



PTSD 101 Course

Transcript for: Cognitive Processing Therapy

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Today, we are going to be talking about the Veterans Affairs Department of Defense clinical practice guidelines for PTSD 2010. We're going to focus on treatment interventions, in specific Cognitive Processing Therapy.

I'm Kate Chard and I am the VA CPT Implementation Director and I work at the Cincinnati VA Medical Center in the University of Cincinnati.

We have three objectives today. The first is to discuss the guideline related to Cognitive Processing Therapy, the second is to review the empirical evidence supporting Cognitive Processing Therapy and the third is to describe and demonstrate some of the clinical applications of CPT.

So, let's start with our first objective. Let's summarize what the clinical practice guidelines say related to CPT.

First, what we need to do is talk about psychotherapy in general. The clinical practice guidelines clearly state that the first line treatment intervention for PTSD should be psychotherapy using either: an exposure based therapy such as Prolonged Exposure and/or a cognitive restructuring therapy such as CPT; or one could use Stress Inoculation Training or EMDR.

Secondly, we would turn to our pharmacotherapy such as our Selective Serotonin Reuptake Inhibitors also known as SSRI's or things like our SNRI's a neuroclass.

This slide discusses a guideline for choosing the intervention of choice for the treatment of PTSD. And the choice of a specific approach should be based upon the severity of the client symptoms and the clinician's expertise in one or more of the treatment methods and, finally, a patient's preference. So, to that end, one might choose psychotherapy in combination with medication or, if the clinician is not comfortable with prescribing or does not have access to a prescriber, they may choose to start with psychotherapy alone.

What this slide further demonstrates is that we have a classification in terms of benefit that have been studied in several randomized control trials. The first box in the top left corner shows us that using trauma-focused psychotherapy that, again, includes parts of exposure/cognitive restructuring is most

effective. The second category in the middle shows us that using patient education, imagery rehearsal, hypnosis and relaxation techniques have some benefit but not the same amount of benefit as our previously discussed interventions.

We also know that Family Therapy is an important part of therapy for many patients and can have some benefit. At this point, the benefit is unknown about using web-based CPT interventions, Acceptance and Commitment Therapy, otherwise known as ACT, or Dialectical Behavioral Therapy, also known as DBT, for the treatment of PTSD.

Cognitive Processing Therapy was developed in 1988 by Dr. Patricia Resick as a twelve session group protocol. Since that time, it has also been implemented as an individual protocol, and a group and individual protocol, for a variety of traumatic experiences. It is a trauma-focused cognitive therapy, but the therapy can be done with or without review of traumatic accounts. In addition, it is recovery focused with the idea being that we're going to be collaborative with our clients and we're going to make sure that our clients have informed choice about the protocol.

Since 2007, the VA has been disseminating Cognitive Processing Therapy throughout its clinics and community based treatment centers. There have been 51 funded workshops and 51 non-rollout workshops to the Department of Defense and Vet centers throughout the States. We also have been doing consultation calls – 36 hours a week and corresponding with mental health administrators throughout the VA about how to do Cognitive Processing Therapy. Finally, as part of the roll out, we have provided advanced lectures on teleconferencing equipment to clinicians in a variety of settings.

As part of the rollout, we developed three CPT manuals with a focus on military and veteran issues. We have the individual manual, the group manual and a materials manual that has all of the information that a client would need to do CPT with their therapist. In addition though, we created a trainer's manual critical for our trainers who are training clinicians throughout the nation in the use of CPT, and a consultant's manual for consulting with clinicians after they've gone to a training to help them with the daily ins and out of how to implement CPT in their practice.

To make the trainings even more clear, we created training videos with bird's-eye views with examples and commentaries about how to do specific parts of the treatment protocol. To help our clinicians in their practice, we created a clinician fact sheet which clinicians can share with other clinicians in their practice and a patient's brochure to share with patients. Both of these tools can be used to educate, and encourage individuals to come and try CPT for the first time.

We also have a VA website with downloadable materials, a discussion board and a calendar, that's available for all VA clinicians to find out more information on all of these topics.

As of 2010, December 1, we have trained 1,916 people in the rollout but we also trained a number of additional participants in the Department of Defense and the community for a total of 4,025 participants across the United States. We've offered 22 advanced lectures on a variety of topics related to CPT and, at this point, we have 432 individuals who have completed the entire training process.

