# 209: PTSD and Cognitive Processing Therapy with Patricia Resick

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## The Origins and Development of Cognitive Processing Therapy

Patricia Resick has worked on extensive research throughout her career. Her interest in studying rape emerged during her internship in South Carolina, where she worked with one of the earliest rape crisis centers in the country. As a rape crisis counselor, Dr. Resick witnessed the urgent need for research as she responded to middle-of-the-night calls. She observed the profound impact of trauma on victims and recognized the shortcomings in the training of medical professionals to handle sexual assault cases.

Dr. Resick's early career was marked by developing trauma treatment before terms like PTSD existed. She explored the fear, anxiety, and depression experienced by trauma survivors and noticed a recurring pattern: she saw distorted thoughts coming from shame, disgust, and betrayal.

In response to her findings, Dr. Resick developed Cognitive Processing Therapy (CPT), a specific protocol designed to address survivors' thoughts and emotions related to trauma, offering a structured approach to trauma therapy, which is modeled after Aaron Beck's cognitive behavioral therapy (CBT) model. Whereas Dr. Beck's model focused on the here and now, Dr. Resick realized there needed to be a focus on the traumatic events. Rather than focus on the beliefs stemming from the trauma, she would go back to the worst trauma, the one causing the PTSD symptoms, using the PTSD Checklist (PCL-5). When interacting with a patient that witnessed significant traumatic events such as domestic violence or abuse, she would evaluate the incident that caused the patient the most distress where they felt like they were going to die.

In CPT, therapists often encounter a recurring pattern of self-blame. Survivors tend to replay scenarios in their minds, pondering what they could have done differently to prevent their suffering. At times, prior beliefs such as “good things happen to good people” and “bad things happen to bad people” can result in the victim questioning if the trauma they experienced occurred simply because they are “bad” people. This belief can lead to feelings of unworthiness, guilt and shame. These feelings must be dismantled by approaching the patient with a set of questions to help expand their thought process and allow them to understand that random and uncontrolled events can lead to suffering, regardless of personal goodness or morality.

Survivors' responses to trauma vary based on their prior experiences. Those with minimal adversity may internalize blame and seek justification, while those who have endured lifelong abuse may perceive trauma as confirmation of their inherent flaws. Utilizing CPT, patients are guided through a structured process to address their thoughts and beliefs about the traumatic event. The therapy consists of 12 individual sessions that help the patient understand the symptoms of PTSD, explore their thoughts and beliefs, and focus on thought processes to help the patient move forward.

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One of the initial assignments is to write an impact statement focused on the identified traumatic event:

"Please write at least one page on **why** you think this traumatic event occurred. You are not being asked to write specifics about the traumatic event. Write about what you have been thinking about the cause of the worst event."

Through this exercise, patients examine 5 areas of how the trauma has affected them: through their sense of safety, trust, power and control, self-esteem, and intimacy.

The investigation into the reasons behind a traumatic event is vital because patients often hold onto their existing belief systems, reshaping the event to fit their preconceived ideas. They may assign blame to themselves, convinced they could have prevented the trauma. This distorted perspective serves as the foundation for therapy and therapists use Socratic questioning to confront these beliefs.

During the therapy session, the therapist aims to establish the patient's "stuck points." This can be explained to the patient by describing stuck points as thoughts about their understanding of why the trauma occurred or thoughts about themselves and the world around them that has changed due to their trauma. Examples of some stuck point thoughts are, "It's my fault," "I should have done something differently," "We should have gone left instead of right," etc. Remember, these are thoughts, not feelings.

Other examples include:
- "If I had done my job better, then other people would have survived."
- "Because I did not tell anyone, I am to blame for the abuse."
- "I can never really be a good, moral person again because of the things that I have done. I am unlovable."

Stuck points do not include behaviors, feelings, facts, questions, or moral statements. They are often formatted in an "if…then…" structure. These are concise statements that reflect a thought that is usually black/white in nature and uses extreme language.

In CPT, the patient is asked to write down these thoughts and then reflect on the thoughts that are helping them move forward and the thoughts that are keeping them stuck. Below are examples that commonly get misidentified as stuck points.

**Not a stuck point:** "Trust"
**Why not?** This is a concept, not a thought. It is not specific, and you need to identify what the person thinks about trust. In this example, you might ask him/her what about trust is a problem.
**Possible related stuck points:** "I can't trust anyone." "If I let anyone get close to me, I will get hurt." "I can never trust my judgment."

