Cognitive Processing Therapy
Veteran/Military Version:

THERAPIST’S MANUAL

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How to Use This Manual

Parts I, II, and III

The veteran/military version of the therapist’s manual for Cognitive Processing Therapy (CPT) has been organized to maximize the ease with which therapists prepare for and conduct CPT.

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

**Part II** includes instructions on each of the 12 sessions. Each session opens with a summary that briefly outlines the format of the session and gives recommended times for each segment of the session. Each segment is then reviewed in detail, with goals, rationale, and sample dialogue. Call-outs are located throughout this section in the right margins of the text to allow therapists to quickly locate specific topics. Sample session progress notes follow the close of each session to facilitate tracking of therapist/patient progress. Relevant patient handouts also follow each session; please refer to the Materials Manual for additional information on handouts.

**Part III** offers information on alternatives to conducting CPT, including variations of CPT and adaptations of CPT for group administration.
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Cognitive Processing Therapy (CPT) is a 12-session therapy that has been found effective for posttraumatic stress disorder (PTSD) and other corollary symptoms following traumatic events (Monson et al., 2006; Resick et al., 2002; Resick & Schnicke, 1992, 1993). Although the research on CPT focused on rape victims originally, we have used the therapy successfully with a range of other traumatic events, including military-related traumas. This revision of the manual is in response to requests for a treatment manual that focuses exclusively on military trauma. The manual has been updated to reflect changes in the therapy over time, particularly with an increase in the amount of practice that is assigned and with some of the handouts. It also includes suggestions from almost two decades of clinical experience with the therapy.

Theory Behind CPT

CPT is based on a social cognitive theory of PTSD that focuses on how the traumatic event is construed and coped with by a person who is trying to regain a sense of mastery and control in his or her life. The other major theory explaining PTSD is Lang’s (1977) information processing theory, which was extended to PTSD by Foa, Steketee, and Rothbaum (1989) in their emotional processing theory of PTSD. In this theory, PTSD is believed to emerge due to the development of a fear network in memory that elicits escape and avoidance behavior. Mental fear structures include stimuli, responses, and meaning elements. Anything associated with the trauma may elicit the fear structure or schema and subsequent avoidance behavior. The fear network in people with PTSD is thought to be stable and broadly generalized so that it is easily accessed. When the fear network is activated by reminders of the trauma, the information in the network enters consciousness (intrusive symptoms). Attempts to avoid this

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activation result in the avoidance symptoms of PTSD. According to emotional processing theory, repetitive exposure to the traumatic memory in a safe environment will result in habituation of the fear and subsequent change in the fear structure. As emotion decreases, patients with PTSD will begin to modify their meaning elements spontaneously and will change their self-statements and reduce their generalization. Repeated exposures to the traumatic memory are thought to result in habituation or a change in the information about the event, and subsequently, the fear structure.

Although social cognitive theories are not incompatible with information/emotional processing theories, these theories focus beyond the development of a fear network to other pertinent affective responses such as horror, anger, sadness, humiliation, or guilt. Some emotions such as fear, anger, or sadness may emanate directly from the trauma (primary emotions) because the event is interpreted as dangerous, abusive, and/or resulting in losses. It is possible that secondary, or manufactured, emotions can also result from faulty interpretations made by the patient. For example, if someone is intentionally attacked by another person, the danger of the situation would lead to a fight-flight-freeze response, and the attending emotions might be anger or fear (primary). However, if in the aftermath, the person blamed himself⁴ for the attack, the person might experience shame. These manufactured emotions would have resulted from thoughts and interpretations about the event rather than the event itself. As long as the individual keeps saying that the event was his fault, he will keep producing shame (hence, manufactured).

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

In a social-cognitive model, affective expression is needed, not for habituation, but in order for the affective elements of the stored trauma memory to be changed. It is assumed that the natural affect, once accessed, will dissipate rather quickly and will no longer be stored with the trauma memory. Also, the work of

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⁴ Throughout this manual, we will refer to a single patient using the pronouns “he” and “she” alternately, rather than saying “she/he” or “him/her.” The term “service member” will also be used as a generic term rather than marine, sailor, airman, etc., and will be used interchangeably with veteran.
accommodating the memory and beliefs can begin. Once faulty beliefs about the event (self-blame, guilt) and over-generalized beliefs about oneself and the world (e.g., safety, trust, control, esteem, intimacy) are challenged, then the secondary emotions will also decrease along with the intrusive reminders. The explanation that CPT therapists give to patients about this process is described in Session 1 along with a handout in the patient materials section.

PTSD as Disorder of Non-Recovery

Because we know that PTSD symptoms are nearly universal immediately following very serious traumatic stressors and that recovery takes a few months under normal circumstances, it may be best to think about diagnosable PTSD as a disruption or stalling out of a normal recovery process, rather than the development of a unique psychopathology. The therapist needs to determine what has interfered with normal recovery. In one case, it may be that the patient believes that he will be overwhelmed by the amount of affect that will emerge if he stops avoiding and numbing himself. Perhaps he was taught as a child that emotions are bad, that “real men” don’t have feelings, and that he should “just get over it.” In another case, a patient may have refused to talk about what happened with anyone because she blames herself for “letting” the event happen and she is so shamed and humiliated that she is convinced that others will blame her, too. In a third case, a patient may have seen something so horrifying that every time he falls asleep and dreams about it, he wakes up in a cold sweat. In order to sleep, he drinks heavily. Another patient is so convinced that she will be victimized again that she refuses to go out any more and has greatly restricted her activities and relationships. In still another case, in which other people were killed, a patient experiences survivor guilt and obsesses over why he was spared when others were killed. He feels unworthy and experiences guilt whenever he laughs or finds himself enjoying something. In all these cases, thoughts or avoidance behaviors are interfering with emotional processing and cognitive restructuring. There are as many individual examples of things that can block a smooth recovery as there are individuals with PTSD.

Pre-Therapy Issues

1. Who Is Appropriate for CPT?

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

If someone cannot engage in treatment for his PTSD because he is so dissociative or has such severe panic attacks that he cannot discuss the trauma at all, then other therapy may need to precede CPT (e.g., grounding techniques, panic control treatment). Depression is the most common comorbidity and is not a rule-out unless the person cannot engage in therapy at all due to the severity of the depression. We have implemented the CPT protocol with those who are abusing substances, but typically not in an outpatient setting if they are substance dependent. However, once someone has stabilized after detoxification, he may be able to engage in CPT. These decisions need to be made on a case-by-case basis in consultation with the patient. The motivation of the patient to reduce her PTSD symptoms may be the most important consideration in whether to proceed with the protocol. Coping skills development is not a part of the protocol, but a therapist may choose to train her patients in affect tolerance skills if she determines that the patients’ skills in this area are so poor that they will act out and engage in self-harm behavior when thinking or talking about the traumatic event. In these cases, the therapist may also consider implementing the CPT-C (without the written trauma account component) rather than CPT (discussed later in Part III of this manual).

2. When Should the CPT Protocol Begin?

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

- When should the CPT protocol begin?
that is not CPT-focused, there is a risk of developing a manner of interacting that will have to be reshaped in order to deliver the manualized therapy (see below regarding CPT with established patient).