The rollout continues and, currently, we're providing additional basic and group workshops to clinicians throughout the nation; but, we're also providing refresher workshops for individuals who may have started the treatment early on and were not able to complete their training at that time. Finally, we have web-based enhancement training and DVDs with new video material and lectures available to individuals who need to learn in a web-based setting easily, at their desk, and continued advanced tutorials that individuals could attend every other month for specific information on the complex issues of providing CPT.

We're also looking at quality assurance and fidelity. In doing so, we're looking at finding ways to measure how well people are adhering to the treatment protocol as they implement this with their patients. Finally, we have created an educational video for patients who are considering CPT. This video is available to program coordinators throughout the VA, it's posted on our VA website and it's also available on the National Center for PTSD (NCPTSD) website to clinicians throughout the nation, not just in the VA.

Now, let's turn our attention to our second objective and review some of the empirical evidence supporting CPT with a variety of patient populations.

Let's talk about some of the clinical trials that have been done on Cognitive Processing Therapy and several of the effectiveness studies done in clinics around the nation. You can see the CPT manual for exact references of all the studies we're going to discuss.

To date, there have been 4 randomized clinical trials on Cognitive Processing Therapy with rape victims, child sexual abuse survivors, Veterans and survivors of rape and assault. So, how well the CPT work? Let's take a look.

As you can see from this slide of the four clinical trials, several of the patients had a comorbid diagnosis of depression and, while many of the studies were done on women, we did include a study which was 93% male looking at Veterans. In several of the cases, the treatments were compared to wait list controls but, in other cases, they were compared to an alternate treatment such as Prolonged Exposure or, in the final case of the Resick 2008 study, the treatment was dismantled to look at the components of CPT to see which mattered the most in helping an individual recover.

ITT, at the top of the slide, implies Intent to Treat Analysis. This is the most conservative way of looking at your data, because it includes all participants who entered a clinical trial in the analysis, whether they drop out after session one or they complete the entire therapy.

Let's take a look at the Clinician Administered PTSD Scale for the treatment of PTSD in all of these clinical trials. The CAPS is considered to be the gold standard for evaluating PTSD, and, as you can see, in all four studies there were significant changes from pre-treatment to post-treatment on the CAPS. This graph shows severity of PTSD and shows us that the individuals, after they complete treatment, are significantly better than they were at pre.

This slide further describes the results from the same studies that we discussed in the previous slide, but these are the result of the treatment completers as opposed to the ITT sample that was depicted on the prior slide. So, these are the individuals that actually complete the therapy and go through all of the sessions. What we can see here is that individuals get better when they participate in Cognitive Processing Therapy and what we see is over a 50% drop across the board in PTSD symptoms.

Here is the Beck Depression Inventory, also known as the BDI, for our same treatment completers. What we note, is though not all drop below the cut off for depression, which is a 14, there was a consistent decrease in symptoms. Also note that these are of average effects and that means we're taking into account those who did not do as well and then those who did incredible well in the therapy. So on the whole, again, although this treatment targets Posttraumatic Stress Disorder, individuals with depression also do well in this therapy.

Let's talk a little bit about what happens when we dismantle CPT and look at its component parts. And we are going to do that looking at a study of female victims of interpersonal violence that Dr. Resick and her colleagues did in 2008.

The participants in this study were 150 women who had a history of at least one sexual or physical assault and who met the criteria for PTSD from that event. They had to be at least three months post-trauma and they had to be stable on any medications for their PTSD for at least three months. They currently cannot meet criteria for psychotic disorder nor could they be a danger to themselves or others due to suicidal or homicidal ideation. In addition, none of them met criteria for current substance dependence, but it was acceptable for them to meet criteria for current substance abuse.

Let's take a look at the PTSD Diagnostic Scale, the PDS, comparing these 3 treatment conditions. The first treatment condition is represented by the red line -- the written accounts, where individuals were asked to write about their traumatic accounts and read them to the therapist, but with none of the cognitive restructuring associated with CPT. The blue line represents CPT in its full format, with the cognitive restructuring and the written narratives. The green line represents CPTC, or CPT-Cognitive-only, where we had individuals go through CPT and do all of the cognitive challenging and restructuring, but without a focus on writing the written narratives.

What this slide shows us is that all three groups got better, but that the CPT-C condition showed a quicker response to the therapy than the other two conditions. Once we got to week six, though, which was the end of the 12 session protocol, CPT and CPT-C were neck-and-neck and they stayed neck-and-neck through post treatment, and then on to the six month follow-up.

