Cognitive Processing Therapy

Cognitive Processing Therapy

Workshop

VA | U.S. Department of Veterans Affairs, Veterans Health Administration, Office of Mental Health & Suicide Prevention

National Center for PTSD, Posttraumatic Stress Disorder

1

Cognitive Processing Therapy

Disclaimer

This project is sponsored by the Uniformed Services University of the Health Sciences (USU); however, the information or content and conclusions do not necessarily represent the official position or policy of, nor should any official endorsement be inferred on the part of, USU, the Department of Defense, or the U.S. Government.

2

Cognitive Processing Therapy

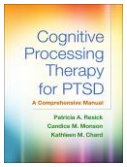
WELCOME AND INTRODUCTIONS

3

3

Orienting to the Workshop

CPT Manual



Handouts from CDP

4

4

COGNITIVE PROCESSING THERAPY (CPT) IS…

- a short-term, evidence-based treatment for PTSD
- a specific protocol that is a form of cognitive-behavioral treatment
- predominantly cognitive and may or may not include a written account
- a treatment that can be conducted in groups or individually

7

7

FORMATS FOR CPT

- **CPT** (No written trauma account)
  - Individual
  - Group
  - Combination
- **CPT+A** (Includes written account)
  - Individual
  - Group
  - Combination

8

8

CPT IN CLINICS

CPT is recovery focused

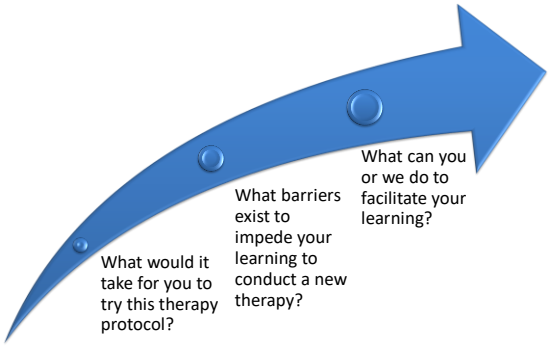
- Underlying expectation is that people can and will recover versus permanently disabled;
- CPT teaches people how to be their own therapist when future problems arise
- Changing the expectancies of clinicians and staff

Regarding contact hours/year, 12 weekly appointments is = seeing clients monthly for a year

9

9

LET'S TALK IMPLEMENTATION



10

10

PRETREATMENT STUCK POINTS

- My client is not ready for trauma-focused therapy
- My clients are more difficult than those in research studies
- My client is too fragile
- Clients will get worse if we talk about their traumas in any detail
- If I use a manual, the "art" of therapy is lost, and it will damage rapport with the client
- CPT won't work with comorbidities (depression, dissociation, substance abuse, personality disorders)

11

External Issues

- Does the agency (or do you) support the time it takes to learn to do CPT?
  - Review material prior to sessions
  - Receive case consultation and/or peer supervision
  - Print materials to conduct the therapy and set up client manuals
  - Schedule at least weekly sessions

12

12

CPT Research Summary

13

13

EMPIRICAL SUPPORT FOR CPT

23 published randomized controlled trials (RCTs) of CPT

Traumas	Populations	Locations	Modalities	Comparison conditions
• Rape • Child sexual abuse • Physical assault • Military sexual trauma • Combat • All studies include individuals with multiple traumas	• Civilian • Active Duty • Veteran • Male • Female • Adolescents	• U.S. • Australia • Germany • Democratic Republic of Congo	• CPT • CPT +A • Individual • Group • Combined • Telehealth • CPT + rTMS • SMART-CPT • D-CPT	• Delayed treatment • Treatment as Usual • Present-Centered Therapy • Prolonged Exposure • Dialogical Exposure Therapy • Written Exposure Therapy • Differing CPT modalities

14

14

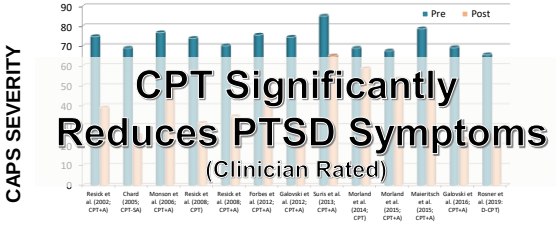
RCT INCLUSION/EXCLUSION CRITERIA

Inclusion	Exclusion
• PTSD diagnosis • 18 years of age • At least 3 months post-trauma • Stable psychiatric medication 1-2 months	• Imminent SI/HI • Uncontrolled mania • Uncontrolled psychosis • Substance dependence • Severe cognitive impairment • Current involvement in violent relationship (some studies)

***Not Exclusion Criteria:**
Personality disorders, substance use/abuse, dissociation, depression, panic, other comorbid conditions, history of multiple traumas

15

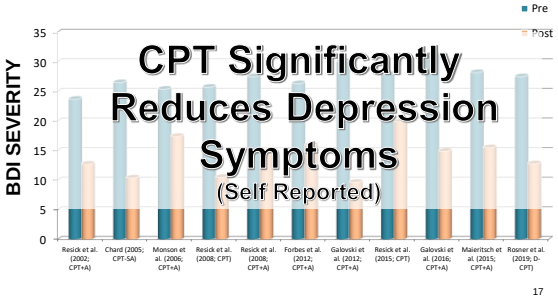
CAPS SEVERITY PRE- AND POST-TREATMENT
(INTENT-TO-TREAT)



16

16

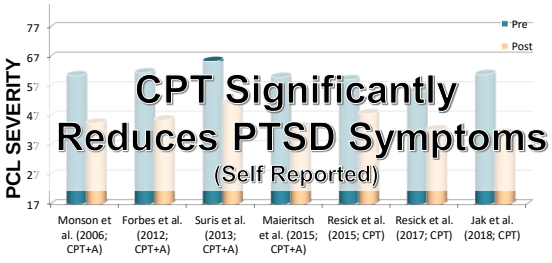
BDI SEVERITY PRE- AND POST-TREATMENT
(INTENT-TO-TREAT)



17

17

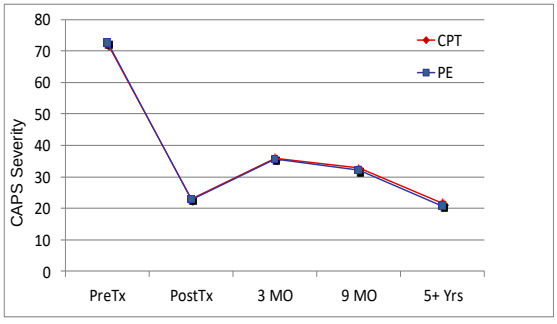
PCL SEVERITY PRE- AND POST-TREATMENT
(INTENT-TO-TREAT)



18

18

LONG-TERM OUTCOME OF CPT
(Resick et al., 2012)



19

19

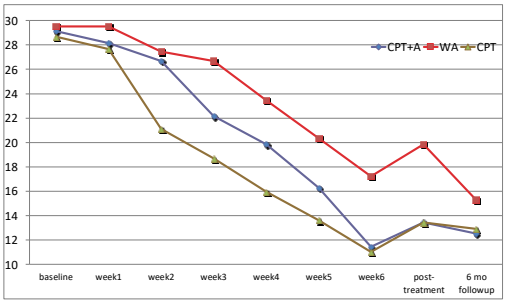
DISMANTLING STUDY
(Resick et al., 2008)

CPT+A	CPT	Written Account (WA)
• 12 sessions/60 min/2x week • Full protocol	• 12 sessions/ 60 min/2x week • Removed the written account (2 sessions) • Extra time spent reviewing cognitive therapy components	• 7 sessions/ 1st week was two 60-minute sessions; 5 120-min weekly sessions • 1-hour writing account • 1-hour reading/processing with therapist

20

20

RANDOM REGRESSION OF PDS



21

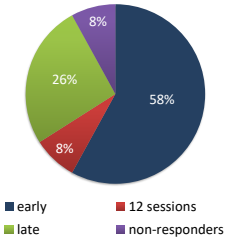
21

Flexible Length Study (Galovski et al., 2012)

Can we improve outcomes by better tailoring the dose of therapy?

- Objective: Determine how many sessions were needed to reach "good end-state functioning" (i.e., PDS≤20 & BDI-II ≤ 18)
- Modified version of CPT+A
  - Treatment continued until participant reached good end-state functioning
  - 18 sessions max
  - Could end before 12 sessions
  - The average was 9 sessions

Number of sessions to good end-state functioning

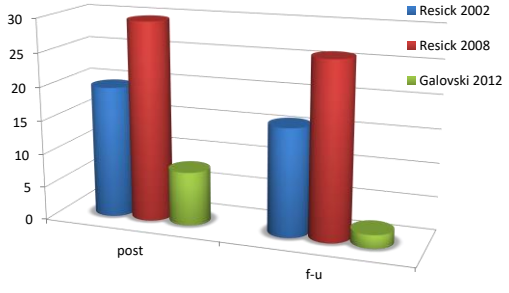


22

22

PTSD positive diagnostic status

(CAPS with CPT completers)



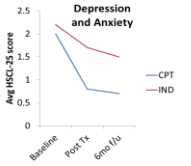
23

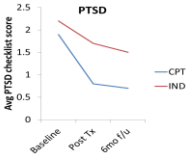
23

CONTROLLED TRIAL OF PSYCHOTHERAPY FOR CONGOLESE SURVIVORS OF SEXUAL VIOLENCE

(Bass et al., 2013)

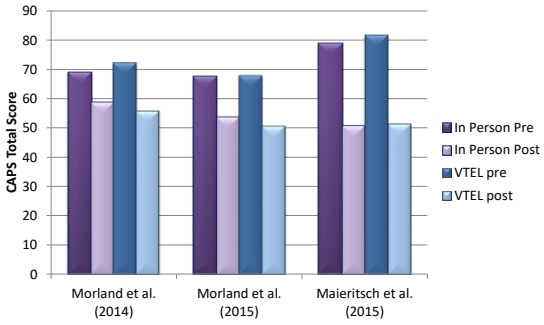
- RCT of group CPT in the Democratic Republic of Congo
  - CPT: 7 villages (n= 157)
  - Individual Support: 8 villages (n= 248)
- Therapists had high school education or less
- Participants were illiterate
  - Worksheets were simplified, participants memorized the forms and concepts
- War was going on around them
- Assessed pre-treatment, post-treatment and 6-month follow up





24

TELEHEALTH (VTC) VS. IN-PERSON CPT RANDOMIZED CONTROLLED TRIALS



25

25

PATIENT CHARACTERISTICS: IMPACT ON CPT OUTCOME?

Sex	• Men and women have similar outcomes
Race	• No differences in tx outcome; AA women may be more likely to drop out early than White women (mixed findings)
Era	• OIF/OEF veterans larger treatment gains but also more likely to drop out than Vietnam veterans; Vietnam era still significant gains
Borderline Personality Disorder	• Borderline personality disorder traits do not predict CPT outcome
Substance Use/Abuse	• No differences in outcome in those with current or past alcohol use disorders
TBI	• Individuals with TBI history do well in CPT; accommodations available only if needed

26

26

CPT OUTCOMES BEYOND PTSD

Studies have demonstrated that CPT results include improvements in:

- Depression
- Hopelessness
- Suicidal ideation
- Guilt
- Anger
- Health concerns
- Dissociation
- Occupational function/economic status
- Social/leisure involvement
- Intimacy/sexual concerns

Remember: When these comorbid issues are present, CPT should be considered. It may help!

27

CPT ENGAGEMENT

Session Timing

- More frequent sessions - better outcomes
- No evidence for less than weekly sessions

Fidelity

- Good treatment fidelity associated with greater symptom reduction
- Critical elements - Socratic questioning skill & prioritizing assimilation before over-accommodation

Dropouts

- About 30% discontinue early (some variability across samples)
- Not all dropouts are negative outcomes

28

SYMPTOMS OF PTSD AND THEORY UNDERLYING CPT

30

30

THINKING ABOUT SYMPTOMS AND WHY OUR CLIENTS HAVE THEM

What symptoms do your patients with PTSD actually talk about? What symptoms bother them the most?

