

The Process of Structured Psychotherapy Training and Supervision in Facilitating a Successful
Treatment of PTSD by a Novice Clinician: The Case of “Leo”

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Abstract

This dissertation consists of the systematic, psychotherapy case study of “Leo,” a 20-year-old Hispanic college junior who presented to therapy with Post-Traumatic Stress Disorder (PTSD), Major Depressive Disorder, mild, and Alcohol Use Disorder. Leo was the first Cognitive-Behavioral Therapy (CBT) case assigned to me in my first year of doctoral clinical training as part of an initial course on CBT, and treating Leo’s comorbid diagnoses presented complex technical challenges. My supervision and the associated therapy in Leo’s case involved two originally unplanned phases. Phase 1 (sessions 1-13) was associated with a *traditional, less structured supervision model*, which focused on targeting Leo’s alcohol use with a generic modality of CBT that included such elements as Motivational Interviewing (MI) in order to lower the frequency of his dissociative episodes and to facilitate Leo’s capacity to fully experience his emotions. Phase 2 (sessions 14-25) was associated with an *emerging, more structured supervision model*, which views the supervisory process as an explicit introduction to and the dedicated practice of specific interventions and skills—in this instance, those associated with Cognitive Processing Therapy (CPT; Resick & Schnicke, 1992). Specifically, this supervision targeted Leo’s increased ability to fully experience his emotions by focusing on: (a) psychoeducation regarding the effects of trauma and how defensive avoidance interferes with adaptive processing of the trauma; (b) teaching Leo thought monitoring and assessing the impact of his trauma on his beliefs; and (c) using imaginal exposure to memories of his trauma in order to examine and challenge the emotions and beliefs impacted by his trauma, allowing for non-pathological re-encoding of his memories of the event. The first part of the case study briefly describes Leo’s clinical situation at the end of Phase 1 and then focuses in detail upon Phase 2, illustrating the strengths of Phase 2 as a successful example of the structured psychotherapy training model in action. An analysis of the supervision and therapy in Phase 2 presents evidence that the successful resolution of Leo’s PTSD immediately following treatment and at 18-month follow-up was facilitated by a number of elements in the supervision, including: (a) explicit training of the therapist in CPT prior to supervision; (b) process-oriented supervision of CPT via the microanalysis of taped sessions; and (c) continued CPT training to complement ongoing supervision

Keywords: alcohol use disorder; case study; cognitive-behavior therapy; cognitive processing therapy; exposure; grief; imaginal exposure; PTSD; pragmatic case study; psychotherapy training; psychotherapy supervision; trauma

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1. CASE CONTEXT AND METHOD

“Leo” was the first Cognitive-Behavioral Therapy (CBT) training case assigned to me in my first year of doctoral training as part of an introductory course on CBT. (Note that the client’s name, other identifying information, and other details of his history have been changed to disguise his identity). Leo was a 20-year-old male who initially presented with Post-Traumatic Stress Disorder (PTSD) and Alcohol Use Disorder. There were two phases of treatment. Phase 1 consisted of 13 sessions of nonspecific CBT treatment that incorporated elements of Motivational Interviewing (Rollnick & Miller, 1995) designed to address Leo’s Alcohol Use Disorder symptoms. This phase of treatment was supervised by Dr. A, who follows a CBT model. This phase of treatment will be summarized as part of the Assessment section of Leo’s treatment summary.

At the end of Phase 1, Leo’s use of alcohol to defensively limit his emotional experience had been eliminated. Leo was very motivated to continue treatment that focused on addressing his PTSD, particularly his feelings of guilt and sole responsibility for the death of a family member, hyperarousal symptoms, dissociations, and changes in his cognitions about himself, others, and the world. For example, Leo perceived that he was a bad person who was unworthy of good things, that he invariably brought misfortune to others, and that he caused danger frequently. These cognitions led to increased symptoms of depression, working too much, strained social relationships and subsequent social isolation, and a high baseline level of anxiety. At the same time, I had completed my initial course in CBT and had learned about Cognitive Processing Therapy (CPT), a treatment developed for the express purpose of treating PTSD. I sought out extra supervision from a supervisor with extensive experience in trauma treatment and CPT, Dr. B. Together, Dr. B and I determined that Phase 2 of treatment would entail me

engaging Leo in CPT in order to treat his PTSD. Dr. B and I collaboratively decided to begin training me in the fundamentals of CPT prior to beginning treatment Phase 2 with Leo. Dr. B provided me with the theory of CPT, module-based web training for CPT, behavioral role plays of CPT skills, and home assignments to complete between training/supervision sessions.

Once Phase 2 of treatment began, Dr. B provided supervision of Leo's therapy, with a detailed focus on viewing and processing videos of my therapy sessions with Leo—that is, with a focus on a microanalysis of therapy. The case study below uses Fishman's (2005; 2013) pragmatic, systematic case study method to focus in detail upon Phase 2, illustrating the strengths of Phase 2 as a successful example of the structured psychotherapy training model in action.

Approximately 15 months after treatment I contacted Leo expressing my interest in writing about his case for publication in a scholarly journal. He eagerly agreed and signed a consent form that indicated that proper disguise of identifying characteristics would be observed.

2. THE CLIENT

Leo, a 20-year-old Hispanic college junior, was referred to the training clinic of a university-based clinical psychology doctoral program. He came to the clinic with a presenting problem of anxiety and depression and stated that these feelings were impeding his academic and social functioning in addition to causing significant distress on a near-constant basis. He was formally diagnosed with Post-Traumatic Stress Syndrome (PTSD) and, secondary to the PTSD, Major Depressive Disorder-Mild and Alcohol Use Disorder (partly as a way of self-medicating for his PTSD).

Leo's psychological difficulties were rooted in a single traumatic event. As a high school senior, Leo was celebrating getting into his highest-ranked college by underage drinking and getting drunk with his closet friends, one of whom was his cousin. At the end of the night, Leo tried to sneak both of them into Leo's home so that Leo's parents would not notice they were intoxicated. However, they were caught, and Leo's parents began yelling at the two of them. Leo's cousin ran out of the house after a few minutes of arguing. Leo ran after his cousin but was unable to catch up to him. With no subsequent communication for 6 weeks, Leo's family received a call from his cousin's family notifying them that his cousin had been found deceased: he had apparently drowned. Leo was unable to learn many more details of his cousin's passing, as his cousin's parents were so grief stricken that they did not elect to share the information they had about his cousin's death. This lack of knowledge was combined with Leo's last memory of his cousin being that Leo was unable to stop his cousin from running away after getting in trouble for something Leo suggested. This combination of factors caused Leo to believe that his cousin's death was his fault.

Leo reported previous psychological treatment: approximately five sessions of CPT and an unknown amount of group grief counseling at the college counseling center. The CPT therapist had left the campus counseling center before the entire CPT protocol could be completed, and Leo was then referred to the training clinic.

3. GUIDING CONCEPTUALIZATION: COGNITIVE PROCESSING THERAPY

Resick and Schnicke (1992) developed a manualized treatment for PTSD called “Cognitive Processing Therapy” (CPT). This approach is organized around three elements: (a) a social cognitive theory of PTSD that focuses on how the traumatic event is construed and coped with by a person who is trying to regain a sense of mastery and control in his or her life; (b) an emotional processing theory of PTSD (Foa, Steketee, Rothbaum, 1989), an extension of Lang’s (1977) information processing theory; and (c) exposure therapy. In controlled studies CPT has accumulated considerable empirical evidence of its effectiveness for this diagnosis, and it is therefore considered one of the treatments of choice for PTSD (Watkins, Sprang, & Rothbaum, 2018).

Housed within the broader cognitive-behavioral therapy (CBT) model, CPT blends multiple theories in order to create a treatment that affects multiple aspects of PTSD. The social-cognitive theories focus more on the content of cognitions and the effect that distorted cognitions have upon emotional responses and behavior. In order to reconcile the information about the traumatic event with prior schemas, people tend to do one or more of three things: assimilate, accommodate, or over-accommodate. Assimilation is altering the incoming information to match prior beliefs (“Because a bad thing happened to me, I must have been punished for something I did”). Accommodation is altering beliefs enough to incorporate the new information (“Although I didn’t use good judgment in that situation, most of the time I make good decisions”). Over-accommodation is altering one’s beliefs about oneself and the world to the extreme in order to feel safer and more in control (“I can’t ever trust my judgment again”).

In a social-cognitive model, affective expression is needed in order for the affective elements of the stored trauma memory to be changed as opposed to habituation to anxiety. It is

assumed that the natural affect, once accessed, will dissipate rather quickly, and will no longer be stored with the trauma memory. Also, the work of accommodating the memory and beliefs can begin. Once faulty beliefs regarding the event (e.g. self-blame, guilt) and over-generalized beliefs about oneself and the world (e.g. safety, trust, control, esteem, intimacy) are challenged, then the secondary emotions will also decrease along with the intrusive reminders. The explanation that CPT therapists give to clients about this process is presented below in my description of Session 1, along with a handout in the patient materials section.

In line with CPT theory, PTSD is believed to emerge due to the development of a fear network in memory that elicits escape and avoidance behavior. Mental fear structures include stimuli, responses, and meaning elements. Anything associated with the trauma may elicit the fear structure or schema and subsequent avoidance behavior. The fear network in people with PTSD is considered to be stable and broadly generalized so that it is easily accessed. When the fear network is activated by stimuli associated with the trauma, the information in the network enters conscious awareness, causing what are called “intrusive symptoms.” Attempts to avoid the emotional and physiological activation associated with these and other symptoms result in the avoidance symptoms of PTSD. According to Emotional Processing Theory, repetitive exposure to the traumatic memory in a safe environment will result in habituation of the fear and subsequent change in the fear structure. As emotion decreases, clients with PTSD will begin to modify their meaning elements spontaneously and will change their self-statements and reduce their generalization. Repeated exposures to the traumatic memory are thought to result in more than habituation, but rather to a change in the information about the event, and subsequently, the fear structure.

CPT uses specific therapy tools and concepts: the ABC Worksheet, the Impact Statement, the Trauma Account, the Challenging Questions Worksheet (CQW), the Patterns of Problematic Thinking Worksheet (PPT), and the Challenging Beliefs Worksheet (CBW).

The ABC Worksheet

This is a tool commonly used in Cognitive-Behavioral Therapy (CPT) that introduces Thought Monitoring to clients. The heuristic, “ABC,” is an acronym for Antecedents, Behaviors, and Consequences. By analyzing events according to antecedent events or triggers, the behaviors themselves, and the consequences of behaviors, clients can understand more about themselves and their patterns of reaction. In CPT, clients often evaluate their thoughts in the context of a particular target behavior and associated emotions and environmental consequences. This process facilitates awareness of the link between thoughts and feelings, and it begins the process of questioning one’s own thoughts. Clients are assigned ABC sheets after the first session and throughout most of therapy.

The Impact Statement

This is a one page, hand-written assignment that instructs the client to describe how they think about the ways in which the traumatic event has affected their lives. Clients are asked to pay attention to how the traumatic event affected their views of themselves, other people, and the world. Additionally, clients are asked to write about why they think this event happened to them, and how has it changed or strengthened their views about themselves, other people, and the world in general. Impact Statements are hand written in order to encourage more effort and emotional experience than typing may induce.

The Trauma Account

This consists of a hand-written narrative of the traumatic event being processed in CPT. Clients write two Trauma Accounts during therapy. The first Trauma Account is assigned as homework to be written early in therapy and clients read it aloud to the therapist in the subsequent session. Reading the Trauma Account serves two purposes: as exposure therapy for the traumatic memories, and for gleaning “Stuck Points” from the narrative. Therapists often encounter resistance to fully engaging in the process of writing the Trauma Account. This can be used by therapists to understand Stuck Points, the thoughts that maintain the traumatic association to their memories, and to correct the course of therapy by addressing client concerns.

A second Trauma Account is assigned toward the middle of therapy. Clients add more sensory detail to the second account to facilitate integration of dissociated sensations and memories. The second account is assigned to be read nightly, especially when clients begin completing Challenging Beliefs Worksheets. The readings function as exposure therapy that habituate clients to their traumatic memories. Additionally, reading the account prior to working on Challenging Beliefs Worksheets (CBWs, see below) activates the memories and emotions associated with the trauma, which facilitates the clinical utility of CBWs. Without activating the memories and emotions associated with the trauma, the CBWs would likely fall prey to intellectualization.

The Challenging Questions Worksheet (CQW)

This contains specific questions regarding a client’s Stuck Points. CQWs ask the client to provide evidence for and against the thoughts inherent to their Stuck Points: specifically, if the thought is based on habit or facts; if there is absolute thinking present in the thought; if there is exaggerated language (such as never, always, etc.) in the thought; if the thought focuses on one

element of the client's experience to the exclusion of other details; if the source of the thought is reliable; if the thought confuses the possible with the likely; if the thought is based on feelings or facts; and if the thought is focused on information unrelated to their experience. These worksheets deepen the process of questioning over-accommodated beliefs.

The Pattern of Problematic Thinking Worksheet (PPT)

These are added to therapy in the session prior to the Challenging Beliefs Worksheets (see below). The PPT worksheets give formal terms to the cognitive distortions implied in the questions asked in Challenging Questions Worksheets, such as "All or Nothing Thinking" and "Emotional Reasoning." This allows clients to question their beliefs with more fluency and ease by naming patterns for heuristic recall.

The Challenging Beliefs Worksheet (CBW)

This is the final worksheet in CPT. They combine every skill used in previous worksheets into one single worksheet. Prior worksheets were used to begin the process of questioning beliefs and to familiarize and to train clients in the use of therapy skills. CBWs formalize the use of all the skills in a specific sequence to restructure over-accommodated beliefs. Clients apply CBWs to Stuck Points to process their beliefs. The therapists often complete some CBWs with clients, focusing on collaboration to facilitate deep encoding of changes to their beliefs and to practice the skill of using CBWs. Clients also complete CBWs as homework in between sessions to facilitate mastery and self-sufficiency, integral elements to third-order therapeutic change.

4. ASSESSMENT OF THE CLIENT'S PROBLEMS, GOALS, STRENGTHS, AND HISTORY

Qualitative Assessment

Family History

There was no known psychiatric history in Leo's family. Leo was the eldest child of Hispanic parents. He had a sister who was approximately five years younger than him. Leo's cousin was approximately one year older than him. His upbringing stressed loyalty to family. This value affected Leo's relationship with his cousin as well as how he related to his family and cousin's memory subsequent to his cousin's death.

Social factors contributed to Leo's presentation as well. Leo assumed many roles within his social group of friends and family: leader, caretaker, and planner. He was considered the smartest of the group and the one most likely to "do great things." To Leo and his peers this meant going to college, finding a lucrative career, and giving back to his community. He incorporated these roles into the cognitive schema of his identity. Leo began leading a dual life when he entered high school. On the one hand, he was a conscientious good student; on the other, he often engaged in physical altercations alongside his cousin.

As his cousin began to engage in frequent altercations and substance use, Leo's loyalty to family contributed to a felt sense of duty to help his cousin in what ways he could. Additionally, his roles as caretaker and leader led to Leo often being considered "the responsible one" as he often figured out ways to keep others safe and/or avoid negative consequences for his peers. He began to both take pride in his abilities and think that failure to avoid negative consequences meant he did not do enough for others.

Leo's loyalty to family contributed to emotional conflict as Leo and his cousin grew older. Although Leo felt an intense loyalty to his cousin, he also knew that his cousin had

difficulties at home. His cousin was often yelled at, there were physical altercations in the family, and he often ran away from home. His cousin's substance use was likely a method of emotional avoidance of his strained family environment. Leo wanted to help his cousin but also knew he needed to maintain loyalty to his aunt and uncle. Unable to resolve this conflict, Leo opted to be his cousin's best friend, confidant, and helper. If he couldn't resolve the conflict, he could at least make his cousin's pain more bearable. Leo internalized this role as part of his identity as well.

The Traumatic Event

As described above, Leo's trauma occurred on the day he learned of his acceptance to his highest ranked college. He wanted to celebrate this achievement with his closest friends, including his cousin. Leo and his friends decided to celebrate by drinking alcohol. However, none of the group happened to be old enough to legally purchase or consume alcohol. Through a mixture of ingenuity and teenage antics, Leo and friends were able to acquire a few bottles of hard liquor. Yet they could not drink in any of their homes as their parents would not condone this. Thus, Leo and friends wound up celebrating outside in the woods fairly close to his home.

As time passed, everyone involved in the celebration become highly intoxicated. Leo decided to end the celebration and bring his cousin home, as his cousin lived much farther away than Leo did from their location and they were both quite intoxicated. When Leo and his cousin arrived at Leo's home, Leo tried to sneak both of them into his home so that Leo's parents would not notice they were intoxicated. For context, Leo's cousin often got in trouble with Leo's parents. Leo especially wanted to avoid getting caught by his parents. Despite his best efforts, Leo and his cousin were caught, and Leo's parents began yelling at the two of them. Leo's

cousin ran out of the house after a few minutes of arguing. Leo ran after his cousin but was unable to catch up to him. He never heard from his cousin after that night.

His cousin had run away before, so he had previously experienced lapsed communication with his cousin. However, this lapse in communication lasted six weeks—much longer than he had ever gone without hearing from his cousin in similar situations. After six weeks Leo's family received a call from his cousin's family notifying them that his cousin had been found deceased; he had apparently drowned. Leo was unable to learn many more details of his cousin's passing as his cousin's parents were so grief stricken that they did not elect to share the information they had about his cousin's death. This lack of knowledge—combined with Leo's last memory of his cousin being unable to stop his cousin from running away after getting in trouble for something Leo suggested—caused Leo to believe that his cousin's death was his fault.

When Leo entered treatment with me he had been affected by the trauma of his cousin's death for three years. The memories of the night his cousin died and many memories of his cousin in general were traumatic stimuli. Aside from Leo's PTSD symptoms, his current life had been built around his cousin's death, which caused a split in how Leo approached and led his life. On the one hand, Leo wanted to make a better life for himself in response to his cousin's death, a desire that was rooted both in their sharing of childhood dreams of a better future as well as an attempt to atone for causing his cousin's death. To that end, Leo studied very frequently, obtained part time employment at his university, and sought to change what he perceived to be "bad habits" from the past. On the other hand, Leo continued to drink excessively despite the guilt he felt regarding his cousin's death being directly linked to alcohol. Leo used alcohol both to attempt to self-medicate (and avoid) his guilt, anxiety, and PTSD symptoms as well as remain

psychologically attached to his cousin by continuing to behave in ways that they both had in the past.

Clinical Presentation in the Assessment Interviews

There were four sessions of clinical assessment that blended assessment and treatment in Phase 1. The clinical assessment interviews indicated Leo's reactions to his trauma. These included: re-experiencing the night of the trauma and other intrusion symptoms; avoidance of thoughts, feelings, and reminders of his cousin; highly negative thoughts and assumptions about themselves and the world; exaggerated blame of himself for the trauma and problems that were occurring in everyday life; negative affect; decrease in activities; feeling isolated and experiencing less positive affects; risky behavior; hypervigilance; heightened startle reaction; and difficulty concentrating and sleeping.

Specifically, Leo would often think of his cousin and the night of his trauma as a reaction to both good and bad events in his life. If Leo experienced something good, he would think of his cousin and wish he were there and subsequently experience negative emotions due to feelings of guilt. If Leo experienced something bad, he would think of the night of the trauma, that he has caused a great deal of problems in the world, and that he cannot atone for his mistake. As such, Leo avoided intentionally thinking of his cousin.

Leo's depression was secondary to the effect PTSD had on his functioning. Specifically, Leo's PTSD symptoms isolated him from social bonds and positive reinforcement by curtailing interpersonal relationships with friends and family, contributing to negative self-perception, and causing him to avoid many situations. Leo reported that he was often "jumpy," had a baseline anxiety level of about 4/10 for the entirety of every day, and had an exaggerated startle reflex.

He would experience increased heart rate, tremulous hands, cold sweats, and shortness of breath and could not discern most stimuli that could cause these reactions.

He reported that his trauma happened during a blizzard and that being cold often made him more anxious and could contribute to dissociative flashbacks to his trauma. Leo reported hypervigilance insofar as constantly looking for signs that friends or loved ones were in danger and a vague sense that something bad could happen at any moment. He reported avoiding any reminders of his cousin, including avoiding returning home from university housing, talking with other family members, contacting friends who knew the deceased, and looking at pictures of the deceased. Despite his attempts at avoidance, Leo reported that he experienced intrusive thoughts regarding his cousin “countless times every day,” including thoughts such as “it was my fault,” “if it weren’t for me he would be alive,” “I need to make sure no one ever ends up like him,” “I’m a bad person for what I did to him,” and “I need to make my whole life about making up for what I did to him.”

Leo reported that he could experience dissociative flashbacks when highly anxious. He was more prone to dissociative flashbacks when intoxicated from alcohol. He stated that he was usually aware of the present while also re-experiencing the events of his trauma during the dissociative flashbacks. Leo also reported that he had infrequently lost awareness of the present entirely. Friends informed him that he continued to talk and move as if he was fully conscious while he relived the night of his trauma in full dissociative flashbacks.

Leo would drink to the point of intoxication approximately two to three times every week. While intoxicated, Leo often got into verbal altercations, could not remember where his friends were, acted impulsively, and had dissociative flashbacks to the night of his trauma. Leo also had extreme difficulty staying asleep, often sleeping for about one hour at a time and

waking up in cold sweats, unable to fall back asleep for approximately 20 minutes each time. Even if Leo went to sleep leaving eight hours to sleep, he frequently slept only about two to three hours each night. Combined with hypervigilance and increased physiological arousal, Leo had great difficulty with sustained attention.

