

THE EFFECT OF A MOTIVATIONAL INTERVIEWING PRETREATMENT ON CBT
TREATMENT OF PTSD IN VETERANS: A PRELIMINARY INVESTIGATION

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ABSTRACT

A significant number of veterans of all generations are affected by Posttraumatic Stress Disorder (PTSD) related to combat experiences as well as other traumatic events. While veterans with PTSD may benefit significantly from the evidence-based treatments available, this population in particular can face numerous obstacles to care, including avoidance of distressing traumatic memories, the impact of stigma, beliefs about psychological treatment, and minimization of the severity and impact of PTSD symptoms. To address these obstacles in the context of individual therapy, the present study used a pragmatic single-case study design to examine the implementation and impact of a Motivational Interviewing (MI) intervention delivered as a pretreatment prior to one veteran's participation in Cognitive Processing Therapy (CPT) for PTSD. In a manner consistent with MI principles and therapeutic techniques, the pretreatment sought to help the veteran explore ambivalence about treatment, identify and strengthen personal reasons for change, and bolster self-efficacy related to his ability to work toward valued change goals. The present study explored the process of integrating MI with CPT and the resulting impact on one Vietnam War veteran's motivation, engagement, and compliance with treatment. In addition, the question of whether MI served to enhance CPT treatment gains with regard to trauma-related symptoms and overall functioning was addressed. Qualitative and quantitative results suggested that the MI pretreatment was associated with improved intrinsic motivation consistent with values espoused by the veteran, which in turn impacted the course of subsequent therapy. In addition, it appeared that the moment-to-moment utilization of MI interventions throughout the process of CPT likely served to enhance client engagement in treatment, although the relationship to homework compliance was less clear. While the

impact of MI on the veteran's experience of trauma-related symptoms and functioning could not be isolated within the present study, the impact of the veteran's pursuit of identified values-consistent goals on PTSD and related symptoms and functioning is discussed.

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Introduction

Posttraumatic Stress Disorder in the Veteran Population

Posttraumatic Stress Disorder (PTSD) is a mental illness that affects approximately 6.8% of adults living in the United States in their lifetime (Kessler, Berglund, Demler, Jin, & Walters, 2005). Affected individuals had a direct or indirect experience of a traumatic event that inspired feelings of fear, terror, or powerlessness. As a result of this encounter, sufferers are plagued with a constellation of cognitive, emotional, and behavioral symptoms, which include reliving the event, experiencing the associated distress and hyperarousal, avoiding reminders of the trauma, and undergoing related changes in thinking and feeling (American Psychiatric Association, 2013).

Among those who suffer from the disorder, military service members and veterans comprise a significant number. The United States Department of Veterans Affairs (VA) suggests that approximately 30 percent of Vietnam War veterans have suffered from PTSD at some point in their lives (Schlenger et al., 1992). Various studies have suggested that one to ten percent of veterans who served in the Gulf War struggle with the disorder (e.g., Barrett et al., 2002; Gray et al., 2002; Kang et al., 2003). Of those recent veterans who served in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), five to 20 percent may have PTSD (Ramchand et al., 2010). According to the Veterans Health Administration, 247,243 OIF and OEF veterans have been assessed or treated for potential PTSD within VA facilities (2012).

Fortunately, several evidence-based treatments are available to those who suffer from PTSD, including Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT; Cukor, Olden, Lee & Difede, 2010). While these empirically supported treatments have proven helpful to veterans and civilians alike, the effectiveness of psychotherapy may be limited based on clients' engagement with treatment (Harpaz-Rotem & Rosenheck, 2011). A host of factors may contribute

to reduced veteran engagement in therapy, including the avoidance symptoms associated with PTSD (Snell & Tusaie, 2008) and beliefs regarding the meaning of psychological treatment (Stecker, Fortney, & Sherbourne, 2011). In order to maximize gains, therapists must address the challenge of helping clients overcome these obstacles to treatment engagement and progress. The present exploratory case study examines the implementation and potential utility of Motivational Interviewing (MI) as a therapeutic intervention intended to help veterans suffering from PTSD maximize: motivation for treatment, adherence to treatment requirements, and treatment gains.

Cognitive Processing Therapy for PTSD

Cognitive Processing Therapy (CPT) is an empirically validated treatment for PTSD, which has been shown to not only alleviate the symptoms of PTSD and depression, but also reduce general anxiety as well as distressing feelings of guilt associated with depression (Monson et al., 2006; Resick, Nishith, Weaver, Astin, & Feuer, 2002). This treatment allows individuals suffering from PTSD to confront their traumatic memories by repeatedly writing out their traumatic memories in increasing levels of detail, reading their accounts, and feeling the emotions that arise during this process without employing avoidance behaviors. CPT integrates these exposure techniques with cognitive therapy focused on challenging the unrealistic and maladaptive beliefs that oftentimes develop following traumatic experiences. Such beliefs may be identified during the course of exposure work focused on emotional processing and challenged through cognitive restructuring. In addition to questioning their unrealistic beliefs, clients develop alternative cognitions that help them to process the trauma and create a more realistic life narrative.

The theoretical basis for CPT comes from both the emotional processing theory of PTSD and the social cognitive theory of PTSD. The emotional processing theory suggests that PTSD is the result of a particularly expansive fear network that is therefore more readily activated (Foa,

Hembree, & Rothbaum, 2007; Foa, Steketee, & Rothbaum, 1989). According to this view, when an individual suffers a traumatic event, the process of classical conditioning leads to the creation of a “fear network” that includes environmental cues related to the trauma, as well as associated emotional (e.g., fear, helplessness), physical (e.g., hyperarousal symptoms), cognitive (e.g., memory of the trauma, thoughts regarding self and the world), and behavioral reactions (e.g., avoidance of internal and external cues) associated with the trauma. The fear network and its associated cognitive, behavioral, emotional, and physical reactions are then activated whenever the individual is exposed to an event that is related to any component of the fear network. That is, when one element of the fear network is activated, so are the many other network elements to which it is connected.

The activation of any part of the fear network leads to the experience of intrusive memories, flashbacks, and nightmares, as well as the related thoughts, emotions, and physical reactions. The painful nature of these experiences leads to avoidance of internal and external cues, similar to the escape behavior likely triggered by the original trauma. However, the avoidance of cues linked with the trauma prevents the individual from habituating to the distress associated with the traumatic memory and activation of the fear network. Furthermore, avoidance of the traumatic memory and associated components of the fear network deprives the individual of the opportunity to learn that the memory of the trauma can eventually be endured and the suffering diminished. Accordingly, treatment informed by the emotional processing theory of PTSD requires that the individual agree to repeatedly revisit the trauma through the process of exposure in a safe and supportive environment. In this process, the fear network becomes activated. Rather than engaging in avoidance behavior, however, the individual draws on the support of the therapeutic relationship and frame to cope with the associated distress. After repeated exposure to the trauma and

associated cues, the individual habituates to the distress, thereby decreasing the strength of the links in the fear network and the experience of PTSD symptoms. (Foa et al., 1989, 2007)

In addition to looking to the emotional processing theory to understand PTSD symptoms and inform appropriate interventions, CPT draws upon the social cognitive theory of PTSD. The social cognitive theory directly addresses the development of negative beliefs about oneself and the world subsequent to trauma, as well as the range of negative emotions associated with these altered beliefs (Resick, Monson, & Chard, 2008). Broadly speaking, the views that may be greatly altered or confirmed by the experience of a traumatic event are beliefs regarding the self (e.g., beliefs related to self-worth), other people (e.g., beliefs regarding the trustworthiness of others), and the world at large (e.g., beliefs about the safety of the world). The social cognitive theory holds that individuals, when faced with a traumatic event that may be difficult to integrate into a life narrative, can a) assimilate incoming information associated with the trauma to be consistent with their original beliefs, b) accommodate by altering their original beliefs based on the information associated with the trauma, or c) over-accommodate by entirely rejecting previous beliefs and developing radically different views due to the new information associated with the trauma.

The social cognitive theory posits that certain emotions, such as fear, sadness, and anger, can be naturally associated with the experience of trauma (Resick, Monson, & Chard, 2008). However, when individuals engage in extremes of assimilation or over-accommodation, the resulting views of self, others, and the world can lead people to experience secondary “manufactured” emotions, such as guilt. In addition, the attempt to assimilate information from the trauma in a way that allows for the preservation of prior worldviews may contribute to avoidance and escape behaviors. Avoidance of the traumatic memory and its associated thoughts and feelings

may then contribute to the re-experiencing of the trauma in the form of intrusive memories, flashbacks, and nightmares (Brewin & Holmes, 2003). The key mechanisms of action identified by the social cognitive theory as perpetuating PTSD symptoms include the assimilation or over-accommodation of information associated with the trauma, as well as the suppression and avoidance of traumatic memories and associated emotions. As discussed earlier, CPT addresses the latter by encouraging individuals to revisit the trauma while allowing themselves to feel any distressing affect originally associated with the traumatic event until it subsides. Subsequently, all relevant beliefs either rigidly confirmed or drastically changed by the trauma through assimilation or over-accommodation are directly examined and questioned in the treatment (Brewin & Holmes, 2003). Individuals are encouraged to alter any beliefs that are deemed unfounded, given the evidence of day-to-day life. In this way, manufactured emotions that originally emerged due to unrealistic views are similarly addressed and dispelled in CPT.

Engaging in CPT has helped veterans of various generations cope with trauma and combat PTSD symptoms; when 101 Vietnam War, OIF and OEF veterans suffering from PTSD were treated with CPT, they experienced significant improvement in PTSD symptoms (Chard, Schumm, Owens, & Cottingham, 2010). Two randomized controlled trials (RCTs) have examined the use of CPT with veterans who have suffered combat trauma. In Australia, Forbes and colleagues (2012) randomly assigned veterans seeking treatment for PTSD at veterans' counseling centers to be treated with treatment-as-usual or CPT for 12 sessions in six weeks. After completing treatment, 37.5% of the veterans who took part in the CPT treatment no longer merited a PTSD diagnosis, while those veterans who received treatment-as-usual evidenced less improvement; only 13% had experienced sufficient symptom relief to no longer warrant the diagnosis. Forbes and colleagues

suggest that it is the work done with the traumatic memory in CPT that facilitates the processing of the trauma and leads to symptom remission.

In the United States, Monson and colleagues (2006) conducted a similar study. However, instead of receiving treatment-as-usual, those veterans who were not treated with CPT were placed on a waitlist. CPT treatment lasted for 12 therapy hours provided over the course of six weeks. Of those individuals who were offered CPT, 50% experienced a significant decrease in PTSD symptoms, 40% experienced PTSD symptom remission to the extent that the individual no longer warranted a PTSD diagnosis, and 20% dropped out of treatment. Researchers concluded that CPT, when used with a sample (which included 6 women and 54 men) of veterans who had experienced trauma related to military service, proved effective in reducing PTSD, depressive, and overall anxiety symptoms. With regard to PTSD symptoms, the veterans in CPT experienced particular improvement in symptoms of re-experiencing and emotional numbing. Additionally, veterans who had received the treatment evidenced improved social adjustment, affect functioning, and distress associated with guilt. The RCTs performed by Monson and colleagues (2006), as well as Forbes et al. (2012), provide strong empirical support for the use of CPT with veterans. The findings are supported by a quasi-experimental study that determined that veterans treated with CPT in a residential PTSD rehabilitation program evidenced greater reductions in PTSD and depressive symptoms, and reported a higher quality of life, improved coping ability, and lower psychological distress than those who received treatment that was simply informed by cognitive behavioral therapy (Alvarez et al., 2011). In particular, the finding that more veterans experienced remission when they engaged with CPT than when they were treated with a cognitive-behavioral-based intervention suggests that CPT may be particularly helpful for the treatment of trauma in veterans (Alvarez et al., 2011).

The cognitive interventions in CPT may effect these changes by targeting the maladaptive cognitive patterns that keep individuals “stuck” unable to trust others. By allowing the veterans to challenge the unrealistic beliefs that develop as a result of the trauma, CPT allows clients to deal with the thoughts that underlie the anxiety, guilt, depression, and anger that may hinder them from engaging fully in alternative exposure treatment (Forbes et al., 2012). As reducing the severity of such feelings predicts better treatment outcome, it may be that CPT allows veterans to transcend the barriers that such feelings represent and recover from symptoms. Because of its direct treatment of the cognitions and emotions that may serve as obstacles to treatment, CPT may be uniquely suited for the treatment of veterans who have developed combat-related PTSD from harrowing military experiences that often include numerous traumatic incidents.

Obstacles to Treatment with Veterans

In spite of the availability of effective treatment for PTSD, many veterans struggling with the disorder do not receive adequate treatment. In one study of CPT for veterans cited above, 20% of the subjects suffering from PTSD dropped out of treatment (Monson et al., 2006). Indeed, in a study of OEF/OIF veterans, those individuals diagnosed with PTSD attended a median of four treatment sessions in the year after receiving feedback regarding their diagnosis (Seal et al., 2010). A study conducted by Harpaz-Rotem and Rosenheck (2011) supported this trend, noting that the OEF and OIF veterans who were diagnosed with some form of mental illness attended an average of eight treatment sessions, an insufficient dosage that is unlikely to prove therapeutic. Such results suggest that, although effective treatments are available for veterans with PTSD, a considerable number of individuals do not experience relief as a result of the challenges to seeking and receiving appropriate care.

The factors that may prevent veterans from accessing effective psychological treatment have been examined by previous research. Among the obstacles is the avoidance of the traumatic memories that characterizes PTSD; veterans who are avoiding reminders of their distressing experiences may not wish to discuss these very experiences in the context of treatment (Snell & Tusaie, 2008). In addition, the social stigma associated with mental illness as well as veterans' beliefs about psychological treatment and their own experience of symptoms may affect their willingness to seek care. Specifically, the belief that psychotherapy will be ineffective or interfere in their lives may deter veterans from seeking treatment (Snell & Tusaie, 2008; Stecker, Fortney, & Sherbourne, 2011). Lorber & Garcia (2010) also hypothesize that the masculine socialization that results from the prevalence of gender norms within the context of military culture may prevent veterans from seeking help. Beliefs regarding individual symptoms may also contribute to a veteran's reluctance in obtaining necessary care; these include beliefs that the veteran's problem is not severe enough to warrant treatment, symptoms can be mastered without treatment, and PTSD-related issues are not a concern for the veteran (Stecker et al., 2011).

Just as beliefs regarding the potential negative aspects of psychological treatment may dissuade individuals from getting treatment, the belief that treatment would help alleviate distressing symptoms and associated problems has been linked to an increased willingness to seek treatment (Stecker, Fortney, Hamilton, Sherbourne, & Ajzen, 2010). In addition, research suggests that veterans who do pursue psychological treatment cite various experiences as influential in their decision. These include the experience of severe problems in relationships with family members and romantic partners, excessive anger, and an increased recognition of how personality traits have changed since the trauma (Snell & Tusaie, 2008). Additional obstacles that deter veterans from accessing appropriate care include beliefs held about the utility of PTSD symptoms, the resulting

ambivalence about treatment, and the decrease in treatment engagement that follows (Murphy, Rosen, Thompson, Murray, & Rainey, 2004). In order to help these individuals benefit from available care, providers must work to address any erroneous beliefs, resolve potential ambivalence, and enhance motivation for and engagement with treatment. Motivational Interviewing (MI) is a therapeutic approach developed to help clinicians and clients work together to accomplish each of these goals.

Motivational Interviewing with Veterans

Initially developed to help people struggling with substance abuse increase their desire and commitment to change, MI fosters a collaborative relationship between therapist and client (Miller & Rollnick, 2012). This joint approach is rooted in assumptions put forth by Carl Rogers, the creator of client-centered psychotherapy. Drawing from this tradition, MI holds that all individuals, in addition to being fundamentally good and “worthwhile,” are innately predisposed to work to better and “actualize” themselves (Rogers, 1959). Rogers (1959) noted, however, that such change can best occur within the context of “unconditional positive regard” and profound acceptance of the person. Similarly, MI posits that accepting people as they are allows them to consider moving toward healthful change (Miller & Rollnick, 2012). This is in direct opposition to rejecting individuals due to their presentation, or attempting to coerce people to act in a way deemed desirable. When self-determination is threatened, people often exhibit reactance by acting in a way that re-establishes their sense of autonomy (Karno & Longabaugh, 2005). Given this understanding, MI advocates a therapeutic stance that accepts the individual as s/he presents in the room, respects each person’s autonomy, and honors the client’s position as the expert on the self (Lundahl & Burke, 2009).

While client-centered, MI is nonetheless directive as it seeks to draw upon the client's strengths and values to enhance motivation for change by resolving ambivalence regarding change. Within this approach, ambivalence is viewed as a ubiquitous and natural component in the process of change. Accordingly, clients are presumed to have valid personal reasons that would lead them to both pursue and avoid change. The task of the clinician, then, is to help clients strengthen their reasons for change and access the personal resources that would allow them to pursue associated goals. Doing so directly by arguing for change in accordance with the "righting reflex," however, frequently has the effect of motivating the client to argue against change in order to fully represent the present ambivalence. Accordingly, Miller and Rollnick (2012) posit that the helper's role is to facilitate the change process by encouraging *client* "change talk" that increases the client's desire for and commitment to change.

It is theorized that increased change talk about reasons and plans for change, along with decreased sustain talk about reasons against change, serves to increase client motivation to change through two processes. Firstly, cognitive dissonance theory suggests that this effect may be due to the client's increased sense of disparity between the individual's stated values and goals, and that person's potentially destructive behavior (Lundahl & Burke, 2009). By evoking and reinforcing change talk, MI helps to increase the dissonance between the client's perception of self and the potentially harmful behavioral pattern. According to cognitive dissonance theory, the discomfort associated with this incongruity can serve to increase motivation to resolve the discrepancy through changing the unhealthy actions (Festinger, 1957; Elliot & Devine, 1994). Secondly, MI seeks to increase individuals' investment in change by drawing upon self-perception theory. Self-perception theory suggests that, when individuals talk extensively about reasons for change and ways to achieve change, they effectively convince themselves that they truly want to change and

have the resources to work toward change (Bem, 1967; Lundahl & Burke, 2009). By evoking and encouraging change talk, MI allows clients to build their own motivation and commitment to change (Hettema, Steele, and Miller, 2005).

The so-called “Spirit of MI” reflects its theoretical underpinnings, which include the following principles: partnership between client and clinician, acceptance of the client, compassion for the client, and evocation of individual reasons for change. By embracing partnership between client and therapist, MI acknowledges that the client has self-knowledge of their values and intrinsic motivation to change, while the therapist has a genuine and curious attitude that can serve to help the client evoke and strengthen personal desire for change. As mentioned earlier, MI also advocates acceptance of clients as inherently good people with an innate wish to take steps toward improving their lives. The MI principle of acceptance also stresses the importance of the therapist attempting to understand the client’s point of view through accurate empathy, respecting the client’s autonomy to choose, and actively affirming the client’s personal strengths and positive movements. Acceptance is also associated with compassion for the client and an orientation toward helping the client. Finally, the MI principle of evocation stems from the assumption that all clients considering change have ambivalence within them. Accordingly, the principle of evocation holds that the therapist’s role is to support the client, explore and evoke the individual’s specific reasons for change, and support the client’s positive resources in moving toward health. (Miller & Rollnick, 2012)

Processes that characterize MI include engaging the client in a collaborative relationship, focusing on working toward a specific purpose, evoking the client’s personal motivation for change, and planning to make desired changes (Miller & Rollnick, 2012). These processes typically persist and build upon one another, but may recur throughout the course of the

intervention. Often the first phase of MI, engaging the client entails creating a strong therapeutic relationship between therapist and client. One of the “common factors” behind various forms of psychotherapy, the therapeutic alliance can influence clients’ continued engagement in therapy as well as treatment outcome (Miller & Rollnick, 2012). The process of focusing entails collaboratively determining an area of client functioning that will be addressed. Once the broad goal and direction of therapeutic intervention has been determined, the therapist works to evoke the client’s reasons for change, eliciting change talk from the client, which will build that individual’s desire and motivation for change. Finally, in the planning stage of MI, the therapist works with the client to transform motivation for change into explicit commitment to change. Once present, the client is supported in generating potential actions that will allow that individual to work toward this commitment. (Miller & Rollnick, 2012)

Throughout each of these processes, the MI approach makes use of specific therapeutic techniques, including open-ended questions, affirmations, reflections, summaries, and advice-giving. Each method is meant to facilitate the creating of a positive therapeutic alliance characterized by accurate empathy and support, as well as selective evocation of client motivation for change. The use of open-ended questions, for instance, is meant to help create a strong therapeutic bond by helping create a common understanding of the patient’s point of view. In addition, asking open-ended question allows the therapist to learn information that may ultimately point to a client’s personal reasons for change. Actively affirming the client’s strengths serves to highlight the individual’s ultimate freedom in deciding to pursue change or remain with the status quo, as well as underscore the client’s inherent worth and natural potential to make progress toward health. By reflecting clients’ statements, as well as their underlying meaning, therapists can validate clients’ experience, demonstrate empathy, and reinforce reasons for change. The

technique of summarizing can also achieve these ends, in addition to helping the client move forward toward change. Finally, seeking permission to give information and relevant suggestions to clients both honors client autonomy and allows for the informed discussion of potential treatment options. This technique is frequently used in the planning stage to provide clients with various paths they might choose to pursue in an attempt to fulfill their stated commitments. (Miller & Rollnick, 2012)

The skillful use of the MI approach can lead clients to engage in a more empathic and collaborative therapeutic relationship, increased change and commitment talk, and decreased sustain talk (Amrhein et al., 2003; Apodaca & Longabaugh, 2009; Hetteme, Steele, & Miller, 2005). These factors, in turn, are linked with greater client change and improved outcome. When utilized as a pretreatment intervention, MI reduces client resistance to therapy, increases the experience of incongruity between client goals and current behavior, and enhances engagement with treatment (Lundahl & Burke, 2009; Apodaca & Longabaugh, 2009). Research has demonstrated that these effects also hold for people struggling with clinical levels of anxiety (Westra, Arkowitz, & Dozois, 2009; Kertes, Westra, Angus, & Marcus, 2011). Given the demonstrated effectiveness of MI in helping clients resolve ambivalence, decrease resistance to treatment, enhance engagement with therapy, and increase compliance with CBT, the intervention holds great promise for veterans who may struggle in making the commitment to seek psychological care for PTSD. Indeed, when OIF veterans diagnosed with a range of psychological disorders took part in such an intervention, those veterans sought mental health treatment at increased rates, highlighting the potential that MI holds to help veterans access care for psychological symptoms (Stecker, Fortney, & Sherbourne, 2011).

The most compelling evidence for the efficacy of MI as a pretreatment intervention for veterans suffering from PTSD comes from two RCTs. In the first, veterans who were taking part in group psychotherapy treatment for PTSD were assigned to participate in a psychoeducational or motivation enhancement-focused group for four weeks near the start of treatment (Murphy, Thompson, Murray, & Uddo, 2009). Compared to the subjects who took part in the psychoeducational group, those veterans who were in the motivational enhancement group seemed more able to assess their need to change and more willing to make necessary changes in their behavior. In addition, they demonstrated a higher level of commitment to pursuing change via group therapy over the course of the treatment, attending a greater number of sessions and continuing with the group for approximately six weeks more than the veterans who received psychoeducation (Murphy et al., 2009). These results suggest that the motivational enhancement intervention was effective at increasing engagement with the ongoing PTSD treatment, further supporting the potential that MI has for doing the same as a pretreatment intervention.

Indeed, the efficacy of MI as a pretreatment for veterans was upheld in a study that examined the effect that MI had on treatment engagement when the therapeutic intervention was implemented over the telephone (Seal et al., 2012). After each phone session in which the clinician utilized MI principles, subjects reported greater treatment engagement than the veterans who did not participate in the MI intervention; this discrepancy was particularly salient after the third MI session. In addition, those subjects who took part in the MI intervention reported a decrease in their perception of stigma associated with psychological treatment. The veterans' enhanced engagement may have led them to seek treatment, as those who participated in the MI were significantly more likely to pursue mental health care after the intervention. Furthermore, the effects of MI bore out over the course of treatment, as these veterans ultimately reported attending

more appointments related to their psychological symptoms (Seal et al., 2012). These findings demonstrate that MI is not only an effective intervention with veterans who may be ambivalent about mental health treatment, but also a therapeutic style that can be utilized flexibly in various contexts, including group settings as well as telephone sessions.

The evidence reviewed above indicates that MI is a powerful tool that can help clients magnify the discrepancy between their current experience and their desired goals, decrease the perceived stigma around mental health treatment, and increase expectations for treatment. In facilitating the creation of a collaborative therapeutic relationship that allows for the exploration and resolution of existing ambivalence regarding treatment, MI helps prepare clients to open the door to further evidence-based treatment. These benefits of MI would be invaluable to veterans who face a host of obstacles that deter them from accessing psychological treatment. Although there is strong evidence that MI is effective at enhancing veterans' engagement in treatment when done in a group setting or via telephone, no RCT has been conducted to examine the efficacy of MI for veterans with PTSD in individual psychotherapy. The present study seeks to address this issue by providing a foundation of exploratory research that examines how MI can be utilized with veterans who are considering PTSD treatment in the context of individual psychotherapy.

Integration of Motivational Interviewing and Cognitive Processing Therapy: Theoretical Compatibility

The basis for exploring the integration of MI interventions and CPT comes from the compatibility and complementarity of many of the theoretical principles that characterize the two approaches. These include the MI and CPT perspectives on the inherent nature of people, the therapeutic relationship, mechanisms of change, intervention goals, and technique.

The MI principle of acceptance assumes that all people have an innate orientation toward positive, healthy growth, and must be accepted with “unconditional positive regard” (Rogers, 1959). Although less explicitly strengths-oriented than MI, CPT aims to help individuals believe in their own self-worth. Indeed, an entire treatment module is devoted to helping clients come to a realistic and positive evaluation of self. Similar to the MI clinician’s compassionate view of the client, CPT suggests that the therapist work to help the client exercise self-compassion and alleviate survivor guilt by accounting for the context of experiences that induce feelings of guilt upon recollection. In addition to echoing the MI principle of acceptance of clients as inherently good and inclined toward progress, CPT offers a complementary perspective: that the natural process of learning realistic beliefs about self, others, and the world can be disrupted by trauma. One goal of CPT is to repair the impact of this disturbance by addressing beliefs that result from assimilation or over-accommodation, and helping people reorient themselves toward the realistic beliefs they might have otherwise held. In the practice of acceptance of the client, MI emphasizes the importance of “accurate empathy” with the client’s experience (Miller & Rollnick, 2012). Similarly, CPT stresses the value of the clinician empathizing with the client’s experience and understanding how potentially unrealistic beliefs developed as a result without becoming submerged in the client’s worldview. From this perspective, the therapist can offer emotional support to the client while also facilitating the examination and restructuring of unrealistic beliefs.