31

31

DSM-5 PTSD Diagnosis: Criterion A

Exposure to actual or threatened a) death, b) serious injury, or c) sexual violation, in one or more of the following ways:

1. Directly experiencing the traumatic event(s)

2. Witnessing, in person, the traumatic event(s) as they occurred to others

3. Learning that the traumatic event(s) occurred to a close family member or close friend; cases of actual or threatened death must have been violent or accidental

4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse); this does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related.

32

32

DSM-5 PTSD Diagnosis

A. Exposure to actual or threatened (a) death, (b) serious injury, or (c) sexual violation

B. Intrusion symptoms (1 or more) (Thinking about the trauma doesn't count; this is about intrusive images, nightmares, flashbacks.)

C. Persistent avoidance of stimuli (1 or more) (But there are thousands of ways to avoid.)

D. Negative alterations in cognitions and mood (2 or more) (i.e., the full range of negative emotions, self or erroneous other blame, change in beliefs)

E. Marked alterations in arousal and reactivity (2 or more) (Arousal items haven't changed, but reckless/self-destructive behavior and aggression have been added.)

F. More than 1 month duration.

G. Causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. Not attributed to the direct physiological effects of a substance or another medical condition (e.g., traumatic brain injury).

Subtype: With prominent dissociative (depersonalization/derealization) symptoms

33

33

A Functional Model of Posttraumatic Stress Disorder

34

34

THINK OF PTSD AS A FAILURE TO RECOVER FROM A TRAUMATIC EVENT.

If the event is severe enough, nearly everyone will have symptoms reflective of PTSD.

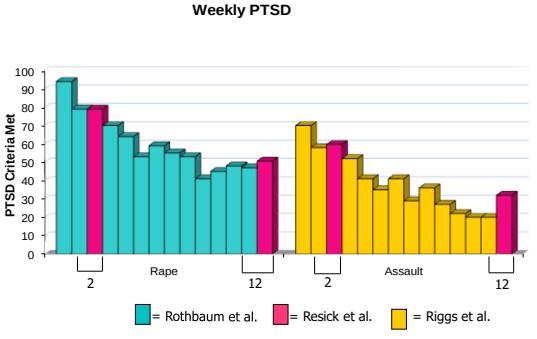
Let's start with the most homogeneous severe event:

rape

35

35

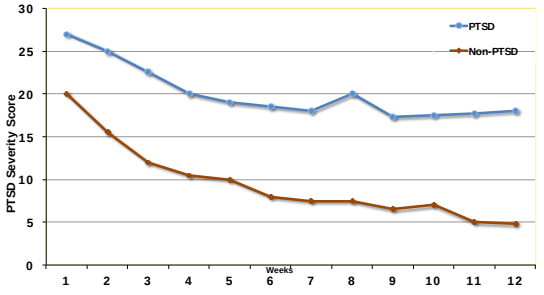
NORMAL RECOVERY



36

36

PTSD AMONG RAPE VICTIMS



(Rothbaum et al., 1992)

37

37

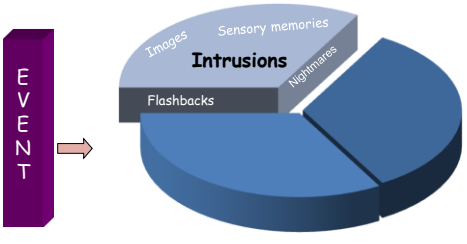
SO, WHAT HAPPENS THAT EITHER FACILITATES OR HINDERS RECOVERY?

Let's look at the relationships between post-trauma symptoms

38

38

1. INTRUSIVE IMAGES AND SENSATIONS



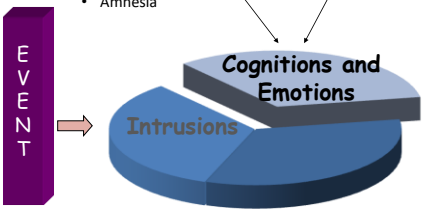
39

39

2. COGNITIONS AND EMOTIONS

Cognitions
- Guilt/self-blame
- Erroneous other blame
- Negative beliefs about future, self, others
- Amnesia

Emotions
- Persistent negative emotions
- Lack of positive emotions
- Detachment from others

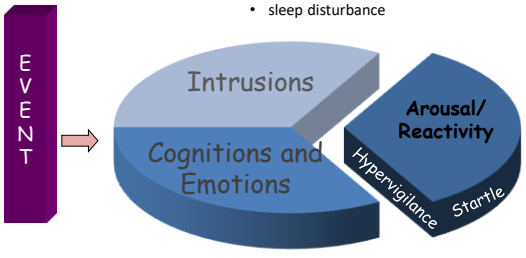


40

40

3. Alterations in arousal and reactivity

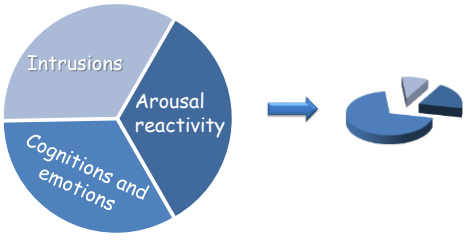
- irritable or aggressive behavior
- reckless or self-destructive behavior
- problems with concentration
- sleep disturbance



41

41

IN NORMAL RECOVERY, INTRUSIONS AND EMOTIONS DECREASE OVER TIME AND NO LONGER TRIGGER EACH OTHER

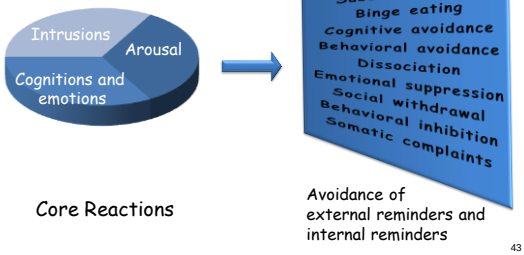


When intrusions occur, natural emotions and arousal run their course, and thoughts have a chance to be examined and corrected. It is an active "approach" process of dealing with the event.

42

42

HOWEVER, IN THOSE WHO DON'T RECOVER, STRONG NEGATIVE AFFECT LEADS TO ESCAPE & AVOIDANCE



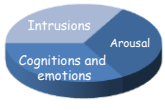
Core Reactions

Avoidance of external reminders and internal reminders

43

43

SUCCESSFUL AVOIDANCE = CHRONIC PTSD



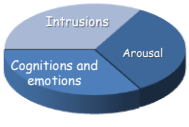
Core Reactions

Escape/Avoidance

44

44

VERY SUCCESSFUL AVOIDANCE = CHRONIC SUBTHRESHOLD PTSD



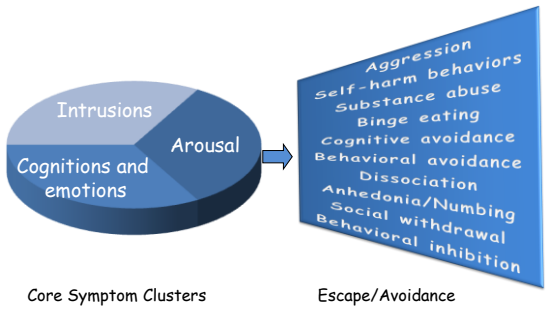
Core Reactions

Escape/Avoidance

45

45

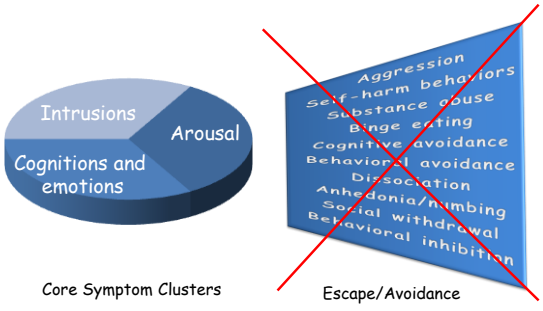
TREATMENT OF PTSD



46

46

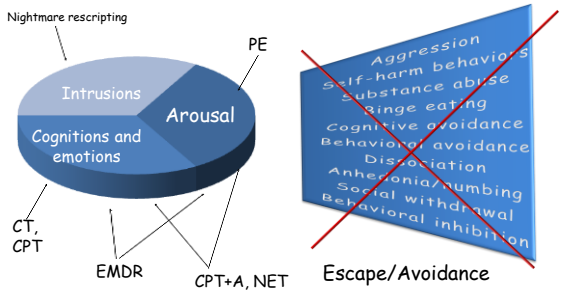
1. PREVENT AVOIDANCE



47

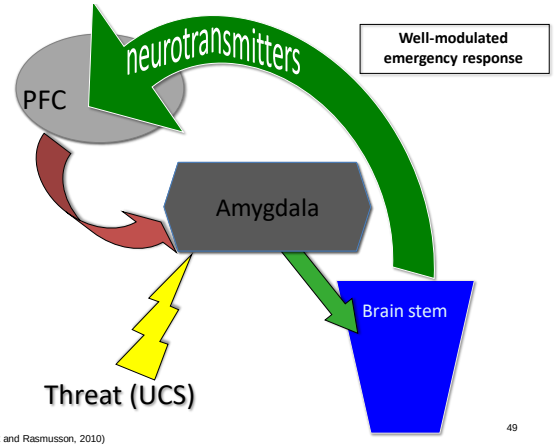
47

2. INTERVENE INTO ONE OR MORE OF CORE SYMPTOM CLUSTERS



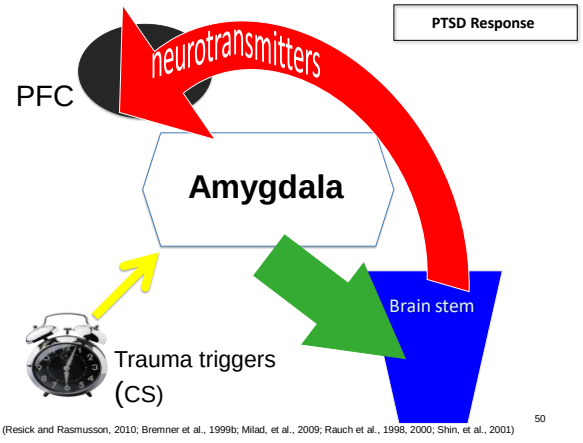
48

48



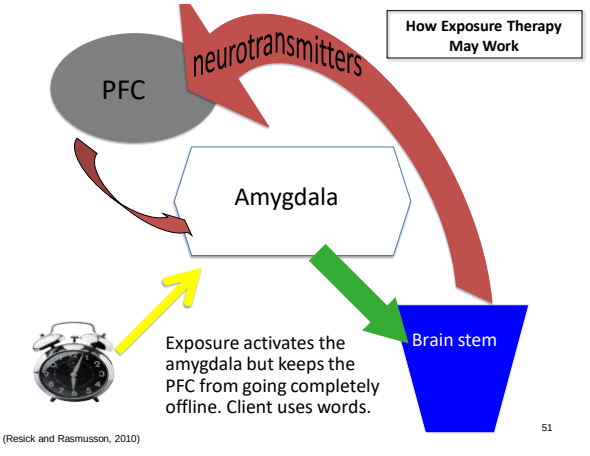
(Resick and Rasmusson, 2010)

49



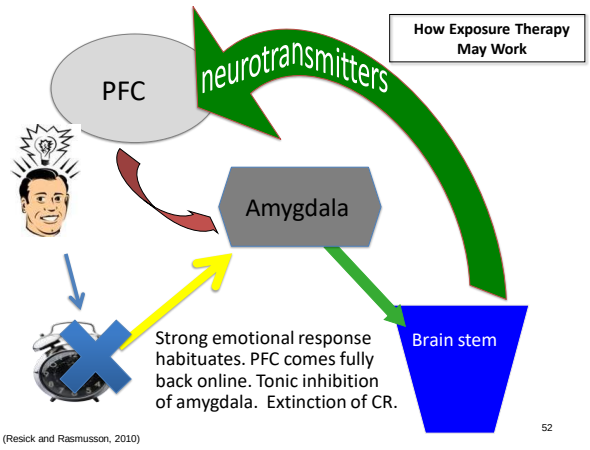
(Resick and Rasmusson, 2010; Bremner et al., 1999b; Milad, et al., 2009; Rauch et al., 1998, 2000; Shin, et al., 2001)