What you see, though, is individuals who received the written account only, without any of the cognitive restructuring, did not do as well as the other two conditions. What this tells us is that we can do Cognitive Processing Therapy with individuals who need to tell their story and want to tell their story through a written account, but we can also be very effective using Cognitive Processing Therapy with individuals who are not yet ready to tell their account or will become so overwhelmed by their traumatic material that they will not be able to complete the therapy.

People often ask me, "But does CPT work over time? How long will these results last in my client?" So, let's talk about a long-term follow-up study comparing Cognitive Processing Therapy and Prolonged Exposure, the two most researched treatments for PTSD in a head-to-head trial.

This study followed-up 171 women five-plus years after they completed their treatment study using CPT and PE. The mean was six years, but with a range of five to ten years post therapy. Of the 171 women that we tried to locate, we could not find 25 and three were deceased. Of the remaining 143, 17 refused to participate and two were located, but were not appropriate due to other things going on in their lives. So, we were able to create a study by looking at the diagnostic interviews on 124 with complete assessments on 119, giving us an 88% participation rate with this six year follow-up.

Again, using the conservative Intent-to-Treat Analysis, we can compare CPT and PE at pre-, post-, three-month, nine-month and five-plus year follow-up. And, what you see is that these two treatments are neck-and-neck and, at five-plus years, they both show a very similar response. Individuals who go through CPT and PE get better and they stay better.

Now, some of you may be wondering that these are treatment studies. What would a patient or a client look like in a clinical setting without all the structure of an actual randomized control trial? So, let's look at some VA clinics in Cincinnati, Madison and Minneapolis and their results after implementing CPT in their clinics.

This slide shows us the PTSD checklist also known as the PCL scores for outpatient clinics. Now, in Minneapolis and in Cincinnati, you see group and individual and individual therapy, while in Madison, you see only individual CPT. Keep in mind that these data represent all areas of Veterans and a wide variety of therapists including students with a range of experience using CPT. What we can see, though, is

there's a clinically significant improvement in all of the different types of patients going through CPT in these clinics.

Looking a little bit more closely at the CPT results comparing our Vietnam Veterans versus our Veterans returning from Iraq and Afghanistan, also known as OEF/OIF, what we see is that both groups do well in CPT. What we do find is there's a trend for Veterans from Operation Enduring Freedom and Operation Iraqi Freedom, Afghanistan and Iraq, to do a little bit better in CPT than Veterans from Vietnam.

This may be because the Veterans from Vietnam have had a longer time to live with PTSD and PTSD has become a part of their life in many ways, shapes and forms that then need to be worked out during and after therapy.

Many people wonder, "What will I do with my client after they go to CPT? Do I do anything with them? Do I send them to primary care?" What we know is that when we looked at the Minneapolis VA, and we looked at the amount of use of mental health appointments after going through CPT, there was a significant drop from the four months prior to receiving CPT to the four months after receiving CPT. What this suggests is that individuals who've received CPT may not be as interested in, or even needing, the same amount of mental health care after receiving treatment.

Many individuals are able to attend residential treatment programs for their PTSD, and what this slide looks at is men and women on the CAPS, the PCL and the BDI, and, what you see is that men and women both do well across all of these measures. We do see a little bit of a difference where we note that the women show a larger drop on this slide in their depression symptoms than the men. This could, though, be due to the fact that more women reported to having depression at pre-treatment than in men, and so there is a bit of a difference in the n size, or the sample size.

A growing area of concern for many of us treating Posttraumatic Stress Disorder is the issue of traumatic brain injury (TBI). In our returning Veterans we see larger and larger numbers of individuals who have had a history of traumatic brain injury, but this is also something that we see in the community setting where individuals may be suffering from PTSD due to a car accident, an industrial accident or a natural disaster, where the PTSD may be associated with a history of traumatic brain injury.

Many people wonder, "Can I use a cognitive based therapy when my individual has a history of TBI?" This slide shows us males in an outpatient setting, males in a residential setting and a TBI residential treatment program focusing again on Cognitive Processing Therapy in a cognitive only model, the CPT-C. What we see looking at the CAPS, the PCL and the BDI is that individuals who go through this TBI PTSD program using CPT do just as well as men without a history of TBI who go through residential programming or men who go through CPT in an outpatient clinic.