*New Patient.* We recommend that with a new patient, the therapist begins the CPT protocol within one to three sessions of assessment and information gathering. Once the therapist determines that the patient indeed has PTSD, is interested in treatment for these symptoms, and that other symptoms and life events are not interfering with treatment, the therapist can introduce the protocol and the contract for CPT (see the Therapist Materials section of the Materials Manual).

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

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

3. Treatment Contracting for CPT

Regardless of whether someone is a new or an established patient, before starting the protocol, the therapist should explain what is expected of both patient and
therapist. This therapy protocol is typically conducted in 12 sessions, which could be administered once or twice a week. The therapy will focus to begin with the worst traumatic event, although it can move to other events after Session 5. The patient will be expected to attend all sessions regularly (once a month is not sufficient) and to complete the practice assignments. The therapist will agree to adhere to the protocol and focus on the PTSD for this period of time. It is helpful for the therapist to explain that her job will also be to recognize and discourage the patient’s avoidance behaviors that have maintained the PTSD.

In the Therapist Materials section of the Materials Manual there is a patient contract that can be used to demark the work that will be done and to engage the patient in the process.

**Overview of CPT Sessions**

The contents of each session are described in Part 2 along with issues that therapists are likely to encounter. The therapy begins with an education component about PTSD, and the patient is asked to write an Impact Statement in order for the patient and therapist to begin to identify problem areas in thinking about the event (i.e., “stuck points”). The patient is then taught to identify and label thoughts and feelings and to recognize the relationship between them. The next two sessions focus on generating a trauma account of the worst traumatic incident, which is read to the therapist in session. During these first five sessions, the therapist uses Socratic questioning to begin to challenge distorted cognitions, particularly those associated with assimilation, such as self-blame, hindsight bias, and other guilt cognitions. Thereafter, the sessions focus on teaching the patient cognitive therapy skills and finally focus on specific topics that are likely to have been disrupted by the traumatic event: safety, trust, power/control, esteem, and intimacy.

After the individual CPT protocol is described in detail, there are subsequent sections on using the protocol without the written trauma account component, a section on delivering CPT in a group format, and a section on treatment issues with comorbid disorders.

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

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

**Socratic Questioning Within CPT**

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

Socratic questioning originated from the early Greek philosopher/teacher Socrates. He believed that humans had innate knowledge and that this knowledge could be revealed by another person asking specific questions. He also contended
that humans who came into knowledge, versus being told, were more likely to retain the information and build on that knowledge to acquire more knowledge. Socratic questioning is routinely used in American law schools, in some forms of cognitive therapy, and specifically in CPT.

Socrates was convinced that thoughtful questioning enabled the logical self-examination of ideas and facilitated the determination of the validity of those ideas. As described in the writings of Plato, a student of Socrates, the teacher feigns ignorance (à la “Columbo” in the modern ages) about a given subject in order to acquire another person’s fullest possible knowledge of the topic. With the capacity to recognize contradictions, Socrates assumed that incomplete or inaccurate ideas would be corrected during the process of disciplined questioning and hence would lead to progressively greater truth and accuracy.

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

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

1. Clarification

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

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

2. Probing Assumptions

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

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

3. Probing Reasons and Evidence

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

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

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

- **What alternative ways of looking at this are there?**
- **What does it do for you to continue to think this way?**
- **Who benefits from this?**
- **What is the difference between…and…?**
- **Why is it better than…?**
- **What are the strengths and weaknesses of…?**
- **How are…and…similar?**
- **What would…say about it?**
- **What if you compared…and…?**
- **How could you look at this another way?**

5. Analyzing Implications and Consequences

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

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

6. Questions About the Question

Patients may sometimes “challenge the therapist” or push therapist-patient boundaries by directly inquiring whether the therapist has experienced a specific traumatic event. For example, patients may ask the therapist directly, “**Have you ever been to war?**” or “**Have you ever been raped?**” In this often difficult situation, therapists may rely both on their good clinical judgment, as well as CPT-specific skills, to inquire why the patient might be interested in this information. It is up to each therapist’s discretion about how much information s/he is willing to disclose. It is also important to consider, as always, the effect
that any disclosure would have on the patient and to use that information to guide your response.

We believe that it might be most useful at these points in therapy to gently question the question. By putting the focus back on the patient and his intentions, the patient can more thoroughly examine his reasons for asking these types of questions. It might be that the patient is attempting to find out whether the therapist can truly understand what he went through, or he may be avoiding discussing his own experience in detail by putting the focus on the therapist. Here are some possible ways to address these types of questions if they arise:

- Are you wondering whether I will be able to handle hearing about your experience?
- Why is this information important to you? What would it mean to you if I did or did not share your experience?
- What would my answer either way mean to you?
- Are you concerned that I don’t understand? Please tell me what you think I am missing. I would like to understand what the experience was like for you.

**Issues in Conducting CPT**

Many therapists were never trained to conduct manualized psychotherapies and may feel uncomfortable with both the concept and the execution. It is important that the patient and therapist agree on the goal for the therapy (trauma work for PTSD and related symptoms) so that the goals do not drift or switch from session to session. Without a firm commitment to the treatment goals, when the therapy is “off track,” the therapist may not know whether to get back on the protocol or to let it slide. As other topics arise, the therapist sometimes isn’t sure whether, or how, to incorporate them into the sessions. A few words on these topics are appropriate here. Once therapists have conducted protocol therapy a few times, they usually find that they become more efficient and effective therapists. They learn to guide the therapy without tangents or delays. They find they can develop rapport with patients through the use of Socratic questions because the patients are explaining to the therapist exactly how they feel and think and the therapist expresses interest and understanding with these questions. There is usually enough time in the session to cover the material for the session and still have time for some other topics, such as things that came up that week or other current issues related to their PTSD (childrearing, job concerns, marital issues, etc.). However, if those are major issues, then the therapist will need to prioritize the order. It is inadvisable to try to deal with several types of therapy for different problems simultaneously.

1. Comorbidity

Although PTSD has very high rates of comorbidity (other disorders along with the PTSD), normally, comorbid depression, anxiety, and dissociation remit along
with PTSD. Therefore, we believe there is rarely a need to deal with other symptoms independently of the PTSD protocol.

Major depressive disorder, which occurs in approximately half of people with PTSD and substance abuse, the rates of which vary depending on the population being studied, are both commonly comorbid with PTSD. Anxiety disorders and personality disorders are also fairly common. Additionally, health problems are associated with PTSD. Fortunately, except for patients with substance dependence, CPT has been tested on patients with a range of disorders in addition to PTSD. Thus far, we have found that those with major depressive disorder improve as much as those without the disorder, although they may begin and end with higher levels of depressive symptoms. Patient-reported health symptoms improve significantly, and measures of anxiety and dissociation also improve over the course of treatment. Other complex symptoms such as an impaired sense of self and tension-reduction behaviors (e.g., self-harming behaviors and acting out) improve markedly with treatment. Nevertheless, there are considerations that should be mentioned with regard to comorbid disorders. Discussing all possible comorbid disorders is beyond the scope of this manual, so we have picked a few of the more common disorders for your consideration.

