PTSD and Cognitive Processing Therapy

Presented by

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DSM-5: 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.

Criterion B

Presence of one or more of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
1. Spontaneous or cued recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
2. Recurrent distressing dreams in which the content or affect of the dream is related to the event(s).
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) are recurring (such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings).

Criterion B

Presence of one or more of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)
5. Marked physiological reactions to reminders of the traumatic event(s)

Criterion C

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by avoidance or efforts to avoid one or more of the following:
1. Distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s)
2. External reminders (i.e., people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about, or that are closely associated with, the traumatic event(s)
Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two or more of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia that is not due to head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous”). (Alternatively, this might be expressed as, e.g., “I’ve lost my soul forever,” or “My whole nervous system is permanently ruined”).
3. Persistent, distorted blame of self or others about the cause or consequences of the traumatic event(s).

Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two or more of the following:

1. Irritable or aggressive behavior
2. Reckless or self-destructive behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems with concentration
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep)

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
H. The disturbance is not attributed to the direct physiological effects of a substance (e.g., medication, drugs, or alcohol) or another medical condition (e.g. traumatic brain injury).
Dissociative Subtype

**Subtype: Posttraumatic Stress Disorder – With Prominent Dissociative (Depersonalization/Derealization) Symptoms**

A. The individual meets the diagnostic criteria for PTSD and in addition experiences persistent or recurrent symptoms of A1, A2, or both:
   
   A1. Depersonalization: Experiences of feeling detached from, and as if one is an outside observer of, one's mental processes or body (e.g., feeling as though one is in a dream, sense of unreality of self or body, or time moving slowly.
   
   A2. Derealization: Experiences of unreality of one’s surroundings (e.g., world around the person is experienced as unreal, dreamlike, distant, or distorted)

B. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts, or behavior during alcohol intoxication), or another medical condition (e.g., complex partial seizures).

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**A Functional Model of Posttraumatic Stress Disorder**

Let’s start with the most homogeneous severe event:

**rape**

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**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.

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**NORMAL RECOVERY**

Weekly PTSD

- Rothbaum et al
- Resick et al
- Riggs et al.
Let’s rearrange and think about post-trauma symptoms a bit differently.
3. Alterations in arousal and reactivity

- Intrusions
- Cognitions
- Emotions
- 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.

However, in those who don’t recover, strong negative affect leads to escape & avoidance

Core Reactions

- Aggression
- Self-harm behaviors
- Substance abuse
- Binging
- Cognitive avoidance
- Behavioral avoidance
- Dissociation
- Emotional suppression
- Social withdrawal
- Behavioral inhibition
- Somatic complaints

Avoidance of external reminders and And internal reminders

Avoidance Criterion

- This list is not exhaustive
- Any behavior that serves to escape/avoid reminders, negative trauma-related emotions, images or thoughts is functioning as avoidance
Can there be different mechanisms of change?

Can change in PTSD symptoms be top-down as well as bottom-up?

**SUCCESSFUL AVOIDANCE = CHRONIC PTSD**

- Intrusions
- Cognitions/emotions
- Arousal/reactivity
- Core Reactions
- Escape/Avoidance

**VERY SUCCESSFUL AVOIDANCE = CHRONIC SUBTHRESHOLD PTSD**

- Intrusions
- Cognitions/emotions
- Arousal/reactivity
- Core Reactions
- Escape/Avoidance

Can change in PTSD symptoms be top-down as well as bottom-up?
What is the role of cognition? Can we find another route to change?

A. Match  B. Label  C. Shapes

Hariri et al. (2000, 2003) on the neocortical modulation of amygdala response


PTSD Response

PFC  Amygdala  Brain stem

Trauma Triggers (CS)

Hariri, Bookheimer & John C. Mazziotta (1999)
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.

A Focus on Cognitive Theory

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

Traumas that lead to PTSD are schema (belief) 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.
Once the trauma is over, it is a memory. It is important information that has to be integrated.

People have three possibilities:

• The information matches and is incorporated.
• They change their view of the world/themselves to incorporate the new information.
• They change too much and interpret everything in light of this new information.