50



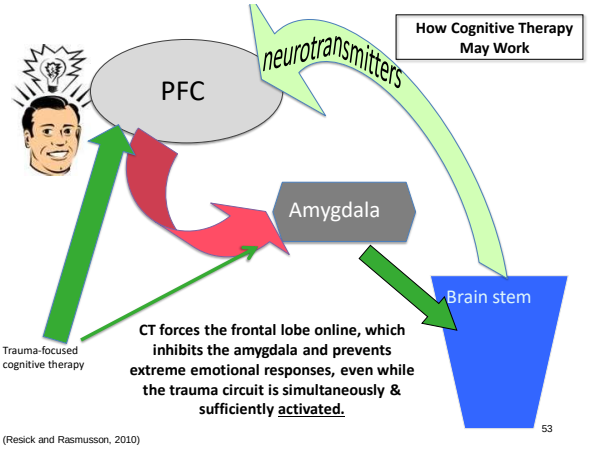
(Resick and Rasmusson, 2010)

51



(Resick and Rasmusson, 2010)

52



(Resick and Rasmusson, 2010)

53

CPT Cognitive Processing Therapy

A FOCUS ON COGNITIVE THEORY

- Throughout their lives, people are taking in information through all of their senses.
- We work to organize all of that information (words, categories, schemas, etc.) in an attempt to understand, predict, and control.
- Most people are taught the "just world belief" by parents, teachers, religions, culture.
- We tend to believe that good behavior is rewarded, and mistakes or bad behavior are punished.

54

54

A FOCUS ON COGNITIVE THEORY

These beliefs work as long as there is no contradictory information.

Traumas that lead to PTSD are schema (beliefs) incongruent with prior positive beliefs and/or schema congruent with previous negative beliefs.

Intrusive symptoms occur as a result of the inability to accommodate the information.

55

55

A FOCUS ON COGNITIVE THEORY

Once the trauma is over, it is a memory.
It is important information that has to be integrated.

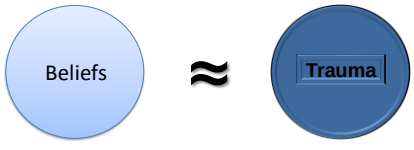
People have three possibilities:

1. The trauma information **matches and is incorporated**.
   - Pre-existing positive beliefs – trauma is understood in light of prior positive beliefs (e.g., It's my fault)
   - Pre-existing negative beliefs – trauma is understood to confirm negative beliefs (e.g., I deserved this)
2. They **change beliefs too much** and interpret everything in light of this new information. (e.g., All men are bad)
3. They change their view of the world/themselves to incorporate the new information in **a balanced way** (GOAL).

56

56

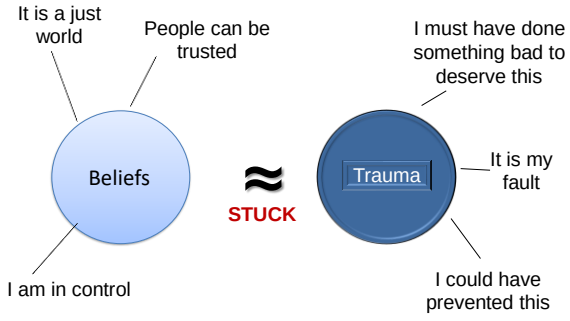
SOCIAL COGNITIVE THEORY OF PTSD



57

57

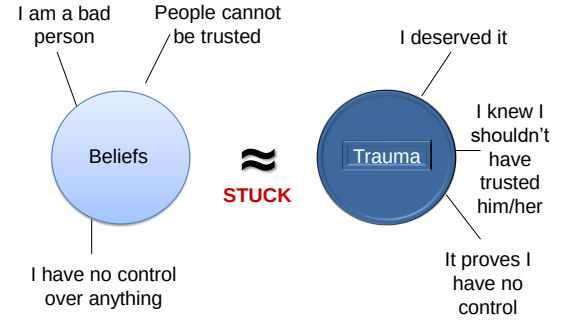
ASSIMILATION – PRE-EXISTING POSITIVE BELIEFS



58

58

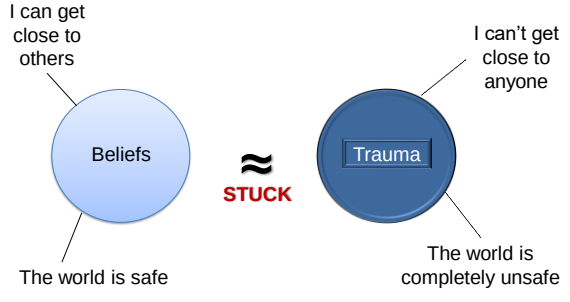
ASSIMILATION - PRE-EXISTING NEGATIVE BELIEFS



59

59

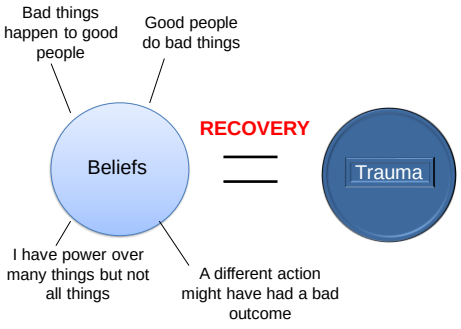
OVER-ACCOMMODATION



60

60

ACCOMMODATION



61

61

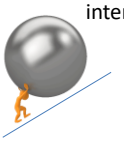
DEFINITION OF A STUCK POINT

Interpretive errors commonly voiced by those with PTSD are called **"Stuck Points".**

Stuck Points are :

Inaccurate and often distressing *beliefs* that interfere with recovery from the psychological impact of trauma,

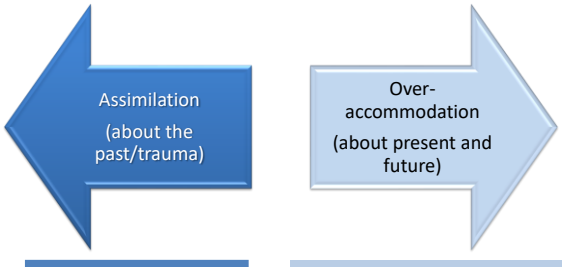
contributing to PTSD.



62

62

IDENTIFYING STUCK POINTS



63

63

ASSIMILATION TAKES PRIORITY

DO NOT SPEND MUCH THERAPY TIME ON OVER-ACCOMMODATION (EVEN LATER IN THERAPY) IF THE ASSIMILATION HAS NOT BEEN RESOLVED.

Distorted beliefs about the trauma are the basis for their PTSD symptoms and their over-accommodation.

64

64

Stuck points are usually:

Black and white	Thoughts not feelings	All or nothing
Thought behind the moral statement or golden rule	If/then statements	Not always "I" statements
Not behaviors	Concise	Not always linked to traumatic event

65

Example Assimilated Stuck Points

Pre-existing Beliefs		Example Stuck Points
If I do the right thing, nothing bad will happen (just world belief).	→ Trauma	I did something bad to deserve this.
I am responsible for my men.	→ Trauma	It was my fault.
If everyone does their job, everything will come out OK.	→ Trauma	I failed.
I will never quit.	→ Trauma	I should have tried harder.
Everything happens for a reason.	→ Trauma	I did something wrong to cause this.
I will never accept defeat.	→ Trauma	I should have prevented it.

66

66

Problems & Sticky Stuck Points: Are you challenging a Stuck Point?

- "Trust" (concept)
- "I am nervous whenever I go on a date" (feeling)
- "I fight with my daughter all the time" (behavior)
- "I witnessed people die" (fact)
- "I don't know what will happen to me" (? of future)
- "The military should take care of its soldiers" (moral statement)

(VHA, 2011) *Stuck Point Help Sheet for Therapists*

67

WHERE DO EMOTIONS FIT IN CPT?

There are two types of emotions	The therapist needs to determine which kind of emotion it is
Natural emotions emanate directly from the event and are hard-wired. • Fight-flight response → fear-anger • Losses → sadness • Disgust → withdrawal	If natural, clients need to feel and let it run its course. Natural emotions dissipate quickly.
Manufactured emotions are produced by thoughts and beliefs. • Self-blame thoughts → guilt • Other-blame thoughts →anger or rage	If manufactured, clients need to change their thinking.

68

SO HOW DOES CPT WORK?

Challenging avoidance

Dissipation of natural emotions

Changes in interpretation about the event changes manufactured emotions

(no habituation required)

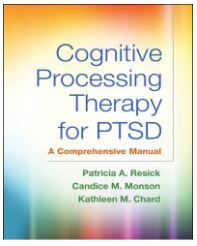
Clients learn not to over-generalize their thinking about a single bad event to all people or themselves as people

(Just because an event has bad consequences, it doesn't have to have big implications.)

69

Cognitive Processing Therapy

COGNITIVE PROCESSING THERAPY SESSION BY SESSION

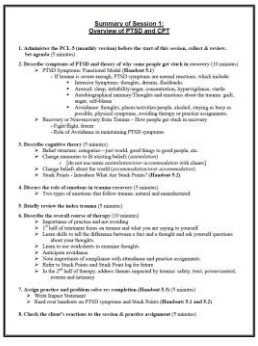


70

70

Cognitive Processing Therapy

CPT Session Summaries


Summary of Session 1:
Overview of PTSD and CPT

1. Administer the PCL-5 (monthly version) before the start of this session, collect & review. Set agenda (5 minutes)

2. Describe symptoms of PTSD and theory of why some people get stuck in recovery (10 minutes)
- PTSD Symptoms: Functional Model (Handout 9.1)
  - If trauma is severe enough, PTSD symptoms are normal reactions, which include:
    - Intrusive Symptoms: thoughts, dreams, flashbacks
    - Arousal: sleep, irritability/anger, concentration, hypervigilance, startle
    - Autobiographical memory: Thoughts and emotions about the trauma: guilt, anger, self-blame
    - Avoidance: thoughts, places/activities/people, alcohol, staying as busy as possible, physical symptoms, avoiding therapy or practice assignments
- Recovery or Not Recovery from Trauma – How people get stuck in recovery
  - Fight/flight, freeze
  - Role of Avoidance in maintaining PTSD symptoms

3. Describe cognitive theory (5 minutes)
- Belief structure: categories—just world, good things to good people, etc.
- Change outcomes to fit existing beliefs (assimilation)
- Change beliefs about the world (accommodation)
- Change beliefs about the world (accommodation)
- Stuck Points - Introduce What Are Stuck Points? (Handout 9.2)

4. Discuss the role of emotions in trauma recovery (5 minutes)
- Two types of emotions that follow trauma: natural and manufactured

5. Briefly review the index trauma (5 minutes)

6. Describe the overall course of therapy (10 minutes)
- Importance of practice and not avoiding
- 1st half of treatment focus on trauma and what you are saying to yourself
- Learn skills to tell the difference between a fact and a thought and ask yourself questions about your thoughts.
- 2nd half of treatment: to examine thoughts.
- Anticipate avoidance.
- Note importance of compliance with attendance and practice assignments
- Refer to Stuck Points and Stuck Point log for future
- In the 2nd half of therapy, address themes impacted by trauma: safety, trust, power/control, esteem and intimacy

7. Assign practice and problem solve re: completion (Handout 9.3) (5 minutes)
- Write Impact Statement
- Hand out handouts on PTSD symptoms and Stuck Points (Handouts 9.1 and 9.2)

8. Check the client's reactions to the session & practice assignment (5 minutes)

71

71

Cognitive Processing Therapy

CPT Session Notes

"Just in time" video review of the agenda for each CPT session.

https://deploymentpsych.org/content/cpt-session-notes

72

72

PHASES OF TREATMENT

- Pretreatment assessment and pretreatment issues
- Education regarding PTSD, thoughts, and emotions
- Processing the trauma
- Learning to challenge
- Trauma themes
- Facing the future

73

73

PHASE 1.
PRETREATMENT ASSESSMENT AND PRETREATMENT ISSUES

74

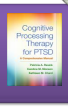
74

PRE-TREATMENT ISSUES

Please assess patients formally to determine whether they have PTSD, and if needed, other comorbid conditions.

