Cognitive Processing Therapy: Moving Towards Effectiveness Research

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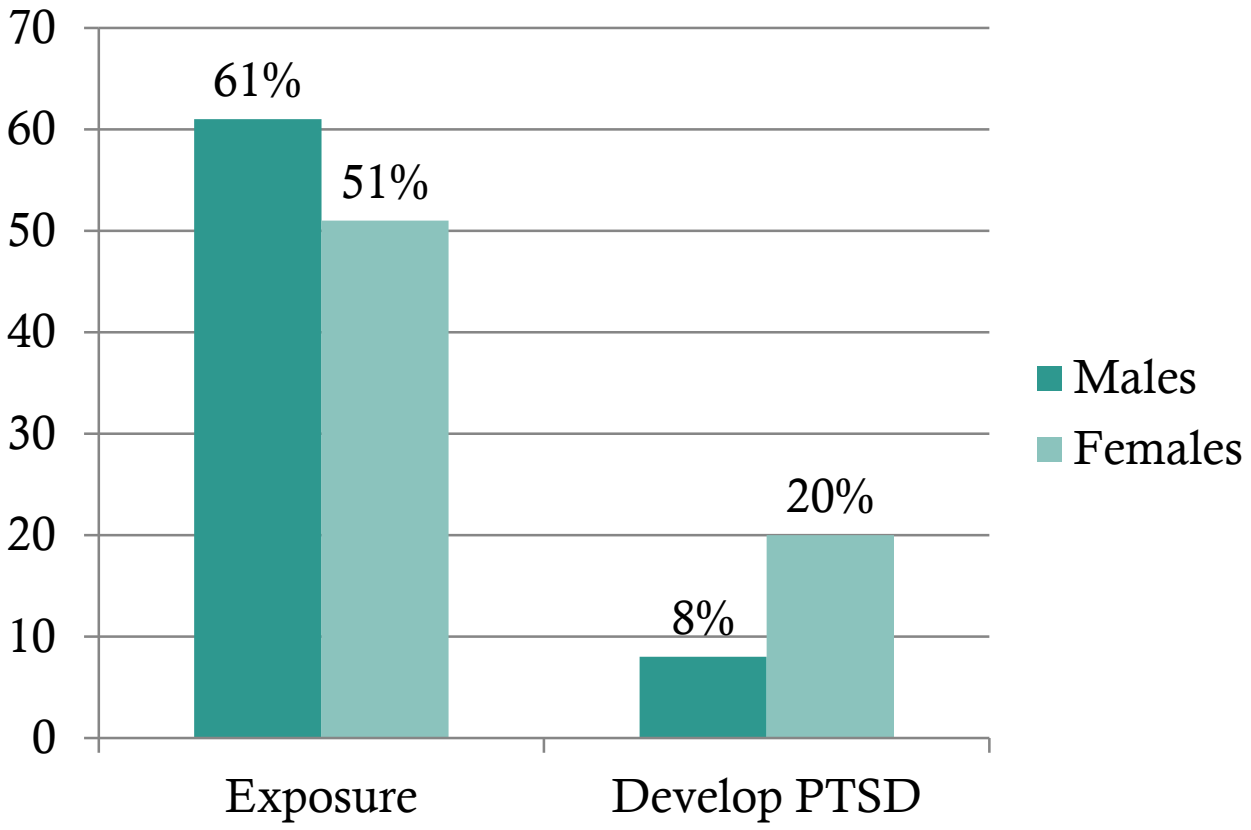
Overview

- Brief review of trauma and PTSD
- Overview of Cognitive Processing Therapy (CPT)
- Discussion of new developments
  - Flexing the structure of the manual
  - Coping with patient crises
  - Supplements to the CPT protocol
- Future research directions

Prevalence

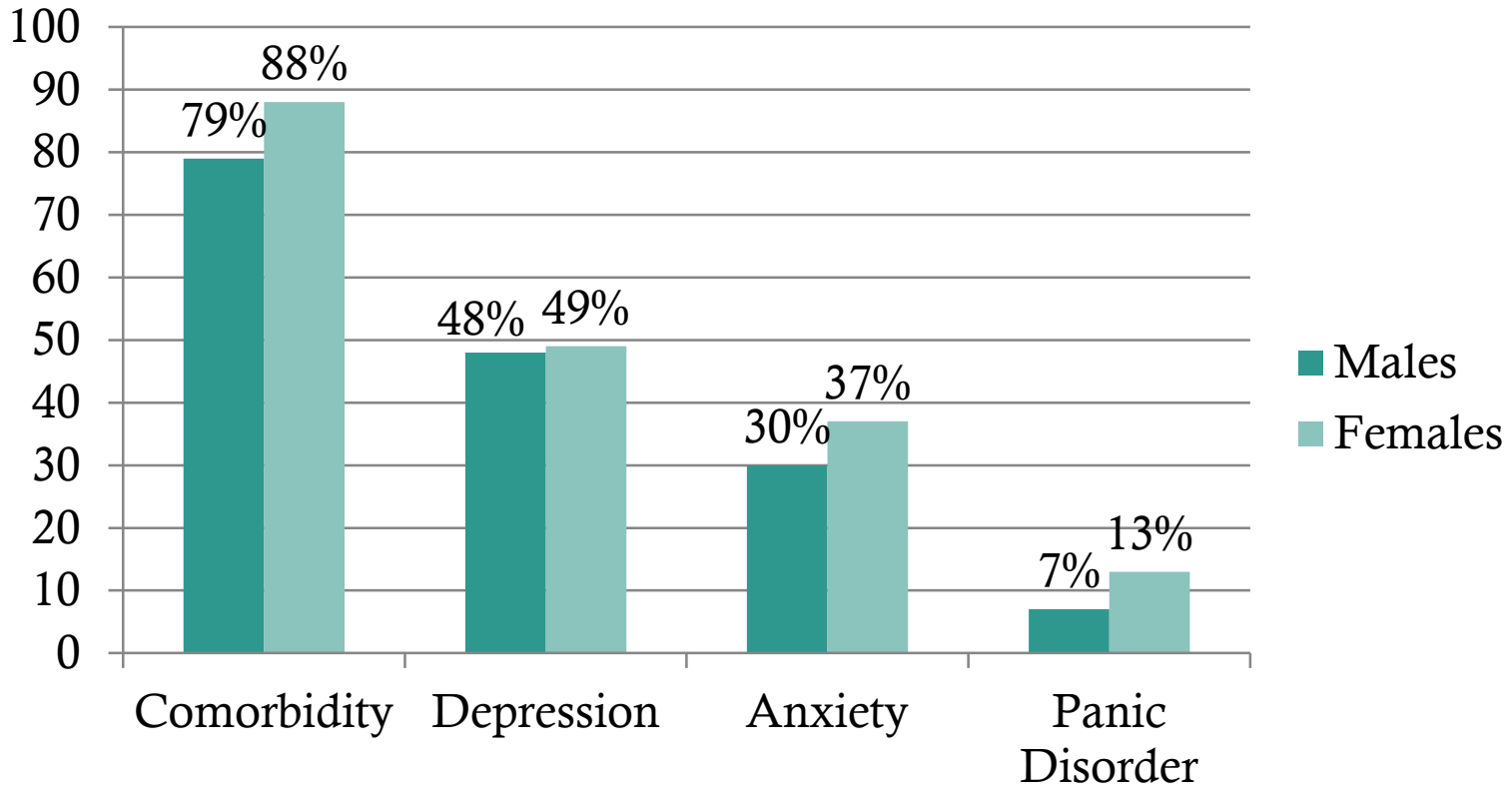
- Trauma exposure
  - 40-60% of adults experience at least 1 lifetime trauma (Breslau, 1991; Norris, 1992)
- Psychopathology
  - Overall lifetime prevalence rate of PTSD for the general population ranges from 8% to 12% (American Psychiatric Association [*DSM-IV-TR*], 2000; Kessler, 2000)