Substance dependence should be treated before addressing PTSD, but substance-abusing patients may be treated with CPT if there is a specific contract for not drinking abusively during the therapy, and if there is a specific focus on the suspected role of abusive drinking as avoidance coping. Further, it may be possible to implement CPT immediately following substance abuse treatment. In fact, if the veteran is following an inpatient admission for detoxification with a residential program, there may be a unique window of opportunity to treat PTSD. It is not unusual for intrusive recollections of traumatic events, particularly nightmares and flashbacks, to emerge after someone has stopped drinking or using drugs. The substance use may have served as a method to avoid these memories and to suppress unwanted emotions. So, after detoxification, these PTSD symptoms may reassert themselves. If the patient is motivated to work on his PTSD, or if the therapist can use the increase in symptoms as a motivator, there may be an opportunity to improve those PTSD symptoms before the patient can fall back into his usual coping method and relapse. At this point, based on clinical experience rather than research, our best predictor of success with CPT with this population is motivation to change. The therapist should ask in a very straightforward fashion whether the patient wants to improve his PTSD symptoms enough to refrain from alcohol or drugs for treatment to commence. Some patients have been able to tolerate CPT, including the account writing, fairly soon after stopping their substance abuse, while others announce that they will relapse if they talk about the trauma even years after sobriety. We take these patients at their word. If someone promises to relapse, we do not implement the protocol, but let them know that it is available when they are ready. Those who proceed with treatment need to understand how their substance abuse has served as avoidance, and the therapist should check in frequently about urges to drink or use. If such urges occur during treatment, they can, in fact, indicate particular
stuck points or important emotions that should be processed. CPT without the trauma account (CPT-C, discussed later in this manual in Part III: Alternatives and Considerations in Conducting CPT) can also be implemented if the therapist and patient determine that the patient is, in fact, too fragile to handle writing about the trauma memory (i.e., reluctance is not due to the more common stuck points about emotions). Typically we have the patients focus on specific child, family, and marital issues after completing the course of PTSD treatment. Sometimes those problems remit when the patient no longer has PTSD interfering with functioning.

Major depressive disorder (MDD) is the most common comorbid disorder with PTSD. Being depressed is not a rule-out for PTSD treatment. In fact, PTSD treatment should successfully address MDD that is often secondary to the PTSD. All treatment outcome studies on PTSD have found substantial and lasting improvement in depressive symptoms along with PTSD improvement. There are only a few caveats to consider. Although medication instability is a typical exclusion criterion for psychosocial treatment outcome studies for pragmatic purposes (i.e., is change attributable to the intervention or the medication?), medication changes can also complicate clinical practice. A clinician may be tempted to throw every possible intervention at the patient at once, expecting to achieve the quickest possible results. However, if a patient is beginning or increasing a medication while starting psychotherapy, neither the patient nor the clinician will know what was effective. Why does this matter? When the patient begins to feel better, she may attribute the change to the medication, even if it is not the case, and not attribute the change to her own efforts. She may even stop complying with psychotherapy. Also, if the medication was the locus of the change, the prescribing physician needs to know what the minimally effective dose of the medication is without the confusion of the common occurrence of increasing symptoms during the trauma account or decreasing symptoms after the trauma accounts or cognitive therapy. The prescribing physician and therapist need to coordinate their efforts to minimize this confusion.

We have occasionally seen patients who were so heavily and multiply medicated that they were unable to engage in treatment or access appropriate emotions. We have also occasionally seen unmedicated patients whose depression was so severe they could not muster the energy to attend treatment or comply with assignments. Either extreme is a problem that must be rectified before appropriate psychotherapy can be implemented. It is important to stress that we are not suggesting that all patients with PTSD, with or without MDD, should be on medications. Rather, we suggest that, if a patient can tolerate her distress for a few more weeks while CPT begins, there may not be a need for medications at all. In addition, many of the young returning service members may not want to begin a regimen of psychotropic medications. There is very little research on the combination or sequencing of medication and psychotherapy to guide us at this point. Good communication between providers can assist with decision making on the appropriateness and sequencing of medication.
As with depression and substance abuse, the concern with other anxiety disorders is whether they are so disabling that they interfere with PTSD treatment. If obsessive-compulsive disorder (OCD), panic disorder, or agoraphobia is so severe that the patient cannot engage in PTSD treatment, then the other disorder should be treated first. If the other anxiety disorder appears to be trauma-related (i.e., the onset, precipitants, and anxious content appear conceptually related to traumatic events) and the person can attend treatment, then it is quite possible that successful treatment of PTSD will improve the comorbid anxiety condition(s) as well. Any therapist who works with PTSD patients in VA will have heard stories of patients who secure their home perimeter every evening before bedtime, sometimes for hours. These superstitious safety behaviors may rise to the level of OCD. When we have treated patients with PTSD and OCD, we have started with the PTSD to see if the OCD symptoms would improve. There is no reason at this point to expect that PTSD symptoms will improve with successful OCD treatment. These OCD types of behaviors can be considered right along with safety issues in Sessions 7 and 8, with the goal of getting the patients to test out their overestimated level of danger (P: ”If I don’t secure the perimeter this amount, my house will be attacked.” T: ”Do your neighbors and the people on the next block march with rifles? Have they been attacked? Has there ever been a time when you couldn’t do it?”). Once the flashbacks, nightmares, and triggered false alarms are reduced, it is easier to explain the principles of behavioral exposure and response prevention along with the cognitive work. Later in the protocol, the therapist could assign the patient to do an experiment to test his assumptions. Although this is not a typical component of CPT, a behavioral experiment might be very helpful with comorbid anxiety disorders. OCD symptoms may also be addressed while working on issues of control. The person with OCD has the temporary illusion of control when engaging in the ritual that is intended to reduce his anxiety. Aside from the fact that the rituals (cleaning, checking, etc.) soon come to control the person rather than the other way around, the therapist can help the patient to accept that he can’t have control over future events (see Session 10) and that the rituals don’t prevent future events from occurring and may be totally irrelevant.

Panic disorder is commonly comorbid with PTSD, and more so under the DSM-IV decision rules than under the previous DSM-III-R, which disallowed the diagnosis in the presence of other Axis I disorders. Our research with CPT indicates an improvement in panic symptoms without any particular extra intervention. However, there are some people who are so crippled by their panic disorder that they cannot tolerate discussing the traumatic event without having panic attacks. In this case, the therapist may want to consider treating the panic disorder first with a cognitive-behavioral treatment such as panic control treatment (Craske, Barlow, & Meadows, 2000) or simultaneously with CPT.

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(Falsetti et al., 2001). Falsetti and her colleagues developed a protocol that combines CPT with panic control treatment.

