An Overview of Cognitive-Behavioral Therapies: Efficacy and Techniques for PTSD

Justin W. Weeks PhD
Karin Humenick-Cullen LIMHP LPC
Maya Krek PLMHP

Nebraska Medicine
SERIOUS MEDICINE. EXTRAORDINARY CARE.

Disclosure Statement

Justin Weeks:

I do not have a financial interest, arrangement or affiliation with a commercial organization that may have a direct or indirect interest in the subject matter of my presentation

Learning Objectives

- Review how to implement evidence-based treatments for PTSD via telehealth or in person
  - Prolonged Exposure
  - Cognitive Processing Therapy
  - Written Exposure Therapy
- Review strategies to implement these treatments into your clinic setting

Anxiety Subspecialty Treatment

AnxST

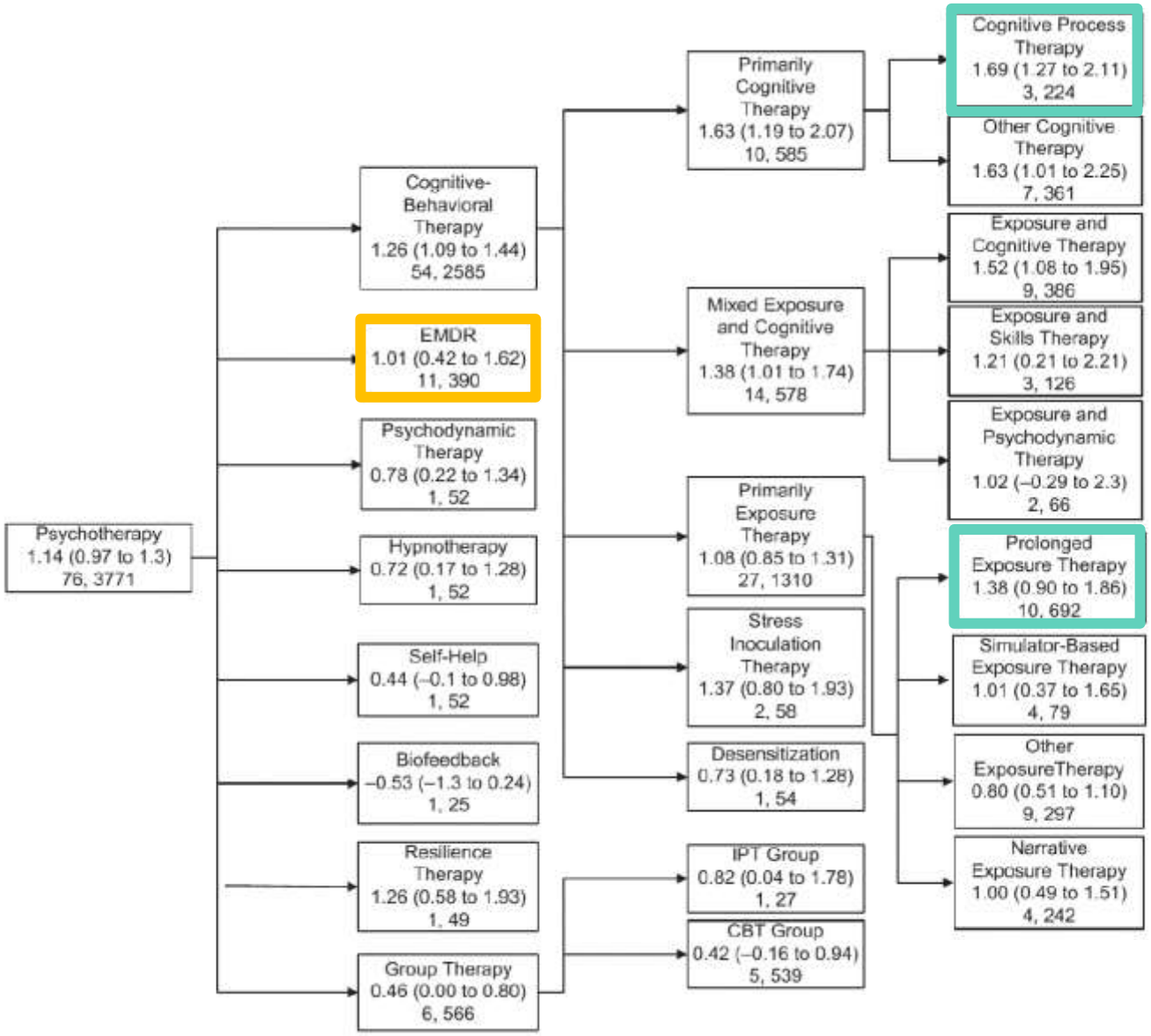
Evidence Base

- Why not EMDR?
    - EMDR is evidence-based
- But…dismantling studies have shown that eye movements are not relevant to EMDR outcomes:
    - Boudewyns & Hyer, 1996
    - Devilly et al., 1998
    - Gosselin & Matthews, 1995
    - Pitman et al., 1996
    - Renfrey & Spates, 1994

Evidence Base

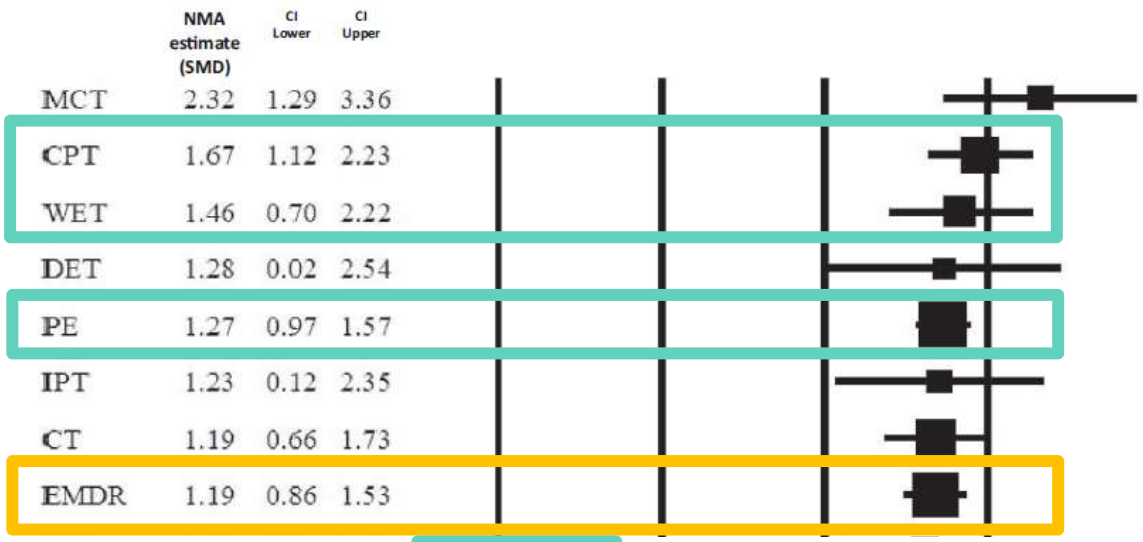
- Watts et al. (2013)
  - Meta-analysis of 112 studies

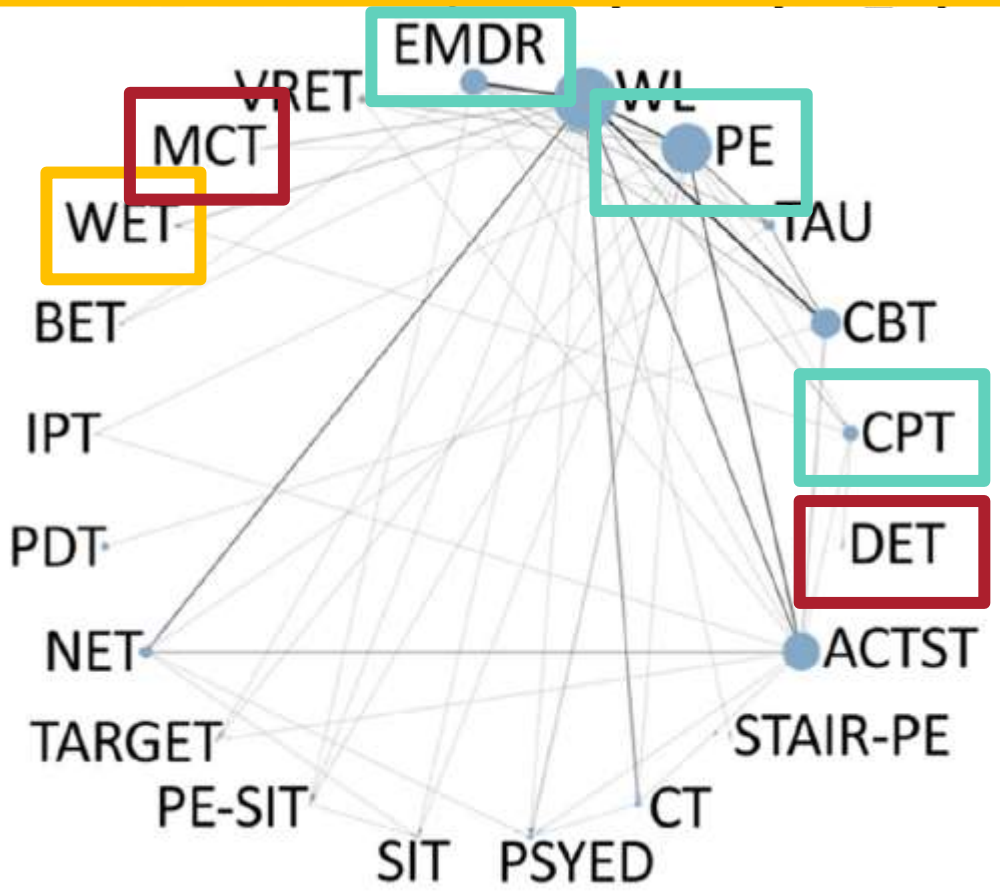
Evidence Base



Evidence Base

- Jericho, Luo, & Berle (2021)
  - Systematic review and network meta-analysis of 82 studies