Describe the therapy you are offering, how it might differ from other former treatment.
(Show introductory video if you have it.)

Therapist contract



(Page 79)

75

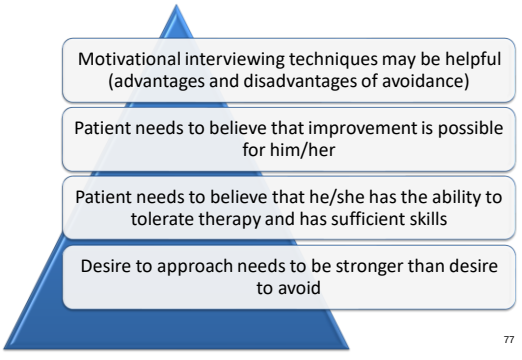
75

OTHER PRE-TREATMENT ISSUES:
CPT FOR WHOM AND WHEN

- Substance abuse/dependence
- Self-harm/suicidality/homicidality
- Dissociation
- Literacy
- Other comorbidity
- Medications and other treatments
- How early can you start?
  - Risk to re-exposure (upcoming deployment, ongoing interpersonal violence)
  - Sufficient skills needed to start?

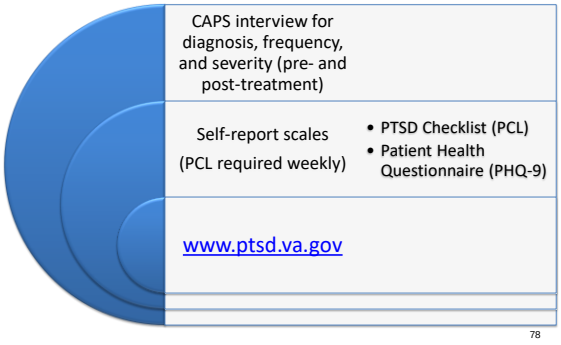
76

PRETREATMENT ISSUES- RATIONALE AND BUY-IN THERAPIST TASKS



77

RECOMMENDED ASSESSMENT MEASURES



78

STRUCTURING SESSIONS

Brief update (mood and PTSD symptoms)

- Objective symptom measures
- Complete practice assignment review ("Let's go over your worksheets" rather than "How was your week?")

Review of practice assignment

- Reviewing practice reinforces completion
- Content is the "meat" of the session
- Use Socratic dialogue and model challenging thoughts
- Use relevant forms regardless of the content

79

79

STRUCTURING SESSIONS (CONT.)

Setting new practice assignment

- Review rationale
- Explain the concept and new assignment
- Start assignment in session
- Problem solve any barriers to assignment completion
- Check in about reactions to the session and to the practice assignment

80

80

PHASE 2. EDUCATION REGARDING PTSD, THOUGHTS, AND EMOTIONS

81

81

SESSION 1. OVERVIEW OF PTSD AND CPT

1. Describe symptoms of PTSD (Handout 5.1)
2. PTSD as a disorder of non-recovery
3. Fight-flight-freeze reactions
4. Cognitive theory of PTSD
   - Just world belief
   - Assimilation versus over-accommodation
   - Goal of accommodation

82

82

SESSION 1. OVERVIEW OF PTSD AND CPT

5. Types of emotions
   - Natural emotions result directly from event; the hardwired response. (Goal is to feel them/ and let them run their course.)
   - Manufactured emotions are based on interpretations of the event. (Goal is to change the thought, which changes the emotion.)
6. Choosing index traumatic event

83

83

SESSION 1. OVERVIEW OF PTSD AND CPT

7. Stuck points
   - Handout 5.2
8. Anticipating avoidance and increasing practice compliance
9. Overview of treatment

84

84

Cognitive Processing Therapy

Stuck points are usually:

- Black and white
- Thoughts not feelings
- All or nothing
- Thought behind the moral statement or golden rule
- If/then statements
- Not always "I" statements
- Not behaviors
- Concise
- Not always linked to traumatic event

85

Cognitive Processing Therapy

Session 1. Video

Theory behind CPT

86

86

Cognitive Processing Therapy

Theory behind CPT

87

87

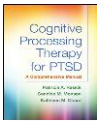
Practice

Goal of practice

- Introduce key cognitive concepts and their role in CPT, including:
  1) Schemas: what they are and how they become more complex with time
  2) The Just World Belief
  3) How new information is interpreted via assimilation or over-accommodation (without using these terms!)
  4) The ultimate goal of CPT: developing balanced beliefs about oneself, the world, and others

Materials needed

- CPT Manual, pages 89-91



- Session Summary for Session #1

88

88

Role Play Exercise: Explain Cognitive Theory and Stuck Points

Materials needed:

- CPT Manual (pgs. 89-91)
- Stuck Points -What Are They? (pg. 99)

Patient scenario:

- Trauma: MST during recent deployment
- 27 year old OND Marine
- No prior mental health treatment but referred by OB/GYN after repeated treatment for STDs
- Symptoms & problems reported so far: intrusive imagery of the incident; bouts of crying; has few friends

Goal: Introduce key cognitive concepts and their role in CPT

1) Schemas: what they are and how they become more complex with time

2) The Just World Belief

3) How new information is interpreted via assimilation or overaccommodation (without using these terms!)

4) The ultimate goal of CPT: developing balanced beliefs about oneself, the world, and others

89

CPT Metaphor Bank

CPT Subject Matter Experts demonstrate how to explain common CPT concepts via metaphors.

https://deploymentpsych.org/CPT_Metaphor_Bank

90

90

SESSION 1. PRACTICE ASSIGNMENT

*"Please write at least a one-page statement on **why** you think your most distressing traumatic event occurred. You are not being asked to write specific details about this event. Write about what you have been thinking about the cause of this 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 statement with you to the next session.

"Also, please read over the two handouts I have given you on PTSD symptoms and Stuck Points so that you understand the ideas we are talking about." (Handout 5.3)

91

91

Explain purpose of Impact Statement: Purpose #1

- Asking "why" reveals stuck points around blame, undoing, and re-interpreting the past **(assimilated stuck points):**
  - "It's my fault; if only I had done this; I should've known," etc.
  - "If only I had gone left instead of right, this wouldn't have happened (assimilated). From this point forward, I can't make decisions because things always go wrong (over-accommodated)."

92

92

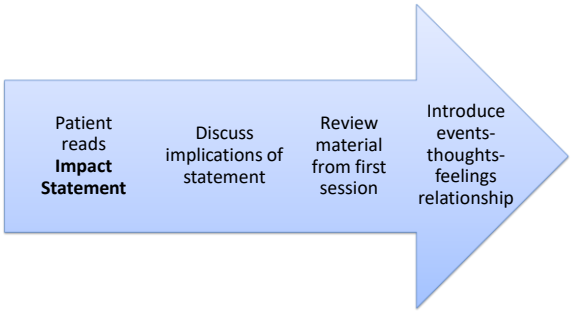
Impact Statement: Purpose #2

- How have my beliefs and my life changed since this trauma?
  - Reveals reasons for wanting to make changes: motivation for therapy.
  - Writing about 5 themes (safety, trust, etc.) identifies areas of challenge that are common to trauma victims and brings to light how these beliefs play out in their lives:
    - Ex: "I don't like crowds because I don't feel safe."
      Stuck Point = Crowds are not safe.

93

93

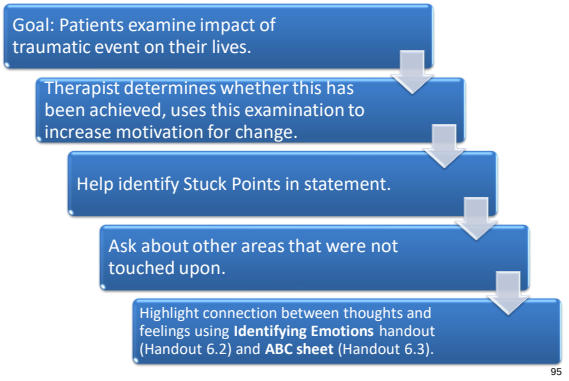
SESSION 2. EXAMINING THE IMPACT OF TRAUMA



94

94

SESSION 2. IMPACT STATEMENT



95

95

SESSION 2. IMPACT STATEMENT

If patient doesn't do practice assignment:

1. Discuss the role of avoidance in maintenance of symptoms.
2. Have the patient say what they would have written if they had done so.
3. Ask patient to write impact statement for next week.
4. Assign the next practice assignment.

96

96

Cognitive Processing Therapy

Session 2.

Video Examples: Impact Statements

Client doesn't do impact statement.
Rape impact statement.
Combat impact statement.

97

97

Cognitive Processing Therapy

Impact Statement: Client didn't write it

98

98

Cognitive Processing Therapy

Rape Impact Statement

99

99

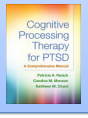
Combat Impact Statement

100

100

Stuck Point Log

- Make a copy of the Stuck Point Log to keep in case it is lost. (Handout 6.1)
- The Stuck Point Log is a living document (keep adding to it):
  - Use it for CQW & PPT
  - Use it for CBW
  - Use it to ID SPs based on 5 themes as they are introduced and any other issues (e.g., moral injury, spirituality, anger, etc.)
  - Use it for patient to continue to identify SPs they need to work on AFTER treatment termination
- Additional Help Sheets:
  - Stuck Point Help Sheet for Patients (Handout 6.4)
  - Stuck Point Help Sheet for Therapists (pg. 113-115)



101

SESSION 2. INTRODUCE ABC WORKSHEET

Using an example from impact statement or something the patient has mentioned, introduce concept of labeling events, thoughts, and emotions

Use an example from life of how most events are open to interpretation

Put example on worksheet

102

102

Cognitive Processing Therapy

ABC Worksheet

Date: _____ patient #: _____

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

Are my thoughts above in column B realistic or helpful?

_____

_____

What can I tell myself on such occasions in the future? _____

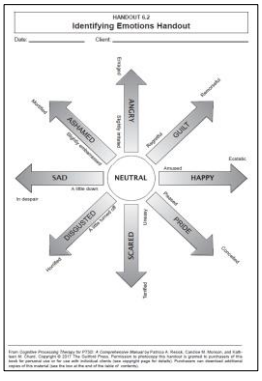
_____

103

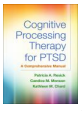
103

Cognitive Processing Therapy

SESSION 2: IDENTIFYING EMOTIONS



Manual
Page 125



104

104

Cognitive Processing Therapy

SESSION 2. PRACTICE ASSIGNMENT

"Please complete the ABC Worksheets to become aware of the connections between events, your thoughts, and your feelings. Complete at least one worksheet each day. Remember to fill out the worksheet as soon after an event as possible, and if you identify any new Stuck Points, add them to the Stuck Point Log. Complete at least one worksheet about the traumatic event that is causing you the most PTSD symptoms. Also, please use the Identifying Emotions Handout to help you determine what emotions you are feeling." (Handout 6.5)

105

105

SESSION 3. WORKING WITH EVENTS, THOUGHTS & EMOTIONS

Review **ABC Worksheets**

Using Socratic questions, help patient generate alternative thoughts and consequent feelings

Gently begin to challenge undoing or self-blame statements about index trauma

106

106

ABC Worksheet

Date: _____ **patient #:** _____ **Mr.A**

ACTIVATING EVENT	BELIEF/STUCK POINT	CONSEQUENCE
A "Something happens"	B " I tell myself something"	C "I feel something"
I get hit by an IED	*How did I make it and the guy next to me lost his leg?*	*Confused* *Scared*

Are my thoughts above in column B realistic or helpful?