There are numerous examples of the symptoms reviewed above. For instance, Leo described chasing after his cousin in the middle of a blizzard; subsequently, Leo would experience increased heart rate and shaking hands as well as increased thoughts of his cousin when Leo was physically cold. While Leo reported that verbal altercations made him feel more anxious than they had previously, Leo now responded to minor disagreements between friends with high levels of anxiety. Leo responded to this anxiety by trying to mediate disputes between friends. However, if his attempts to mediate failed, he would become frustrated. When Leo became frustrated, he would quickly begin to think of himself as a bad person for being frustrated, leading to him thinking about his cousin during the night of the trauma. Given that many verbal disputes occurred while Leo was intoxicated, Leo was often unable to resolve disputes. The subsequent anxiety combined with his intoxicated state led to episodes of dissociation.

Examples of Leo's emotional difficulties were plentiful as well. When Leo obtained his job at University, he initially felt happy and proud of himself; but then he thought of his cousin, wishing that his cousin was there to enjoy this with him. This led to thoughts that he did not deserve to have good things happen to him. If Leo made a mistake while on the job, he would think that this is all he deserves and mentally berate himself for failing others.

Leo had a sense of foreboding, an ever-present feeling that his presence would cause misfortune for others. This became another reason Leo avoided spending time with friends and

family. Avoiding friends and family caused him to feel more guilt as he was failing to be a good son, causing even more harm to his family. Leo felt great shame as well, causing him to withhold the details of his difficulties from his closest friends despite their frequent attempts to try to help him. He told only 2 to 3 of his closest friends about his response to his trauma. These friends would try to help Leo manage himself if he became highly anxious or even dissociated. However, this caused Leo to feel he was a burden to his friends. Leo's friendships thus suffered, as he felt guilty towards those who knew and he relied on for help, and distant from those who did not know.

Diagnosis

The DSM-5 (American Psychiatric Association, 2013) was used to establish psychiatric diagnosis. Leo met criteria for a diagnosis of PTSD. Additionally, Leo presented with depressive symptoms and met criteria for Major Depressive Disorder, mild.

In sum, based on the above information, Leo was given the following formal diagnoses:

Post-traumatic Stress Disorder 309.81

Major Depressive Disorder, Single Episode, Mild 296.21

Alcohol Use Disorder, 303.90

Mental Status at the Beginning of Therapy

Leo was alert and fully oriented during both phases of treatment. During Phase 1, Leo sometimes appeared intensely dysphoric. Leo reported experiencing dissociative flashbacks during one session. His affect was generally appropriate to context and his reported mood was typically anxious or euthymic. Leo's speech was generally normal in rate and prosody, although it was monotone during initial readings of the Impact Statement and Trauma Account. His speech was otherwise on the whole organized, fluent, and at normal volume. His thought process

was logical and coherent, with no loosening of associations or flight of ideas. Leo's body language was generally engaged, although he avoided eye contact, would shrink into his chair, or look down if he failed to complete assignments.

Leo denied a history of head injuries and medical problems. Leo reported that his alcohol consumption had decreased between Phase 1 and Phase 2, and he stated he drank "maybe one or two beers a week" at the beginning of Phase 2. Leo came across as affable and warm. Generally this was appropriate, with a few instances in which his warmth felt forced when discussing negative emotions he did not want to direct at others. Leo denied current or past suicidal or homicidal ideation. Leo described thinking of death insofar as he wanted to meet his cousin, but had no thoughts of harming himself, and no method, plan, or intent. Leo denied a history of self-harm.

Quantitative Assessment

Two standardized, quantitative self-report measures focusing on anxiety-related symptoms were administered to Leo during every session in Phase 1 and 2 as part of treatment monitoring. These instruments include the Clinically Useful Anxiety Outcome Scale (CUXOS) and Beck Depression Inventory-II (BDI-II).

At 15-month follow-up, Leo completed retrospective measures of the CUXOS, BDI-II, and two further self-report measures: the Outcome Questionnaire-45 (OQ-45) and PTSD Symptom Checklist for the DSM5 (PCL-5). Leo's retrospective completion of the CUXOS, BDI-II, OQ-45, and PCL-5 asked him to think of his status at the beginning of Phase 1 of our therapy, at the end of Phase 1 of our therapy (Week 13), and at the current time of the follow-up. Leo did not complete retrospective measures of the OQ-45 and PCL-5 for the end of Phase 2 of our therapy (Week 25).

The measures are described below, and the results are presented in Table 1.

The Clinically Useful Anxiety Outcome Scale (CUXOS; Zimmerman, 2010)

This measure was used to assess Leo's progression through treatment via the reduction of his anxiety symptoms. The CUXOS is a self-report paper measure that evaluates the severity of anxiety symptoms and their change over time as a function of treatment. It is composed of 20 questions rated on a 0-4 Likert scale, with 0 indicating no issues with a particular symptom, and 4 indicating severe issues with a particular symptom. The assessment is scored cumulatively, has a maximum score of 80, and is divided into five severity levels of anxiety, as shown in Table 1.

The Beck Depression Inventory-II (BDI-II; Beck, 1968)

This measure was used to assess Leo's comorbid issues with depressive mood that may be secondary to the ways in which clients cope with PTSD symptoms. This assessment was given due to Leo's self-reported issues with depression, as well as epidemiological data indicating the frequency with which anxiety disorders and depression are comorbid with each other. The BDI-II is a self-report paper measure that evaluates the severity of depression and depressive symptoms. It is composed of 21 questions rated on a 0-3 Likert scale, with 0 indicating no problems with a particular symptom, and 3 indicating frequent or severe problems with a given symptom. The assessment is scored cumulatively, has a max score of 63, and is divided into four severity levels, as shown in Table 1.

Outcome Questionnaire-45 (OQ-45; Lambert et al, 2004)

The 45 self-report items of the OQ-45 measure common symptoms across a wide range of adult mental disorders and syndromes, including difficulties caused by symptoms, relationships, and roles as worker, homemaker, or student. Each item is scored from 1-4 range, yielding a maximum score of 180.

Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5; Weathers et al., 2015).

The PCL-5 is a 20 item self-report measure that assess DSM-5 symptoms of PTSD. The PCL-5 itself cannot be used to make a diagnosis of PTSD; however, its cutoff score of 33 indicates that further evaluation for PTSD by a mental health professional is warranted. Its scores range from 0-80.

Strengths

Leo also demonstrated a number of strengths. His most notable strength at the beginning of treatment was his ability to maintain consistent part-time employment while simultaneously maintaining strong academic performance. He was quickly promoted to a supervisory role in his job and was able to organize teams of coworkers in order to execute complex plans. Leo was a hard worker and often provided coverage for coworkers when asked of him.

Leo also had a close-knit family that provided financial and some emotional support. However, his family had also been affected by the trauma, limiting their ability to provide full emotional support for him regarding the trauma.

Leo was intelligent and motivated to be in treatment, although he was also understandably ambivalent about trauma treatment. Leo was able to conceptually grasp the material covered in treatment; and, once his resistances were addressed, he worked with significant determination to complete prescribed exercises throughout the course of treatment.

Leo was a compassionate young man who cared a great deal for those close to him. However, his compassion and ability to work very hard became pathological as he attempted to over-function in order to either avoid thinking about his trauma or to be worthy of good things.

History of Treatment Before Phase 2 of the Therapy

Treatment Before Phase 1 of My Therapy with Leo

Prior to beginning the Phase 1 of my treatment at the Training Clinic, Leo had attended approximately five sessions of CPT at the University's Counseling Center during his freshman year of University. Leo had thus had some specific previous preparation for the CPT therapy in Phase 2 of my treatment with him. Specifically, before Phase 1 of my treatment with Leo, he had worked on various aspects of the CPT treatment sequence: identifying his thoughts, psychoeducation regarding the difference between thoughts and feelings as well as primary and secondary emotions, developing an Impact Statement regarding how his trauma had impacted his life, and identifying "Stuck Points." Leo's treatment had stopped because the clinician he was working with at the time was graduating and moving on to a different clinical placement. This resulted in Leo understanding aspects of his PTSD on a cognitive level; however, he had not processed the emotions related to his trauma. Thus, his cognitive understanding of his trauma allowed him to intellectualize as an attempted method of coping with his trauma-based emotions. This coping method became ruminative and did little to facilitate healthy functioning.

As a sophomore, Leo returned to the University Counseling Center about a year later and was referred to an unknown number of sessions of group therapy for grief. While this treatment was clinically indicated insofar as Leo indeed needed to grieve the death of his cousin, the grieving process was complicated by PTSD. One of the group's clinicians noticed this and suggested that Leo seek treatment for PTSD at the Training Clinic. Leo consented, and the clinician referred him to the Training Clinic.

Phase 1 of My Treatment with Leo

Now in his third year, Leo was initially evaluated for an alcohol treatment program within the Training Clinic due to his reported frequency and intensity of alcohol consumption. The evaluation determined that he did not have a primary alcohol use issue, and referred him for an intake for individual psychotherapy. Leo was assigned to me as a training case associated with an introductory course in CBT and was the first client with whom worked using CBT.

My supervisor and I collaboratively formulated Leo's problems and created a treatment plan. Specifically, Leo's alcohol use, while obviously a function of attempts to self-medicate his PTSD symptoms, was enough to be considered alcohol abuse. Continued abuse would interfere with trauma therapy. As such, Leo was engaged in a general CBT approach with elements of Motivational Interviewing (Rollnick & Miller, 1995). The general approach would begin to socialize Leo to CBT treatment and the skills he would need to use in MI as well as CPT, such as thought monitoring; understanding causal connections between thoughts, feelings, and behaviors; and cognitive restructuring of non-traumatic beliefs. The MI approach was used in order to facilitate Leo's self-generated and intentional choice to lower his alcohol use. This Phase 1 of treatment included sessions 1-13.

There was a treatment hiatus of about six months in between session 13, the end of Phase 1, and session 14, the beginning of Phase 2. This hiatus coincided with the University's summer session. As he would not be close to the University during the summer, Leo and I collaboratively decided to resume treatment after the summer concluded, at the beginning of Leo's senior year.

Phase 1 of therapy was comprised of an interplay of assessment of Leo's symptoms and functioning, Motivational Interviewing, and Cognitive Therapy interventions with a goal of reducing Leo's alcohol consumption to a level that would allow successful treatment of his

trauma. Motivational Interviewing was used to simultaneously assess his readiness for change and begin the process of change. Cognitive Therapy interventions were used to evaluate and question the thoughts that maintained his current functioning and substance use.

Leo was contemplating changing many aspects of his behavior prior to beginning therapy. Thus, Motivational Interviewing techniques such as Decisional Balances were effective in prompting Leo to change his behavior. Such techniques allowed Leo to practice objectively assessing his behavior, increasing both his desire to change and insight into the antecedents, behaviors, and consequences that he could change. Additionally, Leo discussed his current life stressors. His discussion of these stressors provided more information regarding the effect his trauma had on his everyday behaviors.

Using this information, various attempts at Cognitive Restructuring were made. However, due to my inexperience at the time, I did most of the restructuring work for Leo during these restructurings. This led to a pattern in which Leo would engage with the work and use the restructuring to emotionally regulate during session, but leaving him unable to generalize this regulation to his everyday life. This pattern did not do much regarding trauma treatment, but it did help Leo continue to lower his alcohol use. He sporadically engaged in binge drinking contrasted with periods of complete sobriety. Cognitive restructuring at this point facilitated his recognizing that he was using alcohol as avoidance. This knowledge helped Leo continue to reduce his alcohol use over time.

By the time Leo and I met again for Phase 2 of therapy, he had reduced his alcohol use to approximately twice per week. Also, he had continued to evaluate and question his own drinking habits. Using ABC analysis of his behavior, cognitive restructuring, and his own Decisional Balances, he decided to “drink responsibly.” Rather than binge drink with friends to avoid his

trauma and never drink otherwise, he would drink occasionally. This began to change his association of drinking with managing trauma symptoms. During the treatment intermission, Leo had attended a conference in which he disclosed his trauma to new friends. He had expected to be shamed for it, but instead found compassion and acceptance. The mixture of self-initiated use of therapy techniques that reduced his drinking and increasing social connection facilitated Leo's return to treatment.

Phase 2 of My Treatment with Leo

Leo's PTSD diagnosis met the clinical criteria for an empirically-supported treatment protocol. Towards this end, my second supervisor—Supervisor B—for this case and I decided to use Resick and Schnicke's Cognitive Processing Therapy, a preferred, evidence-based treatment recognized for the treatment of PTSD by APA Guidelines for Trauma (APA, 2017). My supervisor provided me with a web-based learning and CPT training module (<https://cpt.musc.edu>) developed by Resick, Monson, and Chard (2010). My supervisor began working with me a month prior to formally resuming treatment with Leo in order to provide me with training in CPT (descriptions of the training and supervision will be included in Section 6 below, Course of Therapy). Following the web-based training module, I employed a treatment that planned for approximately 12-15 sessions of CPT. The web-based training detailed a 12-session model with explicit instructions, topics, and therapeutic goals for each session. Three extra sessions were anticipated to be used if needed in order to process trauma-related beliefs and emotions as well as the termination of therapy.

The description below constitutes the formulation and treatment plan I developed with Supervisor B.

5. FORMULATION AND TREATMENT PLAN AT THE BEGINNING OF PHASE 2 OF THE THERAPY

Case Formulation

Leo had various beliefs that resulted from the death of his cousin. These included “something terrible happened, and it’s all my fault,” which later became “all bad things that happen are my fault”; “the world is a dangerous place”; “people will get hurt and it will be my fault”; “if I never took off my shoes, he would be alive”; and “if I never drank, he would be alive.” The latter two beliefs are also emblematic of a different method of defending against trauma-related emotions that inadvertently interfere with processing trauma: undoing. Leo wished to “undo” his cousin’s death. Fantasizing about undoing his cousin’s death became ruminative and caused Leo more anxiety, guilt, and shame because he could never truly go back in time and stop his cousin from running away.

Leo ruminated about specific “flashbulb” memories of the night of his cousin’s death, such as when he took off his shoes upon returning home and going to his room. Leo distinctly remembered staring at his shoes and thinking “I should probably put them back on, something might happen.” Leo was unsure if he actually thought something bad *would* or *might* happen, and remembering the thought “something might happen” may be a function of his trauma-related memories encoding that memory with feelings of guilt. When his cousin ran out of the house, Leo fumbled to get his shoes on before pursuing his cousin while barefoot. Leo blamed himself for taking off his shoes—if he had not taken them off, he would not have wasted time trying to get them on, and if he had his shoes on, he might have caught up to his cousin.

Due to his perceived lack of control—as he could not control his cousin and he was less capable of controlling himself due to intoxication—Leo focused exclusively on what he perceived he *could* control about that night. However, this myopic focus on microscopic details

he could have controlled made Leo lose focus on what was impossible to control and contributed to more feelings of guilt and self-reproach. Leo's overaccommodated beliefs caused his high baseline anxiety; hypervigilance; changes in cognitions regarding himself, others, and the world; and intrusion symptoms. In combination with his wish to undo and his normal and dissociative traumatic memories, Leo was constantly being reminded of and feeling guilty about his cousin's death.

Treatment Plan

The plan for treatment followed the sequence outlined in the web-based CPT training. In Session 1, clients are provided with psychoeducation regarding CPT's trauma recovery model, the cognitive theory of PTSD, as well as the function of, problems caused by, and how to avoid avoidance. Clients are asked to provide a brief description of the traumatic event. Home assignments include assigning the Impact Statement.

In Session 2, clients read aloud the Impact Statement assigned the previous session. Therapists listened for Stuck Points as clients read the statement to the therapist. After clients read their Impact Statement, therapists and clients collaboratively identify Stuck Points. Using Stuck Points, therapists and clients identify emotions they felt while reading the Impact Statement. The connections between events, thoughts, and feelings are discussed in relation to Stuck Points. A brief, introductory Socratic dialogue is used to evaluate how flexible a client's thinking was as it pertained to their Stuck Points in addition to identifying more Stuck Points. Finally, clients are introduced to ABC worksheets and instructed on how to complete them. ABC worksheets are assigned for home practice.

In Session 3, therapists review client home practice of ABC worksheets. Mislabeled Behaviors and Consequences are corrected. Trauma-specific ABC worksheets are reviewed as

well. Afterwards, clients are introduced to the next home practice assignment, the Trauma Account. The Trauma Account is a written account of the traumatic incident. Clients are instructed to read the Trauma Account every day.

In Session 4, clients read the Trauma Account to the therapist. Clients were encouraged to discuss thoughts and feelings during their accounts. Therapists attend to Stuck Points and use Socratic Questioning to query clients about Stuck Points pertaining to self-blame. Clients are educated about the differences between blame and responsibility. Clients are assigned home practice: writing a second Trauma Account. Clients are asked to include more sensory details, thoughts, and feelings that occurred during the incident for the second Trauma Account. Additionally, clients are asked to include the feelings they experienced while writing the Trauma Account in parentheses. Clients are instructed to read their new Trauma Account every day.

In Session 5, clients read the second version of their Trauma Account to their therapists. Therapists and clients focus on the differences between the first and second versions in order to help clients view their trauma in the context of what happened at the time of the incident. Additionally, therapists listen for more Stuck Points and self-blame that have been assimilated into clients' beliefs. Therapists ask clients about the process of writing the second Trauma Account, praising their attempts to overcome avoidance and focusing on how it felt to write the second account compared to how it felt to write the first account. Therapists continue to engage clients in Socratic dialogue using questions from a worksheet that would be assigned at the end of the session (Challenging Questions Worksheet). During the Socratic dialogue, therapists focus on helping clients reconstruct how they felt during the incident as opposed to how they felt now. Therapists challenge client self-blame noted in the Trauma Account. Additionally, therapists and clients review the concept of Stuck Points in the context of how the Stuck Points made them feel

during the second Trauma Account. Finally, therapists introduce the Challenging Questions Worksheet to clients. Using an example of a Stuck Point from the client's second Trauma Account, therapist and client collaboratively complete a worksheet in session. Therapists assign clients to complete Challenging Question Worksheets in regards to identified Stuck Points.

In Session 6, therapists and clients review the Challenging Questions Worksheets. Socratic dialogue is used to assist clients in contemplating questions they had difficulty with. Treatment focus shifts from self-blame to overaccommodated beliefs. Therapists introduce clients to the Patterns of Problematic Thinking Worksheet. This worksheet focuses on cognitive distortions as opposed to specific thoughts. Additionally, the worksheet focuses on labeling the patterns in order to help clients identify how automatic problematic patterns caused negative manufactured emotions. Clients are assigned to complete Patterns of Problematic Thinking Worksheets until the next session.

In Session 7, clients review their completed Patterns of Problematic Thinking Worksheets. Therapists use Socratic dialogue to help clients challenge their patterns of problematic thinking. Therapists then introduce the Challenging Beliefs Worksheet and complete this new worksheet with the patient. Finally, clients are introduced to the next module of the treatment, Core Themes in Traumatized Clients. The first core theme introduced is Safety. Clients are assigned reading their Trauma Account and subsequently completing Challenging Beliefs Worksheets after reading the Trauma Account.

In Sessions 8-11+, four more Core Themes in Traumatized Clients are discussed: Trust, Power/Control, Esteem, and Intimacy. Each session in this module begins by discussing the Challenging Beliefs Worksheets assigned as home practice. Socratic dialogue, with a specific emphasis on overaccommodated beliefs, is used to facilitate analysis of Stuck Points. At the end

of Session 10, clients are assigned a new Impact Statement to be read aloud in Session 11. Session 11 combines analysis of the theme of Intimacy as well as termination of therapy. Therapists read the initial Impact Statement to clients and encourage clients to examine the differences between the two statements that have resulted from the therapy. Therapists should look for any remaining cognitive distortions. Finally, therapists encourage clients to take ownership and credit for the changes experienced in therapy.

6. COURSE OF THERAPY, TRAINING, AND THE SUPERVISORY PROCESS

The following section includes an analysis of each of Leo's 12 therapy sessions from Phase 2 of his therapy, labeled 1-12. Analysis of therapy sessions will be complemented by an analysis of the training and supervision sessions. Links between training and supervisory interventions and my in-session thought processes, behaviors, and therapeutic interventions will be established. During descriptions of supervision, phrases in parentheses will indicate types of supervisory interventions. A list of supervisory interventions will follow each supervision session.

Training Session 1

Establishing baseline and shared knowledge of PTSD and its treatment.

I met with Dr. B for my first session of CPT training one month before Phase 2 of Leo's therapy began. Dr. B began training in a didactic fashion, teaching me about the organizing clinical theory with which he approached treatment of PTSD. In this session, Dr. B explicitly encouraged me to ask questions and indicate if I had difficulty understanding aspects of theory or training. He encouraged this in every training and supervision session. He had requested that I complete the entire CPT web-based training—without rushing through—it in a single day.

With that baseline of knowledge established, Dr. B explained that psychological trauma disrupts the normal flow of consciousness, and thus the way memories are encoded. Consciousness is composed of sensations, thoughts, emotions, and memories operating together. Dr. B used a metaphor, stating that these four elements wove together like the multiple strands of fiber that make up a rope, with the rope symbolizing the everyday experience of human consciousness. Everyday consciousness in turn creates episodic narrative memories once the experience is encoded. When someone experiences trauma the rope is broken into its individual

strands. This is a reason why trauma has such a dissociative quality: sensations, thoughts, and feelings are encoded in memory *separately* as opposed to simultaneously. The separate encoding of sensations, feelings, and thoughts causes PTSD to have so many seemingly incidental “triggers,” as without an episodic narrative memory to recall, stimuli that have been associated with the trauma appear “random” to the client.

Dr. B explained that this conceptualization of PTSD naturally leads to its treatment with therapies such as CPT. When people choose to recall something, they are in some ways re-experiencing that which they encoded as a memory. PTSD not only separates memories into unrelated fragments, it makes recalling and re-experiencing the memory itself traumatic. The aim of CPT is to facilitate complete recall of the trauma, challenge the overaccommodated beliefs that resulted from the trauma, and thus allow the memory of the traumatic incident to be non-traumatically re-encoded into memory.

CPT works by using the Impact Statement and Trauma Account to recreate a complete and coherent narrative episodic memory of the traumatic incident. As therapist and client work together to refine the Trauma Account, more details such as emotions, thoughts, and sensations are added to the Trauma Account. Explicit discussions of how the client felt while writing the Trauma Account and during session allow Socratic dialogues regarding Stuck Points and cognitive distortions to take place as well as differentiation of the feelings experienced during the trauma and current feelings.

