

Treating Posttraumatic Stress Disorder using Skills Training in Affective and Interpersonal Regulation (STAIR) and Narrative Story Telling (NST): A Case Study of a Male Juvenile Offender

An Empirically Supported Treatment Case Study
Submitted to the Faculty
of the Psychology Department

of

Washburn University

in partial fulfillment of
the requirements for

MASTER OF ARTS

Psychology Department

by

Soliel Wall

Topeka, Kansas

May 2016

Case Study Approval
Department of Psychology
Washburn University
Topeka, Kansas

May 2016

I hereby recommend that the EST prepared under my supervision by

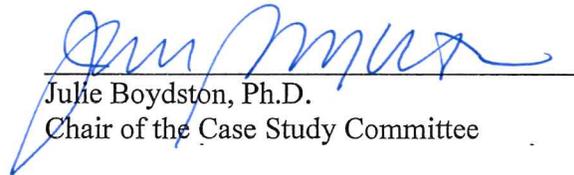
Soliel Wall

Entitled

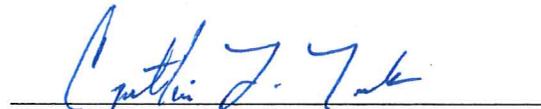
Treating Posttraumatic Stress Disorder using Skills Training in Affective and
Interpersonal Regulation (STAIR) and Narrative Story Telling (NST): A Case Study of a
Male Juvenile Offender

be accepted in partial fulfillment for the

MASTER OF ARTS DEGREE


Julie Boydston, Ph.D.
Chair of the Case Study Committee

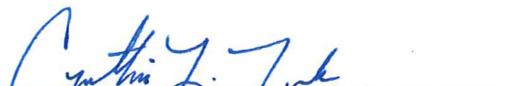

Randy Pembroke, Ph.D.
Vice President for Academic Affairs


Cynthia L. Turk, Ph.D.
Head of the Department

Recommendation Concurred by


Dave Provorse Ph.D.

Committee for the Case Study


Cynthia L. Turk, Ph.D.

Theoretical Foundation

Cloitre, Cohen, and Koenen (2011a) describe psychological trauma as “a circumstance in which an event overwhelms or exceeds a person’s capacity to protect his or her psychic well-being and integrity” (p. 3). In childhood, the power of a traumatic experience such as abuse may be greater than the resources available for recovery. Several factors make children more vulnerable to exposure of repeated abuse. Limitations in the cognitive and physical development of children affects their ability to recognize, avoid, and escape abuse. Children are also unable to control where they live or whom they must depend on. Due to the already limited resources available to children, the occurrence of abuse often leads to a downward spiral of resource losses which continues over the course of abuse and may cause long-term effects after the abuse ends (Walter, Horsey, Palmieri, & Hobfoll, 2010). For example, loss of physical safety and integrity are immediate consequences of abuse; however, victims of childhood abuse also experience the loss of typical psychological and socio-developmental opportunities because of the restrictive social and emotional lifestyles they experience and adopt (Cloitre et al., 2011a; Maughan & Cicchetti, 2002). Since childhood abuse is often perpetrated by a caregiver, the emotional and social developmental tasks typically learned from caregivers are disturbed, and lead to maladaptive completion of these tasks.

Resource Loss Model

Cloitre et al. (2011a) organized the resource losses caused by childhood abuse into three categories: loss of healthy attachment, loss of effective guidance in the development of emotional and social competencies, and loss of support and connection to the larger social community. In the first category, loss of healthy attachment involves the inability of the child to develop autonomy and learn about the world in a secure environment. When the parent or

caregiver is the abuser, there is a betrayal of parenting responsibilities that leads to losses in the sense of security and safety. The child also struggles to develop adequate affective regulation and self-soothing. Loss of healthy attachment in childhood may lead to a loss of trust in relationships that extends into, and restricts the ability to benefit from, later interpersonal situations.

In Cloitre's et al.'s (2010) second category, loss of effective guidance in the development of emotional and social competencies results from the awareness that victims of childhood abuse are often raised in families with limited or maladaptive emotional expression and interpersonal functioning. Here, the emotions of the child are invalidated by the abuse itself, and inconsistent rules for living are presented. The child may learn that there are rules for sexual and physical behavior in general; however, these rules do not apply in the home. This conflicting information often leads to inappropriate behaviors that result in rejection from peers (Hennessy, Rabideau, Cicchetti, & Cummings 1994) An example of this evidenced by Mr. Smith's childhood history includes difficulties with conflict negotiation, such as when he reported almost getting into a fight with another offender over who would sit in a specific chair.

Limited emotional and social knowledge often extends through childhood and into adolescence, resulting in a variety of impairments. For example, abused children are more likely to: 1) have difficulties with social engagement, 2) be uncomfortable with high levels of emotions, 3) report lower self-esteem, 4) drop out of school, 5) use substances, 6) engage in delinquent behavior, and 7) experience interpersonal violence as victims and perpetrators (Polunsky & Follette, 1995). In addition, experiences of interpersonal violence in childhood have different effects on an individual, compared to experiences of violence that occur for the first

time in adulthood, in the form of emotion regulation and interpersonal skill deficits (Cloitre, Scarvalone, & Difede, 1997).

In the third category, loss of perceived support and connection to the larger social community happens as abused children often do not experience full and positive engagement in the community (Cloitre et al., 2011a; Walter et al., 2010). Due to the child's limited emotional and interpersonal resources, they often experience difficulties integrating themselves into the community. The expressed behaviors manifesting from the limited resources make them less attractive to peers and other important figures such as teachers and coaches. For example, a child who struggles to regulate their emotions and display competent social skills is less likely to be approached by peers compared to other children. Abused children may also experience feelings of alienation due to silence about the abuse. A reluctance to be truly seen and heard by others promotes a socially isolated lifestyle. Ironically, people in the community experience discomfort in recognizing and responding to the abuse, which is often exacerbated by beliefs that children can defend themselves, and causes others to distance themselves from these children (Cloitre et al., 2011a).

It is from these resource losses that Cloitre et al. (2011a) proposed the development of PTSD from childhood abuse. Specifically, they proposed that the resources discussed are essential and required in order for an individual to recover from trauma. Due to these resource losses, childhood abuse trauma produces not only the negative symptoms of absence of emotional and social competencies just discussed, but also positive signs such as PTSD symptoms (Cloitre, Miranda, Stoall-McClough, & Han, 2005, Walter et al., 2010).

Therefore, it has been suggested that treatment for children with an abusive history should not merely target the more overt symptoms of PTSD, but also the emotional and

interpersonal difficulties in order to recover the lost resources. Cloitre and colleagues (Cloitre et al., 1997; Cloitre et al., 2005; Cloitre et al., 2011a) have a nearly 20-year history of developing and gaining empirical support for recommending adding components to treatment of PTSD that focus on the development of skills to improve the ability to manage feelings and negotiate relationships.

Attachment

Parents and/or caretakers are an important resource for children. They provide information to the child about how the world works, specifically by protecting the child from threats, and helping them negotiate obstacles, until they have the resources to face these on their own. According to Bowlby (1988), parents help their children build internal and external resources such as problem solving, safety, and competence. Also, a child's sense of self is developed from the value and regard placed on them by their parent (Bowlby, 1988). When a child is abused and the perpetrator is a primary caregiver, the guidance and growth of these internal and external resources is disturbed. While the child's inherent need to be close to the caregiver for safety and support remains, this need for closeness results in abuse. Unfortunately, due to the strength of these needs, an abusive caregiver is often preferred to no caregiver at all, and as such many children will attach to an abusive caregiver if it is all that is available to them (Cloitre et al., 2011a). Since the resources necessary for the development of autonomy are compromised during abuse, the ironic tragedy here is that the child who is abused may become even more dependent on caregivers for protection and comforting, compared to children of non-abusive parents.

The ability to make emotional connections with others is necessary for effective functioning and mental health (Bowlby, 1988). However, when interpersonal relating is learned

in the context of abuse, the result is negative expectations and social behaviors. Interpersonal schemas, or models of relating to others, are rules or expectations formed from different interpersonal events with important people (Cloitre et al., 2011a). The first interpersonal schemas are developed in childhood with caregivers, and continue to influence thoughts, feelings, and behaviors in future interpersonal situations (Bowlby, 1988). Although this influence may be adaptive for those with positive early attachment experiences, it becomes problematic for abuse survivors. Specifically, relying on interpersonal schemas developed in abusive contexts often leads to maladaptive functioning in interpersonal situations that were adaptive and necessary for survival in the past, but are no longer effective.

Empirical Support for Treatment

Cloitre et al. (1997) conceptualized and developed a treatment for childhood abuse survivors from research demonstrating the effects of childhood sexual abuse on an individual's affect regulation, impulse control, and trust and intimacy in relationships. The initial study compared PTSD symptoms, as well as self and interpersonal problems, with "retraumatized" women (meaning they had experienced abuse in childhood, and then also been abused in adulthood) and women who were assaulted only in adulthood. Results showed the rates of PTSD did not differ among re-traumatized women and women assaulted only in adulthood. However, re-traumatized women showed more difficulties recognizing and expressing feelings, had a higher rate of attempted suicides, and were at significantly higher risk for developing a dissociative disorder. In addition, re-traumatized women reported more difficulties with trust, assertiveness, control, and responsibility, and were more likely to experience numerous forms of interpersonal violence.

In another study, Cloitre et al. (2005) found symptoms of PTSD predictive of long-term psychosocial impairment in women with a history of childhood abuse. This same study further reported that difficulties with emotion regulation and interpersonal functioning predicted functional impairment beyond the severity of PTSD symptoms. Additionally, Levitt and Cloitre (2005) supported their phase-based treatment with previous research indicating significant distress, higher dropout rates, and worsening symptoms following exposure treatment for a subset of clients. Clients particularly vulnerable to the adverse effects of exposure-based therapies were identified as those who struggle to tolerate distress and regulate emotions, are vulnerable to dissociation under stress, and struggle to maintain a therapeutic relationship—which are all common characteristics of survivors of childhood abuse (Levitt & Cloitre, 2005).

These findings support earlier recommendations for treatment to incorporate components focusing on emotion regulation and interpersonal functioning in addition to PTSD symptoms. Noteworthy, Cloitre et al. (2011b) surveyed a group of PTSD experts (25 complex PTSD experts, and 25 classic PTSD experts) about the most appropriate treatment for complex PTSD. The majority of expert respondents (82%) reported a phase-based treatment to be most appropriate as a first-line treatment for complex PTSD. More specifically, the majority of respondents rated the two therapeutic interventions of narration of trauma memories and emotion regulation interventions as effective first-line treatment components, and development of interpersonal/social skills as an effective second-line treatment (Cloitre et al., 2011b).

Exposure to Trauma Memories

Prolonged exposure (PE) has demonstrated effectiveness in improving PTSD and other trauma-related problems like depression, anxiety, and anger in over 20 years of research (Rothbaum, Foa, & Hembree, 2007). PE for the treatment of PTSD emphasizes emotional

processing of traumatic events through in vivo and imaginal exposures to memories and situations associated with the trauma (Rothbaum et al., 2007). Studies have demonstrated the effectiveness of PE in the treatment of PTSD in veterans, female victims of sexual and nonsexual assault, and survivors of childhood sexual assault (Foa et al., 1999). In addition, Foa et al. (1999) compared three treatments of PE alone, stress inoculation training (SIT) alone, and the combination PE-SIT, to a fourth wait-list group of females with chronic PTSD related to sexual and nonsexual assault. Compared to the wait-list condition, all three treatment conditions showed a reduction in PTSD, depression, and anxiety symptoms in treatment completers. For non-completers, PE was the only treatment condition that showed a significant reduction in anxiety symptoms. Additionally, the PE condition was found superior to all conditions in reducing symptoms of depression, anxiety, and PTSD. The PE condition also had significantly lower dropouts. Both conditions that included PE (PE alone, and combined SIT-PE) were found superior to conditions not including PE. In addition, a case study of two male juvenile sex offenders with chronic PTSD, and lengthy histories of having experienced sexual, physical, and emotional abuse during their own childhood showed that PE was successful in reducing PTSD symptoms and improving mood (Hunter, 2010).

Importantly, in reviewing the outcomes of their own research, Foa et al. (1999) speculated that the results of PE being superior to PE-SIT may have been due to the fact that session lengths across treatment conditions were the same, meaning double the content was covered in the PE-SIT condition in the same amount of time, leading to potential information overload. Therefore, despite the apparent strong support for using an exposure-only approach in the treatment of childhood abuse victims, this research warrants additional investigation into the potential additive value of supplementing PE with other types of interventions to enhance

treatment outcomes. Based on the conceptualizations of Cloitre et al. (1997; 2005; 2011a; 2011b) that describe the common attachment-based etiology, as well as the manifestations of common problematic behaviors resulting from skills deficits, development of skills in the areas of emotion and interpersonal regulation merit consideration.

Skills Training

Resick, Jordan, Girelli, Hutter, and Marhoefer-Dvorak (1988) compared three types of behavior therapy (Stress Inoculation (SIT), Assertion Training (AT), and Supportive Psychotherapy Plus Information) in a group format for the treatment of PTSD in rape victims. The SIT condition focused on the development of relaxation, cognitive, and problem-solving skills. The AT condition focused on developing assertiveness techniques and cognitive restructuring. The Supportive condition focused on discussion of a variety of topics including fear and anxiety in order to normalize reactions and provide support. Results found that none of the conditions differed significantly in their treatment outcomes. All three conditions produced significant reductions in fear and anxiety compared to a wait-list group. Additionally, reductions in depression symptoms, difficulties with self-esteem and self-concept, and an increase in assertion were found. This research provides a foundation for further investigation into the utility of seeking improvements in PTSD-related symptoms from skill-based treatments.