What can I tell myself on such occasions in the future? _____

107

107

ABC Worksheet

Date: _____ **patient #:** ___ Mr. B__

ACTIVATING EVENT	BELIEF/STUCK POINTS	CONSEQUENCE
A "Something happens"	B " I tell myself something"	C "I feel something"
Child dies in my arms.	*"It was my fault that she died."*	*I feel incompetent and helpless. I avoid holding children and getting close to anyone.*

Are my thoughts above in column realistic or helpful? ***No. I did what I could to save her.***

What can I tell myself on such occasions in the future? ***It wasn't my fault. I did the best I could for her.***

108

108

Cognitive Processing Therapy

ABC Worksheet

Date: _____ **patient #:** ___ Ms. C

ACTIVATING EVENT A "Something happens"	BELIEF/STUCK POINTS B " I tell myself something"	CONSEQUENCE C "I feel something"
My grandfather abused me, and I was hurt by other men in different ways.	*It was my fault because I looked like my grandmother and mother. All men cannot be trusted.*	*Guilt* *Fear* *Rage* *Disgust*

Are my thoughts above in column B realistic or helpful? ***The guilt was unreasonable; it wasn't my fault. All men can't be trusted is an unreasonable statement.***

What can I tell myself on such occasions in the future? ***Each man is an individual; some men can't be trusted but not all.***

109

109

Cognitive Processing Therapy

SESSION 3. SOCRATIC DIALOGUE

At this point in therapy, we do not strongly challenge maladaptive statements

More important to help clarify thoughts and feelings

Work gently with assimilation (self-blame & undoing)

110

110

Cognitive Processing Therapy

Video Example

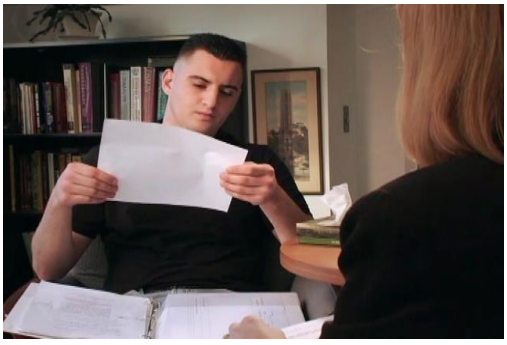
ABC Worksheet

111

111

Cognitive Processing Therapy

Reviewing the ABC Worksheet



112

112

Cognitive Processing Therapy

SESSION 3. PRACTICE ASSIGNMENT FOR CPT

"Please continue to self-monitor events, thoughts, and feelings with the ABC Worksheets on a daily basis to increase your mastery of this skill. You should complete one worksheet each day on the trauma causing you the most distress or other traumas, but you can do additional worksheet items on day-to-day events. Please put any newly noticed Stuck Points on your Stuck Point Log as you use the ABC Worksheets." (Handout 6.6)

113

113

Cognitive Processing Therapy

OUT-OF-TRAINING PRACTICE

Read Chapter 4 "Preparing To Deliver CPT" (Pgs.62-78)

Review "Therapist Stuck Point Guide" (Pgs. 113-115)

Complete "Identifying Stuck Points Practice Assignment" (Handout #3)

114

114

Cognitive Processing Therapy

PHASE 3.

PROCESSING THE TRAUMA

115

115

Cognitive Processing Therapy

SESSION 4. EXAMINING THE INDEX EVENT

Review **ABC Worksheets**

Address Assimilated Stuck Points using Socratic Dialogue

Introduce **Challenging Questions Worksheet**

116

116

Cognitive Processing Therapy

Principles of Socratic Dialogue

117

117

WHAT IS A SOCRATIC DIALOGUE?

Therapist asks questions to assist in challenging the accuracy of thought processes and rectifying those that have kept the patient from recovering

Cornerstone of CPT practice

118

118

PRINCIPLES OF SOCRATIC DIALOGUE

Wisdom *within* each individual that can be drawn out with questions

Knowledge is not a commodity

Power in "coming to know"

Patient autonomy
- Guided discovery
- Collaborative empiricism

Warmth was a major element of Socrates' approach

119

119

HIERARCHY OF SOCRATIC DIALOGUE

C = Clarifying

A = Assumptions

R = Real evidence

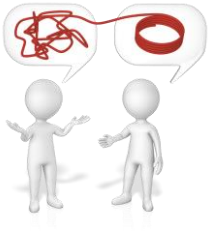
D = Deeper Meaning

120

120

Socratic Questioning Exercise: Changing Minds or Guiding Discovery?

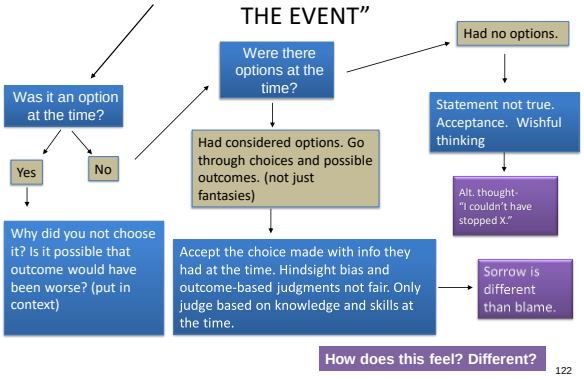
- www.padesky.com



121

121

"IF ONLY I HAD DONE X, I COULD HAVE STOPPED THE EVENT"



122

122

Session 4
Video Clip
"Convoy"

123

123

Cognitive Processing Therapy

Intro to Convoy with Dr. Kate Chard

Introduction to Convoy with Kate Chard

124

124

Cognitive Processing Therapy

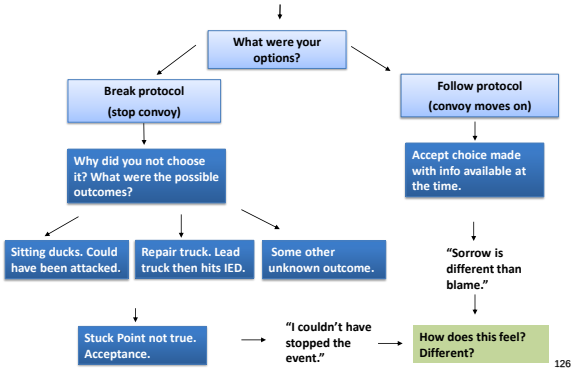
Socratic Dialogue: "Convoy"

125

125

Cognitive Processing Therapy

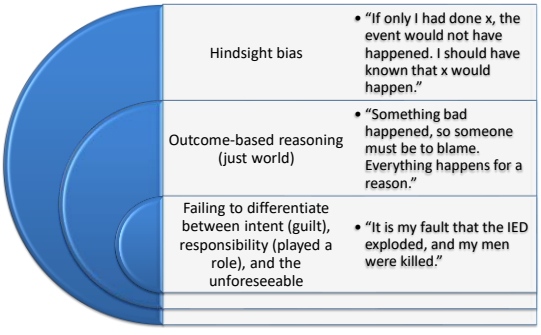
"If I had stopped the truck, It wouldn't have hit the IED"



126

126

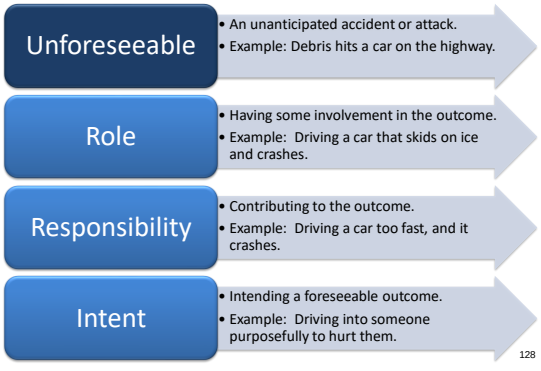
COMMON ASSIMILATION PROBLEMS



127

127

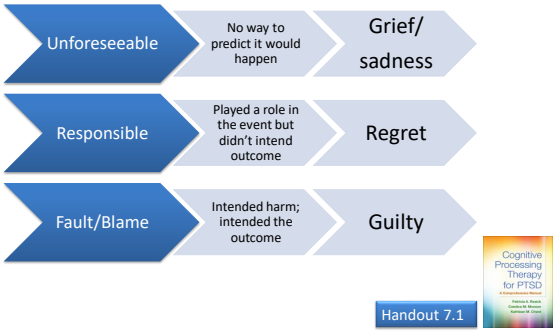
DIFFERENTIATING INTENT



128

128

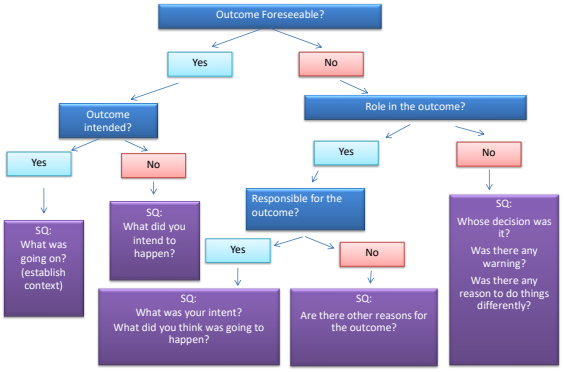
YOUR ROLE IN THE TRAUMATIC EVENT: WHAT ARE THE FACTS?



129

Cognitive Processing Therapy

SOCRATIC QUESTIONS TO DIFFERENTIATE INTENT



130

Cognitive Processing Therapy

Responsibility Pie

What percentage of this is your fault?

How much are you to blame?

131

131

Cognitive Processing Therapy

WHAT WERE OTHER FACTORS INVOLVED?

- Other people **20%**
- Vehicle flat **25%**
- Maintenance **10%**
- Weather **??%**
- Terrain/Visibility **15%**
- Mission **20%**
- .....

➡ **ENEMY** ⬅

Does this feel different?

132

132

Cognitive Processing Therapy

Practice

Role-play activity on
Socratic Dialogue with ABC Worksheet

HANDOUTS #4, #5, and #6

131

133

Cognitive Processing Therapy

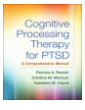
Role Play Exercise: Using Socratic Dialogue and the ABC Worksheet

Materials needed:

- ABC worksheet (pg. 126 or workshop handout)
- Identifying Emotions handouts (pg. 125)
- Socratic method (pgs. 64-68)
- Patient Scenarios (Handout #5)

Goal and Instructions:

- Develop a beginning/intermediate level of competence using the Socratic method to challenge a patient's assimilated stuck point.
- Use Socratic questions to gently challenge the stuck point and help the patient answer the two questions at the bottom of the ABC worksheet.



134

Cognitive Processing Therapy

COMMON MISTAKES

Content

- Making assumptions
- Believing patient's Stuck Point as fact
- Going after over-accommodation before assimilation

Process

- Rhetorical questions
- Too convincing
- Impatience
- Inadvertently validate Stuck Point
- Create power struggle
- Not maintaining balance between validation and challenge

137

137

PROBLEMS & STICKY STUCK POINTS: DETERMINE THE STUCK POINT'S FUNCTION

- Control?
  - *"If it's my fault, then I know what to do to prevent it in the future."*
- Avoidance?
  - Letting go of guilt may open a patient to feeling grief.
  - Distressing thoughts may provide distraction from the reality or meaning of the trauma.
- Fear of questioning/changing long-held beliefs?
  - *"If being good doesn't matter, then what?"*
  - *"Is there no justice? Is there no God?"*
- Belief that changing beliefs means *more* loss?
  - Talking about is very different from experiencing change.

(Resick, 2010; Maeritsch & Resick, 2010)

137

138

CHALLENGING QUESTIONS WORKSHEET

Below is a list of questions to be used in helping you challenge your Stuck Points 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 Stuck Point?
2. Is your Stuck Point a habit or based on facts?
3. In what ways is your Stuck Point not including all of the information?
4. Does your Stuck Point include all-or-none terms?