Therapist and client discuss the complete narrative episodic memory in order to use Socratic dialogue to facilitate the client’s challenges of overaccommodated beliefs. Dr. B explained that Socratic dialogues focus on using guided discovery as opposed to the therapist

explicitly restructuring cognitions in order to avoid “doing the work for the client.” This would limit the effectiveness of treatment.

Specifically, clients are less likely to learn and employ the skills necessary to successfully engage in treatment if therapists do all the work of cognitive restructuring. Additionally, therapist overwork would make clients would be less likely to encode the restructured cognitions into memory, lessening non-traumatic re-encoding of memories and thus hampering the primary intervention of CPT. Thus the home practice assignments given to the client help the client practice the skills necessary complete the narrative episodic memory and challenge their beliefs with minimal assistance from the therapist. Each of the home practice assignments are separate skills that are all used in the final home practice assignment, the Challenging Beliefs Worksheets. Clients read their Trauma Account prior to working on their Challenging Beliefs Worksheets in order to bring the narrative episodic memory and its associated thoughts, feelings, and sensations to the forefront of the client’s thought process. Additionally, consistent reading of the Trauma Account allows for habituation to anxiety to occur.

Orienting me to Dr. B’s supervisory style and expectations.

Dr. B described his expectations of the training and supervision. He requested that I complete the web-based training during the week before the second training session. Once treatment with Leo began, I was to complete the module in the web-based training associated with the current CPT session before I held that session with Leo. I was instructed to record audio and video of as many of my therapy sessions with Leo as possible. Dr. B asked that I watch the recorded therapy sessions, write my process observations and questions, and select moments from each session to present and discuss with Dr. B before every supervision session. Dr. B also noted that together, he and I would aim to complete Leo’s CPT in the “ideal” number of

sessions. However, Dr. B also emphasized that adjustments are made in every course of therapy, and he wanted me to aim for the ideal number of sessions in order to encourage me to work intensely rather than strive for “perfection.”

Training Session 2

Applying Dr. B’s conceptualization of PTSD treatment and web-based training to Leo’s case.

Dr. B began this training session by explaining that he asked me to complete the web-based CPT training again in order to improve my recall of aspects of CPT while he trained me. Similarly, completing each module before each session with Leo would allow me to better guide sessions, recall CPT technique, and anticipate therapeutic challenges on a week-to-week basis. Dr. B asked me to explain Leo’s case to him in as much detail as possible. He sometimes asked me to pause and asked me to describe how the information I was giving him could be understood from the CPT model, encouraging me to *attempt to apply theory to practice* by asking me to understand Leo from the perspective of CPT.

For example, Dr. B engaged in this supervisory intervention when I mentioned that Leo became more anxious and prone to dissociation when he experienced cold weather. Dr. B gave me time to process this question, and I eventually stated that the sensation aspect of Leo’s conscious experience had been traumatically encoded into his memory. Leo was cold as he ran after his cousin, and his dissociated experience of that traumatic night caused him to associate the sensation of being cold with his trauma. Dr. B *praised* my understanding and *expanded upon it*, explaining that Leo also associated both the emotions he felt at that time and the guilt he felt in the present with the sensation of being cold. This caused Leo to become anxious, tremulous, and prone to more frequent and overt dissociative flashbacks.

Next, Dr. B asked me about Leo's Stuck Points. Dr. B capitalized on the fact that I had discussed Stuck Points with Leo during Phase 1 of treatment; additionally, he asked me to theorize about Leo's potential Stuck Points based on my knowledge of Leo gained through Phase 1. This exercise would allow me to empathize with Leo and anticipate the thoughts and beliefs that contributed to the maintenance of Leo's PTSD. By anticipating potential Stuck Points I would be better able to discern evidence of these Stuck Points from Leo's in-session statements. Together, Dr. B and I labeled each of Leo's Stuck Points as evidence of either overaccommodation (it was all my fault, if only I didn't take off my shoes, if only I didn't drink that night) and faulty beliefs about the self (I'm a bad person, bad things happen to those around me, I can't and don't deserve to live a normal life).

Collaborative review of web-based training.

Dr. B reviewed the web-based training module for Session 1 of CPT with me. He asked me how I would verbalize the module's content in ways that Leo would understand. Dr. B also described how he would verbalize the module's content and the thought process that lead to his specific word choices.

Treatment planning.

Dr. B suggested I use the Clinically Useful Anxiety Outcome Scale (CUXOS) as a measure of both Leo's anxiety and treatment progress. He asked me to assess Leo's symptoms via the CUXOS and clinical interview in order to discern whether or not Leo still met diagnostic criteria for PTSD. Session 1 would entail obtaining current information about Leo's life. If he still met criteria for PTSD, I was to do many things in Session 2: introduce the trauma recovery model; the cognitive theory of PTSD; educate Leo on the effect of avoidance on maintaining PTSD/anxiety and instruct Leo to avoid avoidance; ask Leo to give a brief, 5 minute account of

his trauma in session; and assign the Impact Statement as home practice to be brought into Session 2.

Therapy Session 1

Getting current information about Leo.

It had been approximately five months since I had last had a therapy session with Leo. Thus, this session began with a discussion of current events in Leo's life as well as his current PTSD symptoms and functioning. Compared to Phase 1, Leo appeared happier, less distressed, and less anxious. He was warm, affable, and funny. He happily reported that he had made large changes in his drinking habits. Leo only had a single beer after coming home from work approximately twice a week. If he went to a party, he had no more than two drinks.

Leo had previously used his job as avoidance by spending most of his day at work. However, this also caused him to feel very stressed, irritable, and physically tired. Leo started working only his assigned shifts. He limited covering coworker's shifts by creating a new scheduling system that ensured there was almost always coverage. He also obtained a dog over the summer. He mentioned that the dog was actually helpful in managing his stress and anxiety, as he could play with the dog whenever he wanted to. More importantly, his dog would bark a lot if he became anxious, contributing to increased awareness of his emotional states. However, he noticed he tried to suppress his emotions in order to avoid stressing his dog.

Leo's baseline anxiety remained at 4 and he frequently became "randomly" tremulous. Cold weather continued to increase his anxiety. He still felt he was completely at fault for his cousin's death, and, despite doing well in University thus far, was unsure of what he would do for work after college because he was afraid of failing others. Similarly, he still felt he did not deserve to be happy due to his cousin's death. Leo's sleep had minor improvement, as he could

sleep for two to three hours before waking up due to anxiety. He had not had dissociative episodes since spring. Leo still avoided spending time at home, and any reminders of his cousin caused him extreme anxiety.

Leo spontaneously linked his descriptions of recent life events to Stuck Points we had previously ascertained. Leo had disclosed his trauma to people he had recently met when he attended a conference on leadership a few months before restarting therapy. He described being very anxious about this due to his belief that he would bring misfortune to people he became close to. Leo disclosed his trauma despite his anxiety, as he knew this was an irrational thought and wanted to confront his anxieties.

At this juncture, I asked Leo to tell me more about his thoughts and emotions regarding his experience at the conference. He initially thought that these people would judge him harshly and blame him for his cousin's death. He was surprised and delighted to find that, rather than condemnation, he received support from the group he shared with. I asked Leo to compare his behavior at the conference with his behavior during and before Phase 1 of therapy. He realized he had behaved differently than usual by seeking emotional intimacy and authenticity with others. Leo was glad he did so, as he became fast friends with these group members. However, Leo noted that these new friendships had their own unique difficulties, as they knew the "worst" thing about him. While they supported him initially, he still had a vague suspicion that their display of kindness was forced. Leo knew this was related to his Stuck Points and that he had yet to truly overcome them. However, he was proud that he was acting against his anxiety and fear.

At this point I seized the opportunity to begin education about the function of avoidance—Leo had displayed basic understanding of his need to avoid engaging in avoidance. After explaining how avoidance maintains anxiety and beliefs, I asked if Leo could *apply this*

knowledge to what he had mentioned prior to my interjection about avoidance. Leo was able to put this into his own words: just like a phobia, he had to face his fears in order to prove his beliefs about what he feared wrong. He had simply yet to work on his beliefs, so he only made himself anxious. I laughed and noted that this is what the therapy was for, and that we would collaboratively work on his beliefs. Leo mentioned that he was ready to work on the hard parts of treatment.

Setting Leo's expectations for treatment.

After deciding that, despite Leo's new behaviors, he still met criteria for PTSD, I explained that we would engage in a complete treatment of CPT. We would meet once weekly, and in light of the approaching holiday season, I emphasized that during the treatment we would need to keep long interruptions of two or more weeks in between sessions to a minimum. I told Leo that we would be doing uncomfortable things, such as writing Impact Statements and Trauma Accounts. I laughed when I mentioned writing an Impact Statement to Leo. In my own mind, I knew this would be the third or fourth time he would have been asked to do that, and I thought the exercise might even be frustrating for him. Leo laughed along with me at the time.

Leo mentioned that knowing that we were going to expressly work on his trauma made him anxious, as he knew this was going to be difficult work, but that he was tired of being so hurt and anxious due to his trauma. I explained that the next session would help set the stage for the treatment, noting that I would explain the fundamentals of PTSD and its treatment. I praised him for his understanding of avoidance and his efforts at limiting it.

Supervision Session 1

Giving report of the therapy session to Dr. B.

I had watched video of Session 1 prior to supervision. I described the session's themes to Dr. B. Leo still described experiencing symptoms of PTSD. While aspects of functioning had improved, it was possible that he was underreporting his symptoms in order to either impress me or avoid letting the therapy focus on his trauma. Leo could link his thoughts and behaviors to one or two Stuck Points but was unable to process them. Leo appeared highly motivated, and I was eager to begin really working on his trauma with CPT.

Collaborative review of session 1 video.

I wanted Dr. B to review the beginning and end of this session. To me, it seemed the beginning of the session had a "conversational" tone to it. Dr. B remarked that Leo looked as if he felt very comfortable with me and that a good therapeutic relationship would be pivotal in the treatment. He qualified this, describing its positives and negatives. During the first session, a conversational tone and comfort can facilitate more disclosure from Leo. However, I needed to be mindful of attempts on Leo's part to make sessions devoted to trauma work feel more conversational as part of avoidance.

Avoidance can take many, many forms, and part of my job as the therapist was to be vigilant for any use of avoidance. Any form of avoidance would hamper the effectiveness of treatment (fund of knowledge). As such, I needed to be highly aware as well as stay on task. Dr. B suggested I create an agenda for each session and bring the written agenda with me in order to remind myself of the therapeutic tasks of the session (technique). This would allow me to spend more of my concentration on detecting avoidance. He reminded me that dissociation is a part of PTSD and that it could be a very subtle form of avoidance.

We moved on to the next section of video I wanted guidance on: the end of the session. I wanted Dr. B to see this part of the video because this was where I did most of my therapeutic

action. Setting up Leo's expectations for treatment and assigning home practice was quite important. However, I had a vague sense that something was "off" about the ending of the session. As Dr. B observed the recording, he noticed when I laughed after mentioning the Impact Statement. After continuing the video for a minute or so, he had us pause. He cautioned me that laughter at that time will detract from my effectiveness. Dr. B then explained to me that avoidance in PTSD affects therapists as much as it affects their clients. *My perception of his trauma* could influence the entire therapy, from how I set expectations to how I addressed his beliefs in session.

Dr. B posited that I was uncomfortable with the idea of making Leo go through repetitive tasks and focus on his trauma. Additionally, laughter sets up the Impact Statement and Trauma Accounts as scary, things to be avoided. It would make **me** seem like I was anxious and afraid to work with his trauma. A matter of fact approach would be best and help me *establish professional and therapeutic credibility* (use of self). Therapeutic credibility would be necessary in order to gently encourage the client to approach, engage, and process their trauma—they need to believe that I know what I am doing and am not afraid to do the therapeutic work. Nervous laughter caused by my perception of his trauma undermines my credibility. Dr. B suggested I allow myself time to process my own responses to Leo's emotions in sessions in order calm myself and improve my ability to address his trauma with courage and calmness (technique). He assigned me to revisit the first module of the web-based training in order to assist with planning and structuring the next session.

Summary of Distinctive Supervisory Interventions:

- 1) From Dr. B's fund of previous clinical experience, he was able to highlight that I should be vigilant for avoidance with Leo.

2) Regarding technique. Dr. B emphasized that as a therapist I should (a) carefully and deliberately set the agenda for each therapy session; and (b) pause before and after interventions to process my own perceptions and emotions.

3) Regarding my use of self, Dr. B guided me (a) in noticing my own emotional responses and possible avoidance; and (b) in having me present treatment activities as matter of fact to inspire patient confidence and therapist credibility.

Therapy Session 2: Beginning CPT

Agenda setting.

I set the structure of the current session for Leo. The agenda included explaining the cognitive theory of PTSD, explaining the trauma recovery model, providing avoidance education, giving a brief account of his trauma, and assigning home practice. I asked Leo if he had anything he wanted to add to the agenda. Leo simply wanted to discuss his week for his part of the agenda. I thought this would facilitate rapport and a continued assessment of PTSD symptoms.

Educating Leo while avoiding lecturing.

Following the order indicated in the agenda, I began the Psychoeducation portion of the session. I educated Leo about trauma, providing him information from the cognitive theory of PTSD, Trauma Recovery Model, and the model of treatment described by Dr. B. In order to avoid making this portion of the session overly didactic, I demonstrated how specific aspects of Leo's trauma could be understood from these perspectives. Additionally, after one or two demonstrations of how his trauma could be understood from these perspectives, I invited Leo to do the same and apply these perspectives to his own understanding of the trauma. I engaged Leo in a collaborative discussion during the Psychoeducation in order to apply Dr. B's maxim, "don't

do the work for the client,” to this phase of the session. I was concerned that Leo’s recall of the Psychoeducation would be poor if I was overly didactic. Poor recall of the Psychoeducation would decrease Leo’s “buy-in” to treatment and increase the likelihood of him engaging in avoidance.

Drawing on the understanding that Leo gained during supervision, I explained that Leo’s reaction to cold weather was due to his sensations being dissociated by the trauma of that night. When asked to apply this perspective himself, Leo remarked that his extreme physical reaction to minor conflicts between friends activated emotions similar to those he felt on the night of his trauma, thus heightening his anxiety. Additionally, I educated Leo about “natural” and “manufactured” emotions. Primary emotions are emotions that are directly caused by an event; manufactured emotions are emotions caused by our interpretations of events.

Avoidance education.

Although education on avoidance’s function in maintaining PTSD was a part of the session agenda set by the web-based training, I chose to shorten this section of the session due to Leo’s previous education about the role of avoidance in the previous session and Phase 1. I provided examples of avoidance specific to Leo’s life and asked Leo to provide further examples similar to the collaborative discussion during the Psychoeducation portion of session. Providing an example of more complex avoidance, I explained that Leo’s frantically driven attempts to mediate conflict between his friends was rooted in a desire to avoid the emotions he mentioned during the Psychoeducation phase. When asked to provide his own example, Leo mentioned that working too much allowed him to avoid by keeping him too busy to be introspective and think about his trauma.

Brief Trauma Account.

Keeping Dr. B's remarks regarding my own reaction to Leo's trauma in mind, I steeled my nerves and calmly asked Leo to provide a five-minute account of his trauma that included how his reaction to his trauma changed since the end of phase 1. Leo was chagrined at having to recount his trauma to me again and asked if this was necessary. I responded by validating his sense of annoyance at the repetition but emphasized that because he never completed CPT that it was important to give an account during this session. Leo assented and began to relay his trauma in a monotone and semi-pressured fashion.

Leo's Trauma Account was almost exactly the same as described earlier in this case study. Regarding the change in his reaction to his trauma, Leo was now attempting to live a more "normal" life—drinking far less, attempting to make new friends, and beginning to think about his career. However, these changes caused him to actively grapple with his trauma more often. He still believed that he did not deserve to be happy or lead a normal life.

I praised Leo for delivering his brief Trauma Account despite his reluctance and the difficulty of doing so. Keeping with the themes present in the session, I explained to Leo that his monotone delivery of the Trauma Account was a more subtle form of avoidance that allowed him to dissociate from the emotional experience of recalling and describing his trauma.

Assigning home practice.

As we concluded the session, I thanked Leo for participating in the session and agreeing to engage in CPT. I praised him for his hard work, mentioning that he had already created change in his life by lowering his drinking, limiting his work, and attempting to make new and closer friendships. I emphasized that further change was possible. I explained the home practice assignment required for the next session of CPT: the Impact Statement. Leo was instructed to

explain the traumatic event and how it affected his current life and behaviors. He was also instructed to pay specific attention to how the traumatic event affected his views of himself, other people, and the world. He was instructed to hand write at least one page on why he thought this event happened to him, how it had changed or strengthened his views about himself, other people, and the world. Additionally, it was suggested that Leo begin the assignment very soon after session to ensure he had enough time to write about it thoughtfully. Leo stated he understood the assignment and would begin it soon.

Supervision Session 2

Review of session 2 video.

Dr. B focused supervision on Leo's brief Trauma Account, including how I introduced and assigned the Trauma Account in session. He explained his rationale, stating that he wanted to observe my comfort level in assigning and listening to his Trauma Account as well as listen for Stuck Points himself (supervision collaboration). He noted that I was appropriately calm and responded to Leo's reluctance well. Dr. B observed that Leo continued to show assimilation and overaccommodation of problematic beliefs (theory to practice). For example, Leo frequently stated that the events of that night were all his fault. Similarly, Leo still believed that he was a source of misfortune for others. Dr. B encouraged me to look for evidence of Stuck Points in Leo's brief Trauma Account (prescription). I noticed evidence of hindsight bias and self-blame in Leo's statement of "if only I didn't drink that night."

Regarding overaccommodated beliefs, I posited that Leo's vague sense of foreboding was due to an overaccommodated belief that terrible things could happen at any time. Dr. B indicated that these were likely to be found as we assessed the Stuck Points found within his Impact Statement. He also noted that his conjecture was merely theory, and while I should look for

evidence of this theory, I needed to be open to discovering different Stuck Points from within his narrative.

Review of web-based training module: the meaning of the event.

Dr. B and I collaboratively reviewed the web-based training module for the upcoming session. Together, we watched video demonstrations of clients reading their Impact Statements to therapists. Dr. B paused at various times during the video demonstrations and asked if I could describe Stuck Points from information within the Impact Statement (role play). Dr. B evaluated the Stuck Points that I noticed and offered his perspective and Stuck Points that he noticed. We discussed which aspects of the narrative led to the Stuck Points we noticed. I asked Dr. B to share the thought process by which he arrived at his list of Stuck Points. He explained that he was assessing for specific types of statements within a client's narrative. Stuck Points are often if-then statements, statements of "what if," what a client wished they could have done at the time, and focus on self-blame by denial of information to the contrary. To therapists, Stuck Points often appear like leaping to conclusions (fund of knowledge).

Socratic dialogues: what to do at this point in treatment.

CPT describes engaging in Socratic dialogues early on in treatment. Dr. B cautioned me on being overzealous in my use of Socratic dialogues. While technique of Socratic dialogue is part of guided discovery that allows the client to process the assimilation and overaccommodation that causes Stuck Points, attempting to process a Stuck Point at this point in the therapy may not get results. The ability to challenge one's own beliefs is an advanced cognitive skill; further, challenging beliefs that maintain trauma is even more difficult. The purpose of Socratic dialogues at this point in treatment is to provide a client evidence that it is even possible to have different beliefs about their trauma rather than to change their beliefs. As

such, Dr. B wanted me to practice thinking of how to gently posit alternative ways of thinking about the trauma.

The web-based training included sample clinician responses in this vein (technique). Dr. B asked me to imagine responses to Leo's Stuck Points after reviewing these sample responses. He did so by *role playing* as Leo and making various statements that contained Stuck Points (role play). For example, in response to the Stuck Point "if only I didn't drink that night," I could gently challenge Leo's hindsight bias in self-blame by stating "it sounds like you wish you did not drink that night." Dr. B mentioned that challenging Leo's belief that he would bring misfortune to others would be more challenging to confront at this point in treatment. This was because this belief was predicated on Leo's guilt. Without processing the core of Leo's trauma, his guilt would remain unchanged and would be highly difficult to challenge any belief rooted in the guilt.

Identifying emotions and linking thoughts, feelings, and behaviors.

Dr. B reviewed the identifying emotions portion of the module. He suggested using events from Leo's present and recent past in order to facilitate Leo's identification of different feelings and their intensity. I was to ask Leo to describe how he thought and felt at the time and how he would feel and think if certain variables of the event were different. Socratic dialogues could be used at this time to evaluate the flexibility of Leo's thinking (technique). Leo had already demonstrated psychological mindedness and introspection in Phase 1 of treatment.

Introducing ABC worksheets.

Finally, we reviewed how to assign the ABC worksheets. ABC worksheets are known as thought monitoring in typical CBT. These worksheets focus on teaching clients how to evaluate the connections between activating events (A), beliefs or behaviors (B), and consequences (C).

Given that Leo had prior CBT with me in prior CPT, we would assume Leo had competence in evaluating his thinking using this worksheet (therapeutic frame). I would go over a single example of how to complete this worksheet using an event from Leo's life and provide Leo with enough worksheets to do one each day between sessions two and three.

Summary of Distinctive Supervisory Interventions:

1) Dr. B used the experience of supervision itself as an intervention by collaborating with me. By setting an agenda, observing my comfort level, and assessing my skills, he acted as a social role model of verbal and non-verbal therapeutic techniques. The experiential aspect of this intervention facilitated encoding the information he imparted to me on an emotional and cognitive level.

2) Dr. B facilitated bringing my knowledge from theory to practice by explaining how Leo's disclosures mapped onto CPT theory regarding assimilation versus overaccommodation.

3) Regarding agenda setting, Dr. B prescribed that I needed to observe and seize upon Stuck Points in the therapy session.

4) Drawing from his fund of previous clinical experience, Dr. B provided me with examples of Stuck Points Leo might endorse.