STAIR/NST

Combining skills training and prolonged exposure, Cloitre, Koenen, Cohen, and Han (2002) demonstrated significant improvements in affect regulation, interpersonal skills, and PTSD symptoms using Skills Training in Affective and Interpersonal Regulation Followed by Exposure (STAIR- modified PE) in a randomized clinical trial with a wait list control. Participants were self-referred females, who were included if they met criteria for PTSD related

to childhood sexual abuse, physical abuse, or both. Participants in the STAIR-modified PE condition completed two phases of treatment where they first developed emotion management and interpersonal skills, and then later exposed to trauma memories through imaginal exposure.

Results showed a significant decrease in affective regulation problems, interpersonal problems, and PTSD symptoms between pre- and post-treatment for the STAIR-modified PE compared to the wait list. In addition, post-treatment assessment found only 23% of STAIR-modified PE participants still met criteria for PTSD, compared to 75% of wait-list participants. An enduring effect of treatment gains for interpersonal functioning and PTSD symptoms were reported, with adaptive changes not only maintained, but also improved, at both three- and nine-month follow-up for participants in the STAIR-modified PE condition.

In another study, Cloitre et al. (2010) compared three treatment conditions for the treatment of PTSD related to childhood abuse. Conditions were STAIR/Exposure, Support/Exposure, and STAIR/Support. The purpose of the study was to identify whether the addition of skills training prior to exposure would produce better outcomes than exposure without skills training. Results showed the STAIR/Exposure condition to produce significantly better treatment outcomes compared to exposure without skills training. Specifically, the phase-based treatment condition found reductions in emotion regulation problems, anger expression, anxiety, and PTSD symptoms greater than those found in the exposure without skills training condition. Additionally, the STAIR/Exposure condition showed greater improvement with interpersonal problems compared to the other two conditions, lower symptom exacerbation during the exposure phase, and produced the maximum treatment gains at three- and six-month follow-ups (Cloitre et al., 2010). Of particular interest is the authors' observation that the STAIR/Exposure condition experienced fewer dropouts than exposure without skills training.

While the dangers of “information overload” were noted in previous research that attempted to combine exposure-based treatments with other interventions within a limited number of sessions (Foa et al., 1999, p. 199), findings from Cloitre et al. (2010) suggest that the utilization of a phase-based approach may effectively address this danger. These results support earlier research demonstrating the unique symptomology of survivors of childhood abuse, and the benefits of a phase-based treatment incorporating elements to address these symptoms.

Presenting Problem and Relevant History

Demographics and Psychosocial History

Mr. Smith^a is a 19-year-old Caucasian male, currently incarcerated at a juvenile correctional facility. Mr. Smith has been incarcerated for approximately four years and was adjudicated at age 15 on multiple sexual offences perpetrated against his younger siblings and a child of a family friend. Mr. Smith’s original sentence was 65 months with 18 months of aftercare, but he has gained over a year of “good time” sentence reduction. He recently completed high school at the correctional facility and is currently taking college courses and working a welding job at the facility.

Mr. Smith reported his biological parents were never married. He was taken out of his biological mother’s custody as a baby due to her chronic drug use. Mr. Smith reported having occasional contact with his mother growing up and denied having contact with his father. He was adopted by his paternal uncle and his wife when he was two and a half years old. He refers

^a Note: Name has been changed.

to his aunt and uncle as his parents, while making sure it is understood they are not his “real parents.” Mr. Smith reported being raised with his younger half-brother, and his younger female cousin who he considers his sister^b. Mr. Smith reported being homeschooled since second grade. He stated that the challenges of growing up in his family worsened when they became members of a specific church and moved closer to the church so his father could work as a pastor there. During intake, Mr. Smith did not give much detail regarding this information other than his family became very religious and strict.

Presenting Problem

Mr. Smith was referred for trauma therapy services after requesting more frequent visits with his assigned mental health professional. He reported a long history of physical abuse and neglect starting in early childhood and continuing until his incarceration at age 15. Mr. Smith also reported several occasions of sexual abuse as a child. In addition, he reported difficulties with anger, anxiety, and depression, as well as many symptoms of PTSD, which he believed were related to his history of trauma.

Mr. Smith stated his parents treated him differently than his brother and sister. Specifically, Mr. Smith reported being fed only one meal a day, consisting of a bagel and yogurt. Mr. Smith said he would often attempt to steal food or “manipulate” his siblings into sharing their food with him. If caught, he would receive intense punishments, often lasting for several hours. Specifically, Mr. Smith reported being locked in a closet, made to do push-ups for over an hour straight, being pinched, and “smacked upside the head” by his mother on both temples.

^b The clinician will refer to Mr. Smith’s aunt and uncle as “parents,” and Mr. Smith’s cousin as “sister” Including his half-brother, this group of five will be referred to as Mr. Smith’s “family” from this point forward

Mr. Smith also reported being sexually abused twice as a child. He stated the first time was by his biological father, but noted he was so young he doesn't remember the event, and found out about it through his parents. Mr. Smith also reported a sexual assault when he was five, by two teenaged girls, aged 12-13, where he was forced to expose himself.

Observations

Mr.

Smith presented for treatment as compliant and willing to work with the clinician. Specifically, he agreed to practice skills learned in treatment outside of session. During the pretreatment assessment, Mr. Smith appeared open and honest, evidenced by sharing difficult childhood experiences with the clinician, and sharing his concerns for treatment. He also stated he had a habit of "telling professionals what they want to hear" and was going to work hard to "be honest throughout treatment," because he was finally ready to pursue treatment in a more invested manner to enhance the benefits he might derive from sessions. In addition, Mr. Smith agreed to complete any homework requested by the clinician. Over the course of treatment, he honored this commitment by apologizing if he made any mistakes on his homework, or if he failed to complete a homework form.

Mr. Smith showed some narcissistic characteristics in sessions, displaying arrogance in his attitudes, as he often explained his behaviors as "for the benefit of someone else." Mr. Smith also evidenced an inability to recognize or identify with the feelings or needs of others, making statements like "They act this way because they are too dependent." During the interview, Mr. Smith stated that he wanted to make sure the clinician could "handle him," reporting that his case was "unique and more difficult than others." Mr. Smith also demonstrated some affective instability, including inappropriate, intense anger, and difficulty controlling anger when the clinician would take him back to school after sessions. Specifically, Mr. Smith would ask

officers to escort him to his work site, and on several occasions he was told it would be a while. He reacted to this by yelling at officers, punching walls, and cussing. Outside of sessions, this pattern of affective instability and poor anger control was evidenced by repeated arguments with staff members and other offenders, and isolated occasions of physical aggression such as throwing chairs and trash cans, punching walls and breaking soap dispensers off walls, and getting into officers' faces and yelling.

Mr. Smith would often use intellectualization during sessions, as he would conjure elaborate excuses to explain and justify why elements of treatment would never work. He evidenced difficulties with boundaries throughout treatment by asking officers to bring him to "[his] appointment," rather than waiting for the clinician to send for him. Additionally, he would often take on somewhat of a "protector" role while being escorted by the clinician to his unit. Specifically, when other offenders would make inappropriate comments towards the clinician, Mr. Smith would attempt to stand up for the clinician by telling offenders "quit being disrespectful" and telling the clinician "don't listen to them." This clinician had to repeatedly reassure Mr. Smith that his efforts were unnecessary and inappropriate. Other boundary issues included asking the clinician personal questions about her life and reporting inappropriate conversations with other staff members, where Mr. Smith would learn personal information about them. Additionally, Mr. Smith would get defensive and minimize this behavior when told it was inappropriate by making statements such as "I just asked if you had a dog," and "It's not that big of a deal, he's just a cool officer that talks to us."

Assessment

Information on diagnostic symptoms was collected through the administration of a semi-structured diagnostic interview during the intake process during Mr. Smith's initial incarceration

in 2013. This initial assessment also included several psychological tests to make determinations about personality, risk to reoffend sexually, and potential deficits in intelligence. At that time, Mr. Smith was diagnosed with Depressive Disorder NOS, Anxiety Disorder NOS, and Personality Disorder NOS. His score on the Shipley-2 suggested above average intelligence. Scores on the Jesness Inventory-Revised indicated a conformist and pragmatist personality type. Specifically, these results suggested Mr. Smith struggles with hostility towards authorities and will misbehave upon failure to gain acceptance through conformity to the demands of others. Additionally, it indicated Mr. Smith considers it important to be in control and may use manipulation to satisfy his own needs. His initial psychosexual evaluation indicated he was in the high risk range to reoffend sexually.

At the outset of this clinician's contact with Mr. Smith following his request for individual therapy, a semi-structured diagnostic interview was conducted. With the goal of providing differential diagnosis at a more precise level beyond the multiple NOS-level diagnoses available in his file, and consistent with the process used when applying empirically-supported treatments, this clinician inquired about the presence of specific symptoms relevant to depressive disorders, bipolar, anxiety disorders, psychotic disorders, conduct disorder, personality disorders, and substance use disorders.

During the semi-structured diagnostic interview, Mr. Smith endorsed several symptoms of Conduct Disorder. Specifically, he reported harming animals prior to 15-years-old. Mr. Smith stated he was angry once and kicked a frog repeatedly. He once put a cat in a deep freezer for several minutes, and on a separate occasion chased a cat with a vacuum hose. Mr. Smith noted he always felt remorseful after these events and attempted to care for the animals afterwards. He also reported using "manipulation" to force his siblings and family friend into sexual activity on

more than one occasion. He noted his ability to convince his victims into sexual activity and stated he was able to make others believe whatever he wanted them to believe. In addition, he often stole food from the cafeteria when he was first incarcerated.

Mr. Smith also reported depressive symptoms. Specifically, he described an irritable mood more days than not, sadness several times a week, and sleep difficulties. He stated prior to the past year, he struggled with intense anger and sadness almost daily, but noted he mostly just feels irritable now. Mr. Smith remembered being prescribed antidepressant medication around age 15, but noted he and his parents refused the prescription because they did not want the “control” of medication. Mr. Smith also expressed having less energy than his peers. He stated these symptoms impair his social life, as he has the tendency to isolate himself and push others away.

In addition, he endorsed some symptoms of anxiety. Specifically, Mr. Smith described panic symptoms to certain cues reminding him of his trauma, racing thoughts, and excessive worry about the future. Mr. Smith stated that he worries he will never be able reach his lifelong goal of joining the marines due to his legal charges and that he may never be able to see his siblings again due to his having perpetrated sexually against them.

Mr. Smith also disclosed difficulties with anger. Specifically, he stated when “[he] gets to a certain level” he “cannot control [himself].” Mr. Smith denied a lengthy history of physical altercations, but noted he had been in a few fights at the juvenile prison where he was originally placed. He noted he tries to go to his room or practice mindfulness when he feels angry, but stated it does not always work. During his incarceration, he evidenced a lengthy history of verbal altercations and punching walls when he has become extremely angry, occurring more frequently when he was first incarcerated, but less than twice a month in the past year. These incidents have

interfered with his ability to fulfill his goal of reaching a high-level classification and eligibility to move to the “Honors Unit” in the past, and have resulted in his dismissal from the “Honors Unit”, which occurred during the course of this treatment.

PTSD Assessment

To assess for PTSD, the clinician administered the Life Event’s Checklist (LEC-5) and the Clinician-Administered PTSD Checklist for DSM-5 (CAPS-5).

Life-Event’s Checklist (LEC-5). The LEC-5 is a 17-item screening tool administered prior to the Clinician-administered PTSD Scale for DSM-5 (CAPS-5). It includes an array of experiences that are considered potential traumatic events (Gray, Litz, Hsu, & Lombardo, 2004; Weathers et al., 2013a). It was designed for use with veterans and has been successfully applied to a variety of clinical and medical settings to screen for potential traumatic events. Respondents completing the LEC-5 indicate their particular experience with each traumatic event in the correct checkbox (happened to me, witnessed it, learned about it, part of my job, not sure, and doesn’t apply). (Scale available from the National Center for PTSD at www.ptsd.va.gov). The respondent is then administered the CAPS-5 using the event reported to be the “worst” to determine endorsement for Criteria A (Gray et al., 2004).

Psychometric properties have been determined for the original LEC, which was developed at the same time as the Clinician-administered PTSD scale for DSM-IV (CAPS). According to the National Center for PTSD, minor changes were made in the LEC-5 when the original LEC was revised to conform to the DSM-5. Specific changes include the addition of “part of my job,” when rating how the traumatic event was experienced. In addition, item 15 was changed from “Sudden, unexpected death of someone close to you” to “Sudden accidental death.”

The National Center for PTSD (2015) reports “Psychometrics are not currently available for the LEC-5. Given the minimal revisions from the original version of the LEC, few psychometric differences are expected” (Changes from previous LEC for DSM-IV). However, rather extensive psychometrics had been developed for the previous version of this assessment tool, the LEC.