MI also stresses respect for the client’s autonomy, a position endorsed by CPT, which uses Socratic Questioning as a primary therapeutic tool. This collaborative method assumes that, when pressed to examine their beliefs in the context of therapy, clients are able to come to realistic decisions. Furthermore, by encouraging clients to develop the skill of challenging their thoughts, CPT helps individuals enhance their power over PTSD, thereby supporting autonomy in the face of

mental illness. Nonetheless, the approach of CPT complements that of MI; whereas the latter emphasizes that clients already have reasons for change within them, CPT emphasizes using psychoeducation and skill-building to help people implement change by addressing potential skills deficits. MI suggests that therapists take every opportunity to affirm client strengths. CPT acknowledges client strengths, assuming that individuals are able to manage painful affect associated with trauma with therapeutic support. In this way, each approach complements the other; while MI affirms client strengths to promote change, CPT directly encourages the development of these strengths (Earnshaw & King).

Both MI and CPT value a therapeutic relationship that positions client and therapist as partners working toward the client's well-being. However, MI presumes that clients are the "experts" on themselves, and therapists should exhibit a spirit of curious interest and evocation that will stimulate clients to access intrinsic motivation for change (Miller & Rollnick, 2012; Earnshaw & King). CPT looks to clients to identify their beliefs about themselves, others, and the world, while also acknowledging the impact of mental illness on such beliefs. Just as clients can best articulate their present beliefs as "experts," CPT therapists can offer information and interventions to treat the mental illness on which they have expertise. As mentioned earlier, Socratic Questioning is one such intervention, which utilizes techniques similar to MI to help clients reach their own realistic conclusions. Both MI and CPT work to support the client's autonomy. Just as MI acknowledges the client's power to decide whether to pursue change, CPT recognizes that it is the client who determines which beliefs are realistic. Although CPT is more directive and educational than MI, it nonetheless seeks to evoke the client's evaluation of prior beliefs, thereby maintaining the collaborative quality of the therapeutic relationship (Flynn, 2011).

As described earlier, MI and CPT are rooted in different theoretical foundations. Self-perception theory and cognitive dissonance theory account for the way in which MI helps clients resolve ambivalence, increase motivation, and commit to change. Similarly, emotional processing theory and social cognitive theory explain the mechanisms by which CPT helps clients decrease PTSD symptoms by undercutting avoidance and directly challenging unrealistic beliefs. In essence, MI can be used to help clients decide to pursue CPT, and remain engaged throughout treatment.

Although the two approaches have different roles throughout the course of pretreatment and therapy, the proposed mechanisms of action are compatible between the two modes. MI posits that self-perception theory is the mechanism by which change talk leads individuals to argue themselves into change. CPT may be said to use a similar method when the therapist uses Socratic Questioning to encourage the *client* to challenge prior beliefs and articulate new perspectives. Although the CPT therapist spends a great deal of time directly *teaching* the client to challenge unrealistic thoughts, the goal remains the same for both MI and CPT: to help clients reach healthy conclusions by articulating their own arguments and effectively talk themselves into healthy change. In addition, MI is based on the assumption that people experience discomfort when there is a recognizable disparity between their self-image and their observable actions. Cognitive Dissonance Theory can similarly be seen in action in the cognitive restructuring of CPT, in which the therapist helps the client see the disparity between their original beliefs and reality. In this way, the discomfort of cognitive dissonance may be said to motivate, at least in part, the creation of more realistic views that are consistent with clients' experience. In this way, the theoretical underpinnings of MI may be understood to be relevant to clients even after they have committed to the pursuit of change.

Although a number of the MI assumptions may be seen as relevant to the work of CPT, it is worthwhile to note that CPT and MI have different criteria by which therapists measure client progress and change. While CPT places great emphasis on helping individuals combat the symptoms of PTSD to come to *realistic* views about themselves and the world at large, MI adheres to the person's values as the standards by which all actions are measured (Earnshaw & King). Accordingly, whereas CPT may prompt one to ask, "Is this action based in a realistic thought?" an MI-informed clinician might wonder whether a belief encourages action patterns that are consistent with an individual's identified values. Accordingly, the two approaches emphasize several different therapeutic techniques. In the tradition of cognitive-behavioral therapy (CBT), the CPT clinician can be more directive and challenging, whereas the MI therapist is more supportive and evocative, focusing on the client's own values rather than an objectively "correct" reality (Flynn, 2011). Accordingly, the relative prevalence of therapeutic techniques (e.g., open-ended questions, close-ended questions, affirmations, reflections, summaries, clarifications, challenges, etc.) differs between the two approaches. For example, while CPT suggests that therapist address client resistance directly, MI emphasizes the importance of "rolling with resistance" rather than arguing against the client for change (Flynn, 2011). In sum, there is both considerable theoretical compatibility between MI and CPT, as well as a complementary relationship between the two approaches. MI has been proven to be a valuable therapeutic style to help engage veterans to draw upon their personal values and resources to undertake the difficult work of PTSD treatment. The present study sought to examine the integration of these two complementary approaches in the context of individual psychotherapy.

Statement of Specific Hypotheses

Based on the complementarity of these two treatment methods as well as the recognition of the problem posed by veteran dropout from PTSD treatment, the following study investigated the utility and impact of a brief MI intervention delivered as a pretreatment before the client chose whether to engage in CPT. This pretreatment utilized MI principles and techniques to help the client acknowledge ambivalence about pursuing therapy for PTSD and explore personal reasons for change, as well as potential obstacles and reservations. The therapist implemented the supportive therapeutic approach to evoke “change talk” to help the veteran resolve ambivalence about treatment and engage more fully with subsequent therapy (Hettema, Steele, & Miller, 2005). This current study aimed to determine whether an MI pretreatment can promote such changes and thereby help a veteran experience treatment gains from CPT. It was hypothesized that the use of an MI pretreatment with a veteran who subsequently decides to pursue immediate CPT for PTSD would contribute to increased client motivation and engagement with treatment, augment the therapeutic alliance, and enhance compliance with homework. These changes were thought to help the veteran experience further improvement in PTSD, anxiety, and depressive symptoms, as well as general quality of life over the course of treatment.

Methods

Participants

This study sought to recruit three to five veterans of the United States military who suffered from PTSD as a primary disorder. However, due to difficulties with recruitment of eligible participants, the present study was conducted with one veteran. The principal investigator (PI) attempted to recruit participants by contacting veterans service officers (VSOs), veterans organizations (e.g., Vet-2-Vet, Vietnam Veterans of America, Veterans of Foreign Wars, Vetwork, G.I. Go Fund), psychological services clinics (e.g., Rutgers Anxiety Disorders Clinic, Rutgers Psychological Clinic, Farleigh Dickinson University Center for Psychological Services), and mental health organizations (Give an Hour, National Alliance on Mental Illness New Jersey) to increase awareness of the study. VSOs, clinics, and organizations were provided with flyers to distribute to potentially interested participants. In addition, the PI provided brief verbal descriptions of the study to veterans directly. Individuals interested in participating in the study were directed to contact the PI and prescreened by phone. Those veterans who met the selection criteria were asked if they were interested in participating in the study using a script. Those interested in participating were scheduled for a full screening, which involved discussion of: informed consent, confidentiality, and audio recording of sessions, followed by a 90-minute intake interview. At this time, subjects also completed related documents approved by the Rutgers University Institutional Review Board, including forms of informed consent for participation in the study and audio recording of sessions. If individuals deemed eligible for inclusion in the study chose not to participate, they would have been provided with a prepared list of psychological care resources available to them. Screening, assessment, and treatment were completed by the PI at the Rutgers University Anxiety Disorders Clinic with no cost to participants. The therapist worked

under the supervision of a licensed clinical psychologist who directs a PTSD program in addition to treating scores of veterans.

In order to be considered for inclusion in the current study, participants must have been veterans of the United States military who were between 18 and 70 years of age. Subjects must have presented for treatment seeking relief from the after-effects of a traumatic event(s) related to their military service. In order to fully engage in CPT, eligible subjects must also have demonstrated fluency in speaking, reading, and writing English, and been capable of communicating about their past traumas as well as current internal events both verbally and in writing.

Exclusion criteria for subjects included an inability to engage in meaningful verbal exchange with the clinician due to impairment such as, but not limited to: psychosis, dementia, developmental disability, severe problems with attention and concentration, or severely diminished intellectual capacities. Indeed, individuals unable to communicate about their traumatic experiences verbally and writing were not eligible to participate, as CPT involves writing about one's trauma. Accordingly, functional inability to read or write, or severe difficulty with reading or writing, made a veteran unsuitable for inclusion in this study. A final exclusion criterion was the presence of a comorbid psychological disorder that caused severe distress or impairment, effectively preventing the subject from engaging in trauma-focused treatment. Such disorders included untreated bipolar disorder, active substance abuse or dependence, and prominent active suicidal or homicidal ideation (Monson et al., 2006).

Procedures

Study Design

According to the pragmatic paradigm used in the present study, it is critical to examine problems and phenomena within their particular contexts. While traditional research methods can be used to document treatment outcome and effectiveness, it is also important to understand the complex process of therapeutic intervention and change. The pragmatic case study method shows that this can be accomplished by examining how the application of a specific guiding conception and its corresponding interventions impact the treatment of a client presenting with particular problems in individual situations (Fishman, 2005). Accordingly, the present study consists of a case study that employed the pragmatic case study method to examine these very factors (Fishman, 2005). Although several RCTs have been conducted to study the potential benefits of utilizing MI with people suffering with PTSD, none have implemented an MI intervention in the context of direct individual treatment. Therefore, the approach utilized in the present study, while supported by similar and related research, had no precisely corresponding precedent in the existing literature. The systematic case study design was particularly well suited to the exploratory nature of this work as it allowed for the in-depth examination of the processes and outcomes associated with implementing MI interventions as well as the CPT treatment. More specifically, the pragmatic case study method allowed the PI to not only assess the specific influence that MI has on outcome variables, such as symptoms and compliance, but also document the impact of the pretreatment intervention on the process of subsequent therapy. With its emphasis on a clear guiding theory; individual subject context; and continuously utilizing treatment outcome over the course of therapy to inform guiding conception, formulation, and intervention, the pragmatic case study design allowed for an open and rich, yet also thorough and methodical study of a specific case. The

resulting nuanced understanding of how the application of MI principles impacted a veteran immediately and throughout subsequent PTSD treatment can be used to elaborate on the interaction between MI and trauma work and refine the associated interventions, as well as inform subsequent studies.

The present pragmatic case study was conducted in a manner consistent with the principles of disciplined inquiry; namely, specific interventions were based on the participant's needs, as evaluated by a comprehensive assessment (Peterson, 1991). For the veteran whose experience of PTSD subsequent to combat suggested that he would benefit from treatment, findings from the research reviewed above were used together with the therapist's experience and theoretical understanding to create a guiding conception that was utilized to inform case formulation. This integrated formulation determined the appropriate treatment interventions, which were continuously evaluated. Treatment outcome was used to update and refine both case formulation and an understanding of the utility and applicability of the guiding conception (Peterson, 1991). This led to clarification about the potential effectiveness of MI principles with individuals in similar circumstances who may be suffering from PTSD. The systematic nature of the present study allows for a more thorough understanding of the impact that MI may have on clinical work with traumatized veterans, which may then be used as a foundation to determine the potential utility and nature of needed RCT research.

Assessment

Individuals who were interested in participating in the study were directed to call the PI, who conducted a brief pre-screening. During this conversation, the PI elaborated on the nature of the study and answered any questions the caller presented. In addition, the PI sought to determine whether the caller appeared to meet the selection criteria based on the limited information provided

over the phone. Those veterans who seemed eligible were asked if they would like to participate in the study. If individuals eligible for inclusion in the study had chosen not to participate, they would have been referred to appropriate organizations for treatment.

Potential subjects who agreed to participate in the study were scheduled for a meeting with the PI that involved discussion of: informed consent, confidentiality, and audio recording of sessions, followed by a 90-minute intake interview. At this time, veterans also completed related documents approved by the Rutgers University Institutional Review Board, including forms of informed consent for participation in the study and audio recording of sessions. If individuals elected not to participate, they would have been referred for treatment to appropriate organizations. During the clinical interview with the PI, the veteran was asked to discuss the present symptoms, the history of the presenting problem, and an overview of the participant's psychosocial history including family, peer, and romantic relationships, childhood development, experiences within the military, past medical and psychological problems, and work functioning. At this time, participants were also assessed using the Clinician-Administered PTSD Scale (CAPS). In addition, individuals were asked to complete four self-report measures, including the PTSD Checklist-Military (PCL-M), Beck Depression Inventory-II (BDI-II), Beck Anxiety Inventory (BAI), and Outcome Questionnaire (OQ-45.2), to assess PTSD symptoms, depressive symptoms, anxiety symptoms, and overall quality of life, respectively. Following this assessment the principal investigator reviewed the information provided and consulted with a supervisor to determine whether the veteran suffered from PTSD according to the measures administered, and was therefore suitable for this specific treatment. Veterans deemed unsuitable for the study following the intake interview were provided with a list of appropriate referrals and assistance in seeking further care.

Pretreatment

The eligible veteran who agreed to participate in the study was invited to begin the three-session MI pretreatment. He was asked to come 10 minutes early to the first of these sessions in order to complete one additional self-report measure, the Client Motivation for Psychotherapy Scale (CMOTS). Subsequent pretreatment and treatment sessions lasted approximately 1 hour, and involved individual treatment by the PI, a masters-level clinician received ongoing weekly supervision from a licensed clinical psychologist expert in the field of PTSD treatment. At the end of pretreatment, both the subject and the clinician completed the Working Alliance Inventory-Short Form (WAI-S) for the first time. At the end of every session throughout the study, the clinician rated the subject's compliance with any assigned homework using the Homework Compliance Scale (HCS).

Over the course of the three pretreatment sessions, the PI worked to engage the client in a discussion of personal values, elicit ambivalence toward the possibility of change, evoke change talk and personal motivation for change, and collaboratively create a plan to help the client move toward making the desired changes (Miller & Rollnick, 2012). The pretreatment intervention utilized here drew heavily from Interian and Prawda's (2010) Motivational Enhancement Therapy for Antidepressants (META). In META, the initial session comprises the motivation building phase, while later sessions focus on consolidating client commitment to change (Miller & Rollnick, 2012). The authors note that clients may move between the two phases described in earlier MI literature, requiring clinicians to work with individuals at whatever stage of change they inhabit. Similarly, the PI moved between engaging, focusing, evoking, and planning with the client as needed, based on the individual's presentation. Accordingly, the goals and associated interventions pursued in each pretreatment session were also utilized in other sessions, as the task

of each MI intervention was based on the client's moment-to-moment mindset. Furthermore, the basic MI skills of using open-ended questions, affirmations, reflections, and summaries were used in every MI session. The broad goals and methods utilized in the individual pretreatment sessions are described below. (Interian & Prawda, 2010)

Session 1

The primary tasks of the first pretreatment session included: building rapport that allows for the development of a collaborative relationship, collaboratively setting an agenda for the initial session, discussing the client's reasons for electing to participate in a study that offers PTSD treatment, facilitating the identification of personal values that may have influenced the client's decision to explore the possibility of treatment, communicating assessment results to the client, beginning a discussion of potential goals for change related to PTSD based on client's identified values, and offering a summary of the primary discussion points of the session. In this session, the PI used the Values Card Sort (Miller et al., 2001) to facilitate the exploration and identification of personal values (see Table 4). During this task, the client was offered a stack of cards with values printed on them, and asked to categorize them in order of importance. This task was intended to lead to discussion of the client's understanding of the values deemed most important, ways in which the client was acting in accordance with these values, and ways in which the client wished to live even more consistently with these values. This discussion might have focused on discussing how the client's PTSD symptoms impacted the individual's ability live fully in keeping with these stated values. Such a discussion was intended to create discrepancy between the client's view of self and apparent present behaviors influenced by PTSD symptoms. This may in turn have led to a discussion of possible goals for change related to PTSD that would bring the client's present actions more in line with identified values.

Session 2

The primary tasks of the second pretreatment session included: fostering engagement by continuing to build rapport; addressing the client's thoughts regarding the previous session, focusing the discussion on one primary issue (PTSD); eliciting ambivalence by evoking reasons for and against change; evoking and reinforcing change talk related to the client's desire, ability, and commitment to change; and continuing to develop the discrepancy between the client's identified values and present experience. In the process of encouraging change talk, the PI paid particular attention to evoking the client's desire for change, perceived ability to change, reasons for change, and need for change. In addition, mobilizing actions, such as verbalizations of commitment, apparent activation, and even taking steps toward change were promoted. The importance and confidence rulers were utilized in this session to help enhance the client's perception of the importance of making a change and confidence in his ability to change.

Session 3

The primary tasks of the third pretreatment session included: continuing to evoke and reinforce change talk; asking for the client's permission for the therapist to share her thoughts regarding the possibility of change; offering a summary that highlighted the client's commitment to stated values, expressed desire for change, and ability to implement change; eliciting the client's response to the PI's summary; planning for change by identifying desired goals; asking for permission to recommend the present study as a way to pursue change by addressing PTSD symptoms; and asking if the client wished to commit to engaging in the study, or wanted to plan an alternative way of working toward change, if desired. The pretreatment was conducted in a manner that was based on the client's stated values and moment-to-moment needs; although MI is directive in nature, the plan that resulted was based entirely upon the client's values, goals, and

present circumstances. Accordingly, the client might have chosen to: not seek further treatment for PTSD at that time, seek treatment for a different issue, or seek treatment with another provider. If the client had chosen to not participate in the cognitive processing therapy (CPT) treatment offered through this study, the PI would have provided a list of appropriate referrals as well as assistance in seeking further care, if desired. In addition to the explicit implementation of an MI pretreatment that sought to help the client decide whether to pursue treatment for PTSD, MI principles and techniques were integrated throughout the course of CPT in various ways, described below.

The veteran was also asked to complete six self-report measures after completing the three sessions of MI (CMOTS, PCL-M, BDI-II, BAI, OQ-45.2, and WAI-S).

Treatment

As the client elected to pursue treatment for PTSD, 12 sessions were devoted to CPT treatment. The therapy was based on *Cognitive Processing Therapy: Veteran/Military Version*, the protocol developed by Resick, Monson, and Chard (2008) for treating veterans with PTSD. In this treatment, the clinician developed a formulation of the client's presenting problems using the theoretical framework of CPT. This conceptualization informed the course of treatment, which began with providing psychoeducation to the client about the nature of PTSD, as well as the associated tasks of treatment. The therapy then allowed the individual to confront traumatic memories by: repeatedly writing out traumatic memories and their impacts on the client, reading these accounts, and feeling the emotions that arise during this process without employing avoidance behaviors. CPT integrates these exposure techniques with cognitive therapy focused on challenging the unrealistic and maladaptive beliefs that oftentimes develop following traumatic experiences. These "stuck points" were identified during the course of exposure work, then processed and challenged through cognitive restructuring. In particular, stuck points related to the

client's beliefs about safety, trust, power, esteem, and intimacy were directly addressed. In addition to questioning unrealistic beliefs, the individual was supported in developing alternative cognitions that allowed him to process the trauma and create a more realistic life narrative that integrated the newly created meaning ascribed to the trauma.

In addition to the typical course of CPT, MI principles and techniques were drawn upon as needed to maintain client motivation and engagement. Throughout treatment, the therapist consistently worked to explicitly connect the therapeutic interventions of CPT with the client's stated values, goals, and commitment, as identified during the pretreatment. Furthermore, the PI worked to practice the MI principles of collaboration with and empathy for the client. As the process of change is seldom linear, it was expected that the client would experience continued ambivalence regarding change, particularly when faced with the demands of treatment. In such moments, the PI sought to communicate acceptance of the client's state of ambivalence, and utilize the principle of evocation by attempting to help the client recall the factors that contributed to the initial decision to pursue treatment. In addition to drawing upon the spirit of MI in such moments, the PI explicitly referred to the discussions that occurred during pretreatment, emphasizing the client's autonomous decision to pursue treatment in order to live more consistently with his identified values and view of self. Finally, though CPT can require the use of more directive interventions such as client education and close-ended questioning, the therapist used more MI techniques, such as open-ended questions, affirmations, reflections, and summaries, to help the client reconnect with the factors that drove his commitment to treatment. It should be noted that such interventions are alluded to in the present CPT protocol, highlighted as methods of increasing client compliance. In the present study, the PI sought to expand the use of MI-informed

interventions throughout treatment in a deliberate manner, as well as examine the impact of the MI pretreatment on the course of therapy.

Immediately before the 7th session of the CPT treatment, the participant was asked to come in approximately thirty minutes early to complete six self-report measures (CMOTS, PCL-M, BDI-II, BAI, OQ-45.2, and the WAI-S).

Posttreatment Assessment

At the end of the 12 treatment sessions, the subject was asked to complete these same six self-report measures again (CMOTS, PCL-M, BDI-II, BAI, OQ-45.2, and the WAI-S). If the subject had expressed a desire to continue accessing some form of treatment after the completion of the planned course of treatment, client and clinician would have explored the option of continued sessions or alternative treatment if clinically indicated. If required, the PI would have provided appropriate referrals. One month after the final treatment session, the client was asked to complete four self-report measures for the final time (PCL-M, BDI-II, BAI, and OQ-45.2).

Confidentiality

All individuals who met with the clinician for an initial screening were given informed consent forms approved by the Institutional Review Board of Rutgers University, which were reviewed in detail at this time. During this initial meeting, the individual was also encouraged to ask any questions regarding the issue of confidentiality. In addition, the PI stressed the voluntary nature of participation and the subject's right to end involvement with the study at any time. The clinician also discussed audio recording of sessions with the individual and responded to any concerns before obtaining written consent to audio record sessions. All original notes regarding the participant used numbers or codes instead of names and were stored securely in a locked file. Physical audio recordings of sessions were also kept under lock and key and destroyed at the end

of the study; digital recordings were similarly deleted at the end of the study. All protected health information was stored and maintained in compliance with the Health Insurance Portability and Accountability Act (HIPAA). As required by law, session notes and treatment summaries will be kept on file at the Rutgers Anxiety Disorders Clinic for seven years following the termination of the study.

Measures

The *Beck Anxiety Inventory* (BAI) includes 21 items that measure the client's experience of cognitive and somatic symptoms of anxiety in the past week. Scores of 0-7 indicate that the person experiences minimal anxiety, 8-15 indicate mild anxiety, 16-25 indicate moderate anxiety, and 26-63 indicate severe anxiety symptoms. The instrument is self-administered and typically takes less than five minutes to complete. The BAI has shown good internal consistency, reliability, and validity (Beck & Steer, 1991). The measure was completed by the participant at the initial intake session, after the third session of the MI pretreatment, approximately halfway through the CPT treatment (session 7 of the CPT treatment), after the final session of the CPT treatment, and one month after the final session of the CPT treatment.

The *Beck Depression Inventory-II* (BDI-II) consists of 21 items that measure the severity of cognitive, affective, and somatic depression symptoms. Scores of 0-13 suggest the client is experiencing minimal signs of depression, 14-19 suggest mild depressive symptoms, 20-28 suggest moderate depressive symptoms, 29-63 suggest severe depression. The instrument is self-administered and typically takes less than five minutes to complete. The BDI-II has demonstrated good internal consistency and validity (Dozois, Dobson, & Ahnberg, 1998). The measure was completed by the client at the initial intake session, after the third session of the MI pretreatment,

approximately halfway through the CPT treatment (session 7 of the CPT treatment), after the final session of the CPT treatment, and one month after the final session of the CPT treatment.

The *Outcome Questionnaire* (OQ-45.2) consists of 45 questions and contains three subscales: Symptom Distress (emphasizing anxiety and depressive symptoms), Interpersonal Relationships (emphasizing the quality of family and intimate relationships) and Social Role (focused on the quality of functioning in work, school, and family roles). It is self-administered and typically takes less than 15 minutes to complete (Lambert et al., 2004). The reliable measure was completed by the client at the initial intake session, after the third session of the MI pretreatment, approximately halfway through the CPT treatment (session 7 of the CPT treatment), after the final session of the CPT treatment, and one month after the final session of the CPT treatment (Lambert et al., 1996).

The *PTSD Checklist – Military Version* (PCL-M) consists of 17 questions that assess the client's experience of symptoms of Post-Traumatic Stress Disorder, including symptoms of re-experiencing the trauma; physiological arousal when reminded of the trauma; and physical, mental, and emotional avoidance of reminders of the traumatic event. The instrument is self-administered and typically takes less than five minutes to complete. Total severity scores range from 17 to 85, with a recommended cutoff score of 45-50 for outpatient mental health clinics (National Center for PTSD, 2014). The PCL-M has demonstrated good internal consistency, test-retest validity, and validity (Weathers, Litz, Herman, Huska, & Keane, 1993). The measure was completed by the client at the initial intake session, after the third session of the MI pretreatment, approximately halfway through the CPT treatment (session 7 of the CPT treatment), after the final session of the CPT treatment, and one month after the final session of the CPT treatment.

The *Client Motivation for Psychotherapy Scale* (CMOTS) consists of 24 items that assess several aspects of the client's motivation for treatment. These aspects include intrinsic motivation, extrinsic motivation, and amotivation. The item is self-administered and typically takes five minutes to complete. The CMOTS has demonstrated good internal consistency and both convergent and discriminant validity (Pelletier, Tuson, & Haddad, 1997). The measure was completed before the first session of the MI pretreatment, after the third session of the MI pretreatment, approximately halfway through the CPT treatment (session 7 of the CPT treatment), and after the final session of the CPT treatment.

The *Working Alliance Inventory-Short Form* (WAI-S) consists of 12 items that assess the therapeutic alliance that exists between a client and clinician. The shortened scale proposed by Tracey and Kokotowitc (1989) was used. Items prompt both clinician and client to rate the frequency at which they experience aspects of the therapeutic alliance on a 7-point Likert scale. In particular, the WAI-S measures the agreement between clinician and client on the proposed tasks and goals of therapy, as well as the emotional and interpersonal bond between the client and the therapist. The item is self-administered and typically takes less than five minutes to complete. The WAI-S has demonstrated good reliability and validity (Hanson, Curry, & Bandalos, 2002; Munder, Wilmers, Leonhart, Linster, & Barth, 2010). The measure was completed after the third session of the MI pretreatment, halfway through the CPT treatment (session 7 of the CPT treatment), and after the final session of the CPT treatment.

The *Homework Compliance Scale* (HCS) is a rating scale utilized by clinicians to monitor the level of homework compliance demonstrated by the client (Primakoff, Epstein, & Covi, 1986). The scale ranges from 0 to 6, 0 indicating that no psychotherapy homework was given, and 6

indicating the client completed more homework than was requested by the clinician. The therapist gave a rating on to the HCS at the end of every session throughout the study.