5) Regarding specific therapeutic techniques, supervision included (a) models of interventions from the web-based training; and (b) Dr. B applying his own Socratic Questioning to Leo's Stuck Points for me to observe and use in the following session.

6) Dr. B participated in role play of how Leo might respond to interventions and specific interventions I could make using examples from the web-based training for me to model interventions from.

7) By relying on Leo's competence with home practice due to previous therapy, Dr. B encouraged using the frame of therapy itself as a technique. Matter of fact therapeutic frame expectations such as completing home practice could normalize engagement in therapeutic activities.

Therapy Session 3: The Meaning of the Event

Listening to the Impact Statement.

I began the session by asking Leo how the home practice assignment went and to read me the Impact Statement. Leo mentioned that he was drunk when he wrote the Impact Statement, having drank four to five glasses of wine. He stated that he had avoided writing the Impact Statement for most of the week. He drank in order to dull his emotions enough to sit down and write the Impact Statement. Additionally, Leo's Impact Statement had been typed. I emphasized that these behaviors were products of avoidance and would interfere with the effectiveness of treatment. I then had Leo read his Impact Statement. Leo read his Impact Statement in a rehearsed manner, with few visible indicators of emotion. Quoting directly from Leo: "my trauma has changed my entire life. I can't experience joy because I'm not worthy of it, I don't have intimate friendships any more, and I will always be weighed down by responsibility for my cousin's death." This was read in a monotone voice, like an emotionless laundry list that he stammered to get through.

Refining the Impact Statement.

After praising him for his effort and for reading the statement to me, I noted that his writing described how it impacted his perception of himself, but not others or the world. Privately, I theorized that Leo's avoidance via alcohol and typing contributed to the Impact Statement's improper focus. Leo mentioned that the timing of the trauma affected the course of

his life, as he perceived going to college as a time when many people redefine their identities. His identity changed to include “I got my cousin killed.”

Leo remarked that the trauma made him wary of the world and distrustful of people. He closed himself off, avoiding deep emotional experience with others and approached interpersonal relationships with extreme caution. He wanted to find a small core group of friends for a year and then move on to a new group of friends the next. Emotional intimacy with others was threatening. Leo noted minor changes in this regard following the conference by allowing other people to know about his trauma. He remarked that he became an anxious person due to his trauma. He avoided getting close to people because “no one is permanent,” and while everyone dies, he was highly aware of this and did not want to be vulnerable to enduring pain similar to his cousin’s death. Leo felt that the world did not make sense after his cousin’s death. The world was a place where “things just happen, and they can be pretty terrible things, making the world a shitty place.” However, Leo’s perspective changed within the last year: he was now able to “find the good in anything.”

Identifying Stuck Points.

I began to identify Stuck Points with Leo. The most prominent theme was that he could and should have known better. In fact, he should have been able to predict exactly what happened, as his cousin had run away in times of stress before. This was an example of self-blame due to hindsight bias and overaccommodation of guilt and responsibility. Another Stuck Point was that he should not have encouraged his group of friends to drink. This was another example of hindsight bias influencing his perception of his trauma. Leo’s focus on taking off his shoes piqued my interest.

This Stuck Point, which had appeared in Phase 1 of therapy, was a mixture of hindsight bias and defensive undoing. Leo wished he had not taken off his shoes. In his own mind, he found the one pivotal moment he could have changed in order to prevent his cousin's death. His failure to perform that pivotal action caused him to blame himself for his cousin's death. This Stuck Point additionally demonstrated egocentricity. He neglected the possibility that the actions of others (his mother, his friends, his cousin) could influence the outcome. If he focused on the role of others, Leo would have to face his emotions towards his mother in regard to her yelling at Leo's cousin immediately prior to his cousin running out of the house.

Weaving together identifying emotions, the ABCs, and Socratic dialogue.

I noticed that we had already discussed the connection among events, thoughts, and feelings. I decided to probe more regarding his emotions in relation to the Stuck Points we discussed. This led to labeling the natural and manufactured emotions regarding his trauma. Leo recognized that his guilt and self-blame were manufactured due to his interpretation the events of his trauma as predicated on his actions. As he discussed his reluctance to think about his mother's role in the events of his trauma, I pointed out that he did realize many factors were involved in the outcome of his trauma. There were antecedents within his cousin's life that made him more likely to run away. I mentioned this as a gentle Socratic challenge in order to plant the idea of expanding his perspective in his mind for later sessions. Additionally, I was attempting to steer the discussion away from assigning blame to his mother. I thought that working on his feelings regarding his mother's role would be best worked on after I had made progress working on his own feelings of guilt.

Discussion of the ABCs was centered on a session from Phase 1. In this previous session, Leo had discussed feeling extremely guilty due to an incident at his internship. In response, I

engaged Leo in cognitive restructuring. However, I did most of the work of cognitive restructuring. I drew out a flowchart of his actions on a whiteboard while making more definitions and proclamations than asking Socratic questions. Leo did not remember this session or intervention. This emphasized Dr. B's maxim of not doing the work for the client, as they are less likely to encode it into memory. As we discussed this, we were able to quickly establish links between the ABCs while engaging in a much less therapist-directed Socratic dialogue. Leo's thinking was flexible. However, I needed to engage him in such a way where he would be the one struggling with his thoughts and beliefs.

Assigning the ABC worksheets and other home practice.

I re-introduced Leo to the ABC worksheets. We collaboratively completed one regarding a mundane event. I provided Leo with ABC worksheets and asked him to complete two to three of them with specific focus on thoughts related to his trauma. Additionally, I re-assigned the Impact Statement to be written while sober and by hand.

Supervision Session 3

Review of session 3 video.

Dr. B reviewed the video of Leo reading his Impact Statement to me. He too noticed that Leo's reading was shallow. Furthermore, Dr. B agreed that the current Impact Statement presented limited information from which to extrapolate Leo's Stuck Points. He praised the questions I asked in order to clarify Leo's Stuck Points while also providing examples of questions that he would have asked (modeling). Specifically, my questions to Leo were general, such as "how did your cousin's death affect your life?" Dr. B's questions were more targeted, such as "how have your relationships with your friends and family changed since the death of your cousin? How has your approach to relationships changed?" Dr. B noted that it is possible to

ask open ended questions that address specific domains of functioning affected by trauma. He suggested practicing these kinds of questions via role play later in the supervision session, as these kinds of questions would be imperative to ask when Leo read his Trauma Account to me.

Scaffolding case formulation.

Dr. B assisted me in embracing complexity in my case formulation of Leo. He agreed with my assessment of Leo engaging in avoidance by typing his Impact Statement. He expanded upon my understanding of Leo's intoxication while writing the Impact Statement, positing that Leo also chose to be intoxicated in order to simultaneously reconnect with his state during the trauma (theory to practice). While Leo was engaging with therapy, he was not engaged in the emotional experience necessary for non-traumatic re-encoding. Additionally, Leo's avoidance limited the efficacy of interventions aimed at extinguishing Leo's dissociations. Our discussion of Leo's case based on his responses to my questions led us to the understanding that Leo's desire to "find the good in everything" was a defense. Finding the good in everything was a reaction formation against the depression and pessimism Leo experienced in the wake of his cousin's death (theory to practice). Leo avoided the anxiety caused by his pessimism towards the world and others by effortfully seeking the opposite of pessimism. It was a driven need to see the good in things so that he saw less danger. This avoidance interfered with the processing of the trauma.

Role playing improved questions with web-based training.

Dr. B and I reviewed the Trauma Account module of the web-based training. This module included video of a client reading their Trauma Account to a therapist. Dr. B periodically paused during the reading of the web-based Trauma Account to ask me what questions I would ask in order to elicit Leo's Stuck Points (role play). As before, he provided questions that he

would ask (modeling). When asked, Dr. B shared the rationale for why he would ask specific questions. After using the web-based training video for practice, Dr. B took on the role of Leo reading his Trauma Account to me (role play). This allowed me to practice asking questions to elicit Stuck Points specific to Leo's case.

Treatment planning.

Dr. B shared his thoughts regarding my reassignment of the Impact Statement with me. While he understood my intent was to avoid reinforcing Leo's avoidance, he wondered if this would emotionally overload Leo in the next session. The combination of a handwritten Impact Statement, ABC worksheets, and ABC worksheets that specifically focused on the trauma demanded an intense amount of emotional work from Leo during the beginning of treatment. This phase of CPT was supposed to focus on a mixture of building skills, processing and working through avoidance and resistance, and improving tolerance of recalling the trauma.

Dr. B advised that if Leo had not completed all the homework for the next session that I should have Leo verbally produce an Impact Statement in session that would facilitate identification of thoughts and feelings. The handwritten Impact Statement would be reassigned two sessions from now, intended to gauge Leo's tolerance of recalling his trauma. I was to review the web-based training module for this session prior to meeting with Leo for the next session.

Summary of Distinctive Supervisory Interventions:

- 1) By both praising my Socratic Questions and providing questions he would ask, Dr. B modeled how to approach questioning Stuck Points at this point in CPT. This technique facilitated increasing complexity in my clinical thinking.

2) Dr. B facilitated changing my knowledge of CPT and Leo's therapy from theory to practice by (a) linking Leo's behaviors to CPT theory as he explained Leo's alcohol use functioning as avoidance and connecting to the state he was in when the trauma occurred; and (b) illustrating his defensive use of reaction formation, helping me understand what this defense looks like with a real patient.

3) Dr. B refined the way I approached the Trauma Account using Role Play by (a) pausing during the Trauma Account to role play different questions he might ask Leo; and (b) Dr. B role playing Leo's responses to questions I asked.

Therapy Session 4: Identification of Thoughts and Feelings

Verbal Impact Statement and identification of Stuck Points.

I asked about Leo's home practice. He had not completed the handwritten Impact Statement. He asked if he could write the handwritten Impact Statement in session. I explained that this was not a good use of our time, noting that home practice was to help him build skills that we would then use in the session to process his trauma. Leo asked if he could verbally recount his Impact Statement. I agreed to this and asked questions throughout his Impact Statement. Leo began his statement saying that he was always the responsible one and that he failed to protect his cousin. I asked him to tell me more. Leo explained that his family often unfavorably compared his cousin to him because Leo did well in school. This made Leo uncomfortable and want to protect his cousin from his family's criticisms. Assessing his trauma's impact on his current life, I asked Leo how it felt to achieve good things now. Leo's immediate reaction was to say that he does not want to throw his accomplishments in the faces of others like his family did with his cousin. I Socratically asked if he had considered how others felt during these situations. Leo realized that he did not think about his cousin's feelings when

trying to protect him from his family's criticism, and he instinctively attempted to protect his cousin.

Leo mentioned his shoes next, stating "one thing I could have done to improve my chances of saving him was to leave my shoes on." Leo then immediately and spontaneously mentioned that his cousin always ran much faster than he did and that he might have still failed to catch his cousin even if he had his shoes on. I asked Leo how he would have felt if he had his shoes on but still lost his cousin. Leo responded by saying that he would have picked something else to feel bad about, demonstrating flexible thinking and insight. We concluded that this represented the Stuck Point of "nothing is ever good enough unless it could have saved my cousin."

I asked Leo how it felt to interact with others in the wake of his trauma. I asked how it felt to interact with his mom after Leo had difficulty selecting a relationship to describe. Leo explained that he had to do whatever he could to help her out. Leo approached relationships with people close to him in this fashion. For example, Leo mentioned that he had given his brother \$500 to help pay his rent even though this was Leo's entire savings. He stated he had to do whatever he could to help those close to him. Based on the material Leo presented, I decided to weave extracting Stuck Points from his Impact Statement together with identifying emotions through the ABC worksheets. If the activating event was that his brother could not pay his rent, the behavior was helping his brother pay his rent, and the consequent feeling was pride that he could help his brother. However, Leo noticed that he was also stressed because he used his entire savings to do so. He explained that he would rather put himself at risk than leave family at risk. When asked to tell me more about that thought, Leo said he had to do what he could to make up

for his mistake. I then framed this as another example of defensive undoing, linking ABC worksheet analysis to Stuck Points and the manufactured emotions that Stuck Points cause.

Collaborative review of home practice: ABC worksheets.

Leo and I reviewed his completion of the ABC worksheets from the previous week. Leo spontaneously discussed how it felt to complete the ABC worksheets. He felt somewhat confused about differentiating between thoughts and feelings, but he was eager to do the worksheets in order to apply them to events that happened during the week. Leo did not complete the requested two worksheets that specifically pertained to his trauma. There was only one instance of labeling a thought as a feeling. In this instance Leo spent time with his family during Thanksgiving. He thought that his cousin would enjoy the family being together. He listed the resulting emotion as “I feel we are at a good place.” Leo easily understood feedback explaining that a good heuristic to use for differentiating between thoughts and feelings is that feelings can be described in one word. I explained that we sometimes have multiple thoughts that occur before we have a feeling and asked him to describe his response to “I feel we are at a good place” in one word. Leo labeled the emotion he felt in response to this as “content.”

Spending time with an infant nephew was another activating event. He had two thoughts: his nephew had a blank slate, and that he could help make his nephew’s life better, which caused feelings of happiness. I chose to relate this to Leo himself, asking if Leo had a blank slate. Leo said that his nephew represented a chance to do it right by setting him on a good path. This prompted me to analyze the undoing via Socratic questioning: I asked how Leo would feel if his nephew went down a bad path. He would feel guilty and upset. I asked him to reason backwards from feelings to the thoughts that prompt feelings, to which she said that he would have failed

someone else and that he can't help people. Leo said that he had a dirty slate and that anything good he did was overpowered by the guilt he felt for "killing his cousin."

Leo then spontaneously mentioned that his cousin loved playing with children; Leo had a warm smile on his face when he said this. Deciding that identifying feelings in the moment was also good practice, I asked Leo what he was feeling at that moment. Leo said that he loved his nephew and he was happy, but he was also sad because his cousin was not around to experience this.

Providing insight into the mechanisms of treatment in order to facilitate increased buy-in and reduce avoidance.

I realized that Leo spoke of his cousin as if he were still alive. I told Leo that it seemed like his relationship with his cousin was still there and evolving despite the fact that his cousin was gone. I asked Leo if he understood why I mentioned this. After a short pause, Leo said that the vague sense that his cousin was still around was avoidance of processing his trauma. I praised Leo for his understanding and linked his understanding and identifying thoughts and feelings to the rationale for treatment. I mentioned that understanding avoidance and practicing the skills that we used in and between sessions allowed him to process his trauma little by little. There were more skills for him to learn, and each new skill would build upon previous skills to facilitate processing different aspects of his trauma. He was excited about being better able to manage his trauma.

Using the ABCs to understand natural and manufactured emotions.

As Leo had not done an ABC worksheet specific to his trauma, we completed an ABC analysis of a specific trauma related thought in session. Leo began with the belief/thought "my best isn't good enough." When asked to provide the activating event, Leo provided a memory: "failing to catch my cousin." The consequent feelings were sadness and anger at himself. This

led to a discussion of natural and manufactured emotions. I explained that natural emotions were like reflexes, knee-jerk reactions that happen without intent or thought. His sadness was a natural emotion in response to his trauma.

Manufactured emotions are emotions that are caused by our interpretations of events; as such, anger at himself was a manufactured emotion caused by the thought “my best isn’t good enough.” Leo sighed and rolled his eyes. Noticing this, I worried if Leo felt invalidated or put down by what I was saying. He hedged, shifting in his seat without saying anything, prompting me to explain that I was not trying to invalidate his emotions and apologize for doing so. In retrospect, I realize that giving him room to discuss how his experience of feeling invalidated by me in that moment could have strengthened rapport. Trying to repair this relationship rupture, I told Leo that manufactured emotions require intent and effort, and that these emotions interfere with processing trauma. The interpretations he made may not be fair to himself.

Using the ABCs to facilitate Socratic dialogue.

To demonstrate this, I asked Leo to focus on the thought “my best isn’t good enough.” Leo remarked that he felt guilty and thought he was a horrible person. Seizing on this Stuck Point, I asked Leo to compare himself with emergency medical services (EMS) workers. Leo quickly stated that they must be stronger than him for being able to tolerate losing patients even if they did their best. I asked Leo if failure to save someone’s life when one does their best makes someone a bad person. After Leo denied that this made someone a bad person, I asked Leo what he believed would make someone a good or bad person. Leo mentioned selfishness and bad intentions, someone who knows that what they do is bad but does it anyway. This led me to ask what the intentions of EMS workers were. To Leo they had good intentions. Continuing this Socratic dialogue, I asked what made him different than the EMS workers.

Leo stated that if he thought this way about himself it was because he was trying to “give up responsibility for his cousin’s death.” At this point, little time remained in the session. I began to do an ABC analysis of this thought. I noted that doctors and EMS workers analyze the variables that contributed to the loss of any patient and asked if they were trying to avoid responsibility. Leo responded immediately, saying “no, but that doesn’t apply to me.” He mentioned that he could see how the logic of what I was saying applied to others but that it felt wrong to apply to himself. Leo felt conflicted about this. Realizing that the session was drawing to a close, I encouraged Leo to focus on his feelings of confusion and conflict. I explained that the ABC worksheets teach curiosity about and questioning your own thought process as a skill in addition to understanding the links between events, thoughts, and feelings. His ability to notice confusion and conflict was evidence of change, as he previously took thoughts like this for granted.

Linking session content to mechanisms of treatment and assigning home practice.

I explained that CPT teaches many smaller skills while asking clients to repeatedly analyze their trauma to treat the dissociative nature of trauma. Every time Leo recalled his trauma and used the skills being taught in therapy, he was able to re-encode multiple aspects of his trauma—each of which had been previously dissociated—into the a coherent narrative memory. I provided Leo with an analogy. I asked him if it was possible to read a map that had been separated into four pieces. I explained that every time we reprocess something, we were making a more complete Xerox copy of one piece of the map added to a new piece of the map.

Leo voiced understanding of this. I then assigned Leo the home practice for the next session. I explained the purpose of the trauma narrative to him, letting him know that it was to be handwritten, giving as much detail of the night of his trauma as possible, and noting the way he

thought and felt at the time the trauma occurred. He needed to begin writing the Trauma Account as soon as possible, as the home practice included reading the account every night. I strongly emphasized the importance of reading the account every night to Leo. Finally, I provided Leo with ABC worksheets to complete once a day until the next session. I reminded him that one worksheet should analyze a thought related to his trauma.

Supervision Session 4

Review of session 4 recording.

Upon my review of Session 4, I realized that there was a wealth of clinical information present in the beginning and toward the end of the session. I suggested these be the foci of our collaborative review of Session 4's recording (supervision collaboration). Dr. B evaluated my choice to devote the opening of the session to a verbal Impact Statement as well as the Stuck Points I elicited from Leo. Given Leo's prior experience of CPT, Dr. B felt my clinical decision-making, departing from the session structure detailed in the web-based training, was appropriate. Based on Leo's difficulty with the ABC worksheets, he cautioned me to pay close attention to Leo's fluency with ABC worksheets in the future (prescription). Dr. B noted that the Stuck Points I elicited from this session appeared accurate, but that much more meaningful Stuck Points will emerge from Leo's reading of the first and second Trauma Accounts.

Experiential practice of Socratic dialogue.

Dr. B noted that my Socratic dialogue with Leo was improving. Rather than providing Leo with my understanding—accurate or not—we engaged in guided discovery. However, Dr. B cautioned me that my evaluation of Leo's logic would be crucial during Socratic dialogue associated with the Trauma Accounts. To demonstrate the kind of analysis necessary, he asked if he could engage me in a Socratic dialogue about a personal situation in my own life. This would

model the analysis while also providing me with an experiential understanding of what Leo would feel in response to Socratic dialogues. After consenting to this, I recounted a story where I took responsibility for the actions of others. This sense of responsibility contributed to me feeling sad. Dr. B's Socratic dialogue used perspective taking and the "Columbo approach" of voicing confusion about logical inconsistencies in my thought process. In doing so, I understood my own logical fallacies, causing me to feel better about myself (technique, collaboration, role play)

Scaffolding ongoing case formulation and applying it to treatment.

We both noted that while Leo was beginning to engage in more aspects of the treatment, there was still resistance for us to work through. Dr. B posited that Leo's compliance issues, such as repeatedly avoiding the handwritten Impact Statement, may have been a function of lack of consequences. Dr. B explained that I provided consequences by having Leo perform the home practice in session (theory to practice). Additionally, Dr. B invited me to question Leo's claim that his recent experience of increased stress was due to work and social stressors. I thought that it was more than likely that the re-encoding process was causing Leo to have a higher baseline level of anxiety.

Collaborative review of web-based training and assigning home practice.

Dr. B and I reviewed the web-based training associated with the first Trauma Account. He placed emphasis on facilitating Leo's emotional experience of reading the Trauma Account. Experiencing his emotions while elaborating his narrative episodic memory of the trauma was necessary in order to re-encode these dissociated elements of his experience—his emotions and his memories—together (theory to practice). Additionally, my Socratic dialogues needed to analyze Leo's logic on a deeper level in order to facilitate actively processing his beliefs. Home

practice was writing a second Trauma Account that also included a focus on how Leo felt during his trauma and how he felt recounting the trauma narrative to me. Dr. B suggested I provide Leo with written instructions on the differences between the two Trauma Accounts in order to ensure proper completion of the home practice (prescription).

Summary of Distinctive Supervisory Interventions:

1) By allowing me to set the agenda, Dr. B used a collaborative supervision frame to promote a level of autonomy and a sense of competence in a developing therapist. Additionally, Dr. B's seeking permission for experiential supervisory intervention modeled the type of collaboration I could use with Leo.

2) Prescription: Dr. B prescribed important information to evaluate by (a) warning me to not take Leo's skills with ABC worksheets for granted; and (b) providing me with additional instructions to increase homework compliance.

3) Changing my knowledge from theory to practice was facilitated by Dr. B by (a) assessing the impact providing consistent consequences to shape Leo's behavior towards compliance with home practice, since Leo's behavior could have reflected avoidance; and by (b) illustrating how to use Information Processing Theory to understand Leo's increased anxiety. Increased understanding of Leo's anxiety could help me assess the degree to which Leo was emotionally engaging with processing his trauma.

