answering
- Assist patient to analyze and confront stuck points (hindsight bias)
- Begin shifting focus to over-accommodation, as the self-blame resolves
- Address stuck points of self-blame

8. Introduce Patterns of Problematic Thinking Worksheet (10 minutes)

- Go over blank handout
- Go over example

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

9. Introduce Challenging Beliefs Worksheet with a trauma example (10 minutes)

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

- Generate new, balanced, evidence-based statement

10. Introduce the Trauma Account (10 minutes)

- How to write the Trauma Account
- Cognitive therapy for any concerns about the Trauma Account

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

- Full Trauma Account with sensory details
- Daily reading of the full Trauma Account
- Identify stuck points and find examples for each Patterns of Problematic Thinking Worksheet. Notice and write down new examples experienced each day. Look for patterns. Look for ways your reactions to events have been affected by your past bad experiences and the habitual patterns that have developed after them.
- Use a Challenging Beliefs Worksheet each day for stuckpoints identified either in session or during the week
- Problem-solving re: practice completion is very important. Refer to rationale if necessary.

12. Check-in re: client's reactions to session (5 minutes)

Session 2: The Meaning of the Event

The goals of Session 2 are:

1. To begin to determine the client's stuck points and formulate why the client has not recovered naturally from the event (Impact Statement).
2. To review the cognitive-behavioral formulation of ASD
3. To review the Challenging Beliefs Worksheets.
4 To assist the client in answering questions he had difficulties answering.
5. To continue cognitive therapy for stuck points the client is trying to challenge.
6. To introduce and assign the Patterns of Problematic Thinking Worksheet.
7. To begin helping the client to identify and see the connection among events, thoughts, and emotions. The primary vehicle for understanding the client's understanding of her own trauma and its effects is through the Impact Statement. Review of the effects of the trauma on one's life can also be used to enhance motivation for change.

- Session 2 goals

Client Reading of the Impact Statement

- Reviewing the Impact Statement

The therapist should begin the session by asking how the practice assignment went and asking the client 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 client 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 client if she thought about the meaning of the event. **We never reinforce avoidance.** If a client does not do her practice assignment or "forgets to bring it in," we proceed with the assignment orally during the session. The client should read this and all other assignments out loud. If the therapist were to read it, the client 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 client examine the effect that the event has had on his life in several different areas. When reading the essays, it will be important for the therapist to determine whether or not this goal has been achieved. After listening to the Impact Statement, the therapist should praise the client and review with the client 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.

- Using the Impact Statement to address assimilation and over-accommodation

Meaning of the Impact Statement

The therapist should use the framework of the Impact Statement to help the client begin to recognize which of her statements reflect assimilation and over-accommodation. Please note that it is not necessary to use these terms. For example, in response to a client's statement on thinking of ways she 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 or trying to alter the event to fit prior beliefs. Examples of overaccommodation would be *"We are in grave danger all the time," "I can't trust my own judgment,"* and *"I can never feel close to anyone again."* The therapist can mildly point out those extreme statements, while intended to make the client feel safer and more in control, have a heavy price and ultimately do not work.

- Example of Impact Statement

The following is an example of an Impact Statement written by a 34-year-old man who had been sexually abused as a child and is the victim of several adult assaults. Although he is clearly blaming himself for the events (assimilation), he is intimidated by other people and has 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 client's motivation to change. In the process of examining all the ways that the traumatic event has affected the client's beliefs about self and others, it may be possible for the therapist to help the client 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 client have discussed the Impact Statement, the therapist continues to help the client to identify and label thoughts and emotions; to learn to see the connection among events, thoughts, and feelings; and to be reminded of the idea that changing thoughts can change the level and type of emotion experienced.

Review of A-B-C Worksheets

Homework Noncompliance—If the client did not write the initial Impact Statement for the last session, this session should begin with having the client read the Impact Statement and noticing any changes or additions since the last

session. If the client fails to bring in the Impact Statement again or the A-B-C Worksheets, the therapist should have a serious discussion about the client's motivation for treatment at this time. If the client continues to be noncompliant with the assignments, therapy should not proceed without a commitment from the client. The therapist should consider whether some other form of treatment is needed first (e.g., Dialectical Behavior Therapy (DBT), skills, substance abuse treatment, panic disorder treatment) before ASD/PTSD treatment can commence. It is preferable to ask the client to return to treatment when he can devote himself to the work than to have him fail to recover due to noncompliance. If the latter is the case, it will be more difficult to implement the protocol at a later time (*"That therapy didn't work; I'm a failure"*). Remind the client that avoidance behavior is a symptom, not an effective method of coping. If the client recommits to treatment, have him bring in both the Impact Statement and A-B-C- Worksheets, but hold off on the Trauma Account assignment to determine if he is going to follow through. The therapist should begin by going over the A-B-C Worksheets completed for practice. In looking over the worksheets that the client 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)?

- Mismatch between thoughts and emotions

After looking over the entries generally, the therapist assists the client in sorting through the individual items that were problematic for the client. 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 clients to see how increasingly extreme statements result in depression, terror, or other desperate emotions.

- Thoughts vs. feelings

Frequently, clients label thoughts as feelings. For example, one client brought in an A-B-C Worksheet that said *"Get yelled at before I even have my coffee"* at "A," *"I try so hard but never get rewarded"* at "B," and *"I feel like I'm fighting an unsuccessful battle"* at "C." The therapist again labeled the basic emotions for the client and asked her which of the feelings fit the statement best. She said, *"sad and angry."* The therapist pointed out that what she had listed at "C" was actually another thought that could be listed at "B." The client 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. Clients are encouraged to use the words *"I think that ..."* or *"I believe…"* for thoughts and to reserve *"I feel…"* for emotions. (**NOTE:** This misuse of the word "feel" is so common that the therapist may also catch himself. It is quite acceptable, and in fact better, for the therapist to

correct himself during the session if it occurs, thus normalizing how our spoken language can be misapplied.)

It is important for the therapist to praise the efforts of the client and help with corrections in a low-key manner, particularly if the client 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"*).

Review of A-B-C Worksheet Related to Trauma

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

- Example of Socratic questioning

P: *In the "A" column, I wrote "I didn't think about Jack all day when I was at work." My thoughts were "How could I betray him like this? I am worthless." In the "C" column I wrote "shame, angry, and I cancelled my plans for the evening."*
T: *Who were you angry at?*
P: *Myself.*
T: *I'm not sure I understand. How is that a betrayal of Jack?*
P: *I don't know, it just is.*
T: (Therapist waits silently)
P: *Well, it just doesn't seem fair for me to go on with my life, when he can't go on with his.*
T: *But how is that a betrayal? The word "betrayal" makes it sound like you are saying that you were being disloyal or treacherous. Is that what you mean?*
P: *Well, not treacherous, but yes, disloyal.*
T: *Before he died, did you ever have a workday when you didn't think about him all day?*
P: *Sure. Lots of times.*
T: *Were you being disloyal then? Were you betraying him by being busy at work and concentrating on what you were being paid to do?*
P: *Well, no, but that was different. He was alive then. I assumed that I would see him again at the end of the day.*
T: *You said that it wasn't fair for you to go on when he couldn't. If you go on with your work and life and don't think about him all the time, how will you have been disloyal? Why is it different now?*
P: (Tearfully) *I'm afraid that if I am not thinking about him, that it means that I am forgetting him.*
T: (After a long pause to allow the client 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.*

Review of the Challenging Questions Worksheet

- Using Challenging Questions to confront stuck points

The session continues with reviewing the client's answers to the Challenging Questions Worksheet. The therapist assists the client to analyze and confront her stuck points. For the most part, clients do an excellent job answering the questions. The most common problem we encounter is that clients 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 client 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 client will lose sight of the fact that he is trying to answer one question and will wander around using the Challenging Questions to challenge

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

- Focusing on one stuck point

At this point in therapy there should also be a shift in the therapist's behavior. Up until now, the therapist has been asking the Socratic questions to guide the client to question her assumptions. With the introduction of the Challenging Questions, clients 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 client is stuck.

The first two or four 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 client'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 overgeneralized problems with trust if their loved ones let them down in the aftermath of the event. If a client 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 overgeneralized, overaccommodated beliefs are an attempt to feel safer but result in disrupted relationships, fearful behavior, poor self-esteem, or suspicion of others

- Addressing over-accommo-dation

Introduction to Patterns of Faulty Thinking

After discussing the questions, Patterns of Faulty Thinking are introduced. This worksheet is different from the Challenging Questions Worksheet in that it is focused on patterns of thinking and not a specific belief. Rather than focusing on a single thought or belief, the client 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 client give an example from a recent event.

- **Give client Patterns of Faulty Thinking Worksheet**

Introduction to the Challenging Beliefs Worksheet With a Trauma Example

At this point the therapist should introduce the Challenging Beliefs Worksheet (adapted from Beck & Emery[19], 1985, p. 205). The introduction of this worksheet is very important so the client is not overwhelmed by the seeming complexity of it. The worksheet brings together all the skills taught in the worksheets used thus far in the therapy and introduces the notion of alternative thoughts and feelings. The Challenging Beliefs Worksheet will be used throughout the rest of the sessions. The A-B-C Worksheet is incorporated into the two columns on the left. However, at this point the client 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 client begins by examining the challenging questions and answering the most pertinent ones. Next, she looks over the Patterns of Problematic Thinking Worksheet to see if she has been engaging in one of the counterproductive thinking patterns. Then, for the first time, the client is asked to generate another statement that is more balanced and evidence-based.

- **Give client Challenging Beliefs Worksheet**

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

- Developing balanced beliefs

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 client should fill out one worksheet together in session. The therapist should help the client choose at least one stuck point to work on every day over the next week, but should also encourage him to use the worksheets as events occur during the week for practice.

Introduction to the Trauma Account

The out-of-session practice assignment for the next week is to write a detailed account of the chosen index trauma. The client is asked to write down exactly what happened with as many details as possible. He should be encouraged to include sensory detail (sights, sounds, smells, etc.) and his thoughts and feelings during the event. To encourage a more in-depth account, set the expectation that the average handwritten account is about eight pages long. If the client is unable to complete the assignment, he should be encouraged to

- Writing the Trauma Account

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

write as much of it as he can. He may need to write on several occasions to complete the assignment. If he is unable to complete the assignment in one sitting or becomes emotional and needs to stop for a few minutes, he should draw a line at the point he stopped. The therapist may be able to determine some of the stuck points by examining the points at which he quit writing. The client 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 client to pick a time when he has privacy and can cry and feel other emotions without being interrupted or embarrassed. Be direct about discouraging completing practice assignments at work, during lunch, or in a public place. For those with substance abuse issues, directly indicate that they should not write the account while using substances. Identify this as avoidance behavior. Also, the account should be handwritten and not typed. As mentioned previously, there is evidence that writing the account is more evocative. Typing the account lends more objectivity and tends to focus on grammar rather than the emotional engagement that is desired.