The challenge with personality disorders in PTSD treatment is how to stay on track with the protocol and not get derailed by side issues. In other words, the therapist does not attempt to treat the personality disorder but treats the PTSD in spite of the personality disorder. The therapist needs to keep in mind that the patient has been coping with his life circumstances for a long time, albeit ineffectively, and that getting pulled off onto the “crisis of the week” can serve as an avoidance function to doing the trauma work. If one can conceptualize personality disorders as over-generalized patterns of responding across a range of situations, then it is quite easy to see how someone with a long history of trauma, or coping with his trauma, might develop avoidant personality, dependent personality, and so forth. These beliefs and behavioral patterns served a functional purpose, at least at some point in the person’s life. It is now dysfunctional because these patterns are so over-generalized (and probably obsolete). Within the cognitive framework, these over-generalized assumptions and beliefs become reified to the schema level and become automatic filters through which all experiences pass. Any experiences that do not conform to the over-riding schema are either distorted (assimilated) to fit the construct or ignored. Those experiences that appear to confirm the over-riding schema are used as proof and lead to further over-accommodation. It is difficult to challenge a large schema such as “everyone will abandon me” or “I can’t take care of myself,” so the therapist should continually bring these global ideas down to very specific events, thoughts, and emotions and then challenge the evidence on those specific events with Challenging Beliefs Worksheets. When the same assumptions emerge across many worksheets, the therapist can say, “I am detecting a theme here. Across these six worksheets it always comes back to the thought that people are trying to harm you (or whatever the schema is). You have said this to yourself so often and across so many situations that you have come to believe it is carved in stone as TRUTH. And we are going to have to chip away at that belief just like you would have to chip away at stone to get it to change—in this case, one worksheet at a time. Now I see that each time you have done a Challenging Beliefs Worksheet that you were able to challenge the thought that someone was intentionally trying to harm you. How many experiences will you need to have, how much evidence will you need to move to the thought that some people are not trying to harm you? And how would that feel if you believed that?”

While dissociative disorders are relatively rare, dissociative responses are fairly common in traumatized individuals. In fact, peritraumatic dissociation, dissociation during or immediately after the traumatic event, is one of the most robust predictors of PTSD. Dissociation can become conditioned, just like the

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fight-flight response, to previously neutral cues. If the patient dissociates whenever she is reminded of the trauma, such dissociation may interfere with the tasks required during therapy. There are several solutions to this problem. One is that the therapist can work with the patient in advance to refrain from dissociating, through grounding techniques (e.g., cueing to date, time, location, safety; touching a predetermined object as a reminder). The therapist needs to provide a rationale for the patient to learn not to dissociate when stressed. There are two good rationales. One is that dissociation actually puts the veteran at greater risk, in that if she were really in danger, she would have fewer options for extricating herself from the situation. Another rationale for learning not to dissociate is that dissociation is an emergency response, like the fight-flight response, that shuts down immune and other normal functioning. Having this emergency response occur frequently, dysregulates the person’s immune functioning. PTSD has been associated with greater health problems, and people who dissociate frequently are often observed to have higher rates of many physical disorders and diseases.

Another option for problematic dissociation is to use the CPT-C protocol. A third option is to use the CPT protocol but have the patient write the account using techniques to minimize dissociation. One strategy that we have used successfully is to have the patient set a kitchen timer for 5 minutes and start writing. The bell serves to interrupt dissociation, orienting the patient back to the present. The kitchen timer can then be set for 6 minutes, with the patient returning to reading or writing the account. The timer can be set for progressively longer periods to provide graded habituation and stronger grounding skills.

In summary, therapists should not be daunted by comorbid disorders accompanying PTSD or assume that CPT cannot be implemented with patients who have extensive trauma histories. CPT was developed and has been tested with patients who almost all had complex trauma histories and various comorbidities. The decision the clinician must make is whether the comorbid disorder is so severe that it will preclude the patient’s participation in PTSD treatment. In that case, the therapist may want to treat the comorbid disorder before, or simultaneously, with CPT. There are evidence-based cognitive-behavioral therapies for most comorbid conditions that clinicians will encounter. For the most part, however, the treatment of PTSD will improve the comorbid symptoms and may even eliminate the necessity of further treatment for those symptoms.

2. Avoidance

Most veterans present for PTSD treatment many years after the traumatic event. They are usually not in crisis and are able to handle their day-to-day lives (at whatever level they are functioning) without constant intervention. Much of the disruption in the flow of therapy for PTSD comes from avoidance attempts on the part of the patient. We point out avoidance whenever we see it (e.g., changing the subject, showing up late for sessions) and remind the patient that avoidance
maintains PTSD symptoms. If the patient wants to discuss other issues, we save time at the end of the session or attempt to incorporate her issues into the skills that are being taught (i.e., A-B-C Worksheets, Challenging Questions Worksheets, Patterns of Problematic Thinking Worksheets, Challenging Beliefs Worksheets). If the patient does not bring in practice assignments, we do not delay the session but conduct the work in session and then reassign the practice assignment along with the next assignment.

3. Needs of Returning OIF/OEF Veterans

Returning Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) military personnel and veterans may have different needs than veterans from other wars/conflicts. They may prefer two sessions a week so that they can get therapy finished quickly. They may request early morning or evening appointments to accommodate their jobs. They may want their PTSD treatment augmented with couples counseling. They may appear a bit more “raw” than the very chronic Vietnam veterans that most VA clinicians are accustomed to working with. The more accessible emotions are actually an advantage in processing the traumatic events and in motivating change, but therapists who have worked with only very chronic (and emotionally numb) veterans may become alarmed when they first work with these patients. They may think that strong emotions or dissociation should be stabilized or medicated first. However, CPT was developed and tested first with rape victims who may also be very acute and very emotional. As long as patients are willing to engage in therapy and can contract against self-harm and acting out, there is no reason to assume that they need to wait for treatment.

4. PTSD-Related Disability Status

Therapists often express concern about the patient’s disability status and what will happen to her disability status and entitlements if the PTSD is effectively treated. For OIF/OEF veterans, the goal is to have them return to gainful employment and not be on disability for their PTSD. At the beginning of treatment with these patients, they may not be able to conceptualize sleeping through the night again, not being disrupted by flashbacks, or having the concentration to hold down a job. The therapist needs to impart a clear message that these symptoms can improve, to instill some hope in the patient. However, specific career or job planning might be postponed until later in therapy to see how much symptom remission has been achieved. If the veteran sustained head injuries during his deployment, it may not be clear how much of the symptom picture is due to PTSD and how much is due to brain injury until the PTSD symptoms are resolved.

Older veterans (and their therapists) are sometimes reluctant to engage in an efficacious treatment for fear of losing benefits and not being able to support themselves. We highly encourage clinicians to seek out specific information from their Veterans Benefits Administration (VBA) staff about the likelihood that veterans will have their disability rating reevaluated. In our experience, there is
much lore around VBA taking away veterans’ benefits. In our discussion with
VBA staff, they have indicated that they are so burdened with claims that they do
not have time to review older cases unless the veteran is seeking an increase in his
disability or there is some concrete evidence that the veteran is making money
through employment and he is not supposed to be able to be employed. There
may be an infamous case in your VA in which entitlements were taken away or
decreased, but it is important to assess more accurately with the veteran the
probability of such a situation occurring.