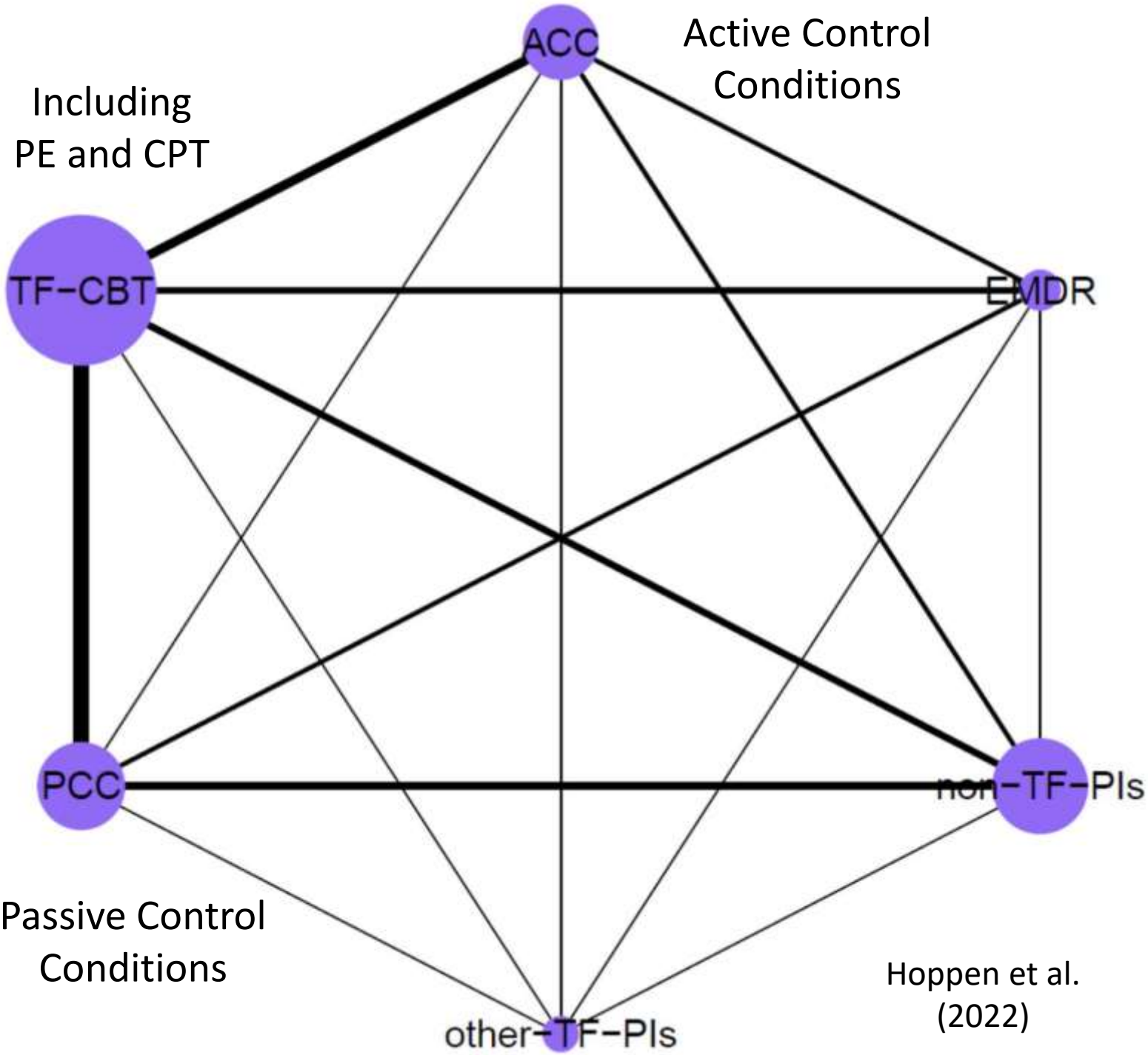




Jericho et al. (2021)

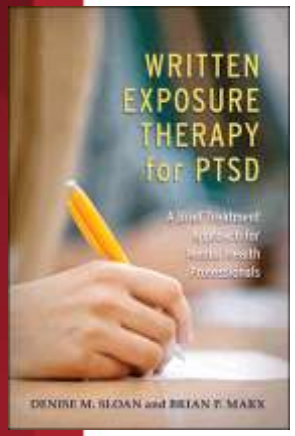
Evidence Base

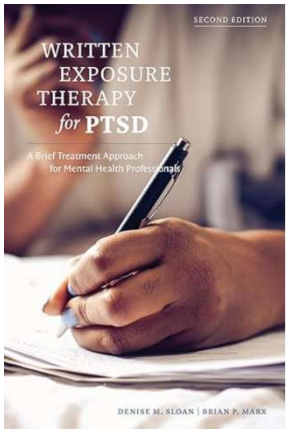
- Hoppen, Jehn, Holling, Mutz, Kip, & Morina (2022)
  - Network and pairwise meta-analysis of 157 studies
    - TF-CBT (including PE and CPT) was robustly the best ranking psychological intervention category across timepoints, above EMDR



Hoppen et al. (2022)

Evidence Base





RESEARCH ARTICLE

WILEY

Long-term treatment gains of a brief exposure-based treatment for PTSD

Johanna Thompson-Hollands[1,2] | Brian P. Marx[1,2] | Daniel J. Lee[3] | Patricia A. Resick[3] | Denise M. Sloan[1,2]

1 | INTRODUCTION

Written Exposure Therapy vs Prolonged Exposure Therapy in the Treatment of Posttraumatic Stress Disorder

A Randomized Clinical Trial

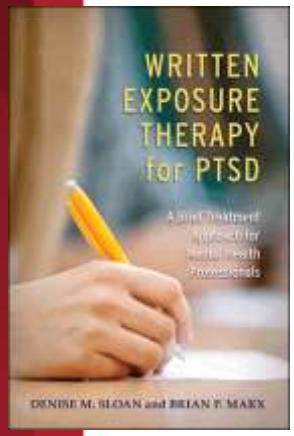
Abstract

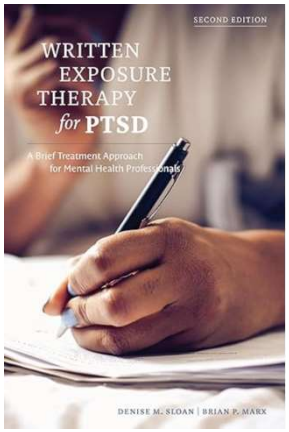
Statistically non-inferior to:

–CPT

–PE

Evidence Base





ELSEVIER

Behavior Therapy

Volume 55, Issue 6, November 2024, Pages 1222-1232

State of the Science: Written Expo
Therapy for the Treatment of Postt
Stress Disorder ☆

Denise M. Sloan, Brian P. Marx

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https://doi.org/10.1016/j.beth.2024.02.004

Although there are effective psychotherapies available for posttraum
(PTSD), brief treatments for PTSD are needed to expand the reach of
exposure therapy (WET) is a brief treatment that has the potential to
need in PTSD treatment and has a rapidly expanding evidence base t
this paper we provide information on how WET was developed, and
proposed underlying mechanisms of the treatment and evidence sup
underlying mechanism. The current evidence supporting WET for th
is reviewed. The evidence indicates that WET is an efficacious and ef
approach for PTSD and is noninferior to more time-intensive evidenc
for PTSD. The paper concludes with suggestions for expanding the ev
that is necessary for it to be considered a first-line treatment approa
practice guidelines.

EDITORIAL

Written Exposure Therapy Finds Solid Footing Alongside First-Line Psychotherapies for Posttraumatic Stress Disorder

Charles T. Taylor, PhD; Murray B. Stein, MD, MPH

Various forms of psychological interventions have proven to be powerful in the treatment of posttraumatic stress disorder (PTSD). Two of the best studied interventions, prolonged exposure (PE) and cognitive processing therapy (CPT), have strong support for their efficacy and have been extensively disseminated by Veterans Affairs, while a third intervention, eye movement desensitization and reprocessing, also is efficacious and widely practiced. Each of these treatments requires considerable therapist training, typically involves numerous sessions over several months, and is variably tolerated by patients. These limitations of extant psychotherapies for PTSD have hastened the demand for therapies that might provide alternatives that are less burdensome for therapists and patients.

One such therapy that has been garnering increased attention is written exposure therapy (WET). WET, which is typically delivered in 5 to 7 sessions, each 45 or 60 minutes in duration, involves writing about the trauma in the presence of the therapist, has no homework requirements, and requires relatively little therapist training in the specific modality, though general patient psychotherapeutic management skills should be considered a prerequisite. WET has been shown in randomized clinical trials to be noninferior to CPT[1] and, in the trial reported by Sloan et al[2] in this issue of *JAMA Psychiatry*, noninferior to PE. We discuss here some important considerations in interpreting the results of this most recent trial.

How Should the Noninferiority Margin Be Defined?

A fundamental element of noninferiority trials is determining the target difference in response (ie, the margin) below which treatments are deemed noninferior. Sloan et al[2] selected a noninferiority margin of 10 for the Clinician-Administered PTSD Scale for *DSM-5* (CAPS-5) (with an SD of 20) based on a statistical rationale that a meaningful separation of treatments would be represented by an effect size difference of 0.50. Would a patient seeking treatment for PTSD agree with this margin? That is, does a 10-point change in CAPS-5 scores represent the point at which a patient would first perceive a meaningful difference in outcomes? The concept of minimal clinically important difference (MCID)[3] may be valuable to use when selecting the noninferiority margin. It represents the smallest change in a disease outcome that a patient would identify as beneficial. Using patient-rated clinical global impressions severity and improvement scales as anchors, previous work identified the MCID on the CAPS for *DSM-IV* as 0.525 SDs for patient Clinical Global Impressions ratings—approximately 7 points on the CAPS for *DSM-IV*.[4] A reduction of 12 to 15 points on the CAPS-5 can be considered indicative of clinically meaningful change,[5] a construct similar but not identical to MCID. Other considerations when defining the noninferiority margin include the cost, burden, and perceived acceptability of the interventions. A larger margin may be acceptable for treatments perceived by patients as being lower burden and more tolerable. WET seems to offer several advantages in those domains. Although the observed difference between WET and PE did not threaten the target margin (the largest between-treatment difference was 2.42 points on the CAPS-5 in favor of WET at week 10), it seems worthwhile, if not essential, to consider the patient's perspective in determining the noninferiority margin—the point at which 2 treatments would yield a minimally important difference to a patient that, in the absence of excessive cost, burden, etc, would dictate a clear treatment choice.

Challenging Prevailing Assumptions of Exposure-Based Therapies

Homework assignments have long been considered critical to the efficacy of exposure-based therapies. If patients fail to complete homework as prescribed by their therapist, treatment success will be limited. Meta-analyses support these claims. Both the quantity and quality of between-session homework exercises is predictive of superior clinical response, demonstrating medium to large effects.[6] Much time is spent in therapy assigning and reviewing homework and troubleshooting when homework assignments were not completed as planned. We assume treatment gains are facilitated when patients take what was learned in session and apply it to their daily lives (eg, confronting fear cues and avoided situations in daily life). WET assigns no homework yet achieved comparable outcomes with a treatment that emphasizes between-session in vivo exposures. How could this be?