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**Not a stuck point:** “I am nervous whenever I go on a date.”
**Why not?** This is describing a feeling, not a thought. In this example, you might ask what patients are telling themselves about the date to help them identify potential stuck points.
**Possible related stuck points:** “If I go on a date, I will get hurt.” “People always take advantage of me.”

The “A-B-C worksheet” helps the patient better understand the connection between their thoughts, feelings, and behaviors.

**A-B-C Worksheet**

**Date:** __________ **Patient:** __________________________

<table>
<tr><td>A<br>Activating Event<br>"Something happens"</td><td rowspan="3">D<br>Challenging Questions<br><br>Evidence for the stuck point?<br><br>Evidence against the stuck point?<br><br>Is the stuck point not including all the information?<br><br>Is the stuck point extreme or exaggerated?<br><br>Is the stuck point based on feelings rather than all the facts?</td><td rowspan="2">E<br>New Belief<br><br>What can I tell myself in the future?</td></tr>
<tr><td>B<br>Belief/Stuck point<br>"I tell myself something"</td></tr>
<tr><td>C<br>Consequence<br>How does the stuck point make me feel?</td><td>F<br>New Consequence<br>How does the new belief make me feel?</td></tr>
</table>

The Challenging Questions Worksheet helps the patient challenge their maladaptive or problematic belief/stuck point. Not all the questions will apply to their stuck point; however, this exercise works to help the patient evaluate their thought processes. Some questions in the Challenging Questions Worksheet include:

- What is the evidence for and against this stuck point?
- Choose one of the next three (whichever one the patient understands best)
  - In what way/s is your stuck point not including all of the information?
  - In what way is your stuck point focused on just one piece of the story?
  - In what way/s is this stuck point focused on unrelated parts of the story?
- Choose 3 of the following (whichever the patient understands best)
  - Is your stuck point a habit or based on fact? (consider whether you have just said this stuck point to yourself so many times that it seems like fact)
  - Does your stuck point include all-or-none terms? (e.g., either-or, black-white, right-wrong, good-bad)

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- Does your stuck point include words or phrases that are extreme or exaggerated? (i.e., always, forever, never, should, must, can't, and every time)
- Where did this stuck point come from? Is this a dependable source of information on this stuck point? (consider where this stuck point comes from – e.g., parents, friends, church, media)
- How is your stuck point confusing something that is possible with something that is likely?
- In what ways is your stuck point based on feelings rather than facts?

**Challenging Beliefs Worksheet**

| 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.<br>Rate belief in each thought/stuck point below from 0-100%<br>(How much do you believe this thought?) | Use **Challenging Questions** to examine your automatic thought from Column B.<br>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?<br>Rate belief in alternative thought(s) from 0-100% |
| | <br><br><br>**C. Emotion(s)**<br>Specify sad, angry, etc., and rate how strongly you feel each emotion from 0-100% | Evidence For?<br>Evidence Against?<br>Habit or fact?<br>Not including all information?<br>All or none?<br>Extreme or exaggerated?<br>Focused on just one piece?<br>Source dependable?<br>Confusing possible with likely?<br>Based on feelings or facts?<br>Focused on unrelated parts? | Jumping to conclusions:<br>Exaggerating or minimizing:<br>Ignoring important parts:<br>Oversimplifying:<br>Over-generalizing:<br>Mind reading:<br>Emotional reasoning: | <br><br><br>**G. Re-rate Old Thought/ Stuck Point**<br>Re-rate how much you now believe the thought/stuck point in Column B from 0-100%<br>**H. Emotion(s)**<br>Now what do you feel? 0-100% |

Choose 1 yellow and 3 green that the client best understands

By guiding patients through this process, therapists facilitate a shift in their emotional response. Instead of feeling guilt and shame, patients may experience grief or anger, which are more appropriate responses to their circumstances. For example, rape victims may transition from self-blame to righteous anger, directing blame towards the perpetrator. This transformation in thinking and emotion is a key aspect of the therapeutic journey, empowering patients to navigate their trauma with greater clarity and resilience.

