Using Cognitive Processing Therapy in a Correctional Setting

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

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April 2016

EST Case Study Approval
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April 2016

I hereby recommend that the EST prepared under my supervision by

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Entitled

Using Cognitive Processing Therapy in a Correctional Setting

be accepted in partial fulfillment for the

MASTER OF ARTS DEGREE

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Theoretical Foundation

Many people who experience a traumatic event also experience some Posttraumatic Stress Disorder (PTSD) symptoms after the trauma; therefore, this response is considered normal (Resick, Monson, & Chard, 2008b). The difference with individuals who develop clinical levels of PTSD is that they have been unsuccessful in their attempts to incorporate the trauma event into their previously held belief systems.

Two main theories explain the maintenance of PTSD symptoms and later spurred the use of techniques to help the client process the trauma in a more adaptive way: emotional processing theory and social cognitive theory (Resick et al., 2008b). Emotional processing theory suggests that PTSD symptoms develop after a trauma through the development of a "fear network." During the trauma, there are multiple stimuli present that become associated with danger through conditioning (Foa, Steketee, & Rothbaum, 1989). For example, an individual who is attacked by a male at night might associate night with danger. The original stimuli present during the trauma become easily generalizable in this fear network to include a wide range of internal and external cues that elicit a fear response and arousal (Foa et al., 1989; Resick et al., 2008b). In addition to the dark, the individual may have first associated the perpetrator with danger but then generalize this fear to all men, which elicits a fear response each time they come in contact with a man.

The arousal associated with the fear network is often distressing for the individual as are reminders of the trauma, and so avoidance is often used by these individuals to decrease their discomfort. However, the avoidance only maintains the PTSD symptoms as it does not allow the individual to learn that these stimuli are not dangerous. In order to change this fear network, exposure is implemented in a safe environment to allow for habituation. It is important that the client activate the fear network with as many trauma cues as possible; therefore, clients are asked

not to avoid situations or memories to allow for learning. In Cognitive Processing Therapy (CPT), exposure is conducted with the written account of the trauma. While exposure has been found to change some cognitions about the trauma or symptoms, such as probability estimates of situations being dangerous, there may be other interpretations of the trauma that are not easily changed with exposure. Therefore, social cognitive theory is also utilized by CPT.

Social cognitive theory postulates that individuals attempt to understand and explain their trauma in an attempt to take control of the memory (Resick et al., 2008b). In order to understand the trauma, people tend to incorporate the trauma into their previously held beliefs, or schemas. Resick et al. (2008b) explain that there are three main ways that people try to interpret the trauma: assimilation, accommodation, and over-accommodation. Assimilation is when the individual alters the trauma memory to fit their prior beliefs. Accommodation is the slight altering of a belief in order to fit the information gained in the trauma. Lastly, there is over-accommodation, which is altering a previous belief in an extreme manner. The most adaptive of these cognitive techniques is accommodation since it allows the individual to incorporate the trauma into their beliefs without extreme changes in those beliefs and associated cognitions. Assimilation and over-accommodation are associated with cognitive distortions that bring about "manufactured emotions" such as guilt, shame, and anger towards the self. Manufactured emotions are a result of the interpretation of the trauma rather than a direct reaction to the trauma such as fear; thus, they become an additional layer to work through before the individual is able to process the primary emotions often experienced in times of danger (anger, sadness, fear).

After a trauma, the individual attempts to understand the trauma in order to incorporate it into previous belief systems about themselves and the world (Resick et al., 2008b). However, the use of assimilation and over-accommodation techniques lead to distress which means that the

trauma is an unresolved issue. It is thought, then, that the individual will experience symptoms such as intrusive thoughts, nightmares, and flashbacks as they attempt to incorporate the trauma experience in a more adaptive way. Therefore, as interpretations of the trauma are an important aspect of PTSD, CPT emphasizes challenging the cognitive distortions that have developed in order to work towards accommodation of the trauma. Challenging beliefs is also thought to help with the distressing emotions often experienced in PTSD such as guilt and anger because the manufactured emotions are associated with the cognitive distortions. By challenging the thoughts, it is proposed that the manufactured emotions decrease as do the intrusive thoughts/images that often accompany them, thereby decreasing the distress of the trauma memories.

Empirical Support

CPT

Cognitive Processing Therapy was first developed for use with rape victims (Resick et al., 2008b); however, its efficacy has also been widely studied with military Veterans. When compared to wait-list groups, CPT has been shown to significantly reduce PTSD symptoms (Monson et al., 2006; Resick, Nishith, Weaver, Astin, & Feuer, 2002; Resick & Schnicke, 1992) as well as comorbid symptoms such as depression, general anxiety, affective functioning, distress from guilt, and social adjustment (Monson et al., 2006). Monson and colleagues (2006) suggest that there may be some differences in what types of symptoms are significantly reduced by CPT. In particular, they found that re-experiencing and emotional numbing symptoms, such as difficulty describing emotions and fear of expressing emotions, improved but that behavioral avoidance and hyperarousal symptoms did not change significantly compared to the waitlist group. Insignificant changes in avoidance and hyperarousal may be because of the shortened

exposure component associated with CPT such that the trauma account is generally given verbally twice in session and is assigned for homework for two weeks. The shortened exposure in CPT is in contrast to other PTSD treatments such as Prolonged Exposure (PE) where exposure is a main component of treatment and repeated many times. However, it has been suggested that CPT is better able to make guilt cognitions less distressing because it works on challenging those maladaptive cognitions. Meta-analysis comparison of CPT to wait-list condition over 4 studies show a large mean effect size (d=1.79) for CPT in the treatment of PTSD symptoms (Lenz, Bruijn, Serman, & Bailey, 2014).

CPT has also been compared to other forms of treatment. Forbes et al. (2012) compared CPT to treatment as usual (TAU) in Australian Veterans receiving care at a Veteran clinical treatment setting. TAU in this study was dependent on the therapist's orientation and included supportive counseling, non-trauma symptom management, or CBT in which some utilized exposure and others did not. Results showed that both TAU and CPT resulted in significant improvement in self and clinician reported PTSD symptoms. However, CPT had significantly larger improvements than TAU. Forbes et al. (2012) suggested that this finding may be due to clients greater engagement in the trauma memory and processing of emotions in CPT compared to other treatments. They also found moderate to large effect sizes on symptoms of depression, anxiety, anger, and physical, psychological, and social quality of life at post-treatment. CPT has also been compared to PE with contradictory results. Jeffreys et al. (2014) found that both CPT and PE resulted in a significant decrease in self-reported PTSD symptoms; however, PE reduced symptoms significantly more than CPT. In comparison, Resick et al. (2002) compared CPT to both PE and a wait-list condition. Their study found that both PE and CPT showed significant decreases in PTSD scores compared to the wait-list, with no significant difference between the

CPT and PE conditions. On further analysis, it was shown that CPT and PE were similar in regard to global guilt and wrongdoing scores but that CPT was superior at lowering hindsight bias and lack of justification scores. General statements of guilt or being at blame for the trauma are suggested to be more easily addressed with exposure while guilt based on interpretation of the guilt, such as hindsight bias and lack of justification may need further attention in order to cognitively restructure. Therefore, CPT was thought to more thoroughly address guilt stemming from interpretation because it addresses maladaptive interpretations of the trauma in the treatment. At 9-month follow up, both PE and CPT were comparable on the amount of participants whose symptoms remained below clinical significance (64% for CPT and 68% for PE). Lastly, a meta-analysis compared CPT to alternative treatments (PE, TAU, trauma-focused therapy, supportive counseling, and present centered therapy) in 6 studies in which CPT was shown to have a medium treatment effect size (d=.62) for PTSD symptoms (Lenz et al., 2014).

