An Overview of Cognitive Processing Therapy for PTSD

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Today’s Agenda

- Overview of PTSD and EBPs for PTSD
- What is CPT?
- Empirical Support for CPT with Different Populations
- Theories behind CPT
- Overview of CPT Sessions
- Role of Clinical Relationship in CPT
- Case Examples
- Training in CPT and Resources
- Q&A
- CE Information
Posttraumatic Stress Disorder

(DSM 5, 2013)

A: Event. Exposure to actual or threatened death, serious injury, or sexual violence. Directly, witnessing, or learn of this happening to loved one; repeated exposure to aversive details of trauma

B: Intrusions. Distressing memories or nightmares / Intrusive Images / Intense reactivity when reminded (sights, sounds, smells)

C: Avoidance. Internal reminders & external reminders

D: Negative Alterations in Cognitions and Mood. Amnesia / Negative beliefs re: oneself, others, world / Persistent distorted thoughts about cause of trauma (blame) / Negative emotional state (guilt, shame, anger, fear) / Anhedonia / Detachment, Estrangement / No positive emotions

E: Arousal. Irritability, anger problems / Reckless, self destructive behavior / Hypervigilance / Hyper startle / Sleep problems / Poor memory, concentration
Not everyone gets PTSD. Most often trauma survivors have a natural recovery.

When people do develop PTSD, 3 decades of research show that people can and do recover.

PTSD is a result of a stalled recovery. Trauma-focused treatment is to get a person “unstuck.”

Recovery is NOT ERASING the event, but rather reducing or eliminating symptoms of PTSD.
Seven trauma-focused psychotherapies are recommended as first-line treatments for PTSD:

- Cognitive Processing Therapy
- Prolonged Exposure
- Eye Movement Desensitization & Reprogramming
- Other specific cognitive behavioral therapies for PTSD
- Brief Eclectic Psychotherapy (BEP)
- Narrative Exposure Therapy (NET)
- Written narrative exposure (WET)

These psychotherapies are recommended over psychopharmacology alone

(Retrieved from www.healthquality.va.gov/guidelines/MH/ptsd/)
What is Cognitive Processing Therapy for PTSD?

- Cognitive behavioral therapy for PTSD developed in 1980s initially to help rape survivors.
- 23 published randomized controlled trials (RCTs) demonstrating its effectiveness.
- Decreases symptoms related to traumas such as child abuse, rape and sexual assault, combat, and natural disasters.
- Endorsed by the U.S. Departments of Veterans Affairs and Defense and by the International Society for Traumatic Stress as a first-line treatment for PTSD.

www.CPTforPTSD.com
CPT has flexible delivery options:

- A short-term, trauma focused psychotherapy
  - 12 session weekly therapy
  - May be completed in 7 -18 sessions

- 1 time weekly or 2 times weekly

- Can be delivered in a group, individual, or combined format

- Can be done with or WITHOUT the trauma narrative: CPT+A or CPT.
EMPIRICAL SUPPORT FOR CPT

23 published randomized controlled trials (RCTs) of CPT

<table>
<thead>
<tr>
<th>Traumas</th>
<th>Populations</th>
<th>Locations</th>
<th>Modalities</th>
<th>Comparison conditions</th>
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</thead>
<tbody>
<tr>
<td>Rape, Child Sexual abuse, Physical Assault, Military Sexual Trauma, Combat</td>
<td>Civilian, Active Duty, Veteran, Male, Female, Adolescents</td>
<td>U.S, Australia, Germany, Democratic Republic of Congo</td>
<td>CPT, CPT +A, Individual, Group, Combined, Telehealth, CPT + rTMS, SMART-CPT, D-CPT</td>
<td>Delayed treatment, Treatment as Usual, Present-Centered Therapy, Prolonged Exposure, Dialogical Exposure Therapy, Written Exposure Therapy, Differing CPT modalities</td>
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All studies include individuals with multiple traumas.

Randomized Controlled Trials of Cognitive Processing Therapy: Clinician Administered PTSD Scale (CAPS) Pre- and Post CPT (Intent to Treat)

CAPS SEVERITY

Pre  Post


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

![Bar chart showing BDI severity pre- and post-treatment across various studies.]

- Resick et al. (2002; CPT+A)
- Chard (2005; CPT-SA)
- Monson et al. (2006; CPT+A)
- Resick et al. (2008; CPT)
- Resick et al. (2008; CPT+A)
- Forbes et al. (2012; CPT+A)
- Galovski et al. (2012; CPT+A)
- Resick et al. (2015; CPT)
- Galovski et al. (2016; CPT+A)
- Maieritsch et al. (2015; CPT+A)
- Rosner et al. (2019; D-CPT)

CPT with Adolescents
(Rosner et al., 2019)

- RCT in Germany comparing D-CPT vs WL
- 14-22 year olds with PTSD from childhood sexual and physical abuse (n=88)
- Tx: Motivational component; affect regulation module: D-CPT (CPT at intense dose and special attention to developmental tasks such as school, career, relationships)
- D-CPT better than WL
- D-CPT phase had best results; questioning the need for extra pre-CPT interventions
- Younger adolescents 14-18 seemed to have better results than 18+.
- Rosner et al. suggests that treating PTSD early “might help prevent borderline symptoms becoming chronic”
## PATIENT CHARACTERISTICS: IMPACT ON CPT OUTCOME?