The therapist should add, *"Don't be surprised if you feel your reactions almost as strongly as you did at the time of the incident. Your feelings have been stored in your memory intact. If you have not dealt with this event, your feelings and the details of the event are quite vivid when you finally confront the memory in its entirety. People tend to remember traumatic events in much greater detail than everyday events. Over time, if you continue to allow yourself to feel your emotions about the event, your feelings will become less intense and less overwhelming."*

- Purposes of writing the full Trauma Account

There are two purposes for the writing assignments. 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 can then be stored without such intense emotions encoded with it. (We have found that the primary natural emotions dissipate quickly and do not need extended exposure work, unlike theories that suggest the repeated prolonged exposures are necessary for habituation.) The second purpose is for the therapist and client together to begin to search for stuck points.

Practice Assignment 1

- **Assign Session 2 practice assignment 1**

> *"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.

Practice Assignment 2

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

- **Assign Session 2 practice assignment 2**

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

Practice Assignment 3

"Use the Challenging Beliefs Worksheet to analyses and confront at least one of your stuck points. If you have issues related to self-blame, complete at least one worksheet to confront this belief. Use the remaining sheets for other stuck points or for events which have occurred to you recently and which have been."

- **Assign Session 2 practice assignment 3**

Sample Session 2 Progress Note

Contact: 90-minute psychotherapy session

Content: This was the second session of CPT for ASD. The client did (not) complete the practice related to writing an Impact Statement describing the impact of her 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 her thinking that interfere with recovery. The relationships amongst thoughts, feelings, and behaviors were reviewed, and an example from her discussion about the impact of her trauma on her life was used to illustrate the cognitive model. The client completed her practice assignment related to challenging stuck points daily with aid of the Challenging Questions Worksheet and Patterns of Problematic Thinking (e.g., minimization, exaggeration, all-or-none thinking) were introduced, and examples from the client's thinking about her traumatic event and life in general were used to illustrate these patterns. She agreed to identify examples of each faulty thinking pattern before the next session, as well as Cognitive Belief Worksheets and writing trauma account.

Plan: Continued CPT for ASD

Initial of Client Last Name: _____________ Client ID: ___________________
Therapist Initials: _______________________ Date: ________________________

PCL-S: Session 2

Instructions:

1. Consider the most stressful experience you have experienced
_________________________________.
(event)

2. Here is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and then indicate, using the numbers to the right, how much you have been bothered by that problem in the past **WEEK**.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing memories, thoughts, or images, of the stressful experience?	1	2	3	4	5
2. Repeated, disturbing dreams of the stressful experience?	1	2	3	4	5
3. Suddenly acting or feeling as if the stressful experience was happening again (as if you were reliving it)?	1	2	3	4	5
4. Feeling very upset when something reminded you of the stressful experience?	1	2	3	4	5
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of the stressful experience?	1	2	3	4	5
6. Avoiding thinking about or talking about the stressful experience or avoiding having feelings related to it?	1	2	3	4	5
7. Avoiding activities or situations because they reminded you of the stressful experience?	1	2	3	4	5
8. Trouble remembering important parts of the stressful experience?	1	2	3	4	5
9. Loss of interest in activities that you used to enjoy?	1	2	3	4	5
10. Feeling distant or cut off from other people?	1	2	3	4	5
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your future will somehow be cut short?	1	2	3	4	5
13. Trouble falling or staying asleep?	1	2	3	4	5
14. Feeling irritable or having angry outbursts?	1	2	3	4	5
15. Having difficulty concentrating?	1	2	3	4	5
16. Being "super-alert" or watchful or on guard?	1	2	3	4	5
17. Feeling jumpy or easily startled?	1	2	3	4	5

PCL-S for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD – Behavioral Science Division.

WAI-12 Client Form

Below is a list of statements about your relationship with your therapist. Consider each item carefully and indicate your level of agreement for each of the following items. Please write down the rating scale because it makes it easier to answer items. When you have completed the questions please place your form in the envelope provided and seal.

Does not Correspond at all **Corresponds Moderately** **Corresponds Exactly**

1	2	3	4	5	6	7

1. My therapist and I agree about the things I will need to do in therapy to help improve my situation.

1	2	3	4	5	6	7

2. What I am doing in therapy gives me new ways of looking at my problem.

1	2	3	4	5	6	7

3. I believe my therapist likes me.

1	2	3	4	5	6	7

4. My therapist does not understand what I am trying to accomplish in therapy.

1	2	3	4	5	6	7

5. I am confident in my therapist's ability to help me.

1	2	3	4	5	6	7

6. My therapist and I are working towards mutually agreed upon goals.

1	2	3	4	5	6	7

7. I feel that my therapist appreciates me.

1	2	3	4	5	6	7

8. We agree on what is important for me to work on.

1	2	3	4	5	6	7

9. My therapist and I trust one another.

1	2	3	4	5	6	7

10. My therapist and I have different ideas on what my problems are.

1	2	3	4	5	6	7

11. We have established a good understanding of the kind of changes that would be good for me.

1	2	3	4	5	6	7

12. I believe the way we are working with my problem is correct.

1	2	3	4	5	6	7

WAI-12 Therapist Form

Below is a list of statements about your relationship with your client. Consider each item carefully and indicate your level of agreement for each of the following items.

Does not Correspond at all **Corresponds Moderately** **Corresponds Exactly**

1	2	3	4	5	6	7

1. My client and I agree about the things he/she will need to do in therapy to help improve his/her situation.

1	2	3	4	5	6	7

2. What my client is doing in therapy gives him/her new ways of looking at his/her problem.

1	2	3	4	5	6	7

3. I believe my client likes me.

1	2	3	4	5	6	7

4. My client does not understand what I am trying to accomplish in therapy.

1	2	3	4	5	6	7

5. I am confident in my client's ability to help him/herself.

1	2	3	4	5	6	7

6. My client and I are working towards mutually agreed upon goals.

1	2	3	4	5	6	7

7. I feel that my client appreciates me.

1	2	3	4	5	6	7

8. We agree on what is important for my client to work on.

1	2	3	4	5	6	7

9. My client and I trust one another.

1	2	3	4	5	6	7

10. My client and I have different ideas on what his/her problems are.

1	2	3	4	5	6	7

11. We have established a good understanding of the kind of changes that would be good for him/her.

1	2	3	4	5	6	7

12. I believe the way we are working with my client's problem is correct.

1	2	3	4	5	6	7

Patterns of Problematic Thinking Worksheet

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

1. **Jumping to conclusions** when the evidence is lacking or even contradictory.

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

3. **Disregarding important aspects** of a situation.

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

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

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

7. **Emotional reasoning** (you have a feeling and assume there must be a reason).

Patterns of Problematic Thinking Worksheet

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

1. **Jumping to conclusions** when the evidence is lacking or even contradictory.
   (Sexual assault victim) If a man is alone with a woman, then the man will hurt the woman.
   I can't trust anyone.
   All men are untrustworthy

2. **Exaggerating or minimizing** a situation (blowing things way out of proportion or shrinking their importance inappropriately).
   Since I did not have any serious injuries, my assault is not as serious or bad as others I've heard about

3. **Disregarding important aspects** of a situation.
   Since I did not fight back, it must mean I wanted it.
   (Disregarding the circumstances that prevented fighting back or in which fighting back might have increased the danger…..I keep forgetting the fact that the perpetrator had a knife, which is important information about how much control I had.)

4. **Oversimplifying** things as good/bad or right/wrong.
   It was wrong of me not to report the assault to the police

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

6. **Mind reading** (you assume people are thinking negatively of you when there is no definite evidence for this).
   Since my friends and family have not brought up the assault, they must think it's my fault or blame me in some way.

7. **Emotional reasoning** (you have a feeling and assume there must be a reason).
   Because I feel scared when I am near a man, it must mean that they intend tot rape me

Challenging Questions Worksheet

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?

Challenging Beliefs Worksheet

A. Situation	B. Thought(s)	D. Challenging Thoughts	E. Faulty Patterns	F. Alternative Thought(s)
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 **Patterns of Faulty Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
	C. Emotion(s) Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100%	Evidence For? Evidence Against? Habit or fact? Interpretations not accurate? All or none? Extreme or exaggerated? Out of context? Source unreliable? Low versus high probability? Based on feelings or facts? Irrelevant factors?	Jumping to conclusions: Exaggerating or minimizing: Disregarding important aspects: Oversimplifying: Over-generalizing: Mind reading: Emotional reasoning:	**G. Re-rate Old Thought(s)** Re-rate how much you now believe the thought(s) in Column B from 0-100% **H. Emotion(s)** Now what do you feel? 0-100%

Challenging Beliefs Worksheet

A. Situation	B. Thought(s)	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
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 **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
I cannot go out in my car alone at night.	*Something bad might happen* **C. Emotion(s)** Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100% *Afraid – 100%* *Helpless – 75%* *Anxious – 75%*	Evidence For? *Something did happen – I got raped* Evidence Against? Habit or fact? Interpretations not accurate? All or none? Extreme or exaggerated? Out of context? Source unreliable? Low versus high probability? Based on feelings or facts? *I am letting myself believe this because I feel scared and not because it is realistic.* Irrelevant factors?	Jumping to conclusions: Exaggerating or minimizing: Disregarding important aspects: Oversimplifying: Over-generalizing: Mind reading: Emotional reasoning: *I feel very small… that I will be hurt or killed flying – 95%*	*I could stay home* **G. Re-rate Old Thought(s)** Re-rate how much you now believe the thought(s) in Column B from 0-100% 15%, 10% **H. Emotion(s)** Now what do you feel? 0-100% Afraid – 40% Helpless – 5% Anxious – 10%

Challenging Beliefs Worksheet

A. Situation	B. Thought(s)	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
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 **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
I perceive myself to be damaged in some way	*I should have seen it coming. – 100%* *Something must be wrong with me that he thought he could rape me in the first place - 60%* **C. Emotion(s)** Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100% Sad – 75% *Helpless – 100%* *Anxious – 75%* *Frightened – 50%*	Evidence For? I was raped Evidence Against? *Little factual evidence except the way I feel about myself "allowing" myself to be betrayed and tricked into thinking he would not hurt me.* Habit or fact? *Confusing a habit of thinking about myself as being damaged because of what others have done throughout my lifetime. Reality states it had nothing to do with anything about me that I was* raped. Interpretations not accurate? *Judgment of being damaged is based on feeling, therefore, the source is unreliable.* Based on feelings or facts? Irrelevant factors?	Jumping to conclusions: *Drawing conclusion – Men rape for reasons to do with themselves, not with women.* Exaggerating or minimizing: *Exaggerating an event – it means that her was violent, not that there's something wrong with me.* Disregarding important aspects: Oversimplifying: Over-generalizing: Mind reading: Emotional reasoning:	*I was not raped because there was something wrong with me, but because there was something wrong with him. – 75%* **G. Re-rate Old Thought(s)** Re-rate how much you now believe the thought(s) in Column B from 0-100% 30%, 10% **H. Emotion(s)** Now what do you feel? 0-100% Sad – 25% Helpless – 80% Anxious – 40% *Frightened – 25%*