Gray et al. (2004) established psychometric properties for the LEC in two studies on different populations. The first study evaluated the LEC’s test-retest reliability and convergent validity with the Traumatic Life Events Questionnaire (TLEQ). The TLEQ is a broad measure of traumatic events, which has demonstrated favorable psychometric properties (Kubany et al., 2000). To evaluate test-retest reliability, the LEC was administered to college undergraduates, and then re-administered an average of seven days later. Reliability coefficients were determined for dichotomized items (e.g.; ”Happened to me” is answered “yes” or “no”) and for items utilizing the full-scale responses (Gray et al., 2004). Test-retest reliability coefficients for direct exposure have been reported as above .50 with a mean of .61 for each of the 17 event categories except “serious injury/death of another”, which produced a .37. Test-retest reliability coefficients for full-scale responses were lower, with 12 of the 17 categories above .40. Convergent validity between similar items on the LEC and TLEQ found seven of the nine items achieved coefficients above .40, with a mean of .55. The two items that failed to reach this level were “Assaulted or threatened with a weapon” and “Sudden, unexpected death of loved one.”

The second psychometric study by Gray et al. (2004) sought to evaluate relationships between the LEC and other measures of psychopathology typically associated with trauma. Investigators compared the number of events reported on the LEC to other measures of trauma. The LEC was found to significantly correlate with these measures, specifically with the trauma-

specific measures including the PTSD Checklist-Military Version (PCL-M), CAPS, and the Mississippi Scale for Combat-Related PTSD). In addition, it was positively correlated with the Beck Depression Inventory and Beck Anxiety Inventory. The LEC-5 appears to have adequate reliability and is appropriate for use in a variety of clinical settings, including the context of therapeutic work with Mr. Smith.

Mr. Smith reported experiencing several events in addition to physical and sexual abuse that could be considered traumatic on the (LEC-5). Specifically, he reported experiencing living through a natural disaster, physical assault, sexual assault and other unwanted or uncomfortable sexual experiences. He reported witnessing a transportation accident, life-threatening illness or injury, and sudden accidental death. However, Mr. Smith reported experiencing the most difficulties with his history of physical and sexual abuse. Having met the qualification for experiencing trauma, justification for administering the CAPS-5 was established for this client.

Clinician-Administered PTSD Checklist for DSM-5 (CAPS-5). The CAPS-5 is a 30-item structured interview. Versions of the CAPS-5 include “past week,” “past month,” and “worst month.” Due to the amount of time required for administration of the CAPS-5 (approximately 45 to 60 minutes), the clinician elected to use the “past month” version each month throughout treatment. Items assess the 20 symptoms of PTSD, as well as the onset and duration of symptoms, subjective distress, impact of symptoms on social and occupational functioning, improvement in symptoms since the previous CAPS administration, response validity, and overall PTSD severity (National Center for PTSD, 2015; Weathers et al., 2013b). Clinicians use an index traumatic event determined through administration of the LEC-5 as a basis for all questions (Weathers et al., 2013b). Standardized questions and additional probes are provided for each symptom’s inquiry. Item’s are presented in DSM-5 clusters, and are given a

severity rating based on clinical judgment with consideration to frequency and intensity. Severity ratings are based on a Likert scale ranging from 0 to 4 where 0 = absent, and 4 = extreme/incapacitating. Symptoms are only considered present if they are given a severity rating of at least 2. Once all items in a DSM-5 cluster are given a severity score, the clinician determines whether the criterion has been met. (Scale available from the National Center for PTSD at www.ptsd.va.gov).

Changes from the CAPS to the CAPS-5 include updates corresponding to DSM-5 PTSD criteria (National Center for PTSD, 2015). Specifically, the CAPS-5 includes questions on depersonalization and derealization, and rates items using only a single severity score with consideration to frequency and intensity, compared to the original CAPS which required frequency and intensity to be rated separately.

Paralleling the previous discussion of psychometric properties of the LEC-5, psychometric properties for the CAPS-5 have not yet been established. Orsillo (2001), and Weathers, Keane, and Davidson (2001) report the CAPS was updated after the publication of the DSM-IV to reflect changes in diagnostic criteria at that time. Due to small changes between the editions of the CAPS through the transitions from DSM-III-R to DSM-IV, it is expected that statistical information will be similar.

Ideal psychometric properties for the original clinician-administered PTSD scale (CAPS-1), corresponding to DSM-III-R have been reported. Specifically, in reviews by Blake et al. (1995); Orsillo (2001); and Weathers et al. (2001), interrater reliability coefficients across all items have been found to range from .92 to .99. In addition, these reviews report test-retest reliability coefficients ranging from .77 to .96 for symptoms clusters, and .90 to .98 for all items. Internal consistency coefficients ranged from Cronbach's alpha = .73 to .95 for symptoms

clusters, and .94 for all items (Blake et al., 1995; Orsillo, 2001; Weathers et al., 2001).

Convergent validity for the total severity score was found with the Mississippi Scale for Combat-related PTSD (.91), and the Posttraumatic Stress Disorder (PK) supplementary scale of the MMPI (.77). The CAPS appears to have excellent reliability and validity and is appropriate for use in a variety of clinical settings, including the context of therapeutic work with Mr. Smith. Unfortunately, no research was found to support to use of the CAPS-5 in juvenile correctional facilities. However, the lack of validation of widely used assessment instruments in juvenile justice populations has been discussed (Penn & Thomas, 2005)

The CAPS-5 past month was administered to Mr. Smith to gather more information on the presence of PTSD symptoms. In addition to initial administration, the CAPS-5 was administered approximately every four weeks during treatment to reflect changes in number of symptoms and symptom intensities. Mr. Smith was asked to specify in detail if he experienced any of the symptoms and whether they were related to his physical abuse, sexual abuse, or both. Initial CAPS-5 results showed the presence of many PTSD symptoms, with most symptoms being related to his history of physical abuse. Specifically, Mr. Smith reported the following intrusive symptoms related to the trauma: recurrent, involuntary, and distressing memories of the trauma; recurrent distressing dreams; flashbacks; intense, prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the trauma such as dawn dish soap and similar verbalizations to statements his parents would make; and marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the trauma in the form of racing heart and jolting. Mr. Smith experienced avoidance to distressing memories, thoughts, or feelings about the event; persistent and exaggerated negative beliefs about himself, others, and the world; persistent self-blame for the event; persistent negative

emotional states of fear and anger; persistent inability to experience positive emotions; irritable behavior and anger outbursts; hypervigilance to his surroundings; exaggerated startle responses; and sleep disturbances. In addition, Mr. Smith recounted a long history of isolating himself from others. He stated these symptoms started about six months after the abuse ended which was after his incarceration at age 15.

Beck Depression Inventory-II (BDI-II)

The Beck Depression Inventory-II (BDI-II) is a 21-item, self-report measure of affective and physical symptoms associated with depression (Palmer & Binks, 2008). For each item, the respondent selects which of the four statements best describes them within the past week. Statements correspond to a score ranging from 0 to 3, where 0 = no presence of the symptom, and 3 = high intensity of the symptom. Scores for all 21 items are summed for a final score, with higher scores representing more severe levels of depression. Total scores in various ranges are categorized according to the severity of impairment, and include: 1-10 = normal, 11-16 = mild mood disturbances, 17-20 = borderline clinical depression, 21-30 = moderate depression, 31-40 = severe depression, and 40-63 = extreme depression. (Scale available from www.pearsonclinical.com). The BDI has been used across a wide variety of clinical and research settings, including correctional settings (Palmer & Binks, 2008; Dozois, Dobson, & Ahnberg, 1998; Arnau, Meagher, Norris, & Bramson, 2001) and is therefore appropriate in the context of therapeutic work with Mr. Smith.

Dozois et al. (1998) examined psychometric properties of the original BDI and the BDI-II using undergraduate psychology students. Analyses found strong internal consistency reliability coefficients for both versions; .89 for the BDI, and .91 for the BDI-II. Strong convergent validity between the two versions was also established (.93). Arnau et al. (2001) examined the

psychometric properties of the BDI-II in a primary care medical setting, where the BDI-II demonstrated strong internal consistency reliability, with an alpha coefficient of .94. Reflecting the high correspondence between psychological depression and physical health, convergent validity was established between the BDI-II and the Medical Outcomes Study Short-Form General Health Survey (SF-20) with negative correlations ranging from -.19 on the physical functioning subscale to -.65 on the mental health subscale, where negative correlations indicate high depression related to lower functioning and lower perception of health (Arnau et al., 2001). In addition, significant differences in BDI-II total scores were found for patients diagnosed with Major Depressive Disorder (MDD) compared to patients not diagnosed with MDD.

In a meta-analysis of studies on psychometric properties of the BDI-II, Richter, Werner, Heerlein, Kraus, and Sauer (1998) reported high internal consistency reliability, with alpha-coefficients above .75, and a mean of .88 for psychiatric samples, and .82 for non-psychiatric samples. Additionally, they reported high content validity for the original BDI when compared to DSM criteria. Richter et al. (1998) also reported moderate to high convergent validity, ranging from .58 to .79, with other self-report scales of affective difficulties such as the MMPI depression scale (MMPI-D), Zung Self-Rating Depression Scale (SDS), Multiple Affect Adjective Checklist (MAACL-D), Depression Scale (D-S), Symptom Check List (SCL-90), and Inventory to Diagnose Depression (IDD), and Hamburg Depression Scale (HDS).

More specific to the current study, Palmer and Binks (2008) evaluated psychometric properties of the BDI-II with 117 incarcerated youths. High internal consistency reliabilities were found ranging from Cronbach's alpha = .81 to .86. In addition, they reported preliminary evidence for convergent validity between higher BDI-II scores and history of suicidal behavior.

The BDI-II was administered during pretreatment assessment, and weekly throughout treatment to track changes in Mr. Smith's level of depression. During pretreatment assessment, Mr. Smith scored an 18 indicating borderline clinical depression. Throughout the 17 weeks of treatment, his BDI scores fluctuated between the baseline high of 18, to as low as 3 by the end of treatment. The full set of weekly scores is presented in Table 1, and discussed in greater detail in the treatment outcomes section of this paper.

Burns Anxiety Inventory (BAI)

The Burns Anxiety Inventory (BAI) is a 33-item, self-report measure of anxiety symptoms. The BAI is broken into three categories: Anxious Feelings, Anxious Thoughts, and Physical Symptoms. Each item is rated on a 4-point Likert scale from 0 to 3, with 0 = not at all, to 3 = a lot. All items are summed for a total score, with higher total scores indicating higher levels of anxiety. Ranges of scores are categorized to indicate level of impairment, with total scores ranging from 0-4 = minimal or no anxiety, 5-10 = borderline anxiety, 11-20 = mild anxiety, 21-30 = moderate anxiety, 31-50 = severe anxiety, and 51-99 = extreme anxiety or panic. (Scale is available free online).

Burns and Eidelson (1998) reported an internal consistency reliability coefficient of $\alpha = .94$ in a study of 483 outpatients. In addition, they reported good convergent validity with the anxiety subscale of the Symptom-checklist 90 (SCL-90) (.86), and discriminant validity with the Beck Depression Inventory (BDI) (.70) (Burns & Eidelson, 1998; Persons, Roberts, & Zalecki, 2003).

The BAI was administered during the pretreatment assessment and weekly throughout treatment to track changes in Mr. Smith's level of anxiety. During pretreatment assessment, Mr. Smith scored a 20 indicating mild anxiety. Throughout the 17 weeks of treatment, his BAI scores

fluctuated between the baseline high of 20, to as low as 1 by the end of treatment. The full set of weekly scores is presented in Table 1, and discussed in greater detail in the treatment outcomes section of this paper.

Clinical Anger Scale (CAS)

The Clinical Anger Scale (CAS) is a 21-item, self-report measure of psychological, physiological, affective, cognitive, and behavioral symptoms related to clinical anger (Snell, Fum, Shuck, Mosley, & Hite, 1995). Similar to the BDI, the respondent selects a single statement, which best reflects their present feeling of anger. Each statement corresponds to a score ranging from 0 to 3, with 0 = no presence of the symptom, and 3 = high intensity of the symptom. Item scores are summed for a total score, with higher scores indicating higher levels of anger. Ranges of scores are categorized to reflect levels of severity or impairment, with total scores ranging from 0-13 = minimal clinical anger, 14-19 = mild clinical anger, 20-28 = moderate clinical anger, and 29-63 = severe clinical anger. (Scale available from <http://www4.semo.edu>).

Snell et al. (1995) examined psychometric properties of the CAS in six non-patient samples, over the course of five years. They reported internal consistency reliability coefficients of alpha = .92 for females, .95 for males, and .94 for males and females. Test-retest reliability for males was .85, .77 for females, and .78 for both males and females. Convergent validity was confirmed by establishing strong positive correlations with the two State-Trait Anger scale subscales in two samples: STAS State Anger (.56) for the first sample, and (.61) for the second sample, and STAS Trait Anger (.55) for both samples. In addition, positive correlations were found between the CAS and the Anger Expression Scale, though not as strong as those between the CAS and STAS, with coefficients ranging from .23 to .45. The CAS was also found to

correlate positively with various measures of psychopathology, personality traits, and other unhealthy behaviors. For example, the CAS was correlated with various subscales on the SCL-90, with coefficients ranging from .39 to .68. In addition, the CAS was positively correlated with Eysenck's neuroticism scale (.28).