The *Clinician-Administered PTSD Scale (CAPS)* is a structured interview that contains 30 items related to the client's experience of PTSD symptoms, as well as any effects that these symptoms have on functioning. Responses are scored on a scale that ranges from 0 to 4, based on the frequency and intensity of the client's experience of the symptoms. It is suggested that clients who receive a score of 1 (0 signifying "none of the time" and 4 signifying "most or all of the time") on frequency and a score of 2 (0 signifying "none" and 4 signifying "extreme") on symptom severity exhibit the symptom as described by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR, APA, 2000). The scale can be used to determine if the client is currently suffering from PTSD as described by the DSM-IV-TR, or has suffered from the disorder at any point. The CAPS has demonstrated good reliability and validity (Blake et al., 1995; Foa & Tolin, 2000). This measure was completed in approximately one hour during the initial intake interview.

Treatment of Data

Data collected over the course of the present study include quantitative data taken from the measures discussed above as well as qualitative data gathered from therapist observation and client self-report in session. Data taken from the measures that have established normative data were assessed using the reliable change index proposed by Jacobson and Truax (1991); these measures include the WAI-S, BAI, BDI-II, OQ-45.2, and PCL-M, which assessed working alliance, anxiety, depressive symptoms, quality of life, and PTSD symptoms, respectively. Combined with the results of the CAPS and the subject's scores on each of these measures at various points in the study, the reliable change indices revealed the presence of significant change in the therapy,

symptoms, and functioning associated with treatment, as well as the endurance of symptom improvement. Normative data were not available for the other measures, which included the CMOTS and HCS. These instruments, which assessed the nature of the subject's motivation for psychotherapy and compliance with homework given in treatment, were analyzed using descriptive statistics.

The quantitative data described above were supplemented and verified by the qualitative data gathered from subjects' verbal self-report of symptoms and overall quality of life in session as well as the therapist's direct observation of subject functioning and behavior. By making use of several sources of information and triangulating data, the PI bolstered the validity of any conclusions drawn (Yin, 2003). In order to better illustrate findings, the audio tapes were transcribed and reviewed. These records of real-time therapist-client interaction spoke to the processes involved in pretreatment and treatment, as well as the impact that MI had on subsequent CPT. In addition, these pieces of therapeutic work served as specific examples of interventions and their immediate effects. In this way, conclusions drawn from the study were supported with detailed examples. Suitably descriptive portions of therapy were selected for inclusion in the course of treatment description by the PI in conjunction with her supervisor.

The present study was designed to explore the potential utility and impact of an MI pretreatment intervention on improving compliance with subsequent PTSD treatment for veterans. The design of the present study allowed the PI and subsequent readers to comprehend the details and complexity of the case and interventions. It is the intention of the PI that any conclusions drawn from the present study may be incorporated into a larger database of similarly systematic case studies, as well as utilized as a foundation from which to design more traditional research, such as RCTs.

Case Description

Client

The client who will be referred to as “Stanley” (a fictitious name) was a 68-year-old retired Caucasian man who lived with his wife and adult son. A veteran of the Vietnam War, Stanley reported experiencing emotional distress associated with recurring memories of his time in Vietnam as well as chronic medical problems. Stanley presented with symptoms of PTSD, as described by the American Psychiatric Association (2000, 2013) in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), as well as the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V). Stanley’s diagnosis was independently established by a licensed clinician with extensive experience with veterans and subsequently corroborated by the PI in the present study. He suffered from intrusive memories and thoughts related to several life-threatening experiences in Vietnam that caused him great emotional distress. This distress was characterized by physiological symptoms of anxiety as well as pervasive feelings of guilt and low self-worth. Stanley reported attempting to push his memories away, frequently avoiding conversations related to Vietnam, experiencing a restricted emotional range, and feeling that he may not “be around” for long. In addition, he struggled to fall asleep, reported occasional angry outbursts, difficulty with concentration, hypervigilance and a heightened startle reflex. Although Stanley reported enjoying his life, he suffered emotional distress as a result of his PTSD symptoms.

After attempting to push away his traumatic memories for over thirty years, Stanley had previously sought individual treatment from a clinic specializing in PTSD to address feelings of anxiety and depression related to his memories of the war as well as ongoing medical problems. In addition, he participated in a support group for Vietnam War veterans for approximately one year

prior to this study. As a former co-facilitator of this group, this study's PI consequently had a previous professional relationship with Stanley. In addition to disseminating information about the study to mental health and veteran organizations, the PI provided a short explanation about the present study to approximately 25 group members following a meeting. Immediately thereafter, Stanley approached the PI to obtain more details about this research study. At this time, Stanley was provided with additional verbal and written information regarding the treatment offered through the present study, as well as the contact information for the PI. Approximately one week later, Stanley called the PI to discuss his interest in participating in the study. At this time, the PI described the process involved in taking part in the study, including completing a prescreening by phone, an assessment screening, the experimental pretreatment, as well as subsequent individual treatment (if elected). Stanley was also informed of the self-report measures to be administered throughout the course of the study. In addition, Stanley was provided with information about the inclusion and exclusion criteria, as well as confidentiality related to clinical materials, including audio recordings. The PI expressed optimism related to his participation in the study, emphasizing the present opportunity for Stanley to continue building upon the gains made in past individual treatment. Stanley consented to participate in a pre-screening via phone at that time. During this time, the PI confirmed that the client appeared to meet inclusion criteria (see below), and was not engaged in ongoing individual treatment elsewhere. Following the prescreening, Stanley expressed a desire to participate in the study by planning an initial assessment. After the assessment, which confirmed Stanley's suitability for the treatment offered through the study, the present course of cognitive behavioral therapy consisted of 15 pre-treatment and treatment sessions that took place over three months.

Assessment

Before beginning formal participation in the study, the PI conducted an initial assessment with Stanley to definitively determine whether he met all inclusion criteria for participation in the study, to provide him with additional information about the study and its requirements, and obtain informed consent for participation in the study. During this initial assessment, the PI engaged the client in an initial unstructured clinical interview that reviewed the client's past and present social, educational, occupational, military, medical, and psychiatric functioning. The assessment also included use of the Clinician-Administered PTSD Scale (CAPS), an objective structured interview that assesses PTSD symptoms and associated features, as well as several self-report instruments, including the BAI, BDI-II, PCL-M, OQ-45.2, and CMOTS. Full descriptions of all measures can be found in Section 2. The client was asked to allow himself approximately thirty minutes to complete these measures following the interview portion of the intake. For quantitative results of all objective measures taken at intake and throughout the study, please see Section 8, Tables 1 and 2.

Family and Social History

In the clinical interview, Stanley described his childhood as “normal,” characterized by good relationships with both parents as well as a number of close friendships, some of which lasted throughout adulthood. He reported having a previously conflictual relationship with his brother, also a Vietnam War veteran, but stated that they had become close in recent years. Stanley married his wife, “Carol” (also a fictitious name), prior to being drafted, and she became pregnant shortly before Stanley was sent overseas. His wife gave birth to their eldest daughter while Stanley was in Vietnam. Stanley said Carol had told him that he came home from Vietnam “different” from the outgoing, sociable young man he had been prior to the war. In addition to their daughter, Stanley

and his wife had a son. Stanley stated that, although there had been times of conflict in their marriage, his relationship with his wife had generally been strong and supportive. However, he noted that he shared “very little” of his experience in Vietnam with his wife, stating that he did not want to cause her more emotional pain than she suffered during his tour. At the time of the present study, Stanley endorsed worrying about his son, who had gone through a divorce and was living with Stanley and Carol, as well as wondering whether the couple had contributed to their children’s respective marital difficulties. In addition, Stanley reported feeling occasionally stressed when caring for his grandchildren; while he cited them as a source of great joy and personal fulfillment, Stanley also noted that their behavior occasionally triggered his anger.

Educational and Vocational History

Stanley had completed high school and enrolled in college to study engineering before he was drafted into the Army. Following his return to the U.S., he completed his Bachelor of Science degree, and began working in sales. He held a sales job with an engineering firm for more than a decade before deciding to start a family business. He worked in this business for the remainder of his career. Stanley reported that he had been forced to close the company upon retiring, an event that he viewed as evidence of his failure to make a lasting impact in his profession. Stanley denied any history of legal problems or significant substance abuse.

Military History

After being drafted into the army, Stanley spent over a year participating in advanced training on a military base. He recalled becoming involved in several sports leagues during his time on the base before receiving his orders. While in Vietnam, Stanley worked as a fire control technician, calibrating the sighting gauges of various instruments, including heavy artillery—frequently with conditions and equipment that were inadequate for the task. He spent much of his

deployment near Dak To, an area in Vietnam that saw significant activity during the war. Stanley reported feeling significant anxiety related to his performance in his military occupational specialty (MOS), expressing a fear that any error in calibration on his part may have led to live rounds landing either short or long of their correct coordinates, costing American lives. After approximately eight months in Vietnam, Stanley returned to a social climate in which the Vietnam War and its soldiers were reviled by many, contributing to the client's stated desire to forget his experiences in Vietnam and return to "normal" life.

Medical History

Although Stanley denied experiencing significant health problems in his youth, he suffered from a host of medical problems in adulthood. He was diagnosed with colon cancer in his forties, and underwent surgery and chemotherapy for one year. Nearly twenty years later, he was treated with radiation therapy for prostate cancer related to previous dioxin exposure. While both treatments were successful, he suffered significant pain as a result of the treatment. In addition, Stanley suffered from hypertension, allergies and asthma, as well as Chronic Obstructive Pulmonary Disease as a result of past cigarette use. An oxygen tank was required for the daily management of Stanley's COPD. Stanley denied taking any drugs aside from prescribed medications, and reported drinking one or two alcoholic drinks up to three times weekly.

Psychiatric History and Present Symptoms

Stanley was initially referred for individual assessment and treatment by his veterans service officer approximately three years prior to his beginning treatment in the present study. Following the initial assessment in the specialty PTSD clinic, Stanley participated in CBT for approximately one year. The earlier treatment focused on addressing Stanley's symptoms of anxiety and depression, as well as several persistent negative beliefs about his tour in Vietnam and

his adjustment to managing severe medical problems. Although Stanley was diagnosed with PTSD at this time, he continuously avoided any focus on his traumatic memories during this treatment, declining to discuss these past experiences. At the end of the initial treatment, Stanley reported that he had experienced some symptom remission. However, in the course of therapy, he said that he had also “let the snakes”—his traumatic memories— “out of the box.” In addition to engaging in CBT, Stanley had been attending an ongoing veterans support group for several years. He reported experiencing great relief associated with discussing issues related to his experience during and following the Vietnam War with fellow veterans.

Speaking of his present relationship with memories from the Vietnam War, Stanley said, “I took all the negative things and filed them away” after returning to the United States. Since the previous course of individual CBT “opened up memories,” however, he said, “I think about some of those things,” referring to several traumatic experiences. Stanley was primarily plagued by memories of a “kid who got hurt because of me,” as well as enduring repeated rocket attacks from the enemy. Stanley ruminated about these memories and his professed guilt during times when he was alone—primarily at night. During the day, he attempted to avoid those specific memories. In the thirty years after his return, Stanley “didn’t mention Vietnam ten times.” Even in more recent years, as he started to speak more openly about his overall experience in Vietnam, Stanley continued to mentally push away the memories he experienced as traumatic by remaining busy.

Stanley denied most depressive symptoms; however, he acknowledged that his mood was sometimes affected by his chronic health problems. While he strove to remain active by playing with his grandchildren, participating in veteran organizations, and travelling regularly, Stanley felt both saddened and anxious when he experienced the physical symptoms (e.g., shortness of breath, fatigue) that reminded him of his medical problems. On occasion, Stanley reported having the

thought “Why should you be around at all?” due to the severity and chronicity of his medical issues. He explained that he did not wish to die or be gone, but rather wondered at his survival of numerous serious illnesses. Stanley denied having any desire, intent, or plan to hurt or kill himself or others. Results from the BDI-II indicated that Stanley was suffering from moderate depressive symptoms. However, several of his symptoms (e.g., fatigue) may be accounted for by the physical symptoms that resulted from his medical problems. As the depressive symptoms present were likely directly linked to ongoing medical problems, Stanley did not meet criteria for a diagnosis of a depressive or adjustment disorder at the time of assessment. In addition to feeling occasional sadness related to his health problems, Stanley worried about his well-being, as well as “what kind of world I’m leaving to the kids.” His worries seldom extended to other areas of his life and did not impact his day-to-day functioning. Rather, Stanley reported that these thoughts occasionally occurred to him at night, in addition to his memories of Vietnam. Stanley’s report of anxiety about his personal health and the future was consistent with the results of the BAI, which indicated that he suffered from mild anxiety symptoms.

In the initial interview, Stanley participated in an assessment that utilized the Life Events Checklist (LEC) and the CAPS to identify experiences that may have been experienced as traumatic by the client (e.g., assault, natural disaster) and assess for related PTSD symptoms. Stanley reported directly experiencing a number of potentially life-threatening events, including an explosion, vehicle accident, combat, exposure to toxic chemicals (dioxin), and two life-threatening illnesses. In addition, Stanley had witnessed and learned of other harrowing events, including violent death and severe accidents. Of the experiences endorsed on the LEC, Stanley identified three events as most severely distressing, both at the time of the event and at the time of this assessment. Stanley described these experiences further during the administration of the CAPS, a

structured interview that can be used to evaluate the presence and severity of PTSD symptoms related to identified traumatic events. It is the opinion of the primary investigator that this administration of the CAPS produced valid results that may have nonetheless been somewhat affected by the client's tendency to minimize symptoms and associated distress.

During administration of the CAPS, Stanley further described the three previously indexed traumatic events alluded to in the LEC. He recalled engaging in "jungle training" shortly after landing in Vietnam. During this training, soldiers were required to participate in a drill in which pairs of soldiers practiced throwing grenades. At one point, Stanley's partner reportedly turned to him and asked about the duration of the delay before the explosion of the grenade. After responding to his partner's question, he moved to get a cigarette from a friend during a break. When the drill resumed, there was an explosion apparently caused by a timing error on the part of his previous partner, which resulted in the death of his sergeant and maiming of his partner. Stanley recalled hearing muffled screams and experiencing the chaos of soldiers at a loss of what to do. At this time, he acknowledged feeling shocked and horrified by the incident. Over time, he felt increasingly guilty, believing that he might have prevented the explosion. Stanley identified this experience and the associated feelings of fear and guilt as the most painful of his wartime memories.

Stanley described a second traumatic memory of his experience living through one particularly severe rocket attack. During this attack, the ammunition from three cargo planes, which had been stored approximately thirty yards from Stanley's tent, was ignited. He recalled feeling terrified, thinking that the explosion was that of an atomic bomb. He spent the entirety of the night as well as the following day in the bunker, enduring the extreme distress brought on by the attack while also attempting to plan potential actions to take, given his mistaken belief that an

atomic bomb had exploded and led radiation to permeate the environment. Later in the course of his tour, Stanley reported having a similar reaction to an event in which he and two others had heard an explosion and screams, and witnessed a fully fueled tank retriever, a specialized armored recovery vehicle, burn in “twenty foot flames.” Stanley recalled running automatically toward the vehicle and throwing mud at the flames in an attempt to extinguish the fire. An hour after the soldiers had put out the fire, Stanley reported that he experienced a wave of fear in response to the dangerous event, indicating retrospective traumatization.

On the CAPS, Stanley endorsed several re-experiencing symptoms related to the traumatic events described. He suffered intrusive images and thoughts related to the traumatic memories several times each week. In addition to causing him considerable emotional distress, these intrusive memories contributed to significant difficulty falling asleep. Although he denied having nightmares related to the trauma, Stanley had experienced flashbacks one to two times monthly for the two years before the assessment. During these flashbacks, he re-experienced the trauma, while still retaining his awareness of the present moment and environment. Stanley experienced significant emotional distress daily due to being reminded of the trauma by environmental triggers or intrusive symptoms. When speaking with veterans about their tours, for instance, Stanley reported immediately thinking of the grenade drill, and feeling intense anxiety and guilt. In addition, Stanley felt angry when reminded of surviving the rocket attacks, unable to answer the question of “Why was I there?” so close to the ammunition. When reminded of the trauma, Stanley also reported experiencing occasional anxiety symptoms, such as increasingly shallow and quick breathing pattern as well as a feeling of restlessness that persisted even after the initial trigger had passed. When exposed to reminders of the trauma in the past, Stanley had occasionally needed to use his inhaler in order to regulate his breathing.

Stanley endorsed engaging in a number of avoidance behaviors in an effort to prevent experiencing the distress associated with re-experiencing the traumatic memories. While he reported staying silent about the topic of Vietnam for thirty years after the war, at the time of the assessment Stanley actively engaged in discussion about his experiences in the military in the context of the veterans support group. In addition, he had previously spoken about his day-to-day experiences in Vietnam in a teaching capacity. As both a group member and an educator, however, Stanley continued to avoid discussing the specific traumatic memories described here. In particular, he sought to avoid thinking about his experience of uncertainty and fear during these events. Furthermore, while he was able to speak to fellow veterans and children, Stanley avoided speaking with his wife or family members about his tour of duty. He reported avoiding thinking and speaking about these memories daily, but stated that this avoidance did not impede his day-to-day life.

In addition to avoiding internal stimuli related to the trauma, Stanley occasionally avoided certain organizations (e.g., Vietnam Veterans of America, Veterans of Foreign Wars) and individuals who triggered his memories. While he reported that his avoidance of triggers had improved in the last two decades, it continued to cause him moderate distress. Stanley also reported noticing moderate symptoms of affective numbing since 1998. In particular, he was not able to feel happy at times when he “should have been,” leading him to experience significant confusion. In addition, Stanley did not demonstrate any affect in his facial expression, bodily posture, or vocal tone when describing the traumatic memories in session. Finally, he endorsed a sense of a foreshortened future, expressing an overall struggle with mortality. He reported frequent thoughts of “How long will I be around?” related to both his health problems as well as his experience of trauma, as indicated by the long duration of this particular symptom. Stanley denied

experiencing any gaps in his memory of the traumatic events, feelings of being disconnected from others, or reduced engagement in activities of interest.

Stanley suffered from a number of arousal symptoms of PTSD, including daily difficulty falling asleep as well as early morning awakening. In addition, he had increased irritability, noting that “little things will set me off” approximately twice weekly. While his irritability often manifested as annoyance, Stanley reported that it “can reach rage.” Stanley also experienced difficulty concentrating on tasks, which had caused significant functional impairment, contributing to a previous car accident. He had an exaggerated startle reflex that he attempted to control. In spite of his efforts, Stanley reported being “jumpy” on occasion. Finally, Stanley exhibited significant hypervigilance a portion of the time, and endorsed a need to sit with his back to the wall and a view of the door at all times. However, Stanley’s hypervigilance did not prevent him from travelling for pleasure with this family.

In addition to the re-experiencing, avoidant, and arousal symptoms of PTSD, Stanley experienced severe distress due to feelings of guilt related to his perceived role in the grenade drill accident. He reported thinking about his supposed responsibility for the accident over half of the time, particularly at nighttime. Stanley also experienced moderately distressing survivor guilt that troubled him the majority of the time, particularly when he had thoughts of living through experiences that other soldiers did not survive. Upon inquiry, Stanley denied all dissociative symptoms (e.g., derealization, depersonalization) linked with PTSD.

Based on the present assessment of symptoms, Stanley suffered from chronic PTSD with delayed expression. Although his score of 28 on the PCL-M did not support this finding, it was consistent with Stanley’s overall minimization of symptoms. According to the client, symptom onset occurred in 1998, when Stanley received a letter inviting him to a memorial for Vietnam War

veterans. After attending the event, Stanley was increasingly disturbed by thoughts of the traumatic memories, as well as the associated symptoms described here. Since that time, he had suffered moderate emotional distress related to the trauma. In spite of his suffering, Stanley functioned moderately well across various domains at the time of this assessment. Nonetheless, he reported that his marriage had been negatively impacted insofar as he was unable to discuss his memories of the war and present experience of distress. Indeed, he reported that his wife had “banned” family members from mentioning Vietnam around him. In addition, he noted thinking that he had “lost time” with his family members as a result of his affective numbing and conflicts that were in part influenced by PTSD symptoms.

In spite of these difficulties, Stanley declared that he enjoyed a supportive, loving, and enduring marriage, as well as good relationships with his children and grandchildren. While his work had been negatively impacted by his symptoms of physiological arousal in the past, Stanley had nonetheless built a business that allowed him to support his family before retiring. In addition, Stanley led an active life, traveling for pleasure frequently, interacting with friends and family on a weekly basis, and deriving a sense of meaning from educating youth about the Vietnam War. These findings were further supported by the results of the OQ-45.2, which indicated that Stanley suffered from clinically significant psychological symptoms that adversely impacted his functioning as well as contributing to difficulty and some dissatisfaction in his relationships.

DSM-IV-TR Diagnosis

The assessment conducted was based on the previous version of the CAPS and PCL-M, both of which utilized clinical criteria described in DSM-IV-TR (APA, 2000). At the outset of the study, the updated measures were not yet available for use. However, Stanley’s initial presentation suggested that he met criteria for PTSD as described in the DSM-V (APA, 2013). In addition to

directly experiencing the rocket attack and vehicle fire described above, he witnessed violent death and injury during the grenade drill. As a result of these experiences, he experienced persistent feelings of guilt, especially related to the grenade drill accident, as well as difficulty experiencing feelings of happiness. Furthermore, Stanley endorsed several fixed, unrealistic beliefs related to his own responsibility for the grenade accident and the safety of the world at large. Therefore, although the present study defines PTSD in accordance with the previous criteria, the case presented is that of an individual afflicted with PTSD as defined most recently.

Strengths

Stanley's ability to maintain a high level of functioning highlights Stanley's considerable strengths, which include: strong family and social supports, above-average intelligence, a sense of humor that facilitates adaptive coping, and an ability to derive meaning from his work educating children about his experiences.

Motivation

Consistent with the MI assumption that the experience of ambivalence is a natural part of change, Stanley demonstrated considerable ambivalence upon intake. In his previous therapy, he had expressed uncertainty about whether he truly suffered as a result of his traumatic experiences. Indeed, it is likely that Stanley's consistent minimization of symptoms prevented Stanley from engaging in trauma-focused treatment, in spite of being diagnosed with PTSD by his previous clinician. During the assessment, Stanley continued to minimize his symptoms, and expressed doubt about the legitimacy of a PTSD diagnosis in his case, oftentimes comparing himself to other veterans who had undergone events he deemed to be more severe as if he was "unworthy" of the diagnosis. By comparing his own traumatic experiences to those of others in this way, Stanley expressed the belief that his suffering did not justify the same label. In short, he endorsed the belief

that his symptoms were not sufficiently severe to merit diagnosis or treatment (Stecker et al., 2011). Stanley's ambivalence was also likely influenced by his previous response to treatment. Although his anxiety and depressive symptoms were reduced over the course of previous treatment, he also reported that discussing his experience in Vietnam with his former clinician had triggered the re-experiencing of his traumatic memories. Stanley said he wished to return the "snakes" of his traumatic memories to a mental "box" that would never be re-opened. Accordingly, he expressed a desire to continue avoiding the painful memories in a way that was consistent with PTSD pathology (Snell & Tusaie, 2008). In spite of these concerns, however, Stanley had experienced positive gains from past individual treatment as well as ongoing participation in a veterans support group. This contributed to his positive view of CBT, which was further strengthened by his previous connection with the primary investigator in the context of the support group. Stanley's ambivalence resulted from a combination of his positive experiences in treatment and his dismissive view of his own symptoms.

In order to clarify the specific nature of Stanley's motivation, the client was asked to complete the CMOTS, a self-report measure designed to assess various types of motivation. Results indicated that Stanley had some intrinsic motivation to participate in treatment. However, he also exhibited similar levels of external regulation, indicating that his pursuit of treatment was influenced by environmental factors. Additionally, his levels of identified and integrated regulation suggested that he was motivated for treatment in part by his pursuit of personal goals and values, respectively. Most notably, results indicated that Stanley's strongest motivating factor may have emerged due to introjected regulation. This finding suggests that Stanley may have been primarily motivated to participate in the present study due to feelings of guilt or anxiety that resulted from a previous externally motivating reason that was no longer present at the time of assessment (e.g., a

spouse who had expressed the importance of the client individually engaging in treatment in the past). Relative to his levels of extrinsic and intrinsic motivation, Stanley's level of amotivation was comparatively low, suggesting that he understood his purpose for engaging in the study. Stanley's reasons for and against change were further explored during the pretreatment. (Pelletier et al., 1997)

Treatment

Initial Conceptualization

Stanley's PTSD symptoms and associated beliefs were influenced by the coalescence of several factors, including his experiences prior to joining the Army, socialization to military culture, exposure to traumatic events in-country, and his individual and national reception upon his return from war. An outgoing and ambitious person from his youth, he reported striving to achieve in academics, sports, and social relationships throughout childhood and adolescence. Stanley appeared largely successful in his efforts, performing well on several athletic teams, graduating from high school and studying engineering in college, and marrying his wife at a young age. In each of these realms, Stanley strove to occupy a position of leadership and responsibility that allowed him to seek to protect others. This practice was influenced in part by modeling within his family; Stanley recalled the memory of telling his parents that he had been drafted, and watching as his father deliberately assumed a nonchalant manner to reassure his mother that Stanley would be safe. These experiences reinforced Stanley's belief in the importance of self-reliance and responsibility, as well as the primacy of protecting others' safety and well-being. These beliefs were further strengthened by the influence of masculine socialization. As a result of these experiences, Stanley learned to view others as trustworthy but vulnerable, in need of his guidance in a world that he viewed as largely safe.

His experience of being drafted into the Army altered his worldviews in various ways. After being drafted, Stanley spent over a year in training, leading him to conclude that he would not be sent overseas. He was so certain of this that he decided to start a family. Accordingly, his surprise at being sent to Vietnam in combination with his awareness of the danger of war likely had the effect of undercutting his belief in the safety and predictability of the world. On the other

hand, his views of himself as effective and responsible for the welfare of others, whom he regarded as needing his protection, were likely strengthened by the culture and mission of the Army.

Furthermore, as a fire control technician, Stanley had the task of ensuring that soldiers were able to rely upon their weapons to defend themselves in battle. In this role, Stanley was taught that he was directly responsible for the lives of his fellow soldiers, a lesson that further intensified his perfectionism. Within the military, Stanley learned that, just as others' lives depended upon his ability to do his job, so too did his life depend on the performance of other soldiers, whom he did not wholly trust. In addition to reinforcing the masculine norm of serving in the role of protector, military culture also likely strengthened his belief that strong men must always be in control of their emotions and avoid any expression of anxiety, fear, or sadness, lest it impair their performance in the field and endanger the unit. This practice likely helped him act effectively during the tank retrieve fire, as he described feeling no fear during the incident, focusing instead on the task of extinguishing the fire. An hour after the danger had passed, however, Stanley realized that his hands were trembling in fear. The impact of training and masculine socialization within the military likely contributed to his delayed awareness of his fear, and similarly likely influenced Stanley's belated reaction to traumatic events.