Challenging Beliefs Worksheet

A. Situation	B. Thought(s)	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
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 **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
If I express anger, I'll be out of control.	*Anger is not right, so it is wrong. – 50%* *Angry people are scary. I don't want to be that way. – 90%* *If I let myself go, I'll be destructive. – 85%* **C. Emotion(s)** Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100% *Angry – 50%* *Fear – 95%*	Evidence For? *Feeling my anger chokes me because I don't let it out.* Evidence Against? *Even Jesus got angry. I have never been really destructive when I was angry.* Habit or fact? Interpretations not accurate? All or none? Extreme or exaggerated? *My phrases and words to describe anger are exaggerated.* Out of context? Source unreliable? Low versus high probability? Based on feelings or facts? Irrelevant factors?	Jumping to conclusions: Exaggerating or minimizing: *Anger is rage instead of what it is—unpleasant.* Disregarding important aspects: Oversimplifying: Over-generalizing: Mind reading: Emotional reasoning: *Because anger feels bad, it is bad/wrong, so I must be, too.*	*Anger is appropriate in some situations. – 100%* *Anger can be expressed without aggression. – 60%* *Anger is an emotion like sadness. I let myself feel that and it is not overwhelming. – 60%* **G. Re-rate Old Thought(s)** Re-rate how much you now believe the thought(s) in Column B from 0-100% *20%, 75%, 50%* **H. Emotion(s)** Now what do you feel? 0-100% *Angry – 50%* *Fear – 70%*

Challenging Beliefs Worksheet

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

Session 3: Meaning of the Event
Problematic Thinking
Safety & Trust Issues

Summary of Session 3: Problematic Thinking & Introducing Safety & Trust Issues

1. Complete Session 3 Practice Assignment Review and set agenda. (5 minutes)

2. Have client read full Trauma Account aloud with affective expression (10 minutes)

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

3. Identify stuck points (10 minutes)

- Use client'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 client had to stop writing and ask about emotions, look for stuck points

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

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

5. Review Challenging Beliefs Worksheet to address 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

6. If necessary, explain difference between responsibility and blame (5 minutes)

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

- Five themes: safety, trust, power/control, esteem, intimacy
- Prior/after: How did trauma affect beliefs about _____ for self? For others?
- If stuck point → worksheet
- Need to recognize how beliefs influence behavior/avoidance
- Help the client 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)
- Go over module

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

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

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

- Rewriting of the full Trauma Account
- Daily reading of the full Trauma Account
- Problem-solving re: practice completion (this is extremely important if practice not completed this session)
- Daily identification of stuck points—one relating to safety and one relating to trust 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.

10. Check-in re: client's reactions to session (5 minutes)

Session 3: Faulty Thinking/Safety & Trust Issues

The goals of Session 3 are:

1. To assist the client in labeling thoughts and emotions in response to events.
2. To have the client read his account, with affective expression.
3. To identify the client's stuck points for the event.
4. To challenge the client's self-blame and guilt with regard to the traumatic event through Socratic questions.
5. To introduce the Safety and Trust issues related to Self and Others
6. To assign the client to write a second detailed account of the traumatic incident with more details and anything that was left out.

- Session 3 goals

Client Reading of Full Trauma Account With Affective Expression

- Client reading of full trauma account

The therapist should begin the session by having the client read the written account. If the client 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 client to describe the event as if she had written it. Be sure to help the client to identify her thoughts and feelings as she recounts the event, but do not have the client write it during session. If the client has brought the written account, having the client, 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 client expresses emotions, the therapist should remain still and not interfere with the expression of affect. Comforting words or even handing the client a tissue can actually interfere with expression of affect because the client is brought back to the present. Clients 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 clients will experience an overwhelming amount of affect. Clients 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 client is expressing, the therapist can begin to do those very things mentioned above—talking to the client, saying the client's name, handing her a tissue, asking questions—to contain the affect.

- Therapist behavior during reading

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

- Therapist guidance during reading

events may not require as many. Others are so long and complex that several writing sessions may be needed to complete the account. Some clients 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 client 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 client should be asked for more detail about that portion of the experience after he has finished reading the whole account.

- Length and content of Trauma Account

If the client reads or recounts the event without any emotion, the therapist should stop the client early in the account and ask him if he is holding back his feelings, and why. The therapist may need to discuss the issue of loss of control and the client'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 client 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 client 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 client 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 client what he was feeling at the time. Again, when a client begins to experience emotions, it is important that the therapist sits quietly and does not disrupt the emotions, minimize them, or interfere in any way.

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

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

Identification of Stuck Points

Finally, the therapist should ask the client about stuck points that may not be in her written account (i.e., what she thought she should have done). Often, clients have regrets afterward because they believe they should have prevented an event, did not fight hard enough, or did or didn't do something that affected others. Sometimes stuck points emerge because other people respond to hearing about the event by 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 client previously believed about how she would act in such a situation. No one knows how she will respond in a particular situation. Sometimes clients jump to the faulty conclusion that if they had acted differently in some way, the event would have turned out

- Stuck points from Trauma Account

differently. Of course, people's fantasies usually result in a good outcome. They don't consider more negative outcomes. In this vein, Socratic questioning about the range of possible outcomes with alternative courses of action is very helpful.

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

Self-blame is often encountered early in therapy as the client recalls the event. This form of assimilation occurs because the client 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 client's control, self-blame and guilt are common. People imagine ways they could have changed personal outcomes; they have regrets about not saving others; they feel guilty about things they did or did not do, and about feelings they did or did not feel during or after the event. This "if only" type thinking serves as assimilation in that it is an attempt to undo the event in retrospect. It usually never occurs to the client 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.

- Self-blame

It is important for the therapist to help the client contextualize the traumatic event. The therapist's job is to guide the client, 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.

- Contextualization of traumatic event

If the client's index event was child physical or sexual abuse, he may be particularly confused by the concept of punishment. He may assume that the event occurred as some form of punishment, an idea that may have been reinforced by the abuser. Later traumas are then also assumed to be some form of punishment. Because the clients 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 client to see that abuse has nothing to do with him as a person, but is only about the abuser and his or her choices.

- Child physical or sexual abuse

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

- Rape

P: *It is my fault that the man raped me. I should have been able to stop it.*

T: *How could you have stopped it?*
P: *I have done self defense classes.*
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, I never expected to be assaulted by my boss.*
T: *So you were surprised by him. Were you confused as to what was going on?*
P: *Yes, very.*
T: *So there was a period of time that you didn't know what was going on and what to do?*
P: *Yes. I just froze for a minute. I said "no" several times but he didn't stop. I remember pushing at him but I remember thinking, "If I fight him, he could kill me."*
T: *Was he bigger than you? Stronger than you?*
P: *Yes. And when he was on top of me, I couldn't move. I couldn't breathe.*
T: *So how could you have stopped it?*
P: *I guess I couldn't have. But, I just keep thinking I should have.*
T: *But that thought doesn't get you anywhere does it? He had surprise on his side, your training didn't include fighting off someone you knew, who was your superior, was bigger, stronger, and had the power to ruin your career. You know, I wonder if you are confusing "I should have" with "I wish I could have."*
P: *I do wish I could have stopped it.*
T: *I wish it hadn't happened either. You didn't deserve to have it happen. And from everything you have told me, I am not hearing any way you could have stopped it. How does it feel to say "I wish I could have stopped it" instead of "I should have stopped it"?*
P: *You know, it does feel different. When I say "I should have," I feel guilty. When I say, "I wish," I just feel a little sad.*

Difference Between Responsibility and Blame

In this stage of CPT focused on addressing assimilation, it is important for the therapist to educate the client about the distinction between blame and responsibility. Responsibility relates to one's actions in a situation that contributes to a certain outcome. A combination of responsibility and intentionality is what determines blame. If there is no intention to do harm, then blame is not appropriate. People are capable of making distinctions in levels of blame and responsibility. An example of that is the distinction that people can make among an accident (no responsibility, no intentionality), negligent manslaughter (responsibility, but no intentionality), and murder (responsibility and intention to kill). The therapist can use Socratic questioning designed to help the client consider the entire context and whenever possible, point out acts of heroism or courage as powerful interventions with clients.

- Responsibility vs. blame

It is possible, however that a client will describe an event in which they did commit what might be considered a sexual assault The original manual (Resick., P.A et al 2007[20])provides comments about perpetration.

Vicarious Traumatization

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, [21]1990a). If a therapist becomes uncomfortable listening to a client'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 client that the therapist can't handle the event either. For example, immediately handing the client a tissue tells the client to pull herself together (and dry up). Shutting the client down is a fatal error on the part of the therapist. In order for the client to be able to accept and integrate the event and tolerate her emotions, the therapist must also be able to do so. Therapists are particularly at risk if they are doing a great deal of trauma work. In these circumstances, the therapist should make sure to get supervision and support in order to continue the work effectively and not suffer unduly. The therapist should also check her own assumptions and thoughts to make sure they are not becoming unbalanced. The principles behind CPT apply to therapists as well as clients.

- Therapist reactions to trauma

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

The session should continue with review of the Patterns of Problematic Thinking. The therapist helps the client to confront the automatic self-statements and replace them with other more adaptive cognitions. The therapist should discuss with the client 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 client 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 client assumes that other people think and feel the same way she does and reacts as if this were the case, resulting in alienation from others. Emotional reasoning about safety and guilt are frequently observed. Because a client feels fear, she then assumes that she is in danger. If a person feels shame or guilt, he may assume that means this is proof he must have done something wrong.

- Reviewing Patterns of Problematic Thinking

Overgeneralizing 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 client 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

- Minimizing over-generalization

[20] Resick, P.. A., Monson, C.M., & Chard, K.M. (2007). *Cognitive processing therapy: veteran/military version.* Washington, DC: Department of Veterans' Affairs.

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

trusted in some way, then the therapist can continue to remind the client that "all" is not accurate. Once the client starts to say, *"Some people cannot be trusted,"* the accompanying emotions are less intense than to say *"all."* (See examples next two pages.)

Introduction to Safety Issues Related to Self and Others

- Introducing safety

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

> *"For the next five sessions we will begin considering specific themes which may be areas of beliefs in your life that were affected by the traumatic event. At each session I will be asking you to consider what your beliefs were prior to the event and to consider how the [index event] has affected them. If we decide together that any of these themes represent stuck points for you, I will be asking you to complete worksheets on them in order for you to begin changing what you are saying to yourself. The five general themes are safety, trust, power and control, esteem, and intimacy. Each of these themes can be considered from two directions, how you view yourself and how you view others.*
>
> *"The first topic we will discuss is safety. If prior to the [event] you thought you were quite safe (that others were not dangerous) and that you could protect yourself, these beliefs are likely to have been disrupted by the event. On the other hand, if you had prior experiences that left you thinking others were dangerous or likely to harm you, or believing that you were unable to protect yourself, then the event would serve to confirm or strengthen those beliefs. When you were growing up did you have any experiences that left you believing you were unsafe or at risk? Were you sheltered? Did you believe you were invulnerable to traumatic events?"*

- Over-generalized fear & safety

After the client 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 client should determine whether she continues to have negative beliefs about the relative safety of others or her ability to protect herself from harm. They should discuss how negative beliefs can elicit anxiety reactions (e.g., *"Something bad will happen to me if I go out alone in my car"*). The client will need to recognize how these beliefs and emotions affect her behavior (avoidance). Overgeneralized fears lead some clients to avoid entire groups of people who were associated with a particular trauma.