## Physiologic Responses to Trauma

When survivors express feelings of freezing during a traumatic event, therapists employ gentle questioning to delve deeper into the situation. Survivors often blame themselves for their physiological responses, unaware that freezing is a common reaction to trauma. There are two types of freeze responses: one occurs as an initial shock to the unexpected event, while the other arises later as a dissociative mechanism, particularly prevalent in individuals who have

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experienced childhood abuse (see disorganized attachment episodes 087 and 088). Dissociation involves a physiological response where the body redirects blood flow and releases endorphins to alleviate pain, resulting in a sense of detachment from reality. With repeated exposure to trauma, this response becomes automatic, hindering the individual's ability to intervene and stop the event.

Through education on the physiology of defense mechanisms, therapists aim to provide survivors with insight into their reactions. They explain how the brain's fight or flight response can inhibit speech during moments of intense danger, as the prefrontal cortex, responsible for language processing, is deactivated.

Here are some examples of questions that are monthly asked to be ranked by patients from the PCL-5:

- Having strong physical reactions when something reminds you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?
- Avoiding memories, thoughts, or feelings related to the stressful experience?
- Trouble remembering important parts of the stressful experience?

While individuals without PTSD typically experience a return to normal functioning once the danger has passed, those with PTSD may struggle to regulate their responses, leading to prolonged states of hyperarousal. This understanding helps survivors contextualize their experiences and work towards healing and recovery.

## Patients with High Levels of Dissociation

In the study explored by Resick and colleagues (2012), participants were assigned to one of three treatment modalities: Cognitive Processing Therapy (CPT) which included both written accounts and cognitive therapy, cognitive therapy alone (CPT-C), and a treatment focusing exclusively on written trauma accounts (WA). The findings revealed that individuals exhibiting higher levels of dissociation, particularly those with significant depersonalization symptoms, demonstrated more favorable outcomes with the comprehensive CPT approach. Whereas those who endorsed low pretreatment levels of dissociation responded most efficiently to CPT-C. The act of writing detailed accounts of their traumatic experiences potentially facilitated the integration of fragmented memories, which, in turn, enhanced the effectiveness of subsequent cognitive therapy. This integrated method was distinctly advantageous for participants with pronounced dissociation, as opposed to other participants who did not display the same level of benefit from either component (written accounts or cognitive therapy) in isolation.

## How to Use Socratic Questioning and Common Mistakes

The process of utilizing Socratic questioning is particularly challenging because it entails guiding patients to think about their experiences differently without attempting to persuade them directly. Instead of convincing patients, therapists teach them specific skills gradually, such as

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distinguishing between facts and opinions and exploring the relationship between their thoughts and emotions. Training materials have evolved to emphasize the importance of using exploratory language rather than confrontational terms like “challenge.” Therapists are cautioned against being overly assertive or pushy, as the goal is to facilitate patients' self-discovery and conviction rather than imposing beliefs onto them.

Successful implementation of Socratic questioning in CPT not only transforms patients' thoughts and emotions but also impacts their physiological responses, including arousal and startle reactions.

The common response to trauma often involves a sense of personal responsibility or guilt, driven by the belief that one must have made a mistake or deserved the outcome. Individuals may engage in a process of hindsight, imagining what they could have done differently to prevent the event or mitigate its impact. This retrospective analysis can lead to feelings of shame and guilt, as individuals grapple with the idea of undoing the past, which is ultimately impossible. Moreover, individuals may adopt an outcome-based reasoning approach, attributing the occurrence of the event to their own actions or decisions. Such tendencies may be reinforced by upbringings in emotionally abusive environments, where individuals are conditioned to accept blame for everything that goes wrong. As a result, these patterns of thought become ingrained, serving as automatic responses to traumatic experiences.

According to Dr. Resick, until individuals confront and challenge these ingrained beliefs, the trauma may persist unresolved. This involves not only examining and adjusting these beliefs, but also placing them in the context of what actually occurred during the traumatic event. Often, due to the deeply impactful nature of traumatic experiences, crucial details are overlooked or the reality of the situation is distorted. For example, someone may blame themselves for not fighting back harder during an assault without considering the physical constraints they faced, such as being held down by multiple assailants. Through Socratic questioning, therapists guide individuals to revisit the factual aspects of the event, encouraging them to confront the discrepancies between their perceptions and reality. This approach focuses on objectively analyzing the events without delving into graphic details or emotions, allowing individuals to gain a clearer understanding of the circumstances surrounding the trauma and challenging their self-blaming assumptions. Ultimately, this process aims to facilitate cognitive restructuring and promote healing by addressing distorted beliefs and fostering a more accurate perspective of the traumatic experience.