ASSIMILATION – PRE-EXISTING POSITIVE BELIEFS

It is a just world
People can be trusted
I am in control

Beliefs

I must have done something bad to deserve this
It is my fault
I could have prevented this

Stuck

ASSIMILATION – PRE-EXISTING NEGATIVE BELIEFS

I am a bad person
People cannot be trusted
I deserved it

Beliefs

I knew I shouldn’t have trusted him/her
See, I have no control

Stuck

It is my fault
I could have prevented this
Beliefs
I can’t get close to anyone
The world is completely unsafe

Beliefs
I can get close to others
The world is safe

Beliefs

TRAUMA
Betrayal
Unsafe
Powerless

STUCK

Beliefs

TRAUMA
Betrayal
Unsafe
Powerless

RECOVERY
A different action might have had a bad outcome
I have power over many things, but not all things

Beliefs

TRAUMA
Betrayal
Unsafe
Powerless

OVER-ACCOMMODATION
I can’t get close to anyone
The world is completely unsafe

ASSIMILATION
I can get close to others
The world is safe

ACCOMMODATION
Bad things happen to good people
Good people do bad things

UNDOING, (“if only, should have”) guilt or blame about trauma
Conclusions, implications of trauma (“never, always, no one”, all re: 5 themes)

IDENTIFYING STUCK POINTS

ASSIMILATION
(about the past/trauma)

OVER-ACCOMMODATION
(about present and future)

Where do emotions fit in CT?

There are two types of emotions
- Natural emotions emanate directly from the event and are hard-wired
  - Fight-flight response → fear
  - Losses → sadness
  - Disgust → withdrawal
- Manufactured emotions are produced by thoughts and beliefs
  - Self-blame thoughts → guilt
  - Other-blame thoughts → anger or rage

The therapist needs to determine which kind of emotion it is
If natural, clients need to feel and let it run its course. Natural emotions dissipate quickly

If manufactured, clients need to change their thinking.
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).

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)
  - Sufficient skills needed to start?

PRETREATMENT ISSUES- RATIONALE AND BUY-IN THERAPIST TASKS

- Motivational interviewing techniques may be helpful (advantages and disadvantages of avoidance)
- Patient needs to believe that improvement is possible for him/her
- Patient needs to believe that he/she has the ability to tolerate therapy and has sufficient skills
- Desire to approach needs to be stronger than desire to avoid.

RECOMMENDED ASSESSMENT MEASURES

- CAPS-5 interview for diagnosis, frequency and severity (pre and post treatment)
- Self-report scales (PCL required weekly)
  - PTSD Checklist (PCL-5)
  - Beck Depression Inventory or other depression checklist

www.ptsd.va.gov
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

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

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

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

Objectives
- Symptom measures
- Complete practice assignment review

Outline of CPT-C in Part 3 of manual
- Session 3: assign more A-B-C practice
- Session 4: Introduce Challenging Questions
- Session 6: Introduction of Challenging Beliefs Worksheet WITHOUT Safety Module
- Session 7: Introduce Safety Module

PROGRESSION THROUGH WORKSHEETS
Analyze, Information gathering, feelings
Impact statement
ABC sheets
Challenging questions
Problematic patterns
Challenging Beliefs Worksheet
Themes

CPT-Cognitive Only
- Also 12 sessions
- Still trauma-focused therapy

Major Changes:
- Session 3: assign more A-B-C practice
- Session 4: Introduce Challenging Questions
- Session 6: Introduction of Challenging Beliefs Worksheet WITHOUT Safety Module
- Session 7: Introduce Safety Module
PHASE 2.
EDUCATION REGARDING PTSD, THOUGHTS, AND EMOTIONS

SESSION 1.
SYMPTOMS AND RATIONALE

1. Describe symptoms of PTSD (handout)
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

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

7. Stuck points
   - Handout
   - Log

8. Anticipating avoidance and increasing practice compliance

9. Overview of treatment
Stuck Point Handout and Log

There are two logs
Patient log & therapist log

The stuck point log is a living document (keep adding to it):
- Use it for ABC sheets (B Column)
- Use it for CQW & PPT
- Use it for CBW
- Use it to ID SPs based on 5 themes as they are introduced
- Use it for pt to continue to identify SPs they need to work on AFTER treatment termination

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

SESSION 2. IMPACT STATEMENT

Patient reads Impact Statement
Discuss implications of statement
Review material from first session
Introduce events-thoughts-feelings relationship

Goal: Patients examine impact of traumatic event on their lives.