The therapist may need to help the client to differentiate prudent safety practices from fear-based avoidance either at the end of this session or during the next session. The client can reduce the probability of being a victim through increased safety practices (e.g., locking doors, but not repeatedly checking them) without feeling fearful and panicky or engaging in excessive avoidance behavior. However, some events are so unpredictable and unavoidable that there is no way to decrease risk (e.g., the World Trade Center attack). Generalized fear is not

going to prevent traumatic events and will only serve to prevent recovery. Along these lines, some clients have focused so much attention on some factor associated with the trauma that they focus all their safety planning on that factor to the exclusion of other higher-risk sources of danger. For example, one client was attacked in her own home. For years afterward she spent a great deal of time and money on alarm systems and safety measures in her home. On the other hand, she was going out to bars and getting drunk with friends on a regular basis. She was even the victim of a "date-rape drug" slipped into one of her drinks. Still, she focused only on the likelihood of being attacked in her home while ignoring higher risks elsewhere.

- Removing generalized fear

The therapist should help the client 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 clients believe that if the event happens once, it will happen again. The therapist may need to give the client some probability statistics and remind him that this event was not a daily, weekly, or even yearly event for him. It is, in fact, a low-probability event. Although the therapist cannot promise that it will not occur again, she can help the client to see that he doesn't have to behave as if it were a high-frequency event. The therapist can also point out that the client is jumping to conclusions without supporting evidence.

- **Give client Safety Module**

The client should be given the Safety Module to remind her of these issues. The modules on safety and other issues are based on the work of McCann & Pearlman[22] (1990a). If self-safety or other-safety issues are evident in the client's statements or behavior, she should complete at least one worksheet on safety before the next session. Otherwise, the client should be encouraged to complete worksheets on other identified stuck points and recent trauma-related events that have been distressing.

Introduction to Trust Issues Related to Self and Others

- Introducing Trust

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

> *"Self-trust is concerned with the belief that one can trust or rely upon one's own perceptions or judgments. After traumatic events, many people begin to second-guess themselves and to question their own judgment about being in the situation that led to the event, their behaviors during the event, or about their ability to judge character if, in the case of an assault, the perpetrator was an acquaintance. Trust in others is also frequently disrupted following traumatic events. Aside from the obvious sense of betrayal that occurs when a trauma is caused intentionally by someone the client thought he or she could trust, sometimes clients feel betrayed by the people they turned to for help or support during or after the event. For example,*

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

if a client thought that someone let him down during battle, he might decide right then and there not to trust anybody. Sometimes clients 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 clients' emotions and they withdraw or try to minimize the event or the impact. Such a withdrawal may be viewed as a rejection by clients, and they come to believe that the other person cannot be trusted to be supportive. Sometimes when more than one member of a family is affected by a traumatic event, such as the traumatic death of a loved one, family members are out of sync with each other. One person wants to talk and needs comfort just as another closes off because she has had all of the emotions that she could handle for a while. Without clear communication, the cycling of grief and withdrawal can be misunderstood as lack of support and can result in problematic interpretations of the situation.

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

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

- **Give client Trust Module**

Practice Assignment 1

For the practice assignment, the therapist asks the client to write the whole account again at least one more time. If the client 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 client should be encouraged to add more sensory details and more of his thoughts and feelings during the incident. The therapist should add that this time, the client is also requested to write his current thoughts and feelings, what he is thinking and feeling as he is writing the account, in parentheses (e.g., *"I'm feeling very angry"*). Also, the trauma may encompass much more than the narrow circumstance of the event. Police or military procedures, medical treatment, funerals, or rejection from loved ones may compound the trauma and should be considered part of the event, for all practical purposes. Memories of these events and concomitant stuck points should be included in the writing assignments and discussions. If the client is experiencing different thoughts and feelings from those in the first account, then he can write his current thoughts or feelings in the margins or in parentheses, e.g., "*At that moment I was absolutely terrified (now I am feeling angry)."*

- Assign Session 3 practice assignment 1

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

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

- Second Trauma Account

Practice Assignment 2

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

- **Assign Session 3 practice assignment 2**

Practice Assignment 3

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

- **Assign Session 3 practice assignment 3**

Sample Session 3 Progress Note

Contact: 90-minute psychotherapy session

Content: This was the third session of CPT for PTSD. The client completed her 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. Stuck points related to Safety and Trust were introduced and were specifically targeted. The client also agreed to complete a Challenging Beliefs Worksheet each day about stuck points before the next session. The session concluded with the assignment to write again about the trauma and to include as many sensory and emotional details, and to re-read daily as possible.

Plan: Continued CPT

Patterns of Problematic Thinking Worksheet

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

1. **Jumping to conclusions** when the evidence is lacking or even contradictory.

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

3. **Disregarding important aspects** of a situation.

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

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

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

7. **Emotional reasoning** (you have a feeling and assume there must be a reason).

Challenging Questions Worksheet

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?

Challenging Beliefs Worksheet

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

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

Rate belief in alternative thought(s) from 0-100%</td></tr>
<tr><td rowspan="3"></td><td></td><td rowspan="3">Evidence For?

Evidence Against?

Habit or fact?

Interpretations not accurate?

All or none?

Extreme or exaggerated?

Out of context?

Source unreliable?

Low versus high probability?

Based on feelings or facts?

Irrelevant factors?</td><td rowspan="3">Jumping to conclusions:

Exaggerating or minimizing:

Disregarding important aspects:

Oversimplifying:

Over-generalizing:

Mind reading:

Emotional reasoning:</td><td></td></tr>
<tr><td>C. Emotion(s)</td><td>G. Re-rate Old Thought(s)
Re-rate how much you now believe the thought(s) in Column B from 0-100%</td></tr>
<tr><td>Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100%</td><td>H. Emotion(s)
Now what do you feel? 0-100%</td></tr>
</table>

Challenging Beliefs Worksheet – Safety Example

A. Situation	B. Thought(s)	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
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 **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
Getting ready for bed	*I'm afraid someone is going to break in. I am not safe* *85%* **C. Emotion(s)** Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100% *Frightened – 85%*	Evidence For? *It's not that hard to break in. I live alone and might be considered an "easy target"* Evidence Against? *I live in a fairly safe neighborhood. I have locks on all my doors* Habit or fact? *I've never had a break in before* Interpretations not accurate? All or none? Extreme or exaggerated? Out of context? Source unreliable? Low versus high probability? Based on feelings or facts? Irrelevant factors?	Jumping to conclusions: *The fact that someone could break in doesn't mean they will* Exaggerating or minimizing: *I minimize the fact that I have improved the safety of my home by adding locks, lights etc.* Disregarding important aspects: Oversimplifying: Over-generalizing: *The fact that I was raped at home doesn't mean that my home is inherently unsafe* Mind reading: Emotional reasoning:	*No place is completely safe. Someone could break in but it is very unlikely and I have taken many precautions to prevent it.* **G. Re-rate Old Thought(s)** Re-rate how much you now believe the thought(s) in Column B from 0-100% *40%* **H. Emotion(s)** Now what do you feel? 0-100% *Anxiety – 40%*

Challenging Beliefs Worksheet – Trust Example

A. Situation	B. Thought(s)	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
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 **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
A friend invites me to a arty but I turn down the invitation because I'm afraid to get to know new people	*If you let down your guard to trust others, they will hurt you. People act nice so that they cane catch you with your guard down.* **C. Emotion(s)** Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100% *Anxious – 98%* *Angry – 85%*	Evidence For? *I was raped because I chose to trust someone who couldn't be trusted* Evidence Against? *I have shown good judgment about people and made good decisions about who is trustworthy in the past. Having trusted one untrustworthy person doesn't mean my judgment is all bad.* Habit or fact? Interpretations not accurate? All or none? Extreme or exaggerated? Out of context? Source unreliable? Low versus high probability? Based on feelings or facts? Irrelevant factors?	Jumping to conclusions: Exaggerating or minimizing: *Talking to a stranger at a party does not mean I have to trust them with everything* Disregarding important aspects: Oversimplifying: Over-generalizing: *Because I was raped once by someone I trusted does not mean I'll be raped again.* Mind reading: Emotional reasoning:	*My trusting did not cause the rape, the rapist did. Just because I don't yet know if someone is trustworthy doesn't mean getting to know then is unsafe. I can take my time and make decisions about them slowly, I don't have to trust them completely.* **G. Re-rate Old Thought(s)** Re-rate how much you now believe the thought(s) in Column B from 0-100% 30% **H. Emotion(s)** Now what do you feel? 0-100% *Anxious – 40%* *Angry (at me) – 25%*

Safety Issues Module

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

Prior Experience

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

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

Resolution

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

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

Prior Experience

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

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

Resolution

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

Trust Issues Module

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

Prior Experience

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

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

Resolution

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

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

Prior Experience

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

Posttraumatic Event Experience

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

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

Resolution

If you previously believed that…	Possible self-statements may be…
If you grew up believing that "no one can be trusted," which was confirmed by the traumatic event, you need to adopt new beliefs that will allow you to enter into new relationships with others instead of withdrawing because you believe others to be untrustworthy.	"Although I may find some people to be untrustworthy, I cannot assume that everyon that way." "Trust is not an all-or-none conce Some may be more trustworthy than others." "Trusting another involves some risk, but I c protect myself by developing trust slowly an including what I learn about that person as I to know him or her."

"Everyone can be trusted," the traumatic event will shatter this belief. In order to avoid becoming suspicious of the trustworthiness of others, including those you used to trust, you will need to understand trust is not either/or.	"I may not be able to trust everyone, but that doesn't mean I have to stop trusting the people I used to trust."
If your beliefs about the trustworthiness of your support system were shattered, it will be necessary to address general issues before you assume that you can no longer trust the support system. Of central importance is to consider their reaction and the reasons why they may have reacted in an unsupportive fashion. Many people simply do not know how to respond and may be reacting out of ignorance. Some respond out of fear or denial because what has happened to you makes them feel vulnerable and may shatter their own beliefs. Practicing how to ask for what you need from them may be a step in assessing their trustworthiness.	
If your attempts to discuss the traumatic event with them leaves you feeling unsupported, you may use self-statements such as "There may be some people I cannot trust talking with about the traumatic event, but they can be trusted to support me in other areas." If that person continues to blame you and make negative judgments about you, you may decide that this person is no longer trustworthy. It's unfortunate, but sometimes you find out that some people you thought of as friends do not turn out to be true friends after a trauma. However, you may also be pleasantly surprised to find that some people have better reactions than you expected.	

Session 4: Review Safety & Trust issues
Introduce Power/Control & Esteem Issues

Summary of Session 4: Review Safety & Trust issues Introduce Power/Control & Esteem Issues

Administer PCL and WAI (in waiting room if possible), collect, and store.