Gender Differences in PTSD
(Kessler, 1995)



(Kessler, 1995)

Psychiatric Comorbidity



Gender Differences in Treatment Outcome

- Research is limited
- Gender disparities in trauma literature
  - Rape and sexual assault literature
    - Focus on females
  - Combat literature
    - Focus on males

Blain, Galovski, & Robinson, 2010

PTSD - Criterion A

- "A person must experience or witness, or be confronted with an event that involved actual or threatened death, or threat of serious injury or a threat to the physical integrity of self or others which is met with extreme fear, helplessness, or horror."

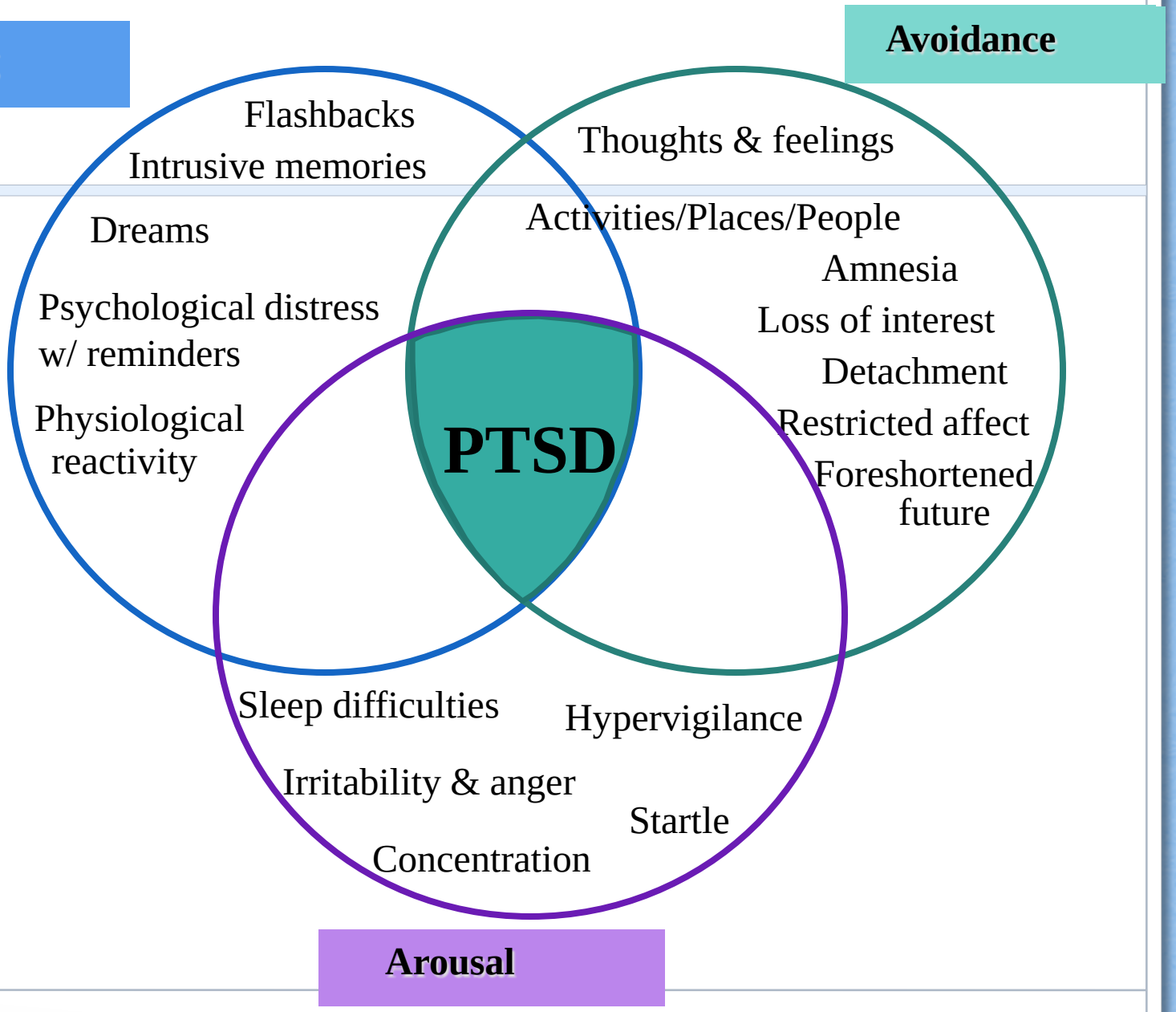
- Symptoms must persist for 1 month after trauma