Many of the previous studies have conducted CPT with either military Veterans or adult rape victims. However, CPT has also been shown to work with other trauma histories as well. Chard (2005) compared CPT to a wait-list condition in women with a history of childhood sexual assault. Post-treatment analysis indicated that CPT treatment led to reduced PTSD, depression, and disassociation symptoms which were maintained at 1-year follow-up. Similar results were found in a single case of trauma from an anti-gay assault (Kaysen, Lostutter, & Goines, 2005), a motor vehicle accident (Galovski & Resick, 2008), and with an analysis of 53 refugees (Schulz, Resick, Huber, & Griffin, 2006). Effect sizes with refugee participants were also comparable to previous findings in which CPT resulted in large pre- to post-treatment effect sizes (Hodge's g=2.6). While CPT has been shown to be effective with various trauma histories,

it has yet to be explored in cases in which PTSD has resulted from a crime committed by the client. The present case study will explore this particular trauma type.

Only one published study was found that conducted CPT with incarcerated, male participants. Ahrens and Rexford (2002) randomized incarcerated male juvenile offenders to group CPT or to a wait-list control. Results indicated that CPT significantly decreased self-reported PTSD and depression symptoms on a four weeks post-treatment measure. Since Ahrens and Rexford's study utilized an adolescent population, it suggests that CPT may be successfully implemented within an incarcerated setting. In the setting of this case study, clients are living in a treatment unit within the correctional facility. Because this site closely resembles a residential setting, it is important to also consider CPT outcomes within this context. Studies that tested CPT in residential programs have shown that participants show a significant reduction in PTSD symptoms after CPT treatment (Alvarez et al., 2011; Voelkel, Pukay-Martin, Walter, & Chard, 2015; Zappert & Westrup, 2008). When CPT was compared to a previous trauma focused treatment, those that participated in CPT had significantly greater improvements in not only PTSD symptoms, but in coping, psychological distress, and quality of life symptoms (Alvarez et al., 2011).

At the beginning of the present case study, the use of exposure therapy was prohibited by the correctional site due to several concerns. Some of the most pressing concerns were the limited environment in which to conduct in-vivo exposures and correctional staff's concern about safety. Concern was raised about possible re-experiencing and arousal symptoms that may increase between sessions after exposures were conducted. Therefore, the clinician initially started treatment without using the Written Account (WA) of the trauma, which is the short exposure component of CPT. Resick et al. (2008b) noted in the CPT manual that treatment can

be conducted without the WA, but instead focus on cognitive components only (CPT-C). Some studies have demonstrated CPT-C can be just as effective as CPT at reducing PTSD and associated symptoms (Resick et al., 2008a; Walter, Dickstein, Barnes, & Chard, 2014), and may be more effective than the WA component alone (Resick et al., 2008a). Schumm, Dickstein, Walter, Owens, and Chard (2015) also argue that CPT results in reductions in self-blame and negative beliefs about self that typically precede PTSD symptoms. The fact that the cognitive component remains unchanged in the CPT-C version may explain why CPT-C is as effective as CPT. However, after seven sessions, the correctional site approved the exposure component. Even though there were concerns about an increase in psychotic symptoms or a decrease in functioning, initial research using exposure treatment with psychotic individuals does not support this idea (de Bont, Minnen, Jongh, 2013; Frueh et al., 2009). In fact, researchers found that general mental health symptoms, including psychotic symptoms, decreased and social relationships improved along with the targeted PTSD symptoms. A review from Grubaugh et al. (2011) corroborates these findings suggesting that CBT is appropriate for this population. With site approval, the exposure component was integrated into treatment; however, it was done so at a later point than is regular per protocol.

Overall, CPT has been shown to be more effective in reducing PTSD symptoms than wait-list and TAU. It is also comparable to PE treatments. CPT was chosen over PE for the present case study in part due to initial setting restraints in the current case study such as initially not being able to utilize exposure. CPT has also shown potential for significant improvement in PTSD symptoms that are comparable to other leading PTSD treatments. Other considerations for CPT included research showing its effectiveness in residential settings and the fact that CPT-C is similar to the full CPT protocol. The evidence that CPT-C and CPT are comparable was

also considered when the exposure component was integrated into treatment, as outcomes were not expected to drastically differ with the addition of exposure.

Presenting Problem and Relevant History

Demographics

Mr. Brown is a 37 year-old, Caucasian male who has never been married and has no children. Currently, Mr. Brown resides in a Midwestern correctional institution after convictions for aggravated arson with substantial risk of bodily harm, aggravated indecent liberties with a child under 14 with lewd fondling/touching, and rape from sexual intercourse with a child under the age of 14. He has been placed in a specialized unit for inmates with mental disorders who cannot effectively function within the general population. In this unit, clients are engaged in multiple programs including psychological group treatment and activity therapy, as well as more individualized sessions once a month with a primary clinician. Mr. Brown was involved in a restrictive housing group, was given pharmacological intervention for physical and mental health needs, and met with his primary clinician once a month to assess current functioning, address behavioral concerns, and problem solve current mental health needs, along with participating in individual CPT bi-weekly. He reported that he is restricted from holding a job because he is living on a voluntary Restrictive Housing (RH) status.

Mr. Brown has current diagnoses of PTSD (primary), Pedophilia, Schizoaffective Disorder (Depressive Type), and Borderline Personality Disorder (BPD). Formal assessments were done in 1997 (approximately 20 years ago) during his intake to the correctional site. At that time, he was given the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), Millon Clinical Multiaxial Inventory (MCMI), and Brief Psychiatric Rating Scale (BPRS) as well as interviewed by psychiatric staff. Mr. Brown was also assessed for cognitive functioning using a

brief IQ measure. Results indicate Mr. Brown's Full Scale Intellectual Quotient of 72, which suggests borderline intellectual functioning. Mr. Brown currently takes multiple medications for his mental health problems. These medications include: Depakote as a mood stabilizer, Zyprexa (atypical antipsychotic) for hallucinations, Levothyroxine for hypothyroidism, Paxil (antidepressant), and Fluphenazine Decanoate injection for chronic schizophrenia as maintenance.