4) By both requesting my permission and Role Playing Socratic questioning with a personal issue of my own, Dr. B provided me with techniques I could use with Leo. The experiential nature of this intervention would facilitate recall of keen Socratic questions and increase my own "buy-in" when I attempted to do so with Leo.

Therapy Session 5: Remembering the Traumatic Event

Reading and re-reading the Trauma Account.

I began this session by asking if Leo had completed the handwritten Impact Statement. Leo had, and I asked him to read it to me. After he did, I asked Leo to read his Trauma Account to me. I took extra precaution to not laugh and ask him to do this in a matter of fact tone. Leo read his Trauma Account; however, while it did not appear to be a rehearsed reading, his reading of the account was completely devoid of affect. I remembered Dr. B's emphasis on the need to experience emotions while reading the Trauma Account. With this in mind, I reminded Leo of the purpose of the account, avoiding avoidance, and his cousin in order to facilitate emotional experience. I then had Leo read his Trauma Account a second time, encouraging him to allow his emotions to be a part of the experience despite the difficulty. I asked Leo about specific memories from the night of his trauma. Leo was able to read the Trauma Account with emotion.

Listening for Stuck Points.

I listened for evidence of Stuck Points as Leo read his Trauma Account. This included investigating places that Leo had taken a break from writing the Trauma Account, upsetting things that he may have omitted from the account, instances of self-blame, and examples of Leo judging his own behavior outside the context of the event, also known as hindsight bias. The Stuck Points I noticed at this time were significant hindsight bias, self-blame, and guilt.

Socratic questioning of Stuck Points.

My Socratic dialogue questioned Leo's self-blame and hindsight bias; grief was held in place by a more complex network of overaccommodated beliefs, so I chose to save questioning it for a later session. Leo had once again focused on the fact that he had taken off his shoes prior to his cousin running away. I questioned if Leo had ever taken off his shoes while his parents yelled

at his cousin before, if his cousin had ever run away before and come back, and if he knew where his cousin was running to. These questions focused on evaluating Leo's assumption that he "should have known better" than to take off his shoes. By analyzing the contextual factors of the time where Leo and his cousin were in his parent's house, we engaged in guided discovery. Leo was able to understand that he could not have predicted that his cousin would run away at that moment; every contextual factor we discussed had happened previously, leading to a sense of familiarity. Similarly, he was able to understand that due to his cousin running away before, he could not have known that this instance of his cousin running away would end catastrophically.

The difference between blame, responsibility, and guilt.

I educated Leo on the differences between blame and responsibility. Focusing on blame first, I asked Leo about an accident that occurred at his job that he had described previously. After Leo understood that it was unfair to blame someone for an accident, I explained that blame generally means there is intent for a bad outcome. I linked this to Leo's description of "bad people" from last session. Describing responsibility, I explained that responsibility was to play a role but not have bad intent. I elicited Leo's thoughts on these concepts and reminded him that, moving forward, we would revisit these as they pertained to him.

Assigning home practice: the second Trauma Account.

I asked Leo to write the entire Trauma Account again. This time, however, he was to add more sensory detail and more of his thoughts and feelings during the incident. Additionally, he was to write his current thoughts and feelings in parentheses while writing the second account. If he experienced different thoughts and feelings from those of the first account, then he could write those thoughts and feelings in the margins or in parentheses. I once again provide Leo with ABC worksheets to facilitate thought monitoring as home practice as well.

Supervision Session 5

Review of session 5 recording.

Dr. B and I focused our attention on the readings of the Trauma Account and my Socratic questioning. Dr. B wanted to listen to Leo's Trauma Account himself to assess what Stuck Points he could discern (supervision collaboration). He noticed my use of Leo's memories to induce emotion in Leo prior to the second reading of the Trauma Account. He cautioned me on doing this, explaining that induced emotion may interfere with the expression of natural emotions related to the Trauma Account (prescription). This would limit proper processing of the traumatic event. Dr. B confirmed the Stuck Points that I had noticed. Additionally, he praised my Socratic questioning while providing further questions that could be asked to help Leo process his trauma (technique).

Case conceptualization through the lens of CPT.

Dr. B noticed that Leo's scores on the CUXOS had been increasing for the past two weeks. We theorized that Leo's anxiety was increasing due to recalling, processing, and re-encoding his traumatic experience. Leo was engaging with the therapeutic process. However, Dr. B noted that it was highly likely that Leo would increase his avoidance in response to the anxiety provoked by processing his trauma (prediction). As such, it was imperative to both assess Leo's completion of home practice and to problem-solve ways in which to increase Leo's compliance with home practice (technique). The home practice, reading the Trauma Account every day, was an essential therapeutic task as it would help Leo habituate to the anxiety inherent in the process. Additionally, reading the Trauma Account would activate memories and emotions necessary to make use of the upcoming sessions and assigned therapy tools.

Review of the web-based training for the next session.

Dr. B emphasized that the reason the second Trauma Account includes information about current feelings is to help Leo view the trauma in the context of what was happening at the time (theory to practice). This, along with Socratic dialogue, would limit the effect of hindsight bias on Leo's thinking. Additionally, it was important to ask Leo about the process of writing the second Trauma Account in order to assess the intensity of the emotions he experienced while writing the it. If Leo's emotions were less intense while writing the second Trauma Account, I could seize on this as an example of how avoiding avoidance is therapeutic and thus increase compliance with upcoming therapeutic tasks (technique).

Conversely, Leo could have experienced more intense emotions while writing the second Trauma Account if he had limited his emotions while writing the first. This would likely increase resistance and avoidance and lower Leo's likelihood of completing upcoming therapeutic tasks. Thus, I needed to maintain awareness of Leo's completion of home practice in addition to his report of the emotional experience of writing the Trauma Account, as well as the emotion I notice in session. This would allow me to get a more thorough understanding of Leo's engagement with treatment and improve interventions aimed at increasing compliance (technique). In addition to continuing Socratic dialogue about Stuck Points, it would be best to review the concept of Stuck Points with him considering Leo's changing thought processes and emotional experience while writing the Trauma Accounts. Finally, I was to assign the Challenging Questions worksheet as home practice at the end of session. It was suggested that we review a sample Challenging Questions worksheet before completing a worksheet on one of Leo's Stuck Points.

Summary of Distinctive Supervisory Interventions:

1) By setting an agenda item, checking in with me while doing so, and explaining his rationale, Dr. B used supervision to collaborate with me. He knew how important a thorough understanding of Leo's Trauma Account was and wanted to aid in processing it with me.

2) Using his own fund of previous clinical experience in Information Processing Theory and CPT, Dr. B prescribed that I avoid using Leo's memories to induce emotions due to the risk of creating manufactured emotions.

3) Dr. B predicted Leo's future behavior based on his previous behavior in order to warn me of risks inherent to this phase of CPT. As sessions intentionally engaged Leo in exposure to his traumatic memories, Leo was likely to engage in further avoidance.

4) Dr. B improved my technique by (a) providing questions to ask regarding Trauma Account; and (b) explaining that it would help to engage Leo in a discussion of ways he could decrease his own avoidance of home practice. This discussion was based on predictions regarding Leo's likely avoidance during this phase of CPT.

5) Dr. B facilitated changing my knowledge of CPT from theory to practice by further explaining how to apply the second Trauma Account to Leo. This would inform the questions I would ask during the second Trauma Account.

Therapy Session 6: Second Trauma Account

Reading the second Trauma Account.

I asked Leo to read the second Trauma Account and encouraged him to allow himself to feel while reading. Leo followed the instructions given in the previous session: the second Trauma Account contained dramatically increased sensory and narrative detail, the emotions and thoughts he experienced during the trauma, and the emotions he experienced while writing the second Trauma Account. Leo recalled being very cold early on in the account. He was so

intoxicated by the end of the night that he almost fell in a river while walking home. As soon as he got home with his cousin, he ran upstairs to his room to hide the bottle of liquor that he was carrying. In the process of doing this he left his cousin alone. His mother was yelling at his cousin by the time Leo returned downstairs. He removed his cousin from this situation and brought his cousin to his room. Leo began setting up a place for his cousin to sleep.

He noticed that his cousin was staring at the door that led to an exit from the home, which caused Leo to lock that particular door. As soon as Leo locked the door, his cousin lunged for the door and Leo caught his cousin by the arm. His cousin broke Leo's grip on his arm and ran downstairs and out of the house with Leo in pursuit. Leo ran out of the house without his shoes; realizing he could not catch up to his cousin without his shoes, he went back to his house to get them. While he hurriedly put his shoes on, Leo told his mother "if something happens to him it's your fault." He then ran out but could not find his cousin. Leo had not put on a coat and was very cold. Leo explained that his memory became less specific at this point. He remembered driving around with his aunt (his cousin's mother) looking for his cousin for hours. At the end of the night, he fell asleep in his cousin's bed.

Evaluating the experience of writing the second Trauma Account.

Leo read the second Trauma Account in a slow and purposive manner. He appeared to be "choked up" and sad while reading the account. I praised Leo for following directions and inquired about how he felt at that moment. Leo explained that he felt cold, sad, and like "nothing was worth it." I asked Leo what he meant by each of the items he listed. Leo felt physically cold as well as emotionally numb. Nothing was worth it in the sense that thinking about his trauma made it hard to assign positive values to anything good he had done since. Feeling sad was obvious. Leo explained that he had written the second Trauma Account in one sitting; he

shivered after mentioning this to me. I asked Leo to tell me more about what he was experiencing in the moment. He was feeling physically cold, but at the same time he had sweaty palms and was feeling shaky.

I praised Leo for his hard work and the emotional tolerance he had displayed. Together, we elaborated on other thoughts and feelings that were present in the account. One notable feeling was that telling his mother that it would be her fault left him with a sense of guilt and like he had hurt his family again. Finally, Leo explained that writing the Trauma Account left him very tired. In session, Leo put on a hat and yawned a great deal during the latter half of the session. Internally, I noted that Leo was currently experiencing cold as a dissociative memory associated with the night of his trauma. I once again praised Leo and encouraged him to continue to engage in the work despite his fatigue, explaining that I was there to support them as well.

Leo continued to broaden his contextual understanding of his trauma.

Leo mentioned that he thought of something he had learned in his classes while he was writing the second Trauma Account. He had learned about the concept of “extreme emotional states” and how these factor into legal decisions. This led him to wonder if he was in an extreme emotional state during his trauma and when he experienced dissociative flashbacks.

Additionally, the seeds of a therapeutic breakthrough occurred as Leo began to grapple with the idea that his cousin could have been in an extreme emotional state when he ran away that night. Leo explained that his cousin was often in trouble and had a very difficult home life. The idea that his cousin was in an extreme state or possibly depressed bothered Leo, but this idea took root and facilitated the expansion of his contextual understanding of his trauma throughout the rest of treatment. I wove Socratic dialogue into this discussion. Additionally, Socratic dialogue was used at this time to continue to question Leo’s Stuck Points.

Challenging questions worksheets (CQWs).

Prior to going over the CQW, I asked Leo if he had read the second Trauma Account every night as instructed when I assigned home practice. He had not but did read it two nights of the week. Leo was studying for finals and explained that reading the Trauma Account made him feel very tired. He wanted to make sure that he did his best on his final exams. I understood this to be both an honest response to an objectively stressful time as well as avoidance. Internally, I attempted to devise methods to increase Leo's compliance. We completed a CQW using an imagined situation: a new ER doctor had lost a patient. Leo and I put in equal effort to complete this example CQW.

Despite his fatigue, Leo was able to identify challenges to the doctor's Stuck Point. We then completed a CQW for one of Leo's Stuck Points: "I was supposed to be the responsible one." I intentionally probed for a great deal of evidence for his Stuck Point in order to demonstrate fairness toward his thoughts in addition to demonstrating the disparity between evidence for and evidence against. Leo struggled with this part of the CQW, but he was able to find more and more evidence against his Stuck Point as we completed other parts of the CQW. Leo's broadening contextual understanding of his trauma also contributed to an understanding that he was not taking all information regarding his trauma into account.

Specifically, he was beginning to realize he was "taking away the autonomy of others" by focusing on his actions as the sole determinant of that night. Similarly, Leo regarded himself as a dependable source of information. Following the Socratic approach, I questioned his dependability on the night of his trauma due to his intoxication. Leo understood he was not reliable on that night without judging himself as unreliable in general. Additionally, we began the work of identifying a core belief that was changed due overaccommodation. Leo understood

that “always” was implied in his Stuck Point and that this was due to him being the person most capable of acting responsible and problem-solving when people were in trouble. We began to understand that his cousin’s death caused him to feel incapable. Internally, I began to understand that this was the reason that Leo felt responsible for so many things. Leo was trying to undo a sense of incapability in order to make up for his cousin’s death and allow Leo to feel like he could handle living in a dangerous world.

Assigning home practice.

We compiled a list of Leo’s Stuck Points so that Leo could begin evaluating them with the CQWs. The home practice was to critically evaluate Stuck Points with the questions present on the worksheet. Not every question would be applicable to every Stuck Point. I encouraged Leo to do his best so that we could review them during the next session. We scheduled our next session for after winter break. I instructed Leo to continue to read the second Trauma Account once a day.

Supervision Session 6

Review of session 6 recording.

We focused on the reading of the second Trauma Account and completing the CQWs. Dr. B agreed that Leo’s second Trauma Account followed instructions and contained a great deal of information from which to glean Stuck Points. He explained that this was a positive prognostic indicator and that Leo was acclimating well to treatment. However, he was indeed engaging in avoidance in regard to reading the account daily (theory to practice). My biggest challenge with Leo would be to increase his compliance with home practice; without consistent reading of his Trauma Account, Leo would be unable to practice the skills contained in any assigned

worksheets in a meaningful way. His practice would be more cognitive, distanced, and likely dissociated, interfering with non-traumatic re-encoding of his trauma.

Applying theory to practice for Leo's Stuck Points.

Dr. B explained that Leo demonstrated overaccommodation and pathological assimilation in response to his trauma (theory to practice). Specifically, Leo had an overaccommodated belief that he was the sole cause of his cousin's death. The trauma also caused Leo to have an overaccommodated belief that he was the cause of many bad things and would thus bring misfortune to others. Leo was hypervigilant in order to avoid "repeating the mistake" he made with his cousin.

Based on Leo's response to talking about his mother, Leo's overaccommodated belief of sole culpability was also rooted in dissociated feelings of guilt for "blaming his mother" for his cousin's death. He responded to the feelings of guilt, caused by the thought that his blame caused his mother deep and chronic pain, by reflexively taking all blame—and thus culpability—onto himself. Leo had an overaccommodated belief of responsibility for the event due to his history of being "the responsible one" for many of his close relationships. This caused overaccommodation of *complete* responsibility, blame, and associated guilt. Leo believed he deserved to feel terrible and guilty due to what happened. Leo responded to his assimilated beliefs with his defensive wish to undo. Outside of his awareness Leo believed that, if he could "undo" his mistake by always helping others and providing opportunities for the next generation, he could prove his assimilated belief to be false.

This spurred Leo's desire for "redemption." By constantly reminding himself of his mistake (and his trauma), the ensuing guilt would cause him to be reflexively helpful. This allowed him to "redeem himself" by being what he perceived to be characteristically good due to

automatically helping others. The overaccommodation and assimilation interacted to form Leo's Stuck Points. "It's all my fault" was an almost one-to-one reflection of his overaccommodation. "I'll cause bad things to happen to others" was a mixture of his sole culpability and assimilation of the blame and guilt. "I shouldn't have taken off my shoes" was a mixture of overaccommodation, assimilation, and associating unrelated aspects of the context to his trauma.

Challenging questions and fatigue.

Dr. B thought that my persistence in collaboratively completing the CQW with Leo was clinically sound but may have overwhelmed Leo (embracing complexity). He was able to apply the challenging questions to personal and hypothetical Stuck Points. On the one hand, I gently but firmly mitigated Leo's avoidance in session by completing the CQW despite his visible mental fatigue; on the other hand, Leo may have had difficulty encoding the work done in session. I explained my thought process that guided my clinical decision making at the time. I thought that reading his Trauma Account and working on the home practice would make Leo tired almost every time he did so. As such, I wanted to train Leo to be able to do the work despite fatigue. In doing so, continued practice would facilitate compliance with further assignments as well as encoding of the work. Dr. B thought this was sound, but he was concerned that Leo would continue to avoid in response to the intensity of the session (supervision collaboration). He suggested that if Leo continued to avoid reading the Trauma Account every night that I try to encourage Leo to read the account a set number of times per week. Treating avoiding avoidance and reading the Trauma Account as a skill, it would be possible to shape Leo's behavior into full engagement with the trauma narrative by reinforcing steps that approximate full engagement (prescription).

Review of web-based training and home practice.

Dr. B and I reviewed the web-based training module for the next session, Challenging Questions. The first step would be to review Leo's completion of his home practice of the CQWs. He emphasized following the module when it advised beginning to move away from "if only" assimilation based Stuck Points to overaccommodation based Stuck Points. The key was to pick the proper Stuck Points and ask Leo the challenging questions through Socratic dialogues. If Leo was able to complete the home practice, Leo would likely be able to challenge his overaccommodated Stuck Points with minor facilitation from me. Dr. B and I reviewed the Patterns of Problematic Thinking Worksheet (PPTW). He asked me to discern which problematic patterns were associated with each of Leo's Stuck Points. He emphasized that after educating Leo about each problematic pattern—with examples—it would be best to allow Leo to identify the patterns for himself (prescription).

Summary of Distinctive Supervisory Interventions:

- 1) The entire conversation regarding Leo's Stuck Points and how they were rooted in pathological overaccommodation helped changed my knowledge of CPT and of Leo from theory to practice.
- 2) Dr. B and I collaboratively discussed our different understandings of the therapy process and Leo's dynamics. Both of us were likely correct, and I learned more about how to proceed keeping both in mind as Dr. B helped me embrace both aspects of complexity.
- 3) By prescribing a more hands-off approach that allowed and expected Leo to identify his own patterns of problematic thinking, Dr. B explained I could engage Leo in experiential understanding of these patterns. This would increase his recall and application of this exercise to his Stuck Points.

Therapy Session 7: Challenging Questions

Review of home practice in overcoming its obstacles.

This session was Leo's first since winter break. Given that Leo's avoidance of home practice was most intense without consistent monitoring and encouragement, my first therapeutic concern was whether or not Leo had engaged in home practice. Leo had read his Trauma Account approximately two or three times, had completed about as many CQWs, and had not brought the worksheets to session. While he had not fully engaged in home practice, he was able to benefit from what work he did complete.

Specifically, Leo noticed that it was becoming easier to read the Trauma Account with every reading. With Dr. B's supervisory wisdom of shaping behavior towards desired ends in mind, I decided to collaborate with Leo in order to discern the primary obstacles that interfered with his engagement and decide on what level of engagement Leo could begin with and accomplish. Many of Leo's concerns pertained to practical life stress and timing. Leo was close to graduation and attempting to decide between furthering his education and seeking his first professional job. As such, Leo was bogged down with applications, tests, studying, and researching what jobs he could reasonably seek. Leo felt that he could not afford the stress of consistently reading his trauma narrative while engaging with all of these demands. Additionally, Leo's stress was compounded by the recent anniversary of his cousin's death, making him even less likely to engage with the trauma, regardless of practical stressors.

Leo was particularly distressed and intermittently tearful while discussing the anniversary. I praised Leo's efforts over winter break, validated his difficulties, and also focused on Leo's experience of each reading becoming easier than the last. I emphasized that this was an experience of a very therapeutic aspect of treatment and that with continued practice it would

become easier still. Thinking about how supervision collaboration helped me, as well as the “Columbo approach,” I asked Leo how we could get him to this point. After a moment of reflection, Leo proposed reading the account a set amount of times during the week. He would read the account three nights this week, four nights next week, and five nights the week after that. I asked Leo if he could set specific days in order to give the behavior concrete plans. Leo agreed to read the Trauma Account on Thursday, Saturday, and Monday. I agreed to Leo’s plan, as it fit the plan Dr. B and I had made. I also believed Leo would be more likely to follow a plan that he made.

Meeting Leo where he was.

Given Leo’s emotional state and lack of home practice, I did not think it was clinically appropriate to continue with the prescribed session agenda. The situation reminded me of Dr. B’s warning that Leo seemed overwhelmed during the previous supervision session. As such, I decided that the best way to move forward with the session was to practice more CQWs with Leo. We selected a Stuck Point to work on: “I pushed for us to drink, so what happened was my fault.”

Patterns of problematic thinking.

Cognitive distortions and patterns of problematic thinking became apparent while completing the CQW. Leo was exaggerating, ignoring important parts of the situation, oversimplifying, overgeneralizing, and using emotional reasoning. Rather than simply telling Leo what each pattern was, I engaged him in challenging questions using the “Columbo approach” that emphasized my own “confusion” regarding each pattern. Leo’s distress lowered throughout the rest of the session.

Assigning home practice.

The home practice was to critically evaluate Stuck Points with the questions present on the CQW. Additionally, Leo was to complete Patterns of Problematic Thinking Worksheets for the same Stuck Points. Not every question would be applicable to every Stuck Point. I encouraged Leo to do his best so that we could review them during the next session and reminded him that it would be best to read the Trauma Account on Thursday, Saturday, and Monday.

Supervision Session 7

Review of session 7 recording.

Based on my review of the recording, I decided that the beginning and the work on the challenging questions worksheet were the most pertinent parts review in supervision. Dr. B agreed with many aspects of my assessment: that Leo's avoidance was expected and understandable given the anniversary reaction, Leo's plan was sound and I should follow it, and he could not begin the next module given the treatment hiatus and his lack of home practice. He noted that while the anniversary reaction amplified Leo's distressing emotions, his heightened emotions could also amplify the benefits of treatment. Finally, allowing Leo to discern the patterns of problematic thinking he engaged in could lead to possible positive and negative outcomes. While it could allow Leo to better encode the work, he could just as easily miss patterns if I did not explain them and press him to think on them and scaffold some level of understanding (technique).