One possibility is patients in WET completed self-directed in vivo prompts (homework exercises [naturalistic exposures] motivated by treatment gains acquired within session. That is, learning occurring within session may have translated to fear antagonistic behaviors outside of session. Between-session exposures may therefore be comparable in WET vs PE—a notable question for future research. If so, one wonders whether there are advantages to self-determined vs therapist-prescribed between-session activities. Autonomous motivation—acting with a sense of volition (compared with acting due to social pressure or guilt)—has been shown to facilitate health behavior change[7] and may be higher when homework is self-determined. In contrast, the therapeutic alliance may be threatened when patients are not fully on board with homework assignments or fail to complete

Real-Time Telehealth Versus Face-to-Face Management for Patients With PTSD in Primary Care: A Systematic Review and Meta-Analysis

Anna Mae Scott, PhD[a,*]; Mina Bakhit, PhD[a]; Hannah Greenwood, BSc(Hons)[a]; Magnolia Cardona, PhD[a]; Justin Clark, BA[a]; Natalia Krzyzaniak, PhD[a]; Ruwani Peiris, MD[a]; and Paul Glasziou, PhD[a]

ABSTRACT

Objective: We conducted a systematic review and meta-analysis of randomized controlled trials comparing real-time telehealth (video, phone) with face-to-face therapy delivery to individuals with posttraumatic stress disorder (PTSD), by primary or allied health care practitioners.

Data Sources: We searched MEDLINE, Embase, CINAHL, and Cochrane Central (inception to November 18, 2020); conducted a citation analysis on included studies (January 7, 2021) in Web of Science; and searched ClinicalTrials.gov and WHO ICTRP (March 25, 2021). No language or publication date restrictions were used.

Study Selection: From 4,651 individual records screened, 13 trials (27 references) met the inclusion criteria.

Data Extraction: Data on PTSD severity, depression severity, quality of life, therapeutic alliance, and treatment satisfaction outcomes were extracted.

Results: There were no differences between telehealth and face-to-face for PTSD severity (at 6 months: standardized mean difference [SMD] = −0.11; 95% CI, −0.28 to 0.06), depression severity (at 6 months: SMD = −0.02; 95% CI, −0.26 to 0.22; $P = .87$), therapeutic alliance (at 3 months: SMD = 0.04; 95% CI, −0.51 to 0.59; $P = .90$), or treatment satisfaction (at 3 months: mean difference = 3.09; 95% CI, −7.76 to 13.94; $P = .58$). One trial reported similar changes in quality of life in telehealth and face-to-face.

Conclusions: Telehealth appears to be a viable alternative for care provision to patients with PTSD. Trials evaluating therapy provision by telephone, and in populations other than veterans, are warranted.

J Clin Psychiatry 2022;83(4):21r14143

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To share: https://doi.org/10.4088/JCP.21r14143

[a]Institute for Evidence-Based Healthcare, Bond University, Robina, Queensland, Australia

[*]Corresponding author: Anna Mae Scott, PhD, Institute for Evidence-Based Healthcare, Bond University, 14 University Drive, Robina, QLD 4226, Australia (ascott@bond.edu.au).

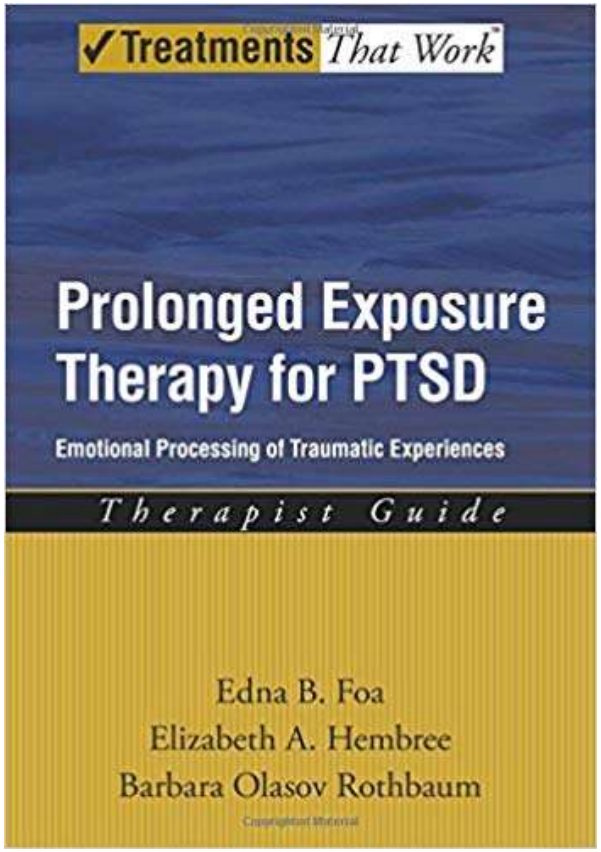
The prevalence and severity of posttraumatic stress disorder (PTSD) worldwide vary depending on regional distribution of intensity, diagnostic validity, and completeness of reporting.[1] The general population in the US has an estimated lifetime prevalence of approximately 6%[2]; in Europe, approximately 2%[3]; and in Australia, 7%.[4] For specific subgroup populations, these estimates may be considerably higher, eg, 29% in women who had experienced physical assaults, 39% for men who had experienced combat,[5] and 36% in children and adolescents who had experienced trauma.[6] The burden of PTSD both to the individual and to society is considerable. In Germany, the overall health care costs for people with PTSD are 3 times higher than for controls (42,870 vs 13,942 EUR across a 5-year period).[7] In the US, PTSD- and depression-related costs for veteran care were estimated to be between $4.0 and $6.2 billion USD over a 2-year period (in 2007 dollars).[8]

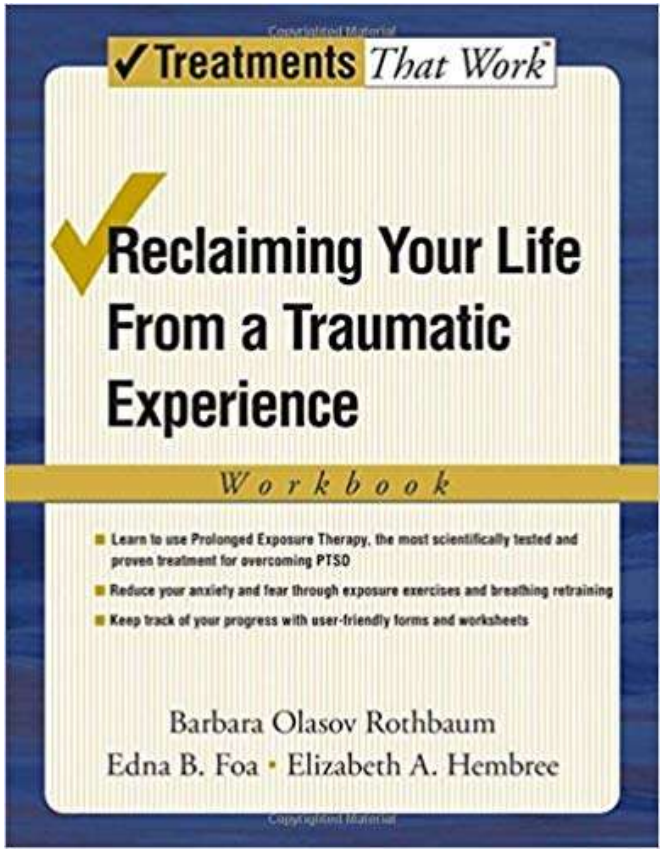
Clinical practice guidelines recommend several therapies for PTSD, including both pharmacologic and psychotherapies. Among the recommended psychotherapies is cognitive behavioral therapy (CBT), covering cognitive processing therapy (CPT), cognitive therapy, and prolonged exposure therapy. Therapies such as CBT or CPT may be delivered individually or in a group setting. Other therapies (such as brief eclectic psychotherapy, eye movement desensitization and reprocessing, and narrative exposure therapy) are also suggested.[9–11]

Telemedicine has been promoted for over a decade by the World Health Organization (WHO) as a solution to geographic access barriers, and it may be more acceptable to people with privacy and confidentiality concerns about using health services for stigmatized conditions.[12] Given that acceptability appears high,[13] it is important not only to highlight the benefits and challenges of remote service provision[14] but also to assess whether telehealth treatment is as effective as that delivered face-to-face.

In a 2016 review, telehealth-delivered therapies for PTSD were equivalent to face-to-face therapies in terms of PTSD symptom reduction, satisfaction, and absence of patient safety events.[15] Several reviews since then have found evidence to support the equivalence of telehealth-delivered interventions for individuals with mental health conditions,[16,17] and of exposure therapies delivered by telehealth versus face-to-face for PTSD more specifically.[15] A 2016 systematic review by Olthuis and colleagues also evaluated a mix of distance-delivered interventions for PTSD—including those delivered synchronously (eg, telephone and videoconferencing) and those delivered asynchronously (including emailed materials or printed materials with phone support).[18] More recently, a review has investigated the feasibility and acceptability of telehealth for processes such as patient triage, staff training, or clinician supervision.[19]

Prolonged Exposure





8-15 Sessions †

Nacasch et al., 2015

Goals of PE

- Gradually and safely confront:
  - Trauma-related memories
  - Feared situations
- Process traumatic memories
- Reduce:
  - Anxiety, fear, and other negative emotions
  - Re-experiencing
  - Hypervigilance

Foa, Hembree, & Rothbaum, 2019

Contraindications for PE

- Self-injurious behavior
  - 1-month hold
    - or
  - Refer to DBT first
- Non-stabilized psychosis
- Ongoing violent living situation
- No traumatic memory