These individuals met criteria for mild traumatic brain injury, moderate and, in two instances, severe traumatic brain injury. What this shows us is that individuals who have a history of traumatic brain injury can still do CPT, especially if the clinician is able to focus on the cognitive restructuring and, hopefully, engage support from other clinicians in areas such as speech, occupational therapy, and physical therapy, as needed.

Whenever I do a presentation on CPT, there are several frequently asked questions that come up from audience participants. I thought I'd review a few of those with you now. First of all, many people ask, is group CPT evidence based?

We have one randomized controlled trial showing that group and individual therapy combined is effective, but we don't have definitive evidence that group CPT alone is evidence based. There are a few relevant studies, though, that we can look at to shed more light on this topic. The first study of rape

victims indicated that group CPT was better than a waitlist control, but participants in this study were not randomized to either condition. Second, there is a brand new study in press suggesting that group CPT is better than group treatments as usual; however, this treatment was not randomized either, and the decreases in PTSD symptoms are smaller than what we have seen in individual formats. No trials to date have compared individual versus group CPT, although there is one underway currently. So, strictly speaking we can't say that group CPT is evidence based. But, these studies do suggest that it might be effective. And for some settings, where there may be good reasons or pressure to run groups, it probably makes sense to use CPT in a group format.

Next, "What do I do with a partial-responder? What do I do with someone who doesn't quite get better?"

The first thing that I would suggest is, when did you identify that they were a partial-responder. Did you check in with them halfway through the therapy? A third of the way through the therapy? Assess their buy-in. Look at their compliance. Are they actually completing the practice assignments? Do they have any stuck points about not getting better? Not being able to get better? Or, "What will happen to me if I do get better?" What we like you do is begin as early as possible to identify people who are stuck and not able to move forward and that is getting in their way. If someone goes through all of the twelve sessions and still needs a little bit more help, has shown great improvement but they're not quite where we think can get, the research suggests that adding an additional couple of sessions can actually help move them all the way down to a non-diagnostic response.

"Well, what do I do with a non-responder then? What do I do with someone who just isn't getting better?"

Again, let's remember to assess buy-in as early as possible and look at their compliance. You never want to drag a patient or a client through your therapy. If they are not participating outside of the office, they are not going to get better. So, what I would do at that point in time is maybe recommend some alternative treatments that they may be more invested in completing. Or, maybe even seeing if they're just not invested in any therapy at this time but they'd be willing to come back later on when their life circumstance changes.

A few more questions: "What about adding medication? When should I or should I add medication?"

Definitely medication can be used for targeting symptoms such as sleep or depression when those symptoms are so unmanageable for the individual that they're getting in the way of therapy. Do not feel like adding medication is a definite need for CPT.

"What if I'm doing group CPT and someone is not participating?"

The first thing we want to make sure we do is make participation a group rule in session one. That will allow you to gently call on them in future sessions if they are not participating, to encourage them to participate in group. You can call on them in the group quietly, you can call on them more assertively, and you can talk to them privately about their lack of participation. Again, if they're not participating in the treatment, they are not going to get better. So, we definitely want them participating.

"What about my complex patients? Does CPT work for them?"

Definitely. Several studies have demonstrated that CPT is efficacious for patients with personality disorders, substance use disorders, and I've mentioned a history of TBI. Your job is to assess each and every one of your patients before starting your CPT therapy to look for any symptoms that will get in the way of their ability to do CPT. But, our experience shows us that a majority of patients are able to do CPT.

Let's move to objective three. In this section, I'm going to describe and demonstrate the clinical application of Cognitive Processing Therapy, including some video clips of Cognitive Processing Therapy in action.

As I've mentioned before, this protocol involves very specific session-by-session content. It includes psycho-education, writing about the impact of the trauma, teaching the clients to connect their thoughts and feelings, and challenge their thoughts about the trauma, and, it can be done with or without those written accounts. What I'd like to do now is go into more detail about the exact session content.

In sessions one through four of CPT, we start with the education and we ask our client to write an impact statement about the impact of their trauma on them in terms of their thoughts and feelings about themselves, others, and the world, and then also focusing on the areas of safety, trust, power and control, self esteem and intimacy. Throughout this, the client identifies stuck points or thoughts that have impeded them from recovering. Things like "I am a failure." "It's my fault the trauma happened." "No one can be trusted."

The client learns the connections between their events, the thoughts and the feelings, so that they can see that what they're telling themselves affects how they feel and how they then respond to future events. Finally, the client writes a detailed account of their traumatic incident or incidents, including explicit sensory details, thoughts, and feelings so that we can begin to examine these accounts for more stuck points. If doing the CPT-Cognitive only model, we do not do an account, but continue to use our other worksheets to identify the thoughts and the feelings related to the trauma and events happening daily in their lives.