Summary of Distinctive Supervisory Interventions:

- 1) Dr. B focused on specific technique in three ways: (a) Socratic Questions used to evaluate patterns of problematic thinking; (b) providing Leo with psychoeducation regarding cognitive distortions could be useful; and (c) assessing each pattern of

problematic thinking and explaining them to Leo to facilitate understanding of each pattern.

Therapy Sessions 8-11: Challenging Questions (repeat module), Challenging Beliefs, and Core Themes in Traumatized Patients-- Together with Supervisor Sessions

In this section, I depart from the previous structure of describing each session in detail to describing an arc of treatment in detail. CPT's final sessions involve repeated use of Socratic questioning and Challenging Beliefs Worksheets to evaluate five different beliefs and themes found to be common in people who have experienced trauma. Thus, after session 8, I aim to describe the therapeutic process across the entire arc of treatment. Description of supervision will be interspersed throughout this section.

Review of home practice in session 8.

At this point, I was anxious to gauge Leo's engagement with home practice. I was delighted to learn that Leo had read the Trauma Account on all three nights as well as completing the CQWs and PPTWs. Leo remarked that reading the Trauma Account was "much easier than I thought it would be," rating the actual difficulty at a 4/10 as compared to the 8/10 he expected. He stated his thoughts and feelings regarding the trauma were beginning to change. Specifically, he was beginning to deeply question how much responsibility he had for the traumatic event. Due to this, while he had previously felt intense sadness and guilt when thinking about his cousin, he was now beginning to feel "bittersweet."

Leo explained that this meant that he was able to feel fondness and happiness that was tempered by sadness when reviewing memories of his cousin. This contributed to a discussion of his treatment compliance and progress. I congratulated him on completing his home practice and linked it to his changing feelings, emphasizing that all the skills we had practiced prior would be used to work on his Stuck Points, allowing him to healthily process his trauma. The work would

be difficult, but the rewards would make up for the difficulty at the very least; at best, he would begin to feel a great deal better. From this point on, Leo began to fully engage in treatment, completely avoiding avoidance. By the next week, he was reading the Trauma Account every night before working on the main worksheet of this arc of treatment: the Challenging Beliefs Worksheet.

The challenging beliefs worksheets (CBWs).

Leo chose to work on his most guarded and deeply held Stuck Point, “it was all my fault,” in his home practice with the CQWs and PPTWs. He was easily able to challenge this belief and point out his patterns of problematic thinking. At this point, I introduced Leo to the Challenging Beliefs Worksheet (CBW). This worksheet combined the skills used in all prior worksheets in order to fully process a given trauma maintaining belief. I explained that we would be using this worksheet to structure the rest of treatment. Note: Please look at Figure 1 to follow the treatment process described.

We began to complete a CBW based on the Stuck Point “it was all my fault.” He rated his belief in the Stuck Point at about 60%. This belief caused Leo to feel regret (55%), shame (65%), guilt (65%), and sadness (80%). He evaluated this belief with various challenging thoughts and questions. The only evidence for this Stuck Point that he could find was that he pushed them to drink. The evidence against this Stuck Point included: there were other people that could have chosen not to drink, his cousin could have chosen not to drink, his cousin’s actions were impacted by his own emotional state and family problems, and he tried to stop his cousin from running out of the house by locking the door. He immediately stated that this Stuck Point was a habit, not a fact. Leo believed that this Stuck Point did not include all information because there were many things that he could not control that night. The Stuck Point was all or

nothing thinking, extreme and exaggerated, confused possible with likely, and was not based on a dependable source because Leo was intoxicated the night of the trauma as his current emotions made it hard to distinguish all the facts. Additionally, the Stuck Point was entirely based on his feelings of guilt and shame for having had any part in his cousin's death.

Regarding patterns of problematic thinking, Leo exaggerated his responsibility for the actions of others and minimized effects the actions of others had on the outcome of that night. Leo realized that he had a confusing response to the problematic pattern known as “mind reading”: on one hand Leo thought he should have known that his cousin was going to run away, while on the other hand Leo previously discounted that his cousin's emotional state had any effect on the night. He knew that this thought was based on emotional reasoning—he felt terrible that his cousin had died, that he had any part in that night, and that in his grief he sought to explain why his cousin had died. Thus, because he felt terrible, it must have been his fault. Leo posited alternative thoughts to his Stuck Point. The alternative thought that resonated most with Leo was “we had done this before, and I could not have known that he would die that night.” He rated his belief in that thought at 70% and in his Stuck Point at 30%. Leo still felt regret, shame, guilt, and sadness; however, he felt much less regret, shame, and guilt. He remarked that the sadness “made sense.” As the session ended, I described the format and topics that would be discussed in the final phase of treatment.

Introduction to core themes in traumatized patients.

I explained to Leo that from this point forward we would be using CBWs to process thoughts and beliefs related to core themes in traumatized patients: Safety, Trust, Power/Control, Esteem, and Intimacy. Leo's traumatic reaction to his cousin's death had affected these realms of his life. For example, he thought that the world was dangerous, that bad things could happen at

any moment, and that he would bring misfortune to others. He felt that the world was no longer safe. Worse, he felt that he was not safe to be around other people. In planning for the next session, I asked Leo if he could read the Trauma Account four nights of the week. Leo countered by saying he felt ready to read it every day. I praised Leo for his determination. I explained that he should read the Trauma Account before working on a CBW in order to generate the emotions and memories necessary to recall his trauma, evaluate and process it, and non-traumatically re-encode the emotions and memories. While he could work on any Stuck Points, I requested that he also focus on Stuck Points that involved beliefs that related to safety.

Supervision of introduction to core themes.

Dr. B noted that while Leo's desire to read his Trauma Account daily could and should be understood as a positive prognostic indicator, I should apply Socratic questions to my own response to Leo's determination as well as to the process of daily Trauma Account readings themselves. Specifically, Leo had described a desire to punish himself for his role in his cousin's death that was acted out by his over-functioning at work. Was it possible that Leo was trying to punish himself again by reading the Trauma Account every day? Self-punishment would interfere with non-pathogenic processing and re-encoding of his traumatic memories (embracing complexity, theory to practice). Applying Socratic questioning to the process of Trauma Account readings, I could ask many things: how Leo felt before, during, and after Trauma Account readings; how Leo felt before and after possible skipped Trauma Account readings; and how he prepared both himself and his environment for his readings (technique). If Leo displayed improved compliance that fell short of his goals for himself, I could use these questions to seize upon and reinforce motivating factors and mitigate interfering factors (prescription).

The Process of Change

To our mutual amazement, a new process of interaction developed between Leo and I. Leo began to fully engage with the home practice every night, and he came to each session with CBWs that pertained to general Stuck Points as well as the themes we discussed. He described reading the Trauma Account every night prior to working on the CBWs, and that he spent between thirty minutes to an hour working on each CBW. Leo laughed and said that “I spend a lot of time staring at my ceiling while thinking really hard on these things.” I asked him to describe the time spent working on CBWs to me. Leo explained that he would work on a section of the CBW, pause, and re-read each thought and introspectively “check in” with his feelings. This was especially helpful when re-rating his feelings after producing alternative thoughts, and part of why a given CBW could take up to an hour. I praised him for this, noting that reading the Trauma Account prior to a CBW gave them more “power” to affect his thoughts as well as that spending time applying each section of the CBW to his traumatic thoughts allowed deeper encoding of changes in his thoughts.

During the session on Safety, Leo first brought up a CBW regarding the thought “I need to succeed in order to redeem myself.” In evaluating this thought using the CBW I began to notice that Leo was becoming much more proficient at evaluating his own thoughts and beliefs. For example, Leo initially thought that making his cousin proud would be the only thing he needed to obtain redemption. I pressed Leo to look for a great deal of evidence for and against his beliefs. Through this process, we came to understand that his underlying thought was that he must succeed, which caused him to feel nervous, pressured, and sad. Leo began to display a thought process that helped him throughout the rest of the therapy: he considered himself an unreliable source insofar as *he* was the only source and these thoughts only occurred during his lowest points. He could not keep torturing himself by immediately and fully believing thoughts

that came to him when he was experiencing intense sadness and distress. This effectively mitigated the worry that reading the Trauma Account every night was a form of self-punishment.

Additionally, I carefully used Socratic questioning and thorough logical analysis to explore the ramifications of Leo's thoughts. For example, if success would make his cousin proud of him, would failure disappoint his cousin? What exactly was failure? If Leo had passed away and I was instead talking to his cousin in therapy, how would Leo feel about his cousin for "failures"? Similarly, Socratic questioning was applied to the CBWs pertaining to each theme. Leo became increasingly adept at using the CBWs. He noticed problems of problematic thinking with ease, especially patterns such as emotional reasoning, jumping to conclusions, and absolute thinking.

I used this increasing skill to touch upon the themes, helping Leo use the Socratic dialogue to make absolute thoughts less extreme, look at the evidence for and against emotional reasoning, and question the conclusions he jumped to. When Leo described feeling relieved that he could "let go of responsibility" for his cousin's death, he looked at me with a pained expression and asked if it was wrong to feel relieved. I countered by asking him what about his thoughts allowed him to feel relieved, to which he said that his cousin would not want him to feel as if he needed redemption. While he tried to stop his cousin in the ways he could, there were many things far beyond Leo's control that led to his cousin running away that night. This prompted me to ask "well then, why would it be wrong to let go?" In my own mind, I was doing my best to avoid prescribing "right and wrong" ways to think that would not have felt authentic to Leo, and thus would have likely interfered with processing.

Dr. B praised and agreed with my decision and clinical reasoning behind avoiding prescribing right and wrong ways to think. However, he warned me that Leo would likely

continue to ask similar questions of me due to Leo's sense of guilt (prediction). Leo's complicated grief could possibly come to the fore of treatment as changes in traumatic beliefs allowed him to fully encounter grief related thoughts and emotions (prediction and theory to practice); his complicated grief was likely to cause Leo to believe that letting go of responsibility would dishonor how he maintained a relationship with his cousin post-mortem.

The process of change continued.

Safety. Leo felt the world was not a safe place because he could not protect those that he cared about. This thought, combined with his desire to find redemption, caused Leo to disregard his own safety at times. Leo became especially suspicious of people during parties when they drank alcohol. This was because Leo could not predict how people behave when they were sober, much less when they were drunk. This prompted me to ask Leo if he thought that drinking alcohol itself was dangerous, which he denied. He mentioned the various times in which he and his friends drank and experienced no severe consequences. I responded by asking him how many times his worst fear actually occurred. Given that someone dying was his worst fear, Leo perceived that he experienced his worst fear once. While random things could happen with or without alcohol, it was highly unlikely that others would die due to his actions.

Additionally, Leo perceived that he was both wiser and less likely to engage in risky drinking. He believed he was better able to prevent negative outcomes and that negative outcomes were far less likely if he was not drinking excessively. Wondering if his talk of responsibility was associated with his complicated grief, I asked Leo about his responsibility for preventing dangerous or negative outcomes. He felt that it was not his responsibility to prevent danger, but due to his experiences, he was better equipped to do so. In my own mind, I was still worried about hypervigilance being his primary means of "ensuring" safety. I asked Leo about

his thoughts about how safe the world was in general. He remarked that he felt the world was safe in general and that serious problems or danger were overall quite rare and almost impossible to predict.

Supervision of safety processing.

Dr. B was impressed that Leo was able to engage with the Trauma Account and CBWs every night. We agreed that it did not seem to be a form of self-punishment. However, there was a risk inherent in this phase: my Socratic Questioning had to be timely and well crafted, or else Leo could internalize maladaptive beliefs as a result of therapy (prescription and technique). Leo's continued focus on responsibility had a chance of being another form of undoing, this time by focusing on preventing future problems as a form of atonement and undoing of his trauma (theory to practice). Dr. B and I reviewed the web module for the Trust session. He role played Leo responding to CBWs regarding Trust (role play).

The process of change continued.

Trust. Leo experienced great difficulty trusting others. There were many reasons for this, but one of the primary reasons was that Leo did not believe he could trust himself in the wake of his cousin's death. If he could not trust himself, trusting others could prove dangerous for them since his actions had caused a death; he did not know if other people were capable enough to make up for his deficiencies. To Leo, trust meant that he could rely on a person, they were consistent, and they made good decisions. His perceived poor decisions on the night of his cousin's death made it more difficult to trust himself. Making matters worse, Leo felt he could not trust a good friend of his due to him being unreliable and often making poor decisions. I used Socratic dialogue to clarify Leo's thoughts, asking him what he thought about his friend. He thought his friend often made decisions that made his own life worse, meaning he could not rely

on him. But did that make Leo feel less affection for his friend? Or would he not be there for his friend? Leo emphatically stated he would always be there for his friend. Together, we came to understand the difference between loyalty and trust, with Leo remaining loyal to his friend even if he could not fully trust his friend to be a source of strength or help.

We completed two CBWs that pertained to Stuck Points about Trust. Leo continued to demonstrate increasing ability to take the perspective of others and evaluate his thoughts and beliefs dispassionately. Through his completion of the CBWs, he realized that his belief that trusting others would get someone hurt was based on habitual thinking that allowed him to keep himself and others “safe” from himself. Leo could enhance his ability to trust by slowly giving others chances to prove their reliability to him. Similarly, by remembering the difference between loyalty and trust, he could better navigate other relationships in his life by not confusing someone’s loyalty as trust in him or a reason he ought to trust in them.

Supervision of trust processing.

Dr. B emphasized the importance of Leo’s thoughts and feelings regarding his ability to trust his friend. Specifically, Leo’s understanding of trust was related to the next module, Power and Control (theory to practice). Using Socratic Dialogue and CBWs to analyze the thoughts and feelings related to trust shed light upon Leo’s thoughts and feelings related to power and control. Dr. B posited that if Leo could trust others, he would not feel as strong a need to control everything himself to maintain safety (prediction). I should work to link the CBWs from the Trust session to CBWs in the Power/Control session (prescription and technique).

The process of change continued.

Power and Control. Leo began the session by describing his thoughts regarding Power and Control. He stated that his beliefs were changing: while he previously thought all bad things

were his fault, he now thought that “I have less control over situations than I think at first. This isn’t such a bad thing, though.” When asked to clarify his statement, Leo remarked that he thought about the night of his trauma and various other events while doing CBWs during the week. Leo described that his choices during the night his cousin died hardly affected the outcome of that night. He had not forced his cousin to drink, and both his cousin and other friends repeatedly altered their plans throughout the course of the day. He realized he could not stop others from doing what they plan or want to do. Leo came to understand that his desire for control was another form of avoidance. By immediately seeking to “control” situations, Leo avoided coming into contact with thoughts regarding possible danger.

Even if Leo contacted thoughts of possible danger, his efforts to control the situation allowed him to avoid the anxiety inherent to thoughts of danger. I reinforced the value of avoiding avoidance and gradually exposing himself to anxiety provoking situations. His Control-based avoidance prevented him from learning that danger was unlikely even without his intervention. We subjected his thoughts regarding Control to analysis with a CBW. Most notably, Leo labeled his desire for control as both a habit and emotional reasoning. Recognizing the patterns of problematic thinking allowed Leo to lower his anxiety without seeking control.

Finally, Leo discussed the thought that any one action can only influence a situation to a certain extent. He noted that this thought contrasted with his habitual thought “my decision to drink is what killed my cousin.” Leo’s perception was shifting, and he began to think about the decisions every other person made on the night of his cousin’s passing. Leo mentioned that, given everyone’s influence on the events preceding his cousin’s passing, the outcome was impossible to predict or control.

Noting that this perception could cause Leo to trust others less, I seized this opportunity to make use of Dr. B's suggestion of linking Trust to Power and Control. I asked Leo if considering the influence of others caused him to trust those involved in the night of his cousin's passing less. He denied this, but I pressed on with Socratic questioning of his thoughts regarding Trust to assess his emotional response to trusting those who, alongside him, were most "responsible" for his cousin's death given his previous perceptions. Were his friends responsible for what happened to his cousin? Did they cause or let or want his cousin to die? Are they bad people who need to constantly seek redemption? We discussed these thoughts and his emotional responses to considering each thought as "true" for him. He felt it would be wrong to blame others for his cousin's death, as they could not predict his cousin's actions and did not intend for such an outcome.

I chose to reinforce the changes in Leo's thought process by asking if it was fair to hold his friends to one standard and himself to another. Leo was beginning to see that he had been judging himself harshly in order to punish himself for his cousin's death, allowing him to be worthy of redemption by suffering for his mistake. Our discussion then changed topics as we discussed his plans for graduation. Leo realized that most of his plans were likely to change based on factors he could not control. Previously, this would have caused him anxiety; currently, Leo felt confident that he would be able to effectively navigate changes to his plans. In my own mind, I hoped that applying the lessons from therapy to Leo's life without an explicit focus on his trauma would foster broader application of the skills he was learning. In the supervision preceding this session, Dr. B suggested I assign Leo specific exercises that pertained to esteem, such as doing a nice thing for himself every day as well as giving and receiving compliments. I provided Leo with these exercises before ending the session.

Supervision of power and control processing.

While processing the Power/Control session with Dr. B, he noted that connecting the work of previous sessions, including Trust and how fair he was to himself as compared to others, facilitated deeper encoding of non-traumatic beliefs (theory to practice). He felt that I did a good job of not “doing the work” for Leo by asking him Socratic questions regarding his thoughts rather than providing him with new thoughts or beliefs (technique). However, he cautioned me that it would be very easy to do the work for Leo in future sessions, and to remain aware of the desire to do so when Socratic questioning became difficult (prediction and prescription). Pursuing logical errors that perpetuate pathogenic thoughts could be very difficult, and many therapists would be likely to advise and support when overwhelmed by the process.

Dr. B suggested that I continue to study and use the “Columbo approach” when I began to feel overwhelmed (technique). If done correctly, reflecting Leo’s statements back to him in a questioning tone would prompt Leo to explain his thought process. At this point in therapy, Leo was more likely to be able to critically evaluate his thought process and explain it to me.

The process of change continued.

Esteem. Leo and I continued our routine of opening the session by exploring CBWs. I reminded him that Esteem was the theme of the session to frame the session for him. As he looked over his CBWs, Leo remarked that he was beginning to understand alternative thoughts on the CBWs as new habitual thoughts. Wanting to know what this meant to him, I asked him to describe his experience of this process. Leo “could not believe the alternative thoughts one hundred percent yet,” but he found it useful to have them as something to fall back on when pathogenic habitual thoughts or responses arose. He said that the thoughts felt like “a relief” and noted that “thinking about my cousin’s death is still sad, I wish he were here, but the thoughts

feel lighter now. Like normal sadness.” I realized that Leo’s complicated grief was becoming disentangled with the traumatic memories, allowing for the normal grieving process to unfold. I silently noted to myself to possibly discuss this with him later in the session but chose to focus on discussing the CBWs to keep to the main task of session.

As we began to evaluate his first CBW, Leo remarked that his memory of the night of the trauma had been improving by reading his Trauma Account and completing the CBWs. Thinking on this, I realized this was what Dr. B meant about trauma’s impact on memories. Reading the account allowed the memories to be intentionally re-experienced, and the CBWs fostered non-pathogenic beliefs and broadening perspective regarding the trauma. The question “to what extent does this belief not take other information into account” particularly came to mind as I considered this.

Leo was creating a new narrative for himself. I once again noted this to myself and proceeded with the CBW Leo had chosen. The belief was “people should be punished for bad acts. I didn’t help my cousin, so I should be punished.” He felt a great deal of anger and resignation regarding this belief as well as some sadness. Thinking this was a great time to use the “Columbo approach,” I asked “so you should be punished?” Leo responded by saying “criminals get punished, but I’m not a criminal. I can’t be held responsible for my cousin’s death.” Deciding that this thought was useful but abstract, I applied it to Leo’s life experience by asking about how his case would be handled in a court. He immediately took in the question and knew that he would not be held responsible, but still felt “bad” due to his role in his cousin’s passing.

At this point I felt a little lost. Where was the Esteem in this material? I asked myself what these thoughts indicated about how Leo feels toward himself and realized that he felt like a

bad person—negative self-esteem—for being at all involved in what happened to his cousin. Thinking that I could bring this discussion away from morality and justice to Esteem, I asked Leo “and law is one way to look at it that can be useful. What does your heart say about these thoughts?” Leo wanted to believe in them but felt it would be wrong of him to do so. Like he would be “dodging responsibility for something I had a part in.” I reflected his words back to him with my own emphasis: “something you had *a* part in.”

Leo then told me a story about a friend who had been held responsible and shamed by his parents and friends for something many others were involved in. The incident was minor, but this friend was still held in some contempt. Leo could not help but think “if they feel he’s bad, what will they think of *me*?” Realizing that Leo’s story of his friend paralleled his own, I noted that Leo felt ashamed but also thought that he shouldn’t have to feel as ashamed due to others playing a role. It seemed to me that he thought that those judging his friend were wrong to do so as they did not have all the information. Leo’s use of the phrase “all the information” reminded me of the “focusing on one aspect” question on the CBW. Applying that to others, I questioned Leo by saying “well, can’t other people fall into the same patterns of problematic thinking on these sheets? Are these people including all the information about your friend?” Leo knew they were not, and he quickly applied this to himself.

Driving this shift in perspective home, I asked Leo “others don’t have all the information. If the people who you fear judgment from watched a video of everyone’s actions on the night your cousin died, what would they think?” Leo quickly realized that they would have seen many other dangerous actions by other people that night. They also would have seen that Leo had made multiple attempts to help his cousin and keep him safe. Those who knew of this night knew Leo and his friends had partied this way before and had never had any catastrophic accidents—

this was not uncommon behavior and had never led to bad conclusions, so no one had reason to be concerned that this night in particular would end in tragedy. Leo realized he was lowering his self-esteem by only including his perspective.