Handout 7.2

139

139

CHALLENGING QUESTIONS CONTINUED

5. Does your Stuck Point include words or phrases that are extreme or exaggerated? (i.e., always, forever, never, need, should, must, can't, and every time).
6. In what way is your Stuck Point focused on just one piece of the story?
7. Where did this Stuck Point come from? Is this a dependable source of information on this Stuck Point?
8. How is your Stuck Point confusing something that is possible with something that is likely?
9. In what ways is your Stuck Point based on feelings rather than facts?
10. In what ways is this Stuck Point focused on unrelated parts of the story?

140

140

SESSION 4. PRACTICE ASSIGNMENT

"Please choose one Stuck Point each day, then answer the questions on the Challenging Questions Worksheet with regard to this Stuck Point. Please work on Stuck Points related directly to the trauma first (e.g., "It is my fault," "I could have prevented it," or "If I had done X, it would not have happened"). Your therapist will give you extra copies of the Challenging Questions Worksheets so you can work on multiple Stuck Points. Completed examples of this worksheet are provided, and a Guide to the Challenging Questions Worksheet is also available." (Handout 7.4)

141

141

Practice

Role-play activity on
Challenging Questions Worksheet

HANDOUTS #4, #5, and #7

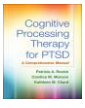
141

142

Role Play Exercise: The Challenging Questions Worksheet

Materials needed:

- Challenging Questions worksheet (pgs. 153-154 or handout)
- Patient Scenarios (Handout #5)

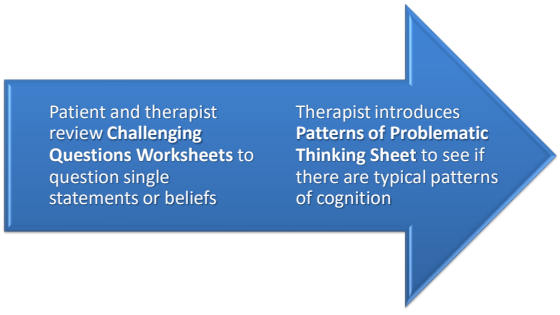


Goal and Instructions:

- Develop a beginning/intermediate level of competence using the Challenging Questions (CQ) worksheet.
- Introduce the CQ to your patient and use the worksheet to challenge an **assimilated** stuck point.

143

SESSION 5. USING THE CHALLENGING QUESTIONS WORKSHEET



146

146

PATTERNS OF PROBLEMATIC THINKING

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 the patterns. Write in the Stuck Point under the appropriate pattern and describe how it fits that pattern. Think about how that pattern affects you.

1. **Jumping to conclusions** or predicting the future?
2. **Exaggerating or minimizing** a situation (blowing things way out of proportion or shrinking their importance inappropriately).

Handout 7.5

147

147

PATTERNS OF PROBLEMATIC THINKING

3. **Ignoring important parts** of a situation.
4. **Over-simplifying** things as good/bad or right/wrong.
5. **Over-generalizing** from a single incident. (Negative event is seen as a never-ending pattern.)
6. **Mind-reading.** (Assuming people are thinking negatively of you when there is no definite evidence for this.)
7. **Emotional reasoning.** (Using emotions as proof, i.e., "I feel fear, so I must be in danger".)

148

148

SESSION 5. PRACTICE ASSIGNMENT

"Your practice assignment is to consider your Stuck Points, as well as some examples of your everyday thinking, and to find ones that fit into each relevant thinking pattern on the Patterns of Problematic Thinking Worksheet. Each day, list a Stuck Point or example of everyday thinking under each pattern, and think about ways in which your reactions to the traumatic event may be affected by these habitual patterns. A completed example of this worksheet is provided." (Handout 7.6)

149

149

Phase 4.

Learning to Challenge: Sessions 6 & 7

150

150

SESSION 6. PATTERNS OF PROBLEMATIC THINKING WORKSHEET

151

151

Cognitive Processing Therapy

Video Example

Patterns of Problematic Thinking

152

152

Cognitive Processing Therapy

Reviewing the Patterns of Problematic Thinking Worksheet

153

153

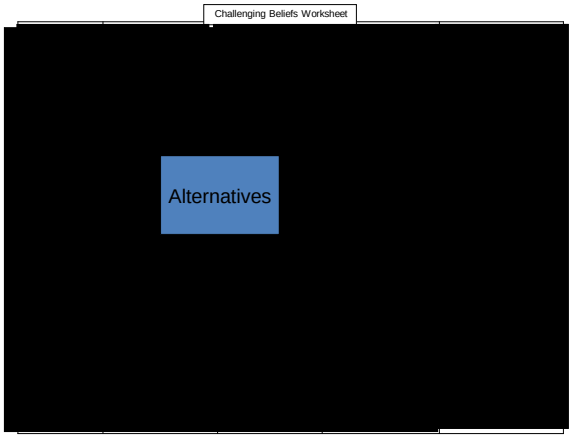
Challenging Beliefs Worksheet

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

Handout 8.1

154

154



155

Cognitive Processing Therapy

Video Example

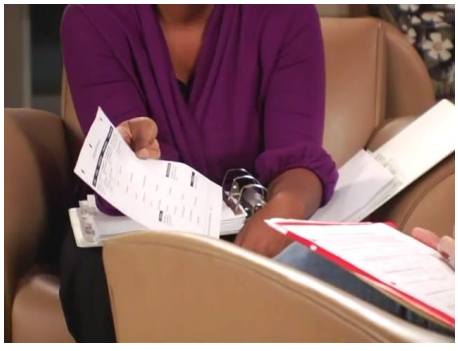
Introducing **Challenging Beliefs Worksheet**

156

156

Cognitive Processing Therapy

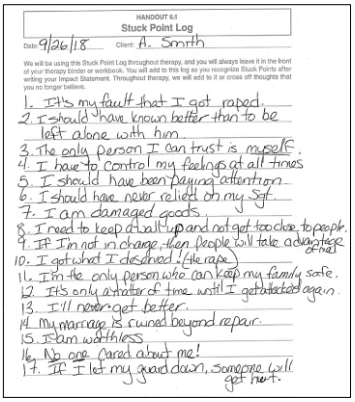
Introducing the Challenging Beliefs Worksheet



157

157

Which are Assimilated?



HANDOUT 6.1
Stuck Point Log

Date 9/26/18 Client: A. Smith

We will be using this Stuck Point Log throughout therapy, and you will always leave it in the front of your therapy binder or workbook. You will add to this log as you recognize Stuck Points after writing your Impact Statement. Throughout therapy, we will add to it or cross off thoughts that you no longer believe.

1. It's my fault that I got raped.
2. I should have known better than to be left alone with him.
3. The only person I can trust is myself.
4. I have to control my feelings at all times.
5. I should have been paying attention.
6. I should have never relied on my Sgt.
7. I am damaged goods.
8. I need to keep it all "up" and not get too close to people.
9. If I'm not in charge, then people will take advantage of me.
10. I got what I deserved! (the rape)
11. I'm the only person who can keep my family safe.
12. It's only a matter of time until I get attacked again.
13. I'll never get better.
14. My marriage is ruined beyond repair.
15. I am worthless.
16. No one cared about me!
17. If I let my guard down, someone will get hurt.

158

158

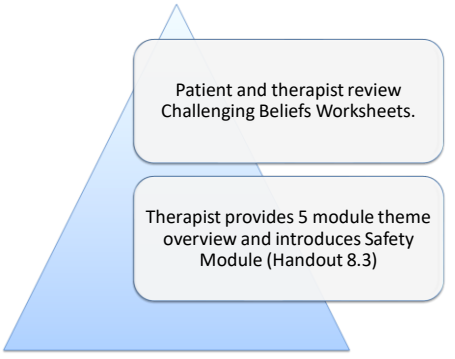
SESSION 6. PRACTICE ASSIGNMENT

"Use the Challenging Beliefs Worksheets to analyze and confront at least one of your Stuck Points each day. You can also use the Challenging Beliefs Worksheets to challenge any negative or problematic thoughts and related emotions you may have about day-to-day events." (Handout 8.2)

159

159

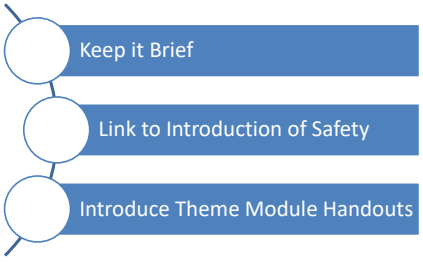
SESSION 7 OVERVIEW: CBWs and Introduction to Modules



160

160

SESSION 7. INTRODUCE THEMES



161

161

INTRODUCE SAFETY MODULE

Self - Safety

- "I can't protect myself from danger."
- "If I go out, I will be hurt."
- "When I feel fear, that means I am in danger."

Other - Safety

- "The world is very dangerous everywhere."
- "People will always try to harm me."
- "There is nowhere safe to be."

160

162

SESSION 7. PRACTICE ASSIGNMENT

"Use the Challenging Beliefs Worksheets to analyze and confront at least one of your Stuck Points each day. Please read over the Safety Issues Module, and think about how your prior beliefs were affected by your trauma. 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." (Handout 8.4)

163

163

PHASE 5. SESSIONS 8-11 TRAUMA THEMES:

SAFETY
TRUST
POWER/CONTROL
ESTEEM
INTIMACY

164

164

FINAL 5 SESSIONS

- Use the **Challenging Beliefs Worksheet** throughout the rest of therapy.
- Each theme can relate to beliefs about self or others.
- Challenging should help clients move from extreme statements to balanced statement.
- Use of the full continuum of thoughts and emotions.

165

165

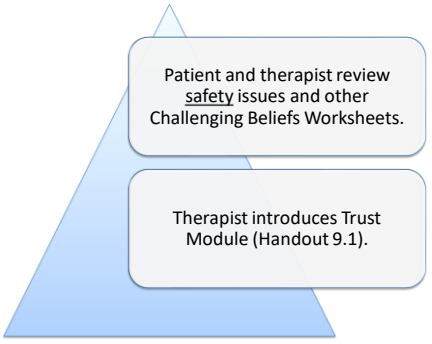
FORMAT FOR FINAL FIVE SESSIONS

- Assess symptoms
- Review module and worksheets and assist as consultant (Client takes on a greater role)
- Focus on individual Stuck Points as well as the theme for the session
- Introduce the new theme and module
- Other specific assignments for sessions 11 & 12

166

166

SESSION 8 OVERVIEW: Processing Safety and Introducing Trust



167

167

SAFETY – EXPLORE PROBABILITY

Challenging safety is primarily about putting actual probabilities into perspective (i.e., if someone is deployed twice and doesn't die, that doesn't mean he will die the third time).

Do traumas happen daily, weekly, monthly, yearly? Are they actually connected, or is the patient connecting only some of the "dots" (leaving out all the good and neutral events)?

168

168

Video Example

Safety CBW

169

169

Cognitive Processing Therapy

Reviewing the Challenging Beliefs Worksheet on Safety

170

170

Cognitive Processing Therapy

Practice

Role-play activity on
CBW and Safety Issues

HANDOUTS #4, #5, and #9

169

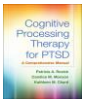
171

Cognitive Processing Therapy

Role Play Exercise: Challenge a Safety-Related Stuck Point with the CBW

Materials needed:

- Challenging Beliefs Worksheet (p. 175 or handout)
- Patient Scenarios (handout #5)



Goal and Instructions:

- Develop a beginning/intermediate level of competence using the Challenging Beliefs Worksheet (CBW) to challenge and change a stuck point.
- Introduce the CBW to your patient and use the worksheet to address a **safety-related** stuck point.

172

INTRODUCE TRUST MODULE

Self - Trust

- "I can't make good decisions."
- "Because I am a poor judge of character, I can't tell who can be trusted."
- "If I make choices, then they never work out."