Now, I'd like to show you a video of a patient with traumatic brain injury and PTSD doing the initial stages of Cognitive Processing Therapy. We're going to work through something called an ABC Sheet. This is a tool we use to help the individual identify an event, their thoughts, and their feelings, and then, look at alternative ways that they can look at the event after they employ some of their new ways of thinking that we've generated through Cognitive Processing Therapy. In this video, you'll see some gentle Socratic questioning, which is using open ended questions to help the individual challenge what they've been telling themselves by looking at more of the evidence.

Therapist: Hi Jake. Welcome back. So it looks like you filled in your PTSD checklist form already. How's the week been with the symptoms?

Patient: Um, you know, you can take a look. We've... there's still been... Some things are a little bit better. It's probably overall better a week, but I had some things that happened what were just, you know, pretty frustrating. And so, it wasn't... I mean, still with being triggered--you know, if I see something that reminds me of what happened, I get physically feeling bad and alert and everything else. and then, you know, down at the bottom there, my concentration has still been a really big problem, and that's probably... All of it together has made me more irritable. And they tell me, you know, my concentration, and a lot of these things with my TBI. It's like, I don't know how much better it's gonna get. So it's all frustrating and it makes me irritable.

Therapist: Well, sure, sure. I notice that the concentrating actually got worse over the past week. Did something happen that is causing that to get worse?

Patient: I mean, I thought I was doing better with all the tricks. The TBI clinic's been working with me about giving myself reminders, but then I – I wrote a time down wrong for when I was supposed to be at a job interview a couple days ago. And I've really been trying to get back to work and I showed up two hours after I was supposed to be there. And so they pretty much said that was my one chance, and they didn't

reschedule. So, you know... extremely frustrated that day. And I haven't been trusting my ability to concentrate or get things right, or trust my memory at all ever since.

Therapist: One of the things we had talked about was using the ABC sheets.

Patient: Yeah, I did a bunch of ABC sheets, but I thought they were in the car but they weren't. And so when I got out, I realized I had forgotten those today, too, so---

Therapist: No worries. No worries. We've always got blanks here, right? So why don't we do one on that together? So the issue was that you were late for the job interview, right?

Patient: Right.

Therapist: What did you tell yourself about that?

Patient: Well, you know, "Here we go. I screwed something up again," and, you know, "I blew it," and I ruined a good opportunity.

Therapist: OK. Well, now, when you say, "I screwed it up," how do you feel?

Patient: Angry at myself... Angry at my TBI, you know. I guess, then I start getting sad when I think about this isn't changing, and it's not feeling like it's getting any better for me.

Therapist: OK. So, I'm wondering: Is there a stuck point in there, then. So you kind of went from, "I screwed up again," to something a little stronger, more permanent.

Patient: I mean, I guess I started thinking, "I'm gonna keep screwing up everything, and nothing's gonna work out right for me."

Therapist: OK. So is "always" in there? Is that what I'm hearing?

Patient: Yeah. I always screw up.

Therapist: OK. Kind of an "always will," right? "I'll screw up everything."

Patient: It seems like it.

Therapist: OK. OK. Well, then why don't we put that on your stuck point log, because I don't think that was on there already. So I'll kind of make a note about that there.

Patient: OK

Therapist: But let's go back and finish up the sheet. So when you say, "I screwed up again. I only have so many chances to get things right. I need to maximize all my chances, " is it realistic to say that to yourself?

Patient: In that case, yeah. I showed up late. I screwed it up.

Therapist: OK. Well, now, remember at the bottom of the sheet, we ask, "Are the thoughts above realistic?" So, "I don't have any chances. I need to take advantage of all of them. I screwed it up." Is that realistic?

Patient: Yeah, that's a fact. I screwed it up.

Therapist: OK. Exactly. So, you know, that happened. But we also know that this is leading you to feeling angry and sad. Is there anything else you could tell yourself in future situations that would lead to something other than angry or sad?

Patient: I mean, I try to be optimistic, and I try to tell myself I won't screw up the next time. I actually have an interview tomorrow that I've been working hard to try to remind myself of the time. You know, I've got it written down ten different places, and my wife's gonna call and make sure I'm on time. And I've got alarms and everything else. And so, like, I know I'll get there on time, at least.