Foa, Hembree, & Rothbaum, 2019

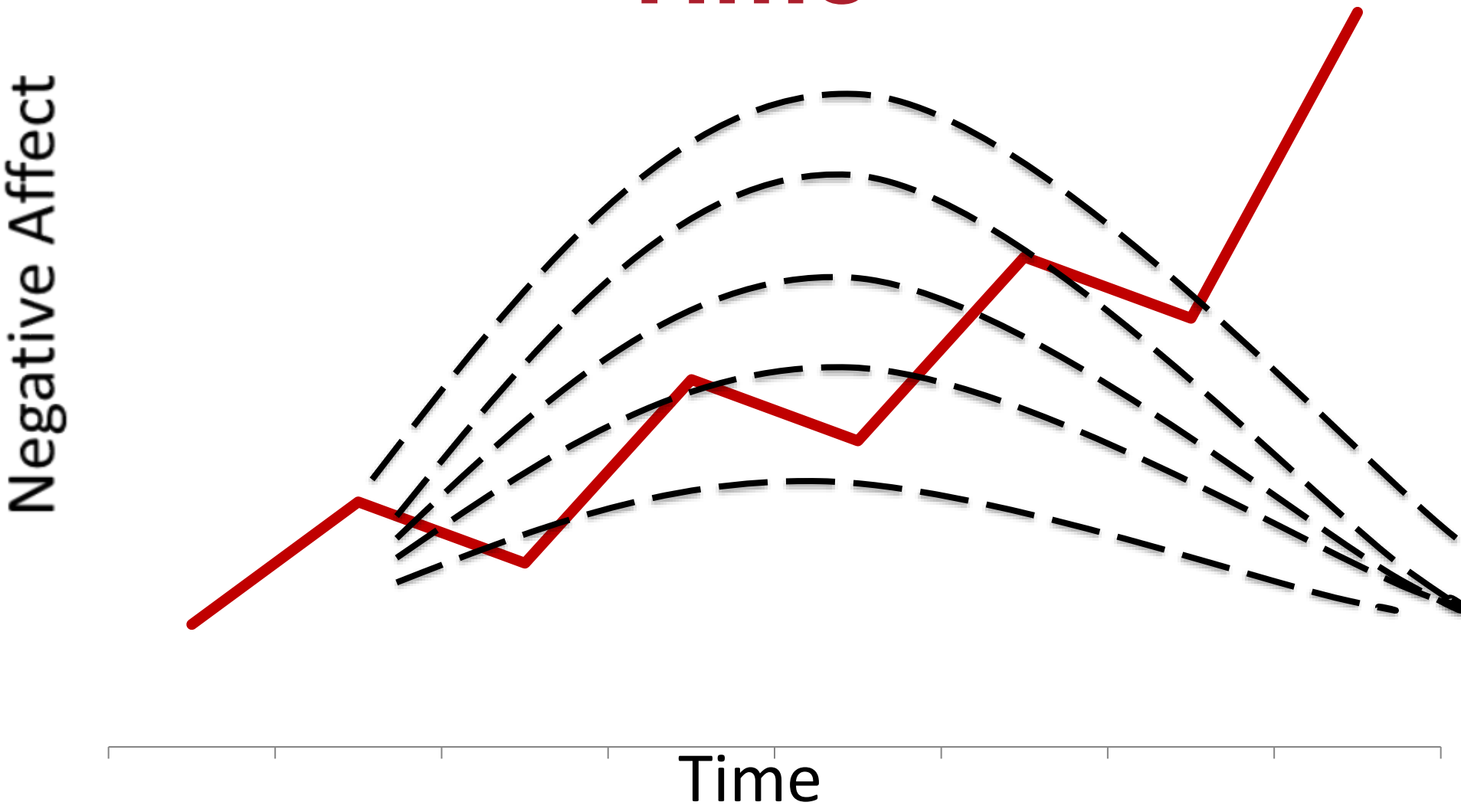
Exposure

Goals of PE

- Gradually and safely confront:
  - Trauma-related memories
  - Feared situations
- Process traumatic memories
- Reduce:
  - Anxiety, fear, and other negative emotions
  - Re-experiencing
  - Hypervigilance

Foa, Hembree, & Rothbaum, 2019

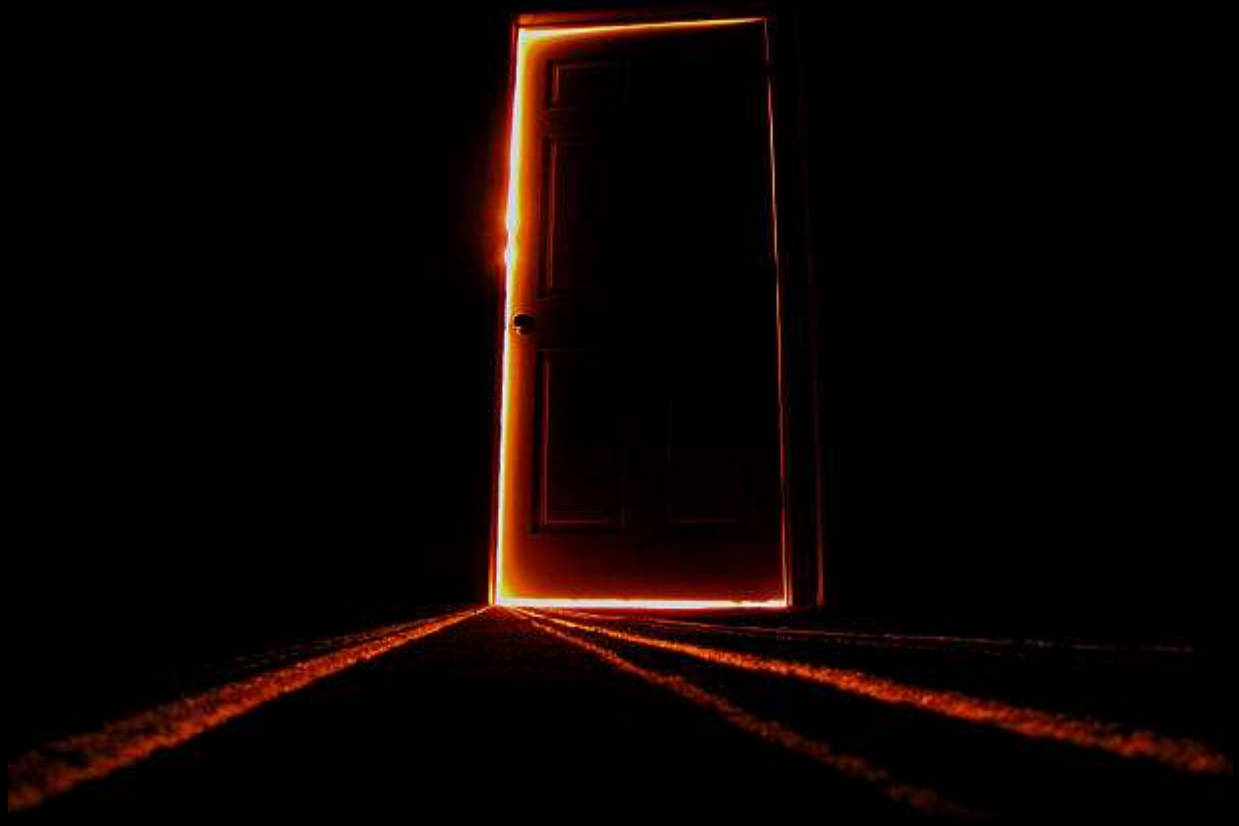
Negative Affect over Time



Emotional Processing

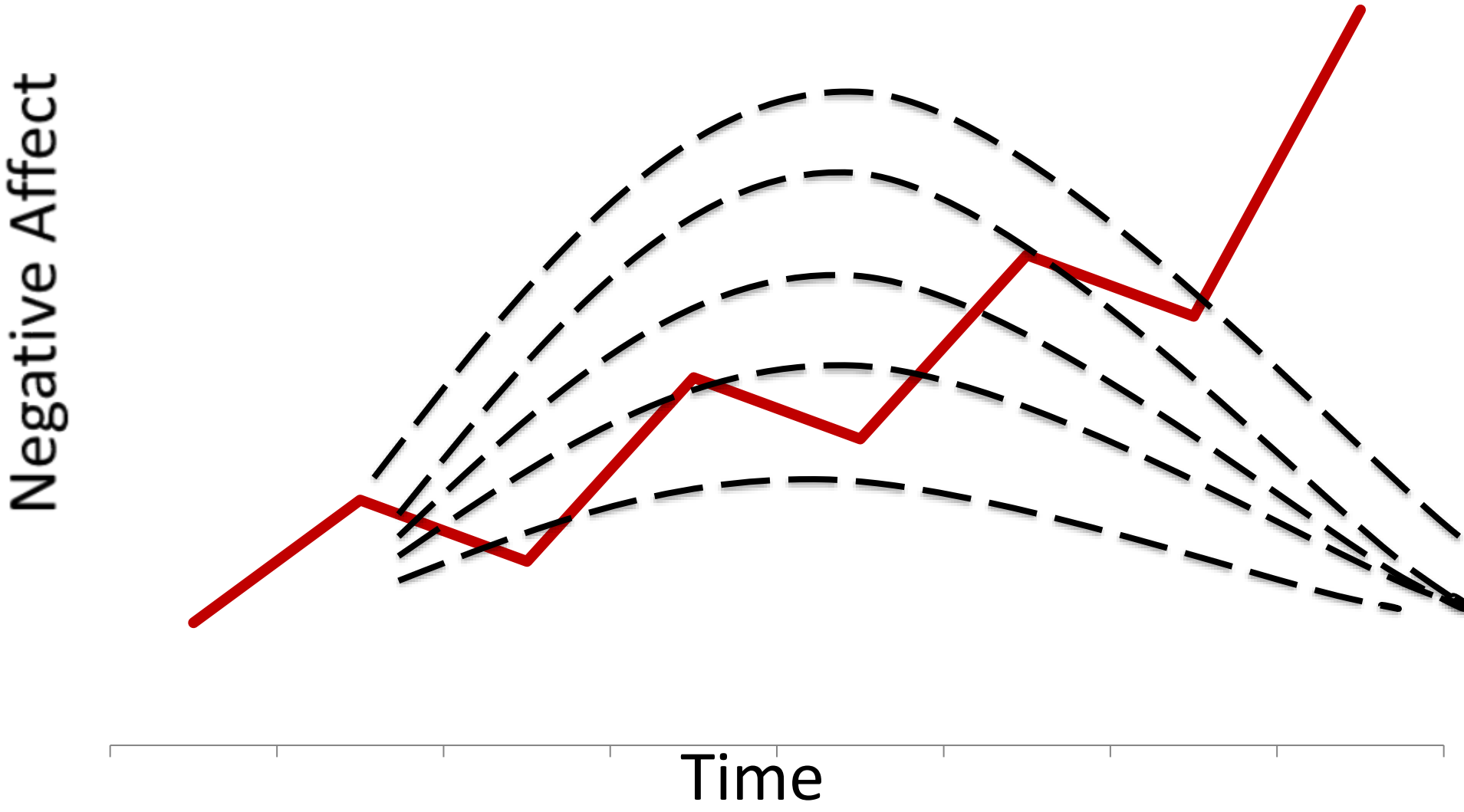
Foa, Hembree, & Rothbaum, 2019

Traumatic Memories: Suppression?



Wegner et al., 1987

Exposure Work



Exposure to Memories

Foa, Yadin, & Lichner, 2012

Keys to Effective PE

- Recommended to initiate in vivo exposure homework:
  - Session 2
- Recommended to initiate imaginal exposure homework:
  - Session 3
    - Close eyes
    - Present tense
    - Details, details, details

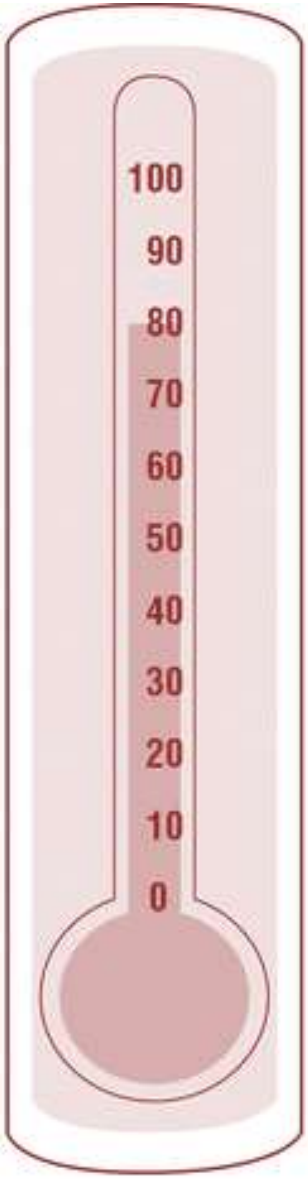
Foa, Hembree, & Rothbaum, 2019

Keys to Effective PE

- Don't use Diaphragmatic Breathing Retraining (DBR) during PE unless essential
  - Safety behavior
- Sessions 5-14
  - Focus on *hot spots*
- Termination session:
  - Entire memory again

Foa, Hembree, & Rothbaum, 2019

Subjective Units of Distress



100 – Highest anxiety/distress that you have ever felt

90 – Extremely anxious/distressed

80 – Very anxious/distressed; can't concentrate. Physiological signs present.