Other - Trust

- "No one can be trusted."
- "If I trust someone, they will hurt me."
- "If I get close to someone, they will leave."

170

173

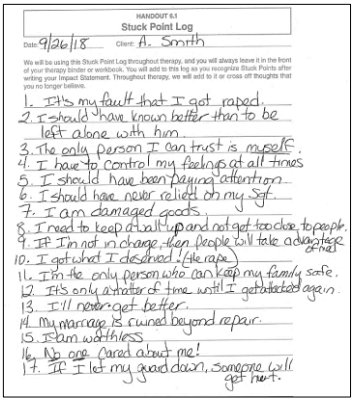
SESSION 8. PRACTICE ASSIGNMENT

"Use the Challenging Beliefs Worksheets to analyze and confront at least one of your Stuck Points each day. Also, please read over the Trust Issues Module, and think about how your prior beliefs were affected by your trauma. If you have trust issues or Stuck Points related to yourself or others, complete at least one worksheet to examine those beliefs. Use the remaining sheets for other Stuck Points or for distressing events that have occurred recently." (Handout 9.2)

174

174

Which are about Trust?



HANDOUT 6.1
Stuck Point Log

Date 9/26/18 Client: A. Smith

We will be using this Stuck Point Log throughout therapy, and you will always leave it in the front of your therapy binder or workbook. You will add to this log as you recognize Stuck Points after writing your Impact Statement. Throughout therapy, we will add to it or cross off thoughts that you no longer believe.

1. It's my fault that I got raped.
2. I should have known better than to be left alone with him.
3. The only person I can trust is myself.
4. I have to control my feelings at all times
5. I should have been paying attention
6. I should have never relied on my Sgt.
7. I am damaged goods.
8. I need to keep it all "up" and not get too close to people.
9. If I'm not in charge, then people will take advantage of me!
10. I got what I deserved. (the rape)
11. I'm the only person who can keep my family safe.
12. It's only a matter of time until I get attacked again.
13. I'll never get better.
14. My marriage is ruined beyond repair.
15. I am worthless.
16. No one cared about me!
17. If I let my guard down, someone will get hurt.

175

175

SESSION 9 OVERVIEW: Processing Trust and Introducing Power/Control

Patient and therapist review trust issues and other Challenging Beliefs Worksheets.

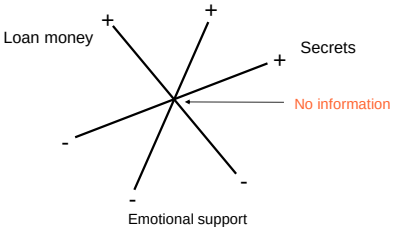
Therapist introduces Power/Control Module (Handout 9.4).

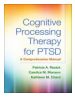
176

176

TRUST STAR WORKSHEET

- Trust with regard to what?
- Generate a list of different types of trust and put on a continuum.





Handout 9.3

177

177

CONTINUUM OF TRUST

Many PTSD patients believe that they should begin from a position of complete trust or complete distrust.

They need to learn to start with "I have no information" and collect data from there.

People make mistakes, and it is important to give people second chances. You can learn to trust more when they don't repeat mistakes. They have changed for you.

178

178

INTRODUCE POWER/CONTROL MODULE

Self - Control

- "If I lose control of my emotions, something bad will happen."
- "I need to be perfect to be in control."
- "If I am not in control, I will be hurt."

Other - Control

- "People will always try to control you."
- "There is no point to speaking up against authority."
- "Others have too much power over me."

176

179

SESSION 9. PRACTICE ASSIGNMENT

"Use the Challenging Beliefs Worksheets to analyze and confront at least one of your Stuck Points each day. Also, if not completed in session, complete the trust star example. Please read over the Power/Control module, and think about how your prior beliefs were affected by your trauma. If you have power/control Stuck Points related to yourself or others, complete at least one worksheet to examine those beliefs. Use the remaining sheets for other Stuck Points on your Stuck Point Log or for distressing events that have occurred recently." (Handout 9.5)

180

180

SESSION 10 OVERVIEW: Processing Power/Control and Introducing Esteem

Patient and therapist review power and control issues and other Challenging Beliefs Worksheets.

Therapist introduces Esteem Module & additional behavioral practice assignments (Handout 9.7).

181

181

POWER/CONTROL: GET SPECIFIC

Control with regard to what? Control of emotions, control over other people's actions, control over urges, control over future events?

If the client says he/she is helpless or has no control, ask them to list all of the decisions they made that day.

Traumas sometimes follow choices and decisions, but that doesn't mean that the choice was a bad decision (outcome-based reasoning).

182

182

Ways of Giving and Taking Power Handout

	GIVING POWER	TAKING POWER
POSITIVE	1. Being altruistic 2. Helping others in need or crisis 3. Sharing yourself with another person as part of the give and take in relationships	1. Being assertive 2. Setting limits and boundaries with others 3. Being honest with yourself and others
NEGATIVE	1. Basing your behaviors solely on the reactions you expect from others 2. Always placing the needs of others above your own 3. Allowing others to easily access your "buttons"	1. Giving ultimatums 2. Testing limits 3. Intentionally upsetting others for personal gain 4. Behaving aggressively

Handout 9.6

183

Video Example

"I can't tolerate other people telling me what to do"

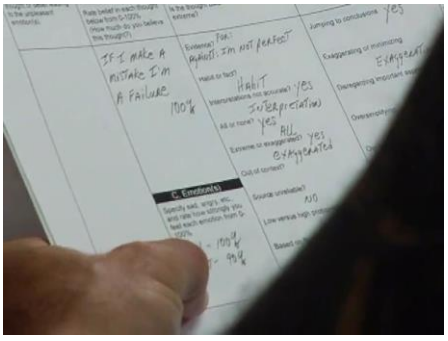
"Bruce"

184

184

Cognitive Processing Therapy

Power/Control: "Bruce"



185

185

Cognitive Processing Therapy

INTRODUCE ESTEEM MODULE

Self - Esteem

- "I am bad."
- "I am worthless."
- "I deserve unhappiness."

Other - Esteem

- "People are only out for themselves."
- "All men are bad."
- "People do not care."

183

186

Cognitive Processing Therapy

NEW ASSIGNMENTS IN ADDITION TO CBW

Giving and receiving compliments

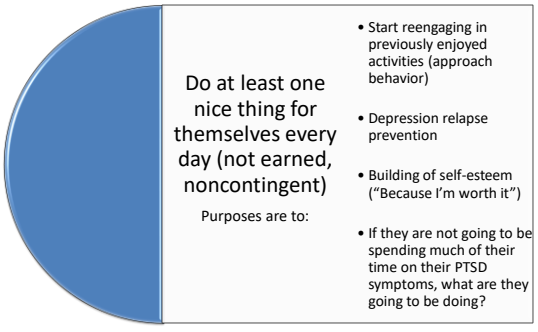
Purposes are to:

- Have them interacting more with other people and focusing their attention outward (giving compliments is a fairly safe interaction)
- Listening to what other people say to them without filtering and distorting
- Considering other sources of information about them
- Help dispute Stuck Points about self

187

187

NEW ASSIGNMENTS IN ADDITION TO CBW



188

188

SESSION 10. PRACTICE ASSIGNMENT

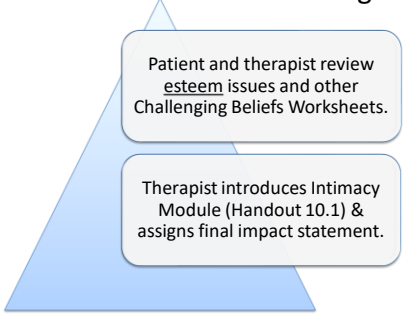
" Use the Challenging Beliefs Worksheets to analyze and confront at least one of your Stuck Points each day. Also, please read over the Esteem Issues Module and think about how your prior beliefs about esteem were affected by your trauma. If you have esteem Stuck Points related to yourself or others, complete at least one worksheet to examine those beliefs. Use the remaining sheets for other Stuck Points on your Stuck Point Log or for distressing events that have occurred recently.

Also, each day before the next session, do one nice thing for yourself "just because," not because you achieved something. Also, practice giving one compliment and receiving one compliment each day. Write the nice things you did for yourself, and the names of the persons whom you complimented and who complimented you, on this sheet. It is better to compliment people for something they did rather than how they look. If any of these assignments result in Stuck Points, please complete a Challenging Beliefs Worksheet on them." (Handout 9.8)

189

189

SESSION 11 OVERVIEW: Processing Esteem and Introducing Intimacy



190

190

INTRODUCE INTIMACY MODULE

Self - Intimacy

- "I can't tolerate being alone."
- "I can't handle my trauma symptoms by myself."
- "I can't take care of myself."

Other - Intimacy

- "If I get close to someone, I will get hurt."
- "I will always be taken advantage of in relationships."
- "All anyone ever wants is sex."

188

191

SESSION 11. PRACTICE ASSIGNMENT

"Read the Intimacy Issues Module and use Challenging Beliefs Worksheets to confront Stuck Points about intimacy related to yourself or others. Continue completing worksheets on previous topics that are still problematic and/or any concerns you have about ending treatment.

Continue to practice doing nice/worthwhile things for yourself and giving and receiving compliments.

*Finally, please write at least one page on what you think **now** about why your 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." (Handout 10.2)*

192

192

6. Facing the Future

193

193

SESSION 12 OVERVIEW: Processing Intimacy and the Final Impact Statement

- Patient and therapist review Challenging Beliefs Worksheets on intimacy.
- Patient reads new Impact Statement.
- Patient and therapist review course of therapy and skills learned.
- Patient and therapist identify future goals and issues which still need attention.

194

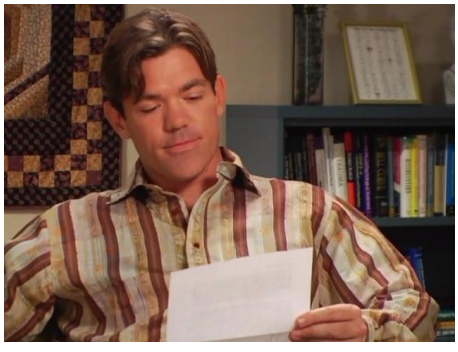
194

- Video Example
- Final Impact Statement

195

195

The Final Impact Statement



196

196

SESSION 12. REVIEW AND GOALS

Review course of therapy and skills learned.

Identify future goals and issues which still need attention.

197

197

Flexible Length CPT

Early Completers

- Mutual agreement between therapist and patient to end early
- Low PCL-5 score (PCL<19), significant functional improvement
- Assign final impact statement prior to final session

Late Completers

- Agree on a limited number of extra CPT sessions (up to 15 total sessions)
- Focus on CBW practice and Stuck Point log
- Delay final impact statement until the final CPT session

198

198

Variation of CPT:

CPT with Written Accounts (CPT+A)

199

199

CPT plus Account (CPT+A)

Also 12 sessions

Adds written account assignment in Sessions 3 and 4

Major Changes:

- Session 3: Assign written account
- Session 4: Reassign written account
- Session 5: Introduce Challenging Questions
- Session 6: Introduce Patterns of Problematic Thinking
- Session 7: Introduce Challenging Beliefs Worksheet AND Safety Module

200

200

CPT VERSUS CPT+A

1. Overview of PTSD and CPT	1. Overview of PTSD and CPT
2. Examining Impact of Trauma	2. Examining Impact of Trauma
3. Working with Events, Thoughts, and Feelings (ABC)	3. Working with Events, Thoughts, and Feelings (ABC)
4. Examining the Index Event (ABC)	4. Remembering Traumatic Events
5. Challenging Questions	5. Remembering Traumatic Events
6. Patterns of Problematic Thinking	6. Challenging Questions
7. Challenging Beliefs	7. Patterns of Problematic Thinking
8. Processing Safety	8. CBW/Processing Safety
9. Processing Trust	9. Processing Trust
10. Processing Power/Control	10. Processing Power/Control
11. Processing Esteem	11. Processing Esteem
12. Processing Intimacy and Meaning of the Event	12. Processing Intimacy and Meaning of the Event

201

201

CPT VERSUS CPT+A?