Therapist: OK

Patient: So, again, I can try to tell myself I'm not gonna screw this up, and...

Therapist: OK.

Patient: That makes me feel a little bit more hopeful, and, I guess "optimistic" is the right word. Yeah, optimistic, good.

Therapist: All right. So, you've been using some of the tricks that you've been taught, then, that's great. You've been using the alarms. You've been using the fridge. You've got your wife calling you. And when you say to yourself, "Well, at least I know I'll be on time. I won't screw up the next time," we're getting to optimistic.

Patient: It takes some work, but, yeah, we're getting there.

Therapist: Yeah? Well, you know, maybe this would be a good time for us to introduce, then, the next sheet. I talked to you last week about how we're going to amp it up a little bit and begin examining these things that you're telling yourself that make you feel bad. What I want to do now is introduce this next worksheet. OK?

So, the Challenging Questions Worksheet. The goal of the worksheet is to let you look at each of your stuck points, right? And put them on the top of the page. But what we're do is look at all the evidence for and against that stuck point. And remember how we talked back in the beginning about how PTSD sometimes lets you only look at information that fits what you've already been thinking negatively about yourself or the world? And our goal is, again, to introduce more flexibility. That maybe there's more ways to look at a situation and more evidence that you can include? This sheet is designed to allow you to see all of the evidence.

And so what we're gonna do is put the stuck point at the top there of "I'm always going to screw things up" and go all the way down. Does that sound like a good idea?

Patient: It looks a little complicated, but if you're saying it's gonna help, we'll give it a try.

Therapist: OK. OK. Well, you can imagine if you could find more evidence like you just did about setting the alarms, and doing all the things that you did, that you'd feel better?

Patient: Yeah.

Therapist: OK. OK. We'll, then, we'll do this one together and see how you feel at the end.

Patient: OK.

Therapist: OK, good.

In the next session of Cognitive Processing Therapy, we get into the meat of the cognitive challenging. We introduce something called the Challenging Questions, which allows us to examine a single “stuck point” on each sheet. Our target here is looking at those stuck points that have been assimilated. In other words, where the individual has taken in information about the trauma without examining it or challenging it for its truth or veracity. What we then move to, is learning about the Patterns of Problematic Thinking.

These are patterns that keep us stuck; patterns such as over generalizing from a single incident, or disregarding information that might be contrary to what they’re thinking at the time. We then bring it all together with the larger Challenging Beliefs worksheet. This worksheet incorporates the ABC Sheets, the Challenging Questions, and the Patterns of Problematic Thinking, but adds on a component where we ask them to generate a new alternative thought; and then, look at their emotions after they’ve identified this new thought. We’re going to use the Challenging Beliefs Worksheet for the remainder of the therapy. The next clip will show the use of these challenging cognitive techniques to move an individual through their stuck point and into an alternative thought. You see the therapist helping the clients challenge their thoughts in a group modality. What you see is that the therapist isn’t focusing on one individual. They’re getting the entire group involved in helping them challenge their thoughts or stuck points related to their traumatic event.

Therapist #1: Why don't we do the same sheet over again but show you that sometimes you can look at a stuck point two different ways, and so if you attempt at looking at it one way, sometimes there's another way to look at it,

Therapist #2: What is the evidence for that belief, "It's my fault."

Client #1: He died. I was the driver. I killed him.

Therapist #2: Okay.

Therapist #1: Anybody else still have a little lingering piece?

Client #2: If I was there, it wouldn't have happened.

Therapist #2: Okay, good. Okay, so let's look at evidence against. What is evidence against the stuck point, "It's my fault"?

Client #1: Well, in my case, I was following orders. They told us that, you know, the kids near, they could have bombs on them, that we need to keep going no matter what, so I was just following orders.

Therapist #1: Mm-hmm. So you've got kind of two separate pieces of information running around your head right now: "I was following orders, the kids could have had bombs, but I was still the driver."

Client #1: Mm-hmm

Therapist #1: How much of the time do you focus on that first part instead of the second part?

Client #1: I focus a lot on being the driver.

Therapist #1: Mm-hmm. Okay, okay. So we'll have to work on that a little bit, won't we, really focusing on the truth of the situation. What would have happened if you hadn't have kept going and you stopped the truck?

Client #1: We could have all died, like, all my buddies, me. We could all be gone.

Therapist #1: Okay, okay. Good.