Therapist determines whether this has been achieved uses this examination to increase motivation for change.

Help identify stuck points in statement.
Ask about other areas that were not touched upon.
Highlight connection between thoughts and feelings.
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

SESSION 3.
EVENTS, THOUGHTS & EMOTIONS

Review A-B-C Worksheets

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

Gently begin to challenge undoing or self-blame statements

A-B-C Sheet

<table>
<thead>
<tr>
<th>ACTIVATING EVENT</th>
<th>BELIEF/STUCK POINT</th>
<th>CONSEQUENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>“Something happens”</td>
<td>“I tell myself something”</td>
<td>“I feel something”</td>
</tr>
</tbody>
</table>

Is it reasonable to tell yourself “B” above?

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

Example:

A-B-C Sheet

<table>
<thead>
<tr>
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<th>CONSEQUENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>“I was raped by my friend.”</td>
<td>“I must have done something that made him think it was OK.”</td>
<td>Guilty Scared</td>
</tr>
</tbody>
</table>

Is it reasonable to tell yourself “B” above?

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

**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.

**Principles of Socratic Dialogue**

**ABC’s of Socratic Dialogue**

**ASK**
- Question everything!
- Don’t assume
- *You can ask anything if you ask right*

**BE on their team**
- Helps to externalize thoughts
- Decreases defensiveness

Think (NOT act) **CRITICALLY** about their logic
- Get non-judgmentally into their head
- Be curious, not confrontational or argumentative
Hierarchies of Dialogue

**C = Clarify**

**A = Assumptions**

**R = Real evidence**

**D = Deeper beliefs**

**A = Assumptions** (continued)

- Assimilation (hindsight, happily ever after, and just world biases)
- “At that time, did you consider breaking protocol? Why not?”
- “Did the insurgent know that you were single and your friend was married?”
- “Why do you assume you could have saved him?”

**A = Assumptions**

- Over-accommodation
  - “Have you been out on patrol and nothing bad happened?”
  - “Have you (or someone else) had alcohol without being attacked?”
  - “What would have happened if you broke the rules to cover your buddy and he was killed anyway?”

**C = Clarify**

- Assimilation
- “What were your expectations for that mission?”
- “What did you know about that road? Was there any reason to think that your buddy was in more danger than usual?”
- Over-accommodation
- “Your thought is that no people can be trusted?”
- “When you say that you have poor judgment what do you mean?”

**Assumptions**

- Over-accommodation
  - “Have you been out on patrol and nothing bad happened?”
  - “Have you (or someone else) had alcohol without being attacked?”
  - “What would have happened if you broke the rules to cover your buddy and he was killed anyway?”

**Clarify**

- “What were your expectations for that mission?”
- “What did you know about that road? Was there any reason to think that your buddy was in more danger than usual?”
- Over-accommodation
- “Your thought is that no people can be trusted?”
- “When you say that you have poor judgment what do you mean?”
Hierarchy of Dialogue

\[ R = \text{Real evidence} \]

- Assimilation
  - “What is the evidence that you would have saved your friend?”
  - “Why were you sent to the other location?”
  - Did the unit commander intend for your friend to be killed? Did he know there was going to be an explosion?
  - “Who actually has the fault, who intended the harm?”

Hierarchy of Dialogue

\[ D = \text{Deeper Beliefs (meaning making)} \]

- Assimilation
  - “What does it mean about you that this event happened to you?”
  - “What does it mean about other people?”
- Over-accommodation
  - “What would that mean if you didn’t have complete control?”
  - “What if you got close to someone and they died?”