70 – Quite anxious/distressed; interfering with functioning. Physiological signs may be present

60 – Moderate-to-strong anxiety or distress

50 – Moderate anxiety/distress; uncomfortable, but can continue to function

40 – Mild-to-moderate anxiety or distress

30 – Mild anxiety/distress; no interference with functioning

20 – Minimal anxiety/distress

10 – Alert and awake; concentrating well

0 – No distress; totally relaxed

Wolpe, 1969

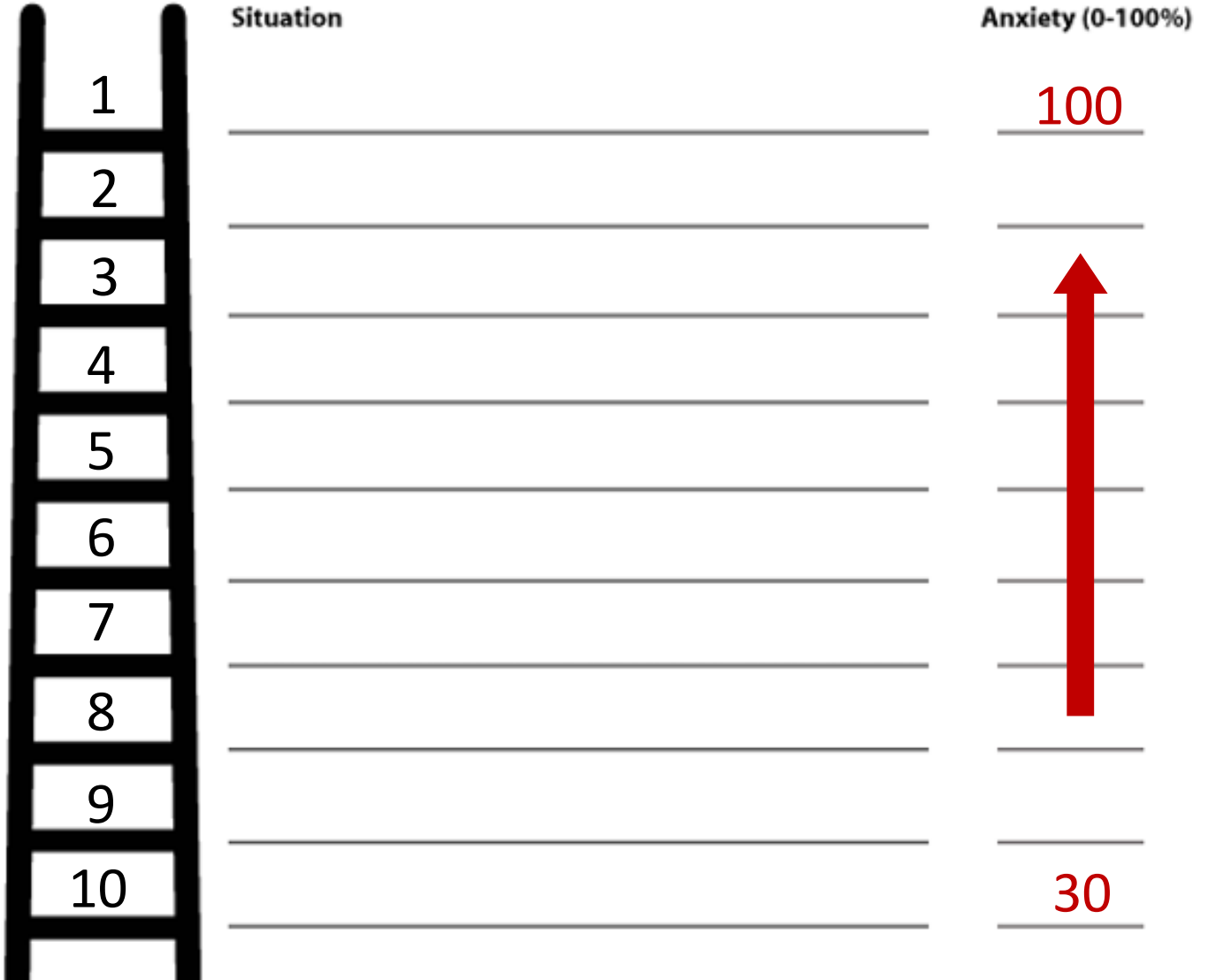
Note: "SUDS" stands for "**Subjective Units of Distress Scale.**" Physiological signs may include, for example, sweating, shaking, increased heart rate or respiration, gastrointestinal distress.

Keys to Effective PE

- Exposures are recommended to last:
  - 35 mins or more
    - or
  - Until SUDS reduce by 50% or more
- Common to repeat exposure on the same memory multiple times per session

Foa, Hembree, & Rothbaum, 2019

Behavioral Exposures



Exposure Planning

- Exposures should be designed to last at least 7 mins†
  - E.g., Don't agree to have patient enter any situation for only ~5 mins – can fuel anxiety/negative affect
  - Can also involve response prevention
    - E.g., not bathing after exposure

Keys to Effective Exposures

- Always set goals which are important to the *patient*
- Objective, behavioral goal
  - Anyone in the room would know if met
  - Objective marker of success
    - Prevents disqualifying the positive
- Emphasize immersion in the exposure

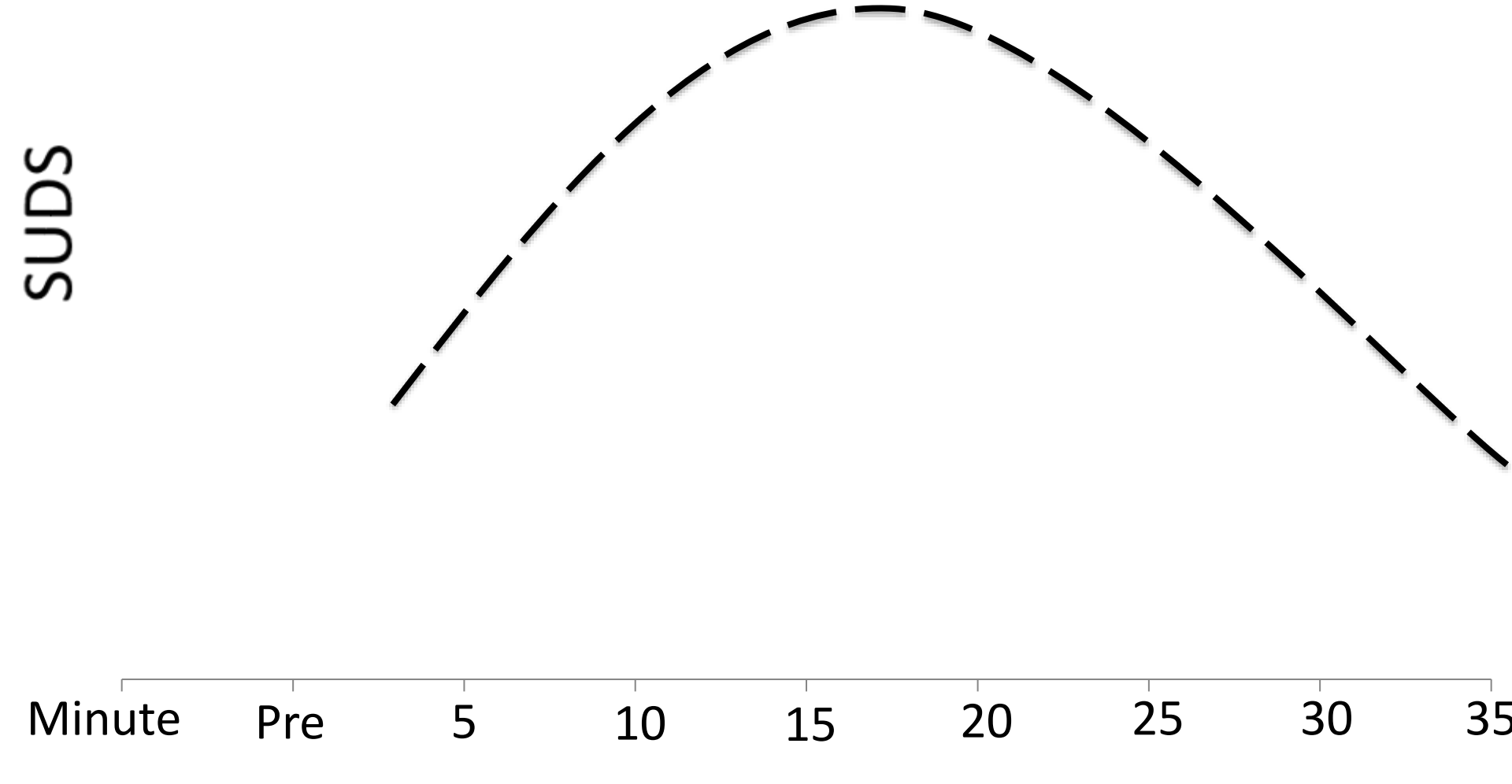
Keys to Effective Exposures

- Always make sure Patient knows when exposures will occur!!
- Ask Patients to commit

Exposure Planning

- Objective Safety
  - Never assign exposures that a typical, reasonable person would consider objectively dangerous

Exposure: Time Course



Debriefing

- Was the objective behavioral goal met?
  - Either *yes* (hopefully) or *no*!
- Hot cognitions?