Therapist #2: Other ideas about evidence against, "It's my fault"?

Client #3: In my case, I had a feeling something would go wrong, and I volunteered to go on this other mission, and if I had been there, there would have been an extra gun, and Shorty wouldn't have got killed.

Client #4: I'm wondering how you would know that.

Client #3: There would have been an extra gun, and we could have taken 'em out, but I wasn't there. As I said, I had a feeling. I didn't think Shorty would get it, I mean...

Client #4: It seems like it's hard to kind of predict the future, though.

Client #5: And like what you were saying, you were saying, "It feels that way." It sounds like it's more your feelings.

Therapist #2: Okay. So the next question: Does your belief distort what really happened when you tell yourself, "It's my fault"? What do you think?

Therapist #1: Focusing on that "fault" word.

Client #1: Well, I think so. I mean, I blame myself, so I guess so.

Therapist #1: Well, one of the words I like to think of at this point is "intent." Did you get up that morning intending to run over a child?

Client #1: No, not at all. I was doing what I was supposed to do.

Therapist #1: So isn't there a big difference in society when we think about, you know, sentencing someone for crimes between someone going out and intending to harm someone versus someone accidentally harming someone versus someone not even realizing they harmed someone and having no responsibility in it at the very bottom? So is "fault" really the right word to use then for what happened with that child?

Client #1: Not really. I mean, I didn't intend to hurt anybody. I was just doing what I was supposed to do.

Therapist #1: And I'd be more worried right now if you were okay with the fact that a child was run over. 302 Is it perhaps healthy even to be sad that it happened?

Client #1: Yeah, yeah.

Therapist #1: Okay, okay. So how about the rest of you? If you think about that word "intent," when you either went on or didn't go on the mission, were you intending for someone to be hurt that day?

Client #3: Well, I was intending to save my behind, which is what I'm struggling with. No, I didn't intend for him to get killed, but...

Therapist #1: So there's a whole other piece there, isn't there? So what's the stuck point behind this now that he's thrown out that he was trying to save himself?

Client #3: I'm a coward.

Therapist #1: That sounds like a pretty big one. Okay, so why don't we have you put that on the sheet. Maybe that's one you could do for your practice assignment tonight. So what's the answer for this one?

Client #5: Yes.

Therapist #2: Okay, how about, are you thinking in all-or-none terms when you tell yourself, "It's my fault"?

Client #5: Yes.

Therapist #2: Okay. How is that?

Client #1: It's pretty much like that black-or-white thinking, not giving yourself any other options.

Therapist #2: And are we using extreme or exaggerated phrases or words when we tell ourselves, "It's my fault"? So what's the answer there?

Client #6: Yeah.

Therapist #2: Okay. And are you taking selected examples out of context when you tell yourself, "It's my fault"? What do you think?

Client #1: I think so. In my case, I mean, I was following orders. They told us these kids might have bombs, so, I mean, given that situation, that was what I was supposed to do, just keep going.

Therapist #1: So you're focusing more on the outcome of what happened, that this kid is now dead, instead of focusing on, "This was my order," and, "What would have happened if I hadn't have done this"?

Client #1: Right.

Therapist #1: Okay.

Client #2: And it just seemed like everything was happening slowly. I can see it. I could see what needed to be done. I can see where I needed to be. I just couldn't get there.

Therapist #1: So in hindsight, it feels like there was a ton of time, even at the time you may have thought there was, but in reality?

Client #2: Seconds. It wasn't that long.

Therapist #1: Could anyone have gotten there that fast?

Client #2: No, I don't think so.

Client #4: I hear what you're saying too, Toby, When I think about my partner dying in my arms, you know, I just keep thinking, "In my arms, in my arms," Like it keeps going over and over in my head, and, "If only maybe I had done a little bit more," or, you know, "There's something else I could have done "or maybe I should have done, but I didn't. "Was it something I forgot to do?" Or, "I just--I kind of froze a little bit," and I hear what you're saying I feel that way too.

Therapist #1: When you think back on it, was there anything else that you could have done?

Client #4: I keep having an image of, "I should have done CPR, or I should have done chest-- something, you know."

Therapist #1: And I'm guessing at the time you made decisions not to do those for a reason.

Client #4: Yeah, yeah. I mean, he was already gone, really.

Therapist #1: Yeah. How would it have been for him to go by himself, not with you there?

Client #4: Oh, it would have been awful for him, you know, for his wife. She asked me about, and I didn't want to say anything, but I talked with her about that I was there by him, and that seemed to comfort her at least a little bit.