Mr. Brown reported that he received treatment prior to incarceration. The first outpatient treatment occurred in 1995 for one year when he discussed trauma he experienced from a fire. He was hospitalized in 1996 for trauma symptoms he was experiencing and received medication and group therapy for trauma symptoms. The hospitalization was documented in a 1997 intake report as lasting for 14 days for "evaluation after sentencing for current offense." Mr. Brown also expressed a history of self-harm and suicidal ideation during incarceration and three placements on suicide watch within the correctional facility. The first self-harm occurred in May 2015 and included cutting with a razor which Mr. Brown reported was from an increase in hallucinations and being unable to handle them. His next placement on suicide watch was when Mr. Brown reported suicidal ideation to the officers. He reported that he was experiencing an increase in both PTSD and psychotic symptoms and was wanting to transfer to the state hospital. Mr. Brown stated at assessment that he has had thoughts of "not wanting to continue living" in the past but that he was not experiencing suicidal ideation at that time.

Prior to incarceration, Mr. Brown was living with his parents and sister. His family was described as middle class and his father's occupation is a preacher. During his school years, Mr. Brown stated that he got into physical fights "all the time" with other students because they made fun of him. These altercations led to his being expelled from at least two different schools. The

last grade Mr. Brown completed was 11th grade and he has not earned his GED. Altercations were also noted within the family, such as when Mr. Brown described hitting his mom and sister. Mr. Brown had not been diagnosed with any mental illness before incarceration, but there were some indicators that he may have been experiencing psychotic symptoms. Indicators included Mr. Brown calling the police to tell them he would kill them, stating he was possessed by Satan, and thinking that others were "out to make fun of him." Since incarceration, Mr. Brown has also had altercations with staff and inmates including fighting, battery, threatening, theft, disruptive behaviors, and breaking correctional rules.

Presenting Problem.

Mr. Brown was referred for individual therapy in order to receive additional services that he was not able to take advantage of while in RH. For example, Mr. Brown was unable to attend groups because his activity is restricted on RH status. He reported difficulties with flashbacks about a fire that he was involved in (see Result and Interpretation section) which consisted of being able to hear the fire and screams of his friend, smelling the fire, and seeing the "roof coming in." He also explained that he was having auditory hallucinations such as hearing whispers that tell him he is a bad person. He stated he wanted help to decrease these symptoms. Mental health and correctional staff also had concerns that Mr. Brown may have an anxiety disorder that was interfering with his participation within the unit, such as leaving his voluntary RH status. Concerns were raised as Mr. Brown had voluntarily placed himself in RH due to expressed safety concerns and was having difficulty participating on his own in order to receive more benefits such as participation in groups or increased interactions with others. Mr. Brown had expressed several times that he wanted to be out of his cell more and did not think that he was getting the help or involvement with programming that he needed; however, involvement is

limited in RH status. It was determined that Mr. Brown could benefit from having a more current assessment to determine his present needs.

Behavioral Observation.

The diagnostic interview was conducted over 4 sessions, one hour each. Mr. Brown would ask to be sent back to his cell around lunch, which occurred an hour after he was escorted by Correctional Officers, thus extending assessment time. Two out of four sessions, Mr. Brown had trouble concentrating as evidenced by his asking for questions to be repeated or taking long pauses before responding. Concentration difficulties resulted in Mr. Brown and the clinician getting through less material than in the other two sessions. Difficulty in concentration was also particularly pronounced when discussing PTSD symptoms.

Throughout the assessment process, Mr. Brown was noted as having a flat affect. When discussing waking up from nightmares, having hallucinations, or experiencing vivid flashbacks, Mr. Brown expressed no visual signs of distress. Even when distress was observed through concentration difficulties as noted above, Mr. Brown's affect remained flat.

It is possible that Mr. Brown may have been overreporting symptoms. For example, Mr. Brown told the clinician that he was coughing up blood three times a day. However, when nursing followed-up with him, he stated that he hadn't coughed up blood in three days and he wasn't currently experiencing it. There were no further reports of these symptoms. When describing his symptoms, Mr. Brown also tended to consistently reply "very distressing" when clinical judgment identified the distress at lower levels. One example is when he discussed how small situations produce uncontrollable worry throughout the day. Mr. Brown stated that he often worried about "forgetting his lunch" on his "bean hole" which would then be cleared off by the correctional officers. Worry was described as "very distressing" but when asked why, he

simply stated that he "would be hungry." It was also noted by staff that he usually has access to canteen food items kept in his cell. He also stated that he "bangs [his] head against [his] cell wall" several times a week when the "voices get bad" but has no physical markers of this behavior and reported that it does not result in any type of damage. Mr. Brown also consistently asked about being transferred to an inpatient hospitalization setting for offenders at almost every session. He suggested that this transfer would be beneficial because it would allow him greater mobility, access to more programming, and closer proximity to his parents, which may be a potential benefit of Mr. Brown overreporting symptoms.

Assessment

Anxiety and Related Disorders Interview Schedule for DSM-5: Lifetime Version (ADIS-5)

The ADIS is a structured interview that assesses DSM-5 criteria for anxiety, mood, obsessive-compulsive, trauma, and other related disorders (Brown & Barlow, 2014). Both current and lifetime prevalence of these symptoms is assessed in the lifetime version of the ADIS. Symptoms are rated on a scale of 0-8 (0 = no distress/impairment and 8 = extreme distress/impairment) where a rating of 4 or above indicates clinical cutoff for symptoms and overall distress or impairment for specified disorders. At the end of the interview, the ADIS also provides screener questions for disorders such as ADHD, eating disorders, and psychosis. Overall, the ADIS is considered to have good to excellent interrater reliability (kappa .67-.86) (Brown & Barlow, 2014; Brown, Di Nardo, Lehman, & Campbell, 2001) and good reliability based on previous versions of the assessment. No current studies have assessed the DSM-5 version of the ADIS, but it is reasonable to assume that reliabilities are similar. Studies evaluating the PTSD section have found conflicting results. The PTSD section of the original ADIS was found to have excellent sensitivity (1.0) and specificity (.91); however more recent

versions have found it to be less stable with lower interrater rates (Keane & Barlow, 2002) such as an interrater reliability of .59 when looking at either principal or concurrent diagnosis (Brown et al., 2001). Brown et al. (2001) also found that disagreements between assessors in the PTSD section were due to differences in client report.