Post

Traumatic

Stress

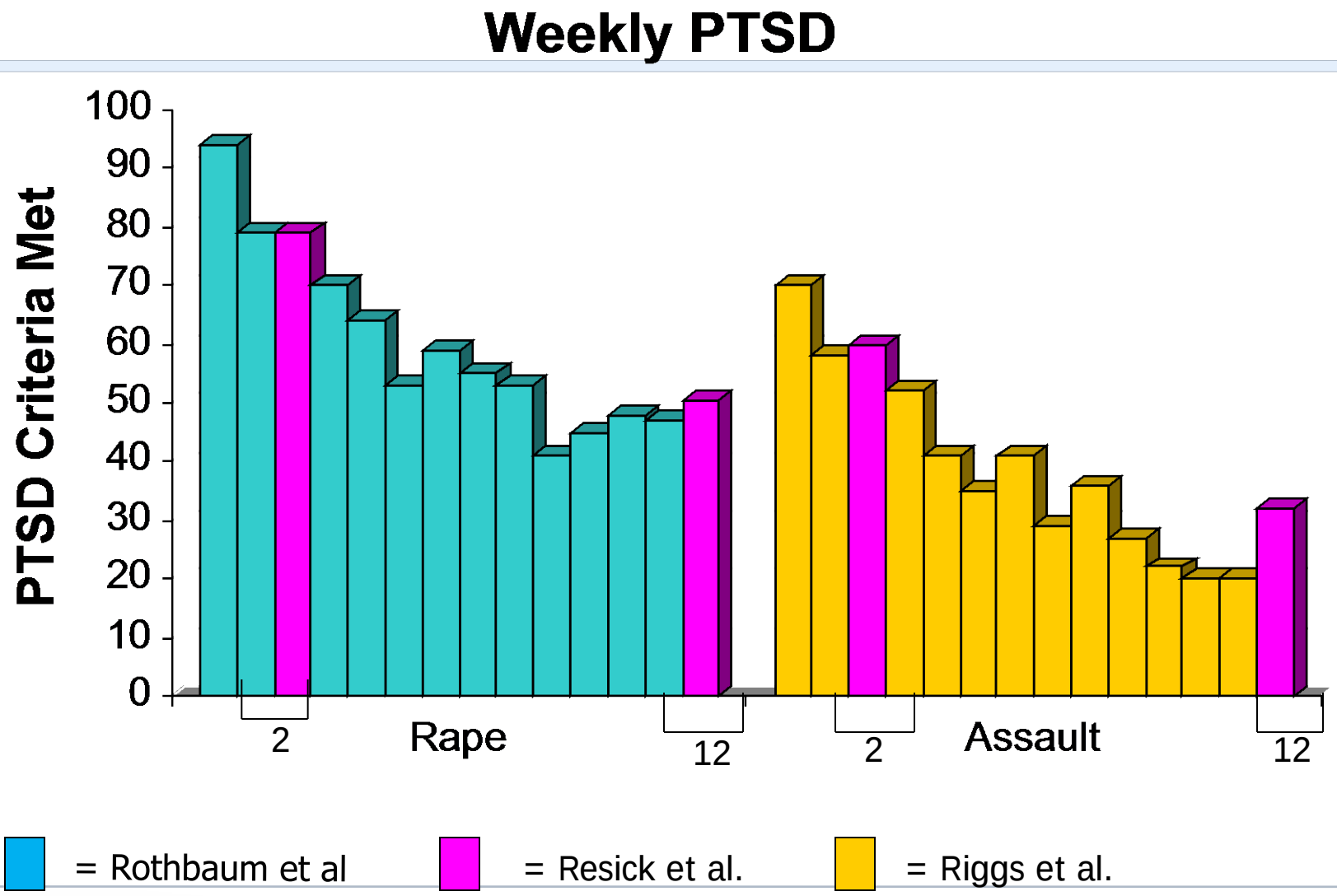
Disorder



Why does PTSD develop?

- Disorder of non-recovery
  - If the event is severe enough, nearly everyone will have symptoms reflective of PTSD
    - Over time, those symptoms decrease
  - Those that get stuck in the recovery process may go on to meet full criteria for PTSD

Normal Recovery



What is Cognitive Processing Therapy (CPT)?

A short-term evidence-based treatment for PTSD

A specific protocol that is a form of cognitive behavioral

Predominantly cognitive and may or may not include a written account

A treatment that can be conducted in groups or individually

Cognitive Theory of Trauma

- Throughout their lives, people are taking in information through all of their senses
- We work to organize all of that information (words, categories, schemas, etc.) in an attempt to understand, predict and control
- Most people are taught the "just world belief"
  - Good behavior is rewarded
  - Bad behavior is punished

Cognitive Theory of Trauma

- These beliefs work as long as there is no contradictory information
- In PTSD, trauma memories either:
  - Conflict with prior positive schemas
  - Appear to confirm maladaptive negative schemas (which may have developed after previous traumas)

Cognitive Theory of Trauma

- **Assimilation** = Distorting event to fit prior schemas
- **Accommodation** = Changing schemas to integrate trauma
- **Over-accommodation** = Overgeneralizing trauma-induced schemas regarding self and others

Identifying Stuck Points

Guilt or blame ("if only…, should have")

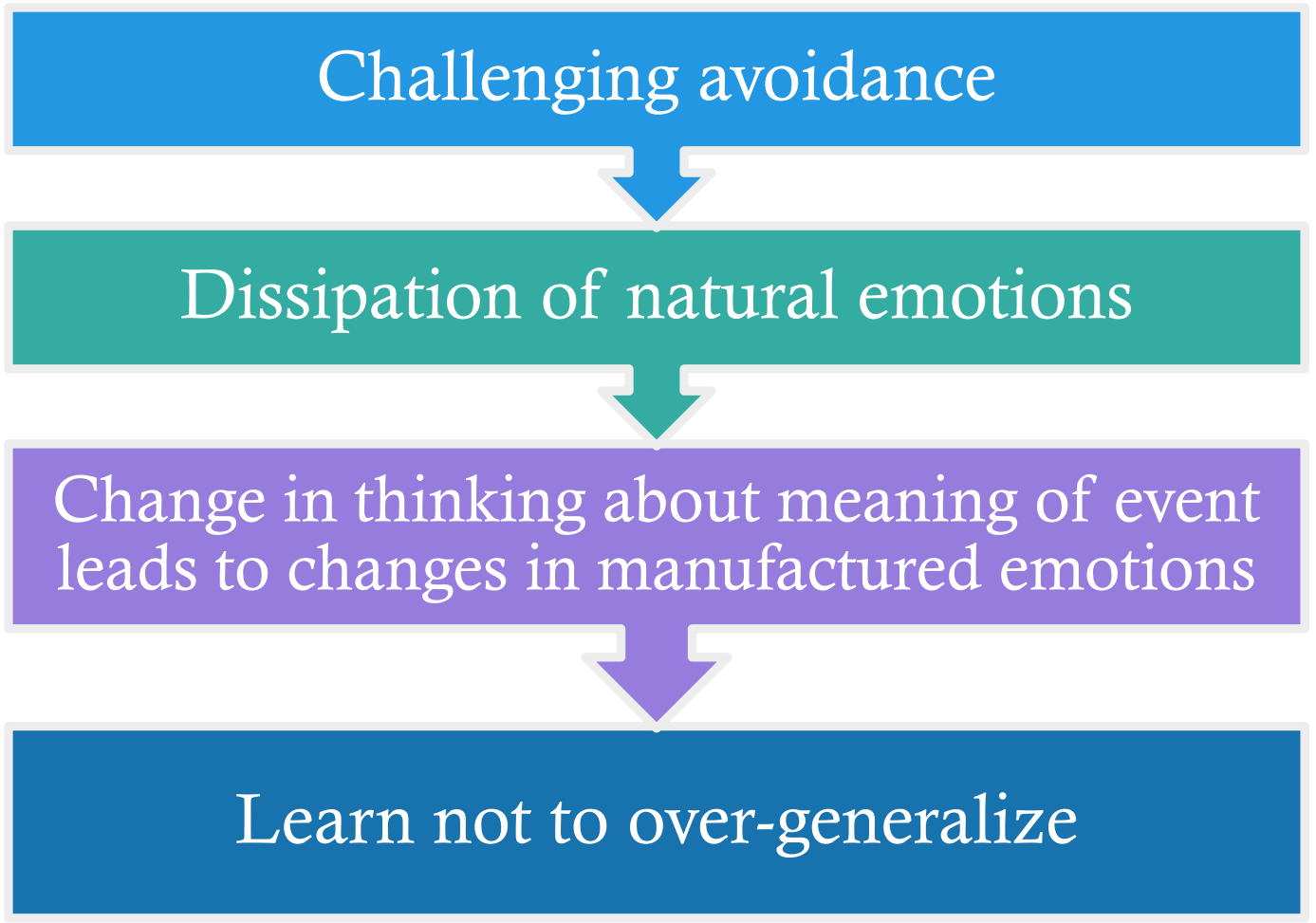
Implications of trauma ("never, always, no one")

So what about emotions?