Exploring sensitive topics surrounding sexual abuse, especially for kids who might have felt arousal during the abuse, can be valuable in therapy. It is common for misconceptions to arise, such as equating arousal with pleasure, which can lead to feelings of confusion and shame. Therapists can use gentle, probing questions rooted in the Socratic method to address these misunderstandings, empowering survivors to understand the distinction and alleviate any burdens of guilt or shame they may carry.

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Asking such questions is vital. For instance, in cases of sexual abuse, inquiring if survivors experienced arousal can challenge misconceptions and prevent them from internalizing false beliefs about their participation. Recognizing the grooming process in child sexual abuse is also crucial, as perpetrators may manipulate victims into believing they consented. Addressing these sensitive topics allows therapists to offer survivors validation and support, aiding in their healing.

Dr. Resick also stresses the importance of therapists seeking consultation or support when dealing with challenging narratives. It is essential for therapists to acknowledge their own emotional reactions and seek help to prevent burnout or avoidance of trauma-related discussions.

## Navigating Sensitivity in Trauma Therapy: Strategies for New Providers

For new providers hesitant about practicing trauma therapy due to their own sensitivity, it is important to acknowledge that while they may empathize with their clients, the trauma belongs to the client, not the provider. It is advisable for clinicians to avoid projecting themselves into their clients' experiences and instead concentrate on supporting clients through their emotions, without internalizing them.

Practical strategies exist to maintain grounding during therapy sessions, such as adhering to the therapeutic model and employing structured questioning techniques. Additionally, supervision plays a vital role in offering guidance on effectively navigating challenging situations.

By prioritizing structured tasks and planning, therapists can ward off dissociation and manage their emotions more effectively. Active thinking plays a key role in maintaining emotional equilibrium and warding off burnout.

It is imperative to acknowledge the importance of seeking support from colleagues and supervisors when faced with distressing narratives. Such support fosters open dialogue among therapists, facilitating the processing of challenging experiences and fostering ongoing professional growth.

## Enhancing Therapist Effectiveness: Insights From Reflective Function

A recent study seeks to understand the critical role of therapist effect in determining treatment outcomes, emphasizing the significance of reflective function (Cologon, 2017). Reflective functioning, defined as the essential human capacity to understand behavior in light of underlying mental states and intentions (Slade, 2005), is measured through the adult attachment interview. It has emerged as a determinant factor, accounting for 70.5% of what constitutes an effective therapist.

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Therapists with higher levels of reflective function demonstrated superior outcomes with patients, underscoring the importance of introspection and the ability to reflect on internal and external experiences. This capacity for reflection may be linked with the therapist's adeptness in CPT, particularly in employing Socratic questioning to guide sessions effectively, but more studies are needed.

In this particular study, therapists with higher levels of reflective function exhibited more significant improvements in their patients' symptoms, highlighting the direct impact of therapists' introspective abilities on treatment outcomes.

The findings suggest that assessing reflective function could serve as a valuable tool in identifying promising therapists early in their training. By nurturing and enhancing reflective abilities, training programs can better equip therapists to excel in trauma therapy and other modalities.

Furthermore, the study highlights the necessity for therapists to engage in their own personal growth and healing. Addressing unresolved traumas and developing self-awareness can enhance therapists' capacity to empathize with their clients and facilitate meaningful therapeutic connections.

## Conclusion:

Reflecting on the insights gained from the comprehensive discussion on Cognitive Processing Therapy (CPT), several critical strategies emerge for enhancing trauma therapy. A pivotal aspect of CPT involves identifying stuck points in patients' narratives about their trauma. These points often correlate with deeply held beliefs that foster guilt, hindering the patient's ability to process grief or express anger effectively. Additionally, the discussion highlighted the significant role of writing exercises, particularly for patients with pronounced dissociative symptoms. This approach serves as a vital tool in helping them articulate and process their traumatic experiences coherently. Another essential strategy is the importance of confronting, rather than succumbing to, the temptation to avoid difficult trauma work. This avoidance can significantly impede therapeutic progress and the achievement of desired outcomes. By actively engaging with patients' traumas and challenging their avoidance behaviors, therapists can facilitate a more effective healing process. These strategies underscore the nuanced complexities of treating trauma and the importance of tailored approaches in therapy.

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