The CAS was administered during the pretreatment assessment, and weekly throughout the course of treatment to track changes in Mr. Smith's level of anger. During pretreatment assessment, Mr. Smith scored a 14, indicating mild clinical anger. Across the 17 weeks of treatment, Mr. Smith's scores on the CAS fluctuated widely, peaking at a level of above baseline with a score of 17, but dropping as low as 2. The full set of weekly scores are presented in Table 1, with a detailed description of the patterns across weeks discussed in detail in the treatment outcomes section of this paper.

Assessment Results and Interpretation

Mr. Smith was assessed using a semi-structured diagnostic interview, Life Event's Checklist, Clinician-administered PTSD Scale for DSM-5, BDI-II, BAI, and CAS to obtain information relevant to the presence of clinical anger, depressive disorders, bipolar, anxiety disorders, psychotic disorders, conduct disorder, personality disorders, PTSD, and substance use disorders.

During administration of the LEC-5, Mr. Smith reported he had experienced and witnessed several potential traumatic events. Ultimately, as determined by administration of the CAPS-5, Mr. Smith's history of physical abuse was the event that most clearly supported a diagnosis of PTSD. During administration of the CAPS-5, Mr. Smith reported 14 symptoms consistent with PTSD. These symptoms support a diagnosis of Posttraumatic Stress Disorder.

Mr. Smith also reported symptoms of anxiety and his score of 20 on the BAI indicated mild anxiety. Mr. Smith's report of panic attacks and racing thoughts appear to be connected to trauma reminders and memories. Due to this, it is the clinician's belief these symptoms are better explained by PTSD, and therefore no anxiety disorders were diagnosed.

Mr. Smith also reported a history of depressive symptoms beginning in his early teens, Mr. Smith also reported the presence of several depressive symptoms on the BDI, with his total score of 18, indicating borderline clinical depression. However, Mr. Smith's report of symptoms indicated no history of a major depressive episode. Additionally, he did not report the number of symptoms required to meet criteria for major depressive disorder or persistent depressive disorder. These depressive symptoms do, however, support Mr. Smith's previous diagnosis of Depressive Disorder NOS, and support a present DSM-5 diagnosis of Other Specified Depressive Disorder.

During the interview Mr. Smith reported some symptoms consistent with conduct disorder. Ultimately, Mr. Smith's report of manipulating individuals into sexual activity was the only symptom consistent with conduct disorder. Due to this, and Mr. Smith's age of 19, conduct disorder was ruled out.

Mr. Smith presented for treatment with several strengths. First, he appears to have an average to above average intellect, evidenced by vocabulary choice, and ability to follow along through treatment and complete homework assignments without any problems. This clinical estimate is supported by his intake screening testing where he produced scores in the above average range on the Shipley. Additionally, Mr. Smith presented as motivated, evidenced by attending all scheduled therapy sessions (a total of 17 sessions in 17 weeks), participating in the

in-session activities by providing examples and asking for clarifications when necessary, and completing homework assignments more weeks than not.

DSM-5 Diagnoses

309.81 Posttraumatic Stress Disorder, with delayed expression (primary)

311 Unspecified Depressive Disorder

Case Conceptualization

Several factors of attachment and resource losses may explain Mr. Smith's development of PTSD and difficulties with emotion regulation and interpersonal functioning. According to Cloitre et al. (2011) and Walter et al. (2010), Mr. Smith's young age at the initial abuse was a disadvantage to having the resources necessary to recover from the abuse. Additionally, his limited resources as a child contributed to his vulnerability for recurrent, chronic abuse throughout his childhood and into adolescence. Mr. Smith experienced a loss of healthy attachment, as his abusers were his aunt and uncle who assumed the role of his parents after his biological parents were unable to adequately care for him.

A direct result of these layered parental losses was Mr. Smith's inability to develop a sense of security and safety. This inability was evident when Mr. Smith recounted "random" abuse, in which his parents would punish him for "no reason." This inability to predict when a "punishment" would occur, or what actions would lead to punishments, left Mr. Smith constantly wondering what was going to happen, which likely contributed to his long-term hypervigilance in all situations. Mr. Smith also failed to develop autonomy. The control his parents placed over him was pervasive and intense, and ranged from his being homeschooled, to clear limitations on whom he could associate with, to when, what, and how often he was allowed to eat.

Loss of effective guidance in the development of emotional and social competencies may help explain Mr. Smith's symptomology in several ways. First, Mr. Smith was presented with rules which applied only to him and not to either of his siblings. He was restricted from eating more than one meal a day, while his brother and sister were provided meals on a more routine basis. He also was allowed less freedom than his brother and sister. Additionally, his emotions were invalidated, first by the abuse itself, and then in a lack of acknowledgement and comfort from his parents. From these experiences, Mr. Smith learned to be passive in interactions with others and did not defend himself in fear that he would be punished. Instead of learning to cope with intense emotions, Mr. Smith learned to turn off his emotions. Mr. Smith showed a history of being somewhat successful in numbing his emotions; however, he demonstrated an inability to turn off or effectively cope with anger. This problem was evidenced in Mr. Smith's aggressive outbursts, which led to disciplinary actions in prison. Additionally, Mr. Smith learned to completely isolate himself from others, for fear of getting hurt. Similarly, Mr. Smith reported an inability to trust anyone.

Also relevant to the loss of effective guidance in the development of emotional and social competencies is Mr. Smith's history of delinquent behavior and interpersonal violence. Specifically, Mr. Smith's lack of social competencies may partially explain his past involvement in multiple sexual offenses. For example, Kahn (2011) explains that "blockage happens when your sexual feelings are blocked, and you can't express them in healthy appropriate ways" (p. 113). This author goes on to explain that some individuals may lack social skills and feel awkward around peers or feel safer emotionally having a relationship with a child who is easier to impress. These examples of blockage of emotional, social and sexual needs contributed to the Mr. Smith's motivation for offending sexually.

With regards to loss of perceived support from the community, it is important to look at Mr. Smith's father and his role in the community. Specifically, Mr. Smith's father was a highly respected pastor in a small town. Because of this, it is unlikely that community members suspected or would have even been willing to believe that abuse was occurring in the family home. Mr. Smith disclosed he would not have been believed if he would have reported the abuse and would have likely received harsh punishment from his parents for having divulged this family secret. Similarly, during Mr. Smith's initial incarceration, the abuse was reported and ruled unsubstantiated upon investigation. Absent alternative attributions, he was left to believe that the abuse was somehow deserved and truly his fault. This pattern likely contributed to Mr. Smith's lack of trust in others and self-blame about the abuse.

With respect to attachment, Mr. Smith tended to minimize his father's abusive actions. As the theory states (Cloitre et al., 2011a) an abusive caregiver is preferred to no caregiver. This pattern was evident throughout treatment, when Mr. Smith would defend his father. Specifically, during approximately the fourth week of treatment, Mr. Smith was informed his father had been re-diagnosed with cancer and had chosen to forego treatment. From this point, through the time of his father's death, Mr. Smith's view of his father changed. Specifically, Mr. Smith shifted the majority of the blame for the abuse he experienced at the hands of his father onto his mother. He also spontaneously offered positive memories of his father, and discounted all negative elements of his memories of the paternal relationship.

Of additional importance and relevance, is the development of interpersonal schemas in the context of abuse and their continued use outside the context of abuse. Mr. Smith's strict and rigid interpersonal schemas have continued to serve as maladaptive in his current life. Specific schemas included "people in positions of authority always abuse power," "The world is an unfair

place,” and “If I get close to someone, they will hurt me.” These schemas have affected Mr. Smith’s ability not only to function appropriately in the prison, but also to accomplish valued personal goals. Specifically, Mr. Smith received disciplinary reports for his disrespect towards officers, due to his belief that they were abusing their power. Mr. Smith also expressed interest in improving his ability to develop and maintain relationships with others and discussed his wish to have friends, romantic relationships, and eventually a family in the future. Despite these goals, he has demonstrated a history of pulling himself away from anyone he began to have a bond with, due to his maladaptive interpersonal schemas.

Treatment Plan

When asked to identify specific goals he would like to accomplish over the course of therapy, Mr. Smith stated he wanted his symptoms to “go away.” With the help of the clinician, Mr. Smith was able to identify several more specific goals for treatment related to impairments caused by his symptoms. Specifically, Mr. Smith came to endorse goals of: 1) Increasing his ability to understand, label, and express emotions appropriately, 2) Improving his ability to develop meaningful relationships with others, and 3) Reducing the intensity of his PTSD, depression, anxiety, and anger symptoms.

Problem: Symptoms of PTSD, depression, anxiety, and anger related to history of abuse

Goal 1: Increase emotional awareness and ability to modulate negative feelings

Objective 1: Youth will increase emotional awareness by learning to identify negative and positive emotions and triggers to these emotions.

Objective 2: Youth will learn physiological, cognitive, and behavioral coping strategies for managing distress and intense negative emotions.

Objective 3: Youth will learn to accept feelings and tolerate distress in the pursuit of valued goals.

Objective 4: Youth will identify feelings elicited by a trauma narrative and learn habituation to fear-eliciting aspects of trauma memories.

Goal 2: Improve interpersonal skills

Objective 1: Youth will learn about interpersonal schemas, and how his early schemas continue to influence feelings and interactions with others.

Objective 2: Youth will learn to develop alternative and more flexible interpersonal schemas in order to allow for positive expectations of others in relationships, and to negotiate interpersonal difficulties.

Objective 3: Youth will learn assertiveness skills in order to advocate for his own rights and needs without violating the rights and needs of others.

Objective 4: Youth will learn to engage with others in a flexible way within a variety of interpersonal contexts.

Objective 5: Youth will organize trauma memories in order to identify trauma-generated beliefs and life themes.

Objective 6: Youth will examine abuse-related schemas from the past and learn to develop and test new schemas for present life.

Course of Treatment

Mr. Smith was seen once a week for 17 weeks. The first phase of treatment (STAIR) was completed in 11 sessions. First, the clinician reviewed the assessment process and Mr. Smith's diagnoses with him and oriented him to the course and goals of treatment. Content during the STAIR phase of treatment focused on teaching, practicing and applying emotion regulation and

interpersonal skills. The emotion regulation module included identification and expression of different emotions, difficulties with problematic emotions, and the three channels of emotions (physiological, cognitive, and behavioral). Additionally, physiological, cognitive, and behavioral emotion regulation strategies were taught and practiced throughout treatment. Mr. Smith demonstrated a preference towards using the cognitive strategies of attention shifting and positive imagery, as well as the time out behavioral strategy. Next, Mr. Smith learned the importance of experiencing positive emotions and developed a list of activities to elicit positive emotions. Although challenging at first, by the end of treatment Mr. Smith was able to experience positive emotions “naturally” or without engagement in these activities. The emotion regulation module ended with a discussion of the presence of distress while pursuing these goals. Here, Mr. Smith identified whether or not distress was necessary and worth tolerating to accomplish his goals identified at the beginning of treatment. Mr. Smith appeared to identify with the concept of acceptance as he related it to mindfulness activities he had previously learned. Additionally, Mr. Smith learned to practice acceptance of distress and to recognize it as a normal part of life.

The second phase of STAIR focused on relationship patterns. First, Mr. Smith identified important aspects of his early childhood relationships and learned that early experiences contribute to models of relating to others (schemas). Psychoeducation was provided on interpersonal schemas, their rigidity, and how they continue to influence current interactions in maladaptive ways. Mr. Smith practiced identifying his interpersonal schemas outside of session through worksheets requiring him to identify different interpersonal situations, feelings and beliefs about himself, and expectations of others in the situations, as well as the resulting action. Next, the therapeutic work focused on developing alternative and more flexible interpersonal

schemas. Developing alternative schemas was done through a series of role-plays in which Mr. Smith and the clinician acted out recent situations. During role-plays, the clinician first acted as the other person in the situations, then she and Mr. Smith switched roles, in order to provide alternative ways of acting in these situations. Mr. Smith practiced alternative schemas outside of session, and reported these interactions on a similar worksheet requiring him to identify alternative beliefs about himself and expectations from others in the situation. The purpose of this worksheet was to provide a link between Mr. Smith's interpersonal schemas and the way he reacts in interpersonal situations. One of Mr. Smith's schemas that affected many of his interactions was "people in authority always abuse their power." In-session role-plays around this schema focused on interactions with staff members that ended poorly. Specifically, Mr. Smith practiced interacting with the alternative belief that the staff member was just doing their job or that all staff members are not the same.

Next, Mr. Smith learned about assertive, nonassertive (passive), and aggressive ways of interacting with others. Mr. Smith identified the link between his childhood abuse in which he was passive and his tendency to act aggressively in current interactions. Emphasis was placed on assertiveness, and Mr. Smith practiced role-plays in session where he utilized several assertiveness techniques (e.g.; "I" messages, making requests, and saying no). The relationship module and STAIR phase of treatment ended with a focus on developing flexibility in relationships. Specific emphasis was on different power dynamics in a variety of relationships (e.g., mother and child; co-worker and boss, between co-workers, etc.), and common difficulties for abuse survivors in those power differentials. Here, Mr. Smith identified goals with people in a variety of relationships (e.g., become closer to his friend, complete his job to a satisfactory

level and maintain a respectful relationship with his boss, work cohesively with his co-workers), and practiced responding in ways consistent with promoting his goals.