Natural Emotions → Allow yourself to feel and they will dissipate quickly

Manufactured Emotions → Change your thinking

So how does CPT work?



Components of CPT

- **Written Trauma Account**
  - Exposure to the traumatic memory
    - Writing and reading about the traumatic event
    - Include all five senses
    - Include feelings / thoughts that occurred during the event
    - Encourage experiencing and expressing of emotions

Components of CPT

- **Cognitive Challenging and Restructuring**
  - Identification of "stuck points"
  - Use of Socratic methods to begin to challenge stuck points
    - Assimilation
    - Over-accommodation
  - Generation of alternative thoughts

CPT Protocol Overview

- Session 1: Education on PTSD, thoughts, and feeling
- Session 2: Meaning of the trauma
- Session 3: Connection between events, thoughts, and feelings
- Session 4: Processing the trauma
- Sessions 5-7: Learning to challenge
- Sessions 8-12: Focus on specific domains
  - Safety, trust, power/control, esteem, intimacy

A. Situation	B. Thought/Stuck Point	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
Describe the event, thought or belief leading to the unpleasant emotion(s).	Write thought/stuck point related to Column A. Rate belief in each thought/stuck point below from 0-100% (How much do you believe this thought?)	Use **Challenging Questions** to examine your automatic thought from Column B. Consider if the thought is balanced and factual or extreme.	Use the **Patterns of Problematic Thinking Worksheet** to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
I led my company into an ambush, and many of my men were killed.	*I should have prevented it – it is my fault that people were killed. – 100%*	Evidence For? *People were killed.* Evidence Against? *There was no way to know that there was going to be an ambush—that's the nature of an ambush. To think I should have known it was coming is to ignore the fact that it was an ambush.* Habit or fact? Interpretations not accurate? All or none? *No one else would have led their company into an ambush.* Extreme or exaggerated? Out of context? Source unreliable? Low versus high probability? Based on feelings or facts? Irrelevant factors?	Jumping to conclusions: Exaggerating or minimizing: Disregarding important aspects: *I haven't been paying attention to the fact that it was an ambush. There was no way I could have known.* Oversimplifying: Over-generalizing: Mind reading: Emotional reasoning: *Because I feel guilty, I AM guilty.*	*There was no way to see it coming at the time. – 85%* *I did the best I could given the circumstances. – 90%* *It's not my fault that people were killed in the ambush. – 75%*
	C. Emotion(s) Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100% *Guilt – 100%* *Helpless – 100%* *Anxious – 75%*			**G. Re-rate Old Thought/Stuck Point** Re-rate how much you now believe the thought/stuck point in Column B from 0-100% *10%* **H. Emotion(s)** Now what do you feel? 0-100% *Guilt – 40%* *Helpless – 80%* *Anxious – 40%*

CPT: From RCT to Practice

- Obstacles to Dissemination of evidence based treatments (EBTs):
  - Perceived overall lack of ecological validity of EBTs
    - Lack of flexibility of treatment manuals in RCTs
    - Use of highly trained therapists
    - Misguided focus on outcome rather than process
    - Unrealistic number of fixed sessions in RCTs
    - High drop-out rates and refractory clients

"This would never work for MY client!"

Patient report

- "The only thing that was bad about this treatment was that I couldn't continue with it for longer… My suggestion, as an option to stopping therapy abruptly and completely, and as a way to ensure more lasting, deeper results (in thinking patterns, etc.), would be to give the client the choice to continue or not. They could continue until they feel comfortable enough to stop. For me, not having the choice to continue was very detrimental to my progress and I lost almost all the progress (and hope!) that I had so precariously attained during treatment."

Moving Toward Effectiveness

Perceived Barrier to Dissemination	Question Addressed by Current Study
Highly trained therapists	Can novice CPT clinicians successfully administer CPT?
Lack of manual flexibility	What happens when my client faces a crisis?
Refractory clients	Session 12 is here and my client still has PTSD!
Fixed # of sessions	My client's scores are way down and s/he is done at session 8?

Research Questions

Improve outcomes by tailoring amount of therapy individually to participants?

Alter the treatment maintenance and relapse rates observed in previous trials?

Individual variables that may predict efficiency of outcome, treatment gain maintenance, and/or relapse?

In shorter durations of therapy, will benefits beyond PTSD be realized?

Goal 1

Compare modified CPT versus symptom-monitoring delayed treatment condition

Goal 2

Compare entire treated population to typical 12 session sample

Goal 3

Analyze gender effects

Goal 4

Identify predictors of amount of treatment necessary to reach good end state functioning

Current study

- **Design**:
  - Immediate treatment vs symptom monitoring control (Semi-crossover)

- **Assessment:**
  - CAPS, PSQI, PILL, PDS*, BDI-II*, QOLI
    - Pre-tx, Post-tx & 3 mo f-u

* Also at each session

Inclusion Criteria

- 18+ years of age
- 3 months post-trauma
- Stable medication 1 month prior to assessment
- Out of violent relationship for 3+ months
- Meets criteria for PTSD

Exclusion Criteria

- Psychosis
- MR
- Active suicidality & parasuicidality
- Current drug/alcohol addiction
- Current abusive relationship/stalked
- Any prior CPT
- Any current trauma-focused treatment

Randomization

- 160 assessed for eligibility
  - 42 ineligible
  - 13 incomplete assessment
  - 5 pilots
- 100 randomized
  - 53 Modified CPT (MCPT)
  - 47 Symptom Monitoring Delayed Treatment Condition (SMDT)

Symptom Monitoring Delayed Treatment Condition

- Daily monitoring of PTSD & depressive symptoms
- Weekly completion of PDS, BDI-II
- Scheduled phone check-ins
- 10 week duration

Modified CPT Condition

- Typical 12 sessions
  - Why problematic?
- Modifications
  - Number of sessions (4-18)
  - Emergency sessions