Stanley's natural response to the grenade drill accident, rocket attack, and tank retriever fire included either immediate or delayed feelings of intense fear and helplessness. Faced with repeated threats to his life or the lives of nearby soldiers, Stanley was struck by the limits of his control over his safety. Referring to the rocket attack that he initially thought was an atomic bomb, Stanley recognized that he would have been killed by shrapnel had he been a few feet further in one direction. Over the course of his tour, and particularly during each traumatic event, Stanley experienced a fear response that led to the creation of a fear network through classical

conditioning. This network included environmental stimuli related to the incidents, such as grenades and sudden noises, as well as Stanley's physical (e.g., arousal), emotional (e.g., horror), cognitive (e.g., memory of the trauma), and behavioral reactions (e.g., escape response) to the event. When any of the associated cues were triggered after his tour, the whole network was activated, leading to Stanley's re-experiencing of the traumatic event. Stanley avoided the re-activation of his traumatic memory by pushing away the memory and associated emotions, thereby inadvertently reinforcing the connections in the network. These avoidance behaviors prevented him from habituating to the fear associated with the trauma and learning that he could survive and tolerate the distress of the traumatic memory, just as he survived the initial event. In this manner, the repeated activation of the fear network and subsequent cognitive or behavioral escape behavior contributed to the development and maintenance of re-experiencing, hyperarousal, and avoidance symptoms of PTSD.

Experiencing numerous traumatic events in Vietnam also led Stanley to strengthen, appropriately modify, or fully renounce previously held beliefs, in some instances further contributing to PTSD symptoms and associated features. His original belief in the importance of self-reliance and responsibility toward others had previously led him to view himself positively as a young man who had excelled in his schooling and family life. Stanley's experience of fear and helplessness in the face of uncontrollable danger likely interacted with and strengthened his previous belief in his responsibility for others' safety. After experiencing the primary emotion of horror associated with the grenade drill accident, he focused on his own fleeting interaction with the injured soldier and blamed himself for not preventing the accident, contributing to feelings of intense secondary guilt. Stanley also questioned his performance as a fire control technician, worrying that he may have contributed to soldiers' deaths with any errors in his work. In addition,

his reticence to share his experience in Vietnam with his wife was borne of his desire to protect her from experiencing emotional pain. Stanley's subsequent avoidance of the traumatic memories and associated cues, as well as his attempts to suppress related affect, likely preserved his strengthened belief in his need to have control and protect others, in spite of experiences that contradicted this view. As explained above, such avoidance and striving for emotional control contributed to Stanley's re-experiencing and hyperarousal symptoms (Lorber & Garcia, 2010). Furthermore, Stanley's early belief that he was duty-bound to protect others was likely impacted by his realization that he could not exert such total control in war, thereby further exacerbating his experience of helplessness. Relatedly, his realization that his life was threatened not only by the enemy, but also by the fallibility of American soldiers, led him to alter his view of safety, believing that the world was truly dangerous. Combined with his increased arousal symptoms, this belief led him to experience hypervigilance, which manifested in behaviors such as sitting facing the door at all times.

The avoidance of traumatic memories and associated primary emotion contributed to both re-experiencing and hyperarousal symptoms. For Stanley, avoidance came in the form of attempting to push away the specific traumatic memories, avoiding particular veterans organizations, affective blunting, and a sense of foreshortened future. Although he spoke of Vietnam in the role of an educator, he did not share or willingly revisit the traumatic events described here. Similarly, he did not discuss his experiences in Vietnam with his wife or family members, though he taught others' children about the war. In avoiding any discussion of his experiences with family members, Stanley also believed he was serving in his role as protector by sparing his wife from recalling the anxiety she experienced during his tour. Furthermore, Stanley's guilt, brought forth by his exaggerated sense of responsibility for others and associated belief that

he had failed fellow soldiers, kept him silent. This guilt was exacerbated by his experience of being reviled upon his return to the U.S. As a result of his avoidance of the traumatic memories and associated fear, as well as his pervasive guilt, Stanley “didn’t mention Vietnam ten times” in the three decades following his return from war.

Although Stanley reported that his PTSD symptoms did not emerge until thirty years after his return, the traumatic experiences exerted a negative impact prior to that time. Stanley reported that he had not been able to discuss his experiences in Vietnam with his wife or family for reasons discussed above. In addition, he had reported previous episodes of excessive alcohol use and angry outbursts that had occurred throughout his life, contributing to past marital problems. Although he likely experienced the after-effects of trauma throughout adulthood, his acute symptoms reportedly emerged after he visited a war memorial. Seeing the memorial triggered the resurgence of memories he had attempted to keep “locked away,” and spurred additional feelings of survivor guilt. In part, his experience of guilt led him to begin volunteering to educate youths about the war, a role that allowed him to derive some sense of meaning from his combat experiences. However, Stanley’s continued avoidance of the most distressing traumatic memories and attempts to suppress associated affect, combined with the continued impact of his altered worldviews, served to maintain his PTSD symptoms.

Stanley’s beliefs regarding the importance of self-reliance, control, and responsibility toward others (particularly family members) also impacted his experience of numerous medical problems. Battling life-threatening diseases such as colon and prostate cancer, as well as COPD, likely forced Stanley to recognize his vulnerability to bodily threats, much like his combat experience forced him to acknowledge his inability to control all aspects of his physical or emotional well-being. The interactions between Stanley’s experience of life-threatening illness and

his valuation of independent control led to the assimilation of these experiences with his original views, such that he experienced intense distress due to the thought that he should not experience such vulnerability. Speaking of one instance in which he found himself stranded on his street, unable to walk home due to COPD symptoms, he expressed sorrow related to his perceived weakness. In addition to feelings of distress, Stanley also likely felt guilt for his inability to exert the control he desired. Furthermore, like his experiences in Vietnam, Stanley's medical problems contradicted his early beliefs regarding safety. Whereas he had seen himself as strong and healthy throughout his life, returning from a war that had taken many others, this view was compromised by his repeated bouts of illness. From his perspective, the world could be seen as particularly unsafe due to the unexpected nature of negative events; while he returned from Vietnam with minimal physical injuries, Stanley's exposure to dioxin led him to develop cancer years after his return. Accordingly, his experience of combat and health problems impacted his worldview significantly, contributing to a position that emphasized the danger of potential internal, as well as external, threats. Such beliefs regarding the pervasive danger of his surroundings and the necessity for total control over oneself and one's environment led Stanley to attend to evidence consistent with these views, thereby reifying his unrealistic beliefs as well as the associated PTSD symptoms.

In spite of the self-maintaining nature of his trauma-related symptoms, Stanley had a natural inclination toward positive, healthy change. Despite his urge to avoid stimuli associated with the Vietnam War, Stanley had visited a war memorial to honor the memories of other soldiers. Even as he experienced the distress of PTSD symptoms following this triggering experience, his desire to pay homage to those who did not return from the war led him to assume the role of teacher, educating children about the war. In addition, he elected to join a support group for veterans, in which he was an active member. Though motivated in part by his desire to allay

feelings of survivor guilt associated with PTSD, these actions bespoke Stanley's intrinsic orientation toward recovery, as they allowed him to experience a sense of meaning associated with his experience.

Stanley's tendency toward health was counterbalanced by the barriers that deterred him from engaging in treatment. In particular, the avoidance associated with PTSD posed an obstacle to his willingness to fully participate in individual treatment. Although he spoke with schoolchildren of his overall experiences in Vietnam, he did not share his traumatic memories. Instead, he typically utilized humor to paint a less harrowing picture of combat for children and civilian adults alike. In addition to avoiding the traumatic memories in a manner consistent with his diagnosis, Stanley expressed a desire to suppress related thoughts and feelings, to put his "snakes back in the box" and ignore them. This desire was influenced in part by his belief in the importance of total emotional control, and the danger associated with perceived vulnerability. As discussed earlier, the masculine socialization that Stanley experienced throughout his life further reinforced this view of emotional distress as indicative of personal weakness. Moreover, Stanley's survivor guilt led him to minimize his symptoms and associated suffering due to his belief that he did not "deserve" the diagnosis of PTSD, which he viewed as reserved for those "grunts" who had survived the most grisly of combat experiences. Finally, Stanley struggled to engage in individual sessions due to his COPD, which made speaking for extended periods of time challenging.

Stanley's experience of ambivalence related to pursuing treatment for PTSD impacted the nature of his motivation for engaging in CBT in the context of this study. The results of the CMOTS indicated that Stanley's strongest motivation for treatment resulted from the influence of introjected regulation. That is, Stanley may have previously received feedback from an external source that led him to experience feelings of guilt that motivated him to pursue treatment at the

time of the study. He reported that his wife had described him as altered upon his return from the war. Combined with his view of himself as a responsible man who addresses problems head-on, this feedback may have spurred dissonance and associated feelings of discomfort that continued to exert an influence on his participation in the study. In the course of the motivational interviewing pretreatment, Stanley's desire to share his experience with his grandchildren also proved to be a strong motivational factor, as he wished to have his story remembered in future years. Finally, Stanley's participation in the present treatment may have been influenced by his desire to contribute to research that might prove helpful to other veterans as well as the PI, with whom he had a previous working relationship in the context of a veteran support group.

Treatment Plan

Although Stanley experienced both subjective distress and impairment in his ability to connect fully with his family as a result of PTSD, his ambivalence about treatment was significant. As MI has been demonstrated to help veterans suffering from PTSD engage more fully and benefit from psychological treatment, the MI pretreatment incorporated into the present study was deemed appropriate. Devoting initial sessions to exploring, evoking, and enhancing Stanley's personal motivation for treatment was especially suited for the client, given the specific nature of his ambivalence, which was largely influenced by PTSD psychopathology itself (e.g., avoidance, survivor guilt). Accordingly, as described above, three MI pretreatment sessions were added to the course of Cognitive Processing Therapy for PTSD. Pretreatment goals included: helping Stanley identify core values and recognize the impact of PTSD symptoms on his ability to live in a manner consistent with his values; enhancing his motivation to address symptoms in order to allow him to meet personal goals; and agreeing upon an appropriate plan.

To work toward these goals, the initial sessions focused on the processes of building client engagement, focusing on the possibility of change, evoking reasons for change, and collaboratively planning a course of action. Further details regarding the focus of each of the three sessions can be found in Section 2. Beyond addressing Stanley's initial motivation for treatment, the discussions that took place during the pretreatment would also be incorporated throughout subsequent CPT treatment in order to help him connect the difficult work of treatment with the pursuit of his personal goals.

Given the client's clear trauma-related distress, it was the hope of the PI that Stanley would elect to engage in PTSD treatment offered in the present study, as he did. Goals for CPT treatment included reducing overall PTSD symptoms. For Stanley, this included reducing his experience of flashbacks, intrusive thoughts and images of the traumatic events, acute anxiety, difficulty sleeping, day-to-day physiological arousal, and irritability. Treatment was also targeted toward dispelling his belief in his responsibility for the deaths of others, and associated survivor guilt and rumination. Additional goals of treatment included helping Stanley speak with his close family members about the traumatic memories as a man (rather than as an educational authority on Vietnam), and experience a larger range of emotions, including sadness as well as joy and love. Finally, while the anxiety and depressive symptoms associated with Stanley's ongoing medical problems were not an explicit target of CPT, it was the hope of the PI that Stanley's improved ability to cope with difficult affect and increased emotional connection and engagement with loved ones would help him manage medical stressors.

CPT for Stanley involved engaging the client in psychoeducation regarding trauma, natural responses to trauma, and the factors that contribute to the development and maintenance of PTSD. For Stanley, the therapist sought to emphasize the biological basis of physiological and emotional

responses to trauma in an effort to normalize the traumatic response he suffered (Lorber & Garcia, 2010). Such a discussion was intended to help Stanley revise his initial understanding of PTSD as a disease that is “earned” only by those who suffered the most violent and grisly of traumatic experiences—a view largely influenced by his experience of masculine socialization (Lorber & Garcia, 2010). Psychoeducation was aimed at helping Stanley see PTSD as a disorder of natural recovery from trauma, as posited in CPT. With this perspective, the therapist sought to engage the client in cognitive work to dispel his notion that experiencing such a response without first undergoing the worst imaginable experiences was a marker of personal weakness. Rather, his active engagement in a difficult treatment was framed as a brave step toward fighting against his PTSD in pursuit of his values.

Subsequent sessions were aimed at helping Stanley recall the traumatic memories and process the associated primary emotions by repeatedly writing and reading his recollection of the event. By engaging in this process, the PI intended that Stanley would habituate to the natural affect and weaken the fear network connections that contributed to re-experiencing symptoms. In later sessions, the therapist attempted to collaborate with Stanley to identify instances of assimilation and over-accommodation in his foundational beliefs related to issues such as safety and self-esteem. These cognitive interventions were aimed at helping Stanley come to realistic beliefs on these topics. Combined with reduced re-experiencing, hyper-arousal, and avoidance symptoms, as well as his revised evaluation of the traumatic event, these updated views were intended to allow Stanley to reach the personal goals identified during pretreatment.

Course of Treatment

Pretreatment Session 1

As described in Section 2, the overarching goal of the initial pretreatment session was to engage the client. Accordingly, key tasks included continuing to build rapport in the context of a collaborative relationship, jointly setting the session agenda, discussing assessment results, and engaging in a discussion of Stanley's personal values as they related to his participation in the present study and PTSD. In this discussion, the therapist had hoped to begin developing discrepancy that might have led to the identification of potential goals for change, and reflect this dissonance and as well as any possible areas for change to the client while drawing upon the spirit of MI.

When Stanley entered the room, he spoke of ways he was helping to care for his wife following a recent surgery she underwent, as well as their desire to take several trips following her recovery. The therapist began the process of identifying and reflecting Stanley's values, naming and affirming his clear commitment to taking care of his loved ones, as well as his value of being active in seeking out new and enjoyable experiences. In addition, the therapist spoke with Stanley about his future travel plans. This discussion as well as the affirmation of the client's values and strengths helped to build rapport and convey unconditional positive regard in an open, collaborative therapeutic relationship.

In discussing the agenda for the day's session, the therapist suggested having a conversation regarding the assessment results, the client's reactions, and his personal reasons for participating in the study, and elicited Stanley's input on the agenda. Stanley spontaneously expressed his enjoyment of the group, stating that while his supportive interaction with other members was fun, his previous experience of individual psychotherapy had also led him to

examine painful issues. In this moment, Stanley began voicing his ambivalence regarding individual therapy for PTSD. The therapist reflected his ambivalence back to Stanley, and extended his initial statement to emphasize the ways in which the group had allowed him to address painful experiences with the support of fellow veterans, as well as a sense of humor. In so doing, the therapist sought to both acknowledge Stanley's natural ambivalence and highlight his strengths, including personal humor as well as the support of the group.

Before providing assessment feedback, the therapist elicited the client's reaction to the assessment. Stanley stated that he was aware of suffering minimal PTSD symptoms, as well as his reticence to "admit to that much," saying "two and a half years ago...I was adamantly, 'No, I don't have any problems whatsoever.'" Stanley gave voice to his remaining ambivalence as well as his continued progression in recognizing the impact of traumatic experiences, indicating that he was likely in the "contemplation" stage of change, in accordance with the transtheoretical model (DiClemente et al., 1991). In discussing the nature of PTSD, the therapist normalized the disorder as an indication of his strength and adaptability in battle (Lorber & Garcia, 2010). The therapist engaged Stanley in a conversation of the client's re-experiencing, avoidance, arousal, and cognitive symptoms. While discussing the nature of intrusive symptoms, Stanley continued to voice his ambivalence related to directly addressing his PTSD, stating, "Now [the previous therapist has] opened Pandora's Box on me, and here I'm fighting all these snakes...I was real happy when I didn't have to deal with them. But now...I can't stuff them back in." In offering a reflection, the therapist validated Stanley's desire to suppress the snakes of his memories as well as his disappointment that this approach had not proven helpful due to the nature of PTSD.

In the course of discussing relevant symptoms, Stanley voiced another source of ambivalence:

Stanley: “I’m willing to admit all those things and agree with them. However, the other side of me looks out at a guy like Walter [a fictitious name], who had one of his best buddies get shot and killed five feet from where he was, and I don’t have any experiences like that. Mine, on a scale of one to ten, was a two...Walter has PTSD—he couldn’t avoid it...I don’t have that resume.”

Therapist: ...On the one hand, you see what’s going on for you in the here and now. You see these memories. On the other, being in the group, you almost feel like you haven’t had the experiences other guys have, so how could you have the same thing that they do?

In reflecting Stanley’s ambivalence, the therapist wondered if he held the belief that “I might not deserve to [address] this, because it might not be as bad as others’ [problems].”

Acknowledging this thought as one that had troubled him, Stanley spontaneously recalled a conversation with an employee at the VA hospital who had told him, “Don’t you know that you earned these benefits?...Besides, if you don’t use it...Washington will cut our budget, and then we won’t be able to take care of anybody.” Recognizing the significance of this conversation, with the client had recalled verbatim, the therapist reflected and extended this experience, stating “The concern was, ‘Am I taking something away from one of my brothers?’...Part of the thing that made you come to the realization that you did was that being part of the community of veterans who are served by the VA, you’re being there from your brothers... By maintaining that there is this need...By advocating, almost.” In the course of this discussion, it became clear that Stanley’s value of protecting others, including other veterans, interacted with his view of his PTSD symptoms, as well as his willingness to engage in treatment. This value was highlighted in an affirming summary: “The thread I see is how strong your sense of commitment to others and that camaraderie [are]—whether that’s downstairs [in group], whether that’s in the VA, whether that’s while you were still serving. That’s a very strong value for you.” Once this value had been named

and reflected, Stanley became increasingly reflective, and described a particularly poignant experience of survivor guilt while looking at the names of fallen soldiers at the Vietnam War Memorial.

Stanley: It dawned on me that those guys on that wall, those names, they can't talk anymore. Somebody silenced them. And here I am, able to walk and talk. So maybe I have to talk for them...Maybe it's my responsibility to them.

Therapist: Being the voice for those who can't talk...being their representative is a big value for you.

Stanley: It justifies me being alive in my mind. It gives me a reason.

Stanley's expression of survivor guilt underscored several key personal values, including his commitment to honoring fallen veterans, and giving voice to their experiences. These values were recognized as potential motivating factors for Stanley's engagement in individual treatment. After highlighting these values, the therapist worked with Stanley to explore other personal values using the Values Card Sort (Miller et al., 2001; see Table 4). His identified values included: commitment, family, faithfulness, comfort, pleasure, humor, leisure, monogamy and sexuality. The therapist affirmed his dedication to his identity as a family man, and asked Stanley to reflect upon and prioritize his stated values prior to the second session.

Pretreatment Session 2

Goals for the second pretreatment session included continuing to discuss Stanley's primary personal values, focusing on the relationship between PTSD and his ability to live in accordance with his values, eliciting ambivalence related to engaging in individual treatment for PTSD, and

evoking change talk. In the process of engaging Stanley in this discussion, the therapist was aware of the nature of expressed change talk (e.g., preparatory vs. mobilizing change talk).

As discussed in the previous session, Stanley had thought about the personal values identified earlier, and prioritized them. In descending order of importance, Stanley's top identified values were: family, monogamy, faithfulness, commitment, and comfort. The therapist engaged Stanley in a discussion of ways he lived in accordance with these values in the past and present. Stanley spoke primarily of the strength of his commitment to his family, which had led him to take on leadership roles, fight larger organizations, and remain close to his grandchildren in spite of a desire to move to a warmer climate. He said, "We do as much as we can with the kids...because as soon as it's gone, it's gone."

To focus on the intersection between Stanley's personal values and PTSD symptoms, the therapist asked Stanley to discuss the ways in which his PTSD symptoms affected his ability to "live out those values—the commitment, the family, the being present with them." In this moment, Stanley's voice lowered as he referred to times in which his grandchildren's antics had triggered his anger. He shared his fear that his anger might negatively impact his relationships with his grandchildren, who had been scared by his previous outbursts, before underscoring the infrequency of these outbursts. Using an amplified reflection to help him argue for change, the therapist said, "There are *very* few times that it gets out of hand to the point that you wonder what impact it could ultimately have on your family...and how your family could see you." Stanley responded reflectively, stating, "Those that are close to me...they know...they're wary, then, of me." This discussion helped Stanley see the discrepancy between his deeply held values and his behavior, as influenced by his PTSD symptoms.

Stanley revealed another way that his ability to live fully in accordance with this value of family was affected, sharing a conversation he had with a nephew approximately six months before. In this discussion, Stanley had asked his nephew if he might like to see Stanley's medal from Vietnam.

Stanley: He said, 'You know, everybody understood for all these years: don't ever bring up Vietnam to Uncle Stanley...I said, 'Really?'

Therapist: How did that make you feel, hearing how other people had stayed away and limited themselves in how they could talk to you?

In this moment, Stanley reflected upon other family members who had minimal knowledge of his military experiences, such as his niece, before continuing:

Stanley: I understood that I had done it. And I understood then that it was a mistake...I didn't want to ever talk about those things, but maybe it was wrong to not ever let them know anything about what I had done, where I was.

Therapist: It cut you off from them in a small way.

Stanley: I did that, yes. But now I said, 'Well, now I can talk to you about them, because I'm getting older and if I don't talk to you about them, then you'll never know anything. And maybe you should know something about me. I mean, I never told my kids very much.

Therapist: At the time, you thought that was the way you wanted it to be. That was the only way you could be with them. But something changed.

In relating this discussion, Stanley had demonstrated desire for change so that he might be known by the younger generation. In addition, his recent efforts to engage select relatives indicated to both Stanley and the therapist that he was able to change the way in which he interacted with his traumatic memories in the service of his values. The therapist encouraged Stanley to continue

engaging in change talk by asking him to elaborate on his experience sharing limited aspects of his experience with this nephew, and more recently, his son. Stanley responded:

It was something akin to setting me free in some ways, to where I had put up this fence, this wall, and okay no I tore it down, and maybe that's a good thing. On the other flip side of that coin is that, for me, now that I'm talking freely with those around me about certain things, well I didn't only tear down the fence for them. I tore it down for me, too. Which means that some of the snakes that I let out of the box, I've got to deal with. Which is why I'm talking with you...because I go into the same shell, it won't be the same...This time I know that the key has been found to those cabinets, and I won't be able to lock it up like I did for those thirty years.

Here, the client expressed his desire for change, describing the freedom of tearing down the barrier that PTSD had erected between Stanley and his loved ones, as well as his need for change, absent a viable alternative. The therapist reflected both elements, including his need to “contain the snakes” that had been let loose. Offering a brief summary, the therapist said, “The side of you that people know—the business, the work, the gambler, the sports coach, the local representative...that left you incompletely known, that you weren't able to have that connection. And that's why you chose to do this.”

Pretreatment Session 3

In the final session of the pretreatment, the therapist had hoped to continue evoking and strengthening Stanley's change talk. Previous conversations indicated that Stanley had a clear desire and need for change, citing his urgent desire to connect with his family by sharing his experiences in Vietnam as a primary reason for engaging in PTSD treatment. As his expressed desire, reason, and need for change appeared apparent, the therapist sought to focus on helping

Stanley bolster his sense of self-efficacy in the task by affirming strengths and past successes. The therapist had also intended to offer a summary of Stanley's previous statements related to his motivation for PTSD treatment before engaging him in a planning discussion. In discussing Stanley's desired plan, the therapist's goal was to identify, elicit, and strengthen the client's commitment to change, preparatory activation for change, and any steps taken toward change. The therapist's final goal was to ask permission to provide Stanley with information about participation in the study as a means of addressing PTSD and working toward his goals, and eliciting Stanley's commitment toward pursuing change in the way he wished.

At the start of this session, Stanley was describing a recent trip he had taken with his wife, during which the couple had taken time to shop for presents for their children and grandchildren. The therapist reflected upon this as evidence of Stanley's strong commitment to maintaining his connection to the younger generations in his family. In the course of this discussion, the therapist summarized the previous session before shifting focus to Stanley's efficacy in acting upon his values: "You have the commitment to work toward that connection... You already started talking about this last time... when you were sharing things with your nephew. Can you tell me about other times when you feel you've been successful in starting to open up or address the PTSD specifically?" Stanley responded by recounting a memory of showing his son the medal he had received for his service. Stanley described telling his son that he had been awarded the honor for doing his job in accordance with his training. In an effort to highlight Stanley's personal role and affirm his strengths, the therapist asked Stanley to reflect upon the characteristics that had allowed him to act effectively when faced with a burning tank.

Stanley: It's tough to give myself any praise... but I guess you could say I had a sense of right and wrong.

Therapist: In that moment, you felt like you drew upon that sense of knowing what was right and wrong, having that gut instinct of what you need to do...and going immediately to that...that's from you...your ability to think on your feet and commit to doing your duty.

To further reinforce Stanley's sense of self-efficacy, the therapist asked him to discuss the experience of sharing his memories with his son as an activating step toward change. In the course of this conversation, Stanley expressed his previous reservations about sharing his memories, stating "I really didn't think anybody wanted to hear, and that went on for thirty years." In this instance, the therapist affirmed the strength of Stanley's commitment to fostering a close relationship with his son, as "it took some guts to...go out on that limb when [Stanley] was thinking that nobody wanted to hear about it." Facing the emotional pain associated with difficult memories as well as his fear of sharing a traumatic experience with his son was shown to be an act of courage (and a testament to his ability to undertake the challenge of trauma-focused treatment). This understanding of the act of sharing his experiences was in line with the values revered within the military culture, as well as Stanley's strong desire for close connection with family members who would be enriched by carrying his memories.

Subsequent discussion focused on helping Stanley articulate potential goals associated with his expressed values, and collaboratively planning steps toward change. In discussing his goals, Stanley once again referred to the "snakes" of his traumatic memories: "I can't destroy them...But I can conduct myself in a manner that they don't... affect me negatively." The therapist reflected and extended Stanley's expressed desire to master his trauma before further probing how he imagined this might look. Two primary goals emerged: to share aspects of his experience with chosen family members, and "not have that become a trigger to make [him] lose sleep that night." At this point, Stanley had verbalized his desire for change, as well as the personal reasons behind

his specific goals. In addition, he had spoken of previous steps he had taken by sharing his medal with his son, as well as his willingness to work toward speaking with younger members of his family. Believing that Stanley had not only accessed, but also significantly increased his motivation to change, the therapist asked for the client's permission to discuss potential steps toward Stanley's goals. Stanley assented, and then retreated:

Stanley: Tell me, is that an admission on my part that I'm telling you I got a problem? Or think I do? 'Cause I don't know that I have said that, and I don't know if I'm thinking that.

Therapist: Okay.

Stanley: But maybe I am. I don't know. I'm investigating it.