Leo realized that “we’re all the heroes of our own stories. If it’s from my perspective, my memory only, I see what happened as written, directed, and filmed by me. *Controlled* by me. But there was so much other stuff going on that night that I had absolutely no control over.” I reflected the word “control” back to Leo, noting that it had many layers. Leo responded by mentioning that his perspective on his trauma for the past few years had treated his cousin as a non-living object. I validated this experience and explained that this was part of defensive undoing. In our wish to undo, we think only about what we could have undone. But this causes all or nothing thinking and leaves out other aspects of events, such as the free will and decisions of others. Leo looked relieved but in pain at the same time. I asked him what was going on for him. “But a good person would have helped him.” “So, because you weren’t able to...” “I’m a bad person.”

We evaluated this with a CBW. Was it fair that Leo had always had the role of being the responsible one? Where did this role come from? Leo was always the most capable and most trusted by adults, so he was trusted to cover for his cousin and others when they were “being wild.” I wondered aloud what it meant to be capable of doing something but not doing it. Leo said it would feel like choosing not to do it, withholding positives from others. This could make someone bad. I asked Leo if he chose to not help his cousin that night. Leo responded by saying “I didn’t *do* anything that went against my morals then. Just don’t hurt others is my moral code. My cousin made his own decisions that night. I couldn’t have known, been responsible or fully capable of doing anything about what went on in his head then.” Wanting to emphasize this

growing change, I asked Leo what his cousin would say in regards to punishing himself for not “doing better” that night. Leo said his cousin would not want him to punish himself. He was able to believe this ninety percent, and it came with a large feeling of relief.

I finally realized we were discussing Leo’s Stuck Point related to self-esteem. He overaccommodated a belief that he did not deserve anything good because he “killed his cousin.” Leo verbalized this thought almost verbatim during session. Leo found it hard to receive compliments from others; however, he noted that “it wasn’t that I can’t believe it because of what happened, it’s just...kinda awkward? I don’t know what to say when I get complimented other than shyly saying thanks.”

Thinking about his Stuck Point, I asked Leo how he would have thought and felt when receiving compliments in the past. He mentioned that he would have disavowed the validity of the compliment, thinking “I’m just doing it for my cousin.” I probed more by asking “and..?”, Leo said “...and nothing is good enough to make up for what I did.” These thoughts did not occur any more, as he was learning to shoulder a reasonable amount of responsibility for his role in his trauma. Giving compliments was much easier for Leo, as he always sought to see the good in others. I internally noted that his seeking the good in others seemed reflexive, prompting me to ask if this optimism was at all related to his response to his cousin’s passing. He easily realized that he had black and white thinking, labeling others as good for not making the mistake he had and himself as bad for letting his cousin die. He had recently had to evaluate the performance of people he worked with and found it much easier to give honest and balanced feedback. He would note what they did well and what they could improve upon, whereas in the past he would solely focus on their good work and avoid even thinking about improving weaknesses.

Supervision of esteem processing and termination.

During supervision, Dr. B remarked that I did well with not filling in the blanks for Leo during the session. Leo still appeared to have Stuck Points related to Esteem, but he seemed to be working through them. The last session allowed Leo to critically evaluate his self-disparaging thoughts. I could improve my use of the “Columbo approach” by doing more than reflecting Leo’s words back to him when I felt confused. Rather, I could also repeat his own logical processes back to him with a sense of confusion to have Leo explain—or fail to explain—the logic that led to his pathogenic beliefs (technique). Dr. B then moved on to explain the last session. Intimacy could prove to be quite difficult for Leo given that his trauma centered around the loss of a close loved one. He could quite easily have a very deeply held belief that he should not get close to others (prediction). That much was evident in Leo’s dreams regarding friends and family dying when he would try to run to them. It would be necessary to focus on Leo’s current relationships, how Leo’s response to his trauma had impacted these relationships, and if these responses interfered with what he wanted from his relationships. Per the CPT web module, Leo was to complete a new Impact Statement along with completing CBWs regarding Intimacy.

By evaluating how different the new Impact Statement was compared to the first Impact Statement, I would be able to see and emphasize the dramatic differences as well as search for remaining cognitive distortions to attend to in the final session (theory to practice). Unattended distortions could become problematic in the future, leading to relapse. Additionally, focusing on the therapeutic relationship would allow Leo to see that relationships can be safe and challenge him to grow further. Dr. B suggested an intervention that was not included in the usual CPT modules to focus on the therapeutic relationship (prescription). He asked me to instruct Leo to write a letter to me regarding his feelings about and responses to therapy. He would read it to me

during the last session. I was to do the same regarding my experience of Leo's therapy. We would discuss how he appeared when he began therapy versus how he appeared now, what he would have changed, and goals for the future.

The process of change continued.

Intimacy. Leo began the final session by reading his new Impact Statement. His new Impact Statement was characterized by themes of "then versus now." Almost all the "now" portions of the new Impact Statement described his newfound perspective on his trauma. He no longer believed that his cousin's death was his fault because "he had always been the responsible one," and realized it was unfair as it was an expectation placed upon him by others. He considered his cousin's role in the events of his own death more as time went on. While he would sometimes feel guilty, he was able to quickly realize that these were automatic thoughts based in habit and hindsight bias.

In realizing his cousin's role in Leo's traumatic night, he began to feel sad for his cousin. Leo realized that the feelings of guilt he had in the past interfered with grieving his cousin's passing. The feelings of sadness he had recently been experiencing reflected appropriate sadness regarding his cousin's death as well as increased understanding of just how much emotional pain his cousin was experiencing at the time. This gave Leo more motivation to live a good life for his cousin's sake; only this time, the desire came from a desire to not repeat the tragedy of his cousin's life as opposed to an unconscious wish to undo his cousin's death.

Keeping Dr. B's words in mind, I used minor Socratic Questioning regarding the guilt he mentioned as well as his desire to positively live in his cousin's memory. As this was the last session, relapse prevention was key, and both of those statements were related to Stuck Points. When I asked about the guilt, Leo mentioned that it still felt automatic for him. However, it no

longer had the weight, power, or “stickiness” it once had. He no longer believed in the thoughts that led to guilt and could easily question and refute them. As I asked about living for his cousin, Leo explained that he knew his cousin would want him to be happy. Leo would be happiest if he could live up to the potential his cousin had always praised him for—the potential his cousin felt would change their futures for the better. By keeping his cousin’s memory in mind, Leo could find more pride and self-esteem in his successes.

We then moved on to the CBWs regarding Intimacy. Leo discussed themes pertaining to intimacy received from others as well as intimacy toward himself. He still had difficulty letting others in. He behaved in ways that created interpersonal distance to protect himself from forming meaningful attachments, as without meaningful attachments, there would be no one to grieve if something terrible happened. We assessed this via a CBW he completed. Once more keeping Dr. B’s words in mind, I rarely spoke and intervened; if I did speak, it was to ask clarifying questions. I needed to help Leo be his own therapist.

Using the therapeutic relationship, I could convey my confidence in him. This led to a simple intervention: I replied to Leo’s Stuck Point by saying “That sounds difficult. How did you change that belief?” The statement allowed me to have a more hands-off approach, allow him to show me that he did this therapeutic work on his own, and implicitly let him know that I believed he was able to effectively change such a stuck, difficult belief on his own. Leo’s CBW regarding this thought was concise, labeled the cognitive distortions and patterns of problematic thinking, and used effective alternative beliefs. I nodded and praised him. He then moved onto a second CBW regarding how he felt about self-related intimacy. He clarified, explaining that to him, this meant engaging in appropriate self-care. He realized he often sacrificed for others due to guilt in

reaction to his cousin's death. If he sacrificed, he could somehow make up for being such a terrible person.

As his beliefs began to change, he was increasingly able to engage in self-care without guilt. He took less shifts at work, he ate better, he slept better, he went to the gym, he dressed better, and he spent time with his dog. He attributed these changes to being able to grapple with the Stuck Point. "I'm a bad person because I killed my cousin, so I don't deserve kindness or good things." By addressing the automatic thoughts about his guilt, he was able to have compassion toward himself.

Finally, we read and then exchanged the letters that Dr. B suggested we write. I read my letter to him first. My letter to Leo included a lot of praise regarding his therapeutic progress. I felt that he was making huge strides. I emphasized the strength of will and courage it took to engage in the exposures to the Trauma Account. Because of these qualities, I also emphasized that the healing he experienced and continued to experience came from within. My job was simply to facilitate certain aspects of the change process. In saying this, I aimed to more explicitly remind him that the tools of change were in his hands. In fact, they were always in his hands, so the end of therapy was not me giving him the tools as a parting gift; rather, I was confident he was able to use the tools and strength that had always been within him.

I let him know how happy I was for him, and that the person sitting in front of me truly seemed like a new man. He definitely had a bright future ahead of him. Using the letter, I linked his themes regarding Intimacy and his new Impact Statement to the therapeutic relationship. The trust and intimacy shared in our therapy together were also necessary elements of change. In working with me, he had already begun to change his avoidant interpersonal style, even from the first session.

Leo then read his letter to me. In it, he thanked me for continuing to help him despite his early resistance. He explained how therapy had felt to him. Early in the process, he had often felt like running out of the room when we doing exposures. But my calm presence, my belief that he could tolerate the experience and grow from it, and his own desire for change helped him not flee from the room or treatment itself. He described how intense his feelings were in the beginning of therapy, well before we began the CPT protocol. He could hardly believe how different he felt now. He was extremely grateful for his newfound sense of freedom and the ability to enjoy the present. He finally felt hopeful about his future. He was very sad for the therapy to end as he felt close to me after the experience of working through his PTSD together, something he avoided talking about during the earlier discussion on Intimacy. He ended his letter by thanking me for my belief in him.

I was very touched by his letter. I focused on his sadness related to the end of therapy. Given the cause of his PTSD, it would be very therapeutic for him to have a positive relationship end on a positive note. This sadness was a natural emotion, one that we could hold together. I told Leo that another reason I could hold the sadness with him was because I also felt sad. I really enjoyed the work we did together and bearing witness to his healing and growth was an honor and a delight. My sadness was balanced by excitement for Leo, as I knew that he had so much more freedom to continue to improve his future. I told Leo that he no longer met criteria for PTSD. And, more than a simple return to baseline, Leo was stronger for his experience. We shook hands and parted ways.

Termination

Overall, Phases 1 and 2 of therapy were conducted over approximately 1½ academic years, for a total of 25 therapy sessions, with about half that time devoted to Phase 2. Throughout

all our sessions, I felt there was a very solid therapeutic alliance between us, and Leo maintained motivation for treatment despite intermittent periods of avoidance. He regularly attended sessions and was predictably active and engaged in the therapy process. When he had manifested challenging behaviors during our sessions, such as avoidance of homework assignments or lack of emotional presence in session, he was open to productively exploring these behaviors to make effective use of the therapy process.

The termination session highlighted the quality of the therapeutic relationship, which facilitated Leo's engagement in a difficult therapy. Accepting his ambivalence while kindly pressing him to engage for his own benefit, using keen Socratic Questions, and highlighting the gains he did make in the beginning phases of the CPT module increased his engagement and were ways in which I attempted to increase the success of the therapy. He no longer believed he was culpable for his cousin's death. He continued to explore the role his cousin played in his own death, which allowed him to healthily grieve his cousin's life as well as his death. Leo no longer experienced dissociative flashbacks, did not use alcohol to cope, his baseline level of anxiety was well within the normal range, he did not experience hyperarousal in regard to reminders of his cousin, and he no longer had altered cognitions about himself, the world, and the future. Given his experience in therapy, he reported that he would definitely return to therapy if he ever felt the need for assistance in the future.

7. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION

I collected the quantitative scores reported in Table 1, which were used for outcome monitoring throughout treatment as well as retrospective monitoring at follow-up. The outcome measures were used to gauge the relative progress of treatment. If Leo's symptoms persisted or worsened on the outcome measures, such information would be used to consult with Leo and Dr. B to redirect treatment to more beneficial ends. Throughout the therapy I had weekly, individual supervision, which was crucially valuable to me in reflecting on the therapy process in each session, including my own skills in employing CPT, how to manage Leo's emotions, and on how to proceed in the next session. Also, Leo's response to the various therapeutic tasks I proposed in the therapy and as homework assignments provided me with feedback as to the degree Leo was open and motivated at the time to work on his traumatic reaction.

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

15-Month Follow-up

I interviewed Leo approximately 15 months later as a follow-up with three purposes: to gain consent to use his case for the case study, to assess the long-term results of treatment, and to gather more data about his experiences during specific times in treatment. I engaged Leo in an unstructured interview regarding his current life experiences to assess for the presence of lingering PTSD symptomology. Leo had experienced some difficulties, but none were related to a relapse of PTSD symptoms. He had some difficulty with occupational stress, feeling unfulfilled and overworked in his current job. He had recently ended a romantic relationship. He reported that he continued to consume one or two units of alcohol approximately one or two nights a week.

I administered various treatment measures, including the CUXOS, OQ-45, BDI-II, and PCL-5. I asked Leo to complete three copies of each of these measures. Each different copy would assess how he remembered feeling during the beginning, middle, and end of treatment. Leo's current stresses were most strongly reflected on his current CUXOS and OQ-45. However, he was continuing to use therapy skills, such as Socratic questioning of his own thoughts, evaluating for distortions and patterns of problematic thinking, and challenging his beliefs to adapt to these situations. While he believed that he needed to continue at his current job for some more time to build up his work experience, he was very confident that he deserved and could obtain more fulfilling work. The end of the romantic relationship appeared to be due to a difference in life and career paths, and he was not distressed due to the break up.

Quantitative Outcome Results

Phase 1

There were significant changes in Leo's scores on all self-report measures by the end of Phase 1 (Week 13). By week 13, Leo's CUXOS scores had changed from the severe range to the moderate range. His scores on the BDI-II had changed from the severe range to the moderate range. His retrospective OQ-45 scores had changed by 14 points; while his scores remained in the elevated clinical range, changes of 14 points on the OQ-45 or more are statistically significant. His scores on the PCL-5 remained within the clinical range. However, the 18-point difference between Week 1 and Week 13 on the PCL-5 indicates a substantial decrease in his overall level of distress related to PTSD symptoms.

Phase 2

There were even more drastic and significant changes in Leo's scores on CUXOS and BDI-II by both the end of Phase 2 (Week 25) and 15-month follow-up. By week 25, Leo's scores on the CUXOS had changed from the moderate range to the non-anxious range. His scores on the BDI-II had changed from the moderate range to the minimal range. By 15-month follow-up, Leo's scores on all four self-report measures remained in the non-clinical ranges. Leo's scores on the CUXOS were in the minimal range. His scores on the BDI-II remained in the minimal range. His scores on the OQ-45 were no longer in the clinical range and had changed by 49 points, approximately 3.5 times the minimum statistically significant score change on the OQ-45. His scores on the PCL-5 changed from 46 to 7 points, placing his follow-up scores in the non-clinical range.

Qualitative Outcome Results

Phase 1

Leo's changes as observed on the above Outcome Measures must be understood while considering the effect that exposure therapies for trauma treatment have on anxiety prior to completion of the therapy. While his overall distress had decreased and he no longer managed his symptoms with alcohol by week 13, the changes he experienced decreased his overall and substance-mediated avoidance, which coincided with a mostly commensurate increase in his anxiety. His alcohol consumption had radically changed by the time he reached out to begin Phase 2. Prior to and during Phase 1, Leo had engaged in frequent binge drinking, consuming ten or more units of alcohol on a single occasion up to three times per week. Ironically, while one intent of his alcohol consumption was to reduce hyperarousal symptoms, intoxication connected him with the state experienced on the night of the trauma. During various episodes of intense intoxication, Leo experienced many dissociative flashback episodes in which he was either mostly or completely unaware of the present moment. This contributed to both shame when others witnessed his dissociative episodes and traumatic re-exposure to his memories.

By week 13, Leo remained anxious. His baseline level of anxiety was reduced compared to week 1, but he remained in high levels of distress. Leo continued to engage in binge drinking, although at a decreased rate of approximately once per every two weeks. He continued to use the therapy tools provided in Phase 1 to make changes between Phase 1 and Phase 2, using Decisional Balances regarding the outcomes of binge drinking and cognitive restructuring regarding the thoughts and feelings that contributed to binge drinking. His sleep had begun to improve slightly, shifting from waking up for twenty minutes for every hour of sleep to being able to sleep for approximately three hours at a time. Leo reported feeling more "emotionally

drained” during the period between Phase 1 and 2, likely due to more cognitively effortful avoidance of traumatic reminders and memories. He continued to work many shifts at his job in order to occupy himself, depriving himself of the free time needed to ruminate about his trauma. One of the most dramatic changes prior to Phase 2 was Leo’s social changes. Leo attended a conference and risked disclosing his trauma to people he wished to befriend. While he expected to be rebuked, he was given sympathy and compassion. This new experience began to alter the overaccommodated beliefs about himself: his sense of unworthiness, guilt, and need for redemption.

Phase 2

By the time Leo began Phase 2, his alcohol consumption had drastically changed. He consumed approximately one to two units of alcohol on one to two occasions per week. He no longer experienced dissociative flashbacks or became extremely intoxicated. He was sleeping approximately five undisturbed hours per night. He had changed his work habits, working only the shifts he was scheduled for. He continued to experience an elevated baseline level of anxiety, to become more anxious due to cold weather, and to avoid reminders of his cousin. While his subjective distress remained clinically significant, his presence in the therapy room was different. He was often happier, able to smile, and able to approach his anxiety with self-compassion, wit, and determination.

By week 25, Leo was transformed. His baseline level of anxiety fell to minimal levels. The sources of his anxiety were everyday stressors of college students: assignments, grades, thinking about graduation, relationships, and missing family. There was almost no anxiety related to the death of his cousin. In fact, we began changing our therapeutic lexicon: rather than calling the stressor that precipitated his PTSD “his trauma,” we called it “the death of his

cousin.” His depression had completely remitted, and he felt happy more often than not, experienced joy from previously enjoyed activities, and all other opposites of depression symptoms.

Leo was able to discuss his cousin without avoidance and self-reproach. Rather, he experienced a bittersweet sadness indicative of progressing through uncomplicated grieving. Leo slept seven uninterrupted hours a night, joking that college students generally cannot hope for more than that. He no longer experienced increased anxiety due to cold weather. He freely enjoyed time with friends, having no excessive worries about their safety or if he would bring catastrophe to them. He continued to drink one to two units of alcohol per occasion, once to twice per week. Finally, Leo intentionally went to his cousin’s grave to speak with him. The experience was extremely sad, but Leo’s sadness was tolerable and therapeutic.

The Supervisory Process in Phase 2 and Its Impact on the Case’s Clinical Process and Outcome, and on the Therapist’s Learning Experience

The role of my own inexperience as a therapist in training.

Therapist competence plays an indelible role in treatment. As Leo was my first training case in CBT, I was developing competence as both a psychotherapist and in CBT/CPT. I knew Leo was in a great deal of emotional pain. I had a strong desire to help him, leading to interventions that did not always remain useful. I am reminded of the cognitive restructuring I did *for* Leo in Phase 1. In retrospect, this was a classic rookie mistake: a neophyte therapist struggling to reduce current distress because the therapist is also distressed and wants to feel useful. In doing so, they become overly didactic. The patient is then far less likely to remember the intervention, as they did not do the emotional work—the therapist did. Conversely, when Leo did the bulk of the emotional work with CBWs, his recall and use of CPT skills increased dramatically.

There is a confound to this case study inherent in the discussion of competence. Therapists in training also learn to make better use of psychotherapy training and supervision as they progress in their graduate training (Stoltenberg & McNeill, 1997). In writing this case study, I have realized I learn much more from supervision now than I did when treating Leo. It is impossible to objectively evaluate the importance and effectiveness of psychotherapy training and post-training supervision when therapist variables cause training and supervision to be differentially effective. Despite the impossibility of this task, the present case study was written with the goal of improving the field's understanding of factors and techniques that can benefit psychotherapy training and post-training supervision at any level of expertise. Given the relative dearth of research on standardized psychotherapy supervision, much research is needed to discern the effects of amount of graduate training on trainee therapists' ability to learn from supervision. It is my hope that future pragmatic case studies will include information regarding the supervision process as well. This information can be invaluable for improving the supervision process, as well as for training future supervisors.

The role of training between Phase 1 and Phase 2.

Dr. B began three modules of training in CPT with me before Phase 2 began. This allowed me to spend extra time reviewing CPT's model before meeting with Leo. Additionally, I was able to apply the fund of knowledge being developed through training to my clinical knowledge of Leo, and vice versa. Training and supervision complemented each other: training established a fund of knowledge I could reliably draw from to structure a CPT session, while supervision helped me tailor my general knowledge of CPT to my interventions with and understanding of Leo in particular. Additionally, treatment and supervision improved my understanding of CPT, transforming my declarative knowledge into burgeoning procedural

knowledge. Procedural knowledge facilitated deeper understanding and increased recall of CPT theory.

The role of supervision in avoiding avoidance in Phase 2.

Avoidance of anxiety and traumatic reminders was the defining factor of Phase 2. A theme of Dr. B's supervisory interventions during the first 6 sessions of Phase 2 was addressing Leo's avoidance. Rather than framing the goal as reducing Leo's avoidance, Dr. B framed the goal as understanding Leo's reasons for avoidance. In understanding and addressing these reasons with Leo, he would begin to feel safe enough to truly immerse himself in the exposure portion of treatment. Dr. B initially implored me to address practical issues that interfered with adherence to CPT homework: the time of day and environment in which he attempted his homework. Additionally, choosing a time of day in which Leo had the energy to do emotional work was important. Setting specific times and places facilitated Leo's ability to attempt homework. Dr. B predicted that these interventions would not lead to treatment adherence; rather, his attempts at homework would inspire anxiety that Leo and I could collaboratively seek to understand. Avoidance of even attempting the homework allowed Leo to keep the anxiety so abstract that it could not be put into words.

Once Leo began to grapple with his anxiety, Dr. B focused on questions that I could use to understand Leo's anxiety. What did you feel? Where did you feel it? What did you expect to happen if you thought about this? What would be the worst thing that would happen? Dr. B did so in the context of a "microanalysis" of session video during supervision. Rather than abstractly handing me questions that *might* be useful in the session, Dr. B paused at specific moments, explained his observations, told me what he would ask, and why he would ask that. We could then discuss and role play potential scenarios based on how Leo may respond to such questions.