On the ADIS-5, Mr. Brown reported worry about his health and the health of others. In particular, Mr. Brown stated that he worried about his family getting in an accident or getting a terminal illness and he would not be able to be there to "take care of them." He was also worried about contracting a terminal illness himself, especially cancer. Mr. Brown noted that cancer runs in his family and he believes he is susceptible to the diagnosis. His worry was due to situational factors such as being incarcerated. Mr. Brown also noted that his worry will likely lessen when he is released from prison because he will be with his family and he knows that they "will be right back."

Mr. Brown explained that he has been involved in several traumatic events in his lifetime. The worst trauma was a house fire he was involved that occurred in 1995. He reported his friend started the fire while he, the friend, and the friend's parents were inside. Mr. Brown stated that he believed the friend was suicidal around the time of the fire and was talking about his adoptive parents not loving him. The fire was considered by Mr. Brown to be a possible murder-suicide on the part of his friend. This fire resulted in his friend's death, but he and the friend's parents were able to escape. Mr. Brown described seeing his friend running upstairs while the house was on fire while telling Mr. Brown to get out of the house. Mr. Brown listened to his friend and left the house and later realized that his friend had not survived. He described listening to and seeing the friend's mother's distress upon learning that her son was not outside with them and trying to comfort her in the back of an ambulance on the way to the hospital. He explained he sustained a

concussion from falling down the stairs due to what he referred to as a "backdraft" and was close to death from smoke inhalation. He also stated that the friend's parents had been badly burned and sent to the hospital. Mr. Brown explained that this fire was the worst trauma he experienced, which produces the most symptoms. While the fire has been corroborated from correctional files, it should be noted that Mr. Brown was convicted of setting the fire. This is consistent with the intake report in 1997 that states his refusal to take responsibility for the crime. Mr. Brown admitted that the fire incident is what led to his imprisonment, but continues to express his innocence.

Symptoms experienced since the fire include flashbacks, nightmares, and intrusive thoughts. Mr. Brown explained that he experiences flashbacks of being in the fire where he can see and smell the fire and hear the crackle of flames and the screams of his friend. He described having nightmares that awaken him. Mr. Brown reported that he tries to avoid the memories or thoughts of the fire; for example, changing the channel on the television when he sees a fire since this is a cue for intrusive memories or flashbacks. As noted previously, Mr. Brown has also described problems with concentration and self-destructive behavior that prohibit him from functioning normally. He explained that he has negative self-talk such as "I am a failure" or "I'm a nobody" and suffers from flashbacks and hallucinations more often at night when it is quiet.

Mr. Brown also reported several other traumas. He reported that he has been sexually assaulted multiple times during incarceration. Mr. Brown described one of these as a gang rape, which occurred in 1997 by what he believed to be three men. He stated that he wasn't awake during the incident as he was knocked out, but that he woke up with anal bleeding and realized he had been sexually assaulted. Mr. Brown noted that this incident resulted in his developing

hemorrhoids, which is consistent with current medical charts. He also reported that he was sexually abused by a babysitter when he was 9-10 years old. Mr. Brown mentioned that distressing memories of the sexual assaults arise when the hemorrhoids flare up. In addition, he reported living through a tornado when he was young and witnessed the devastation afterwards, including seeing dead bodies. Mr. Brown could not recall exactly when this event occurred but stated he thought it might have been around 1991. He explained that he sometimes sees images from this event in his nightmares.

Mr. Brown expressed that he experiences psychotic symptoms, which often co-occur with his PTSD symptoms. He stated that he sees faces in the mirror that he described as being half skull and half-rotting flesh, a demon, which he referred to as the "Great Shalock," and a "second me." At times, these visual hallucinations are also accompanied by auditory hallucinations. Mr. Brown explained that the "second me" tells him that he is a bad person and he sometimes hears whispers that also say bad things about him. He reported that in the past the whispers have been commanding, for example, telling him to "take vengeance on the judge and prosecutor." However, Mr. Brown denied that the auditory hallucinations are currently commanding. He also described times when he felt like the demon was trying to enter into his body, such as "right before the fire" and times when he feels like he is "in another person's body and being controlled by them." Both are consistent with bizarre delusions. When discussing places that he may avoid, Mr. Brown described disliking parking lots or stores, as he was afraid someone might attack him or that others would be talking about him, which is consistent with paranoid thinking. Mr. Brown explained that the hallucinations and delusions began before his crime of arson, when he was approximately 15 years old.

Mr. Brown also described experiencing depressed mood, such as being sad or down most of the time. He stated that he often sleeps most of the day and has trouble getting out of bed. Mr. Brown explained that he is late to meetings with other correction staff or does not attend sessions due to inability to get out of bed. He noted that the depressed feelings are worse at night due to being alone and experiencing worse PTSD and psychotic symptoms. Mr. Brown explained that he has consistently experienced these symptoms after the fire for 2 months or more.

PCL-5

The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) was utilized to monitor treatment as suggested by Resick et al. (2008b) in the CPT manual. The PCL-5 is the newest version of the PCL that was updated to include DSM-5 diagnostic symptoms utilizing 20 self-report items which asks clients to rate how much they are bothered by each symptoms (0 = not at all to 4 = extremely). Scores on the PCL-5 can range from 0-80 with higher scores indicating higher symptom severity. Bovin et al. (2015) indicate that a PCL-5 total score between 31 and 33 had highest diagnostic utility for clinical presence of PTSD. However, a more stringent cutoff of 38 is suggested (Weathers et al., 2013) until further psychometric studies are available since prior research suggests that cutoff rates may differ (Blanchard et al., 1996; Grubaugh et al., 2007; Yeager, Magruder, Knapp, Nicholas, & Frueh, 2007) depending on the population and what the screening goal is (Wilkins, Lang, & Norman, 2011). The PCL-5 can also be used to measure change in symptoms across time. Weathers et al. (2013) suggest that for previous versions a 5-10 point change suggests reliable change while 10-15 point change indicated clinically significant change, and the minimum 5-10 point change should be used for the PCL-5.

Only a few studies are available on the psychometric properties of the PCL-5 since it was recently updated. These studies indicate excellent internal consistency (.95-.96) (Blevins, Weathers, Davis, Witte, & Domino, 2015; Bovin et al., 2015; Wortmann et al., 2016) and test-retest reliability ranging from .82-.84 (Blevins et al., 2015; Bovin et al., 2015). It also shows excellent convergent validity with the PCL, civilian and specific stressor versions (r= .85-.87) (Blevins et al., 2015; Bovin et al., 2015; Wortmann et al., 2016). In addition, internal consistency and test-retest reliability is consistent with psychometric properties of previous versions of PCL as well. The PCL-5 was highly correlated with other PTSD symptom scales (.68-.85), depression (.64-.74), anxiety (.61-.67), WHODAS (.68), somatoform (.53), and panic (.50) symptom scales. Convergent scores were not surprising given that PTSD symptoms have similarities with anxiety and depression disorders. Past versions of the PCL have also demonstrated a strong correlation with the Clinical-Administered PTSD Scale (CAPS) (Grubaugh Elhai, Cusack, Wells, & Frueh, 2007; Monson et al., 2008) with Pearson's correlate of .93 (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). Divergent validity was shown by weaker associations with alcohol abuse (.10-.14) and psychopathy (.08) symptom scales (Bovin et al., 2015).