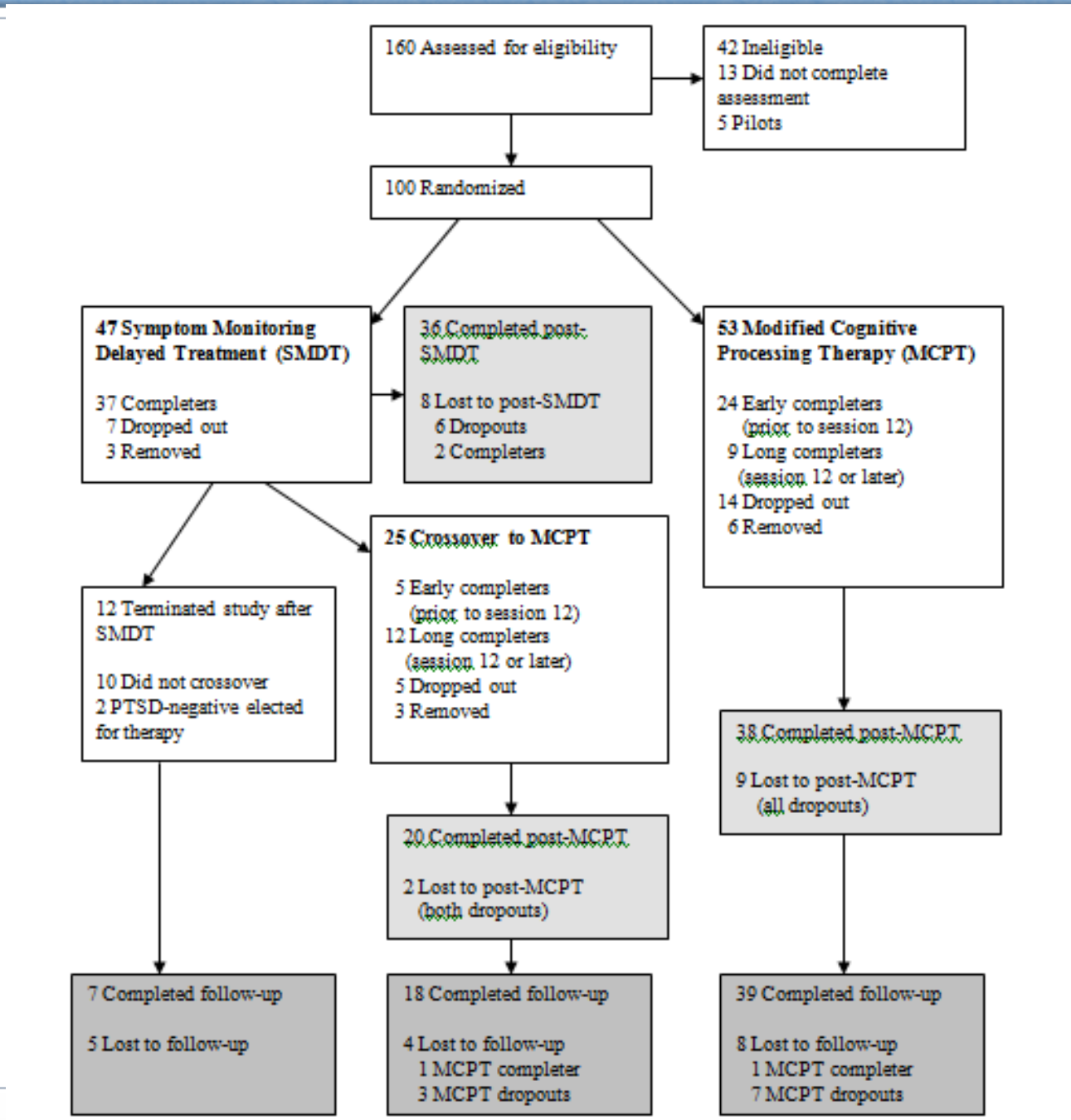
Sample Demographic Information

Age	**67% female and 33% male**
Gender	**19-68 (M=40.42, SD=11.66)**
Race	**52% African American** **43% Caucasian** **5% Asian, American Indian & other**
Income	**66% $20,000 or less**
Education	**66% had some post-hs** **M=13.2, SD=2.89**
Relationship status	**56% Single** **22% Married/cohabitating** **22% Separated/divorced/widowed**

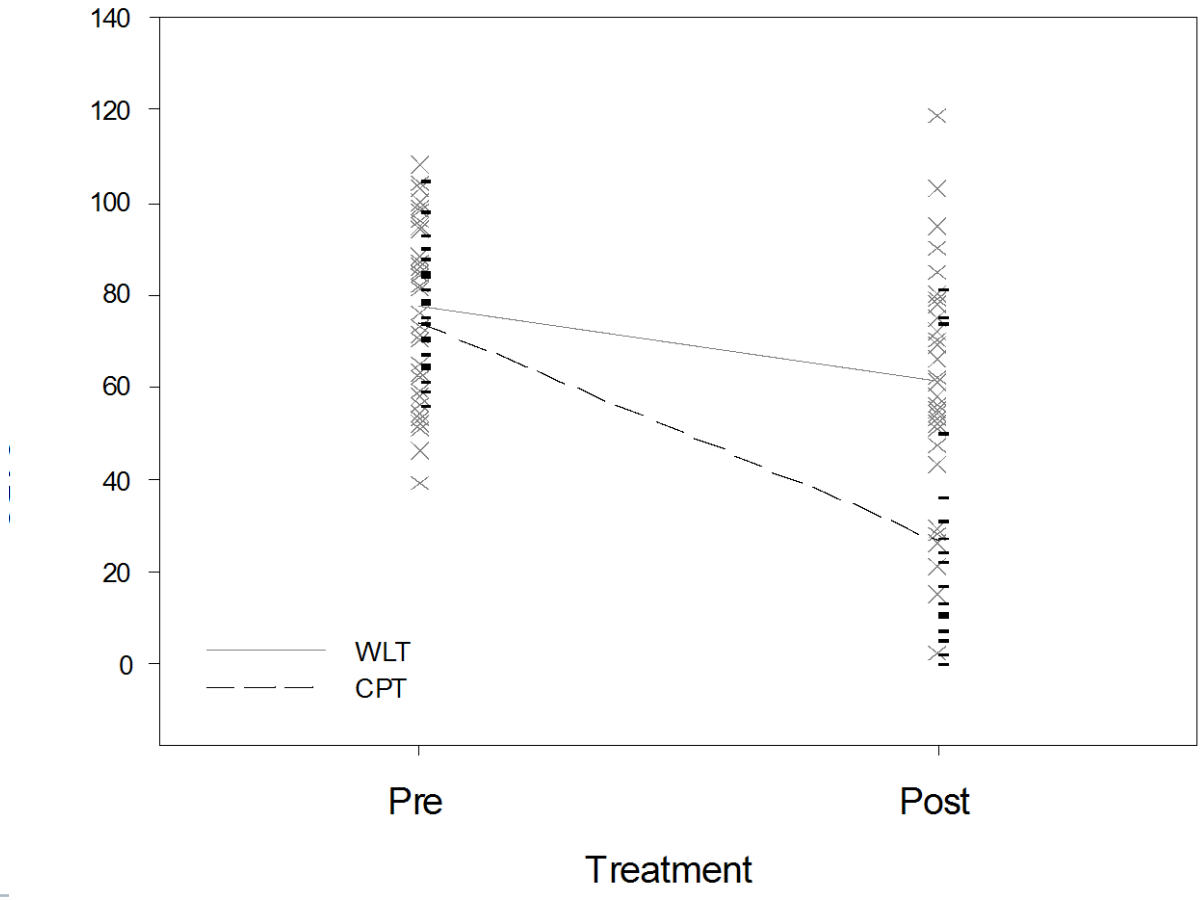
Trauma	Lifetime	Index Event
CSA	64%	41%
CPA	57%	13%
ASA	51%	23%
APA	65%	22%
DV	53%	