FACTORS THAT INFLUENCE THE CHOICE

Let the Patient Choose!

CPT	CPT + A
– Patient does not want to write account.	– Patient would like to write an account.
– Patient really has no recollection of the event.	– Account writing and sharing full details might be therapeutic.
– Impending deployment/not enough time for full protocol.	– Patient states he has little or no memory of the event due to avoidance (writing acct may help recover the details).
– Want more time to develop cognitive skills.	– Patient is highly dissociative or has history of frequent child sexual abuse.
– Conceptualization of case warrants more cognitive restructuring.	– Therapist believes that the patient needs to express avoided emotions.
– Conducting group therapy.	

202

202

CPT vs CPT+A

Offer choice of CPT or CPT+A.

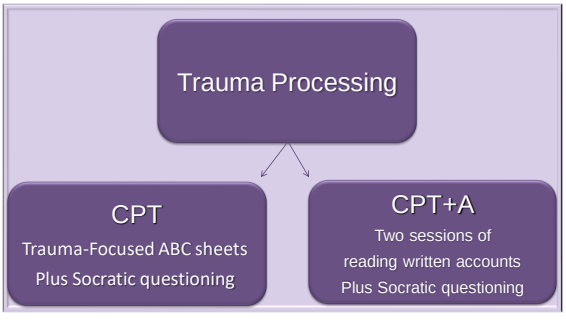
Make decision to do CPT or CPT+A before the start of treatment, then stick with that plan.

In CPT+A, if the patient doesn't write account in sessions 4 and 5, do not "switch back to CPT." Ask the patient to do the account orally and reassign so as to not reinforce avoidance.

203

203

CPT OR CPT+A PROCESSING APPROACHES



204

204

Purpose of "Trauma Processing" Assignments: twofold

- People get "stuck" in non-recovery 2 ways:
  - Thoughts (Stuck Points)
  - Feelings (numbed-out, stuffed away, anger)
- The trauma-focused worksheets and the trauma account target this "stuckness" by
  - Identifying Stuck Points and challenging them
  - Emotional processing: unlocking and expressing emotions that dissipate over time
- It is helpful to explain this rationale when giving the assignment to increase understanding of the purpose and importance of completing the assignments.

205

205

SESSION 3. PRACTICE ASSIGNMENT FOR CPT+A

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

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

206

206

SESSION 4. CPT+A FIRST ACCOUNT

- Patient reads account aloud to therapist.
- Patient and therapist discuss reactions to writing it/reading it.
- First work on emotions. Sit with them, name them.
- Therapist gently challenges self-blame and hindsight bias. Be curious.

207

207

SESSION 4. PRACTICE ASSIGNMENT FOR CPT + A

"Write another account of the whole traumatic incident as soon as possible. If you were unable to complete the assignment the first time, please write more than you did 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 - for instance "(Right now I'm feeling very angry)". Remember to read over the new account every day before the next session.

"Also, continue to work with the ABC Worksheets every day."

208

208

SESSION 5 FOR CPT + A SECOND ACCOUNT

209

209

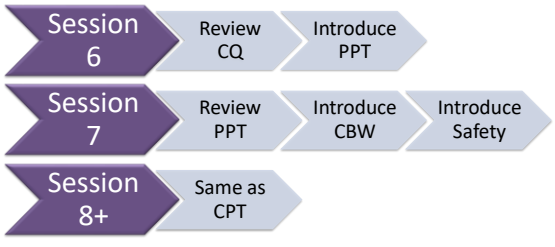
SESSION 5 FOR CPT +A PRACTICE ASSIGNMENT

"Please choose one Stuck Point each day, and answer the questions on the Challenging Questions Worksheet with regard to each of these Stuck Points. There are extra copies of the Challenging Questions Worksheets provided so you can work on multiple Stuck Points. If you have not finished your accounts of the traumatic event(s), please continue to work on them. Read them over before the next session, and bring all of your worksheets and Trauma Accounts to the next session."

210

210

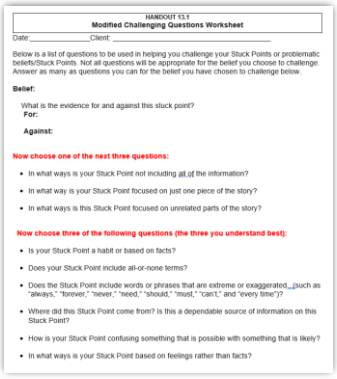
AFTER THE ACCOUNTS IN CPT+A



211

211

Modified Challenging Questions Worksheet



HANDOUT 13.1
Modified Challenging Questions Worksheet

Date:_____Client: _____

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

Belief:

What is the evidence for and against this stuck point?
For:

Against:

Now choose one of the next three questions:

- In what ways is your Stuck Point not including all of the information?
- In what way is your Stuck Point focused on just one piece of the story?
- In what ways is this Stuck Point focused on unrelated parts of the story?

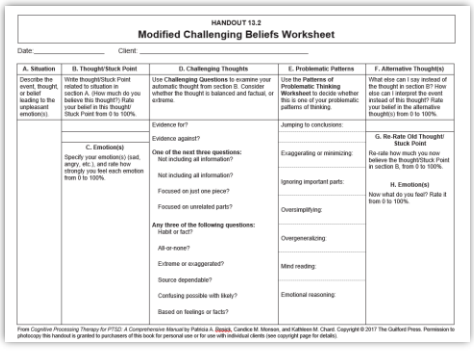
Now choose three of the following questions (the three you understand best):

- Is your Stuck Point a habit or based on facts?
- Does your Stuck Point include all-or-none terms?
- Does the Stuck Point include words or phrases that are extreme or exaggerated (such as "always," "forever," "never," "need," "should," "must," "can't," and "every time")?
- Where did this Stuck Point come from? Is this a dependable source of information on this Stuck Point?
- How is your Stuck Point confusing something that is possible with something that is likely?
- In what ways is your Stuck Point based on feelings rather than facts?

212

212

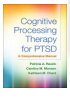
Modified Challenging Beliefs Worksheet (#1)



HANDOUT 13.2
Modified Challenging Beliefs Worksheet

Date:_____ Client: _____

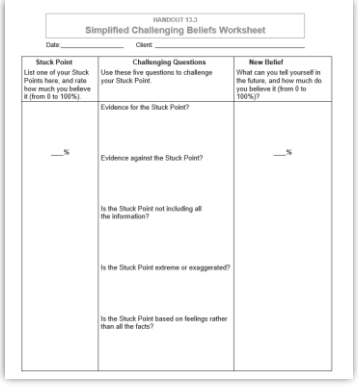
A. Situation	B. Thought/Stuck Point	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
Describe the event, thought, or belief leading to the unpleasant emotion(s).	Write thought/Stuck Point related to situation in section A. (How much do you believe this thought?) Rate your belief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



209

213

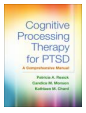
Modified Challenging Beliefs Worksheet (#2)



HANDOUT 13.3
Simplified Challenging Beliefs Worksheet

Date:_____ Client: _____

Stuck Point	Challenging Questions	New Belief
List one of your Stuck Points here, and rate how much you believe it (from 0 to 100%).	Use these five questions to challenge your Stuck Point.	What can you tell yourself in the future, and how much do you believe it (from 0 to 100%)?
	Evidence for the Stuck Point?	
___%	Evidence against the Stuck Point?	___%
	Is the Stuck Point not including all the information?	
	Is the Stuck Point extreme or exaggerated?	
	Is the Stuck Point based on feelings rather than all the facts?	



214

214

RECOMMENDED READINGS FOR LEARNING COGNITIVE THERAPY APPROACH

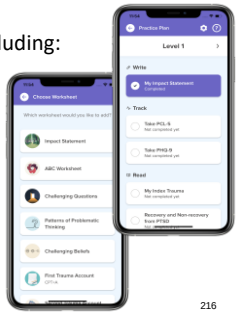
- Beck, J. (2011). *Cognitive behavior therapy: Basics and beyond.* Guilford Press.
- Wright, J., Brown, G., Thase, M., Basco, M., (2017). *Learning cognitive-behavior therapy: An illlustrated guide.* American Psychiatric Press.

215

215

CPT COACH APP

- Designed for patients to use while in CPT with a provider
- Contains support materials including:
  - assignments
  - readings
  - PTSD symptom monitoring
  - CPT worksheets
  - appointment reminders
  - therapist contact information
- Can be used on phones or tablets



216

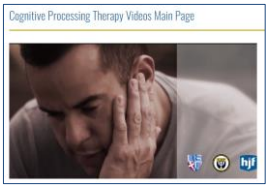
216

CPT VIA TELEHEALTH

- Standard CPT protocol can be delivered.
- CPT can be delivered in both the individual and group format.
- Training in clinical video teleconferencing (VTC) will assist in therapist confidence/ comfort.
- Collaboration with on-site support staff is essential.
- Pre-treatment orientation session is helpful – introduce VTEL modality.

218

CDP Expert Demonstration Videos



- Introducing CPT to a client
- Identifying Stuck Points
- Working with guilt
- Identifying the Index Trauma
- And more…..

https://deploymentpsych.org/CPT-videos-main-page

221

221

CPT Case Consultation

222

222

Why is Consultation Important?

- ❖ Consolidates workshop learning.
- ❖ Promotes use of critical thinking skills via review of specific case examples and implementation strategies.
- ❖ Provides more opportunities to practice Socratic questioning and other CPT skills.
- ❖ Builds CPT community; you can meet and learn from other CPT clinicians.
- ❖ Most importantly, helps patients by teaching clinicians how to provide the best CPT care possible.

223

223

Consultation with CDP Experts

- Monthly CPT Virtual Office Hours:
  https://deploymentpsych.org/consultation-call
  (Register once and then join whenever you can)
- A confidential message sent through our **Ask the Expert** webpage at
  http://deploymentpsych.org/content/ask-expert
  (requires logging into the website)
- A dedicated consultation email:
  consultation@deploymentpsych.org

224

224

Achieve CPT Provider Status

- After successful completion of CPT training requirements, be added to CPT Provider Roster at www.cptforptsd.com
- 2 levels of provider status:
  - CPT Provider
  - Quality-Rated CPT Provider

225

225

deploymentpsych.org

- Descriptions and schedules of upcoming training events
- Blog updated daily with a range of relevant content
- Articles by subject matter experts related to deployment psychology, including PTSD, suicide prevention, depression, and insomnia
- Other resources and information for behavioral health providers
- Links to CDP's Facebook page and Twitter feed

225

229

Other Learning Opportunities

- CDP Presents - Monthly Webinar Series
  - Live and archived
  - CEs free for live, small fee for on-demand CEs
  - View archived webinars free for no CEs
- On-demand Courses
  - Military Culture
  - Deployment Cycle
  - Intro to PE and CPT
  - …and more!

226

230

Provider Support

CDP's "Provider Portal" is exclusively for individuals trained by CDP in evidence-based psychotherapies (e.g., CPT, PE, and CBT-I)

- Consultation resources
- Printable fact sheets, manuals, handouts, and other materials
- FAQs and 1:1 interaction with answers from SMEs
- Videos, webinars, and other multimedia training aids

Participants in CDP's evidence-based training will automatically receive an email instructing them how to activate their user name and access the "Provider Portal" section at Deploymentpsych.org.

227

231

Center for Deployment Psychology

Department of Medical & Clinical Psychology
Uniformed Services University of the Health Sciences
4301 Jones Bridge Road
Bethesda, MD 20813-4768

Contact Us

Email: cdp-ggg@usuhs.edu
Website: deploymentpsych.org
Facebook: http://www.facebook.com/DeploymentPsych
Twitter: @DeploymentPsych

228

232

Cognitive Processing Therapy

Questions?

233