The second phase of treatment (NST) focused on repeated telling of trauma memories to reduce fears of memories and PTSD symptoms and to examine and contrast abuse-related interpersonal schemas. During this phase of treatment, Mr. Smith learned about the subjective units of distress scale (SUDS) for narrative work, and developed a memory hierarchy, consisting of eight memories ranging from rating of 50 to 90 on the SUDS scale. Mr. Smith and the clinician made a verbal contract for, and completed four narrative sessions. During the first narrative session, Mr. Smith began practice with a neutral memory in order to become familiar with the new structure of sessions. Subsequent sessions began with the narrative storytelling, in which Mr. Smith would tell his memory 2 to 3 times, with the clinician gently prompting for more details each time. At the end of each session of exposure work, the clinician inquired about Mr. Smith's emotions and used techniques to make sure Mr. Smith had returned to the present and was no longer immersed in the memory. Next, Mr. Smith and the clinician worked through identifying and revising interpersonal schemas imbedded in the memories. The first memory used was the seventh of eight memories on Mr. Smith's hierarchy, with a SUDS rating of 53. This memory was selected as it produced the most distress Mr. Smith believed he could handle at the time.

Evaluation of Treatment Outcomes

Mr. Smith responded well to the emotion regulation module. Specifically, Mr. Smith completed his emotion self-monitoring homework each week and practiced emotion regulation strategies successfully both in and out of session. Additionally, as Mr. Smith progressed through the emotion regulation module, he was able to identify experiencing more emotions than when

he first started treatment, evidenced by his self-monitoring worksheets, and self-reported ability to experience positive emotions with some effort. Specific emotions included sadness, peace, excitement, and fear. Although Mr. Smith became angry with the therapist when he began experiencing emotions of sadness and fear, the therapist viewed these feelings as progress when noting Mr. Smith's history of emotional numbing.

Mr. Smith evidenced some difficulties during the interpersonal patterns module. Specifically, Mr. Smith was less willing to complete out-of-session interpersonal schema worksheet homework and more time was devoted during sessions to the discussion of interactions that had occurred during the previous week. Additionally, as expected with survivors of childhood abuse, Mr. Smith demonstrated strict, rigid interpersonal schemas and experienced difficulties generating and considering alternative schemas. Particularly challenging for Mr. Smith was the ability to provide examples in his current life that did not support his interpersonal schemas. Alternatively, Mr. Smith tended to provide examples supporting the accuracy of his schemas, even when examples were not fitting. For example, when discussing his schema "all people in authority abuse their power," Mr. Smith gave examples of times he felt officers were unjust in their directives, even when noting these directives were a result of his engagement in unauthorized actions. This tendency evidenced how indoctrinated Mr. Smith has become in the patterns of exclusively and unerringly processing and filtering his experiences through his maladaptive schemas. Mr. Smith was, however, able to identify how his beliefs about himself and others in situations resulted in actions inconsistent with his goals. As such, some effort was made outside of session to consider his goals and behave in ways that promoted these goals.

Mr. Smith attended four sessions of Narrative Story Telling (NST), which consisted of imaginal exposure to two separate memories. The first memory was used in three of the NST

sessions. While habituation to the trauma memory narrated within session was minimal, the clinician noted several differences between the three sessions suggesting some therapeutic value. During the first NST session, Mr. Smith required a great deal of probing from the therapist to provide detail and to stay in a first person narration. Additionally, during that session, Mr. Smith showed strong physical reactions to the memory, evidenced by clenching fists, tearing up, stuttering, and contorting his body during the especially difficult parts. His first repetition SUDS pattern was 30, 35, 55, 60, 75, and 60, followed by 65, 50, 40, 55, 65, and 60 during the second repetition. During the second and third NST session, Mr. Smith required very little probing for details, or reminders to stay in first person language. Additionally, Mr. Smith appeared more relaxed, evidenced by his posture. His SUDS pattern for the second NST session was 50, 55, 63, 76, and 60 during the first repetition, followed by 60, 60, 73, and 60 during the second. His SUDs pattern during the third NST session decreased dramatically: 38, 40, 48, 40 during the first repetition, and 40, 43, 45, 35 during the second. Because this memory had been recorded during the second session for transcription, the clinician was able to provide Mr. Smith with a copy of the memory to read twice a day each day between sessions. Mr. Smith recorded his pre- and post-exposure SUDS each day. During the fourth NST session, a new memory was selected, warranted by his homework form evidencing little to no distress for the first memory remained. For this session, Mr. Smith selected his second memory on the hierarchy with a SUDS rating of 90. Minimal habituation was noted, and as with the first memory, Mr. Smith required more probing for details, and was the most emotionally and physically reactive, evidenced by tearing up, clenching fists, and pausing throughout. His SUDS for the first repetition were 85, 90, 90, 93, 97, 88, and 80, followed by 85, 87, 87, 90, 85, and 80 for the second. Despite this evidence of

progress, as noted above, Mr. Smith continued to struggle to challenge the interpersonal schemas imbedded in these memories.

With regards to Mr. Smith's symptoms of depression, anxiety, and anger, the weekly scores (See Table 1) show an overall pattern of decreased symptoms in all three areas. Mr. Smith's initial BDI score indicated borderline clinical depression, initial BAI score indicated mild anxiety, and initial CAS score indicated mild clinical anger. Mr. Smith's final BDI score was in the normal range, final BAI score indicated minimal to no anxiety, and his final CAS score indicated minimal clinical anger. Closer examination of the pattern across the weeks reveals a pattern of fluctuations of reported symptoms. Scores on the BDI, BAI, and CAS appeared to fluctuate in the same direction each week, meaning when one increased, the others increased as well. Additionally, Mr. Smith typically reported more anxiety symptoms compared to depression and anger symptoms. Specifically, he reported symptoms in the borderline to mild range of anxiety during 15 of the 17 weeks of treatment compared to four weeks of borderline to mild depression, and four weeks of mild anger. Interestingly, Mr. Smith's anxiety ratings from pretreatment to the final session show the largest difference.

Upon reflection, elevations in his symptoms may be explained by several life events that occurred over the course of treatment. For example, during week four of treatment, Mr. Smith was advised that his father had been re-diagnosed with cancer, and had chosen not to receive treatment. Sometime during weeks seven through nine, Mr. Smith's father passed away, and his mother came to visit him for the first time since his incarceration. Additionally, during week 11, Mr. Smith was accused of masturbating in the unit game room in front of other residents (an incident he denied), and stated the officer was trying to get him kicked off the Honors Unit. During week 13, Mr. Smith was involved in an argument with a unit officer where he yelled in

the officer's face, punched a wall, and threw several chairs and a trashcan on the unit. This incident resulted in placement in segregation for several days, and ultimately led to his removal from Honors Unit, and termination from his job. It is the clinician's belief that the officer's tone of voice may have triggered a flashback. However, this incident suggests Mr. Smith would benefit from continued practice with emotion regulation strategies. In addition, Mr. Smith began the NST phase of treatment during week 13, which may also partially explain the increase in anxiety and anger.

With regards to the presence of Mr. Smith's symptoms of PTSD, his patterns of CAPS-5 monthly scores (See Table 2) show an overall improvement in PTSD symptoms throughout the course of treatment. The final CAPS-5 administration occurred after the fourth NST session and indicated Mr. Smith no longer met criteria for PTSD.

Table 1: Weekly scores for depression, anxiety, and anger.

BDI, BAI, and CAS Weekly Scores^c			
	BDI	BAI	CAS
Pretreatment	18	20	14
Week 1	16	19	12
Week 2	10	8	10
Week 3	9	10	8
Week 4	11	11	14

^c NOTE: BDI = Beck Depression Inventory; BAI = Burns Anxiety Inventory; CAS = Clinical Anger Scale

Week 5	7	9	6
Week 6	8	5	9
Week 7	9	10	8
Week 8	13	13	17
Week 9	9	11	15
Week 10	5	8	7
Week 11	8	8	10
Week 12	4	5	3
Week 13	4	19	10
Week 14	4	6	5
Week 15	8	9	8
Week 16	6	4	6
Week 17	3	1	2

Table 2: Monthly CAPS-5 scores for PTSD symptoms

Monthly CAPS-5 Scores		
	# of PTSD Symptoms	Interpretation
Pretreatment	14	PTSD criteria met
1 Month	9	PTSD criteria met
2 Month	8	Subclinical
3 Month	7	Subclinical
4 Month	5	Subclinical

Self-evaluation

The transcript provided was the 14th treatment session and the second NST exposure session. At this point in treatment, Mr. Smith had been given the rationale for narrative storytelling, created a memory hierarchy, practiced the process with a neutral memory, and went through a memory from his hierarchy twice in the previous session. The plan for the session was to start by reviewing homework of identifying schemas imbedded in the memory, then continue imaginal exposure to the same memory, and continue post processing and challenging of schemas imbedded in the memory. The goals of the session were to elicit more detail from the narrative to promote higher emotional engagement in the memory, and to challenge the accuracy and utility of schemas in Mr. Smith's current life.

The clinician demonstrated some strengths over the course of the session. The first was to pull out more detail regarding Mr. Smith's thoughts about himself and others from his homework. Specifically, the clinician was able to assist Mr. Smith to arrive at the schemas "I have to be constantly aware of my surrounding or something bad will happen," and "To be close to someone equals getting hurt." Additionally, during the second repetition of the memory, the clinician was able to gather more detail regarding senses, thoughts, and feelings, which were not previously expressed. An example of this was how Mr. Smith was awakened the next morning after being abused. This part of the narrative was glossed over quickly during the first repetition, and the clinician noticed Mr. Smith skipping over details again during the second repetition. Once Mr. Smith was probed for details on this matter, he became emotionally reactive, prompting the clinician to ask for a SUDS rating, which confirmed distress during this section of the retelling. Additionally, the clinician noted the dish soap part of the story to be the most distressing, and noticed Mr. Smith's tendency to talk through it quickly. The clinician was able

to ask for more detail regarding the taste and sensations of the soap, to promote full emotional engagement. Another example of the clinician gathering more detail on vague areas of the narrative was towards the end when Mr. Smith stated he was bent over in the car. The clinician originally questioned this because of her own confusion, but was able to elicit subtle, underlying components of the punishment (i.e., not allowed to see the outside world because that would promote relief). A final example of detail was when the clinician asked about others in the car. During the first repetition it appeared Mr. Smith was alone in the car with his parents, but upon probing during the second repetition, Mr. Smith disclosed his brother and sister were sitting next to him in the backseat, and noted they had no reaction to the punishment. The clinician believed this detail was important for relating Mr. Smith to the resource loss model, specifically to the loss of perceived support from the community.

There are also areas where the clinician can improve. One of those areas was helping Mr. Smith identify schemas. Specifically, it became clear to the clinician that the Interpersonal Schemas Worksheet was confusing to Mr. Smith and completing it did not result in the identification of schemas. As a result, continuing to use the worksheet as a guide proved ineffective. Instead, the clinician could have used the downward arrow technique more than what was used in the transcript to elicit Mr. Smith's schemas.

The clinician also struggled when challenging Mr. Smith's interpersonal schemas. As noted in the theory, clients commonly present with rigid and inflexible schemas. It is apparent from the transcript that the clinician attempted to challenge the schemas too much at the current point in treatment. Due to this, instead of providing examples as to how the schemas didn't fit in his current life, Mr. Smith tended to argue as to how the schemas are still accurate. Instead, the

clinician could have pointed out known inconsistencies with these schemas in Mr. Smith's current life, and saved the more direct challenging for a later exposure session.

Another challenge for the clinician was providing Mr. Smith with a way to continue his exposure daily outside of session. Due to facility restriction, Mr. Smith was not permitted to keep a recording device in his room. The clinician was unsure how to handle this challenge, and volunteered to transcribe the exposure for Mr. Smith so he would be able to read it each day. Although not a bad idea, this proved to be an impossible task for the clinician in following sessions due to the long amount of time required for such a task. Instead, the clinician could have suggested Mr. Smith journal the memory in his free time (this method was used in later sessions; however, this method could show an absence of detail as the clinician would not be there to probe.

The clinician also should have begun the second repetition closer to the time of the punishment. The session ran long due to the length of the memory, and the necessity of providing time for at least two repetitions. This was challenging for the clinician to judge, as it appeared Mr. Smith was still emotionally reactive during the introduction of the memory when discussing details regarding sneaking out of his room. It is apparent that the most difficult areas of the memory began when Mr. Smith was caught in the kitchen. By beginning the memory at this part, the clinician could have saved time, and/or had time in session for a third repetition.