Initial findings for the use of the PCL-5 indicate its use in evaluating PTSD symptom change during treatment. Ability of PCL-5 to measure symptom change is shown to be comparable to PTSD Symptoms Scale, Interview (Wortmann et al., 2016) if not more conservative. Previous versions of PCL were also compared to CAPS. Monson et al. (2008) found that participants self-reported more gains with PCL than clinician administered CAPS. However, Forbes, Creamer, and Biddle (2001) indicate that participants are more likely to rate

their symptoms as more severe than clinicians would. Overall, findings indicate that PCL-5 is one tool clinicians can use to measure symptom change.

At the beginning of treatment, Mr. Brown completed the PCL-5. His total score of 57 is above the suggested cutoff of 38 and suggests that he is experiencing symptoms of PTSD and distress at a clinical level. Mr. Brown's self-report was that he was experiencing nightmares, flashbacks, intrusive thoughts, avoidance, strong negative beliefs about himself, others, and the world, and hyperarousal as "quite a bit" or "extremely" distressing. He also reported that he was moderately distressed about having a loss of interest in activities that he used to enjoy.

Calgary Depression Scale (CDS)

The Calgary Depression Scale (CDS) is a semi-structured interview used to assess depression in schizophrenia (Addington, Addington, & Maticka-Tyndale, 1993). It was developed as a way to differentiate depressive and schizophrenia symptoms such as positive and negative symptoms as well as medication side effects. Differentiating depression and schizophrenic symptoms was particularly beneficial for because Mr. Brown because he was presenting with current psychotic symptoms, including hallucinations and possible side effects of medical treatment such as flattened affect. The CDS is a 9-item measure that assesses depressed mood, hopelessness, references of guilt, and suicidality. Clinicians rate client symptom responses on a 4 point Likert scale (0= none to 3= severe). Scores can range from 0-27 with a score of 6 or above suggesting depression (Addington et al., 1993; Muller et al., 2005), and has shown 82% specificity and 85% sensitivity in predicting these symptoms (Addington et al., 1993).

Evaluation of CDS psychometric properties in participants diagnosed with schizophrenia suggests it is psychometrically sound. Interrater reliability ranges from .87-.90 (Addington,

Addington, & Atkinson, 1996; Muller et al., 2005; Muller, Muller, & Fellgiebel, 2006) and internal consistency Cronbach's alpha ranges between .76-.83 (Muller et al., 2005; Schennach et al., 2012). Convergent validity was assessed by comparing CDS to frequently used depression measures such as the Hamilton Depression Rating Scale (*r* .68-.83), Burns Depression Inventory (*r* .83), and Positive and Negative Symptoms Scale (PANSS)- Depression subscale (*r* .26-.78) (Kim et al., 2006; Kontaxakis et al., 2000; El Yazaji et al., 2002) and DSM diagnostic criteria (*r* .64-.94) (Addington et al., 1993; Kim et al., 2006). Discriminant validity was shown when CDS total scores were not significantly correlated with PANSS positive (-.09 to .11), PANSS negative scales (-.2-.08) (Addington et al., 1996; Kim et al., 2006; El Yazaji et al., 2002), or extrapyramidal scales such as the Extrapyramidal Symptom Rating Scale (*r* .23) (Collins et al., 1996) or SARS (*r* .07) (Kim et al., 2006). Overall, studies show the CDS is able to differentiate depressive symptoms from schizophrenia symptoms and medication side effects more effectively than other depression measures.

At the beginning of treatment, Mr. Brown completed the CDS. His total score of 6 suggested that Mr. Brown was experiencing mild depressive symptoms. During the interview, Mr. Brown explained that he tends to sleep most of the day and sometimes finds it hard to get up in order to attend sessions. He reported depressed mood for most of the day, nearly every day of the week as well as feeling physically exhausted. He also stated having mild feelings of hopelessness.

WHODAS 2.0

The World Health Organizations Disability Assessment Schedule 2.0 was developed to assess an individual's level of functioning in six different domains (Ustun, Kostanjsek, Chatterji, & Rehm, 2010). These domains include: cognition, mobility, self-care, getting along, life

activities such as work, school, and domestic responsibilities, and participation. The WHODAS has been studied in a variety of cultural settings, with both physical and mental disorders, and can be used to assess functional impairments that may arise from mental health disorders. Each item is rated by the client on a scale from 0-4 (0= no problem to 4= extreme problems). The complex scoring method will be utilized over the simple scoring method as it allows for comparison of functioning with a normed group. Therefore, scores range from 0-100 with higher scores indicating lower functioning ability or greater disability.

Overall, the WHODAS been demonstrated to be a reliable and valid measure of functioning and disability (Federici, Meloni, & Lo Presti, 2009; Ustun et al., 2010). The overall scale has demonstrated good internal consistency (α .92-.97) for all disabilities (Noonan, Kopec, Noreau, Singer, & Dvorak, 2009; Ustun et al., 2010) and for participants with mental health disabilities (α= .98) along with the domains for mental health (α .92-.94) (Ustun et al., 2010). Test-retest reliability has been reported at .98 for the overall score and .93-.96 within the domains (Ustun et al., 2010). The WHODAS also has correlated with other measures of functioning and disability such as measures of depression (HAM-D *r* .33-.52 for domains), psychotic symptoms (PANSS *r* .37-.52 for domains), quality of life, sleep disorders, and anxiety disorders (Federici et al., 2009; Guilera et al., 2012). The WHODAS also demonstrated discriminant validity such as with studies indicating that individuals with mental health problems had significantly higher scores on the WHODAS than those without mental disorders (Collings, 2005). The WHODAS has also demonstrated sensitivity to identify change in functioning over time (Ustun et al., 2010) as comparable to the Short Form 36- Health Survey (Federici et al., 2009) and other social functioning measures (Ustun et al., 2010). However, concern has been noted that clients with schizophrenic spectrum disorders may not have adequate insight to their

functioning or problem areas to provide adequate determinants (Chopra, Couper, & Herrman, 2004; Guilera et al., 2012). Therefore, the interviewer-administered version of the WHODAS was used with Mr. Brown.

Mr. Brown was given the WHODAS at the beginning of treatment. His total disability score with complex score calculation was 20.31%. In particular, Mr. Brown believes that he has difficulties in areas of cognition (50% disability) and participation (71.88% disability). He stated that he has trouble concentrating, forgets what people have said to him and experiences faulty processing of information. The major area that he identified having trouble with interpersonal interactions. Low social functioning was evident in the corrections unit as he has voluntarily placed himself in segregation and does not participate in mental health groups or yard time. Mr. Brown indicated a desire to get involved in more mental health programming.