Exposure Planning

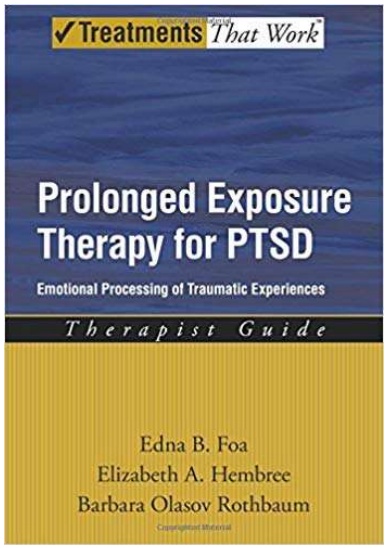
- In vivo: Remind patient that avoidance begets avoidance
  - Recommend that exposures be completed by a certain time/date

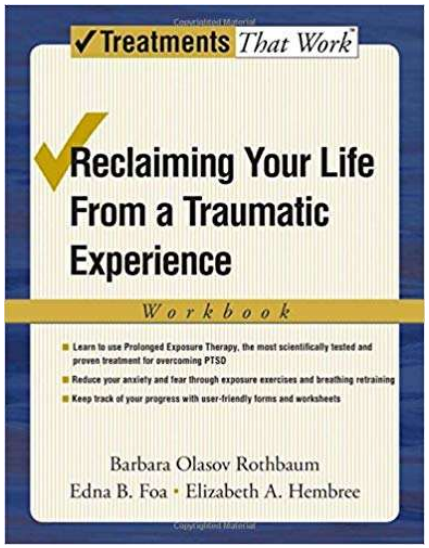
Reminders of Treatment Content

- Recommended to record:
  - DBR
  - Imaginal exposure
  - Debriefing/processing

Foa, Yadin, & Lichner, 2012

How To Implement in My Practice?





CTSA Certified Workshop

Center for the Treatment and Study of Anxiety

University of Pennsylvania

Foa, Hembree, & Rothbaum, 2019

PE: Coach App

PE Coach

Prolonged Exposure (PE) is an evidence-based psychotherapy for PTSD that helps you decrease distress about your trauma. PE has been shown to be one of the most effective treatments for PTSD. PE Coach is a mobile application (mobile app) for patients to use with their therapists during PE therapy for PTSD.

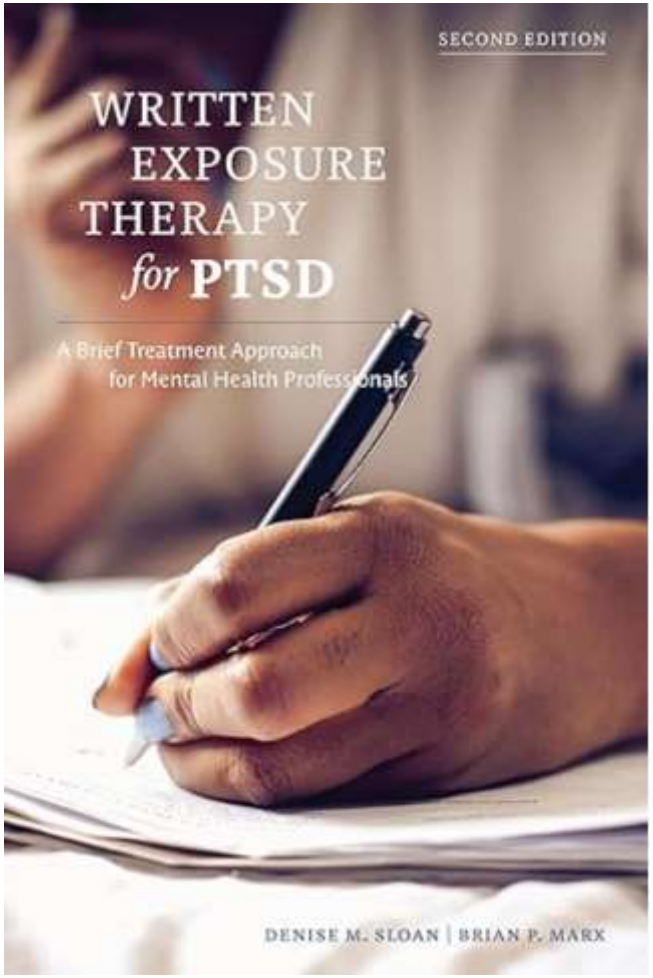
PE Coach is a treatment companion that helps you and your therapist work through the PE treatment manual.

Features include:

- Education about PE therapy and common reactions to trauma.
- Ability to record your PE therapy session as an audio file on your mobile device.
- Reminders to complete homework.
- Tools to keep track of tasks you did between sessions.
- Ability to track your PTSD symptoms over time.
- Guidance for breathing retraining - ways to change your breathing that help reduce your stress.

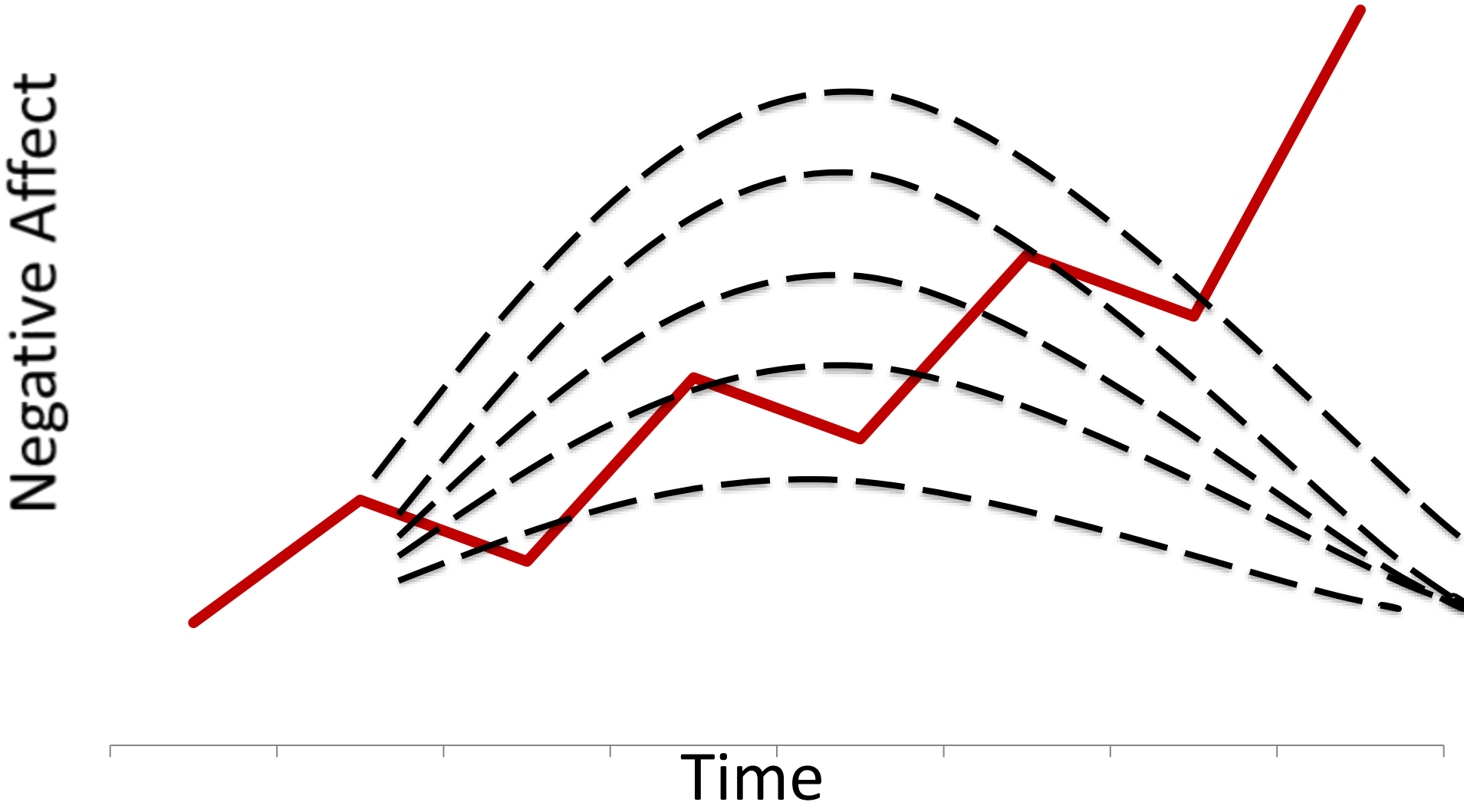
www.ptsd.va.gov

Written Exposure Therapy

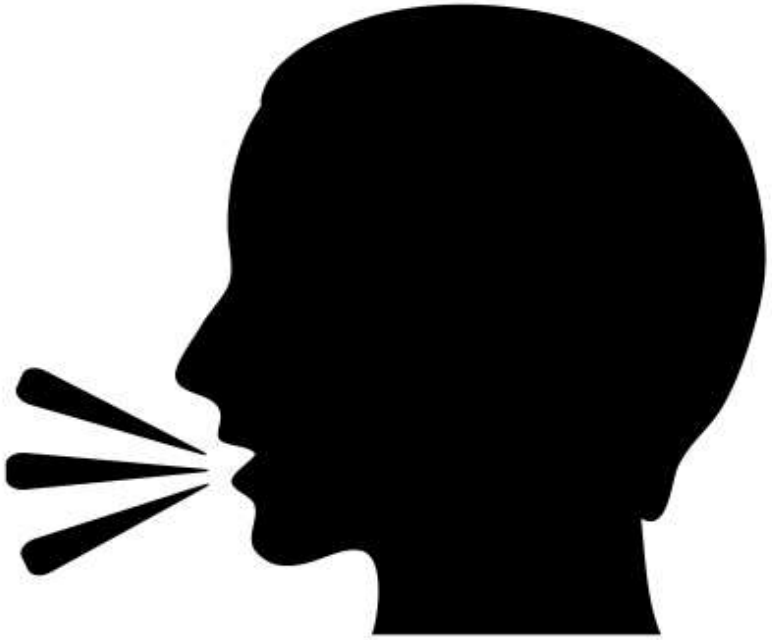


5 Sessions

Exposure Work



Exposure to Memories in Written Exposure Therapy



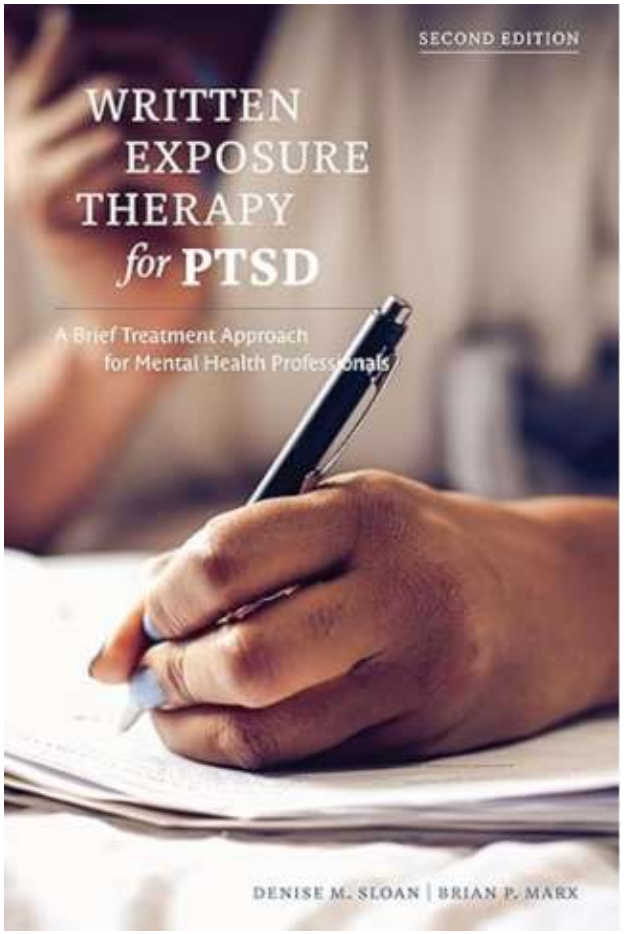
Sloan & Marx, 2025

Contraindications for WriT

- Self-injurious behavior
  - (1-month hold
    - or
  - Refer to DBT first)
- Non-stabilized psychosis
- No traumatic memory