Therapist #1: How do you think it would have been for you if you hadn't had been there and you would just have images of what it might have been like for him.

Client #4: I think it would have been worse. I think I would have been having even more nightmares, yeah.

Therapist #1: You know, and I think we're also missing-- and obviously he's not here to speak for himself, but do you think maybe he was feeling scared and, you know, petrified and not knowing what was happening, and maybe having you there, talking to him, holding him, may have comforted him in his last minutes. Is that possible?

Client #3: I think I'd rather be dying with someone I knew than all by myself, so... If I had a choice. I don't know about anybody else, but...

After we've taught our clients how to challenge their stuck points, we can begin working on focused challenges. We look at the areas of safety, trust, power / control, self esteem, and intimacy using the larger challenging beliefs workshop. What we're looking for is those beliefs that have become over-accommodated. In other words, taking a belief that some people can be trusted and turning it into a belief that no one can be trusted, no place is safe.

After we go through these steps, and we have them challenge their stuck points, we ask them to rewrite, for Session 12, their impact statement about how they've been affected by their trauma. We then have them compare the new impact statement with the original impact statement that they wrote for us for Session 2. What this allows us to do is come full circle, where the individual can compare their thinking then with their thinking now and solidify an understanding of the changes they've made in their thoughts and feelings about the traumatic event.

Let's turn our attention to a case presentation. Let's talk about James, whose name has been changed for the purposes of confidentiality. James is twenty-five year old Afghanistan War Veteran. He was diagnosed with PTSD while still in the military, and was discharged with an honorable discharge due to PTSD. He has a history of opioid and cannabis dependence, although, when he came to us, he was no longer using either. And, he did have a severe history of traumatic brain injury, with one month of post trauma amnesia. He had damage also to his knee, ankles, several vertebrae and some severe facial scarring due to the same traumatic incident.

When James came to our residential program, he reported that he had spent over \$250,000 of his combat pay in under a year on nothing that he could remember. In addition, he reported that he had problems with attention, his memory, impulsivity and decision making. And, he was admitted to our eight-week PTSD and Traumatic Brain Injury Program. Using neuropsychological testing, we confirmed that all

of his problems were things that we could identify and test as well. And, we offered him Cognitive Processing Therapy, augmented with psycho-education groups and cognitive retraining, using the CogSmart model.

What this slide shows us is James' data. What you can see is that at pre-treatment, James met for PTSD, based on his CAPS over 45, almost at 68. He also met for PTSD based on the PCL, which showed a score of 53, over the cutoff of 50. His depression was never very strong, typically in the mild category.

After treatment, at post-treatment, at eight weeks, he no longer met criteria for PTSD based on either the CAPS or PCL and his depression lessened, although minimal to begin with. After his discharge, we reassessed James at three months and eighteen months via phone. At that point, James had to have significant surgery due to the problems related to his physical damage in the injury. In addition, he had significant financial concerns that were causing him a great deal of stress.

What you can see, though, is, although his PTSD symptoms were rising, he still, at 18 months, does not meet criteria for Post Traumatic Stress Disorder. And, he spontaneously reported in a phone interview that he believed many of his symptoms were just due to triggers from stress in his life, not a resurgence of his PTSD.

We have several take home messages from today. First of all, there is strong evidence that CPT is effective in individual formats. And there is one study showing that a combined group and individual format is effective. There is also growing support that CPT may be effective in groups, but we will have to wait a little longer for the definitive results. In addition, CPT is effective with or without the written trauma account. And, CPT is effective with complex cases, including personality disorders, individuals with a history of substance abuse and individuals with a history of personality disorders.

What I'd like, is for each one of you is to consider is, "Is CPT right for me?" And, "Is CPT right for my clients?" What we often find, is the answer to both of those questions is yes. And, we would like to encourage you to learn more about CPT, looking at the National Center for PTSD website, and please, feel free to contact any of us if you have questions.

I'd like to acknowledge several people that make the CPT Rollout possible. First, the VA Office of Mental Health Services, which funds the CPT Rollout. Second, my coauthors, Patricia Resick and Candice Monson who helped write all of the CPT training materials. And last, but not least, all of the CPT staff and national trainers who take care of the day in and day out operations of the rollout and perform the trainings and consultation across the United States. Without these people, we would not have the products that we have today and, each and every one of them is a critical part of our rollout. Thank you.