DSM-5 Diagnoses

Summary of Findings

Mr. Brown was referred for additional services in response to continued voluntary RH status and anxiety related to interacting with others on the unit. The ADIS interview was administered to assess psychiatric concerns, including PTSD and anxiety. Mr. Brown presented with hallucinations and flashbacks of a fire that he was involved in as a teenager in 1995. He described reliving the fire, avoiding reminders of the fire, experiencing difficulties concentrating, and having nightmares about the fire. These symptoms began after the fire and were described as distressing. Mr. Brown was also given the PCL-5 which indicated that he is experiencing PTSD symptomology above the clinical cutoff. Therefore, he meets diagnostic criteria for PTSD.

Throughout the interview, Mr. Brown also described symptoms consistent with a psychotic disorder. Mr. Brown stated that he has both auditory and visual hallucinations that consist of seeing a demon that throws fire at him, seeing faces, and hearing whispers or voices. Mr. Brown also explained that there have been times when he thought that the demon was trying to enter his body or felt like he was "in another person's body and being controlled by them," which is consistent with delusions. Mr. Brown may also evidence paranoia since he has experienced continued discomfort around others and fear that they would hurt him. These symptoms reportedly began around the age of 15 before the traumatic fire and depressive symptoms. Review of past intake reports suggest that Mr. Brown has not always experienced psychotic symptoms as evidenced by an absence of psychotic concerns or diagnosis. Therefore, a recurrent, currently acute episode specifier should be added for Mr. Brown.

Depressive symptoms were also noted by Mr. Brown such as feeling sad, sleeping for much of the day, feeling hopeless about the future, and feeling down about himself. Mr. Brown stated that the depressed mood started after the fire in 1995 and has remained incessant. Mr. Brown explained that the depressive symptoms get worse when he is experiencing hallucinations, nightmares, and flashbacks. Simultaneous symptom increases suggest that there may be some overlap in the depressive symptoms and comorbid disorders. However, he also expressed feeling down when considering his current situation including not being with his family, and thinking that others will always see him as a "monster." Mr. Brown's score on the CDS differentiated his depressive symptoms from psychotic symptoms at the beginning of treatment. Pervasive depressive symptoms present for more than two years are consistent with Persistent Depressive Disorder. However, because a psychotic disorder is present, a diagnosis of

PDD is being ruled out at this time per the DSM-5 requirement that limit diagnosis if symptoms are better explained by another disorder, in this case, Schizoaffective Disorder, Depressive Type.

Mr. Brown also expressed concerns about himself or his family getting a terminal illness, such as cancer, while he is incarcerated. He also dislikes being away from his family. Mr. Brown noted these concerns are real consequences of being incarcerated and having a family background of terminal cancer. However, Mr. Brown noted that he thinks these concerns would decrease after he is released from prison, as he would be able to be with his family at that time. Since concerns are related to his current situation and his expectation that these worries would discontinue outside of the current context, a diagnosis of GAD was not given.

*Note: The diagnoses given are consistent with previous assessments through the correctional site. Pedophilia criteria was not assessed through the ADIS nor is this diagnosis routinely assessed by mental health staff within this unit. There is a specialized treatment program within the facility that addresses sexual crime treatment and thus is not dealt with by the inmate's primary mental health staff. Personality disorders are also not assessed using the ADIS and were not a target for intervention since difficulties in this area would be targeted by another mental health group.

Diagnosis

309.81 Posttraumatic Stress Disorder (primary)

295.70 Schizoaffective Disorder, Depressive Type, multiple episodes, currently in acute episode

Recommendations

Since Mr. Brown's primary complaint were symptoms associated with PTSD, these symptoms were the primary focus of treatment. In addition, he was already being treated with

medication for Schizoaffective Disorder. Cognitive Processing Therapy was utilized as an evidenced based treatment for PTSD since the site did not initially allow exposure therapies. CPT was also considered for Mr. Brown due to potential similarities between offense-related PTSD and military-based PTSD for which CPT has been shown to be effective. During treatment, both psychotic and depressive symptoms were monitored. As these symptoms may interact with one another, the psychotic and depressive symptoms were monitored throughout treatment to see if they correlate with PTSD symptoms. In addition, the clinician monitored psychotic symptoms for any increases that may indicate the need to also treat the Schizoaffective Disorder.

Case Conceptualization

Several factors have likely influenced Mr. Brown's development of PTSD. Keane and Barlow (2002) suggest that there is a general biological vulnerability in individuals who develop anxiety related disorders, including PTSD. These individuals may be more reactive to emotional stressors than others and are more likely to reach an aroused anxiety state. Along with the biological vulnerability, there is also a psychological vulnerability that influences the development of PTSD. Generally, the psychological vulnerability is when the individual perceives events as being uncontrollable and unpredictable and thus more likely to reach a learned or actual fear state. Mr. Brown described being sexually abused as a child by a babysitter which could have resulted in a psychological vulnerability for him after this trauma occurred such as beliefs that "others will hurt me." This belief was strengthened after the traumatic fire with a reported belief that "I will be hurt again" if I get close to others. The previous abuse history could also influence higher reactivity to being hurt by others, such as experiencing higher arousal (anxiety or fear) when potential harm is perceived. Widom (2014)

suggests that early aversive experience can lead to development of maladaptive schemas about interacting with others, which could lead to an overreaction response when the individual perceives the situation as dangerous. Those maladaptive schemas may explain the aggressive reaction some have that lead them to commit crimes. Therefore, the maladaptive cognitions associated with the psychological vulnerability from past aversive experiences may help explain both the development of Mr. Brown's PTSD and aggression.

PTSD also requires a real stressor that initiates a fear response (Keane & Barlow, 2002). The real life stressor for Mr. Brown was the traumatic fire he was involved in about 20 years ago for which he was later convicted. Mr. Brown reported that this fire resulted in threat of potential death, medical treatment for severe symptoms due to smoke inhalation, witnessing his friend's death, and witnessing the distress of his friend's parents. The real life stressor of being in the fire with serious consequences resulted in a fear response, which has since generalized to a learned fear response to cues about the fire. Mr. Brown now reports distress when reminded about the fire. Such as seeing a fire on television. He then tries to avoid these reminders by turning off the television or changing the channel. By avoiding, Mr. Brown has not learned that the situation does not warrant a real fear response because it is a learned reaction to trauma cues. Another factor that contributes to maintenance of PTSD is the maladaptive cognitions that perpetuate avoidance and instigate manufactured emotions such as guilt and anger at self. Mr. Brown stated that after the fire, he has continued to have maladaptive cognitions such as "I am a monster," "I am a nobody," and "I will get hurt again" if in a relationship with others, which has led to social withdrawal. Mr. Brown also expressed a lot of guilt, which he described as "survivors guilt" over his friend's death. His thoughts around this include, "I should have saved him," "I should have known he was hurting that much," and "I should have talked with him about what was

going on." These thoughts have maintained the guilt and anger towards self, making it hard to accommodate the trauma and move on.