1. Complete Session 4 Practice Assignment Review and set agenda. (5 minutes)

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

3. Engage client in challenging assumptions and conclusions that the client had made after processing affect, with particular focus on self-blame if still necessary (10 minutes)
- Help client reduce use of word **blame**, which implies intentionality

4. Review Challenging Beliefs Worksheet to address stuck points related to safety (15 minutes)
- Review Safety Module; focus on patient's self- or other- safety issues
- Probability: Low vs. high = reality vs. fear
- Calculate %'s

5. Discuss judgment issues that may arise from stuck points related to trust (15 minutes)
- Trust falls on a continuum, not "all or none"
- Different kinds of trust: with money vs. with a secret
- "Star" diagram
- Discuss client's social support systems (family and friends): may be protecting themselves from emotions/helplessness/vulnerability, inadequacy/ignorance—not rejection

5. Introduce third of five problem areas: Power/control issues related to <u>self</u> and <u>others</u> (10 minutes)
- Self-power (self-efficacy)
- People naturally expect they can solve problems and meet new challenges
- Traumatized people often try to control everything–to stay safe
- Lack of TOTAL CONTROL may feel like NO CONTROL
- Power over others:
  - Need to control may spill into relationships, ruining old ones and preventing new ones

6. Introduce fourth of five problem areas: Esteem issues related to <u>self</u> and <u>others</u> (10 minutes)

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

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

- Identify stuck points, one relating to Power/Control (and Safety or Trust as needed), and confront them using the Challenging Beliefs Worksheet.
- Identify stuck points daily, one relating to Esteem issues, and confront them using the Challenging Beliefs Worksheet
- Practice giving and receiving compliments daily
- Do at least one nice thing for self each day
- Continue to work on Trauma Account(s) if not finished, and read over daily

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

Session 4: Review Safety & Trust issues Introduce Power/Control & Esteem Issues

The goals of Session 4 are:

- Session 4 goals

1. To have the client read and discuss the second version of the Trauma Account.
2. To discuss the new additions (or deletions).
3. To check the progress of affective expression and self-blame/guilt and other forms of assimilation.
4. To continue cognitive therapy on stuck points for the event.
5. To review the Challenging Beliefs Worksheets related to Safety/Trust stuck points.
6. To introduce Power/Control and Esteem issues related to Self and Others.
7. To assign the client to practice giving and receiving compliments.
8. To assign the client to do at least one nice thing for herself every day (pleasant events scheduling).

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

- Reading of the second Trauma Account

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

Challenging Assumptions and Conclusions With a Focus on Self-Blame

- Examining various forms of assimilation

The therapist should continue to use Socratic questions, particularly the questions listed on the Challenging Questions Worksheet in order to continue to help the client to examine assimilation, self-blame, and other forms of hindsight bias. By including questions that the client will be introduced to, he will begin to become acquainted with the concepts. Hopefully, by the time the client has completed two accounts and has put the event back into context, much of the self-blame will have diminished. As with Session 3, it is important for the therapist to keep in mind that often the self-blame and assimilation occur because the client is not remembering how he was thinking, feeling, or coping during the event. The client 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 client back in the full context of the situation, the client can then see

that the event (or his component of the event) was not preventable and hence, he is not to blame.

The therapist can help the client reduce her use of the words "blame" or "fault" by catching it whenever the client uses the words. Once the therapist and client have established that the client 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 3, "blame" implies intentionality. If the client agrees that she did not intend the outcome, then the words blame or fault are not appropriate or accurate.

Review of the Challenging Beliefs Worksheet to Address Safety Stuck Points

- Review Challenging Beliefs Worksheets

The therapist should begin the session by going over the worksheets and discussing the client's success or problems in changing cognitions (and subsequent emotions). The therapist and client should use the Challenging Questions to help the client confront problematic cognitions that he was unable to modify himself. As an example, one client was in an elevator that fell 20 floors and then stopped just as it reached the bottom. Aside from having nightmares and flashbacks, he found himself unable to get back into an elevator again. His thought was *"Elevators are unsafe"* and *"The next time I am going to die."* On the worksheet, the client 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.

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

- Probability estimates

Unfortunately, the above example is sometimes typical of the forms filled out for the first time by clients. The clients are sometimes so entrenched in their beliefs that they can't look at them any other way. For this client (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 client 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 client how often he rode in elevators before. The client informed the therapist that his apartment and work place both had elevators, and he estimated that he had ridden in elevators six to eight times a day for the past 20 years. The therapist asked him if he had been in an elevator crash before and when the client 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 client probably had a greater chance of being in a car accident, yet he didn't avoid driving and was not in perpetual fear of an accident. The client agreed with the statements and began to rethink his beliefs. The client and therapist completed the worksheet a second time. Under the column "Challenging Questions" they noted *"Confusing a low probability for a high probability event."* Under the "Patterns of Problematic Thinking" column they circled *"Jumping to conclusions, either/or thinking, and emotional reasoning."* He then re-rated his fear as 40%. The next week he reported that he had gone on an elevator for a few floors and was not as frightened. The idea that the next time would result in death was also challenged successfully. Once a client has a worksheet that successfully challenges a stuck point, the client should be encouraged to re-read the worksheet regularly so that the reasoning becomes comfortable.

- Example of a rape victim

Another client, a woman who has been raped by a stranger, who struggled with her first Challenging Beliefs Worksheet, believed that she could not go out in her car alone at night. She could not see the difference between the ideas *"something bad could happen"* and *"something will happen."* Her high level of fear led her to emotional reasoning and to the assumption that she was in danger. The therapist asked him how many times she had been raped or vicitimised in other ways, and she said she had been robbed once 10 years earlier. Then the therapist asked him how many times she used to go out and was told that she went out approximately twice a week. When the therapist asked her how she concluded she was in danger, her response was *"but it could happen again."* The therapist agreed with that statement but not the assumption that it *will* happen and had her notice how she felt when she said it *could* happen versus that it *will* happen. The client was able to acknowledge that the two statements felt somewhat different and that *could* was different from *will* in terms of probability (100% for the latter and something less for the former). The therapist assigned her to work on this with more Challenging Beliefs Worksheets.

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

As with the other sessions, the therapist should begin by going over the practice assignments and discussing the client's success or difficulties in changing cognitions. Although trust is often an issue for clients with ASD/PTSD generally, it is particularly an issue for those who were victimized by acquaintances (for example, in sexual trauma situations). They often think that they should have been able to tell that this person might harm them and, as a result, they begin to question their judgment in whom they can or cannot trust. Looking back at the event, many people look for clues and indicators

that may have indicated that this event was going to happen. They judge themselves as having failed at preventing what they determined to be a preventable event (or at least the outcome was preventable for them, as in the case of a disaster).

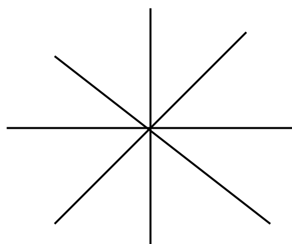
Discussion of Judgment Issues Arising From Stuck Points Related to Trust

- Explaining trust

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

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

T: *Along with different levels of trust, there are also different kinds of trust. Have you ever met anyone that you would trust to $20 but wouldn't want to trust with a secret?*
P: *Yes.*
T: *I can imagine someone that I would trust with my life, but I wouldn't expect him to remember to return $20.*
P: *I know someone like that.*
T: *I know someone else that I would not trust with my opinion about the weather. He'd figure out some way to insult me. However, it takes time to determine in which ways you can and cannot trust someone.*
P: *That's why I think it is safer just to distrust everyone to begin with.*
T: *The problem with that is that people are always trying to dig out of a deep hole with you then. When is it enough? And weren't you saying that you were feeling very alone and wish you had more friends?*
P: *Yeah, but if I started out by trusting everyone, then I might get hurt.*
T: *True. I agree that starting out by assuming that everyone is trustworthy would be risky. How about starting out somewhere other than the two extremes?*
P: *What do you mean?*
T: *Well, what if we called the middle point between total trust and total distrust "0", meaning no information? And rather than a single line with a middle point like a seesaw, we could think of it as having lines coming out in many directions.* (Therapist draws lines on paper for the client 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 client—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 client interprets their reactions as rejection. Sometimes the client cannot even recognize that family members are also hurting and upset because of what happened to him. It is not unusual for a client to say, *"But why would they be upset? It happened to me."* The therapist can discuss with the client 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"*).

- Trust & others' reactions

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

- Self-trust

Introduction to Power/Control Issues Related to Self and Others

The theme of power and control is introduced next as the topic. The client is given the Power/Control Module to read and work with. 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

- **Give client Power/ Control Handout**

everything or they will be completely out of control. Again, there is a tendency to engage in either/or thinking. Conversely, if someone overgeneralizes 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 clients with ASD/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 client should continue using worksheets to analyze and confront these beliefs.

Introduction to Esteem Issues Related to Self and Others

- Introducing Esteem

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

- **Give client Esteem handout**

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

Practice Assignment 1

- **Assign Session 4 practice assignment 1**

> *"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."*

Practice Assignment 2

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

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

- **Assign Session 4 practice assignment 2**

Practice Assignment 3

"Keep reading your trauma account everyday for homework"

- **Assign Session 4 practice assignment 3**

Sample Session 4 Progress Note

Contact: 90-minute psychotherapy session

Content: This was the fourth session of CPT for PTSD. The client completed her practice assignment related to rewriting her traumatic event, including further elaboration and inclusion of her current thoughts and feelings. He was able to experience the associated emotions, and her distress related to them was decreased compared to the last session. Cognitions about safety and trust were specifically targeted for cognitive restructuring. The client agreed to identify one Power-/control- and Esteem related stuck point each day to challenge with the aid of the Challenging Beliefs Worksheet. The client also agreed to complete a Challenging Beliefs Worksheet about stuck points and give or receive a compliment each day before the next session. She also agreed to do one nice thing for himself daily and re-read trauma account.

Plan: Continued CPT

Initial of Client Last Name: _____________ Client ID: ___________________
Therapist Initials: ______________________ Date: ____________

PCL-S: Session 4

Instructions:

1. Consider the most stressful experience you have experienced
_________________________________.
(event)

2. Here is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and then indicate, using the numbers to the right, how much you have been bothered by that problem in the past **WEEK.**

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing memories, thoughts, or images, of the stressful experience?	1	2	3	4	5
2. Repeated, disturbing dreams of the stressful experience?	1	2	3	4	5
3. Suddenly acting or feeling as if the stressful experience was happening again (as if you were reliving it)?	1	2	3	4	5
4. Feeling very upset when something reminded you of the stressful experience?	1	2	3	4	5
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of the stressful experience?	1	2	3	4	5
6. Avoiding thinking about or talking about the stressful experience or avoiding having feelings related to it?	1	2	3	4	5
7. Avoiding activities or situations because they reminded you of the stressful experience?	1	2	3	4	5
8. Trouble remembering important parts of the stressful experience?	1	2	3	4	5
9. Loss of interest in activities that you used to enjoy?	1	2	3	4	5
10. Feeling distant or cut off from other people?	1	2	3	4	5
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your future will somehow be cut short?	1	2	3	4	5
13. Trouble falling or staying asleep?	1	2	3	4	5
14. Feeling irritable or having angry outbursts?	1	2	3	4	5
15. Having difficulty concentrating?	1	2	3	4	5
16. Being "super-alert" or watchful or on guard?	1	2	3	4	5
17. Feeling jumpy or easily startled?	1	2	3	4	5

PCL-S for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD – Behavioral Science Division.

Initial of Client Last Name: _____________ Client ID: ___________________

Therapist Initials: ______________________ Date: ____________

WAI-12 Client Form

Below is a list of statements about your relationship with your therapist. Consider each item carefully and indicate your level of agreement for each of the following items. Please write down the rating scale because it makes it easier to answer items. When you have completed the questions please place your form in the envelope provided and seal.