Hierarchy of Dialogue

\[ R = \text{Real evidence (continued)} \]

- Over-accommodation
  - “Looking at the other people in your life, why would this person’s actions mean that other people are less trustworthy?”
  - In what ways can you trust the other people in your life?
  - “When you say ‘I have bad judgment, are you talking about in every aspect? What about as a parent/spouse, etc?”

Hierarchy of Dialogue

\[ C = \text{Common Mistakes} \]

- Content
  - Make assumptions
  - Go after over-accommodation before assimilation

- Process
  - Rhetorical questions
  - Have to be a cogent line of questioning
  - Too convincing
  - Impatience
  - Inadvertently validate stuck point
  - Create power struggle
  - Not maintained balance between validation and challenge
**Belief/Stuck Point:**

1. What is the evidence for and against this idea?
2. Is your belief a habit or based on facts?
3. In what ways is your Stuck Point not including all the information?
4. Are you thinking in all-or-none terms?
CHALLENGING QUESTIONS CONTINUED

5. Does the Stuck Point include words or phrases that are extreme or exaggerated? (i.e., always, forever, never, need, should, must, can’t and every time).
6. In what ways is your Stuck Point focused on just one piece of the story?
7. Where did this study 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?

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).

SESSION 5. CHALLENGING QUESTIONS

Patient and therapist review Challenging Questions Worksheets to question single statements or beliefs

Therapist introduces Patterns of Problematic Thinking Sheet to see if there are typical patterns of cognition

PATTERNS OF PROBLEMATIC THINKING

3. **Ignoring important parts** of a situation
4. **Oversimplifying** things as good/bad or right/wrong
5. **Over-generalizing** from a single incident (a negative event is seen as a never-ending pattern)
6. **Mind-reading** (you assume people are thinking negatively of you when there is no definite evidence for this)
7. **Emotional reasoning** (using emotions as proof, e.g., “I feel fear so I must be in danger”)
### Challenging Beliefs Worksheet

<table>
<thead>
<tr>
<th>A. Situation</th>
<th>B. Thought/Stuck point</th>
<th>C. Emotion(s)</th>
<th>D. Challenging Thoughts</th>
<th>E. Problematic patterns</th>
<th>F. Alternative Thought</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe the event, thought or belief leading to the unpleasant emotion(s).</td>
<td>Write thought/Stuck point related to Column A. Rate belief in each thought/stuck point below from 0-100% (How much do you believe this thought?)</td>
<td>Evidence for? Evidence Against? Habit or Fact? Not including all information? All or none? Extreme or exaggerated? Focused on just one piece? Source dependable? Confusing possible with likely? Based on feelings or facts? Focused on unrelated parts?</td>
<td>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.</td>
<td>What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%</td>
<td></td>
</tr>
<tr>
<td>Evidence for? Evidence Against? Habit or Fact? Not including all information? All or none? Extreme or exaggerated? Focused on just one piece? Source dependable? Confusing possible with likely? Based on feelings or facts? Focused on unrelated parts?</td>
<td>Jumping to conclusions Exaggerating or minimizing Ignoring important parts Oversimplifying Overgeneralizing Mind reading Emotional reasoning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Emotion(s)</td>
<td>Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100%</td>
<td>G. Re-rate how much you now believe the thought/Stuck point in Column B from 0-100%</td>
<td>H. Emotion(s)</td>
<td>Now what do you feel? 0-100%</td>
<td></td>
</tr>
</tbody>
</table>

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**CBW Worksheet**

<table>
<thead>
<tr>
<th>A. Activating Event</th>
<th>B. Belief/Stuck point</th>
<th>C. Consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Something happens&quot;</td>
<td>&quot;I tell myself something&quot;</td>
<td>How does the stuck point make me feel?</td>
</tr>
</tbody>
</table>

**E. New Belief**

What can I tell myself in the future?

**F. New Consequence**

How does the new belief make me feel?

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**Alternatives**
Beliefs Related to Self

- Belief you can protect yourself from harm and have some control over events.
- Associated symptoms include anxiety, intrusive thoughts about danger, irritability, startle responses, intense fears about future dangers.

Beliefs Related to Others

- Belief about dangerousness of other people and expectancies about the intent of others to cause harm, injury, or loss.
- Symptoms include avoidant or phobic responses, social withdrawal.