During the interview and treatment, Mr. Brown described his PTSD symptoms and psychotic symptoms as interacting with one another. Mr. Brown described times in which he would be reminded of the fire, become distressed, and then see faces or hear voices telling him that he was a bad person. Tarrier (2008) suggests that stress can increase or exacerbate psychotic symptoms. In this case, Mr. Brown's PTSD symptoms and the distress associated with trauma reminders act as a stressor which increase psychotic symptoms such as hallucinations. In the same way, maladaptive cognitions can also play a role in psychotic symptoms such as social isolation and even hallucinations. Mr. Brown reported hearing voices that would tell him that he was a bad person which parallels his maladaptive cognitions such as "I am a nobody." In these ways, PTSD symptoms can correlate with schizoaffective symptoms and therefore, attention should be given to the PTSD as well in order to help with treatment of schizoaffective disorder.

Treatment Goals and Plan

Problem 1: Experiencing PTSD symptoms related to fire, including avoidance, nightmares, intrusive thoughts, and negative emotions.

Goal: Decrease intensity and distress of symptoms

Objective 1: Mr. Brown will learn to identify thoughts and feelings associated with trauma reminders.

Objective 2: Mr. Brown will identify assimilation or over-accommodations in thoughts about the trauma with emphasis on beliefs about safety, trust, power/control, intimacy, and self-esteem related to self, others, and the world.

Objective 3: Mr. Brown will utilize challenging questions with distorted cognitions in order to achieve accommodation.

Problem 2: Difficulties interacting in the unit and being involved in unit programming

Goal: Increase participation in programing such as activity groups and mental health groups.

Objective 1: Mr. Brown will transfer to Treatment Status by stating willingness to become more involved in programming.

Objective 2: Mr. Brown will increase participation in activity and mental health groups.

Objective 3: Mr. Brown will increase interaction with general population such as going to yard outside the unit, going to pill line on his own, and going to lunch hall.

Course of Treatment

Treatment with Mr. Brown followed the Cognitive Processing Protocol. According to this protocol, after the client has been assessed and determined to have PTSD a review of the diagnosis should be given. During the review, psychoeducation is provided about symptoms and how symptoms are maintained in the context of the theory. As cognitions and emotions are a main component of this cognitive-behavioral treatment, the client is then asked to monitor their thoughts and emotions so that they can begin to identify how the two are related and how they are related to situations that arise in their everyday life. After the client is able to identify thoughts and emotions, the clinician begins to challenge thoughts to help the client think in

flexible ways and also as a way to monitor what the client will be asked to do later in treatment. The client is then asked to challenge his/her own thinking, identify problematic thinking patterns, and then devise alternative responses to the original belief based on the challenging questions he/she asked. Lastly, clients are asked to combine the components to identify belief changes in five core areas after the trauma: safety, trust, self-esteem, power/control, and intimacy. Clients are asked to identify beliefs before the trauma and changes to these beliefs after the trauma and then process thoughts that show assimilation or over-accommodation in order to get closer to the treatment goal of accommodation.

Treatment began with psychoeducation about PTSD. Psychoeducation included discussing symptoms of PTSD, which Mr. Brown reported he already understood from addressing it in past treatment. The clinician explained how cues from the trauma become conditioned and generalized to produce and maintain symptoms such as arousal and avoidance. The role of cognitions and emotions associated with such thoughts were also discussed along with how these emotions and cognitions maintain re-experiencing symptoms, nightmares, and negative affect. Since CPT posits that symptoms of PTSD are a normal response to trauma, clinically significant PTSD was explained as when an individual cannot process, or synthesize the trauma with their previously held beliefs. Inability to synthesize the trauma led to discussing treatment with a focus on how beliefs strengthened or changed after the trauma event and ways to move cognitions from assimilation and over-accommodation to accommodation. Mr. Brown struggled with identifying thoughts about the trauma that were associated with negative emotions he was feeling. He stated that he would try to think about the fire in a positive way such as saying, “there was nothing I could have done to stop him;” however, he did not readily identify maladaptive cognitions or thoughts associated with continued symptoms.

The next few sessions focused on helping Mr. Brown identify thoughts and emotions associated with trauma reminders as well as how antecedents, thoughts, and emotions are connected with one another. Identification of thoughts and emotions was done through discussion in session as well as with ABC (Activating Event, Beliefs/Stuck Point, Consequences/Feelings) worksheets. Mr. Brown was better able to identify his feelings compared to thoughts. The clinician often had to elicit thoughts during homework review and clarify deeper thoughts that were leading to his emotions. Mr. Brown was also asked to identify changes in beliefs around the trauma through writing and reading an "Impact Statement." The Impact Statement was used to identify maladaptive cognitions associated with the fire as they mapped onto assimilation, accommodation, and over-accommodation which provided cognitions to address later in treatment. Over-accommodation was noted when Mr. Brown provided statements such as "when I get close to others, I get hurt" and assimilation was noted with statements such as "I am a nobody" because I could not save my friend. Mr. Brown identified a lot of guilt over the trauma with thoughts such as "I should have known he was going to do something," "I should have stayed up to talk to him," and "I should have been able to save him." Maladaptive thoughts such as this then led to manufactured emotions for Mr. Brown, such as guilt and anger towards self. Natural emotions which had yet to be resolved included grief for having lost a close friend. He was asked to continue identifying the thoughts and emotions that were established patterns and distressing for him, otherwise known as "Stuck Points." Identification of these patterns were gathered through homework and discussion of the trauma.

Mr. Brown had expressed a need for more mental health programming which was paralleled by staff's encouragement to increase participation and functioning within the unit. Eventually the goal was to increase Mr. Brown's ability to function in the general population as a

way to transition to his life outside of the correctional system. His projected release date is just over two years away. To address both Mr. Brown's and staff concerns, Mr. Brown was placed on Treatment Unit Status (TUS) after four sessions of CPT, which involved Mr. Brown being able to leave segregation status and engage in mental health programing and yard time in the unit without having to engage with the general population such as going to the meal hall, pill line for medications, or living in a cell with others. His placement on TUS was also a way to encourage Mr. Brown to stop avoiding feared situations which were associated with both PTSD and psychotic symptoms. TUS would include gradual steps toward engagement with the unit and then with general population outside of the unit. Therefore, Mr. Brown assisted with developing a hierarchy to become more interpersonally involved. While Mr. Brown was on TUS and going through the transitions involved, he was asked to also identify thoughts and emotions about being on this status and about becoming more involved. He was asked to do these along with identifying thoughts and emotions associated with the trauma. Then Mr. Brown was moved off segregation status and into TUS, which meant that he could attend sessions without an officer escort or handcuffs and was able to go to yard on the unit. Mr. Brown stated that he was enjoying being able to socialize with others.