PTSD-related disability seems to present as the biggest challenge if a patient is
actively seeking a disability rating or increase in her existing rating. We
encourage clinicians to be up-front with patients about the timing of CPT in
relation to their pursuit of service-connected benefits. If they are actively trying to
prove that they have symptoms of PTSD, it is logically not the time to engage in a
therapy that is shown to decrease symptoms. It is far better to prevent the veteran
from having a failed therapy experience by delaying a course of CPT than it is to
proceed with a course that was doomed from the outset. There are many disabled
and nondisabled veterans with PTSD who are not seeking a change in their rating
who are better positioned to take advantage of the benefits of CPT. Veterans in
the claims process may want to seek a supportive therapy or non-trauma-focused
intervention while awaiting the outcome of their claims.

If someone is rated with a permanent 100% service-connected PTSD disability,
the veteran has every right to benefit from symptom reduction to improve the
quality of her life. If the veteran is not considered permanently and 100%
disabled by her PTSD, then the therapist should ask the patient to consider the
costs and benefits of symptom reduction and quality of life if her PTSD
improved, and the probability that her service-connected entitlement would even
change as a result of an improvement in her PTSD. Therapists should remember
that there is the option of diagnosing with PTSD, In Partial Remission, in their
progress note documentation.

In some cases, disability status is actually a stuck point that needs to be
challenged because it has an alternative function (“If I am not a disabled veteran,
who am I?” “If I stop receiving the benefits, that means the government thinks
what happened to me was not important”).

5. Religion and Morality

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

You should not avoid these topics, because they may prove to be at the heart of your patient’s PTSD. Even if you have a different set of religious beliefs (or are agnostic or atheist), it is not a good reason to avoid these topics. You need to wade into cross-cultural beliefs as part of your work, and religion is an important part of your patient’s culture. The just world belief is probably the most common assumption that is taught, not just by religions but also by parents and teachers. People like to believe that if they follow the rules that good things will happen and that if someone breaks the rules that they will be punished. People fail to learn this as a probability statement (“If I follow the rules, it decreases my risk of something bad happening”), which would be more realistic. If people hold strongly to the just world belief, then they may engage in backward reasoning. This would lead them to the conclusion that if something bad happened to them, they are being punished. However, if they can’t figure out what they did wrong, they will end up railing at the unfairness of the situation or of God. No religion guarantees that good behavior will always be rewarded and bad behavior punished (here on earth), so if your patient says this, then he may have either distorted his religion or was taught this by a mistaken parent or religious leader. Like any profession, there is variability on how educated or adherent a religious leader is to the tenets of the religion. Please make sure you differentiate the religion itself from an individual practitioner when you discuss these issues. You may be able to check with the tenets of the religion through a Web search or by talking to clergy at your VA or your own place of worship.

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

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

The question that may logically follow “Why me?” is “Why not you?” If someone wonders why she was spared (language that implies intent) when others were killed, the same line of questioning can proceed. Is there logic to war, to who dies or who lives? Because someone is a good person, did that make her more immune to being killed in war? Unfortunately, the military, as well as religions, may reinforce the notion that if something bad happened, someone made a mistake. In the military, after events transpire, service members may be subject to debriefings to determine “what went wrong.” While it is understandable that military leaders are attempting to reduce risk in the future, they are also planting the message that someone made mistakes for the outcome to be as it was (as opposed to the possibility that an ambush worked or that the combatants were outmanned in a particular situation).

The concepts of self- or other-forgiveness are sometimes brought up in therapy. If these issues are comfortable concepts for a patient, she probably would not bring them up for discussion. Instead, they are typically mentioned because there is some discomfort with or conflict over the subjects. As noted above, with regard to self-forgiveness, it is very important for you to first challenge the specifics of the event to see if your patient has anything to forgive herself for. Because it is almost axiomatic that people will blame themselves for traumatic events, it does not mean that they intended the outcome. Therefore, blame and guilt may be misplaced. If someone is the victim of a crime, she is just that, a victim. There is nothing she could have done that would justify what happened to her. Because a woman feels dirty or violated does not mean that she did anything wrong that needs forgiveness. This would be an example of emotional reasoning. Killing someone in war is not the same as murdering someone. The person may have had no other options than what occurred at the time, so the Socratic questioning needs to establish intent, available options at the time, etc. One should only discuss self-forgiveness when it has been established that the patient had intended harm against an innocent person, that he had other available options at the time and willfully chose this course of action. Killing a civilian by accident (e.g., someone caught in the crossfire) in a war is just that, an accident. Committing an atrocity (raping women or children, torturing people) is clearly intended harm. Guilt is an appropriate response to committing an atrocity or a crime. A patient may well need to accept what he has done, be repentant, and seek out self-forgiveness, or if religious, forgiveness within the church or other place of worship. Even then you should work with your patient to contextualize who he was then with what his values are now to help him realize that he is not the same as when the event occurred. Once all this has been thoroughly processed and digested, some form of restitution or community service may assist the patient in moving beyond his permanent, self-inflicted sentence.

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

6. Military Sexual Trauma (MST)

Although there are many different types of traumatic experiences, each unique in its own way, experiences of sexual trauma often raise special issues for patients and clinicians. This is particularly true when the trauma is what the VA terms “military sexual trauma”; that is, sexual assault or repeated, threatening acts of sexual harassment that occurred while the veteran was in the military. Sexual assault is any sort of sexual activity between at least two people in which someone is involved against his or her will. Physical force may or may not be used. The sexual activity involved can include many different experiences such as unwanted touching, grabbing, oral sex, anal sex, sexual penetration with an object, and/or sexual intercourse. Sexual harassment that falls into the category of MST involves repeated, unsolicited, and threatening verbal or physical contact of a sexual nature. Examples of this include threats of retaliation for not being sexually cooperative or implied faster promotions or better treatment in exchange for being sexually cooperative.

A number of studies have shown that MST experiences are extremely prevalent among veterans; rates are typically even higher among veterans using VA healthcare. Although sexual trauma occurs more frequently among women than among men, the disproportionate ratio of men to women in the military means that as a clinician working with veterans, you are about equally likely to encounter men with experiences of MST as you are to encounter women with experiences of MST. In general, rape is the trauma most likely to be associated with PTSD, meaning that you may treat sexual trauma quite frequently in your CPT work.

While there is little empirical data comparing experiences of military sexual trauma with experiences of sexual harassment and assault that occur outside of military service, there are aspects of MST that may make these experiences qualitatively different for victims. For example, because sexual trauma associated with military service most often occurs in a setting where the victim lives...
works, many victims must continue to interact and work closely with their perpetrators on an ongoing basis after the trauma. This often increases their sense of helplessness and powerlessness and may leave them at risk for additional victimization. Given the “total” nature of the military environment, this victimization may take a variety of forms. Victims may need to rely on their perpetrators (or associates of their perpetrator) to authorize medical and psychological care or provide for other basic needs. There may also be career-related consequences for victims in that perpetrators are frequently peers or supervisors with the power to influence work evaluations and decisions about promotions. Even if this is not the case, victims may face the difficult choice of either continuing military careers in which they are forced to have frequent contact with their perpetrators or sacrificing career goals in order to protect themselves from future victimization or retraumatization.