Does not Correspond at all			Corresponds Moderately		Corresponds Exactly	
1	2	3	4	5	6	7

1. My therapist and I agree about the things I will need to do in therapy to help improve my situation.

1	2	3	4	5	6	7

2. What I am doing in therapy gives me new ways of looking at my problem.

1	2	3	4	5	6	7

3. I believe my therapist likes me.

1	2	3	4	5	6	7

4. My therapist does not understand what I am trying to accomplish in therapy.

1	2	3	4	5	6	7

5. I am confident in my therapist's ability to help me.

1	2	3	4	5	6	7

6. My therapist and I are working towards mutually agreed upon goals.

1	2	3	4	5	6	7

7. I feel that my therapist appreciates me.

1	2	3	4	5	6	7

8. We agree on what is important for me to work on.

1	2	3	4	5	6	7

9. My therapist and I trust one another.

1	2	3	4	5	6	7

10. My therapist and I have different ideas on what my problems are.

1	2	3	4	5	6	7

11. We have established a good understanding of the kind of changes that would be good for me.

1	2	3	4	5	6	7

12. I believe the way we are working with my problem is correct.

1	2	3	4	5	6	7

Initial of Client Last Name: _____________ Client ID: ___________________
Therapist Initials: ______________________ Date: ____________

WAI-12 Therapist Form

Below is a list of statements about your relationship with your client. Consider each item carefully and indicate your level of agreement for each of the following items.

Does not Correspond at all **Corresponds Moderately** **Corresponds Exactly**

1	2	3	4	5	6	7

1. My client and I agree about the things he/she will need to do in therapy to help improve his/her situation.

1	2	3	4	5	6	7

2. What my client is doing in therapy gives him/her new ways of looking at his/her problem.

1	2	3	4	5	6	7

3. I believe my client likes me.

1	2	3	4	5	6	7

4. My client does not understand what I am trying to accomplish in therapy.

1	2	3	4	5	6	7

5. I am confident in my client's ability to help him/herself.

1	2	3	4	5	6	7

6. My client and I are working towards mutually agreed upon goals.

1	2	3	4	5	6	7

7. I feel that my client appreciates me.

1	2	3	4	5	6	7

8. We agree on what is important for my client to work on.

1	2	3	4	5	6	7

9. My client and I trust one another.

1	2	3	4	5	6	7

10. My client and I have different ideas on what his/her problems are.

1	2	3	4	5	6	7

11. We have established a good understanding of the kind of changes that would be good for him/her.

1	2	3	4	5	6	7

12. I believe the way we are working with my client's problem is correct.

1	2	3	4	5	6	7

Challenging Beliefs Worksheet

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

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

Rate belief in alternative thought(s) from 0-100%</td></tr>
<tr><td rowspan="3"></td><td></td><td rowspan="3">Evidence For?

Evidence Against?

Habit or fact?

Interpretations not accurate?

All or none?

Extreme or exaggerated?

Out of context?

Source unreliable?

Low versus high probability?

Based on feelings or facts?

Irrelevant factors?</td><td rowspan="3">Jumping to conclusions:

Exaggerating or minimizing:

Disregarding important aspects:

Oversimplifying:

Over-generalizing:

Mind reading:

Emotional reasoning:</td><td></td></tr>
<tr><td>C. Emotion(s)</td><td>G. Re-rate Old Thought(s)
Re-rate how much you now believe the thought(s) in Column B from 0-100%</td></tr>
<tr><td>Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100%</td><td>H. Emotion(s)
Now what do you feel? 0-100%</td></tr>
</table>

Challenging Beliefs Worksheet- Power/Control Example

A. Situation

Describe the event, thought or belief leading to the unpleasant emotion(s).

I sometime lash out at others since the rape.

B. Thought(s)

Write thought(s) related to Column A.

Rate belief in each thought below from 0-100%
(How much do you believe this thought?)

I'm out of control. If other people see me lose my temper they will think I'm crazy. I should be able to control my emotions.

C. Emotion(s)

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

D. Challenging Thoughts

Use **Challenging Questions** to examine your automatic thoughts from Column B.

Is the thought balanced and factual or extreme?

Evidence For?
All my life I was told that strong people don't lose control of their emotions. My parents never lost control.

Evidence Against?

Habit or fact?

Interpretations not accurate?

All or none?
Most people would not react the way my parents did, they would understand that I was upset.

Extreme or exaggerated?
"crazy", certainties not probabilities

Out of context?

Source unreliable?

Low versus high probability?

Based on feelings or facts?
I've lost my temper before and no-one has ever called me crazy

Irrelevant factors?

E. Problematic Patterns

Use the **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.

Jumping to conclusions:
Drawing conclusions about what others will think when I really don't know.

Exaggerating or minimizing:
Few people think someone is crazy just because they lose their temper

Disregarding important aspects:
My family wasn't healthy and just because they believed something doesn't make it true. It's not bad or wrong to show your emotions

Oversimplifying:

Over-generalizing:

Mind reading:

Emotional reasoning:

F. Alternative Thought(s)

What else can I say instead of Column B? How else can I interpret the event instead of Column B?

Rate belief in alternative thought(s) from 0-100%

I'm human and humans sometimes lose control of their emotions. There are certain situations where I'd prefer not to lose my temper, but it still wouldn't mean I'm crazy if I did.

65%

G. Re-rate Old Thought(s)

Re-rate how much you now believe the thought(s) in Column B from 0-100%

40%

H. Emotion(s)

Now what do you feel? 0-100%

Frightened – 45%
Guilty – 30%

Challenging Beliefs Worksheet – Esteem Example

A. Situation	B. Thought(s)	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
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 **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
I was raped	*Something must be wrong with me that the rapist through I would be a good target.* *70%* **C. Emotion(s)** Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100% *Sad – 75%* *Frightened – 50%*	Evidence For? *Little factual evidence except the way I feel about 'allowing" myself to be betrayed and tricked into thinking I was safe* Evidence Against? Habit or fact? *Confusing a habit of thinking about myself as a victim because of things other people have done to me throughout my lifetime. The reality is that it had nothing to do with anything about me that I was raped.* Interpretations not accurate? All or none? Extreme or exaggerated? Out of context? Source unreliable? Low versus high probability? Based on feelings or facts? Irrelevant factors?	Jumping to conclusions: *Drawing conclusions that people rape for their own reasons, it has nothing to do with the people they victimize.* Exaggerating or minimizing: *Exaggerating an event it means that the perpetrator was a violent person, not that there's something wrong with me.* Disregarding important aspects: Oversimplifying: Over-generalizing: Mind reading: Emotional reasoning:	*I was not raped because there was something wrong with me of the choices I make, but because there was something wrong with the rapist.* *75%* **G. Re-rate Old Thought(s)** Re-rate how much you now believe the thought(s) in Column B from 0-100% *30%* **H. Emotion(s)** Now what do you feel? 0-100% *Sad – 25%* *Frightened – 25%*

Power/Control Issues Module

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

Prior Experience

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

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

Resolution

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

Helplessness or powerlessness—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 events.	"I cannot control all events outside of myself, but I do have some control over what happens to me and my reactions to events."

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

Prior Experience

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

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

Resolution

If you previously believed that…	Possible self-statements may be…
Powerlessness—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.	"Even though I cannot always get everyth want in a relationship, I do have the abilit influence others by standing up for my rig 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).	"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."

Ways of Giving and Taking Power

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

Esteem Issues Module

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

Prior Experience

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

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

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

Resolution

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

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

Prior Experience

Negative	Positive
If you had many bad experiences with people in the past or had difficulty taking in	If your prior experiences with people had been positive, and if negative events in the world

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.	did not seem to apply to your life, the event was probably a belief-shattering event. Prior beliefs in the basic goodness of other people may be particularly disrupted if people, who were assumed to be supportive, were not there for you after the event.

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

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

Resolution

	Possible self-statements may be…
It will be important for you to reconsider the automatic assumption that people are no good, and consider how that belief has affected your behavior and social life in general.	
When you first meet someone, it is important that you do not form snap judgments because these tend to be based on stereotypes, which are not generally true for the majority of people	

you will meet. It is all right to adopt a "wait and see" attitude, which allows you flexibility in developing your perceptions about the other person and does not penalize the person whom you are trying to get to know.	
If, over time, this person makes you uncomfortable, or does things that you do not approve of, you are free to stop trying to develop the relationship and end it. Be aware, however, that all people make mistakes, and consider your ground rules for friendships or intimate relationships. If you confront the person with something that makes you uncomfortable, you can use that person's reaction to your request in making a decision about what you want from that person in the future (i.e., if the person is apologetic and makes a genuine effort to avoid making the same mistake, then you might want to continue getting to know this person. If the person is insensitive to your request or belittles you in some other way, then you may want to get out of this relationship.) The important point is, like trust, you need time to get to know people and form an opinion of them. It is important that you adopt a view of others that is balanced and allows for changes.	"Although there are people I do not respect and do not wish to know, I cannot assume this about everyone I meet. I may come to this conclusion later, but it will be after I have learned more about this person."
If those you expected support from let you down, don't drop these people altogether at first. Talk to them about how you feel and what you want from them. Use their reactions to your request as a way of evaluating where you want these relationships to go.	"People sometimes make mistakes. I will try to find out whether they understand it was a mistake or whether it reflects a negative characteristic of that person, which may end the relationship for me if it is something I cannot accept."

Session 5 Review Power/Control & Esteem Issues
Introducing Intimacy Issues

Summary of Session 5: Review Power/Control & Esteem Issues Introducing Intimacy Issues

1. **Complete Session 5 Practice Assignment Review and set agenda.** (5 minutes)

2. **Discuss connection between power/control and self-blame, and help challenge related problematic cognitions using the Challenging Beliefs Worksheet** (15 minutes)
   - Help client gain a *balanced* view of power/control
     - No such thing as total control, but not completely helpless either
   - Address anger issues:
     - Over-arousal, lack of sleep, increased startled reactions
     - "Stuffed" when unable to express at time of event
     - Anger vs. aggression (not the same thing)—can come out on family
     - Anger at self for "should have dones"
     - Innocence/responsibility/intentionality
     - Is described by others as a "control freak"

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

4. **Discuss client's reactions to giving and receiving compliments and engaging in a pleasant activity** (5 minutes)
   - Reinforce—How did it go?
   - <u>Compliments/Pleasant Activities</u>
     - What happened?
     - Able to hear for self?
     - Recipients pleased?
     - Continue to talk?
     - Like it?
     - Feel you deserved it?
     - Feel guilty?
     - Encourage *more* and enjoy!

5. **Help client identify esteem issues and assumptions, and challenge them using Challenging Beliefs Worksheet** (20 minutes)
   - Does client believe she is *permanently* damaged as a result of the trauma?
   - Perfectionist? Does client believe she made a mistake?
   - Esteem for others—overgeneralize disregard to whole groups?

4. **Introduce fifth of five problem areas: Intimacy issues related to self and others** (10 minutes)
   - How have relationships been affected by the trauma?
   - Self-intimacy—ability to calm and soothe oneself?
   - How were these both *before* and *after*?
   - Any problems: e.g., food? alcohol? spending?