At this moment, the therapist saw Stanley's hesitation and the resulting fluctuation in his readiness for change when facing the development of a concrete plan. As the client had expressed his uncertainty related to "a problem," the therapist hypothesized that may have been experiencing additional shame associated with considering treatment for a trauma-related disorder that he did not believe he had "earned" in the course of his service. Rather than challenging Stanley's hesitation and natural ambivalence, the therapist drew upon the spirit of MI and attempted to "roll with resistance" by presenting a summary that focused on reflecting Stanley's stated goals and strengths.

Therapist. You're investigating it. I like that. Well, what I've heard from you is that what you're talking about is: becoming as open as you can with the people you want to know you completely, and enjoying all of your time...with your wife...with your family. And that some of these...traumatic memories are getting in the way of that. They're affecting your sleep. They're affecting you much you feel like you can relate to somebody because they...make you close off

that part of yourself. And if you're pushing these things away, you can't open up to talk to your nephew or granddaughter... That's what I've heard. So regardless of label, what I've heard from you is that the reason that you wanted to investigate and explore this possibility is because you see these things as really important to you. And furthermore, you see yourself as being able to address them, based on previous experience.

Stanley responded with increased expressed commitment, expressing willingness to discuss potential steps. With the client's renewed permission, the therapist posited the present study as one opportunity to help Stanley cope with the effects of trauma, so that he might pursue his goals of sharing his difficult experiences with his loved ones with minimal distress. In doing so, the therapist stressed the availability of other possibilities, and supported Stanley's autonomy in choosing his desired path. Responding in kind, Stanley stated, "Yeah. I'd like to see what your program will do... I'll tell you if I need to quit," with a laugh.

Treatment Session 1

Based upon the protocol put forth by Resick, Monson, and Chard (2008), the first session is largely centered around psychoeducation and orientation to treatment. In addition, this session includes a cursory review of the most distressing traumatic memory, the preliminary identification of potential "stuck points" to be addressed later in treatment, and discussion of the first assigned "impact statement" of the effects of the traumatic experience. As the therapeutic relationship with Stanley had been developed in the context of the veterans support group, as well as during the assessment and pretreatment, the therapist placed less emphasis on explicit rapport building. During the initial session, Stanley's expressed values and primary goals for treatment were primarily referenced by both client and therapist when looking ahead to the process of therapy.

The therapist also attempted to draw upon the spirit of MI, as well as the associated interventions, including a heavy stress on collaboration, reflection, validation, and support of Stanley's autonomy.

In this vein, the therapist expressed a desire to spend more time speaking to give Stanley information about PTSD and the present treatment, and obtained Stanley's assent before continuing. As Stanley had reported experiencing the highest distress related to his memory of the grenade drill accident, the therapist engaged him in a psychoeducational discussion grounded in Stanley's report of recent symptoms associated with this memory. The therapist explained the influence that Stanley's efforts to "push away" likely had on his re-experiencing symptoms, including nightmares as well as intrusive memories, and the associated arousal symptoms. While speaking of the ways in which the fight, flight, and freeze responses might be activated by internal stimuli or external triggers as well as the role of conditioning, Stanley discussed the resurgence of memories and associated symptoms he had experienced in his previous individual treatment. Normalizing his experience as the result of conditioning, the therapist also validated his avoidance symptoms as a "double-edged sword: when you avoid [the memories]...you're not experiencing that pain. And yet at the same time, when you avoid them, you amplify them." In this way, the therapist presented PTSD as a disorder of recovery following trauma, as presented in CPT and represented in the psychoeducational handout (Handout 1; see Table 5).

In discussing the primary source of his distress, Stanley reported feeling intense guilt the previous night, prompted by intrusive memories and thoughts of Vietnam. He linked this guilt with his fear that he was "not performing at 100% efficiency" and "maybe somewhere along the line, [he] fixed one of those instruments wrong," leading a soldier to be killed or injured. In addition to reflecting the pain of Stanley's feelings of guilt and acknowledging Stanley's characteristic desire

to perform at his utmost, the therapist suggested that Stanley's guilt and associated beliefs about himself were affected by his experience of trauma. At this point, the clinician engaged Stanley in a conversation about the ways in which assimilation and over-accommodation that can result from undergoing experiences can shake one's entire worldview, leading to manufactured emotions such as guilt, in addition to the natural feelings associated with suffering traumatic events.

During this discussion, the therapist shared common beliefs associated with PTSD using a handout of stuck points (Handout 2; see Table 5). The therapist wondered whether Stanley might be assuming responsibility that was not his to shoulder as a result of the "just world belief." Stanley stated that he recognized his feelings as survivor guilt, but nonetheless thought that, "if I had been bright enough...maybe I could've prevented it." The therapist reflected Stanley's feeling of sadness and guilt, while also highlighting the potential influence of hindsight bias. In addition, the therapist related this belief to his earlier statement that he had somehow "ordained it," the grenade drill accident, to happen. Stanley stated that he was 99.8% sure that he had executed his tasks correctly, but experienced significant distress because he was not 100% certain. The therapist sought to normalize his distress and frame his survivor guilt as a product of assimilation associated with PTSD: "In spite of that 99.8%...your brain wants to think...because things go wrong, maybe I'm the one responsible." This discussion indicated that Stanley's strong belief in his responsibility for the grenade drill accident, as well as the well-being of the soldiers whose weapons he fixed, constituted a stuck point and a focus for future examination. Accordingly, the therapist did not continue challenging this thought.

The therapist also acknowledged the influence of Stanley's values on his belief regarding his guilt, stating that, based on "that sense of responsibility that you take upon yourself as a leader, you probably expect a hell of a lot more from yourself than you do from the guy beside you."

Stanley agreed that he expected himself to be “Superman...because I knew that mistake I made could be catastrophic, I couldn’t allow myself to make one.” While acknowledging the client’s commitment to perfection in the service of protecting his fellow soldiers as well as himself, the therapist also linked Stanley’s expectations and the resulting guilt with his present valued position as a grandfather desiring to be close with his family members, wondering the impact that his guilt had on his relationships. The clinician framed one aim of treatment as examining his beliefs carefully and determining his desired present stance rather than allowing the PTSD to mold his beliefs and associated actions. In these discussions, therapist and client hearkened back to the discussions about Stanley’s values, linking Stanley’s engagement in treatment that would address present symptoms and challenges with his client’s long-term goals.

Before continuing a discussion of other goals of treatment, including experiencing emotions associated with trauma, the therapist asked Stanley to identify his most distressing memory in brief. Stanley identified the grenade drill accident, and briefly described the experience, continuing to verbalize his regret that he did not foresee the accident. Drawing upon the spirit of MI, the therapist obtained agreement from Stanley to utilize treatment to revisit this memory, feel the associated emotions, and determine his true thoughts related to any “stuck points” that emerged from his experiences in Vietnam. In response to the therapist discussing experiential avoidance as found in PTSD, Stanley stated that he had not noticed the enduring impact of the trauma on his beliefs, which had been building over time. The therapist related the work of questioning his stuck points to his ultimate goal, stating “If there are stuck points that you feel, you can change those a little bit...that you would be more able to open yourself up to other people, then that just brings you closer to where you want to be...in terms of father, grandfather, family member. And that’s the whole point...to look where you are right now and if this is where you want to be.” In this way, the

therapist once again linked his full engagement in treatment with his values, while also supporting his self-determination. In the final moments of the session, the therapist discussed the impact statement, in which Stanley would write about his thoughts regarding why the traumatic event happened, and how it altered or strengthened his worldviews, and anticipated any obstacles to completion. At this time, the Stuck Point Log was also introduced to track identified stuck points (Handout 3; see Table 5). Stanley continued to verbalize his commitment to the therapy, while also expressing his ambivalence about sharing his traumatic experience with those closest to him.

Treatment Session 2

Goals for the second session included collaboratively setting the agenda before having Stanley read the impact statement aloud, jointly identifying potential stuck points apparent in the impact statement, reviewing the CBT model and formulation of PTSD, and discussing the ways in which his thoughts, feelings, and actions impact one another. To elucidate this relationship, the Activating Event-Belief-Consequence (A-B-C) Worksheet was used to help Stanley recognize the specific beliefs that were activated by various events, related primary emotions, as well as the associated consequences (Handout 5; see Table 5). Furthermore, the A-B-C sheets were used in and out of session to question the accuracy of these beliefs and articulate an alternative perspective, if appropriate.

In the impact statement, Stanley wrote that he believed the grenade drill accident occurred “because a young soldier was not properly trained about throwing a grenade, but also because I did not realize that he was scared and trying to reach out for help. Often I think about that failure on my part, and how my innocent behavior of changing positions in line, and the ensuing drop of the grenade, resulted in one dead and two seriously wounded.” Referring to the long-term impact that

the traumatic event had on his personal views, Stanley wrote that, as a soldier, he had initially developed “increased confidence” that he would “be able to control my own destiny, and find a way out of each and every dangerous situation I would experience.” Nonetheless, Stanley stated that he frequently thought about his “fallibility,” worrying “about if I ever did something that caused harm to some good guys. I know that my actions at the grenade drill did so. I can only wonder if some other action—mistake—did so as well.”

In discussing his experience of writing the impact statement, Stanley revealed that he had read the fourth version of the impact statement. Upon inquiry, he disclosed that his fear that he had made an error in repairing weapons caused him to become stuck in previous iterations of the impact statement. Stanley’s difficulty with the question of his responsibility, not only related to the grenade drill accident, but also to his work fixing instruments, indicated the presence of a stuck point resulting from assimilation that would be discussed later on. In the moment, however, the therapist utilized Socratic questioning to elicit Stanley’s thoughts about the factors that influenced the successful discharge of weapons outside of his own repairs. In the course of this discussion, the client identified other factors that influenced the well-being of soldiers, and recognized the evolution of his beliefs regarding the extent of his control in the world.

Based on Stanley’s reported experience of writing the impact statement, the therapist engaged Stanley in identifying stuck points that had arisen in that process. The first that emerged was Stanley’s belief that his failure led to the deaths of others. Discussing his traumatic memory, Stanley described a frequent “daydream” in which he had successfully prevented the accident by speaking with the soldier. In response to Socratic questioning, Stanley stated that, although a positive outcome might not have been likely, he believed it would have been possible. The therapist encouraged Stanley to consider that the possibility of making such a statement was not

truly an option, as he had not considered the possibility that the soldier had never thrown a grenade. Although he was willing to reflect upon the points that emerged in the discussion, Stanley was unwavering in viewing himself as the responsible party.

Both therapist and client agreed that this belief constituted a stuck point related to his past belief that he had “total control over [his] destiny.” However, Stanley acknowledged that he no longer viewed himself as “superman” due to his medical problems. The therapist noted that Stanley’s belief in his omnipotence, and the associated sense of responsibility for the soldier’s death, likely resulted from the assimilation of combat experiences to previously held beliefs, while his present belief that he was powerless was likely the effect of over-accommodation to the foundation-shaking diagnoses he had received in recent years. Stanley acknowledged that this was likely the case, while expressing continued attachment to both stuck points.

Relating Stanley’s feelings of guilt and helplessness with his viewpoints regarding control, the therapist engaged him in a psychoeducational discussion about the nature of primary and manufactured emotions using Handout 4 (see Table 5). At this time, the therapist asked whether Stanley had experienced additional primary emotions (e.g., fear) at the time of the grenade explosion. Stanley acknowledged feeling confused and scared in the immediate aftermath of the explosion. The therapist normalized both his experience of fear, as well as his apparent remove from the emotion, framing this as a “survival response” that had served him well in combat. Stanley responded to this view, as his present belief was that it “should’ve been me” in that explosion would have likely impaired his ability to do what was needed in war. The therapist also noted that his primary experience of survivor guilt associated with the trauma was influenced by his belief in his total control over circumstances in a chaotic warzone.

While presenting the CBT formulation of post-traumatic reactions, the therapist noted the link between Stanley's stuck points, such as his belief that he had caused the soldier's death by not acting, and his experience of emotions—particularly the manufactured emotions like shame, as well as the resulting impact on his ability to share his experience with others, as he desired. In this discussion, the therapist highlighted the discrepancy between his personal values and the impact of his stuck points, as well as related thoughts. The A-B-C worksheets were used to help Stanley identify his beliefs in response to activating events, and the resulting impact on his actions. The client worked with the therapist to frame several events from this perspective, and agreed to continue completing the worksheets in the coming days.

Treatment Session 3

In reviewing the completed A-B-C sheets with the client, the therapist planned to continue identifying thoughts, as well as both primary and secondary feelings. Special attention was paid to questioning any stuck points that emerged, particularly related to the traumatic event. In addition to reviewing A-B-C worksheet related to the grenade drill accident, the therapist had also planned to discuss the writing of the trauma account, as well as anticipate any potential obstacles.

When discussing his experience of recognizing and challenging cognitions that had emerged in recent days, Stanley identified thoughts related to his present life, in addition to those associated with his experiences in Vietnam. He disclosed that he had the thoughts that he was incompetent when he was unable to repair a pool mechanism. The theme of failure also emerged in his discussion of thoughts prompted by remember the traumatic event. The primary cognition that Stanley identified was, "I should have realized this kid was scared...and reaching out to me for help." He presented an A-B-C sheet that reflected his ability to challenge this thought associated

with high levels of guilt, as he noted that “it wouldn’t have been rational to think he’d never held a grenade before,” and concluded that “I didn’t change position specifically to get away from him, so I shouldn’t accept the guilt for what happened.” Despite challenging this thought and the resulting feeling on paper, Stanley nonetheless believed that he was at fault for not acting after the soldier asked him the question regarding the delay on the grenade.

In addition to reinforcing Stanley for engaging in the difficult task of challenging day-to-day, as well as more emotion-laden cognitions, the therapist utilized Socratic questioning to encourage him to continue in this vein. When prompted to consider other contextual factors that had led to an unprepared soldier throwing a live grenade, Stanley engaged in assigning percentages to those circumstances and individuals that he deemed partially responsible. After discussing the role of the basic training instructors, commanding officer, staff sergeant, and the soldier himself, Stanley found himself assigning 145% of the responsibility to the aforementioned parties. In response to the question of how his small role would “go up against that 145%,” Stanley maintained that he “could’ve erased all of their mistakes.” However, he returned to the point that, in order to do so, he would have had to recognize the possibility that this soldier had completed basic training and arrived to fight in Vietnam without being trained to use grenades. When the therapist reflected that responding differently to the soldier’s question “wasn’t an option at the time,” as the situation that occurred “wasn’t a possibility,” Stanley noted that he held himself to a “superhuman” standard.

When the therapist reflected upon Stanley’s use of “superhuman” to describe his expectations for himself, the client himself wondered whether he was “being realistic.” When asked to consider his view of his own expectations, Stanley stated that he held himself “to a higher standard of conduct” than others. The completed A-B-C sheet related to his work as a fire control

instrument repairman further confirmed this inclination. Memories of times when he had experienced difficulty calibrating instruments led the client to believe that he was not “the best fire control instrument repairmen...maybe not even adequate.” Although he was able to challenge this cognition, acknowledging that he had no evidence of committing a serious error in his MOS, and produce an alternative statement, Stanley continued to wonder about the possibility of a “deadly” mistake, and experienced the associated fear and guilt. While discussing thoughts related to Stanley’s feared errors, as well as his expectation of perfection, the therapist summarized Stanley’s view as, “Unless it’s 100%, or number one, it’s not acceptable”—for him alone. In addition to helping the client recognize this as a “stuck point” that would be revisited later on in treatment, the therapist used Socratic questioning to engage Stanley in questioning the cost and benefits associated with this perspective, once again attempting to relate the stuck belief to which Stanley was attached with his valued goals, as discussed in pretreatment.

In the remainder of the session, the therapist introduced the rationale behind writing the trauma narrative in great detail, and helped Stanley troubleshoot any anticipated obstacles to completing the assignment. In addition, the therapist discussed how the client might continue challenging identified stuck points, as well as daily automatic thoughts, using the A-B-C sheets. When the therapist checked in with Stanley at the end of the appointment, eliciting any additional thoughts and questions, the client asked, “Why are you and everyone else here concerned about this old guy?” In this moment, Stanley had identified one source of ambivalence—namely, his own survivor guilt. When the therapist asked whether Stanley believed he “deserved” the diagnosis of PTSD, as well as the associated care, he compared his own experience to that of several other veterans. The client said, “They experienced death that I didn’t with my own eyes experience.” In this moment, the therapist recognized his guilt as resulting from stuck points related to his assumed

responsibility for others' deaths. Rather than return to challenging these beliefs at the end of session, the therapist utilized an MI spirit to help Stanley consider the impact of his suffering.

Therapist: "Even though you have this thought of, you know, I...haven't earned the right to have these symptoms, the fact of the matter is that you do stay up at night. And the fact of the matter is...they do get in the way of things you would like to be and have right now."

Client: Yeah. I'll agree with that. Two years ago...I would have argued with you that I did not have a PTSD problem whatsoever. I now understand that there is a problem.

Treatment Session 4

Beyond reviewing Stanley's identified thoughts using the A-B-C sheets, the bulk of the fourth session was devoted to helping Stanley read the trauma account, fully experience the associated emotions in session, and begin to question any stuck points that emerged—particularly forms of assimilation, including self-blame and the accompanying survivor guilt. In addition, the homework was discussed, which included continuing to challenge thoughts as well as rewriting, elaborating upon, and re-reading the trauma account daily.

After briefly discussing the A-B-C sheets with Stanley, the therapist praised the client for continuing to do the difficult work of treatment, including writing the account of his trauma. In preparing Stanley to speak his full trauma account in the session, the therapist briefly reviewed the rationale for Stanley to revisit the traumatic event, attending to the aspects of his experience he might wish to avoid and allow himself to feel any emotions. After expressing understanding and desire to share his narrative, Stanley began reading his written account. Stanley read a description of his first experiences in Vietnam, placing marked emphasis on slight details unrelated to the event with minimal emotional expression. His focus on objective details, rather than his own

experience, continued as he described the soldier asking him about the delay after pulling the grenade pin with little affect. At this moment, the therapist attempted to help Stanley access his affective experience by probing for details of his sensory and emotional experience. As Stanley continued his account, describing how he “quickly just gave him an answer,” he demonstrated present feelings of guilt while reflecting upon the experience. He described hearing an explosion “that wasn’t right,” followed by soldiers running, screaming for medics, and feeling “overwhelmed by all the activity.” In response to probing questions about the details of this experience, Stanley described seeing three men carried out, feeling “numb” with a sense of “bewilderment.” He described noticing himself “shaking,” but denied feeling fearful at the time of the explosion, indicating that he was likely experiencing dissociation during the accident. He described first feeling fearful the following day, when he learned that the soldier who had asked him about the delay had never been trained to throw a grenade, and the thought occurred to him that he “should have been that second guy” who was killed by the explosion.

When prompted for his experience of reading the account, Stanley said, “You are making me a little emotional,” describing feelings of sadness and guilt that “somewhere out there, there’s a guy who wound up standing where I was supposed to be standing, and he got hurt.” In the course of reading his narrative both in and outside of session, Stanley identified stuck points related to his felt sense of survivor guilt. In addition to his belief that he was to blame for the death of the young soldier in the grenade drill, Stanley held the belief that he may have “caused harm to good guys” by incorrectly calibrating instruments. These thoughts also related to Stanley’s view that he did not deserve the same treatment as other combat veterans, as he was somehow inferior to them for these perceived missteps. The therapist briefly engaged Stanley in Socratic questioning about his self-blame for the grenade drill accident. However, primary attention was devoted to discussing

Stanley's belief regarding his need to suppress his emotional experience, as this belief might have prevented him from benefiting from the emotional processing intended by the writing and re-reading of the trauma account, if left unchallenged.

Although it was clear that Stanley had dissociated at the time of the traumatic event, the therapist also wondered aloud whether the client had been avoiding feeling or expressing the feelings that emerged for him during while reading the account, simultaneously normalizing the desire to avoid painful affect. Agreeing, Stanley said, "I was making sure I wasn't gonna break down and cry or do something like that...I was gonna hold back. It's what I always do."

Using Socratic questioning, the therapist engaged Stanley in a discussion of his fear about allowing himself to experience the feelings without holding back. This was deemed to be of primary importance, as Stanley would reap limited benefits from treatment if he were not able to experience the associated natural feelings. The client stated that he was wary of being "vulnerable to making mistakes" as a result of feeling negative emotions, both while he was in Vietnam and "back here in the real world." Discussing instances in which Stanley had experienced and expressed negative feelings, the therapist worked with Stanley to challenge this belief that he had to fully control his feelings at all times, and provided psychoeducation about the time-limited nature of natural feelings. While Stanley agreed that the difficult emotions would run their course, as indicated by previous experience, he maintained that "the easier of the two things to do is to not show [his feelings]...easier in the sense of not subjecting myself to my own anger [at]...my own capacity to make mistakes." In addition to the self-blame that was clear throughout the trauma account, Stanley's belief that he must control all emotional experience and expression was identified as a stuck point.

In addition to engaging the client in Socratic questioning, the therapist continued to draw upon MI when Stanley noted that, in spite of this belief, he had “opened up more” in recent years. Reflecting that he had done this for years in spite of the fact that he experiences it as “easier” to live with the survivor guilt than revisit the additional painful feelings associated with the trauma, the therapist sought to develop discrepancy between Stanley’s expressed belief and his actions. This led to a discussion of the impact of his desire to control all affective expression on valued aspects of his life, including his ability to connect with family members. In the course of this discussion, the therapist also likened the work of treatment to fighting a battle for one’s values, stating, “When I think soldier, I think somebody who goes toward the battle... You were running toward the fire, toward the danger, even though it was more difficult... and I wonder if one way of seeing this might be similar—running toward the negative feelings because you know they’ll run their course.” Both desiring to do this work and fearful of appearing vulnerable to those around him, Stanley expressed his desire to continue in treatment. At the end of the session, the therapist expressed appreciation for Stanley’s strength engaging in the difficult work.

Treatment Session 5

In the fifth treatment session, goals included reviewing the thoughts challenged using the A-B-C sheets, as well as the client’s experience of writing and reading the second version of the trauma account. As in the previous session, the client was asked to re-read the second trauma account, feeling all emotions as they emerged, consider the differences between the first and second written narratives. In addition to challenging stuck points apparent in the account, the therapist planned to use the Challenging Questions Worksheet (Handout 6; see Table 5) to help the client examine stuck points in session, as well as independently outside of session.

At the outset of this session, Stanley reported that he had experienced more difficulty maintaining sleep, as he was worried about his granddaughter, who would be undergoing surgery. Stanley expressed how he wished he could protect her from the fear and pain, and felt helpless to do so. The therapist engaged Stanley in a discussion of ways he might best support her through the frightening ordeal, continuing to fulfill the role of an involved and loving grandfather.

In discussing Stanley's experience of writing and reading the second trauma account, as well as sharing this emotional experience with the therapist in session, he noted that his urge to protect women contributed to his difficulty expressing his feelings in session: "It's kind of tough for me to really show externally my emotions like that—especially to a lady." Returning to the analogy of PTSD treatment as a battle that the client was fighting, the therapist remarked upon the difficulty of focusing "exclusively on the task at hand" when one is concerned about the battle buddy intended to offer protection and support. Stanley nodded in understanding, and said that "I'm comfortable with you now that I'll protect you a lot less," explaining that "I still have a mechanism where I don't show externally all the emotions...it's always been my makeup." When the therapist probed about the client's experience of suppressing fear, which had been minimally expressed in his initial trauma account, Stanley related his need to suppress his emotional expression to survival in a warzone, stating "you had fear 24/7...but you keep that fear suppressed because if you didn't...you wouldn't be able to function," and make a fatal mistake. In the subsequent discussion, the therapist sought to emphasize Stanley's safety in the present, which allowed for his emotional experience, which would help him experience relief in the trauma treatment. The therapist also expressed her appreciation for the client's bravery experiencing the emotion when alone, as well as the relationship that had been developed with the client that allowed Stanley to express his feelings as much as he had in session.

When discussing his experience of writing the second trauma account, Stanley reported that he had typed it on a computer before handwriting it. The therapist reviewed the rationale for handwriting the narrative, as this would enhance the emotional impact and processing, which Stanley understood. He noted that the experience of writing and reading the narrative had been more emotional, as he had found the diary entry he wrote immediately after the trauma, leading him to recall more aspects of the event. Reading the account, Stanley described in greater sensory detail the events before and during the traumatic event, when “all hell broke loose.” He described feeling shocked and “unnerved,” experiencing “a jumble of emotions, including sadness that it had happened, happiness that [he] had escaped injury, and anger at everyone for even holding the drill.” After the reading, the therapist encouraged Stanley to describe the fear he had acknowledged earlier, which Stanley associated with his initial realization that “somebody got killed,” and the terrifying question, “How am I going to make it for the next eight months?” The therapist praised Stanley for his willingness to approach this difficult emotion in spite of his reservations, noting that this would help the feelings run their course, as previously discussed.

As he was writing the account and reading it in session, Stanley noted his present-day thoughts related to his lack of awareness of the soldier’s inexperience, stating that his “curt” response “was not a malicious thing, but it may have proved fatal.” He described the feelings of sadness and guilt linked with his belief that he “pretty much blew [the soldier] off,” although “logic” would state that “nobody would’ve acted any differently.” Together with the increased intensity of his natural emotions, Stanley’s clear ambivalence about his own guilt constituted a difference from the initial trauma account. Nonetheless, he clearly expressed a form of assimilation in his self-blame as he described his desired version of events, in which he had probed the questioning soldier, leading the soldier to reveal to Stanley and the sergeant that he could not

throw a grenade. The therapist engaged Stanley in cognitive restructuring, asking him to speculate about the likelihood that all of the required events he imagined would have actually occurred, including the soldier honestly disclosing his ignorance and the sergeant responding. Stanley agreed that there was no “guarantee” that the tragedy could have been averted, stating that it would likely have turned out the same. At this point, the therapist also provided psychoeducation regarding hindsight bias and the difference between responsibility and blame, to which the client responded, “One’s a crime, the other’s an accident.” When asked how he viewed his response to the soldier, Stanley said, “Surely not a crime. I had in no way any kind of intent to bring harm to this kid.” With continued Socratic questioning and discussion and use of the Challenging Questions sheet, he concluded: “I don’t think I blame myself. I feel guilty [about] my perfectly innocent actions.” Stanley was encouraged to continue reading the second trauma account and using the Challenging Questions to examine other stuck points daily.

Treatment Session 6

In addition to reviewing his experience of revisiting the traumatic memory, session goals included discussing the Challenging Questions worksheets completed by the client, and continuing to examine stuck points with an increased focus on forms of over-accommodation. Additionally, in accordance with the CPT protocol, the clinician planned to review patterns of problematic thinking using the CPT handout of the same name (Handout 7; see Table 5), providing further psychoeducation regarding the influence of cognitive distortions, and engage Stanley in a discussion of the thinking traps that had the greatest impact on his life.