Most military groups are characterized by high unit cohesion, particularly during combat. Although this level of solidarity is typically a positive aspect of military service, the dynamic it creates may amplify the difficulties of responding to sexual harassment and assault in this environment. For example, the high value placed on organizational cohesion may make it taboo to divulge any negative information about a fellow soldier. As a result, many victims are reluctant to report sexual trauma and may struggle to identify even to themselves that what occurred was an assault. Those who choose to report to those in authority often feel that they are not believed or, even worse, find themselves blamed for what happened. They may be encouraged to keep silent and their reports may be ignored. Having this type of invalidating experience often has a significant negative impact on the victim’s posttrauma adjustment.

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

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

Patients are often reluctant to bring up this topic in therapy. They may feel deep shame that they experienced sexual arousal in a situation in which they believe it to be inappropriate and may view it as some type of personal failing. The therapist can help alleviate this guilt and shame through education and should bring up the topic in a low-key and routine way if the patient does not broach the topic. One of the simplest ways to help the patient to think differently about it is to remind the patient that sexual arousal is not a voluntary response any more than being tickled is. In fact, tickling is a good analogy to use. Someone can be tickled against his will, be laughing, and hate it at the same time. When nerve endings are stimulated, there is no conscious choice about whether those nerve endings should react. If the patient is helped to see that his or her reactions were the normal outcome of stimulation and not some moral choice, he or she should experience relief and the lessening of guilt or shame. Please refer to the Patient Workbook for examples of an A-B-C Worksheet, Challenging Questions Worksheet, and Challenging Beliefs Worksheet on MST.

7. Ongoing Symptom Assessment Using PTSD and Depression Scales

It is recommended that the patient be assessed, not just before and after treatment but during treatment as well. We typically give patients a brief PTSD scale and a depression scale, such as the Beck Depression Inventory\(^7\) (if comorbid depression is a problem), once a week. The PCL-S monthly version is administered once before the first session and evaluates the patient’s symptoms during the past month. Subsequent administrations of the PCL-S evaluate the patient’s symptoms during the prior week and are administered weekly. We recommend that the weekly versions of the PCL-S be given to the patient while he is waiting for the start of the session. Most often there is a large drop in symptoms when the assimilation about the trauma is resolving. Typically this occurs around the fifth or sixth session with the trauma account and cognitive therapy focusing on the traumatic event itself. Occasionally this takes longer, but with frequent assessment, the therapist can monitor the progress and see when the shift occurs. Both the monthly and weekly versions of the PCL-S are located in the Therapist Materials section of the Materials Manual.

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8. A Note on Session 2a—Bereavement

Included in this manual is a module for traumatic bereavement (Session 2a). This module is not included as 1 of the 12 sessions but could be added to the therapy. If the additional bereavement session is added, the protocol becomes 13 sessions; session 2a does not replace any of the other sessions. We recommend that the session be added early in therapy, perhaps as the third session. Although we expect PTSD to remit as a result of treatment, we do not necessarily expect bereavement to remit. Grief is a normal reaction to loss and is not a disorder. Bereavement may have a long and varied course. The goal of dealing with grief issues within CPT is not to shorten the natural course of adjustment but to remove blocks and barriers (distorted cognitions, assumptions, expectations) that are interfering with normal bereavement. Therefore, the focus is on normal grief, myths about bereavement, and stuck points that therapists may need to focus on in this domain. If the bereavement session is added to CPT, one possibility is to have the patients write two Impact Statements if they have both lost a loved one and have PTSD related to something that happened to them directly. One statement would be about what it means that the traumatic event happened to them. The other statement would be about what it means that the loved one has died.
Part 3: Alternatives and Considerations in Conducting CPT

CPT Without the Trauma Account (CPT-C)

Recently, Resick and colleagues completed a dismantling study of CPT (Resick et al., 2008). In that study we compared the full 12-session CPT protocol with its constituent parts: CPT without the written trauma account (CPT-C) and the written trauma account without the cognitive therapy (CPT-W). We found that all three conditions were the same by post-treatment, but the trajectory of change was different. Throughout the course of therapy, the CPT-C group showed significantly faster improvement than the CPT-W condition, which only caught up at the end. CPT-C also showed faster improvements than CPT until the two trauma account sessions were completed. CPT fell between the other two groups after that. The CPT-C group also had only a 15% drop-out rate compared to 26% each for the other two conditions.

Because the above results need to be replicated, and because the first study with veterans used the full CPT protocol (Monson et al., 2006), we have included the full protocol here for training and implementation. However, these recent results indicate that CPT-C is a good alternative for those veterans for whom the trauma account is problematic. It also provides a good solution to the dilemma of how to handle the trauma accounts in group treatment. For whom is the trauma account problematic? In our studies of CPT, we have never excluded people with personality disorders or other comorbidities as long as the person was lucid, not engaging in any self- or other-harm behaviors, or under current risk by others (e.g., domestic violence or stalking). Therefore, CPT was tested with people who had a range of disorders who did not worsen with the administration of the trauma account. However, one might consider using CPT-C if a patient is so avoidant that he already has one foot out the door. Some patients arrive in therapy announcing that they cannot or will not talk about the traumatic event. Most of the time we have been able to do cognitive therapy around these stuck points, and they find the account to be a beneficial component. If the patient will quit treatment rather than do the account, CPT-C should be used. In giving people a choice of which version of the protocol to use, we have found some veterans will choose the CPT protocol.

The CPT-C protocol does not ignore the processing of emotions. Patients are encouraged to both feel and label their natural event-related emotions and to challenge those that are secondary to appraisals and thoughts (manufactured). However, because the trauma account is an assignment that tends to elicit stronger emotions, the therapist using the CPT-C protocol needs to make a specific effort to draw out natural emotions and to help the patient notice the differences in emotions when she changes her self-dialogue. Also, the therapist cannot wait until the account is read to determine the patient’s stuck points.
therapist may need to do more Socratic questioning to bring out enough details about the traumatic event to challenge the stuck points adequately.

The CPT-C protocol is still 12 sessions. Rather than shortening the therapy (which would be possible), we took advantage of the opportunity to reinforce new skills and divide up two sessions with as much information as in the original protocol. The first change is at Session 3. Instead of assigning the trauma account or moving straight to challenging questions, we continue to focus solely on A-B-C Worksheets. In the CPT protocol, patients are asked to continue working on A-B-C Worksheets and write their accounts. We believe that 1 week of doing the worksheets is often not sufficient, especially if the patient has difficulty identifying his thoughts or labeling his emotions. Therefore, an additional week of practice is very beneficial before the challenging questions are introduced. This also gives the therapist an additional session to challenge the patient’s stuck points about the worst traumatic event, and focus on assimilation regarding that event before the patient is asked to begin doing it himself.

The next change occurs at Session 4. Instead of re-assigning the written account, patients are asked to complete Challenging Questions Worksheets on a daily basis with a focus on assimilation. In Session 5 the next worksheet, Patterns of Problematic Thinking, is introduced.