5. **Assign practice and problem solve re: completion** (5 minutes)
   - Client should identify stuck points, one of which relates to Intimacy issues, and confront them using the Challenging Beliefs Worksheet
   - Write Impact Statement (discuss the purpose of this)
   - Continue to give and receive compliments
   - Continue to do at least one nice thing for self each day
   - Have the client continue reading Trauma Accounts if she still has strong emotions about them.

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

Session 5: Review Power/Control Issues Introducing Intimacy Issues

The goals of Session 5 are:

- Session 5 goals

1. To review the client's Challenging Beliefs Worksheets on Power/Control and Esteem issues.
2. To review the compliments and nice things that the client has done for himself.
3. To introduce the concepts of self- and other-Intimacy issues.
4. To assign Challenging Beliefs Worksheets on intimacy.
5. To assign a new Impact Statement.
6. To continue the assignment to practice giving and receiving compliments.
7. To continue the assignment to do at least one nice thing for herself every day (pleasant events scheduling).

Connection Between Power/Control and Self-Blame

- Helping the client gain a balanced view

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

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

- Addressing control issues

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

- Addressing anger issues

The topic of anger frequently emerges in treatment. Some anger is related to the hyperarousal symptoms of ASD/PTSD such as irritability from physiological arousal, lack of sleep, and frequent startle reactions. It is important to also remember that while fear is associated with the fight-flight response, so is anger. Environmental cues may trigger anger associated with the fight response that did not stop when the imminent danger stopped.

- Anger vs. aggression

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

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

One client 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 client that most people have difficulties following severe traumas and that some events in life are too big to be handled all alone.

Ways of Giving and Taking Power

Go over the Ways of Giving and Taking Power Handout (given in previous section).

- Ways of giving and taking power

> *"There are many ways people give and take their power. You can do this appropriately or inappropriately and this sheet gives us some examples. For example, if you tell your partner you will not have sex unless he/she does XYZ, you are taking power in a negative way. Or, if you base your actions or behaviors solely on the reactions you expect from others, you are giving your power away. If, on the other hand, you do something (or do not do something) because you want to and it makes you feel good, you are taking your power appropriately.*

"Can you give me an example of things that you do that fit in each of the categories below? Are these behaviors that you would like to change? What stuck points keep your from making the changes you would like to make?"

Giving and Receiving Compliments

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

- Giving and receiving compliments

Identifying Esteem Issues and Assumptions

The client and therapist then discuss the Challenging Beliefs Worksheets on esteem. A very common stuck point on the topic of self-esteem is that the client is now damaged in some way because of the event. Because he has been suffering from flashbacks, nightmares, startle reactions, etc., the client may have concluded that he is crazy or is permanently damaged. Perceiving oneself as damaged, believing that one has poor judgment, or believing that others blame him for things he did or did not do about the event all eat away at

- Identifying self-esteem issues & assumptions

one's global perception of self-esteem. In the case of interpersonal crimes (such as sexual trauma) the victim may also conclude that there must have been something wrong with him to begin with to have been targeted. If the client makes global negative comments about himself, the therapist can begin by pinning down what the client is being self-critical about. Like trust, esteem is a global construct that is multidimensional.

- Addressing perfectionism

It is sometimes helpful to address issues about perfectionism here. Clients often have poor opinions of themselves because they so harshly judge themselves whenever they make a mistake. This overgeneralization follows logically from the client's belief that she made mistakes before, during, or after the traumatic event. It may be helpful for the therapist to remind the client about the basic unfairness she is practicing with 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 clients to overgeneralize their disregard for the perpetrator of a traumatic event to an entire group (e.g., all men, Asians or Iraqis). In these cases when the client 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 client will need to look for and acknowledge the exceptions to his overgeneralized schema in order to accommodate the schema more realistically.

- Addressing selective attention

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

- Addressing an over-accommodated viewpoint of the government

Another topic that emerges frequently with clients as another-esteem issue is an over-accommodated viewpoint of an organization (e.g, "government", Centrelink, the police). Just like the words "trust" or "control," "government" is an overly general term. In fact, some clients with ASD/PTSD use their outrage at the government as an avoidance strategy. Instead of focusing on specific traumatic events, some clients with ASD/PTSD will immediately try to move the focus to politics and the government (avoidance by rhetoric or diatribe). It is important for the therapist early in therapy to bring the focus of the discussion back to the index event and not allow the client 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 000 no one answers the phone?"* As with other overly vague terms, it is important for the client to move off of the extreme and see the different types and categories that he might in fact judge in a more graded fashion. Although this issue might emerge early in therapy, it could reemerge with the topic of esteem and can be challenged again.

Intimacy Issues Related to Self and Others

The topic of intimacy is introduced toward the end of the session, and the therapist and client briefly discuss how relationships may have been affected by the event. Intimacy with others (or lack of intimacy) will be easier to identify than self-intimacy. However, it is important that there is a focus on nonsexual intimacy as well as sexual intimacy. Self-intimacy is the ability to soothe and calm oneself and to be alone without feeling lonely or empty. Self-intimacy moves beyond self-esteem and includes a strong sense of self-efficacy and comfort with one's own company. The client is encouraged to recognize how intimacy with self and others was before the event and how it was affected by the event. The therapist and client should discuss any problems with inappropriate external attempts to self-soothe (e.g., alcohol, food, spending, etc.) that were likely discussed earlier in the therapy but should be reinforced here. Again, the client should use the Challenging Beliefs Worksheets to confront maladaptive self-statements and to generate more comforting statements.

- Introducing Intimacy
- **Give client Intimacy handout**

Finally, in order to assess how the client's beliefs have changed since the start of treatment, the client 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 client should write about her current thoughts and not how she may have thought in the past.

Practice Assignment 1

> *"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.*

- **Assign Session 5 practice assignment 1**

Practice Assignment 2

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

- **Assign Session 5 practice assignment 2**

Sample Session 5 Progress Note

Contact: 90-minute psychotherapy session

Content: This was the 5th session of CPT for PTSD. The client completed her practice assignment related to completing the Challenging Beliefs Worksheet daily, giving/receiving a compliment each day, and doing something nice for himself each day. Examples from the worksheets were reviewed to offer further cognitive restructuring and to fine-tune completion of the worksheets. Power/Control and Esteem-related stuck points were specifically targeted. Stuck points related to intimacy were introduced, and she agreed to read materials related to this theme. The client 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 herself, others, and the world related to her traumatic experiences.

Plan: Continued CPT

Challenging Beliefs Worksheet

A. Situation	B. Thought(s)	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
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 **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
	C. Emotion(s) Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100%	Evidence For? Evidence Against? Habit or fact? Interpretations not accurate? All or none? Extreme or exaggerated? Out of context? Source unreliable? Low versus high probability? Based on feelings or facts? Irrelevant factors?	Jumping to conclusions: Exaggerating or minimizing: Disregarding important aspects: Oversimplifying: Over-generalizing: Mind reading: Emotional reasoning:	**G. Re-rate Old Thought(s)** Re-rate how much you now believe the thought(s) in Column B from 0=100% **H. Emotion(s)** Now what do you feel? 0=100%

Challenging Beliefs Worksheet – Intimacy Example

A. Situation	B. Thought(s)	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
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 **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
A friend wants to set me up for a date with someone she knows	*I can't get involved with anyone because since this assault I am to afraid to let anyone close enough to see how restricted my life has become* *75%* **C. Emotion(s)** Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100% *Fear – 50%* *Sadness – 80%* *Anger – 50%*	Evidence For? *One person I told about the assault while we were dating was very supportive at the time, but became more and more distant after that and finally stopped calling altogether.* Evidence Against? Habit or fact? Interpretations not accurate? All or none? *Most healthy people would not run from a relationship* Extreme or exaggerated? Out of context? Source unreliable? *Coming from past negative experience and from an unhealthy person* Low versus high probability? Based on feelings or facts? Irrelevant factors?	Jumping to conclusions: *Because one date may have had problems dealing with it does not mean others will* Exaggerating or minimizing: Disregarding important aspects: *That a person was not healthy or secure* Oversimplifying: *If I tell someone who can't deal with it, it is not necessarily bad because I could find out something important about the relationship* Over-generalizing: *Just because they couldn't deal with it does not mean that I'm damaged. It means they re not capable* Mind reading: Emotional reasoning:	*A date could tell me they don't want anything to do with me because I am dealing with having been assaulted.* **G. Re-rate Old Thought(s)** Re-rate how much you now believe the thought(s) in Column B from 0=100% I40% **H. Emotion(s)** Now what do you feel? 0=100% *Fear – 25%* *Sadness – 40%* *Anger – 10%*

Intimacy Issues Module

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

Prior Experience

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

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

Resolution

New beliefs	A possible self-statement may be…
Understanding the typical reactions to trauma may help you feel less panicky about what you are experiencing. Most people cannot recover from such a major traumatic event without the support of others. External sources of comfort, such as alcohol or food, are just crutches that, instead of helping you to recover, may in fact prolong your reactions. They may comfort you in the short run because you use them to avoid and suppress your feelings. The feelings do not go away, however, and you then have to deal with the consequences of the excess food,	"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."

spending, alcohol, etc., which compound the problem.	

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

Prior Experience

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

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

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

Resolution

New beliefs	Possible self-statements about [ ] may be…
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	[New relationships] "Even though a former relationship did not work out, it does not mean that I cannot have satisfying intimate relationships in the future. I cannot continue to believe and behave as though everyone will betray me. I will need to take risks in developing relationships in the future, but if I take it slow, I will have a better chance of telling whether this person can be trusted."

and alone.	
Attempt to resolve your issues with the people who let you down and hurt you by asking them for what you need and letting them know how you feel about what they said or did. If they are unable to adjust to your requests and are unable to give you what you need, you may decide that you can no longer be close to those people. You may find, however, that they responded as they did out of ignorance or fear. As a result of your efforts, communication may improve and you may end up feeling closer to them than you did before the traumatic event.	[Existing relationships] "I can still be close to people, but I may not be able (or want) to be intimate with everyone I meet. I may lose prior or future intimate relationships with others who cannot meet me half-way, but this is not my fault or due to the fact that I did not try."

Session 6: Stuck Points
Future Directions

Summary of Session 6: Stuck Points & Future Directions

Administer PCL and WAI (in waiting room if possible), collect, and store.

1. **Complete Session 6 Practice Assignment Review and set agenda.** (5 minutes)

2. **Help client identify intimacy issues, and any remaining stuck points, and challenge them using Challenging Beliefs Worksheet** (15 minutes)
   - Focus on development and maintenance of *relationships*
   - Be watchful for deficits in self-soothing (Food? Alcohol? Spending?)
   - Intimacy
     - Interpersonal Intimacy—withdrawal from others
     - Sexual Intimacy—physical cueing

3. **Client to read Impact Statement(s)** (15 minutes)
   - Client to read final Impact Statement and go over its meaning
   - Therapist to read original Impact Statement
   - Compare the two
   - Note how beliefs have changed by work in therapy in only a short period
   - Reinforce client's progress as a result of the work done
   - Any remaining distortions or problematic beliefs?