References

- Arnau, R. C., Meagher, M. W., Norris, M. P., & Bramson, R. (2001). Psychometric evaluation of the Beck Depression Inventory-II with primary care medical patients. *Health Psychology, 20*(2), 112-119. doi:10.1037/0278-6133.20.2.112
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Publishing.
- Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Gusman, F. D., Charney, D. S., & Keane, T. M. (1995). *The development of a clinician-administered PTSD scale*. (PDF) *Journal of Traumatic Stress, 8*, 75-90. doi: 10.1002/jts.2490080106
- Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. Basic Books.
- Burns, D. D., & Eidelson, R. J. (1998). Why are depression and anxiety correlated? A test of the tripartite model. *Journal of Consulting and Clinical Psychology, 66*(3), 461-473.
- Cloitre, M., Cohen, L. R., & Koenen, K. C. (2011a). *Treating survivors of childhood abuse: Psychotherapy for the interrupted life*. New York: Guilford Press.
- Cloitre, M., Courtois, C. A., Charuvastra, A., Carapezza, R., Stolbach, B. C., & Green, B. L. (2011b). Treatment of complex PTSD: Results of the ISTSS expert clinician survey on best practices. *Journal of traumatic stress, 24*(6), 615-627.
- Cloitre, M., Koenen, K. C., Cohen, L. R., & Han, H. (2002). Skills training in affective and interpersonal regulation followed by exposure: A phase-based treatment for PTSD related to childhood abuse. *Journal of Consulting and Clinical Psychology, 70*(5), 1067-1074. doi:10.1037/0022-006X.70.5.1067
- Cloitre, M., Miranda, R., Stovall-McClough, K. C., & Han, H. (2005). Beyond PTSD: Emotion Regulation and Interpersonal Problems as Predictors of Functional Impairment in Survivors of Childhood Abuse. *Behavior Therapy, 36*(2), 119-124. doi:10.1016/S0005-7894(05)80060-7
- Cloitre, M., Scarvalone, P., & Difede, J. (1997). Posttraumatic stress disorder, self- and interpersonal dysfunction among sexually retraumatized women. *Journal of Traumatic Stress, 10*(3), 437-452. doi:10.1023/A:1024893305226
- Cloitre, M., Stovall-McClough, K. C., Noonan, K., Zorbas, P., Cherry, S., Jackson, C. L., & Petkova, E. (2010). Treatment for PTSD related to childhood abuse: A randomized controlled trial. *American Journal of Psychiatry, 167*(12), 1557-1564. doi:10.1176/j.1099-7102.2010.167.12.1557
- Dozois, D. A., Dobson, K. S., & Ahnberg, J. L. (1998). A psychometric evaluation of the Beck Depression Inventory-II. *Psychological Assessment, 10*(2), 83-89. doi:10.1037/1040-3590.10.2.83
- Foa, E. B., Dancu, C. V., Hembree, E. A., Jaycox, L. H., Meadows, E. A., & Street, G. P. (1999). A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *Journal Of Consulting And Clinical Psychology, 67*(2), 194-200. doi:10.1037/0022-006X.67.2.194
- Gray, M. J., Litz, B. T., Hsu, J. L., & Lombardo, T. W. (2004). Psychometric properties of the life events checklist. *Assessment, 11*(4), 330-341.
- Hennessy, K. D., Rabideau, G. J., Cicchetti, D., & Cummings, E. M. (1994). Responses of physically abused and nonabused children to different forms of interadult anger. *Child Development, 65*(3), 815-828. doi:10.2307/1131420

- Hunter, J. A. (2010). Prolonged exposure treatment of chronic PTSD in juvenile sex offenders: Promising results from two case studies. *Child & Youth Care Forum, 39*(5), 367-384. doi:10.1007/s10566-010-9108-4
- Kahn, T. J. (2011). *Pathways: A guided workbook for youth beginning treatment*. Brandon, Vermont: Safer Society Press
- Kubany, E. S., Leisen, M. B., Kaplan, A. S., Watson, S. B., Haynes, S. N., Owens, J. A., & Burns, K. (2000). Development and preliminary validation of a brief broad-spectrum measure of trauma exposure: The Traumatic Life Events Questionnaire. *Psychological Assessment, 12*(2), 210-224. doi:10.1037/1040-3590.12.2.210
- Levitt, J. T., & Cloitre, M. (2005). A clinician's guide to STAIR/MPE: Treatment for PTSD related to childhood abuse. *Cognitive and Behavioral Practice, 12*(1), 40-52.
- Maughan, A., & Cicchetti, D. (2002). Impact of child maltreatment and interadult violence on children's emotion regulation abilities and socioemotional adjustment. *Child Development, 73*(5), 1525-1542. doi:10.1111/1467-8624.00488
- National Center for PTSD. (2015). Life Events Checklist for DSM-5 (LEC-5) Retrieved from http://www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp
- Orsillo, Susan M. (2001). Measures for acute stress disorder and posttraumatic stress disorder. In M.M. Antony & S.M. Orsillo (Eds.), *Practitioner's guide to empirically based measures of anxiety* (pp. 255-307). New York: Kluwer Academic/Plenum.
- Palmer, E. J., & Binks, C. (2008). Psychometric properties of the Beck Depression Inventory- II with incarcerated male offenders aged 18–21 years. *Criminal Behaviour and Mental Health, 18*(4), 232-242.
- Penn, J., & Thomas, C (2005). Practice Parameter for the Assessment and Treatment of Youth in Juvenile Detention and Correctional Facilities. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(10), 1085-1098. doi:10.1097/01.chi.0000175325.14481.21
- Persons, J. B., Roberts, N. A., & Zalecki, C. A. (2003). Anxiety and depression change together during treatment. *Behavior Therapy, 34*(2), 149-163.
- Polusny, M. A., & Follette, V. M. (1995). Long-term correlates of child sexual abuse: Theory and review of the empirical literature. *Applied & Preventive Psychology, 4*(3), 143-166. doi:10.1016/S0962-1849(05)80055-1
- Resick, P. A., Jordan, C. G., Girelli, S. A., Hutter, C. K., & Marhoefer-Dvorak, S. (1988). A comparative outcome study of behavioral group therapy for sexual assault victims. *Behavior Therapy, 19*(3), 385-401. doi:10.1016/S0005-7894(88)80011-X
- Richter, P., Werner, J., Heerlein, A. E. S., Kraus, A., & Sauer, H. (1998). On the validity of the Beck Depression Inventory. *Psychopathology, 31*(3), 160-168.
- Rothbaum, B. O., Foa, E. B., & Hembree, E. A. (2007). *Reclaiming your life from a traumatic experience: Workbook*. New York, NY: Oxford University Press.
- Snell, W. E., Fum, S., Shuck, R. L., Mosley, J.A., & Hite, T. L. (1995). The Clinical Anger Scale: Preliminary reliability and validity. *Journal of Clinical Psychology, 51*, 215-226.
- Walter, K. H., Horsey, K. J., Palmieri, P. A., & Hobfoll, S. E. (2010). The role of protective self-cognitions in the relationship between childhood trauma and later resource loss. *Journal Of Traumatic Stress, 23*(2), 264-273.
- Weathers, F.W., Blake, D.D., Schnurr, P.P., Kaloupek, D.G., Marx, B.P., & Keane, T.M. (2013a). *The Life Events Checklist for DSM-5 (LEC-5)*. Instrument available from the National Center for PTSD at www.ptsd.va.gov

- Weathers, F.W., Blake, D.D., Schnurr, P.P., Kaloupek, D.G., Marx, B.P., & Keane, T.M. (2013b). *The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)*. Interview available from the National Center for PTSD at www.ptsd.va.gov.
- Weathers, F. W., Keane, T. M., & Davidson, J. R. (2001). Clinician-Administered PTSD Scale: A review of the first ten years of research. *Depression and Anxiety, 13*, 132-156. doi: 10.1002/da.1029

Session 14 Transcript: Narrative Story Telling

Therapist: Alright so you said that you did the homework right? Which was just thinking about thoughts and feelings and beliefs related to the memory we went over last week. So why don't you walk me through this

Client: uhm interpersonal situation. What happened? Who was involved? I did the memory from last week.

Therapist: ok

Client: I put I was caught by my dad stealing whoppers out of the kitchen

Therapist: ok

Client: What I believe about myself. I put that I felt like I had to get some food. I had to be cautious and extremely aware or I'd get caught

Therapist: ok

Client: Uhm how did I expect the other person to respond to me? I expected a violent response if I got caught. I also didn't expect to get much food the next day.

Therapist: mmhmm

Client: And what did I do as a result, I snuck from my room to get some whoppers, I was caught and hit several times, and forced to do pushups for a while.

Therapist: K, so under what do I feel and think about myself, there's also a pretty big thought that came out of that that you said several times, do you remember what that was?

Client: Not really

Therapist: you said that you kept thinking when we were going through the memory that you should have done this better, right?

Client: Yeah and I won't make the same mistake twice

Therapist: Yep there ya go

Therapist: Ok you did good pulling that out. So what kind of beliefs does that lead to that you have about yourself or other people or the world?

Client: Uhm, that I should be constantly aware of my surroundings

Therapist: Ok, so I have to be constantly aware of my surroundings, that's a good one, lets write that down over here. Ok so when you say I have to be constantly aware of my surroundings, what does that mean? It sounds like I have to be constantly aware of my surroundings or...?

Client: Or something bad is going to happen to be

Therapist: Ok so if I'm not aware, something bad is gonna happen

Client: Yeah, something unexpected

Therapist: Ok, lets write that down too.

Therapist: Ok, so what does that mean in relation to other people, or having any type of relationship with another person? How does that thought or belief affect that?

Client: You have to be aware of what the other person is doing, or they'll try to trick you or something, somehow. It'll happen eventually

Therapist: So how can you put that into a statement?

Client: Uhm, well I don't want to sound like a pessimist

Therapist: No that's not what it sounds like. Just put it in a sentence that makes sense for you

Client: uhm

Therapist: so I heard you say people will eventually trick you or betray you.

Client: Yeah. I put "People will almost always betray you if you get too close."

Therapist: K. so being close to somebody means what? Being close to somebody equals getting hurt? If that what that's saying

Client: Well yeah, eventually

Therapist: Ok let's write that down

Therapist: Ok, so we are going to continue to work with this memory again today. We will continue with this memory until we see the decrease in anxiety that we talked about before. And then when we will finish we will go through this again and see if there are different thoughts or beliefs that come out of it, and then talk about how those beliefs may or may not fit with your current life, ok?

Client: Ok

Therapist: So what questions do you have before we get started?

Client: none

Therapist: None? Ok, so we are working with the whoppers memory right?

Client: Yeah

Therapist: Ok so how did we do this last time?

Client: You had me tell the story in first person statements

Therapist: yes

Client: So "I am" stuff like that

Therapist: mmhmm

Client: And also you'll be asking for my SUDs were... which would be my anxiety level just during different parts of the story

Therapist: Yep, and what do you remember about the SUDs? What's the scale?

Client: 0 to 100

Therapist: Right and 0 being what?

Client: None

Therapist: And 100 being?

Client: overwhelming

Therapist: Good, like the worst you've ever experienced. Ok and you can use any number on that scale remember?

Client: Yeah

Therapist: Ok, and so, yes, we are going to do this in first person, and remember to try and tell as many details as you can, uhm, including what kinds of things are you seeing, feeling, hearing, touching, smelling, as well as thoughts and feelings: what emotions you are feeling, what kinds of thoughts are you having in the situation. So... questions about that?

Client: I just don't want it to be so different from the last time, like I can see there could be more ways like different feelings. I think I'll be able to describe it better this time.

Therapist: Ok, so just like last time, during the first time, I'll let you go through it without probing you for detail; I'll just be asking for your SUDs. So just like last time, if you feel

comfortable close your eyes; if not, pick a spot on the floor or the wall to fix your focus on. Ok, and what is your SUDs right now with anticipation about going through this memory?

Client: Probably like half way

Therapist: 50?

Client: Yeah

Therapist: Ok, alright and you can get started

Client: so I'm laying in my bed I just went through my day I feel exhausted and emotionally drained, because I had to be emotionally guarded, so this is just my time to let my guard down. And I didn't get, I haven't gotten that much food today, I've had like a bagel and a yogurt, or a yogurt and a cheese stick and a glass of water. So I'm pretty hungry and my moms and work, it's just my dad so I feel like it's a prime opportunity, or there's less chance that I'll get caught by one person instead of two. So I guess it's a good time to get up and see if there's some sort of food I can eat. So I sneak out of my bed. Uhm we live in an old house so everything squeaks if you touch it. My heart is beating with anticipation with what I'm about to do. I need to focus and make sure I don't step in the center of the floor, and I need to stay on the outside. So I walk around the perimeter of the room because that's where the floorboards are most secure they won't pop or creak or give my position away. So I go to the door, it's old so I have to open it a certain way or else it'll make too much noise. So I go to the door and I carefully grab the handle and if I'm careless and just reach for the handle, it will rattle. So I slowly put my hand around it and twist it slowly before I push. As I twist I pull up on the door to that way it doesn't drag again the floor. And it slides out, and I stop to take a breath because I had been holding my breath. When I stop to breathe, I listen for any signs of discovery or movement. I hear my dad talking in the other room. He's talking on the phone. That means everything is good, I just have to take a look to see his position, to make sure he won't easily move or something. So I take a couple steps to my left and peep around the corner, and I see he has his feet propped up on the chair and he's on the phone watching TV.

Therapist: SUDs?

Client: uh 55 probably. Uhm, he has his feet propped on the chair and he's talking to someone on the phone. And I listen for a couple seconds make sure the convo is still going. Then I start to walk down the hallway. I have to walk carefully; be very quiet and walk from my heel to my toe so I don't put too much pressure down. Also, I have to stay away from the center of the floor, until I get to the kitchen at least. I walk into the kitchen and stop and look around and I'm kind of I still feel the thrill of the adrenaline I guess and uhm my heart is pounding but I'm able to still focus to try to see what there is for me to eat. There's a couple loaves of bread in the basket. I know if I open the fridge it'll make too much noise. So I open the cabinet and I look up and I see Tupperware with some cookies in it. Way too much noise. I see a little milk carton that's full of whoppers, and I figured that would probably at least help. So I climbed up onto the little counter and uhh as I climb up on the little counter I am still keeping an eye out and listening and trying to be very careful. Every sound I hear is magnified, so every sound I make makes me nervous

because its louder to me than it is. The cabinet it still a pretty good distance away, so I step across to the little ice and water compartment on the fridge and set my foot down on the base of it. And I'm reaching across for the Whoppers. I know I can't take too long, but I still have to hurry but be very careful at the same time. So I reach in for the Whoppers, and uhm I open the lip of it and I start to try to pour some out, but they are stuck a little so it's more difficult to pour some out. I give it a little bit of a shake to shake some out, and it makes noise, I feel like it makes too much noise. Now I'm tipping it more and more and you can hear it rattling. As I'm listening, subconsciously I don't hear anything, nothing, I guess this is where I should have realized that something was wrong, because I should have been hearing noise. I let myself slip, I was just focused on what I was doing. So I feel like the anticipation I've got, what I want in my hand and I'm just trying so get it and so I've shut out a bunch of other stuff that I should have been paying attention to. And as I tip it over, it rattles some more and just as I put a couple in my hand I hear like a pop coming from my right. I look over and I see a phone light and it comes around the corner and lifts up and there's nothing I can do. My dad shows up in the kitchen and he's probably like a foot away from me when he sees what I'm doing he basically pushes me or punches me like I don't know he just knocks me off the counter. I literally slide across the room, across the kitchen and I hit the other cabinet.