Phase 5. Sessions 8-11
Trauma Themes:
- Safety
- Trust
- Power/Control
- Esteem
- Intimacy

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
SESSION 8. CBW AND SAFETY
Challenging safety is primarily about putting actual probabilities into perspective (e.g., 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)?

SESSION 9. TRUST ISSUES
Trust with regard to what?
Generate a list of different types of trust and put on a continuum.

Introducing Trust
Go over the module briefly regarding self and other trust.

Look at the Stuck Point Log, clarify the wording on any trust stuck points and assign them for the next session.

Patient should continue to work on any other assimilated stuck points from the log.

Don’t be surprised if they test your trustworthiness with new information or misbehavior.
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.

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.

Again, 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).

Other control is concerned with authority, the idea that other people are trying to control you, or that it is always bad when other people are in positions of authority and can tell you what to do.

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### Ways of Giving and Taking Power Handout

<table>
<thead>
<tr>
<th>GIVING POWER</th>
<th>TAKING POWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Being altruistic</td>
<td>1. Being assertive</td>
</tr>
<tr>
<td>2. Helping others in need or crisis</td>
<td>2. Setting limits and boundaries with others</td>
</tr>
<tr>
<td>3. Sharing yourself with another person as part of the give and take in relationships</td>
<td>3. Being honest with yourself and others</td>
</tr>
<tr>
<td>1. Basing your behaviors solely on the reactions you expect from others</td>
<td>1. Giving ultimatums</td>
</tr>
<tr>
<td>2. Always placing the needs of others above your own</td>
<td>2. Testing limits</td>
</tr>
<tr>
<td>3. Allowing others to easily access your “buttons”</td>
<td>3. Intentionally upsetting others for personal gain</td>
</tr>
</tbody>
</table>
Beliefs related to Self

Belief in your own worth.

Being understood, respected, and taken seriously is basic to the development of self-esteem.

Beliefs related to Others

Beliefs about other people that match the reality of the other person and are revised as new information is received.

Examples:
- People are uncaring, indifferent, selfish
- People are bad, evil, or malicious

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

Do at least one nice thing for themselves every day (not earned, noncontingent)

Purposes are to:
- Start reengaging in previously enjoyed activities (approach behavior)
- Depression relapse prevention
- Building of self-esteem ("Because I'm worth it")
- If they are not going to be spending much of their time on their PTSD symptoms, what are they going to be doing?
SESSION 11. ESTEEM ISSUES

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

Patient and therapist review other practice.

Therapist introduces Intimacy Module.

SESSION 11. INTRODUCING INTIMACY

Beliefs related to Self

Self-intimacy is the ability to self-soothe
Self-intimacy is more than self-esteem. It is about your relationship with yourself the ability to calm oneself

SESSION 11. INTRODUCING INTIMACY

Beliefs related to Others

• Ability to be alone without feeling lonely, empty or anxious
• Being comfortable in your own skin
• Enjoying your own company
• Knowing what you like and don’t like and how you want to spend your time
• Not needing other peoples’ approval
• It is an ongoing process (developmental considerations)

SESSION 11. INTRODUCING INTIMACY

• Need for intimacy, connection, and closeness is a basic human need.
• This can be damaged through insensitive, hurtful, or non-empathic responses from others.
• Other intimacy includes the full range of relationships from acquaintances, to deep friendships, and intimate partners.

SESSION 12. INTIMACY AND FINAL IMPACT

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.
Variable Length CPT

The first 12 sessions are conducted exactly the same.
If someone responds early (<19 on PCL), the therapist and client discuss whether he/she is finished with goals. If they decide to stop early, therapist assigns final impact statement and they have one more session.
At final session, they go over the changes in meaning of event, content of session, and future goals.

Variable Length Therapy: Late Responders

If the patient still has PTSD at 11th session the therapist should review items on the PCL as well as the Stuck Point log and discuss continuing for a few more sessions.
Do not assign the impact statement, but have them continue the two behavioral assignments.
Sessions are based on completing CBWs on the remaining stuck points. Continue doing CPT.