4. **Involve client in reviewing the course of treatment and client's progress** (10 minutes)
   - Review concepts and skills
   - Client to reflect on own good work, progress, and changes made
   - Client to take credit for facing and dealing with difficult and traumatic event
   - Continuing success depends on client's continuing practice of skills learned
   - Lapse versus relapse distinction

5. **Administer Therapy Expectancy Questionnaire**

6. **Help client identify goals for the future and delineate strategies for meeting them** (5 minutes)
   - Also remind client that he is taking over as therapist now and should continue to use the skills that he has learned

Session 6: Stuck Points & Future Directions

The goals of Session 6 are:

- Session 6 goals

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

Identifying Intimacy Issues and Assumptions

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

- Self-intimacy

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

- Nonsexual intimacy with others

With regard to intimacy with others, two types of intimacy are often issues: closeness with family/friends and sexual intimacy. Many people with ASD/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

clients 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 ASD/ PTSD and depression can interfere with normal sexual functioning, particularly sexual desire. However, to sexual assault victims, sexual behavior becomes particularly threatening because the act of being sexual has become a cue associated with the assault, and because of the level of trust and vulnerability that is necessary for sexual intimacy. The clients' 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 client. Although CPT is not intended as a sex therapy, this cognitive therapy can be useful in identifying and correcting problematic cognitions that may interfere with sexual functioning. However, more serious dysfunctions should be treated with other therapy protocols designed specifically for the purpose.

- Sexual intimacy

Client Reading of the New Impact Statement

The therapist and client should go over the new Impact Statement about the meaning of the event. The client should first read her new Impact Statement to the therapist. Below is an example of a new Impact Statement written by a woman who had been raped by an acquaintance.

- New Impact Statement

> *"What it means to me that I was raped is that an acquaintance intimidated me and took that which was not freely given. Not only did he take sex but he took my trust in myself, he took my feelings of control and he shattered my self-esteem. I will always hate him for that. But one thing I won't allow him to take my determination to get them back. It's time for me to grab the bull by the horns and lead it where I want it to go. I foresee a long road but I'm anxious to travel down it.*
>
> *I believed for a long time that the rape was my fault. I don't believe that anymore and that is a great relief. I know I was frightened and I did what I felt I had to do to survive. I wouldn't freely do those things normally. There wasn't any tenderness – it was all violently taken. Coming to that realization has brought about a lot of peace of mind and also the avenue for healing. I'll never be the person I was before and part of me is sad for that, but part of me knows, in time, I'll be stronger because of the rape….. in time."*

The therapist subsequently reads to the client her original Impact Statement that the therapist kept from the second session (or subsequent session if not brought to the second session) so that the client can see how much change has taken place in a rather short period. Usually, there is a remarkable change in the second Impact Statement from the first, and a typical client remark is *"Did I really think that?"* The client should be encouraged to examine how her beliefs have changed as a result of the work she has done in therapy. The

therapist should also look for any remaining distortions or problematic beliefs that may need further intervention.

Review of the Course of Treatment and Client Progress

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 client is reminded that her success in recovering will depend on her persistence to practice her new skills and resistance to returning to old avoidance patterns or problematic thinking patterns. Any remaining stuck points should be identified and strategies for confronting them should be reiterated. We usually give clients extra blank Challenging Beliefs Worksheets with which they can continue to work on residual stuck points if necessary. Clients 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.

- Reviewing concepts with client

Lapse versus Relapse and Client Goals for the Future

Clients should be reminded that if they encounter a reminder and have a flashback, nightmare, or sudden memory they had not accessed before, it doesn't mean that they are relapsing. In response to any of these intrusive experiences, the client should be encouraged to write an account if needed or to utilize with his worksheets. He should be encouraged to experience his natural emotions and to check his thoughts to make sure they are not extreme. Generally clients are able to manage little setbacks with the skills taught in therapy. Goals for the future are discussed. Clients 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.

- Goals for the future

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. We remind clients that people change their roles, and to some extent their identity, at different points in their lives. The therapist should help the client to see that these are normal questions, and instead of fearing the future, he now has the opportunity to explore and decide how he wants to spend his time. They adopt new leisure activities or do volunteer work. They spend time with grandchildren. The therapist should guide the client to see these changes in a positive light and should encourage him to explore his options.

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

- ASD/PTSD in younger clients

A Note on Aftercare

- Aftercare

We recommend that in a normal clinical setting, after completing the protocol, whether conducted weekly or twice a week, the therapist set up a follow-up appointment for a month or two into the future. The client should be encouraged to continue to use her Challenging Beliefs Worksheets on any remaining stuck points. The follow-up session should include the same assessment measures that were used during treatment and can be used to get the client back on track or to reinforce gains. This practice is also helpful in instilling with clients 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.

Sample Session 6 Progress Note

Contact: 90-minute psychotherapy session

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

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

Initial of Client Last Name: _____________ Client ID: ____________________
Therapist Initials: _______________________ Date: ____________ Session: ___________

PCL-S: Session 6

Instructions:

1. Consider the most stressful experience you have experienced _________________________________.
(event)
2. Here is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and then indicate, using the numbers to the right, how much you have been bothered by that problem in the past **WEEK**.

	Not at all	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1. Repeated, disturbing memories, thoughts, or images, of the stressful experience?	1	2	3	4	5
2. Repeated, disturbing dreams of the stressful experience?	1	2	3	4	5
3. Suddenly acting or feeling as if the stressful experience was happening again (as if you were reliving it)?	1	2	3	4	5
4. Feeling very upset when something reminded you of the stressful experience?	1	2	3	4	5
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of the stressful experience?	1	2	3	4	5
6. Avoiding thinking about or talking about the stressful experience or avoiding having feelings related to it?	1	2	3	4	5
7. Avoiding activities or situations because they reminded you of the stressful experience?	1	2	3	4	5
8. Trouble remembering important parts of the stressful experience?	1	2	3	4	5
9. Loss of interest in activities that you used to enjoy?	1	2	3	4	5
10. Feeling distant or cut off from other people?	1	2	3	4	5
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your future will somehow be cut short?	1	2	3	4	5
13. Trouble falling or staying asleep?	1	2	3	4	5
14. Feeling irritable or having angry outbursts?	1	2	3	4	5
15. Having difficulty concentrating?	1	2	3	4	5
16. Being “super-alert” or watchful or on guard?	1	2	3	4	5
17. Feeling jumpy or easily startled?	1	2	3	4	5

PCL-S for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD – Behavioral Science Division.

Initial of Client Last Name: _____________ Client ID: ___________________
Therapist Initials: ______________________ Date: ____________ Session: ___________

WAI-12 Client Form

Below is a list of statements about your relationship with your therapist. Consider each item carefully and indicate your level of agreement for each of the following items. Please write down the rating scale because it makes it easier to answer items. When you have completed the questions please place your form in the envelope provided and seal.

Does not Correspond at all **Corresponds Moderately** **Corresponds Exactly**

1	2	3	4	5	6	7

1. My therapist and I agree about the things I will need to do in therapy to help improve my situation.

1	2	3	4	5	6	7

2. What I am doing in therapy gives me new ways of looking at my problem.

1	2	3	4	5	6	7

3. I believe my therapist likes me.

1	2	3	4	5	6	7

4. My therapist does not understand what I am trying to accomplish in therapy.

1	2	3	4	5	6	7

5. I am confident in my therapist's ability to help me.

1	2	3	4	5	6	7

6. My therapist and I are working towards mutually agreed upon goals.

1	2	3	4	5	6	7

7. I feel that my therapist appreciates me.

1	2	3	4	5	6	7

8. We agree on what is important for me to work on.

1	2	3	4	5	6	7

9. My therapist and I trust one another.

1	2	3	4	5	6	7

10. My therapist and I have different ideas on what my problems are.

1	2	3	4	5	6	7

11. We have established a good understanding of the kind of changes that would be good for me.

1	2	3	4	5	6	7

12. I believe the way we are working with my problem is correct.

1	2	3	4	5	6	7

Initial of Client Last Name: _____________ Client ID: ___________________
Therapist Initials: ______________________ Date: ____________ Session: ___________

WAI-12 Therapist Form

Below is a list of statements about your relationship with your client. Consider each item carefully and indicate your level of agreement for each of the following items.

Does not Correspond at all			Corresponds Moderately		Corresponds Exactly	
1	2	3	4	5	6	7

1. My client and I agree about the things he/she will need to do in therapy to help improve his/her situation.

1	2	3	4	5	6	7

2. What my client is doing in therapy gives him/her new ways of looking at his/her problem.

1	2	3	4	5	6	7

3. I believe my client likes me.

1	2	3	4	5	6	7

4. My client does not understand what I am trying to accomplish in therapy.

1	2	3	4	5	6	7

5. I am confident in my client's ability to help him/herself.

1	2	3	4	5	6	7

6. My client and I are working towards mutually agreed upon goals.

1	2	3	4	5	6	7

7. I feel that my client appreciates me.

1	2	3	4	5	6	7

8. We agree on what is important for my client to work on.

1	2	3	4	5	6	7

9. My client and I trust one another.

1	2	3	4	5	6	7

10. My client and I have different ideas on what his/her problems are.

1	2	3	4	5	6	7

11. We have established a good understanding of the kind of changes that would be good for him/her.

1	2	3	4	5	6	7

12. I believe the way we are working with my client's problem is correct.

1	2	3	4	5	6	7

7

Initial of Client Last Name: _____________ Client ID: ___________________
Therapist Initials: ______________________ Date: ____________ Session: ___________

Therapeutic Outcome Questionnaire – Post Treatment

Subject ID#: ______________ **Date: ______________________**

Therapy: CPT TAU
(circle one)

INSTRUCTIONS: Please circle one number for each question which best represents your feelings about the treatment program.

1	2	3	4	5	6	7	8	9
Not at All		**Very Little**		**Somewhat**		**Moderately**		**Extremely**

Question									
How logical does this type of treatment seem to you now?	1	2	3	4	5	6	7	8	9
How successful was this treatment in reducing your trauma-related symptoms?	1	2	3	4	5	6	7	8	9
How successful was this treatment in reducing other personal problems?	1	2	3	4	5	6	7	8	9
How confident would you be in recommending this treatment to a friend with similar problems?	1	2	3	4	5	6	7	8	9

Patterns of Problematic Thinking Worksheet

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

1. **Jumping to conclusions** when the evidence is lacking or even contradictory.

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

3. **Disregarding important aspects** of a situation.

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

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

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

7. **Emotional reasoning** (you have a feeling and assume there must be a reason).

Challenging Questions Worksheet

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?

Challenging Beliefs Worksheet

A. Situation	B. Thought(s)	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
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 **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
	C. Emotion(s) Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100%	Evidence For? Evidence Against? Habit or fact? Interpretations not accurate? All or none? Extreme or exaggerated? Out of context? Source unreliable? Low versus high probability? Based on feelings or facts? Irrelevant factors?	Jumping to conclusions: Exaggerating or minimizing: Disregarding important aspects: Oversimplifying: Over-generalizing: Mind reading: Emotional reasoning:	**G. Re-rate Old Thought(s)** Re-rate how much you now believe the thought(s) in Column B from 0-100% **H. Emotion(s)** Now what do you feel? 0-100%