Stanley reported that he had read the trauma account repeatedly. He expressed frustration that, while his sense of guilt, fear, and anger had diminished over repeated readings, such that he

did not blame himself for the accident and could “write this now without any tearing up,” Stanley was nonetheless saddened by the tragedy of the needless loss of a soldier from whom he could not “disassociate.” He described, “I was a little hardened back then as to the tragedy itself...I guess I realized right away that this kind of shit was going to happen a lot.”

In describing his recent feelings of sadness at the loss, Stanley also expressed self-judgment, stating that he should have felt the sadness in Vietnam. In an effort to help Stanley recognize the factors that prevented him from feeling sadness at the time of the accident, the therapist engaged him in a discussion using Socratic questioning, wondering about the probable effect of mourning while in-country. He acknowledged the danger, stating “that’s when you’re half-stepping, and that’s when you can be taken out.” The therapist agreed, pointing out that he had reason to suppress his feelings in a warzone, as well as opportunity and reason to express them in the safety of the present environment. Furthermore, the therapist discussed the utility of his judgment, stating that perhaps “there’s no room for should or shouldn’t have here. Maybe it’s just what [he] needed to do.” Stanley responded, noting additional strategies that had served to help him focus on surviving his tour without being impacted by loss.

As he openly described ways in which he had previously suppressed his emotional experience and connection with others, it is notable that Stanley’s increased openness was also associated with a decrease in the intensity of his natural feelings. Additionally, the client noted that this allowed him to “talk about this now with pretty much anybody,” including his granddaughter, with whom he had initially wished to share his experience. Noting the significance of this statement, the therapist asked Stanley to reflect upon his stated ability to share “that part of [him]self” with his granddaughter, and feel closer with his family, as he had desired before electing to begin the treatment.

In reviewing the Challenging Questions Worksheets he had completed, continued attention was paid to assimilation, as Stanley described his previous belief that he “was not a very reliable instrument repairman,” and may have therefore inadvertently placed others at risk. Stanley had been able to effectively dispute this thought, noting that he had only once been questioned on his work, which was found to be faultless. He concluded that he was largely influenced by his feelings of anxiety, rather than objective facts, and concluded that he “should let the track record speak for itself.” He questioned cognitions related to his view of himself as a “failure” in various other domains—including driving as well as parenting—in a similar way, and engaged in cognitive work with the therapist. Stanley drew upon this discussion as well as his self-reflection to express that he struggled most with jumping to conclusions and minimization of positive evidence in a psychoeducational discussion of the “Patterns of Problematic Thinking.” During this discussion, the therapist discussed examples of the described thinking traps, emphasizing the ubiquity of these patterns, and prompted Stanley to reflect upon the impact of these thinking traps in his life. He noted the negative impact of overgeneralization, which had contributed to increased feelings of anxiety and anger upon visiting the VA for his care. The homework of observing instances in which he falls into the trap of various unrealistic thinking patterns was discussed and planned in the final moments of session, before Stanley left to visit his recovering granddaughter.

Treatment Session 7

In the following session, therapist and client planned to review the stuck points identified as instances illustrating the patterns of problematic thinking discussed earlier. In addition to designating these automatic thoughts as products of thinking traps, the therapist and client would collaboratively evaluate these thoughts and their impact on feelings and behaviors, as well as

produce alternative views. The Challenging Beliefs Worksheet (Handout 8; see Table 5) would also be introduced to help the client integrate the process of cognitive restructuring with trauma-related stuck points and automatic thoughts. Finally, the therapist planned to discuss the anticipated foci for upcoming sessions, and begin discussing the ways in which exposure to trauma may have impacted the client's views related to safety, drawing upon the Safety issues Module (Handout 9; see Table 5). For homework, the clinician planned to encourage the client to use the Challenging Beliefs Worksheet to examine these views in and out of session.

Immediately before the session, Stanley completed self-report measures to evaluate PTSD, depressive, and anxiety symptoms, as well as overall functioning, motivation for change, and the therapeutic alliance. After Stanley finished the measures, the therapist checked in with Stanley on his experience of treatment overall, as well as reflect upon his progress, in order to determine if he found the treatment helpful in providing relief and allowing him to pursue his identified value-driven goals. Stanley described enjoying therapy, through which he learned to “not hit myself upside the head as hard as I normally did.” When discussing Stanley's experience supporting his granddaughter in her recovery from surgery, he stated that he had completed the homework of reflecting upon patterns of problematic thinking the day before, as “there were other priorities” with his granddaughter. Acknowledging the importance of being with his granddaughter and supporting his family, the therapist reflected upon his involvement as indicative of the client's clear commitment to his family. In addition to expressing respect for his commitment, the therapist noted how this very value had also motivated Stanley's initial engagement in treatment, and engaged him in anticipating future obstacles to completing homework, problem solving when necessary.

As Stanley had sought to identify stuck points that were impacted by cognitive distortions the previous evening, he had primarily focused on identifying the thinking traps related to his previously discussed stuck point related to self-blame. He noted that he was jumping to conclusions and exaggerating his responsibility and role in the event, and came to the same alternative view he had described earlier –that he was not to blame for the accident. Upon inquiry, Stanley noted that his feelings of sadness and guilt decreased markedly when he reminded himself of the realistic view that he was not responsible for the accident. However, he said, “It’s comforting to this point, the 99.8 point. But I can never get to that 100 point because I was there.” In discussing the impact of the initial stuck point, he referred to the past, when self-blame and feelings of guilt would keep him awake at night, and the improvement he had experienced, “closing that file cabinet and getting to sleep.” In addition, Stanley said he could now speak with his granddaughter about his experience, sharing more of his life with his family. The therapist highlighted the difference between his initial presentation and difficulty fully connecting with family members, and present state, praising him for implementing challenging skills that allowed him to “think about coming to her and having this conversation, and feeling completely open with her.” Although he recognized his progress, Stanley also expressed guilt that he had not disclosed his experience to his family sooner. Using this thought, the therapist engaged Stanley in a discussion of a related maladaptive thinking pattern and its impact on his emotional experience of sadness and shame. Using Socratic questioning, the therapist encouraged Stanley to discuss the cultural context that had contributed to his previous reluctance to share his experiences, while also recognizing that previous experiences of speaking with trusted others brought him “closer to people.” Collaboratively, client and therapist produced an alternative statement that helped to further lower Stanley’s feelings of guilt.

The therapist then worked with Stanley to help Stanley use the Challenging Beliefs Worksheet to go through the full process of identifying, evaluating, and challenging stuck points, noting the changing emotional impact. Stanley chose to use the stuck point of “being less than 100% competent,” and therefore incompetent, to practice “pulling the strings together” to challenge his stuck points. Triggered by a memory of a past car accident, this stuck point led Stanley to feel increasingly sad. Supported by the clinician, Stanley discussed evidence relevant to this cognition, the habitual nature of this thought given his traumatic experience, and the role of overgeneralization. He determined that he was partially at fault for the car accident, but concluded that “one mistake probably shouldn’t cloud the rest” of his actions, and fully his sense of competence.

The therapist oriented Stanley to the way in which treatment would focus on challenging any stuck points particularly related to safety, trust, control, esteem, and intimacy—those areas so often affected by trauma. In discussing the ways in which Stanley’s traumatic experiences impacted his beliefs about his safety, the safety of others, and his ability to protect himself and others, Stanley said that he learned “that place was dangerous,” but also came to believe that the world was becoming increasingly more dangerous, such that he reported feeling “concerned about the world that [he is] leaving for [his] grandkids.” The therapist encouraged Stanley to reflect further upon his beliefs regarding safety, and challenge one related stuck point before the next session. Stanley worked with the therapist to identify all stuck points he would address, and anticipate any obstacles to completion.

When the therapist checked in with Stanley about his experience of the session, he asked for her view of “the ultimate goal” for him. Assuring him that she would answer his question, the therapist asked him to express his present goal for treatment. Stanley shared his hope that he might

“accept the things that happened as something in ancient history...And just get to the point where if I think about the grenade...I can dismiss it,” in a way that acknowledged the tragedy while not accepting responsibility. In addition, he wished to share this experience with those close with him. The therapist validated these goals, and reminded Stanley of his previous wish to “look in the mirror and say...you’re not such a bad guy after all.” Responding to his question, the clinician said that her intention was to help Stanley achieve his goals, helping him address the PTSD symptoms, including his sense of competence and self-esteem, so that he might share his experiences with the younger generations. Responding, Stanley expressed a wish to speak with his son, and share “some stories” that he “never wanted him to know.”

Treatment Session 8

Goals for the eighth session included reviewing the stuck points that Stanley identified, and in so doing helping him further examine and challenge any unrealistic beliefs related to the safety of self or others. In addition to discussing stuck points associated with the Safety Issues Module, the therapist planned to introduce the Trust Issues Module (Handout 10; see Table 5), engaging Stanley in a discussion of ways in which his trust of himself as well as others may have been altered by trauma, and begin identifying potential stuck points to address.

When discussing the stuck points Stanley had independently challenged since the previous session, the therapist noted that he had not worked with a stuck point related to safety, and received permission to discuss this further. Rather, he had challenged stuck points that were related to his beliefs about his own competence and supposed failings, including his presumed role in contributing to his children’s marital difficulties, as well as previously discussed thoughts about his responsibility for the grenade drill accident and potential mistakes in his work as an instrument

repairman. Stanley had successfully challenged these thoughts, concluding that he had sought to “instill proper values and set a very good example” for his children, was “probably adequate” in his MOS and never told of a repair error, and was not responsible for the accident. Indeed, he continued to express a strong belief that he was not in any way “at fault” for the accident, remarking, “I think we’ve killed that [belief].” In addition to discussing the ways in which he was able to identify thinking traps—particularly jumping to conclusions and emotional reasoning—and challenge these stuck points, the therapist worked with the client to address two stuck point that he had struggled to challenge.

The first related to Stanley’s view that officers had deliberately neglected to assist a nearby infantry troop that was grossly outnumbered because they “didn’t care enough about those infantry guys out there getting hammered to make up the retaliatory force.” In discussing this stuck point, the therapist prompted Stanley to examine the evidence and consider alternative interpretations of that information. Ultimately, Stanley concluded that “they were simply abiding by the schooling had been given,” and “they didn’t have the approval to...go out there and mobilize us,” while nonetheless maintaining that he would have preferred to help the nearby troops, and lamenting the losses. In addition, the therapist engaged Stanley in questioning two opposing beliefs about his control—both his belief that he fully “controlled [his] destiny” in Vietnam, and had no control over his health following the cancer diagnosis. The therapist prompted Stanley to consider ways in which he did not have control in a warzone, as well as ways in which he exerted his power to improve his health, such as changing his diet, pursuing medical treatment, and “trying to make sure [he] live[s] today” without “wasting it.” Hoping to elicit additional ways in which he productively exerted control in his day-to-day life in a way that was consistent with his values, the therapist highlighted how Stanley’s commitment to living near his family, spending time with his

grandchildren, and participating in treatment in order to share his experiences with the younger generations were all ways of exerting control. Responding to both previous views that he had full control in the past, and no control in the present, Stanley concluded that he could “control his actions” within the context of external events.

As one goal was to address any safety-related stuck points, the therapist probed for these beliefs, reflecting upon a statement that Stanley had made the previous session that he viewed the world as increasingly dangerous due to recent world events. Stanley grounded this view in his political leanings, emphasizing that that he felt safe from danger from other people and in the world prior to the Vietnam War, and returned to this perspective after the war. He stated, “I felt for most of my adult life that I was pretty safe,” describing the Vietnam War as a “short chapter in my life” that concluded upon his return to the U.S. Probing further, the therapist noted that he typically sits directly opposite the door in public spaces, including the support group. Stanley acknowledged the behavior, stating that in Vietnam, “you learned to be on guard. You learned not to trust the world because you were in a part of it that wasn’t very trustworthy.” Noting the basis of his “habit,” he also stated that this previous belief had a limited impact, as he saw the danger he experienced in Vietnam as a “different chapter” in his life, and viewed himself as presently safe, interacting with people who were not primarily dangerous.

While discussing his views of safety, Stanley referred to the interpersonal sense of safety and trust in others, noting how he felt especially safe in the veteran support group because he knew that the experiences he shared were not “going to be wrapped around [his] neck and squeezed.” In other settings, he reported feeling less safe sharing with others, whom he deemed as less trustworthy. When the therapist noted how “safety and trust go hand in hand,” Stanley, responded that he found them to be “the same.” In the subsequent discussion of beliefs related to the trust of

others and oneself, Stanley indicated that he trusted his present actions and judgment, noting that his experience in the war had served to help him mature in his judgment. He maintained this view in spite of related stuck points, in which he questioned his responsibility for perceived oversights. Reflecting upon his view of others' trustworthiness, he described his view prior to the Vietnam War as "kind of naïve," in that he believed what he was told. However, he "became a little hardened" after the war, no longer taking "anyone at their face value." When asked about his present beliefs, Stanley said that he was "back at the point where [he] might be naïve and gullible again," as he strives to believe others until he is proven wrong. The therapist encouraged Stanley to continue examining his thoughts related to trust, and challenging any stuck points that emerged in the coming days.

Treatment Session 9

The following session, Stanley reported that he had not challenged the identified stuck points as planned, as he had spent a great deal of time with his granddaughter. However, he had addressed stuck points related to trust in writing about the evolution of his beliefs regarding trust of self and others. In addition to addressing the issue of homework compliance and challenging stuck points in session, the therapist planned to engage Stanley in a discussion of the impact of these beliefs while also examining their basis. The Power and Control Issues Module (Handout 11; see Table 5) would also be introduced and discussed, as per the CPT protocol, and the therapist planned to help Stanley plan times he might address any stuck points, including those related to control, outside of the session.

As mentioned, Stanley had not completed the Challenging Beliefs Worksheet for stuck points, stating that he had had spent a great deal of time with his younger granddaughter, who was

still recovering from surgery. While once again validating the clear importance of being present and supportive for his granddaughter, the therapist engaged Stanley in a brief discussion of ways he might complete the homework as planned, building upon Stanley's ability to write critically about his changing beliefs relating to trust. While Stanley was largely unconcerned about his recent difficulty completing the homework as planned, he expressed a willingness to continue examining his stuck points inside and outside of session. He participated in planning how he might complete the worksheets at the end of session.

While Stanley did not use the Challenging Beliefs Worksheets, he had reflected greatly upon the issue of trust and described the evolution of his beliefs in writing. In his text, he noted that he had trusted both himself and "most other people" fully before deploying. While he stated that his trust in his abilities grew over the course of his tour, he wrote that several experiences, including the grenade drill accident, taught him "some GIs would not be trustworthy at all." When he came home, Stanley had decreased trust in others. His difficulty trusting enough to share his experience led him to avoid forming close friendships with acquaintances. Expressing regret that he had not build closer relationships, Stanley wrote: "All of this has me now looking to be more comfortable with a greater number of people regarding my combat zone experiences," a goal he intended to pursue by first sharing his difficult experiences with his granddaughter before "branching out" further.

Although Stanley said that he felt comfortable in his own abilities and judgment following the trauma, the therapist probed further for potential stuck points, noting that the views he had expressed earlier in treatment about his own presumed responsibility for the grenade drill accident "doesn't seem very trusting of your own...judgment in the past." Acknowledging the "contradiction" of "blaming [himself] for not being better than he was" while also, "thinking [he]

was Superman,” Stanley said that he had not initially doubted his judgment upon returning from Vietnam. Rather, he stated that his self-blame came much later, and had dissolved over the course of treatment. Stanley said, “I’ve used the word ‘accident’ more the last couple of weeks...accidents happen. You can’t prevent it.” When asked about his present beliefs about his ability to trust his judgment, he responded, “I trust myself...and I trust some people who’ve become close to me.”

In discussing his trust in others, Stanley referred to additional experiences in Vietnam in which he learned that other people were not necessarily trustworthy. He mentioned an instance when he had been unable to determine whether a Vietnamese farmer was a potential enemy, and described his distrust of all young children he encountered, as he knew “too many stories about ten-year-old kids that had remote detonated bombs strapped to their back.” Acknowledging the ways in which his experiences in a combat zone had influenced his distrust of others, the therapist engaged the client in a discussion about the applicability of these beliefs in the U.S. While he described coming “more toward the center,” viewing some people as potentially trustworthy, Stanley described continued struggles trusting others enough to befriend them.

In particular, Stanley noted that he seldom trusted others enough to share his experiences in the war, fearing that they might use the information against him, or see him as a “pot-smoking babykiller.” The therapist discussed various gradation and forms of trust, using the “star” diagram put forth in CPT to depict the way in which a single person can inspire various levels of different kinds of trust, and prompting Stanley to consider individuals he would trust to a great extent in some ways (e.g., sharing a difficult memory) but not others (e.g., caring for a grandchild). In this way, the therapist and Stanley challenged his view of others as either entirely or not at all trustworthy. Stanley acknowledged ways in which he assessed his willingness to share his

experience with other people, stating that he built this form of trust over time by gradually offering information about his experience, and using others' response to determine their trustworthiness.

In the course of this discussion, Stanley noted that he did not share his experiences in Vietnam with his wife, not because he did not trust her to be supportive and understanding, but because he did not wish to hurt her by reminding her of an emotionally difficult time. Using Socratic questioning, the therapist encouraged Stanley to consider his wife's reason for avoiding reminders of the war in the past, leading him to agree with the therapist that she likely felt "helpless" and afraid for his safety. While Stanley wished to continue protecting his wife, he discussed his desire to share his experience with his eldest granddaughter. In addition to highlighting the growing trust that was present between the client and his grandchild, the therapist noted his commitment to sharing all of his experiences to "bring [them] even closer together." In response, Stanley shared his desire to show her his diary entries from the war, as well as tell her of times in which he was "scared and vulnerable."

Introducing the power and control module, the therapist questioned Stanley about his beliefs about his power to exert control over external situations, and his power in relationships with others. Stanley reported that he had seen himself as in control of events and relationships prior to his experience in Vietnam, and sought to increase his control over both his experience and external circumstances following his return. Focusing on his subsequent desire to fully control his emotional expression, Stanley reflected upon his recent move toward "the point where I understand I don't need total control," noting that he occasionally felt apprehensive because he knew he could not "hold anything back from [the therapist]," whom he trusted. The therapist acknowledged the difficulty of expressing his feelings to the extent that he had and expressed personal appreciation for his willingness to experiment with decreasing his control over his

emotional expression in session. Upon inquiry, Stanley reported that he had experienced gains associated with treatment, denying intrusive symptoms associated with traumatic memories. In addition to reinforcing the work Stanley had done to contribute to the reduction in symptoms, the therapist encouraged Stanley to consider the control module and address related stuck points, planning when he might complete this homework.

Treatment Session 10

In the following session, goals included reviewing additional stuck points, including those related to the issue of power and control, and helping Stanley arrive at a realistic view of his self-efficacy and a more balanced approach to sharing power in relationships. In addition, the therapist planned to introduce the Esteem Issues Module (Handout 12; see Table 5) and encourage the client to examine his beliefs regarding his own value as well as the value of others, as well as the potential impact of trauma on these views. The homework associated with this module in CPT was aimed at helping the client explore his beliefs related to esteem, and actively practice engaging in both pleasurable activities that connote Stanley's inherent worth and behaviors that show his esteem for others.

At the start of the session, Stanley presented a stack of photographs taken in Vietnam. The therapist expressed her appreciation for Stanley willingness to share these pictures. In response to the clinician's request that Stanley "walk [her] through" the photos, Stanley shared about his experience on his first day in the field, as well as his feelings as he witnessed aircraft in flames nearby. Thanking him for sharing these difficult memories, the therapist asked Stanley to reflect upon the experience of discussing his experiences with the therapist, with veterans, and with those closest to him. Stanley reported feeling comfortable sharing the photos with the therapist, whom he

trusted, and described the process by which he became increasingly willing to share his experiences with others, “little by little” moving away from his initial perspective that his tour of duty was “pretty much insignificant,” as he was not infantry. Similarly, he reported showing several photographs to his granddaughter, the “first step” toward sharing some of his more difficult and influential experiences in Vietnam.

Since the previous session, Stanley had written about his evolving views related to the issue of control in addition to using worksheets to challenge related and other stuck points daily. He wrote of believing that he “controlled [his] destiny” and must work to maintain this power, a belief that was initially strengthened during his tour. Following the traumatic grenade accident, Stanley initially believed that he had an infallible “power that would keep [him] safe” in the future. Upon reflection, however, he concluded that he had limited control over “external factors,” although he had the “ability to act correctly in dangerous situations” based on his training and assessment of others’ ability. In addition, Stanley examined his experience of attempting to control his emotions, writing that while he could “control not showing that fear externally,” he could not suppress his experience of fear in dangerous situations. The therapist praised Stanley for actively questioning his identified stuck points.

While he was comfortable with his new belief regarding his ability to exert control over his world, Stanley reported struggling to challenge his belief that he must fully control his emotions, a view that had been strengthened during his tour. He described thinking that he must always have his “poker face,” taking extra care to suppress any expression of negative emotion. Encouraging Stanley to consider the factors that influenced his perspective, the therapist highlighted the way in which such stoicism is linked with masculinity as well as explicitly taught in the military. Stanley responded, noting that although he was “scared as hell” in Vietnam, he “couldn’t show that to

anybody else,” as he thought expressing his fear would “lessen what [he] look[ed] like to others.” When the therapist inquired about his present fear, Stanley replied, “I’m supposed to be the head of the family,” stating that he did not want to “portray some kind of vulnerability.” To identify the precise stuck point, the therapist asked Stanley about the implication of showing vulnerability as a family leader, which he expressed as a fear that vulnerability may prevent him from supporting his family, effectively “failing them.”

Much of the session was spent addressing Stanley’s belief that he must exert “100% control” over his feelings in order to avoid failing his family. To address this stuck point, the therapist prompted Stanley to consider confirming and disconfirming evidence, focusing on his personal experience. Stanley recalled a time in which he had expressed feelings of sadness and grief when he was “watching [his mother] die” to wife. When the therapist asked whether sharing his feelings with his wife had constituted a “failure,” he said that it did not. Similar examples were also noted. The therapist used Socratic questioning to encourage Stanley to consider the role of all or nothing thinking in his initial belief, offering one view of control as being “on a continuum” rather than full or absent. Stanley disagreed, stating that, even when he allows himself to express some emotion, he is ultimately fully “controlling how much [he] show[s].” In addition to challenging his initial stuck point, the therapist asked Stanley to consider his previous experiences of allowing himself to lower his level of control and express vulnerability to fellow veterans as well as family members. The client reported that each of these experiences “felt pretty good.” Reflecting his experience, the therapist offered a connection to his initial values, suggesting that there might be a part of him that benefited from letting go of “some of that airtight control...in order to bring [him] closer” to his family, and be even “more of that head of the family.” Stanley agreed that he ultimately wished to share his emotional experience to some extent and viewed it as

his responsibility to his grandchildren, concluding: “there are times when it’s okay for me to put my emotions out on the table. Likewise I’m sure there are other times when it’s not.” In addition to arriving at this intermediate stance on his need to control his emotional expression, Stanley engaged in a discussion of his view of power in relationships, noting that he saw that he had enjoyed considerable, but not total, power in increasingly equitable relationships—most notably in his marriage.

The remainder of the session was primarily devoted to discussing the impact of Stanley’s traumatic experiences on his original beliefs regarding the value he assigned to both himself and others. Introducing the esteem module, the therapist noted the ways in which trauma can often shape individuals’ views of themselves and other people, encouraging Stanley to consider the evolution of his beliefs related to esteem. Stanley maintained that he viewed himself as “okay,” a perspective that has not shifted greatly following his return from Vietnam. The therapist reflected upon Stanley’s earlier statement, that he felt reluctant to share his experiences in Vietnam and receive psychological care in part because of his belief that he does not “deserve” the same treatment as infantry. Stanley described that he had increasingly moved away from this perspective, but continued to “hold [him]self to a standard [he] can’t maintain.” He expressed disappointment with his career, and the resulting impact on his self-esteem. When asked what he made of this view of himself, Stanley said, “I probably shouldn’t be the one grading my own exams,” prompting the therapist to acknowledge his “harsh” grading of himself, relative to others. In a thoughtful tone, Stanley agreed to challenge related stuck points, including his view that he was “not totally adequate” in various roles, using the Challenging Beliefs Worksheets. In addition, Stanley would further review and consider the esteem module, actively do pleasant

activities consistent with a positive evaluation of himself, and practice valuing others and sharing power in relationships in various ways, as described in Handout 13 (see Table 5).

Treatment Session 11

In the eleventh session, the therapist planned to review Stanley's experience of giving compliments as well as allowing himself to accept them and pursue pleasant activities for the simple enjoyment of them. In addition, Stanley's beliefs related to self-esteem and esteem for others would be reviewed and relevant stuck points discussed and challenged. The therapist also planned to introduce the final module of Intimacy (Handout 14; see Table 5), and encourage Stanley to consider ways in his approach to intimacy with himself and others had changed throughout his life. At the end, the final assignment of continuing to give and receive compliments, doing additional pleasant activities, challenging stuck points related to intimacy, and writing a revised impact statement was also discussed.

While Stanley had written significantly about the evolution of his beliefs about himself and others, he had not taken any steps to give compliments, receive them openly, or allow himself to enjoy pleasant activities. Upon inquiry, Stanley stated that he had spent less time with other family members, as he and others had been visiting his granddaughter, who was still recovering from surgery. Nonetheless, Stanley had encountered opportunities but was ultimately unable to experiment with these behavioral assignments. In an effort to better understand the obstacle encountered, the therapist asked Stanley how he might feel either receiving or giving a compliment. Stanley noted his tendency to discount compliments, as he "either didn't consider it such a big achievement, or thought [he] could have done [the task] even better." With continued probing into the relationship between the client's perfectionism and difficulty with compliments,

he expressed the belief that a self-critical view keeps him “always on [his] toes to...be better next time.” He noted that while his perfectionism dated back to childhood, when he would blame himself for not hitting a homerun earlier in a baseball game, this tendency was amplified during his time in Vietnam. He cited a fear that if he had seen himself as “a really good soldier,” he might have slipped. The therapist validated Stanley’s feeling of fear associated with his experience in Vietnam, stating “in that environment, complacency would’ve translated into danger pretty immediately in your mind...What about this environment?” Prompting Stanley to consider the likely consequences of believing the last compliment he received from his granddaughter, the therapist helped Stanley recognize the different levels of danger between a combat zone and his present surroundings.

In the course of this discussion, Stanley shared his sadness that his granddaughter had a similarly self-critical view of herself, noting that he made an effort to compliment her regularly to help her see herself more accurately. Drawing upon previous discussion about the client’s love for his granddaughter and strong value in building a close relationship with her, the therapist reinforced Stanley for complimenting his granddaughter and encouraged him to reflect upon the experience, which he “loved.” Using Socratic questioning, the therapist also prompted the client to consider why he felt sad about his granddaughter’s perfectionism and self-criticism when he saw his own as protective. He noted that he did not apply his perfectionistic standards to others, whom he saw as primarily competent. He acknowledged that his granddaughter had not grown complacent or made more mistakes because of his compliments, expressing his desire that she be confident and happy with herself. Reflecting the joy that Stanley felt supporting his granddaughter in this way, as well as the diminished belief that compliments would necessarily lead to dangerous

complacency, the therapist asked Stanley if he would be willing to attempt the experiment once more, which he agreed to do.