Results Aim #1

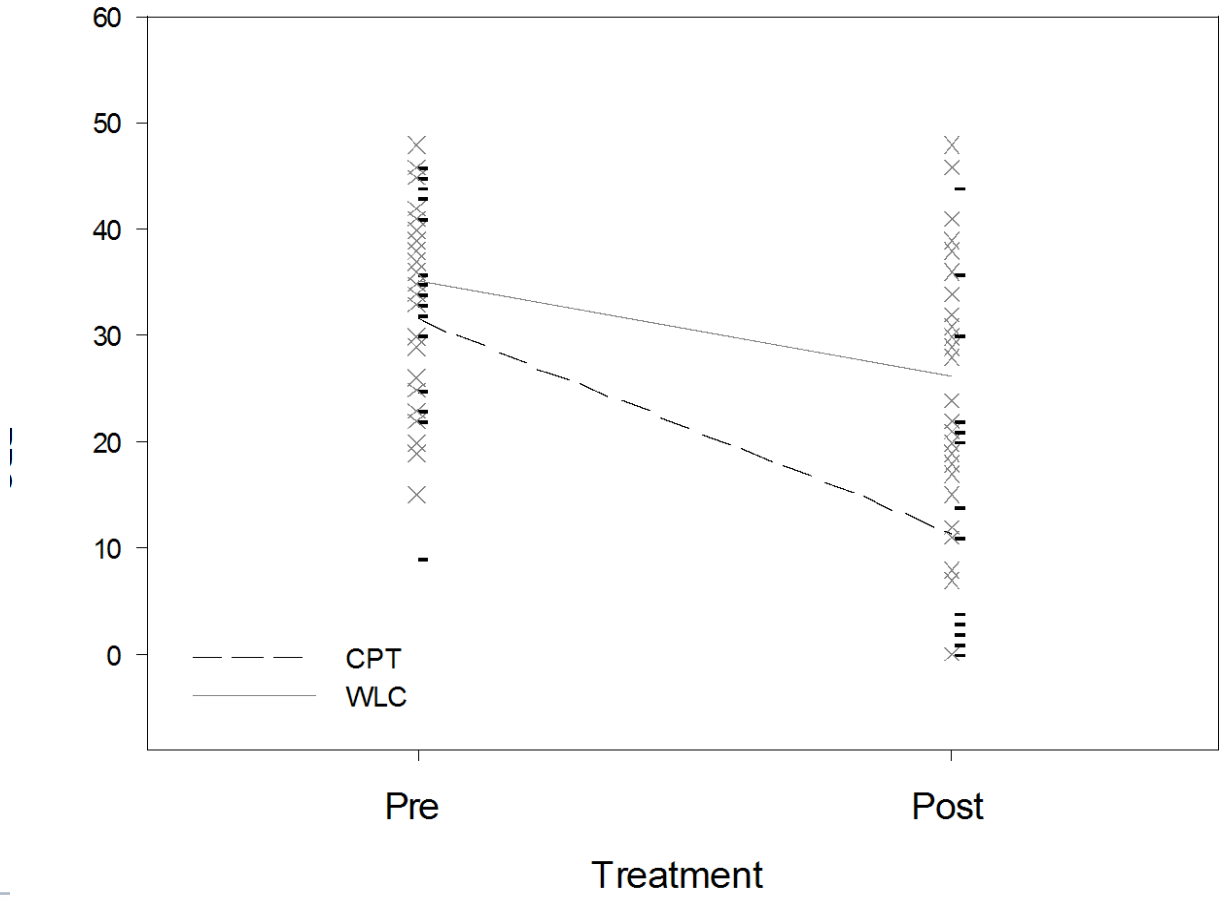
- Compare MCPT to SMDT
- CAPS:
  - MCPT improved 31.6 points more than SMDT
- PDS:
  - MCPT improved 11.1 points more than SMDT
- BDI:
  - MCPT improved 12.4 points more than SMDT


160 Assessed for eligibility
42 Ineligible
13 Did not complete assessment
5 Pilots
100 Randomized
47 Symptom Monitoring Delayed Treatment (SMDT)
37 Completers
7 Dropped out
3 Removed
36 Completed post-SMDT
8 Lost to post-SMDT
6 Dropouts
2 Completers
53 Modified Cognitive Processing Therapy (MCPT)
24 Early completers (prior to session 12)
9 Long completers (session 12 or later)
14 Dropped out
6 Removed
12 Terminated study after SMDT
10 Did not crossover
2 PTSD-negative elected for therapy
25 Crossover to MCPT
5 Early completers (prior to session 12)
12 Long completers (session 12 or later)
5 Dropped out
3 Removed
38 Completed post-MCPT
9 Lost to post-MCPT (all dropouts)
20 Completed post-MCPT
2 Lost to post-MCPT (both dropouts)
7 Completed follow-up
5 Lost to follow-up
18 Completed follow-up
4 Lost to follow-up
1 MCPT completer
3 MCPT dropouts
39 Completed follow-up
8 Lost to follow-up
1 MCPT completer
7 MCPT dropouts

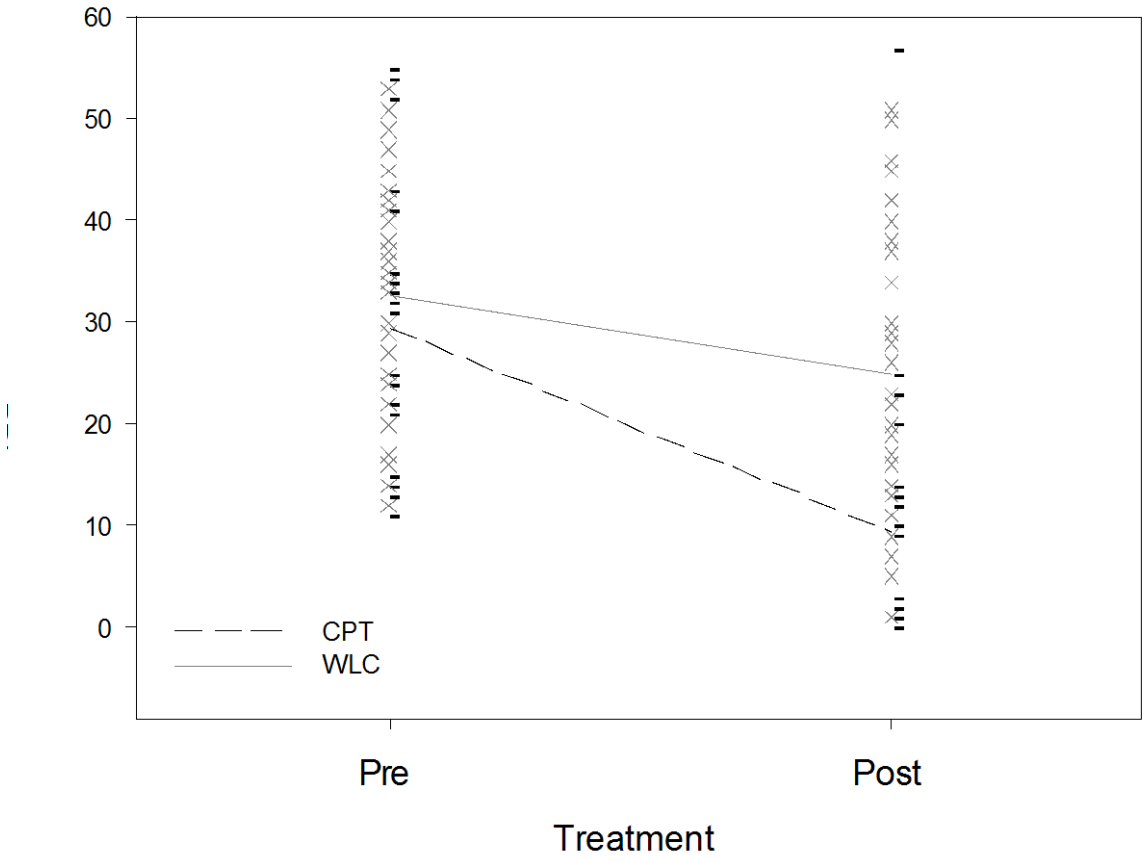
CAPS Change



PDS Change



BDI Change



Additional Improvements

- MCPT greater improvements:
  - Trauma-related anxious-arousal
  - Depression
  - Intrusive experiences
  - Defensive avoidance