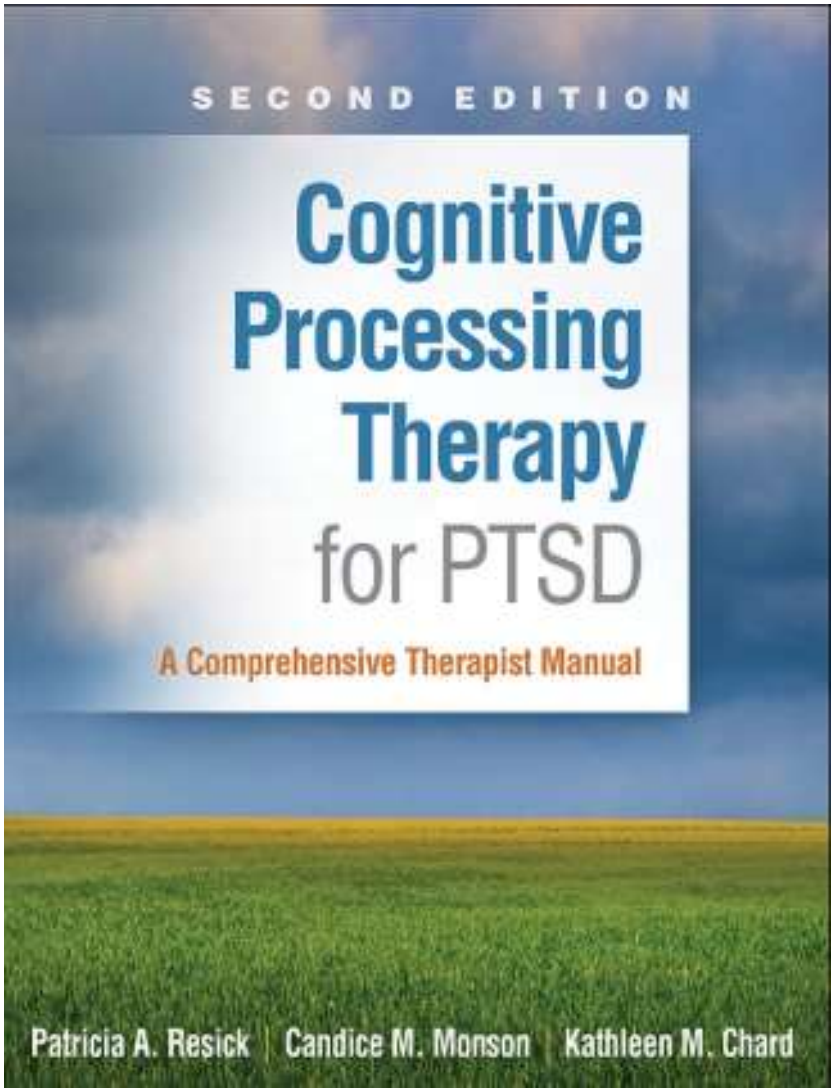
Sloan & Marx, 2025

How To Implement in My Practice?



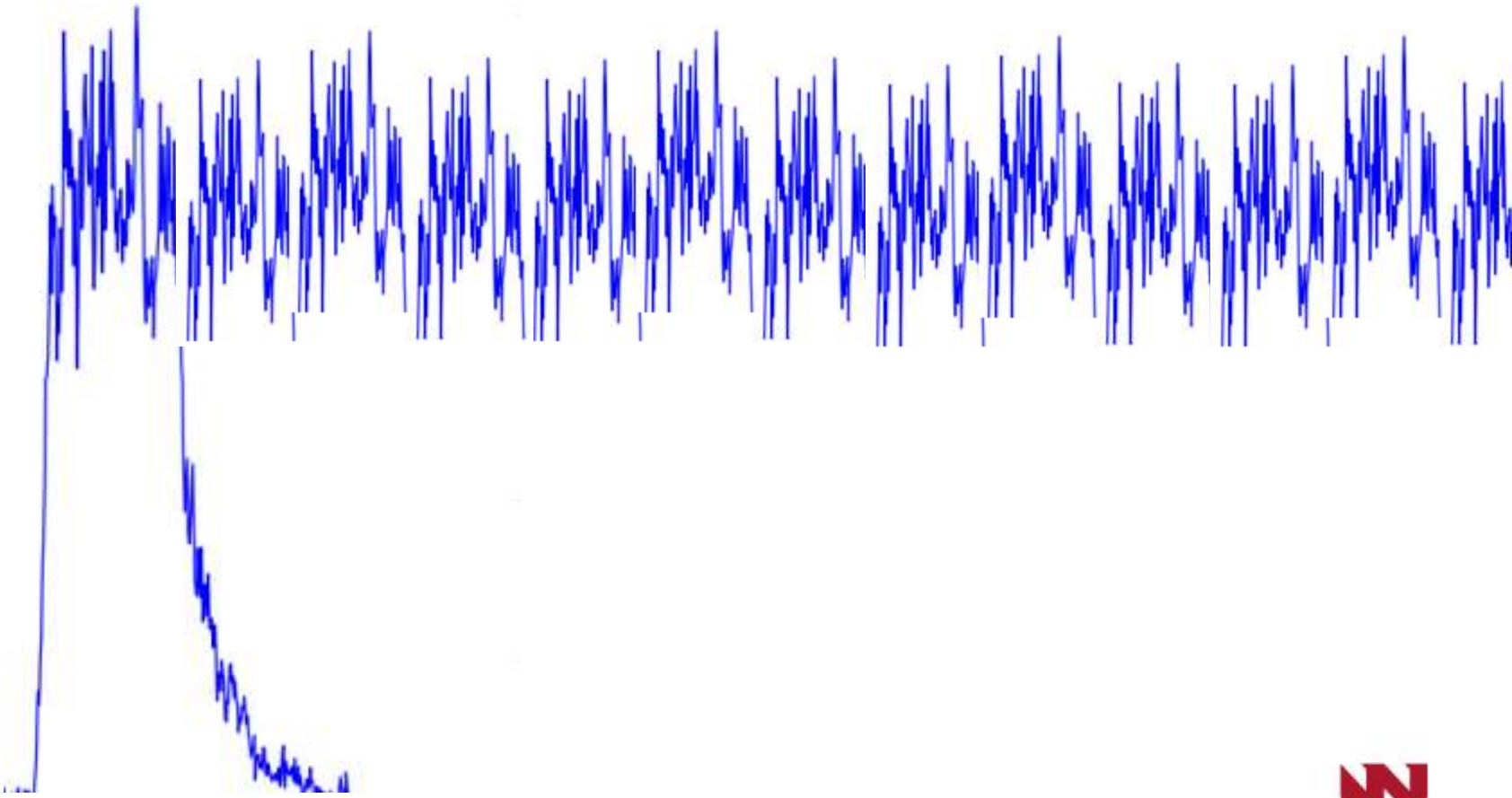
Sloan & Marx, 2025

Cognitive Processing Therapy



12 Sessions

PTSD:
Disorder of Nonrecovery



0-2 days

Resick, Monson, & LoSavio (2017)

Goals of CPT

- Examine the impact of the trauma on thoughts and feelings
- Decrease avoidance and emotional numbing
- Consider alternative viewpoints of the trauma, oneself, and the world
- Reduce distress related to memories of the trauma
- Reduce negative emotions

Resick, P.A., Monson, C.M., & Chard, K.M. (2024)

Contraindications for CPT

- SI/HI with imminent risk
  - ~~Self-injurious behavior~~
- Non-stabilized psychosis/mania
- Substance use that requires immediate detox
- Extreme dissociation tendencies that put self or others at risk
- ~~No traumatic memory~~

Resick, P.A., Monson, C.M., & Chard, K.M. (2024)

Keys to Effective CPT

- Identify *Stuck Points*
  - what one is saying to oneself about the trauma and the consequences of the trauma
- Help patients to examine and challenge their *stuck points*
  - To get them "unstuck" from recovering from the trauma
  - Via Socratic dialogue
  - Via Cognitive Restructuring

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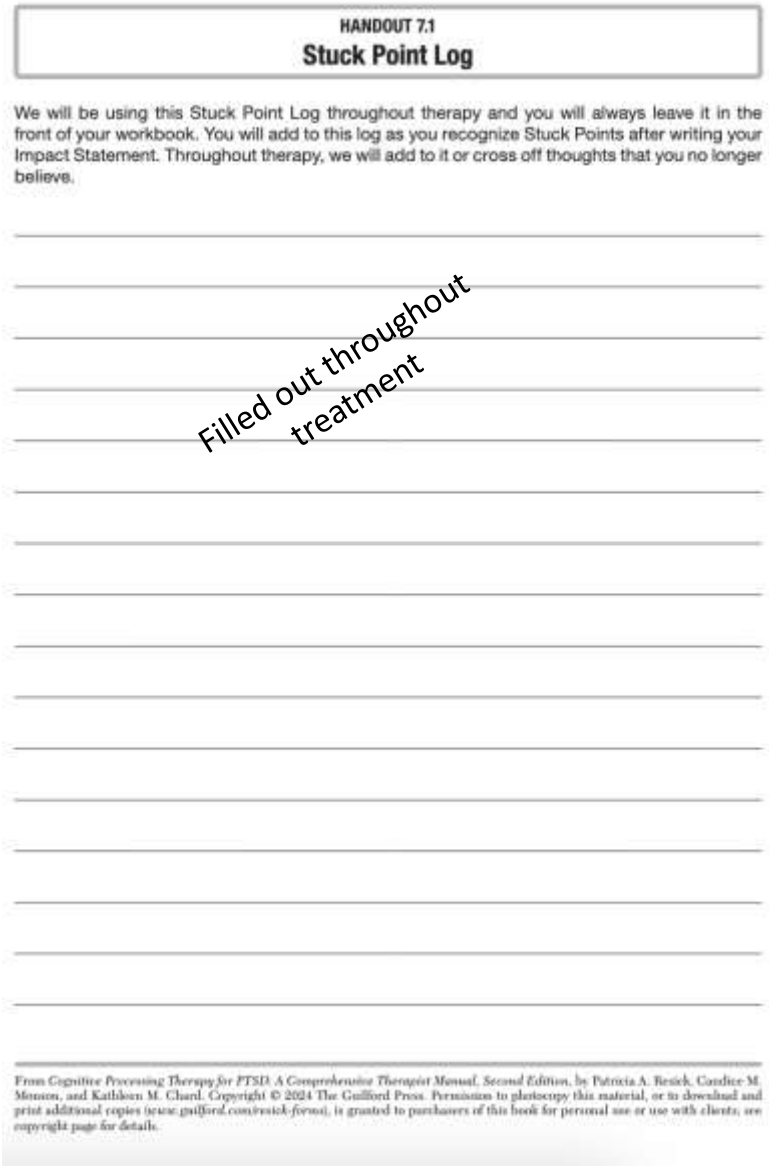
Impact Statement