Therapist: SUDs?

Client: 65. Uhm so I get knocked across the room, I'm on the floor, I'm terrified. I don't know where I messed up at this point, trying to make my mind go back, I'm still not focused on that, I'm trying to avoid getting hit. And there's Whoppers everywhere, when I hit the cabinet the Whoppers went everywhere, sliding all over the floor. I've still got like 2-3 in my hand. My dad turns on the kitchen light and starts coming towards me. I try to get up, and he kicks me or hits me or something. It goes on for a little bit, but I'm more in a panic that I got caught than I am feeling the pain of what's going on, so I don't really feel what's going on. I'm more disappointed that I go caught. I know it's only gonna go downhill from here. After I get through all his additional anger he calls me into the living room and makes me do pushups a couple feet from his chair. Right now my adrenaline is still pumping so I don't feel the strain on the pushups, or muscle tension, I just go with it automatic like I'm a machine just not thinking about what I'm doing just doing it. I'm thinking about what I did wrong, what I could have done differently. I should have noticed he wasn't talking on the phone anymore; I should have noticed him get up. As I'm thinking all this he's telling me it was by coincidence that the phone just happened to cut off at that time, and he was on the phone with my grandma and the phone just happened to cut off. He heard something in the kitchen and that's when the phone cut off. That's where I made my mistake. I should have been listening, should have been listening for the constant noise in the background, because most of the time it's not silence you want, it's the noise that's your cover, and so I should have noticed and stopped. I also left my door open so I wouldn't have to open it again. I should have shut my door because when he went to investigate he went down that hallway and he seen my door open so he knew I was out and assumed I was in the kitchen. There's a bunch of things I could have done differently. So I'm doing pushups as I'm thinking about all this. Eventually my body wears out. Once he sees that he just tells me to lay on my face on the floor. So I'm lying on my face on the rug on the floor and I spend my night there face down on the carpet. Next morning it was back to pushups, and after I was done with pushups they made me do jumping jacks and stuff like that. Then my mom is home the next day so she

took over what was going on with the punishment. The whoppers were still on the floor. She had me pick them all up and then had me uhm.

Therapist: SUDs?

Client: 75-76. Had me pick up all the whoppers and shove them all into my mouth, as many as I could and, but first she put dish soap in my mouth, then had me shove whoppers in there until I couldn't get anymore, then she put more dish soap on it. She has me hold it like that in my mouth. Then we have to go to the store so I have to get in the car and have to bend my head over to my knees in the car. This is normal, but I have all this stuff in my mouth and it's burning my mouth and I just, in the inside I'm not really worried about what I feel, what my body feels, I feel hate, a strong hate. She's always trying to come up with something to make my life worse. I feel like what if I did do something wrong because no one can be right all the time. And then I have this thought that I was just trying to get food, could have got something a little less, I mean bread would have sustained me. As I'm bending over my saliva builds on and the soap is tearing my mouth apart and it burns in my throat. She has me sit up long enough so I can chew up all the whoppers I can. I can't even move my mouth but I have to chew. I'm chewing and swallowing and the soap is burning my throat as it goes down. I just hate it, and after I'm done chewing and swallowing, I have to bend back over. After that it kind of faded back into my normal routine. So I'm bending over then when we get home she makes me unload all this stuff and from there it's just back to my normal routine.

Therapist: Final SUDs?

Client: probably 60

Therapist: Alright, good job. Let's start over and remember this time I'll be probing for more detail ok. Go ahead and close your eyes and get started.

Client: I'm in my room it's nighttime, probably about 10:30. I'm exhausted physically exhausted, I feel physically exhausted. I just went throughout my day and didn't have much to eat probably a bagel and a cheeses stick or a yogurt and bagel and a glass of water. That's all I had at about 11:00 that morning. I was kind of physically fatigued, and I felt shaky and I figured in my head I'm not gonna get that much more tomorrow so I better go get some while I can. My dad's here alone, he's somewhere, I'll figure that out. I gotta get some food but I gotta be very careful. So I get up out of my bed after I make that decision. Gotta be careful because we live in this old house and uhm everything is pretty old so you'll be walking on the floorboards and they'll creak or pop and give away where you're at. And the doors pretty old so as I walk toward the door I gotta stay at the perimeter of the room close to the wall where the floors are built more solid and wont pop randomly when you don't expect it. I go around the room and by the time I get to my door I... this is where I gotta be very careful. I gotta open the door, but if I reach my hand out and touch it normally the handle with rattle and he'll hear that so I reach my hand out and very gently like close it over and make sure I've got a solid hold of the handle, make sure it doesn't rattle.

Therapist: mmhmm

Client: And I lift up on the door I lift it up so it doesn't drag and I gently scoot it out, slide the door open and I already turned the handle so that way the latch doesn't lock, and turn behind me and pop the door so it'll be easy access back in and I won't have to worry about making the noise opening it again and then having to shut it. I hear a voice coming from my left. My dad's in there, he's the only one home so I'm assuming that's him so I look to my left and he's in there talking on the phone and he has his feet propped up on a recliner chair and he's watching TV. So I think to myself that's pretty good cover. The TV's going, he's on the phone, he has his feet propped he's not going anywhere real fast. So I kinda, kinda, uh, relax a little more than I probably would have had he been in an easier spot to get up or closer to the kitchen. He was a pretty good distance away so I felt that was a little more safe. Still had to be careful. I feel anticipation and my adrenaline is pumping and I really I don't know, even though I'm doing this because I feel like I need to, I still feel the thrill of it and anticipation and I walk through the hallway still trying to stay to the perimeter of it so I don't cause it to pop, or if I'm not in the perimeter I kind of step from one side of the hallway to the next; that's a pretty close space. I walk into the kitchen, and I start to look around, looking for some food, what can I eat? I go from the easiest point of access, I know in the cabinet there is cereal but that was out of the question because they are in plastic bags and it makes way too much noise.

Therapist: mmhmm

Client: Plus, the bread, I could eat bread out of the basket but I don't really feel like eating bread again so... I kinda skip that notion. Then I open the cabinets up and most of its just canned stuff: applesauce or canned vegetables and stuff like that.

Therapist: mmhmm

Client: And at the top there's like Tupperware container and cookies that are still in the wrappers, but that's very kind of fragile plastic, so it'll, it'll make too much noise to try and get into that. I see a milk, it's like a carton of whoppers up there, I figured that probably wouldn't be too hard to get, and it's a little different than what I usually eat. So that's my goal now; I'm not really focused on much else other than that but before I get up there I start to listen; still I still heard not much going on; I hear my dad talking on the phone in the other room. Everything's ok so I climb up on the little counter and I step my foot across, uhm so to the uh refrigerator there's a little compartment where you can get your ice and your water; I put my foot on that and then reach across and grab, grab the whoppers. I have to move a little can of peanuts or something out of my way, but I just slide it didn't make noise. I pull the whoppers out and I can tell there's a little more than halfway full which is a good thing because now they won't notice if there's only a couple gone as compared to if there was only a couple in there, they would notice. So everything is working in my favor, I'm intently focused on this, I start to tip it over and nothing moves in there it's like they are settles in there so you gotta shake it a little bit, and

Therapist: What are you thinking?

Client: I'm thinking I'm kind of irritated; it's not as easy as I was hoping, they're packed in there which means I have to take a risk and make more noise. So I kind of like shake it lose a little bit.

It's kind of rattling and as I shake the cardboard it makes a lot of noise, to me anyways, because everything is amplified every little pop I make or stepping on the counter or something, every sound I make is just amplified. But I've learned to judge it and discount it a little more. Maybe that's part of my mistake, but I start to tip it I'm not thinking about anything else, I'm just thinking how to get this with as little noise as possible, but as I tip it in all the noise its making its rolling across it's like roaring in my ears basically. But the thing is whenever you do have to make noise when you're doing something like that you gotta make sure it's on a constant level not sporadically it can't be loud noise stop loud noise. It's got to be gently...noise so I tip it slowly so that way there's noise at a constant level. People are more likely to hear noise when it just happens and stops than a constant. Anyways, I'm not thinking about anything else; that's where I make my mistake again. And I tip it over and get a couple in my hand and as I'm tipping it it's still roaring in ears but then there's something I hear I just can't miss I hear a pop in the hallway someone stopped in the center or where the floorboards will pop randomly and I turn a look and I see a phone light and so I kinda like freeze.

Therapist: What are you thinking?

Client: I'm thinking great I'm pretty much caught but there's a small chance that he's not coming to me. Small chance that he's just going to his room and if I stop then maybe I won't be noticed so I kinda freeze, but I kinda look and he comes around the corner his phone is shining in my eyes, I turn away. He yells something, he yelled a lot of things but he pushes or punched me or I don't know, I don't know, he knocks me off the counter somehow. My left arm hits the cabinet. My right hand is still holding the carton of whoppers,

Therapist: SUDs?

Client: Uhm, I guess like 60.

Therapist: So your right hand is still holding onto the whoppers.

Client: Yeah and uh so whenever he knocks me off my left arm hits the cabinet door which swings open and hits the other side, and uh

Therapist: What does it feel like?

Client: it doesn't feel I don't notice it really I just notice the noise because my mind is so trained in noise I don't notice what I feel. I kind of dread what's going to happen I know something crazy is about to happen, I mean I've been caught that means I've failed I mean I'm kind of disappointed after everything I thought it was gonna be an easy one but I'm not really thinking about that too much right now because there's a big situation in my face, so I hit the floor and kind of slide over and hit the other cabinet across the kitchen my dad advances on my yelling and screaming about how I shouldn't be up and how he trusted me but I'm up doing this,

Therapist: You're on the floor right now?

Client: Yeah

Therapist: And dad's on the floor or standing above you?

Client: he's standing above me and he's advancing towards me and there's whoppers everywhere they just rolled across the floor and then he yells about how I just wasted a bunch of money by wasting the whoppers

Therapist: mmhmm

Client: and he comes up on me and hits me a couple times kind of kicks me and once he calms down just a little bit and I know I just have just get past it, it won't be too long, I'm not gonna get hit too many times

Therapist: What are you thinking when you're being hit?

Client: I'm thinking it will end eventually, its nothing I can't handle, just get past it. I don't feel anything I don't have to, anything physical I can shut out of my mind because if you don't want to feel it then you won't feel it. So, and he's hitting me and kicking me there's just not really anything I'm just thinking about what's gonna come next because that's gonna be the long thing, this little thing won't last long. And sure enough he had me follow him into the living room, has me do pushups and my adrenaline is still pumping I don't feel, I don't feel the pushups the strain, I'm exhausted I just don't feel exhausted because of my energy...my panic and my adrenaline is still pumping. So I'm pumping out pushups just going and he's telling me kind of what happened in a way was a coincidence, and he said it wasn't a coincidence, but that God told him that something was going on or something like that and so the phone cut off and it was just telling me how the phone cut off and he heard something so he came in there to look at it, and looked over and saw my door was propped. As he's telling me this I'm realizing where my mistakes are pretty sure he said the phone cut off so I should have noticed that he wasn't talking anymore, but instead I was focused on what I was doing, I didn't split my brain up appropriately. Then he tells me how the door's propped open so he assumed that I was in my room just playing around, but then he seen the door open so he knew where I was at.

Therapist: mmhmm

Client: If I would have kept my door shut instead of propping it open he would have stood and tried to listen and if he wouldn't have heard anything he would have returned back to where he was but he knew where I was because he knew if I wasn't in my room that's where I'd be. So I'm doing pushups and thinking about all this. I'm still shaking because I'm pretty hungry and my arms give out a couple times, then he tells me just lay there, I'm not getting any pushups done so I can just lay on my face; that's all I'm getting done anyways. So I lay there on my face and eventually I end up falling asleep. Uhm my mom comes home sometime in the middle of the night and she kind of takes over and I'm dreading this

Therapist: So mom comes home while you're asleep?

Client: Yeah but I hear something and I wake up.

Therapist: What were you thinking when your mom came home?

Client: my heart sinks like that kind of feeling where it goes into your stomach and think ugh, it's about to get worse now. I was hoping, I kept hoping it would be over before she got home and he would send me to bed and just tell her about it but now the situations confronting her; she showers and takes over. My dad goes to bed and she sits in his recliner chair while I sleep on the floor. The next morning I'm back to doing pushups around 11:00 or something.

Therapist: How do you wake up?