Semi-Crossover Design

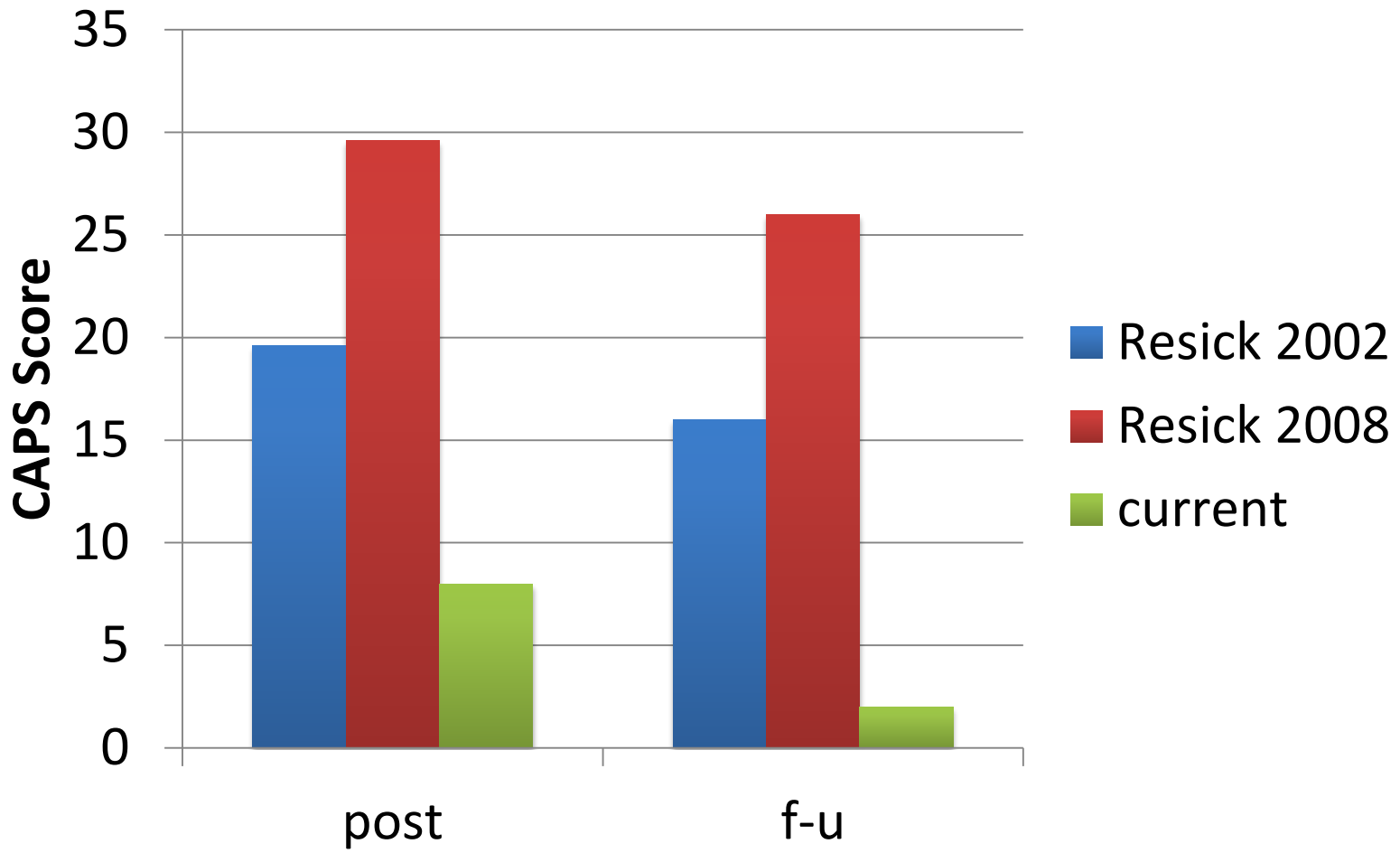
- Following SM condition, 27 subjects crossed over to CPT (thus we intended to treat 80 people with CPT)
  - 51 completed treatment
  - 19 dropped out
  - 10 were removed

Results Aim #2

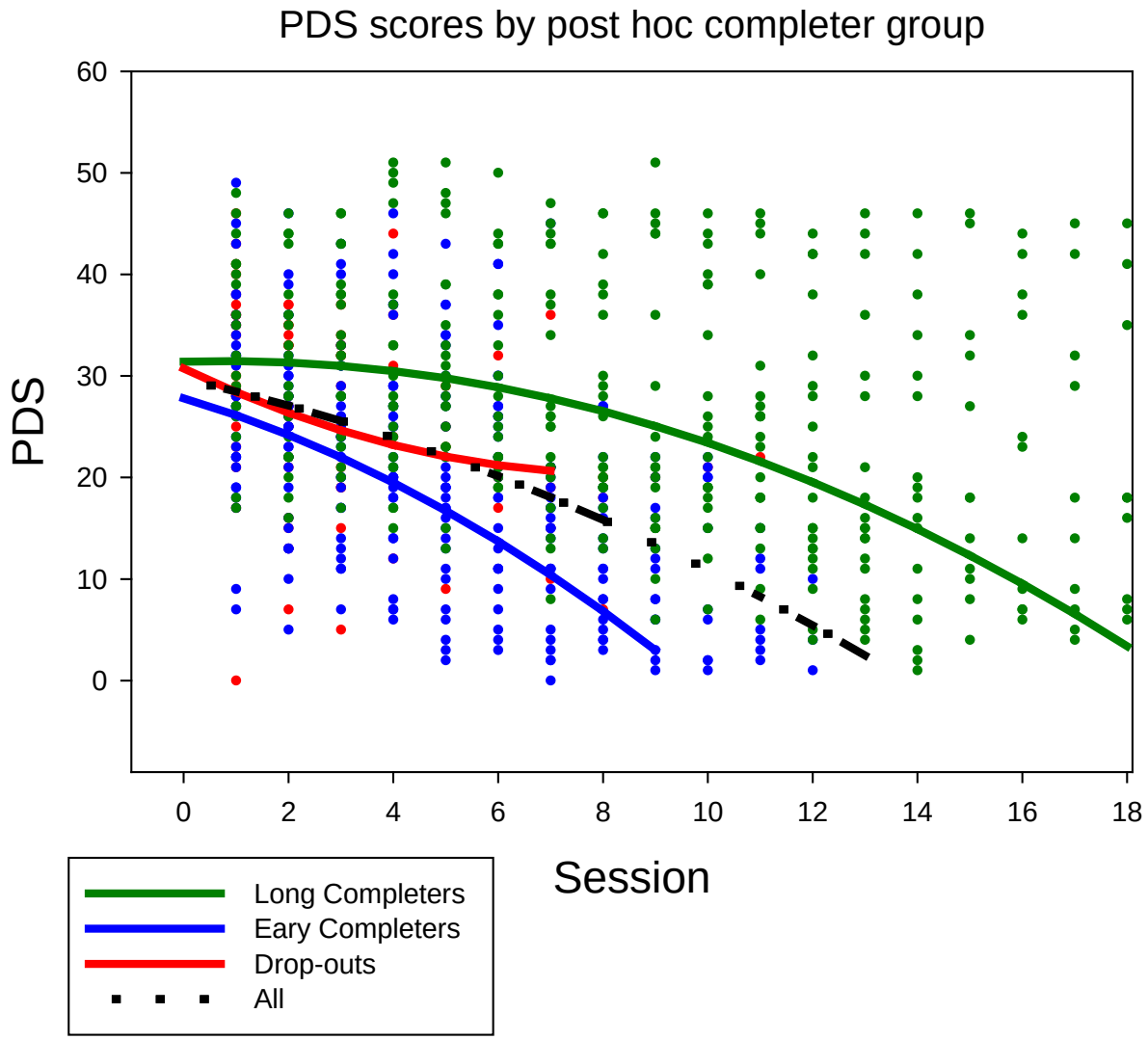
- Compare ITT treated sample to sample of typical 12 session CPT
- Good end state functioning:
  - PDS < 20
  - BDI < 18
  - Therapist/client agreement that goals had been achieved
  - PTSD negative status confirmed by blind, independent assessor