- Read impact statement aloud
- Look for *stuck points* together – record on Stuck point Log
  - Themes: safety, trust, power/control, esteem, intimacy
  - Often formatted as "if...then" statements
  - Often include extreme language
    - "never"
    - "always"
    - "everyone"



HANDOUT 7.1

Stuck Point Log

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

Filled out throughout treatment

Resick, P.A., Monson, C.M., & Chard, K.M. (2024)

ABCs

HANDOUT 7.3c

ABC Worksheet: Example 3

Date: Client:

ACTIVATING EVENT A "Something happens."	BELIEF/STUCK POINT B "I tell myself something."	CONSEQUENCE C "I feel something."
I build a porch and the railing comes loose.	I can never do anything right.	Anger at myself and sadness

Goal: understand relationship between thoughts (stuck points) and (manufactured) feelings

- HW – 1 *stuck point* per day – at least some on the index trauma; (others can be day-to-day evets)

Are my thoughts above in "B" *realistic* and/or *helpful*? No. It wouldn't hold up in a court of law because I do SOME things right.

What can you tell yourself on such occasions in the future? There are some things that I do alright. It is not true that I "never" do anything right.

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Belief:

It is my fault that my uncle had sex with me. [Therapist asked whether the Stuck Point had a hidden word, "all."]

1. What is the evidence for and against this Stuck Point?

   For:

   ~~*I must have done something that made him think it was OK.*~~ [After more questions by therapist about fault and intent:] *There is no evidence for its being my fault.*

   Against:

   I didn't want to do it, and I told him so. He threatened to hurt my little sister. He said no one would believe me. He was an adult, and I was a child. He was bigger and stronger than me.

2. Is your Stuck Point a habit or based on facts?

   Habit. I have been saying this to myself for 25 years.

3. In what ways is your Stuck Point not including all of the information?

   How could it be my fault? I didn't even know what sex was when he started. You don't do that to kids. Just because he read me stories and babysat me didn't give him the right to do that.

4. Does your Stuck Point include all-or-none terms?

   Well, we talked about the hidden word "all." I thought it was all my fault and didn't even think about really blaming him. I was too scared of him, and my mother loved him.

5. Does the Stuck Point include words or phrases that are extreme or exaggerated (such as "always," "forever," "never," "need," "should," "must," "can't," and "every time")?

   "All my fault."

6. In what way is your Stuck Point focused on just one piece of the story?

   Because he did it to me, I assumed it was about me. I didn't think about the fact that I was a child or that what he did was a crime. I told him "No," and he threatened my family.

Resick, P.A., Monson, C.M., & Chard, K.M. (2016)

7. Where did this Stuck Point come from? Is this a dependable source of information on this Stuck Point?

   Mostly from me, but I think he said things that made it seem like it was my fault. I was so pretty, that he couldn't keep his hands off of me, I was special, etc.

8. How is your Stuck Point confusing something that is possible with something that is likely?

   N/A.

9. In what ways is your Stuck Point based on feelings rather than facts?

   Because I felt guilty and shameful, I thought it must be my fault.

10. In what ways is this Stuck Point focused on unrelated parts of the story?

    I must have thought that I had more control over the situation than I did.

- Help Patients to notice their own patterns
- Ultimately help Patients take over their own **Socratic Questioning**

Resick, P.A., Monson, C.M., & Chard, K.M. (2016)

Thinking Patterns

- **Jumping to conclusions/** predicting the future
- **Ignoring important parts** of a situation
- **Oversimplifying**
  - "Good-bad"; "right-wrong"
- **Overreaching** from a single incident

Resick, P.A., Monson, C.M., & Chard, K.M. (2024)

Thinking Patterns

- **Mind reading**
  - E.g., assuming that people are thinking negatively of you in the absence of evidence
- **Emotional reasoning**
  - E.g., I feel fear, so I must be in danger

Resick, P.A., Monson, C.M., & Chard, K.M. (2024)

HANDOUT 11.1

Alternative Thoughts Worksheet

Date: _____

Name: _____

A. Situation

Describe the event, thought, or belief leading to the unpleasant emotion(s).

B. Thought/Stuck Point

Write down the thought/Stuck Point related to the situation in section A. Rate your belief in this thought/Stuck Point from 0 to 100%. (How much do you believe this thought?)

C. Emotion(s)

Specify your emotion(s) (sad, angry, etc.), and rate how strongly you feel each emotion from 0 to 100%.

D. Exploring Questions

Use the **Exploring Questions Worksheet** to examine your automatic thought from section B. Consider whether the thought is balanced and factual, or extreme.

Evidence against?

Information not including?

All-or-none? Extreme or exaggerated?

Overfocused on just one piece?

Source questionable?

Confusing possible with definite?

Based on feelings or facts?

E. Thinking Patterns

Use the **Thinking Patterns Worksheet** to decide whether this is one of your problematic patterns of thinking.

Jumping to conclusions or predicting the future

Ignoring important parts of a situation

Oversimplifying or overreaching

Mind reading

Emotional reasoning

F. Alternative Thought(s)

What else can I say instead of the thought in section B? How else can I interpret the event instead of this thought? Rate your belief in the alternative thought(s) from 0 to 100%.

G. Rerate Old Thought/ Stuck Point

Rerate how much you now believe the thought/ Stuck Point in section B, from 0 to 100%.

H. Emotion(s)

Now what do you feel? Rate it from 0 to 100%.

Resick, P.A., Monson, C.M., & Chard, K.M. (2024)

Alternative Thoughts/ Rational Responses

- "Rebuttal" to *stuck points*
- RRs should always be:
  - Short
  - Sweet (not include neg words)
  - Evidence-based
  - In patient's *own* words
    - what would seem most calming in that specific moment?

Wrapping up Cognitive Work

- Always have the patient leave with the Alternative Thought written down
  - E.g., “I was not the cause”
- Assign for use when:
  - Entering a feared situation
  - *Any other time* the relevant automatic thoughts/stuck points surface

Trauma Themes

- Safety
- Trust
- Power/control
- Esteem
- Intimacy
  - Can be reviewed in any order, and only as relevant

Resick, P.A., Monson, C.M., & Chard, K.M. (2024)

Socratic Questioning

1) **Clarifying questions**
   - Examine beliefs more deeply by requesting more information
   - Help bring back to context (e.g., how big was the attacker?)
2) **Probing** assumptions
   - Challenge unquestioned beliefs
     - (e.g., If I just never went drinking, everything would have been okay)

Resick, P.A., Monson, C.M., & Chard, K.M. (2024)

Socratic Questioning

3) **Probing reasons and evidence** – helps patients examine the actual evidence supporting their beliefs (what evidence do you have that this was your fault?)

4) **Challenging underlying or core beliefs**

- E.g.,“I am worthless” “I deserve bad things”

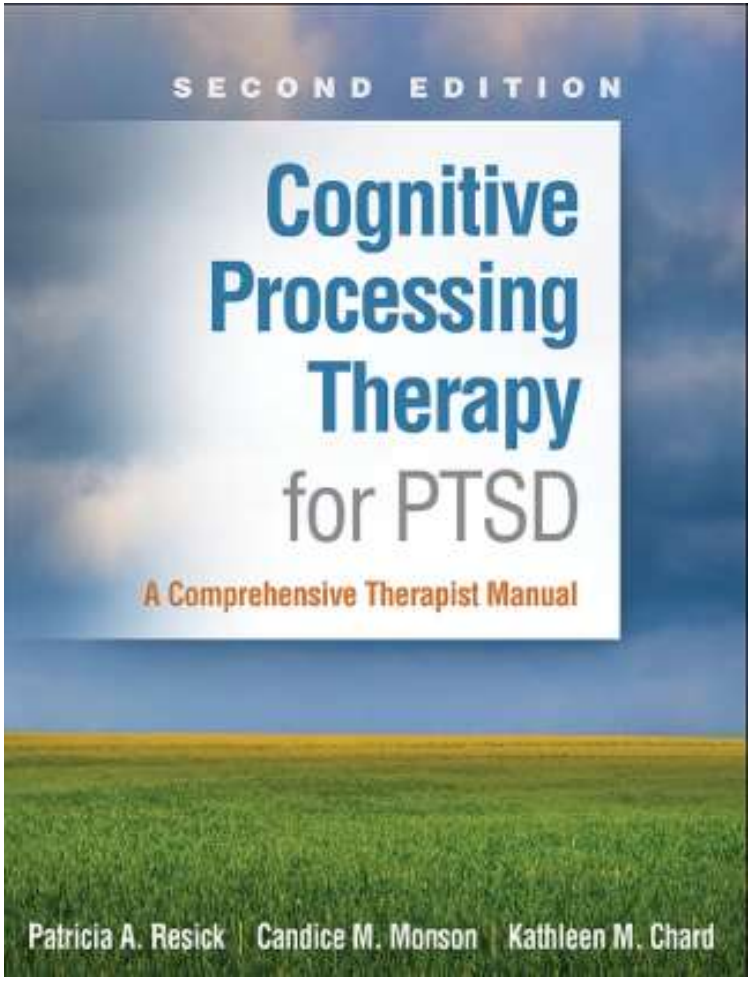
Resick, P.A., Monson, C.M., & Chard, K.M. (2024)

Keys to Effective CPT

- Remind that the trauma is in the past and is not occurring now
    - When patients stop avoiding the trauma memory, they have an opportunity to make positive change
- Impact statements
    - Pre- and Post-treatment

Resick, P.A., Monson, C.M., & Chard, K.M. (2024)

How To Implement in My Practice?



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How To Implement in My Practice?

CPT Coach 12+

Cognitive Processing Therapy

US Department of Veterans Affairs (VA)

Designed for iPad

★★★★☆ 3.8 • 17 Ratings

Free

View in Mac App Store ↗

Resick, P.A., Monson, C.M., & Chard, K.M. (2024)

Medication Considerations

- Recommend scheduled medications only
- (or, no medications)
  - At minimum, ask Patient to commit to not taking PRNs in the context of exposure work

Metrics

PTSD:Metrics

- PTSD Checklist-5 (PCL-5)
  - Blevins et al., 2015

Minimum: Sessions 1, [4-8], [8-15]

(Every 2 sessions
Foa et al., 2019)

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