Client: she pinches me awake under my arm.

Therapist: Ok, so she pinches you and now you're awake.

Client: Yeah...and uh...

Therapist: SUDs?

Client: uhm...like 73

Therapist: ok

Client: And so then I'm going through this and I'm in the kitchen, she had me pick up all the whoppers on the floor. She put dawn dish soap in my mouth.

Therapist: How many whoppers are in your mouth?

Client: I don't know, there probably like 25-30, I don't know it seems like a lot, basically all the ones that were on the floor she made me shove them in on top of the dawn dish soap then threw the rest away. So then the chocolate starts to melt and mix with the soap and it tastes nasty.

Therapist: What does it taste like?

Client: I don't know, it tastes nasty, I taste the artificial apple from the soap, and the burning from the soap: it feels like it's eating away my flesh. Then I can feel the whoppers dissolving in my mouth and stuff and I can taste little balls of chocolate flavor in the back of my mouth.

Therapist: What are you thinking?

Client: That it's disgusting and I never want to experience this again. I messed up and I made too many mistakes I'm not gonna make the same mistake again. And then we have to go somewhere so she has me stand up and bend over in a little area and I overhear them talking saying we have to go to the store and I have to have all this in my mouth, trying to hold it so I'm not drooling everywhere, trying to hold it all in my mouth. Now they are having me get into the car and

making me bend over and touch my head to my knees lift my arms up over my head, put the palm of my hands on top of my head.

Therapist: And what is the purpose of that?

Client: They don't want me seeing the outside world and they want me to get some sort of punishment, and I have relief in the car, they thought I was having too much relief while I was in the car. They always told me it was a test this is just a test.

Therapist: What's a test?

Client: Everything that they would have me do was some sort of quote-unquote test just to have them be able to do it. It's just a test to see if you'll listen, just a test to see if you can do it without arguing. If you would have just got down and done 25 pushups you would have been done, but that's not the case because I did more than that they just want to use that as an excuse. So I'm in the car bent over and my saliva starts to build up and I can't keep stuff in my mouth that well so I have to keep adjusting. She tells me to sit up and chew it and swallow it. At least now they put a limit to my discomfort, instead I won't have to hold this stuff in my mouth forever; now I just have to chew it up, and it's gonna hurt, it's gonna burn but I put that out of my mind. So I do it and it burns my throat, the taste is horrible, my tongue and the inside of my mouth is already dissolved: skin coming off with my tongue and stuff.

Therapist: What are your parents doing?

Client: My parents are driving and not paying attention; well I guess my mom is looking at me from the passenger's seat.

Therapist: Ok, so you're by yourself?

Client: My brother and sister are to my right. I'm always supposed to sit diagonal to the passenger seat so they can see me. If my mom is driving alone I'm supposed to sit diagonal from the driver's seat so she can look back and see me.

Therapist: What are your brother and sister doing?

Client: This is normal so my brother and sister don't pay attention; they just look out the window or something. And I swallow it and wipe my mouth and she had me bend back over and they go in the store and I stay in the car bent over the whole time, for like an hour, it killed my back but eventually it ends and once we get back they have me unload all the heavy stuff: the bottles of water, and I start going about my day. They have me clean this, clean that, clean this and then next day my routine starts over.

Therapist: Final SUDs?

Client: About 60

Therapist: 60?

Client: Yeah

Therapist: Alright, good job. Let's take a couple minutes and take some deep breaths.

Therapist: Can you tell me where you are right now?

Client: G unit classroom

Therapist: ok, what's the name of this building?

Client: KJCC

Therapist: ok

Client: It's nasty

Therapist: What's nasty?

Client: The soap

Therapist: Yeah, that seems to be the most difficult part of the story every time

Client: Yeah

Therapist: Why do you think that is?

Client: because every time she did it, the effects last for days. My mouth burns, it's hard to eat my yogurt.

Therapist: mmhmm. Ok you did a really good job staying in first person, and adding in all the details this time. So now we're gonna talk about all the thoughts, feelings, beliefs those sort of things. So thinking back to that memory and that situation. So you're hungry, and going to the kitchen to get something to eat because you're hungry. So what kinds of thought do you have about yourself in those moments?

Client: uhm... I probably won't get that much food tomorrow, so I better do it now when it's the most convenient.

Therapist: ok, what else

Client: uhm...

Therapist: What about thoughts based around being hungry and not having food?

Client: well, at this point it was pretty normal; it was almost a nightly or every other night thing that I would go into the kitchen and get food

Therapist: So this was pretty normal for you; you just got caught this time?

Client: Yeah

Therapist: ok, so what about... any thoughts about what does it mean that mom and dad don't feed me? Any thoughts about yourself or others based around that?

Client: I just don't think they thought about it, they gave me my one thing and sometimes they'll give me another thing. 5 taquitos probably is what it was.

Therapist: In a day?

Client: Yeah, 5 taquitos and a bagel and yogurt pretty much made my day. But a lot of times I only had one of those.

Therapist: And what happened if you asked for food?

Client: (laughing) You don't ask for anything in that house

Therapist: Did you ever ask for food?

Client: A long time ago and I learned my lesson.

Therapist: so what about family meals? Does everyone sit down and eat together?

Client: Sometimes or when we had company or went somewhere. But then I had to watch my mom. I could only eat one bite at a time. Like I would eat a bite, and then I'd have to look at her and she'd nod when it was ok for me to eat again, because otherwise I would finish first and start looking at other people's food, and they'd start offering me their food and I'd take it. And I got in trouble for that so many times.

Therapist: So on a normal day everyone ate together or no?

Client: On a normal day everyone ate randomly...they called in "fending" like fend for yourself, everyone would just go in the kitchen and get whatever they wanted...except me

Therapist: So we have "I better do this now or I'm gonna be hungry." What are some other themes that came up for you, thinking back to that memory that you thought or felt about yourself?

Client: Nothing stands out

Therapist: Ok, so something I heard over and over again was "I made too many mistakes."

Client: Yeah I made too many mistakes, amateur mistakes

Therapist: So what does that mean about you?

Client: It means I better never to it again

Therapist: So you made too many mistakes, so it was your fault?

Client: Yeah

Therapist: That situation was your fault? What part was your fault?

Client: I didn't shut my door all the way I didn't pay attention that my dad wasn't on the phone anymore, and I should have went back and looked to make sure he wouldn't come. I've had situations like that before where I know what I'm doing and I don't make that mistake, I see him getting up and I'm always able to make it back to my room.

Therapist: So when you say it's your fault, what's your fault? Getting caught is your fault? The punishment that followed is your fault? What part?

Client: All of the above. I got caught. I shouldn't have been so stupid, then the punishment that follows is the appropriate punishment I get for being stupid for opening my door and leaving it open and not noticing. That's what I consider the punishment for, I don't consider getting food wrong if I'm not getting fed.

Therapist: ok

Client: It's a punishment for doing what I did, messing up.

Therapist: Ok, what do you think about that punishment?

Client: I think it's over extensive at times, but I think I can always get through it just like everything else.

Therapist: Ok, do you think it was the correct punishment? Do you think you should have been punished for that?

Client: For messing up like that? Yeah

Therapist: So you should be punished because you messed up?

Client: Yeah

Therapist: Ok, alright, so what about how did you expect other people to act in the situation?

Client: Well I didn't expect to be caught, so I didn't expect anything from them

Therapist: mmhmm, when you did get caught?

Client: I expected what I got: a violent response. Uhm pushups for a long time, just to be a long, drawn-out process.

Therapist: Ok, so what kinds of things, just like we did here with the homework, based on this experience and the thoughts and feelings you have about yourself and the other people, what kind of beliefs do you have based on this memory?

Client: Always be aware of your surroundings, and you can also notice when someone is up to something

Therapist: So what if you're not aware of your surroundings?

Client: Something is going to likely be unpredictable and sneak up on you. Not necessarily someone, but something is gonna happen

Therapist: If you're not aware of your surroundings? Is that something you still think?

Client: Yeah, that's common sense, if you're not aware something is going to catch you off guard. If you are aware you're better able to handle it.

Therapist: Ok, and there's also a lot of "I made the mistake," a lot of kind of blame that I heard.

Client: Yeah

Therapist: So what belief or schema comes from that?

Client: Self-blame I guess.

Therapist: What about you deserving to be cared for in a proper way? What do you think about that?

Client: Uhm now?

Therapist: yeah

Client: Well I've realized that all of that was pretty messed up, but at the time I thought it was pretty normal, I never went to school, no one ever told me otherwise. I was always being told there was something wrong with me, so I would try to change things about myself to make them not act like this, but it never made sense, I feel like I would dig myself in a hole like I would steal food because I was hungry and they said if I stopped stealing food they would give it to me. So I would stop stealing food and they still wouldn't give it to me. So that never worked, I got stuck where I couldn't not do it but I tried it their way.

Therapist: So what about relating and connecting to other people? What comes out of this experience?

Client: You can't trust somebody

Therapist: Is that something you still believe?

Client: Yeah

Therapist: So you can't trust someone? Can't trust anyone?

Client: Can't trust anyone

Therapist: Why can't you trust ANYONE?

Client: Because it's better than trying to pick and choose who can you, instead of going around like mm I can trust you, it's just easier not to trust anybody because the majority of people are going to betray you anyways, so unless, the only way I trust someone is if they show extremely in my face that they can be trusted, and even then I get a little nervous because that's just a little too obvious for me, like if they are sitting around with a sign over their head saying "trust me" that's a sign to not trust them. But if they prove it in a way where I know they're not gonna manipulate me that one of the closest ways for me to trust someone. But I always still keep my distance.

Therapist: ok, any other kinds of schemas or beliefs that comes from this situation about relating to other people? What does it mean to be close to somebody?

Client: uhm, I don't know. It's better to be closer to yourself.

Therapist: Because that goes back to you can't trust anybody and people will hurt you?

Client: Well, nobody knows how to hurt you more than your friend, I mean your friends probably worse, because if it's your enemy you expect it from them, when it's your friend you don't. So based off that logic its perfectly reasonable not to trust people. There's a quote that says something like "If you want a good enemy, chose a friend; he knows exactly where to hit you."

Client: a friend knows all your vulnerable points, all your weak spots. It's a point where you can't trust someone to be in that spot, and I guess that's why I wanted to be in treatment because I want to change that outlook, but I don't see how you're supposed to

Therapist: So what if you're vulnerable- what does that mean?

Client: It means you're gonna get hurt

Therapist: So to be vulnerable means to get hurt?

Client: Whenever you start to feel emotions you become vulnerable, when you start to feel anything you become vulnerable, and I was vulnerable in that situation and I got hurt.

Therapist: So how do all these schemas we've just talked about affect you now in your life? So they made sense in your childhood based on these experiences, right?

Client: And until I reach a point where I feel that it doesn't make sense anymore, I'm still gonna think that. It still makes sense to me

Therapist: Have any of these interfered with your current life?

Client: well I'm in jail so...

Therapist: how does that related to jail?

Client: Well, I'm not trying to build relationships here, but I feel like I will in the future. If someone is trying to put themselves out there and be my friends...and it has happened here every once in a while you get somebody that you feel like you can trust, like I had a friend in here, I've had a couple. Some of them proved themselves untrustworthy and I'm not surprised.

Therapist: ok

Client: But it's also because some of this it's cuz you keep an eye on your surroundings, you're expecting it when it happens

Therapist: So this has kind of affected your ability to get close to people, right?

Client: Yeah, I've gotten to the point where I can trust some people but it's never to the point where it's whole.

Therapist: So what are some examples that prove that "I can't trust anybody" is not accurate in your current life?

Client: some examples...

Therapist: Are there any examples in your current life to show that that's...

Client: No, and I know that's a textbook universal, "You can't trust anyone" that's an absolute

Therapist: ok, good!

Client: But I put that there on purpose, sometimes the absolute is necessary, I don't believe there's not a single soul that could be trusted, I just think finding it is too much work and it puts you in a vulnerable point so it's better to just not trust anyone.

Therapist: So what I'm asking you though is have there been ANY examples of anyone you've been able to trust in your recent life.

Client: Not 100%, just a little bit

Therapist: Ok, a little bit

Client: Yeah, I mean like, obviously, I trust you or I wouldn't be talking about all this. I trust you to a point.

Therapist: Are there others?

Client: There was a friend here too

Therapist: And did that friend betray you?

Client: Well no.... not yet

Therapist: Ok, others?

Client: No, I mean Miss Jones^d I can trust her to do certain things but it's a different kind of trust though

Therapist: Right, right, but it is still trust, right?

Client: Yeah

Therapist: ok, so we're just looking at this from a different perspective. When you were a child you learned that you couldn't trust people because of the way you were treated. So now we are just looking at how maybe that's not 100% accurate in your current life, right?

Client: Yeah

Therapist: So we aren't saying it's absolutely not accurate, but now we do have examples that show that it's not 100% accurate, right?

Client: Yeah

Therapist: What are your thoughts on that?

Client: That's true

Therapist: Alright, so we're gonna keep working with these schemas because they keep coming up.

^d Note: name has been changed for confidentiality.

Client: Ok

Therapist: Ok, so what's gonna happen is I'm gonna type the exposure part up and bring it to you, and I want you to read it twice a day until the next session, since you can't have the recorder in your room. Questions or concerns about that?

Client: No, I'll read it. It will probably get boring after a while, but I'll do it

Therapist: Ok then I will get that to you as soon as I can by the end of today

Client: Ok.