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Sex</strong></td>
<td>• Men and women have similar outcomes</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td>• No differences in Tx outcome, AA women may be more likely to drop out early than White women (mixed findings)</td>
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<tr>
<td><strong>Era</strong></td>
<td>• OIF/OEF Veterans larger treatment gains, but also more likely to drop out than Vietnam Veterans, Vietnam era still significant gains</td>
</tr>
<tr>
<td><strong>Borderline Personality Disorder</strong></td>
<td>• Borderline Personality Disorder traits do not predict CPT outcome</td>
</tr>
<tr>
<td><strong>Substance Use/Abuse</strong></td>
<td>• No differences in outcome in those with current or past alcohol use disorders</td>
</tr>
<tr>
<td><strong>TBI</strong></td>
<td>• Individuals with TBI history do well in CPT, accommodations available only if needed</td>
</tr>
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</table>
CBT & Social Cognitive Theory of PTSD

- **Cognitive Behavioral Theory:**
  - How we think influences how we feel, which drives how we behave; behavior reinforces thoughts & feelings.

- **Social Cognitive Theory of PTSD:**
  - To make sense of the world, humans constantly ask “why.” We organize our life experiences into categories, or schemas, to make meaning.
  - Traumas that lead to PTSD clash with prior schemas or confirm them.

- **PTSD occurs when natural recovery “stalls”;** the survivor cannot make sense of the trauma with their schemas. The results are the negative thoughts and feelings and other symptoms of PTSD.

(Resick, et al, 2017)
In CPT, four ways a person’s recovery stalls after a trauma:

- **AVOIDANCE**

- **Stuck Points:** trauma misappraisals – blame & undoing

- **Stuck Points:** Extreme conclusions about self/others/world after trauma

- **Manufactured emotions prevail and block natural emotions**

(Resick, et al, 2017)
CPT helps people get unstuck – and integrate the trauma

Education about PTSD, thoughts, and emotions

Trauma processing to:
• Block avoidance
• Dissipate natural emotions
• Identify and challenge event specific stuck points

Examine here and now stuck points post event

Goal: By blocking avoidance, we help clients achieve more balanced thinking about self, trauma, others, and the world and help them to accept the event happened just as it did.

(Resick, et al., 2017)
When to Implement CPT: Pre-Treatment Issues to Consider

- Recommended for adult or adolescent (14 +) clients with:
  - PTSD and comorbid diagnoses (e.g., depression, anxiety, substance use)

- Not Recommended for clients with:
  - Active suicidal behavior, or actively homicidal
  - Current psychosis or active mania
Phase 1: Pre-Treatment

- Assess for PTSD
- Description of the therapy and how it might differ from other treatment
- Motivational assessment and enhancement
- Informed Consent
- For multi-traumatized: finding index event
Phase 2: Education on PTSD, Thoughts, and Emotions

Sessions 1, 2, & 3

• Education about PTSD
• Begin to identify stuck points.
• Introduce events-thoughts-feelings relationship via ABC worksheet

• Practice Assignments:
  • Session 1: Assign Impact Statement
  • Session 2: Stuck Point Log & Assign Daily ABC sheet
  • Session 3: ABC sheets focused on trauma
Phase 3: Processing the Trauma

Sessions 4 & 5

• Trauma processing
  • Challenge stuck points with a focus on self-blame, other-blame, or undoing with aid of worksheets
  • Access natural emotions
  • CPT +A includes *optional* written trauma narrative to enhance trauma processing

• Practice Assignments:
  • Session 4: Use Challenging Questions Worksheets to continued challenging of stuck points
  • Session 5: Introduce Patterns of Problematic Thinking Sheet to identify typical patterns in thinking
Phase 4: Learning to Challenge

Sessions 6 & 7

- Introduce Challenging Beliefs Worksheets (CBW)
- Continued focus on self blame, undoing

Practice Assignments
- Session 6: Assign Daily CBWs
- Session 7: Daily CBWs and introduction of trauma themes
Phase 5: Trauma Themes

Sessions 8-12

• Use the Challenging Beliefs Worksheets (CBW) to address themes of safety, trust, power/control, esteem and intimacy, as well as other stuck points.

• Clients move from extreme statements to balanced statements.