The last major change involves dividing Session 7 of the CPT protocol (in CPT-C Session 6), in which the Challenging Beliefs Worksheet and Safety Module are both introduced after going over the Patterns of Problematic Thinking assignment. In the CPT-C protocol, the Challenging Beliefs Worksheet is introduced, but not the Safety Module. Again, this gives the therapist another opportunity to elicit assimilated beliefs about the worst trauma that might have emerged more naturally with the trauma account. The Safety Module and the topic of over-accommodated safety are introduced in the next session (Session 7). From Session 8 on, the protocols are identical. The outline for CPT-C is as follows:

**CPT Without the Trauma Account (CPT-C) Outline**

**Session 1:** Symptoms of PTSD, explanation of symptoms (cognitive theory), description of therapy. Practice assignment: Write Impact Statement and complete Stuck Point Log.

**Session 2:** Patient reads Impact Statement. Therapist and patient discuss meaning of trauma. Begin to identify stuck points and problematic areas. Review symptoms of PTSD and theory. Introduction of A-B-C Worksheets with explanation of relationship among thoughts, feelings, and behavior. Practice assignment: Complete 1 A-B-C sheet each day including at least one on the worst trauma.
Session 3: Review A-B-C practice assignment. Discuss stuck points with a focus on assimilation. Review the event with regard to any acceptance or blame issues. Begin Socratic questioning regarding stuck points. Practice assignment: Reassign A-B-C Worksheets.

Session 4: Review A-B-C practice assignment and challenge assimilation with Socratic questions. Introduce Challenging Questions Worksheet to challenge specific assimilated beliefs regarding the trauma. Practice assignment: Challenge one stuck point per day using the Challenging Questions Worksheet (focus on assimilation/blame).

Session 5: Review Challenging Questions Worksheets. Introduce Patterns of Problematic Thinking Worksheet. Practice assignment: Complete Patterns of Problematic Thinking Worksheet on a daily basis. Continue using Challenging Questions as needed. Make sure patient understands the importance of balance in beliefs rather than extreme, either/or thinking.

Session 6: Review practice assignment. Determine patterns of problematic thinking. Introduce Challenging Beliefs Worksheet. Teach patient to use the new worksheet to challenge cognitions about the trauma(s). Practice assignment: Complete Challenging Beliefs Worksheets daily on the trauma, as well as, everyday events.

Session 7: Review Challenging Beliefs Worksheets. Introduce Safety Module. Discuss how previous beliefs about safety might have been disrupted or seemingly confirmed by the index event. Use Challenging Beliefs Worksheet to challenge safety beliefs. Practice assignment: Read Safety Module and complete Challenging Beliefs Worksheets on safety.

Session 8: Review Challenging Beliefs Worksheets and help patients to challenge problematic beliefs they were unable to complete successfully on their own. Introduce Trust Module. Pick out any stuck points on self-trust or other-trust. Practice assignment: Read Trust Module and complete Challenging Beliefs Worksheets on trust.

Session 9: Review Challenging Beliefs Worksheets. Introduce Power/Control Module. Discuss how prior beliefs were affected by the trauma. Practice assignment: Read Power/Control Module and complete Challenging Beliefs Worksheets on power/control. Continue to challenge other stuck points on a daily basis using the Challenging Beliefs Worksheets.

Session 10: Review Challenging Beliefs Worksheets. Introduce module on Esteem (self-esteem and regard for others). Practice assignment: Read module and complete Challenging Beliefs Worksheets on esteem, as well as assignments regarding giving and receiving compliments and doing nice things for self. Continue to challenge other stuck points on a daily basis using the Challenging Beliefs Worksheets.

Session 12: Go over all the Challenging Beliefs Worksheets. Have patient read the final Impact Statement. Read the first Impact Statement and compare the differences. Discuss any intimacy stuck points. Review the entire therapy and identify any remaining issues the patient may need to continue to work on. Encourage the patient to continue with behavioral assignments on compliments and doing nice things for self. Remind patient that he is taking over as therapist now and should continue to use skills he has learned.

Group CPT Administration

CPT has been shown to be effective in a group format, either alone or in combination with individual therapy. Group CPT has been used to treat PTSD successfully in a variety of patient populations, including rape victims, childhood sexual abuse survivors, combat veterans, and military sexual trauma victims. The format also has been used in residential treatment programs in conjunction with other treatments (such as coping-skill building, Dialectical Behavior Therapy, and Acceptance and Commitment Therapy to name a few). Please see the CPT Group Manual for details on conducting CPT in a group.
Appendix A: Glossary of CPT Terms
Accommodation: The goal of CPT is to encourage accommodation, which involves accepting that the traumatic event occurred and discovering ways to successfully integrate the experience into the individual’s life (e.g., “In spite of this bad event happening to me, I am a good person.”). Accommodation reflects balanced thinking.

Assimilation: Information about an event is absorbed without changing prior beliefs. The incoming information may be altered to match prior beliefs in order to reconcile information about the traumatic event with prior schemas. Assimilation frequently serves as a process of engaging in undoing or self-blame for the trauma (e.g., “If only I had…”, “I should have stopped it” “It wasn’t really abuse”).

CPT: A 12-session trauma-focused, manualized therapy based on the social cognitive theory of PTSD that focuses on how the traumatic event is construed and coped with by a person who is trying to regain a sense of mastery and control in his or her life. CPT has been found effective for posttraumatic stress disorder (PTSD) and other corollary symptoms following traumatic events.

CPT COLLAGE website: A part of an interactive community of websites for VHA employees on the VA intranet providing CPT materials and resources including consultation opportunities. Information on cognitive processing therapy in general and the CPT Implementation Program can be found on the CPT COLLAGE VA intranet.

http://vaww.collage.research.med.va.gov/collage/cpt/

CPT-C: 12-session cognitive-only CPT (without the written trauma account). The CPT-C modification is indicated for certain patients (e.g., patients who refuse to write an account, have impending redeployment, have less overall time available, or have no or limited recollection of the event). CPT-C can also be indicated when therapists want to allot more time for the patient to develop cognitive skills. CPT-C remains trauma-focused and does not ignore the processing of emotions.

Emotional processing theory: A theory of PTSD developed by Foa, Steketee, and Rothbaum (1989) derived from information processing theory (Lang, 1977). In this theory, PTSD is believed to emerge due to the development of a fear network in memory that elicits escape and avoidance behavior. Mental fear structures include stimuli, responses, and meaning elements. Anything associated with the trauma may elicit the fear structure or schema and subsequent avoidance behavior. Prolonged exposure therapy for PTSD is based on emotional processing theory.

Fight-flight-freeze reactions: Natural and automatic, fear/flee/freeze or anger/aggression reactions that occur when faced with a traumatic situation.

Grounding techniques: Techniques such as cueing to date, time, location, or safety; or touching a predetermined object used when patients are dissociative to help orient back to the present.
**Hindsight bias, 20/20 hindsight:** An example of a distorted cognition associated with assimilation. A person with hindsight bias may believe that he/she knew an outcome in advance (e.g., “If only I had ____________, this would not (might not) have happened.” “I knew that I shouldn’t trust him”).

**Impact statement:** A written description of how the patients’ worst trauma has affected their life including a discussion of the patients’ beliefs about the cause of the event and of each of the following five primary themes that are be addressed in CPT: safety, trust, power/control, esteem, and intimacy. The impact statement is given as a practice assignment in session 1 and again in session 11.