As Stanley had noted in this discussion, he had always been exacting in his standards for himself, stating that he usually sets “unrealistic goals” and fails to meet them. He stated that he had not seen himself as “worthless,” but rather faulted himself for not being “perfect or the best.” His experiences in Vietnam further strengthened this view, as he understood the potential cost of a “mistake,” such as the one he initially believed he committed in the grenade drill. Stanley’s related stuck points included his belief that he was not good enough as an instrument repairman. Building on his written challenges, in which Stanley acknowledged that he has a “habit of down-grading [him]self,” and had considerable experience working in his MOS, the therapist used Socratic questioning to help him examine the evidence related to his thought and recognize the limitations of repairing equipment in monsoon season. In addition, the therapist encouraged Stanley to look at the consequences of his perfectionistic standards, noting that, had he demanded perfection in his work, given the environmental restrictions and lack of resources, soldiers would have gone without weapons. In addition to challenging this stuck point, Stanley and the clinician collaborated to address a related stuck point that he was a “failure” because he did not meet his career objectives as an entrepreneur. Stanley concluded that he was not a failure as a soldier or a business owner, although he regretted closing his business. Seeking to link this perspective with Stanley’s personal values, the clinician engaged him in a discussion of the impact of holding this alternative view on his ability to help his granddaughter build her self-esteem, and connect with her over his previous experience in Vietnam, as he initially planned. Stanley responded positively, agreeing to set a day and time to share this part of his life with his granddaughter.

In the remainder of the session, the therapist engaged Stanley in a discussion of his beliefs regarding intimacy with himself and others, including his sense of comfort with himself, self-efficacy, and willingness to nurture closeness with others. Stanley noted that his faith in his ability to manage difficulties, while initially high, had decreased in the years after his tour. Similarly, he described that, although he had strived to protect others throughout his life, he had been somewhat removed from loved ones following his return home, although he stated that he had recently felt closer with others as he felt increasingly “trustworthy” and trusting of others. In the course of this discussion, the therapist offered psychoeducation on the potential impact of trauma on beliefs related to intimacy, and encouraged Stanley to continue examining his views and challenging associated stuck points, as well as completing the behavioral tasks discussed earlier and a revised impact statement.

Treatment Session 12

Goals for the final session of CPT included discussing Stanley’s beliefs related to intimacy, reviewing problematic stuck points as needed, and discussing the client’s experience engaging in pleasurable activities and both giving and receiving compliments. In addition to completing the final module of CPT, therapist and client planned to review Stanley’s new impact statement and compare it to the original written at the start of treatment. Finally, the therapist hoped to discuss Stanley’s experience of treatment and its various components, and plan how he might continue implementing these skills to pursue identified future goals.

Following the previous discussion, Stanley had completed all homework tasks, including engaging in pleasant activities by spending time with his neighbors and grandchildren, and both giving and receiving compliments in an open manner. Although he noted some discomfort and

skepticism when he tried to accept his grandson's praise at face value, Stanley reported that he found it "pretty neat," and would continue. Similarly, he described feeling "great" complimenting his granddaughter, whom he had described as similarly affected by self-doubts.

In accordance with one of his chief goals for treatment, Stanley also reported that he had approached his granddaughter and shared his "tenure in Vietnam," including "the full story of the grenade accident," as planned in the previous session. When the therapist probed for his initial expectations, he expressed worrying that his granddaughter might be "upset" by hearing of his experiences or think less of him. Stanley described sharing his memories in Vietnam as well as the emotional experience of being sad and afraid "24/7." He noted that he had exposed himself as different from "the typical tough guy," a view that the therapist reframed as especially admirable, suggesting that a true "tough guy" was someone who was willing to face "the difficult things," including painful memories and emotions. The clinician asked Stanley to reflect upon his experience of sharing these memories with his granddaughter, relative to his initial expectations. Stanley described feeling warmly toward his granddaughter, who was "trying to understand" his experience and ultimately "learned some things about [her grandfather]." In violation of his prediction, his granddaughter had demonstrated great interest, asking for more conversations of this nature in the future, requesting to visit a Vietnam War memorial, and expressing a wish that he would share his experience with her classmates. Stanley described feeling closer to his granddaughter, and built upon this experience by sharing the memory of the grenade drill accident with his wife, who later approached him. He described feeling surprised that "she wanted to hear," as he had believed that she wished to forget the fact of his tour. Like the experience of sharing his memories with his granddaughter, the conversation with his wife led him to feel "more connected" with her, and thank her for hearing his story. Beyond meeting his initial goal for treatment,

Stanley's discussion of his memories with his loved ones indicated a growing willingness to share this aspect of his experience with his family in the service of growing closer with them.

Sharing his experiences with loved ones reflected Stanley's evolving beliefs related to intimacy with other people. In discussing the progression of his beliefs, Stanley noted that while he had felt able to conquer challenges, manage his own distress, and feel open in his relationships with others prior to joining the military, "the experience in Vietnam hardened [him] a little bit." He described feeling initially reticent to being emotionally open in existing relationships or building new ones, relating this to his difficulty building trust. When asked about his present beliefs, he expressed a desire to be close with others, as well as a need to "think it out a little bit" while building trust over time. Similarly, Stanley said that his experiences in Vietnam led him to question his ability to manage high-stakes situations, such as those he encountered daily as a soldier. Relating his doubt to his subsequent desire to "be Superman," Stanley acknowledged that, while he can set his expectations "too high," he presently felt able to manage his feelings and address challenges arising in his environment, as he had when coping with feelings of sadness, fear, and guilt when sharing his experiences in Vietnam with family members. In describing his views, he said: "I think I like me to a certain degree. Not 100%," but he felt described feeling "comfortable" accepting himself.

When the therapist asked Stanley to reflect upon his experience of writing the new impact statement, the client reflected a similar movement toward self-acceptance and away from guilt. In the statement he read, Stanley wrote: "The grenade drill happened because the guy was not previously trained, which I didn't think of since this was virtually impossible...I didn't cause the accident, and it's highly unlikely that I had any power to prevent it. I shouldn't hold myself accountable for not being able to read his mind." Speaking of his movement away from the

inexperienced soldier, which had led him to feel further guilt, Stanley said, “It was happenstance.” Stanley described his present beliefs related to safety, trust, control, esteem and intimacy. Regarding safety, he wrote that his Vietnam experience led him to feel “concerned about the world in general,” indicating an understanding that “this comes from being ‘on alert’ all the time in the combat zone,” rather than from a necessarily accurate assessment. Relatedly, Stanley wrote that his experience in Vietnam, when he “couldn’t tell the enemy from the friendly” contributed to difficulty trusting others. Speaking of his present views, Stanley stated that he trusts those close to him fully, but must “take time to build a trust with someone” new, which he hopes to do. In contrast to his initial view that he had full control, and was therefore to blame for the grenade drill accident, Stanley expressed his belief that “there is a finite number of things that I control,” including his efforts to maintain his health and his relationships, and he “shouldn’t fret over the rest.” Relatedly, Stanley expressed feeling increasingly “comfortable in [his] own skin,” citing his lifetime accomplishments, which included maintaining a loving marriage and raising a family, in which he felt increasingly close with his loved ones. Overall, Stanley wrote that he believed he had “passed the life course,” made more challenging by consistent homework, and appreciated new “new angles by which to view [his] history.”

After discussing Stanley’s experience of writing the impact statement for the second time, the therapist read out the client’s initial impact statement with Stanley’s permission. The therapist prompted Stanley to reflect upon the differences between the two, which he summarized as his revised view of his responsibility for the accident, his ability to control tragic events, and his overall view of himself as acceptable. Stanley said, “I can honestly look in the mirror and say to myself, you never half-stepped...I’m not grading myself as deeply as I did back there.” The

therapist reflected the significance of this change, which led him to feel more “happy with [him]self,” and how his efforts engaging in treatment led directly to these changes.

In addition, the clinician engaged Stanley in a discussion to review the skills he developed over the course of treatment, as well as his experience at various stages of the therapy. Stanley described finding the tools utilized in treatment (e.g., challenging his beliefs, writing and reading the trauma account) helpful in allowing him to entertain a different perspective, particularly related to trust, self-esteem, and intimacy with others. Praising him for the difficult work of not only revisiting the pain associated with traumatic memories, but also many of the associated worldviews he had taken as fact, the clinician noted that Stanley’s strength, openness, and commitment had led him to experience these significant gains in a little over one month. Linking his efforts to his initial decision to pursue treatment, the therapist highlighted the way in which “being less critical, accepting [him]self” had allowed Stanley to “dive in” and “deal with the difficult emotions” and memories in away that “directly allowed [him] to feel comfortable enough to have this experience with [his granddaughter]. To have that conversation with [his wife].” Recalling that Stanley’s original motivation was founded in his values of commitment and family, the therapist reminded him of his goal to “be fully known” by his family members, and emphasized the way in which his work in treatment led him to share this aspect of himself and feel more connected with his family: “Talk about living your values! You were doing it.” Stanley agreed, saying that he did it because he wanted his granddaughter to “know who [he] was once when [he] was young. And maybe that’ll make her understand better what [he is] now that [he’s] not young.” In the final moments of the treatment, the clinician engaged Stanley in a discussion of his experience of ending the treatment, and prompted him to discuss future goals he might pursue, implementing the skills practiced in session. Stanley described his wish to further build upon his

connection with his granddaughter and other family members, expressing optimism. Although the CPT treatment ended in this final session, the clinician met with Stanley once more to discuss his interest in additional treatment, which he declined.

Results

Quantitative Results

In addition to monitoring the process and outcome of the described interventions through the role of participant-observer, the clinician also used several objective outcome measures as discussed in Section 2. Clinical symptoms were measured throughout the assessment, pre-treatment, and treatment, in addition to one month after the completion of the planned therapy. The CAPS was used to assess PTSD symptoms at intake. At this time, PTSD, depressive, and anxiety symptoms, as well as overall functioning, were also measured using the PCL-M, BDI-II, BAI, and OQ-45.2. These instruments were also completed immediately after the completion of the MI pre-treatment, at the mid-point of CPT treatment, after treatment, and one month post-treatment. The client's level of motivation was also assessed at intake, after the MI pretreatment, midway through CPT treatment, and immediately after treatment. Similarly, measures of client-therapist alliance were used after MI pre-treatment, midway through treatment, and following the completion of CPT. Finally, Stanley's compliance with homework was assessed at every treatment session at which assignments were reviewed.

Based upon both qualitative assessment, summarized in Section 3, and results obtained with the CAPS, Stanley's described symptoms initially met criteria for PTSD (see Table 1). Most notably, he experienced clinically significant distress related to hyperarousal symptoms, avoidance symptoms, and re-experiencing symptoms, as well as feelings of guilt over his perceived past actions. During the administration of the CAPS, Stanley expressed particular distress associated with the following symptoms: difficulty sleeping, a decreased sense of closeness with loved ones, intrusive memories of the traumatic events, and related feelings of guilt. A summary of Stanley's PTSD symptoms as assessed using the CAPS can be found in Table 1. Although Stanley was not

assessed with the CAPS a second time, the PCL-M was used to assess PTSD symptom severity throughout the course of MI and CPT, as well as following treatment. Per recommendations set forth by the National Center for PTSD (2014), a cutoff score of 45-50 was used to determine the presence of clinically significant PTSD symptoms in the specialized outpatient mental health clinic. Upon intake, Stanley's reported symptoms were sub-threshold according to this metric. Considering with the results of the CAPS, Stanley's self-described reticence to acknowledge distress associated with symptoms, and his guilt about "deserving" PTSD treatment, it was collaboratively determined by both the PI and her supervisor that Stanley was likely minimizing at intake, when he scored 28 on the PCL-M. This hypothesis was supported by his score of 46 on the same measure immediately following three sessions of MI, which addressed the impact of his symptoms, bringing them into relief. Based on the PCL-M, Stanley's symptoms decreased over the course of subsequent treatment (see Table 2). Although they were greater at follow-up, his PTSD symptoms remained subclinical. Using the reliable change index (RCI), Stanley evidenced reliable change in his PTSD symptoms as measured by the PCL-M between intake and post-treatment (Jacobson & Truax, 1991; Ruggiero, Del Ben, Scotti, & Rabalais, 2003). Although there was no reliable change evident in Stanley's PTSD symptoms, as measured by the PCL-M, between intake and follow-up, it should be noted that Stanley's tendency to minimize symptoms and distress was likely influencing his scores on this and other measures at all assessment points.

Other measures of symptoms and functioning indicated overall improvement over the course of the study (see Table 2). Results from the BDI-II indicated that Stanley was experiencing moderate depressive symptoms at intake. While his score following MI was invalid, as he did not complete all items on the instrument, subsequent administrations indicated that he had mild depressive symptoms mid-treatment, and minimal depressive symptoms following treatment and

one month later. Results from the BDI-II suggest that Stanley achieved reliable change between intake and post-treatment, as well as between intake and follow-up. There was no reliable change in anxiety symptoms (Beck, Epstein, Brown, & Steer, 1988), as Stanley's score on the BAI indicated an increase from mild to moderate anxiety symptoms between intake and the completion of the MI pretreatment, as discrepancy was developed, and a subsequent return to minimal anxiety symptoms that was maintained at one month follow-up. With regard to functioning across various domains, Stanley's responses on the OQ-45.2 indicated clinically significant impairment in the areas of symptom distress and interpersonal relationships, as well as on the score of general functioning. There was reliable change in each of these areas between intake and post-treatment, as well as between intake and follow-up. Stanley's scores on these dimensions of functioning were not clinically significant following CPT treatment. No reliable change was found in Stanley's functioning in social roles and his scores were subclinical both before and after treatment.

In addition to the qualitative changes in motivation, therapeutic alliance, and treatment engagement described in Section 5, objective measures were used to track the nature and evolution of client motivation for change and treatment, working alliance as perceived by client and therapist, and homework compliance. As described in the initial assessment of the client presented in Section 3, Stanley's initial motivation for treatment appeared to be the product of introjected regulation related to feelings of guilt or responsibility informed by other's feedback. Over the course of the MI pretreatment, Stanley's level of introjected regulation decreased, while his levels of identified regulation and intrinsic motivation increased, as initially hypothesized (see Table 3). These results suggest that Stanley's motivation became increasingly rooted in his personal desire for change, as well as his own identified values and goals. However, his external regulation also increased over this period, suggesting that he was also increasingly influenced by environmental

factors, such as others' desires. Over the course of CPT treatment, Stanley's level of intrinsic motivation, integrated regulation, and identified regulation continued to increase, speaking to the continued growth of this desire for change for its own sake as well as its consistency with his core personal values and wishes. Furthermore, these results suggest that Stanley's motivation for change increased over the course of CPT treatment influenced by MI, as well as over the course of the MI pretreatment itself, based on the overall increasing levels of intrinsic motivation, integrated regulation, and identified regulation throughout the study.

Like Stanley's motivation, the working alliance grew over the course of the treatment and was perceived similarly by both client and clinician. In particular, reliable change could be seen between the outset of treatment and post-treatment in both the client's and the therapist's perceptions of mutual agreement about the way in which treatment would help Stanley achieve his goals. In addition, the therapist's confidence about the agreed-upon treatment goals had increased midway through treatment, demonstrating reliable change. Stanley's confidence demonstrated similar reliable change between the start of CPT and post-treatment. However, Stanley's compliance with homework varied over the course of treatment in a way that reflected ongoing life events, most notably his granddaughter's surgery and subsequent recovery. For full results, please see Figure 1.

Qualitative Results

At the outset of his participation in the present study, Stanley was experiencing PTSD symptoms, including intrusive thoughts and memories, flashbacks, avoidance of painful thoughts and memories, affective numbing, irritability, hypervigilance, survivor guilt, and significant feelings of distress. While he clearly suffered from PTSD symptoms, Stanley presented with the greatest subjective distress in relation to feelings of guilt and decreased self-acceptance associated

with depressive symptoms. Likely associated with Stanley's intense feelings of guilt, he expressed a belief that he was not "worthy" of the PTSD diagnosis, minimized his symptoms considerably, and voiced a wish to suppress the terrible memories. Over the course of the motivational interviewing pretreatment, Stanley increasingly acknowledged the impact of his experience of traumatic events on his present PTSD symptoms, emotional experience, and family. Although Stanley's awareness of the significant impact of his trauma and associated feelings of ambivalence fluctuated during pretreatment and treatment, he repeatedly recognized the effects of PTSD on his ability to feel close with loved ones and pass on his legacy. As his desire for connection with family was his primary reason for change, this enhanced recognition not only motivated Stanley to fully engage in treatment, but also likely contributed to significant improvement in interpersonal relations over the course of treatment, as reflected in the OQ-45.2 (see Table 2). In addition to improving his relationships throughout treatment, Stanley concluded that he did indeed "deserve" care for his symptoms. Following CPT, he reported a sizeable decrease in re-experiencing, avoidance, and arousal symptoms of PTSD, expressing significantly less distress in relation to the traumatic memories.

During treatment, Stanley increasingly expressed difficult emotions, including feelings of fear, sadness, and guilt, to the clinician and his family members. The associated beliefs over his need to exert full control over his feelings changed, as he shared difficult memories and feelings with various people in his life. Stanley's beliefs about his responsibility for the grenade drill also diminished greatly, such that he acknowledged that he was not at fault, calling the traumatic event an "accident" for which he was not to blame. In the final impact statement, Stanley wrote that the tragedy "simply happened." As his self-criticism and self-blame for the grenade drill accident as well as other perceived "failures" declined, Stanley voiced increased self-acceptance, stating, "I

like me to a certain degree.” His improved self-esteem was likely associated with a significant decrease in depressive symptoms, as indicated by Stanley’s reduced BDI-II score at termination (see Table 2). Relatedly, the client demonstrated increased trust in himself, as well as a growing willingness to gradually build trust in his relationships with select others that was reflected in his Challenging Beliefs Worksheets as well as his behavior. In his final impact statement, Stanley concluded, “there is a finite number of things [he] can control...and [he] shouldn’t fret over the rest.” Overall, Stanley’s active examination and reformulation of previous stuck points suggested the development of improved cognitive flexibility that allowed the client to consider “new angles” during treatment, as he noted in his final impact statement.

Stanley’s treatment gains led him to accomplish his initial goal of sharing his experiences in Vietnam—including his traumatic memories—with his granddaughter, thereby building increased closeness and passing along his legacy. While he had initially shared “very little” with his family, leading his wife to ban relatives from discussing the war, over the course of treatment Stanley increasingly shared difficult memories with his clinician, granddaughter, and wife. In addition to memories, photographs, and the diary entries detailing his day-to-day experience of being in Vietnam that he had kept stored away for years, Stanley shared his traumatic memories and associated feelings of sadness, fear, and guilt. As a result, he reported feeling emotionally close with his granddaughter as well as his wife. At the end of treatment, his wartime experiences were no longer a forbidden subject, and Stanley was increasingly living in accordance with his identified values. Stanley’s gains extended beyond symptom relief, as he alleviated feelings of emotional isolation through increased engagement with loved ones.

Discussion

The present study was intended to examine the impact of integrating MI pretreatment, principles, and interventions with subsequent CPT treatment for veterans. Specifically, the PI had hoped to study the potential impact of including an MI intervention prior to CBT treatment as a method of enhancing the client's experience in benefiting from the process of CBT therapy, as well as improving subsequent treatment outcome. It was hypothesized that the integration of an MI pretreatment with CPT would enhance client motivation, engagement in treatment, alliance with the therapist, and compliance with homework in the course of treatment, as well as amplify any associated effect on PTSD, anxiety, and depressive symptoms, and in turn overall functioning.

Based on the process of the course of treatment, as well as the qualitative and quantitative outcomes observed throughout the study, it appeared that the MI pretreatment helped to enhance Stanley's motivation for and commitment to change. At the outset of the study, he evidenced considerable ambivalence related to treatment. While his level of ambivalence continued to fluctuate throughout the course of treatment as new obstacles emerged, his overall level of motivation increased throughout the study. Notably, Stanley's level of intrinsic motivation for change increased over the course of the pretreatment, a trend that also continued throughout CPT. Based on therapist observation, Stanley's identification of core personal values, including his commitment to his family and building close relationships with the younger generation, as well as his development of the congruent goal of sharing his experiences in Vietnam with his granddaughter were highly influential. When he identified these values and an associated goal, Stanley was increasingly able to appreciate the ways in which his PTSD symptoms prevented him from sharing this aspect of himself. Stanley accomplished this goal, sharing both pleasant and

painful memories with his granddaughter, demonstrating the strength of his intrinsic motivation and commitment.

It is likely that the MI pretreatment and subsequent integration of MI principles and techniques also served to enhance client engagement with treatment, as indicated by Stanley's level of participation in various aspects of treatment, such as: recalling and writing about his traumatic experiences and their impact, experiencing connected primary emotions, and examining affected beliefs (Drieschner, Lammers, & van der Staak, 2004). While he actively participated in considering, discussing, and writing about the impact of the traumatic experiences, Stanley continued to demonstrate ambivalence about experiencing the associated emotions in session. His reticence was influenced by trauma-related avoidance of the painful feelings and his beliefs regarding the significance of exhibiting negative affect—particularly to a female clinician. Similarly, Stanley did not immediately complete behavioral tasks assigned as homework at all times (e.g., giving compliments). The clinician drew upon MI principles in both instances, as described in Section 4, leading to somewhat improved engagement as demonstrated by Stanley's increased willingness to share his feelings with the clinician and offer praise to his family members. In these interventions, the clinician used MI techniques in addition to referring back to Stanley's stated values and goals to help him access his personal reasons for engaging in the difficult tasks of treatment. Thus, while it cannot be decisively concluded that the MI pretreatment had a positive effect on Stanley's engagement in treatment, it appears this was likely the case, given Stanley's momentary and subsequent responses to the MI-driven interventions. The apparent effectiveness of MI interventions in helping Stanley pursue challenging undertakings suggests that MI may be particularly useful in enhancing moment-to-moment engagement and compliance with difficult tasks.

It is more difficult to isolate the impact of MI on therapeutic alliance, as the working relationship was not assessed at the outset of clinical work. While objective assessment demonstrated the improvement of therapeutic alliance, as indicated by reliable change in the degree of client and therapist agreement about treatment goals and methods, this may have resulted from the simple development of the relationship and open discussion between client and therapist. Accordingly, although the principles of MI (e.g., regard for the client, support of the individual's autonomy and self-efficacy) are conducive to the formation of a strong alliance, it is difficult to disentangle the impact of the MI approach from the largely compatible therapeutic relationship fostered in CPT. Similarly, the present study did not support a positive relationship between MI and homework compliance for Stanley, as originally hypothesized and suggested by the existing literature (Westra & Dozois, 2006). Although specific MI-based interventions appeared effective in motivating the client to complete assignments after initial difficulty, it cannot be concluded that this was directly related to the MI pretreatment. Rather, Stanley's rate of homework completion seemed to mirror the presence of ongoing life stressors, such as his granddaughter's surgery and recovery. Thus, the present case study indicates that the use of MI principles and interventions may aid in homework compliance when a client experiences individual obstacles to completion.

When examining the impact of MI on symptom outcome, it is presumed that the intervention did not independently or directly lead to improvement in PTSD, anxiety, or depressive symptoms. Rather the MI pretreatment and subsequent integration with CPT was hypothesized to impact symptoms by enhancing the process variables associated with cognitive-behavioral treatment, as discussed above, thereby allowing the client to experience greater gains from treatment. Indeed, the MI pretreatment appeared to impact Stanley's acknowledgement of present PTSD symptoms. While he met criteria for the disorder according to the CAPS, his self-report

score did not meet the clinical cut-off point at intake as a result of probable minimization (National Center for PTSD, 2014). Following the MI pretreatment, however, in which Stanley discussed the ways that trauma-related symptoms impacted his ability to live in accordance with his personal values, his self-reported PTSD symptoms met criteria for the disorder. Stanley's subsequent acknowledgement of the impact of his traumatic experiences indicates that engaging in the MI intervention likely helped him better appreciate the extent of his PTSD symptoms, and in turn access motivation for addressing them through treatment. The client's symptoms of PTSD did improve significantly through the course of treatment. While data suggest that Stanley experienced an increase in PTSD symptoms in the month after he completed treatment, the severity of symptoms was still lower than at the outset of CPT. Unearthed in the process of MI pretreatment, Stanley's goal to share his experiences in Vietnam with his granddaughter proved a chief motivating factor for change. In pursuit of this goal, Stanley not only revisited the painful memories and feelings himself through the course of CPT, but also approached related experiences outside of treatment (e.g., reading his diary, sharing photographs taken in Vietnam). Furthermore, in addition to sharing his memories of traumatic experiences as well as the events that comprised his day-to-day life in Vietnam with his granddaughter, he also ventured to share certain memories with his wife, thereby enhancing his sense of emotional intimacy with his loved ones. By decreasing experiential and in-vivo avoidance of traumatic memories and associated cues, as well as directly fostering emotional openness, Stanley's pursuit of his original goal served to directly combat PTSD, thereby likely enhancing treatment outcome.

While the integration of MI may have served to enhance PTSD symptom improvement, results from the present study suggest that the pretreatment intervention served to increase the client's experience of overall anxiety. Stanley's heightened experience of self-reported anxiety

may reflect his increased willingness to acknowledge the presence and impact of his psychological symptoms as the result of the enhanced sense of discrepancy between his initial experience and his stated values, as well as his amplified urgency for change, as spurred by the MI pretreatment.

Conversely, Stanley's depressive symptoms decreased over the course of CPT, which may or may not relate to the client's engagement in MI.

Finally, Stanley's quality of life across various domains, including psychological and interpersonal functioning, improved significantly over the course of the pretreatment as well as subsequent therapy. Both Stanley's continuously improved self-report assessment of his personal functioning and the clinician's qualitative assessment of the process of treatment suggest that MI likely amplified the effects of CPT treatment. Specifically, the pretreatment helped Stanley identify and articulate personal values that were related to his functioning and satisfaction in various aspects of his life, including his marital and family relationships. The client's enhanced awareness of these values, and subsequent pursuit of related goals, likely enhanced his ability to be the husband and grandfather that he wished to be, less hindered by the impact of PTSD symptoms. In addition to highlighting the need for these changes, MI as integrated in the initial pretreatment and throughout the course of CPT also sought to enhance Stanley's sense of self-efficacy, helping him appreciate his own ability to achieve his desired goals in these important domains.