• Practice Assignments

• Assign Daily CBWs, including one on session theme

• Other specific assignments for sessions 11 & 12
Phase 6: Facing the Future

Session 12

- Review Final CBWs
- Process Final Impact Statement (compare with first statement)
- Review the Course of Treatment
- Identify New Goals and Issues to be Addressed

- Successful completion possible at Session 7-Session 18.
Role of Clinical Relationship in CPT

- Warmth and empathy
- Gracious, gentle, AND direct
- Informed consent is essential and a continual process
- Shared decision making
- Motivation is built on rationale; getting client buy-in
- Collaborative empiricism: client & therapist are “detectives together”
- Therapist Models
  - compassionate examination of the facts
  - acceptance of natural emotions
- Therapist teaches clients to be their own therapist
Case 1 (disguised to protect confidentiality)

35 yo Hispanic single female with MDD, PTSD with two young children. Multiple traumas in her life. CPT 2x a week in outpatient setting. Index: raped during end of pregnancy.

SESSION 1 PCL: 57
SESSION 4 PCL: 46
SESSION 6 PCL: 42
SESSION 9 PCL: 22
SESSION 12 PCL: 12

EXAMPLE OF STUCK POINTS ADDRESSED: It is my fault my daughter has behavioral problems. The rape caused her behavioral problems. I should have told him no. I should have handled the packages myself. I should have gone to my family’s house instead of the store. It is my fault because I asked him for help.
Case 2  (disguised to protect confidentiality)

16 yo Caucasian female. Index: sexual abuse by family friend. Hx of suicide attempt within the last year. CPT in outpatient setting.

SESSION 1 PCL: 56
SESSION 2 PCL: 29
SESSION 5 PCL: 30
SESSION 6 PCL: 8
SESSION 10 PCL 6
SESSION 12 PCL: 0
Monthly Follow-up PCL: 0.

EXAMPLE STUCK POINTS ADDRESSED: If my parents were more vigilant, I wouldn’t have been in the situation. It is my parents’ fault. I should have told sooner. If my parents had been on top of things, he wouldn’t have had the opportunity to abuse me. If I trust again, I will be hurt.
Case 3  (disguised to protect confidentiality)

29 yo African American married female. PTSD and AUD. CPT 2x a week in an outpatient setting. Index: Witnessed sibling being sexually abused by adult family member when they were children
SESSION 1 PCL: 39
SESSION 3 PCL: 20
SESSION 6 PCL: 8.
SESSION 9 Ended CPT as an early response. PCL: 7

EXAMPLE OF STUCK POINTS ADDRESSED:
I should have done something in the moment. It is my fault my sibling was abused. I should have known what he was going to do. I should have fought him. It’s my fault because I didn’t stop it. I should have been able to protect my sibling. Because I didn’t stop it, I am no good.
Training in CPT

- 2- or 3-day workshop led by an approved CPT Trainer.
- Optional 5-6 months of weekly case consultation. Clinicians who complete training requirements may be listed on the CPT Provider roster.
- [www.CPTforPTSD.com](http://www.CPTforPTSD.com) for trainings near you or to invite a trainer to come to your agency

****Upcoming Training****

NYU CPT Training Initiative funded by the Gavin Farrell Foundation. Workshops + Learning Collaborative Model

October 28 & 29, 2019 AND January 27, 2020 in New York, NY

To learn more and to apply:
[www.socialwork.nyu/alumni/continuing-education](http://www.socialwork.nyu/alumni/continuing-education)
More about CPT


www.CPTforPTSD.com

Free on-line training in CPT: www.musc.edu/cpt

This American Life “10 Sessions” Episode (August 23, 2019) www.thisamericanlife.org/682/ten-sessions

Whiteboard video about CPT:
Topics for Further Study

National Center for PTSD: www.ptsd.va.gov

More about CPT and PE:
http://www.ptsd.va.gov/apps/AboutFace/therapies.html

Veterans discuss experiences with PTSD and treatment:
http://www.ptsd.va.gov/apps/AboutFace/
Sources


Questions?
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  - OR
  - CE Portal: [https://sswforms.es.its.nyu.edu/](https://sswforms.es.its.nyu.edu/)
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  - Scroll down & select today’s webinar under “Online Learning”
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For Questions: Call us at 212-998-5973 or email us at silver.continuingeducation@nyu.edu.
More about Wendy

Wendy Bassett, LCSW-R, is a psychotherapist with a private practice in Manhattan. Wendy’s expertise is posttraumatic stress disorder (PTSD) and brief, evidence-based cognitive behavioral therapies for PTSD with individuals, groups, and couples. Wendy is a Cognitive Processing Therapy (CPT) for PTSD trainer and consultant. For more than a decade, she worked with veterans with PTSD at VA Connecticut Healthcare System in West Haven, CT. A graduate of Smith College School for Social Work, she is currently an Assistant Clinical Professor of Psychiatry, Yale School of Medicine, and an Adjunct Lecturer at NYU Silver School for Social Work.

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