Completion Status (N=50)		%
Early	4-11 sessions	58% (N=29)
Long	12+ sessions	42% (N=21)

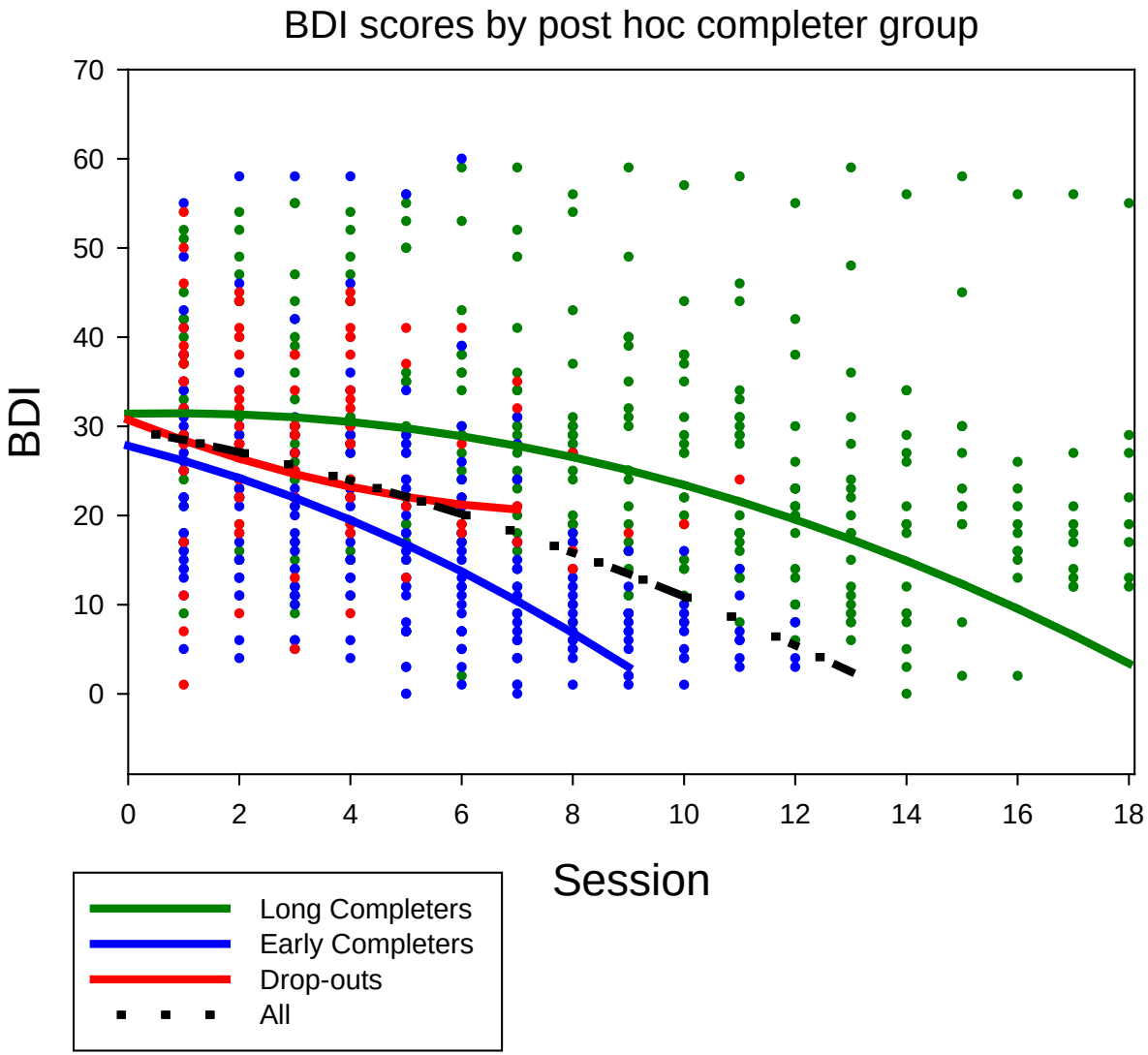
Comparison to previous trials



PDS & Completion Status



BDI & Completion Status



Results Aim #3

- Gender comparison
- Pre-tx: women higher global guilt, hindsight bias, guilt cognitions
- Across time: women more improvement in PDS and global guilt
- Overall mostly similar results

Results Aim #4

Identify predictors of amount of treatment necessary

- Individual predictors
  - White race
  - Longer time since index trauma
  - Dependent personality
- Trauma predictors
  - Anxious arousal
  - Trauma-related depression
  - Intrusive experiences,
  - Dissociation
  - Impaired self-reference

Conclusions

- Recover from PTSD at varying dosages of CPT
- Decreases in PTSD, depressive symptoms, sleep impairment, health-related concerns in “early” treatment completers
- Well-maintained at a 3month follow-up

Manual Flexibility: Emergency Sessions

Crisis

Client's Choice

Session Content

Session devoted to topic with understanding that next session would return to trauma-focused work

Cognitive work continued on emergency topic

Emergency Sessions

- Unexpected divorce
- Family death
- Sexual harassment
- Loss of job / home
- Diagnosis of life-threatening illness
- Prosecution of assailant

Are emergency sessions helpful?

- Despite chaotic lives of vast majority of the sample, only 15% chose to use an emergency session.
- There was no difference in:
  - Treatment outcome status (early completers, long completers, drop-outs)
  - PTSD or depression symptom change
- What we don't know…
  - What would have happened to participants had they not been offered the option of the emergency session?

Future Directions

- Will briefer courses of therapy generalize as well to secondary outcomes?
- Replication with other trauma types?
- Can we expand our clinical repertoire to influence additional concerns such as sleep?

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Questions or Comments?