While it is impossible to isolate the key agents of change through the current study, the strength of Stanley's commitment to his goal of sharing his experiences in Vietnam appeared to have a great impact on his willingness to engage in the difficult tasks of treatment *throughout* the therapy. When he experienced difficulty with an aspect of the treatment, be it the revisiting of a traumatic memory or the examination of a painful fear, accessing his value-driven goal of sharing this aspect of himself with his family seemed to help Stanley connect with his original reasons for

pursuing treatment. In the moments when the therapist helped Stanley access and actively pursue this value of connection with family members (be it his wife, son, or his granddaughter, as initially intended), there was a great sense of true collaboration within the treatment. It was in these moments that the spirit of MI was being most embodied in the course of PTSD treatment. Furthermore, in accordance with the strong impact of his commitment to pursuing his identified goal on the process of therapy, it was the quality of his close interpersonal relationships that were most improved, as per the OQ-45.2, over and above the overall improvement in symptoms.

In examining the process of the MI pretreatment, subsequent CPT treatment, and the integration of the principles and outcome of the MI pretreatment throughout therapy, this case study suggests that using an MI approach to identify the client's personal values and goals, evoke related reasons for change, and translate these reasons into a commitment to a planned course of action can work effectively as a precursor to formal PTSD treatment with veterans. Following the broad agenda described in Section II, Stanley engaged with the clinician in the pretreatment, identifying his key values of family and connection, and formulating a personal goal to share his experiences with his granddaughter, which he might pursue by utilizing treatment to address his PTSD symptoms.

Based on his identified goal and engagement in planning to pursue treatment through the present study, the transition from MI pretreatment to CPT was largely fluid, as the treatment phase effectively constituted the execution of his chosen plan. Although Stanley independently chose to pursue treatment through the present study following a collaborative discussion, the spirit of MI would have been better represented had Stanley been offered a wider range of treatment options immediately and easily available to him, in addition to the option of treatment through the present study and referrals to other cost-free therapy. Additionally, the transition between MI pretreatment

and treatment was complicated by the shift from the largely open yet directive therapeutic style taken in pretreatment to the similarly collaborative yet increasingly prescriptive nature of CPT. This change, while not dramatic, was nonetheless observed by the client, who stated that he viewed the therapist increasingly as a “teacher,” and the treatment as “a course.” Speaking to the emphasis that CPT places on psychoeducation and a deliberate examination of identified stuck points using cognitive-behavioral methods, Stanley’s experience elucidates one of the challenges of shifting from a relatively less structured intervention to a more structured treatment. In order to help ease this transition, the clinician extended the length of many sessions to allow Stanley greater opportunity to discuss those items that he wished to add to the agenda, such as his concern about his granddaughter when she was undergoing surgery. In addition, the therapist also described the particulars associated with CPT treatment in the final pretreatment session. Although Stanley was informed about the increasingly directive nature of CPT prior to deciding to engage in the treatment, additional emphasis on this difference might help smooth this transition while further serving to increase the client’s autonomy in determining how to pursue his chosen goal. Throughout the course of the treatment in the present study, the clinician also repeatedly asked permission to engage Stanley in various therapeutic tasks, drawing upon the MI spirit to enhance Stanley’s experience of his own agency in a more directive, yet ultimately collaborative, treatment.

The process of integrating the outcome of the MI pretreatment as well as the MI spirit and associated interventions illustrated the overall compatibility between the two approaches. In addition to helping reinforce and support Stanley’s autonomy throughout the treatment, the therapist largely used Socratic questioning to help the client come to independent, value-driven conclusions about his beliefs related to various stuck points. In this process, she selectively reflected Stanley’s reasons and cited evidence for changing his views to be more compatible with

his values and goals. Using MI techniques to help Stanley examine the impact of his stuck points on his ability to live consistently with his values proved particularly effective when the client struggled with specific stuck points. For instance, when Stanley expressed his belief that he must fully control all expression of negative affect, the therapist worked with Stanley to both recognize the impact of this belief on his relationships with family members, and reframe the sharing of his emotional experience as a sign of strength and courage. Although he did not allow himself to fully express his painful feelings, the intervention appeared effective in helping Stanley accept his feelings when thinking of his experiences outside of session.

The therapist also sought to draw upon MI by explicitly referring to Stanley's stated values and goals throughout the treatment, which helped him access motivation for change in the face of emerging obstacles as well as the difficulty of treatment itself. Interventions focused on helping Stanley pursue his larger aim—such as setting small goals, anticipating obstacles, using problem-solving in planning, and determining next steps—were also included throughout the course of treatment. These tools proved effective in helping Stanley achieve his goal of sharing his experiences in Vietnam with his granddaughter, and go further to build upon the resultant behavioral momentum to engage in similar, value-congruent actions, such as sharing his experience of treatment with his wife. In the process, he not only accomplished his initial goal, but also strengthened his emotional connection with his loved ones, acting upon his new beliefs related to intimacy, which he developed over the course of CPT. In sum, the MI pretreatment and its subsequent integration with CPT appeared to be effective in not only helping Stanley access his personal motivation and reasons for change, but also pursue the associated goals throughout the course of treatment, achieving both symptom relief and his individual goal of sharing his experiences with his family.

Limitations and Future Directions

The present study is affected by several limitations, which suggest potential directions for future research. First, the investigator faced significant difficulty recruiting subjects, ultimately conducting a single case study rather than the planned series. As described in Section 2, recruitment efforts included the distribution of flyers, which described the study as providing a treatment for PTSD. Because the materials advertising the study indicated that the treatment offered may be trauma-focused, those who called the investigator had a requisite amount of motivation for treatment at the outset. Accordingly, it is probable that those veterans who were strongly impacted by many of the barriers to treatment engagement previously did not contact the investigator upon seeing the flyer. Challenges that likely deterred potential candidates from contacting the investigator likely included the obstacles to treatment engagement discussed in Section 1. These barriers included the avoidance associated with PTSD and the resultant minimization of symptoms, which impacted Stanley (Snell & Tusaie, 2008). Minimization of trauma-related symptoms may lead to decreased interest in available interventions (including the present study) or even underdiagnosis. Additional factors that may have deterred potential participants from engaging in the study include the associated stigma and shame associated with masculine socialization, particularly as the study was advertised in meetings and physical spaces of certain veterans organizations in which individuals were likely socializing with peers (Lorber & Garcia, 2010). The beliefs surrounding a potential negative impact of treatment may have also dissuaded suffering veterans from participating (Snell & Tusaie, 2008; Stecker, Fortney, & Sherbourne, 2011), particularly because this study was described as an “experimental” treatment for PTSD that may have aroused anxiety and suspicion. Finally, veterans who did not receive a dishonorable discharge may be able to receive their medical and mental health care through the

VA in a single location. Access to ongoing treatment in a care setting where individuals already receive other forms of care may be preferred to participation in a time-limited study in an unfamiliar clinic. Any of these factors may have served as barriers to veteran participation in the present study, in spite of the large number of veterans in need of PTSD treatment.

Because this study examines a single case, the generalizability of conclusions drawn is quite limited. This is especially true of the present case study, as the client discussed here is not representative of many of the veterans requiring treatment for PTSD. Stanley sought treatment decades after his wartime experience, and did not present with severe PTSD symptoms; indeed, he had completed a course of treatment in the past and was functioning in his various roles in spite of symptom-related distress. Relatedly, the changes in PTSD, depressive, and anxiety symptoms were not dramatic, given his moderate level of initial distress. Additionally, the conclusions drawn here are limited, as more information is required to better understand which factors contributed to the increase in depressive and PTSD symptoms between immediate post-treatment and follow-up. Furthermore, although Stanley discussed a number of traumatic memories, he was clearly most disturbed by one primary index trauma and the associated survivor guilt. In these respects, Stanley's presentation and experience may not reflect that of many veterans, who may have undergone multiple deployments with several traumatic events that contribute to equally severe distress. For those individuals with more severe or complex presentations, the initial utilization of MI to highlight the intersection of personal goals and values with the anticipated gains of treatment, as well as its integration throughout the course of treatment, may prove even more helpful for the process and outcome of psychotherapy. However, as the process of treatment would likely be complicated by additional factors, such as grief, the process of integrating MI into the course of treatment may be similarly affected.

The present case study was intended to use qualitative observation as well as quantitative assessment to examine the implementation of an MI pretreatment associated with trauma-focused treatment. As the present study utilizes a single-case pragmatic case study design for this purpose, the conclusions discussed here are limited and cannot be generalized. In order to determine if the MI pretreatment and subsequent integration with CBT positively impacts the process and outcome of treatment, an RCT must be conducted to compare the effects of the MI and CPT intervention with a control condition that provides subjects with an alternative pretreatment of equal duration. Such a study would help to determine whether the process of integrating MI with PTSD treatment truly enhances treatment engagement and gains, or if it simply dovetails with the challenging process of trauma-focused psychotherapy.

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Appendix

Table 1
Results of Assessment Using Clinician-Administered PTSD Scale

PTSD Symptoms	Frequency	Intensity	Severity Score	Number of Symptoms	Criterion Met	Global Rating
Re-Experiencing	9	7	16	2	Yes	-
Avoidance	11	8	19	3	Yes	-
Hyperarousal	11	10	21	5	Yes	-
Subjective Distress	-	2	-	-	Yes	-
Impairment: Social	-	1	-	-	No	-
Impairment: Occupational	-	1	-	-	No	-
Associated Features	-	-	-	-	-	-
Guilt Over Actions	3	3	6	-	-	-
Survivor Guilt	3	2	5	-	-	-
Reduced Awareness	0	0	0	-	-	-
Derealization	0	0	0	-	-	-
Depersonalization	0	0	0	-	-	-
Global Validity	-	-	-	-	-	1
Global Severity	-	-	-	-	-	2

* The results of the administered CAPS represented here can be regarded as valid. The Global Validity score of 1 on a scale of 0 to 4 indicates that although the present administration has good validity, the client's minimization of symptoms and impairment likely had a slight impact on validity of present results (see Section 5). The global severity score was assigned by the clinician based on an overall understanding of the severity, distress, and impairment associated with the client's symptoms as assessed in the CAPS. Stanley's global severity score of 2 indicates that he suffers from distress and moderate impairment in functioning as a result of the trauma-related symptoms noted here.

****Based on the administration of the CAPS, the client met criteria for clinically significant trauma-related symptoms, including two re-experiencing symptoms, three avoidance symptoms, five hyperarousal symptoms, and significant associated distress, as well as associated feelings of guilt (Blake et al., 1995).**

*****The scores provided above reflect the client's scores related to the frequency of each symptom category, the intensity of distress and impairment associated with each symptom category, and the combined severity of each respective symptom category. Both frequency and intensity scores range from 0, indicating that Stanley never experienced related symptoms or suffered no associated distress or impairment, to 20 for re-experiencing symptoms, 28 for avoidance symptoms, and 20 for hyperarousal symptoms. Higher scores indicate that Stanley reported experiencing symptoms with more frequency or experiencing greater associated distress or impairment. The severity scores range from 0 to 40 for re-experiencing symptoms, 56 for avoidance symptoms, and 40 for hyperarousal symptoms, with lower scores reflecting lower symptoms severity, while higher scores indicate greater symptom severity. Dashes indicate no score for the relevant category.**

Table 2
Client Symptoms and Distress Throughout Pretreatment and Treatment

Measure	Clinical Cut-Off Score	Intake	After Pretreatment	Mid-Treatment	Post-Treatment	One-Month Follow-Up
Beck Anxiety Inventory	n/a	8 ^b	25 ^a	12 ^b	8 ^b	4 ^c
Beck Depression Inventory-II	n/a	21 ^a	Invalid	14 ^b	1* ^c	6* ^c
Outcome Questionnaire-45.2	63	63 [^]	48	51	26*	29*
Symptom Distress	36	36 [^]	36 [^]	28	17*	23*
Interpersonal Relations	15	22 [^]	12	10	5*	4*
Social Role	12	5	0	13	4	2
PTSD Checklist - Military	45-40	28	46 [^]	33	2*	25

*The Reliable Change Index (RCI) was used to determine the presence of statistically significant and meaningful change in clinical symptoms, as described by Jacobson and Truax (1991). Scores marked with an asterisk indicate that Stanley experienced statistically significant change in symptoms assessed by the respective measure between intake and post-treatment and/or between intake and one month follow-up.

[^] Based on self-report assessment using each respective measure, scores signify clinically significant distress or impairment associated with PTSD symptoms or overall functioning based on cutoff scores for PCL-M (National Center for PTSD, 2014) and OQ-45.2 (Lambert et al., 2004).

^a Scores indicate that the subject suffers from moderate anxiety or depressive symptoms, with a BAI score of 16-25 or a BDI-II score of 20-28 (Beck & Steer, 1993; Beck, Steer, & Brown, 1996).

^b Scores indicate that the subject suffers from mild anxiety or depressive symptoms, with a BAI score of 8-15 or a BDI-II score of 14-19 (Beck & Steer, 1993; Beck, Steer, & Brown, 1996).

^c Scores indicate that the subject suffers from minimal anxiety or depressive symptoms, with a BAI score of 0-7 or a BDI-II score of 0-13 (Beck & Steer, 1993; Beck, Steer, & Brown, 1996)

Table 3
Client Motivation and Alliance Throughout Pretreatment and Treatment

Measure	Intake	After Pretreatment	Mid-Treatment	Post-Treatment
Client Motivation for Therapy Scale	-	-	-	-
Intrinsic Motivation	15	18	19	21
Integrated Regulation	15	14	21	25
Identified Regulation	13	18	18	24
Introjected Regulation	20	12	12	19
External Regulation	12	15	10	12
Amotivation	8	9	13	9
Working Alliance Inventory-Short Form	-	-	-	-
Task (Client)	-	19	23	26***
Task (Therapist)	-	19	22	24***
Bond (Client)	-	24	27	24
Bond (Therapist)	-	23	25	26
Goal (Client)	-	20	23	26***
Goal (Therapist)	-	21	25***	24
Total (Client)	-	63	73	76
Total (Therapist)	-	63	72	74

*The Client Motivation For Therapy Scale provides a measure of various types of motivation, with subscale scores ranging from 4 to 28. Higher scores indicate that the client's desire for change is more impacted by the form of motivation indicated.

**The WAI-S was used to assess overall working alliance between client and clinician, and measure both individuals' subjective experience of concordance on treatment goals, mutual agreement about way in which the tasks of treatment will help the client work toward identified goals, and the bond between client and therapist. Total scores range from 12 to 84, and individual subscale scores each range from 7 to 28 (Tracey and Kokotowitc, 1989).

***The Reliable Change Index (RCI) was used to determine the presence of statistically significant and meaningful change in working alliance, as described by Jacobson and Truax (1991). Subscale cores marked with three asterisks indicate statistically significant change in components of therapeutic alliance, as assessed by the WAI-S, between the initial administration after pretreatment, midway through treatment, and post-treatment. The RCI could not be calculated for total scores.

Table 4
Planned Agendas for Pretreatment and Treatment

Session	Primary Agenda Tasks	Worksheets or Structured Tasks	Homework Assigned	Homework Compliance (HCS)
MI Session 1	<ul style="list-style-type: none"> - Build rapport - Discuss reasons for exploring present study - Identify personal values & relationship to PTSD - Begin developing discrepancy between values and impact of PTSD - Communicate assessment results with permission - Begin discussing potential areas of change - Provide summary of discussion 	<ul style="list-style-type: none"> - Values Card Sort: card-sorting activity that facilitates the identification of personal values and categorization by importance (Miller et al., 2001) 	<ul style="list-style-type: none"> - Rank top values by order of importance 	<p>Assigned homework fully completed</p> <p>HCS not given</p>
MI Session 2	<ul style="list-style-type: none"> - Discuss top-ranked values - Focus on impact of PTSD on Stanley's ability to live by values - Elicit ambivalence & evoke reasons for and against change - Evoke and reinforce change talk - Promote mobilizing action 	<ul style="list-style-type: none"> - Importance Ruler: Therapeutic tool used to elicit, reinforce, and strengthen importance assigned to pursuit of change - Confidence Ruler: Therapeutic tool used to elicit, reinforce, and strengthen Stanley's confidence in ability to effect change 	<ul style="list-style-type: none"> - None 	n/a

Table 4 Continued

Session	Primary Agenda Tasks	Worksheets or Structured Tasks	Homework Assigned	Homework Compliance (HCS)
MI Session 3	<ul style="list-style-type: none"> - Continue evoking & reinforcing change talk - Summarize Stanley's commitment to values (including desire, reasons, need for change, and ability to pursue values) - With permission, offer feedback about change goals in relation to values and recommendations - Present study as means to pursue values and goals by treating PTSD - Support Stanley's autonomy in deciding 	None	- None	n/a
CPT Session 1	<ul style="list-style-type: none"> - Psychoeducation about PTSD as disorder of recovery, cognitive theory, & emotions - Brief description of trauma memory - Discussion of stuck points in relation to goals for treatment - Identification of potential obstacles to treatment 	<ul style="list-style-type: none"> - PTSD Symptoms Handout - Stuck Point Handout - Stuck Point Log 	- Write first impact statement	5

Table 4 Continued

Session	Primary Agenda Tasks	Worksheets or Structured Tasks	Homework Assigned	Homework Compliance (HCS)
CPT Session 2	<ul style="list-style-type: none"> - Reading of impact statement - Discuss meaning of impact statement and stuck points - Psychoeducation about CBT model of PTSD and treatment - Psychoeducation about primary and secondary emotions in relation to CBT model 	<ul style="list-style-type: none"> - Stuck Point Log - Identifying Emotions Handout - A-B-C Worksheet 	<ul style="list-style-type: none"> - Daily A-B-C worksheets, including trauma-related sheet 	6
CPT Session 3	<ul style="list-style-type: none"> - Review homework - Discuss trauma-related worksheet - Begin identifying relevant stuck points - Use Socratic questioning and cognitive techniques to help Stanley begin challenging stuck points, especially related to self-blame - Discuss written trauma account 	<ul style="list-style-type: none"> - A-B-C Worksheet 	<ul style="list-style-type: none"> - Write narrative account of most difficult traumatic memory 	4

Table 4 Continued

Session	Primary Agenda Tasks	Worksheets or Structured Tasks	Homework Assigned	Homework Compliance (HCS)
CPT Session 4	<ul style="list-style-type: none"> - Review homework - Have Stanley read trauma account with emotional expression - Identify stuck points - Challenge stuck points resulting from assimilation (e.g., self-blame) 		<ul style="list-style-type: none"> - Rewrite trauma narrative account with increased sensory detail - Re-read account daily - Daily A-B-C worksheets 	5
CPT Session 5	<ul style="list-style-type: none"> - Review homework - Read second trauma account aloud - Discuss differences in experience between past and present, and between readings of trauma account - Discuss additional or altered stuck points - Introduce ways of challenging affected beliefs 	<ul style="list-style-type: none"> - A-B-C Worksheet - Challenging Questions Worksheet 	<ul style="list-style-type: none"> - Read trauma account daily - Daily Challenging Questions Worksheet 	5

Table 4 Continued

Session	Primary Agenda Tasks	Worksheets or Structured Tasks	Homework Assigned	Homework Compliance (HCS)
CPT Session 6	<ul style="list-style-type: none"> - Review homework - Cognitive therapy for stuck points - Discuss cognitive distortions - Use Socratic questioning to help challenge impacted stuck points 	<ul style="list-style-type: none"> - Challenging Questions Worksheet - Patterns of Problematic Thinking Worksheet 	<ul style="list-style-type: none"> - Identify stuck points - Identify and challenge patterns of problematic thinking - Re-read trauma account if needed - Challenging Questions Worksheet, if needed 	4
CPT Session 7	<ul style="list-style-type: none"> - Review homework - Challenge belief related to traumatic event - Introduce areas of belief related to trauma - Introduce Safety Module 	<ul style="list-style-type: none"> - Patterns of Problematic Thinking Worksheet - Challenging Beliefs Worksheet - Safety Module Handouts 	<ul style="list-style-type: none"> - Read Safety Module - Identify and challenge stuck points daily - Identify and challenge at least one stuck point related to safety 	5
CPT Session 8	<ul style="list-style-type: none"> - Review homework - Help Stanley challenge stuck points related to safety - Introduce Trust Module 	<ul style="list-style-type: none"> - Challenging Beliefs Worksheet - Trust Module Handouts 	<ul style="list-style-type: none"> - Identify and challenge stuck points daily - Identify and challenge at least one stuck point related to trust 	3

Table 4 Continued

Session	Primary Agenda Tasks	Worksheets or Structured Tasks	Homework Assigned	Homework Compliance (HCS)
CPT Session 9	<ul style="list-style-type: none"> - Review homework - Help Stanley challenge stuck points related to trust - Discuss different gradations and types of trust - Introduce Power & Control Module 	<ul style="list-style-type: none"> - Challenging Beliefs Worksheet - Power/Control Issues Module Handouts 	<ul style="list-style-type: none"> - Identify and challenge stuck points daily - Identify and challenge at least one stuck point related to power & control 	4
CPT Session 10	<ul style="list-style-type: none"> - Review homework - Help Stanley challenge stuck points related to power - Discuss ways of giving & taking power - Introduce Esteem Module 	<ul style="list-style-type: none"> - Challenging Beliefs Worksheet - Esteem Module Handouts - Ways of Giving and Taking Power Handout 	<ul style="list-style-type: none"> - Identify and challenge stuck points daily - Identify and challenge at least one stuck point related to esteem - Practice giving and receiving compliments - Daily pleasurable activities 	4
CPT Session 11	<ul style="list-style-type: none"> - Review homework - Help Stanley challenge stuck points related to esteem - Introduce Intimacy Module 	<ul style="list-style-type: none"> - Challenging Beliefs Worksheet - Intimacy Module Handouts 	<ul style="list-style-type: none"> - Identify and challenge stuck points daily - Identify and challenge at least one stuck point related to intimacy - Continue daily pleasurable activities and giving/receiving compliments - Write new impact statement 	5

Table 4 Continued

Session	Primary Agenda Tasks	Worksheets or Structured Tasks	Homework Assigned	Homework Compliance (HCS)
CPT Session 12	<ul style="list-style-type: none"> - Review homework - Help Stanley challenge stuck points related to intimacy - Read & discuss impact statement (present and initial) - Review concepts, skills, and beliefs developed through course of treatment -Identify future goals 		- None	0 (n/a)

Table 5
Handouts Used Throughout Cognitive Processing Therapy

Handout	Handout Title	Sessions Used	Description
1	Posttrauma Reactions That Lead to PTSD	1	Describes cycle of emotional, cognitive, and intrusive events contributing to avoidance and related PTSD symptoms.
2	Stuck Points—What Are They?	1	Defines stuck points and explains the development of stuck points through assimilation and over-accommodation.
3	Stuck Point Log	1, 2	Log that prompts client to record relevant stuck points.
4	Identifying Emotions Handout	2	Visual representation of primary emotions at various degrees.
5	A-B-C Worksheet	2, 3, 4, 5	Assists client in identifying activating event, associated belief, and consequence. Prompts client to challenge belief and generate alternative view if appropriate.
6	Challenging Questions Worksheet	5, 6	Provides list of questions to prompt client to challenge stuck points and other unrealistic beliefs.
7	Patterns of Problematic Thinking Worksheet	6, 7	Provides list of cognitive distortions to prompt client to identify stuck points impacted by “patterns of problematic thinking.”

Table 5 Continued

Handout	Handout Title	Sessions Used	Description
8	Challenging Beliefs Worksheet	7, 8, 9, 10, 11, 12	Provides prompts to help client identify situation, associated thoughts, emotions, potential challenging questions, potential cognitive distortions, alternative cognitions, and resulting impact.
9	Safety Issues Module	7	Provides information about ways in which beliefs related to safety of self and others can produce stuck points through assimilation or over-accommodation.
10	Trust Issues Module	8	Provides information about ways in which beliefs related to trust of self and others can produce stuck points through assimilation or over-accommodation.
11	Power/Control Issues Module	9	Provides information about ways in which beliefs related to power and control over self and others can produce stuck points through assimilation or over-accommodation.
12	Esteem Issues Module	10	Provides information about ways in which beliefs related to esteem toward self and others can produce stuck points through assimilation or over-accommodation.
13	Ways of Giving and Taking Power	10	Provides examples of ways in which individuals can give and take powers in positive and negative ways.
14	Intimacy Issues Module	11	Provides information about ways in which beliefs related to intimacy with oneself and others can produce stuck points through assimilation or over-accommodation.

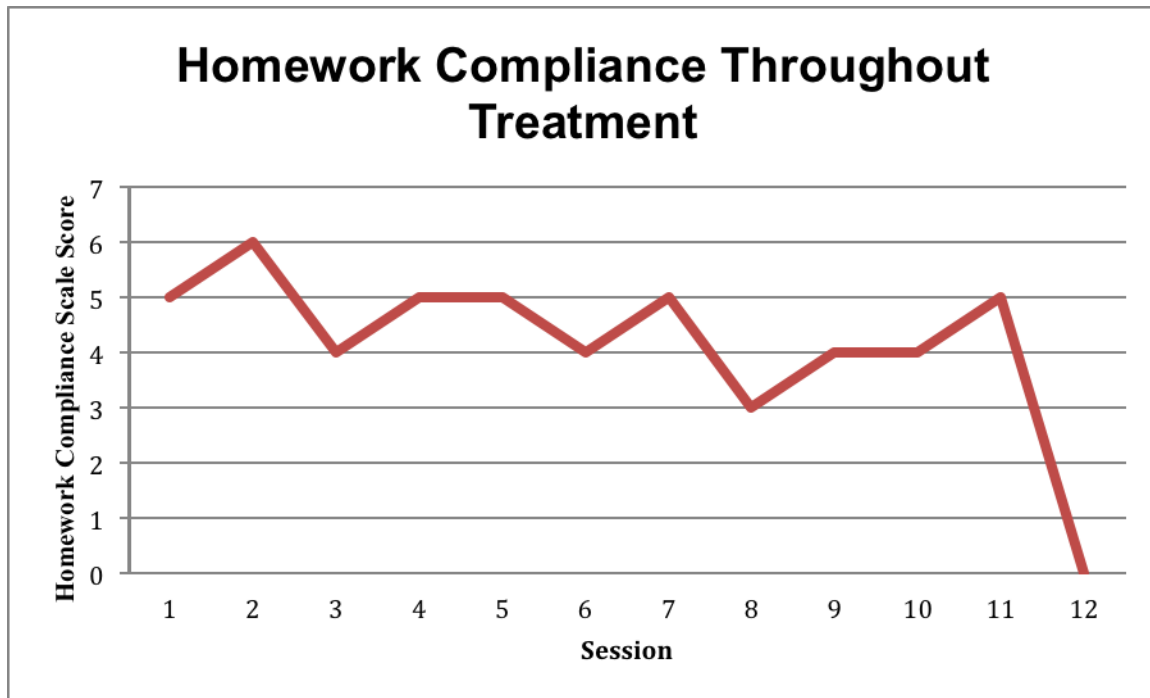


Figure 1. Homework Compliance Throughout Treatment

*Scores of 0 indicate no homework assigned on specified session.