**Index trauma:** The trauma chosen for the written trauma account by the patient and therapist. The index trauma is generally the worst trauma. One of the major benefits of selecting the worst trauma is that there is more likely to be generalization of new, more balanced cognitions from worst event to less severe event than the other way around. Additionally, the worst trauma account may yield the most relevant stuck points and can reinforce a sense of mastery for the patient.

**Just world belief:** The belief that the world is an orderly, predictable, and fair place, where people get what they deserve (i.e. good things happen to good people, bad things happen to bad people). This is a cognitive distortion theorized to impact trauma recovery and is addressed in CPT.

**Military sexual trauma (MST):** Sexual assault or repeated, unsolicited, threatening acts of sexual harassment that occurred while the veteran was in the military.

**Natural emotions vs. manufactured emotions:** Natural emotions are emotions that follow directly after an event and would be universally experienced, i.e. a hard-wired response, such as fear when in danger, or sadness in response to loss. Manufactured emotions are feelings experienced not directly from an event but instead based on an interpretation of an event (e.g., guilt, shame).

**Over-accommodation:** Altering one’s beliefs about oneself and the world to the extreme to feel safer and more in control in order to reconcile information about the traumatic event with prior schemas. Over-accommodation typically involves generalizing trauma-based reactions to non-traumatic situations (e.g., “I can never trust anyone again.”). These beliefs often fit into the themes that constitute the final five sessions of CPT.

**PCL (PTSD Checklist):** The PCL is a 17-item self-report measure of the 17 DSM-IV symptoms of PTSD. Respondents rate how much they were bothered by that problem in the past week or month.
Posttraumatic stress disorder (PTSD): Psychological disorder defined in the DSM-IV as an intense reaction of fear, helplessness, or horror to the direct experience, witnessing, or confrontation of a traumatic event. Symptoms are broken down into 3 distinct clusters:

- **Re-experiencing**: Intrusive thoughts, dreams, or flashbacks of the trauma; also includes psychological and physiological distress to reminders of trauma.
- **Avoidance**: Avoidance and general numbing of responses to reminders of the trauma.
- **Hyperarousal**: General increase in arousal including difficulties sleeping or concentrating, exaggerated startle response, hypervigilance, and angry outbursts.

Prolonged Exposure (PE): An empirically supported cognitive behavioral therapy that treats PTSD across a variety of settings and trauma populations. The main therapeutic components are direct (“in vivo”) and imaginal exposure to the traumatic event. Unlike CPT, cognitive restructuring is not a main or required component of PE. PE construes PTSD as a disorder induced by an overactive fear network which elicits avoidance and prevents full emotional processing of the trauma. The goal of PE is to facilitate emotional processing through activating and then modifying this fear network through exposure exercises.

Social cognitive theory: A theory that postulates that the way in which an individual cognitively processes a traumatic event impacts his/her emotions. According to this theory, recovery from PTSD relies on the activation, and subsequent correction, of faulty cognitions and their related emotions. Full cognitive processing of the trauma will alleviate negative emotions associated with the trauma and reduce symptomatology.

Socratic questioning: A cognitive therapy technique in which the therapist asks leading questions to assist the patient in challenging the accuracy of his/her thinking and rectifying inaccurate thought patterns in a way that alleviates psychological distress.

Six categories of Socratic questioning:

- **Clarification** - “Tell me more” questions which help patients examine their beliefs/assumptions on a deeper level and provide information necessary for the therapist to fully understand the situation.
- **Probing assumptions** – “Why” and “How” questions designed to challenge patients’ presuppositions and unquestioned beliefs.
- **Probing reasons and evidence** – Questions that assist patients in looking at the actual evidence behind their beliefs. This is a similar process to probing assumptions.
- **Questioning viewpoints and perspectives** – Challenging patients’ position through asking questions about alternative viewpoints and perspectives.
- **Analyzing implications and consequences** – Questions that help the patient examine the potential outcomes of his/her beliefs to see if they are desirable or even make sense.
- **Questions about the question** – A technique of responding when the therapist is directly questioned by the patient. Instead of providing an answer to the question, the therapist responds with another question that returns the focus back on the patient.
**Stuck points:** Patients’ problem-areas in thinking that interfere with the recovery process and that are keeping them "stuck." Stuck points can include both assimilated and overaccommodated beliefs. Stuck points are continually identified throughout CPT and become primary targets for practice assignments and in-session work.

**Survivor Guilt:** A manufactured emotion associated with surviving a traumatic event that others, often loved ones, did not survive. Survivor guilt is also applicable to situations in which an individual did not suffer as serious injuries/consequences from a trauma as others, often associated with feelings of worthlessness. The “why not me?” question is the flip side of the question “Why me?” and implies a belief in a just world.

**PTSD as a disorder of non-recovery:** A perspective of PTSD as a “stalling-out” of the normal trauma-recovery process rather than the development of a unique psychopathology. This perspective is based on the evidence that PTSD symptoms are nearly universally observed immediately following serious traumatic stressors, with most individuals achieving recovery over the course of several months. Those who remain symptomatic after several months are considered to have stagnated in this normal recovery process and can be diagnosed with PTSD.

**Traumatic bereavement:** Bereavement in response to a traumatic death; the trauma component adds unique issues to the typical course of bereavement. Additionally, PTSD may interfere with the normal bereavement process, and bereavement may interfere with PTSD treatment. CPT addresses these issues with an optional session 2a in which traumatic bereavement is specifically addressed through psychoeducation of the grief process, identification/processing of stuck points associated with the traumatic loss, and cognitive adjustment to life without the deceased individual(s).

**Vicarious traumatization:** A reaction that occurs when an individual begins experiencing PTSD-like symptoms, questioning his/her own vulnerabilities, and/or feeling fear/concern for his/her own safety in response to hearing a detailed or graphic account of another’s trauma history. Vicarious traumatization is often observed in mental health professionals who treat trauma patients, emphasizing the importance of self-awareness and self-care when working with trauma populations.

**5 CPT Themes:** Five general themes of over-accommodation specifically are addressed in the last 5 sessions of the CPT protocol. Each session includes psychoeducation, where a theme is discussed in relation to self and others, and a theme-related practice assignment. Specific theme-related stuck points are identified and targeted for practice assignment and in-session work.

- **Safety** – Beliefs regarding one’s own ability to control events and protect self/others from harm and the dangerousness/harmful intentions of others.
- **Trust** – Adopting a healthy balance of trust and mistrust. This includes both trust of one’s own perceptions/judgments and the reliability of other’s promises, intentions, and behavior.
- **Power/Control** – Beliefs of one’s own capability to meet challenges as well as the ability to maintain power and control outcomes in the context of interpersonal...
relationships. This also includes the extent to which others have control over one’s life.

- **Esteem** – Perspectives of self-worth and the worth of others. This includes personal needs of being understood and respected as well as fostering realistic views, and challenging rigid/stereotypical views, of others.
- **Intimacy** – Fostering of self-intimacy (the ability to soothe oneself and be alone without feeling lonely or empty) and ability to connect with others. This also focuses on the innate human desire for closeness with others.
Appendix B: Literature on CPT