Dr. B also facilitated my own emotional understanding of treatment interventions. By experiencing Socratic questioning, I was both able to experience the emotional changes that occur in response to Socratic questioning and see the types of questions used. Socratic questioning can be a difficult skill to employ. Therapists must be careful to not lead their patients while questioning. They need to empathically assess the logic of the patient's statements. This is why Dr. B explained that "your logic game must be very precise" when we began to use Socratic questioning in the context of CBWs. Leading questions would not lead to emotional change. Empathic failures could result in Leo feeling shame, which would inhibit expression and processing of natural emotions and overaccommodated beliefs, or even lead to treatment dropout. The experiential learning I gained from undergoing CBT and CPT interventions as well as role plays were imperative supervisory interventions.

Persistent attention to avoidance, empathic understanding of his reasons for avoidance, and Socratic questioning of the beliefs that led to it, eventually culminated in a treatment breakthrough. Leo suddenly began to consistently and deeply engage with CBWs. He was finally avoiding avoidance. While he could not evaluate his beliefs on his own at this point, the beliefs that we worked on restructuring in sessions and during his first CBWs provided such profound relief that he began zealously working with me in treatment. Supervision foci with Dr. B changed in response to this. At this point, Dr. B focused supervision on two interventions: (1) orienting Leo to the individual skills on a CBW he had difficulty with so *he* could complete it with minor assistance from me, and (2) careful Socratic questioning regarding Leo's deepest overaccommodated belief. He still believed that his cousin's passing as his fault, which manifested in various Stuck Points. I addressed Stuck Points in session. In supervision, Dr. B continued microanalysis of my interventions. We continued to guess how Leo's Stuck Points

would present themselves in the context of the next session's focus and how we may use Socratic questioning to address the Stuck Point.

Creating lasting change using the challenging beliefs worksheets.

Restructuring the overaccommodated beliefs that underpinned Leo's Stuck Points was the most beneficial aspect of treatment during the entirety of Phase 2. This process would have been severely hampered had we not addressed Leo's avoidance in the first half of Phase 2. Re-reading his Trauma Account between sessions was essential, as it provided the activation of both his emotions and traumatically dissociated memories required to process his trauma according to the CPT model. Had Leo continued to avoid CPT homework, efforts at restructuring his beliefs would likely have remained purely cognitive.

In retrospect, I realize that Dr. B's change in supervision foci coincided with the "third order of change" in psychotherapy. There are three orders of change in psychotherapy (Sperry & Carlson, 2013). Symptom reduction is first order change. Therapists helping patients change maladaptive patterns is second order change. Patients learning to change their own maladaptive patterns is third order change: essentially, becoming one's own therapist. Leo had already experienced first and second order change, and it was time to focus treatment on third order change. It seems CPT was structured for third order change from the inception. Every skill used in the CBWs was taught individually and practiced in and between sessions. This was essential. If we were to simultaneously resolve Leo's PTSD and maintain fidelity to CPT's 12 session model, Leo would have to become his own therapist.

Dr. B's supervisory interventions helped me avoid making the same mistake I had made when I fed Leo the entirety of a cognitive restructuring in Phase 1. In the microanalysis of session video, Dr. B identified instances in which I could have reminded Leo of skills practiced

during previous sessions and on previous worksheets. When Leo first indicated he was struggling, I would orient him back to the CBW as a whole and ask him which section of the worksheet was proving difficult. I would then question the thoughts and feelings associated with that section. Next, I would orient him to the knowledge and skills associated with that section as well as other thoughts and feelings that had been addressed with those skills. Dr. B wanted me to focus on “new” Stuck Points that could not be processed by relying on previous experience and skills. This way, Leo built self-efficacy by succeeding at the difficult work we were doing while his growing skills were continually scaffolded on an as needed basis.

By the end of treatment, Leo began to use the various skills learned through the worksheets to accomplish two psychological feats: (1) he was able to question his beliefs and (2) use his newfound skepticism of his beliefs to enhance his theory of mind of others. Questioning his own assumptions and beliefs facilitated his enhanced theory of mind: by realizing the effect of his beliefs, he became curious about the thoughts and beliefs of others. By enhancing his theory of mind of others, he began to notice that his cousin was a volitional actor in the events leading to his death; similarly, Leo realized he had been perceiving the memory of his cousin that night as someone without free will.

How the Pre-Phase-1 and Phase-1 Therapies Related to the Phase 2 Therapy

How I began to use Pre-Phase-1 and Phase-1 therapies as treatment progressed.

Due to my inexperience, I did not intentionally use the therapies prior to Phase 1 to inform my treatment with Leo during Phase 1. I knew that these therapies existed, but my own anxieties regarding treatment caused me to engage in avoidance. I had already felt overwhelmed, and searching for more information made me afraid of further complicating a case I already felt daunted by. However, Dr. B began the process of using the previous therapies to inform

treatment early on in supervision. Dr. B was curious about how much of CPT Leo had completed, why Leo stopped, what he remembered of the treatment, how long ago it had been, and the current state of Leo's PTSD considering his previous therapy experience.

Collaboratively, we used Leo's current state to inform our understanding of his readiness to engage in an exposure-based trauma treatment. Dr. B cautioned me that truly processing Leo's trauma would be almost impossible if he did not change his alcohol use, as the alcohol use would interfere with emotional experiencing and processing.

Dr. B continued this trend in simple and complex ways. Knowing that Leo had been in group therapy for grief indicated that Leo had not grieved his cousin's death. While this was obvious, it informed the complex CPT and Information Processing Theory-based understanding of Leo: specifically, Leo's most guarded defense of undoing. Leo's wish to psychologically undo his cousin's death via rumination was a complicated grief that simultaneously maintained his traumatic memories.

The role of Phase 1 itself: expectations versus reality.

I have realized that I expected too much from both Leo and myself. Leo was highly motivated for treatment, but treatment was extraordinarily difficult. Exposure based trauma treatments are fraught with high levels of patient dropout, with up to 40% of patients dropping out of CPT and Prolonged Exposure well before an adequate dose of treatment can be delivered (NICE Guidelines, 2018). Dropout rates are higher for patients with substance use issues (Brady et al, 2001; Mills et al, 2012; Foa et al, 2013; Frost et al, 2014; Imel et al, 2013). And, while I was intimidated due to my first CBT training case being so complex, I still wanted to "cure" Leo, and do so within the 12 session model of CPT despite being a neophyte therapist. Doing so

would “prove I was a good therapist” and worthy of being trained, an important goal during my first year of training.

Thus, while Phase 1 had many functions, easing Leo into treatment and creating a strong enough therapeutic relationship to withstand the pressures of CPT may well have been its most important function. Leo’s PTSD treatment was not a pure implementation of CPT. However, various Randomized Control Trials implementing CPT have consistently excluded patients with major complications, such as: homelessness, substance use disorders, domestic violence, suicidal and/or homicidal ideation, severe and persistent mental illness, severe chronic medical illnesses, mandated treatment, pregnancy, cognitive impairment, and current incarceration (Bradley et al, 2005; Najavits et al, 2013; Watts et al, 2014). Treatment with patients with major complications such as Leo’s alcohol use may require adjustments to the therapeutic frame, especially length of treatment. Treatment dropout was a definite concern. An autobiographical case study example is presented by David J. Morris, a former marine, who illustrates of the risks of single-minded focus on treatment fidelity for exposure-based trauma therapies:

“...after a month of [prolonged exposure] therapy, I began to have problems. When I think back on that time, the word that comes to mind is ‘nausea’. I felt sick inside, the blood hot in my veins. Never a good sleeper, I became an insomniac of the highest order. I couldn’t read, let alone write...

One day, my cellphone failed to dial out and I stabbed it repeatedly with a stainless steel knife until I bent the blade 90 degrees. When I mentioned all this to my therapist, he seemed unsurprised...

Following a heated discussion, in which I declared the therapy ‘insane and dangerous’ and my therapist ardently defended it, we decided to call it quits. Before I left, he

admonished me: ‘P.E. has worked for many, many people, so I would be careful about saying that it doesn't work just because it didn't work for you’.

Within a few weeks, my body returned to normal. My agitation subsided to the lower, simmering level it had been at before I went to the V.A. I began once more to sleep, read and write. I never spoke about the I.E.D. attack again.

In one sense, my therapist was right: Prolonged exposure has worked for many people. It has arguably the best empirical support of any PTSD therapy currently in use by the V.A. One recent study found that among veterans who completed at least eight sessions of treatment, prolonged exposure therapy decreased the proportion who screened positive for PTSD by about 40 percentage points. But the treatment may not be as effective as the V.A. would have you believe: About a quarter of the veterans in that study dropped out of the treatment prematurely, much as I had....

My own disappointment is that after waiting three months [to start therapy], after completing endless forms, I was offered an overhyped therapy built on the premise that the best way to escape the aftereffects of hell was to go through hell again.” (Morris, 2015).

I did not want Leo to experience anything like this. The reality of Leo’s treatment required that I be a responsive and reflective practitioner in order to adapt to his needs. The evidence indicates a high probability that Leo could have dropped out of treatment had I focused solely on delivering 12 sessions of CPT. The 13 sessions of Phase 1 allowed Leo to become comfortable with treatment while we simultaneously focused on reducing his use of alcohol. CBT techniques such as ABC sheets, thought logging, decisional balances, and cognitive restructuring were strewn throughout Phase 1. These techniques provided support at the time of intervention as well as a fund of knowledge that facilitated Leo’s activity in Phase 2.

Phase 2 built upon all of Leo’s therapeutic work until this point. We formulated Leo’s PTSD using culture, family history, grief, and CPT theory. Leo had already begun to work on

grief, indicating that he had some level of insight regarding his need to grieve his cousin's death. With this understanding framing the exposure therapy, we built upon Leo's previous CPT therapy as well as my attempts at CPT during Phase 1. Leo already had some skill with home practice and knew what to expect. Dr. B and I used this to inform the presentation of home practice. Rather than feeling overwhelmed by the assignments themselves and the rationale, we could focus on engaging Leo in a Socratic Dialogue regarding his anxieties and the rationale for exposure. Finally, Leo had various benefits from Phase 1 that increased his buy-in to therapy in general: decreased alcohol consumption and subjective distress, lack of dissociative flashbacks, increased social connection, and changes in sleep. With observable changes and no substance use precluding emotional experience, we were able to begin the cognitive and emotional processing.

Strengths and weaknesses of each therapy.

Pre-Phase 1, Phase 1, and Phase 2 therapies all had relative strengths and weaknesses. Regarding strengths, Leo's Pre-Phase 1 therapy occurred soon after the trauma itself. Leo was engaged in CPT and had begun to process some of his Stuck Points. Phase 1 allowed Leo to withstand the pressures of CPT.

However, there were also weaknesses in each Phase. Leo's Pre-Phase 1 therapy ended well before even the introduction of Patterns of Problematic Thinking. Leo had only developed a Trauma Account. This led to exposures that were not fully processed, leaving the risk of traumatic exposures. Without full processing, Leo had an intellectual understanding of disparate aspects of his PTSD. Thus he intellectualized his emotions, talking about emotion rather than feeling it, during Phase 1 and the first half of Phase 2. While Phase 1 was useful and reduced his alcohol consumption, my own avoidance prolonged Leo's distress. I may have been able to treat Leo's PTSD in fewer sessions had I intentionally used Phase 1 to ease Leo into the therapeutic

relationship. Given the cost of psychotherapy and the low amount of sessions many therapists have to engage patients in CPT at the Veteran's Administration, reducing utilization is an important consideration.

Phase 2 included its share of weaknesses. The focus on CPT risked Leo fleeing treatment. Consistent attention to Leo's home practice left me little room to attend to Leo in the moment, curtailing my already limited ability to titrate his anxiety to remain within useful levels. This was unavoidable, and clinical experience allows many of these intentional, slow decisions to become automatic and faster, facilitating easier focus on all of the mentioned treatment considerations. I often felt an intense pressure to "fit everything in," including Leo himself. However, this is likely part and parcel of psychotherapy training with neophyte therapists. This highlights the need for continuing education and re-training as therapist expertise grows.

Reflections on Dissemination, Implementation, and Psychotherapy Training of Graduate Students

The world of clinical psychology is increasingly becoming aware of the impact of trauma, which has led to a commensurate increase in interest and research regarding trauma informed therapy. The Veteran's Administration has adopted CPT and Prolonged Exposure (PE) (Foa et al, 2007) as gold standard PTSD treatments (Karlson, et al. 2010). This adoption represents one of the largest undertakings of dissemination and implementation of evidenced based treatment in the United States. As such, if these treatments are to become widespread and standard, quality training and supervision of these treatments is imperative. However, there are various difficulties in dissemination (Borah et al, 2013), ranging from limited availability of trainers, limited organizational support for training, limited availability of supervision, and more. These factors would likely limit the likelihood of other professionals receiving the highly competent, sensitive, responsive training and supervision that was essential to the success of my

treatment. If such a large dissemination and implementation project is fraught with difficulties, what implications does this have for the rest of psychotherapy training and supervision?

One of the purposes of this study is to use the thick knowledge presented in this pragmatic case study to reflect on the importance of and current state of psychotherapy supervision. My hypothesis is that supervision played an enormous role in the outcome of Leo's treatment precisely because this was my first ever CBT training case. I had no other fund of knowledge or psychotherapy skills to draw upon in this treatment. Supervision has been defined as a core competency in the practice of psychology by the APA (Falender et al, 2004). Yet many clinicians do not receive formal training and supervision in this area (Scott, Ingram, Vitanza, & Smith, 2000). While the state of affairs has changed within the last decade and many graduate programs have coursework in supervision, the old paradigm of supervision seems to still reign: you can provide good supervision because you received good supervision. This psychotherapy aphorism is countered by another aphorism: if getting supervision created good supervisors, then psychotherapy patients would become good psychotherapists. Yet supervision is rarely studied for various reasons; to name a few, there are issues of confidentiality, technological limitations, and sheer complexity.

To rectify this, various models of monitoring the quality of supervision have been presented. One model that seems applicable to Leo's case was posited by Beidas and Kendal (2010). They suggest a "Systems-Contextual" (SC) model for supervision of evidence-based treatments. The SC model recommends accounting for the effects of therapist variables, client variables, organizational support, quality of training program, and training on therapist behavior in session. The strength of this model is in how it intentionally evaluates the multiple sources of reinforcement, punishment, and practical barriers in a system that influence how a particular

therapist behaves. Psychotherapy supervision is often thought of as a dyad, but this ignores the fact that training occurs within graduate programs that are often housed in universities.

There are systems within systems that affect therapists during training, which can affect their behavior as professionals. Leo's case was assigned as part of my coursework in CBT, and I had to inject class requirements into the treatment. I worked under the license of one supervisor, then another. Each of those supervisors had a role within the training clinic. They interfaced with my training program. My training program interfaced with the university in which it was housed. Each systemic layer provided differential reinforcement or punishment of my behaviors as a therapist. Similarly, each system layer differentially reinforced supervisor behavior. This adds to the complexity of studying supervision.

The Beidas and Kendal (2010) model seems to represent a top-down approach to supervision. Conversely, Bennet-Levy et al (2009) examined efficacy of training methods for CBT skills and competencies. Their analysis of specific supervisory techniques and interventions was a form of bottom-up analysis of supervision, focused on how specific interventions affected therapist behavior. Coursework and readings were optimal for increasing declarative knowledge. Other techniques, such as modelling, role play, and self-exploration work were experiential supervisory interventions that facilitated deeper encoding of complex behaviors. These techniques combined declarative knowledge, piecemeal shaping of behaviors, and the emotional impact of role plays as multiple routes of encoding procedural knowledge. This is similar to my experience of Dr. B's role plays after completing the web-based CPT modules. These were even more effective thanks to microanalysis of Leo's session content. My use of the CPT module was enhanced by the use of web-based resources.

Wolf (2011) analyzed using internet and video technology in supervision and training, noting that it has both benefits and risks. Teleconferencing can eliminate practical barriers to supervision and training. However, web-based information may only serve to improve declarative knowledge. The CPT module includes video modelling, which has demonstrated effectiveness in transforming declarative knowledge into procedural knowledge. Dr. B's supervision foci aided my journey of gaining procedural knowledge. By explaining his thoughts to me, he increased my declarative knowledge. Applying his expertise to microanalysis of session content helped me understand *the process* he used to arrive at those conclusions. Role playing therapy with Dr. B as myself, as Leo's therapist, and as Leo, further allowed me to attempt to use clinical judgment that could be refined. Finally, providing psychotherapy and receiving feedback on my interventions via Leo's responses within session and via Dr. B's responses in supervision provided differential reinforcement for my behavior as a therapist. I reflected upon an intervention, what the intervention did for Leo and for myself, and the results. This reflective practice greatly improved my skills as a novice therapist.

Milne and Reiser (2012) analyzed the needs of and possibilities within the realm of CBT supervision. They posit that "the current basis of CBT supervision largely rests on descriptions of CBT supervision provided by Liese and Beck (1997) and Padesky (1996) almost 15 years ago." However, there has been an explosion of technological advances that can support supervision within the 20 years that have passed since Liese, Beck, and Padesky's work. Watching video of therapy is easier than ever, allowing microanalysis of specific moments in supervision. Supervision itself benefits, as it can also be recorded for the supervision of supervision in training programs. Unfortunately, while CBT enjoys a rich empirical basis, CBT

supervision has been lagging behind treatment (Armstrong and Freeston, 2006; Milne and James, 2000; Lambert and Ogles, 2004; Wheeler and Richards, 2007).

Milne and Reiser report that the structure of CBT supervision closely parallels CBT sessions: checking in, reminders of the previous session's work, agenda setting, working through agenda items, summarizing, homework, and feedback. Dr. B used each of these supervisory interventions with me, providing a "social role model" form of supervision. Additionally, he specifically addressed my therapeutic techniques using Socratic questioning of me, guided discovery, and collaboratively formulating the case with me through the lens of CPT theory. While Milne and Reiser found that most CBT supervision literature was largely descriptive, emphasizing principles in order to create declarative knowledge, Dr. B's supervision style was simultaneously didactic and experiential. This facilitated transforming declarative knowledge into procedural knowledge.

Dr. B's supervision reflects the philosophy of a United Kingdom governmental mandate known as Improving Access to Psychological Therapies (Watkins, 2012). IAPT's competency framework includes an emphasis on evaluating supervisee competence through direct observation of therapy and through the use of outcome monitoring tools in each session (Beck et al, 2008; Newman, 2010). In line with this, my use of the CUXOS measure in each session, while not a tool for measuring PTSD, provided a clinically useful outcome scale sensitive to changes in Leo's trauma-based anxiety.

Some questions that are helpful to further reflect on include: how would the outcome of Leo's treatment have differed had I had different, less responsive supervision? How would the outcome differed had I had Dr. B as my supervisor for Phase 1, considering that Leo needed time to truly participate in CPT? And from a dissemination and implementation standpoint, how can

we disseminate training in responsive supervision in order to further disseminate competent therapists?

My work with Leo was foundational in my psychotherapy training. It helped me more fully understand the complexity of psychotherapy with any disorder. I was extremely fortunate to have had two wonderful supervisors whose differing styles of supervision seemed to map so well onto Leo's needs at those specific treatment junctures. On the other hand, I wonder how much the needs Leo reported to me during each phase of therapy were influenced by the styles of my supervisors that I brought into the treatment room with me. I have felt the influence of Leo's case throughout the rest of my graduate training. As a result, as a therapist, I constantly ask myself what do my patients need, how can I provide what they need, and how can I as a supervisee communicate those needs to my supervisors and receive training that facilitates my ability to provide for those needs. More than anything, I have learned to approach being a therapist and a supervisee with reverence for the importance of the work and humility for how much there still is to learn.

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Table 1. Change in Symptom Measures Over Phase 1 and 2 of Therapy

Measure	Domain Measured	Week 1	Week 13	Week 25	15 Month follow-up
CUXOS ^a	Anxiety	45*	34*	1	11
BDI-II ^b	Depression	47*	22*	3	3
OQ-45 ^{c#}	Overall symptom distress and dysfunction	90*#	76*#	Not available	27
PCL-5 ^{d#}	Post-Traumatic Stress Disorder	74*#	46*#	Not available	7

Clinical Meanings of Scores

^a CUXOS: 0-10, nonanxious; 11-20, minimal; 21-30, mild; 31-40, moderate, 41-80, severe

^b BDI-II: 0-13, minimal; 14-19, minor; 20-28, moderate; 29-63, severe

^c OQ-45: scores equal to or greater than 63 are in the clinical range; changes over time in a score of 14 or more points is statistically significant.

^d PCL-5: scores equal to or greater than 33 are in the clinical range

* Score in the clinical range

The OQ-45 and the PLC-5 were administered only at the 15-month follow-up, with retrospective ratings at that time about the client's experience in Week 1 and Week 13.

Figure 1. Challenging Beliefs Worksheet

Challenging Beliefs Worksheet				
A. Situation	B. Thought/Stuck Point	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
Describe the event, thought or belief leading to the unpleasant emotion(s).	Write thought/stuck point related to Column A. Rate belief in each thought/stuck point below from 0-100% (How much do you believe this thought?)	Use Challenging Questions to examine your automatic thought from Column B. Consider if the thought is balanced and factual or extreme.	Use the Patterns of Problematic Thinking Worksheet to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
		Evidence For? Evidence Against? Habit or fact? Not including all information? All or none? Extreme or exaggerated? Focused on just one piece? Source dependable? Confusing possible with likely? Based on feelings or facts? Focused on unrelated parts?	Jumping to conclusions: Exaggerating or minimizing: Ignoring important parts: Oversimplifying: Over-generalizing: Mind reading: Emotional reasoning:	G. Re-rate Old Thought/Stuck Point Re-rate how much you now believe the thought/stuck point in Column B from 0-100% H. Emotion(s) Now what do you feel? 0-100%