As work on identifying thoughts and feelings continued, the use of Socratic questions began in session to model flexible thinking and encourage Mr. Brown to use Challenging Questions with his own thoughts. Mr. Brown had explained several times in session that when he had thoughts that caused him distress, such as "I should have saved him" he then tried to change that thought to something such as "There's nothing more I could have done" or "It wasn't my fault." Mr. Brown stated that these were things he was taught in previous groups. However, Mr. Brown stated that he did not always believe those statements which may suggest why he was

still experiencing distress when he thought about the trauma. Mr. Brown also made multiple comments about trying not to think about the trauma at all, suggesting avoidance. Therefore, the Trauma Narrative which is a part of the CPT protocol to address avoidance of trauma memories was conducted. The Trauma Narrative also elicits distressing cognitions and associated emotions. For Mr. Brown, there was concern that he may experience an increase in symptoms that he would be unable to handle alone if he were to write the Trauma Account for homework, as is standard CPT protocol. Other security concerns were also expressed such that Mr. Brown may react aggressively or be unstable and thus need more diligent observation. Due to these concerns, the Trauma Narrative was conducted in session rather than assigned as homework.

At this point in treatment, Mr. Brown was verbally providing a Trauma Account at the beginning of session and would continue until distress levels begin to decrease from high to moderate levels. Mr. Brown was also introduced to the Challenging Questions and Problematic Thinking Patterns in an attempt to encourage more flexible thinking about the trauma event or symptoms. Mr. Brown had some challenges with understanding and applying the Challenging Questions as written in the CPT manual, which may be a result of lower intellectual functioning. Therefore, the questions were reworded to foster understanding and correct use of challenging questions. Rewording of questions was helpful as Mr. Brown was better able to complete the Challenging Questions worksheets for homework.

Mr. Brown had been doing well on the first step of TUS for two weeks, therefore he was encouraged to attend behavioral health or activity therapy groups. He stated that activity therapy groups would be easier to attend than behavioral health groups because there was less of a chance to be “called out” in front of the group. Therefore, activity groups were encouraged as his first step in attending groups. He was asked to complete the same worksheets being used in

the CPT treatment to identify his thoughts and feelings about attending group. He has provided multiple thoughts such as "someone will say something to me and I will snap" or "they will call me out and I will be pressured into giving personal information." Mr. Brown was encouraged to fill out the Challenging Questions worksheet around this but had not done so. Thus, the Challenging Questions worksheet was done in session to encourage him to think about alternative outcomes and benefits of attending group.

At this time, treatment continues. The plan is to further acclimate Mr. Brown to the Challenging Questions worksheet and then move on to using the Challenging Questions in order to generate alternative thoughts about given situations. Treatment will then move to address the five main areas of beliefs that include safety, power/control, trust, intimacy, and self-esteem and encourage accommodation of the trauma into previous belief system. Mr. Brown will also continue TUS with the short term goal at this time of being able to attend his activity therapy group.

Evaluation of Treatment

Over the course of treatment, Mr. Brown attended 16 and declined 12 sessions. At the beginning of treatment, Mr. Brown struggled with identifying cognitions and knowing how his thoughts were associated with PTSD symptoms. He did very well at recognizing the emotions he experienced, such as scared, guilty, and sad but was unsure of which thoughts were associated with those emotions. Therefore, the clinician asked questions to identify thoughts when Mr. Brown gave emotions to help him relate them to PTSD symptoms. Mr. Brown continued identifying the connection between thoughts and emotions by working on the ABC worksheets between sessions. He became better able to identify more thoughts such as "I should have saved him" or "I should have known that he was not ok that night."

Exposure was also conducted with Mr. Brown during the tenth treatment session. At the beginning of exposure therapy Mr. Brown talked about other topics before exposure as a way to delay exposure without providing a reason why. Mr. Brown was reminded of the reason to not avoid and he agreed to proceed with the exposure. Table 1 provides an overview of Mr. Brown's Subjective Units of Distress Scale (SUDS) scores over the exposures on a 1-10 scale (1=no distress; 10=worst distress).

Table 1

Ratings of Distress During Exposure Using the Subjective Units of Distress Scale (SUDS)

Distress Ratings During Exposure				
Exposure	SUDS			
	Before beginning exposure	Two time points during exposure		At the end of exposure
1	6	10	10	10
2	8	10	8	9
3	8	10	9	10
4	8	10	8	6

It was also noted that Mr. Brown's PCL-5 scores had begun to decline after start of exposure, from 52 to 45. The next increase in scores was due to a multitude of factors including the anniversary of the fire, Mr. Brown's frustration at not receiving a replacement radio or the medical attention he thought he needed, as well as a significant reduction in mental health care staff. During this time, Mr. Brown attempted suicide by hanging and was placed on a suicide watch for several days. Before this attempt, suicidal ideation was assessed with Mr. Brown stating that was not experiencing current suicidal ideation and was looking forward to releasing

and being with his family again. After the attempt, Mr. Brown identified that he believed the increase in symptoms was due to the anniversary and an increase in auditory hallucinations that were telling him to "go ahead and end it." He also explained that he was being "hard on himself" during this time such as telling himself he was a "nobody." However, Mr. Brown stated that he did not remember tying the sheet around his neck or completing motions to complete the hanging. Clinician also assessed what coping strategies Mr. Brown was using to handle these symptoms, to which he replied that he was not utilizing any. Directly after this event the clinician and Mr. Brown worked on a creating a list of coping strategies that Mr. Brown could use when experiencing different emotions as he identified that this might be helpful at that time. Overall, Mr. Brown's suicide attempt was not attributed to the exposure component but to a combination of stressors outside of sessions that led to an increase in symptoms. Mr. Brown had noticed a decrease in PTSD symptoms after beginning exposure up until the culmination of noted stressors.

Another part of treatment that was important for Mr. Brown was to engage more in treatment groups and with others in the population. When treatment first began, Mr. Brown had been on segregation status since September 2015 in which he was not allowed out of his cell without an officer escort. The need for an escort also meant that he was not able to attend groups or go to the yard. After seven meetings with Mr. Brown, he was able to move onto the Treatment Unit, which meant that he could go to session or groups and the yard without an escort. Mr. Brown reported and was witnessed by the clinician as going to group and interacting with others, which he stated he was enjoying. After two weeks of doing well at this, he was then encouraged to begin attempts to attend programming groups. Mr. Brown has not yet attended a group but has been able to identify cognitions around his being hesitant to attend. He explained

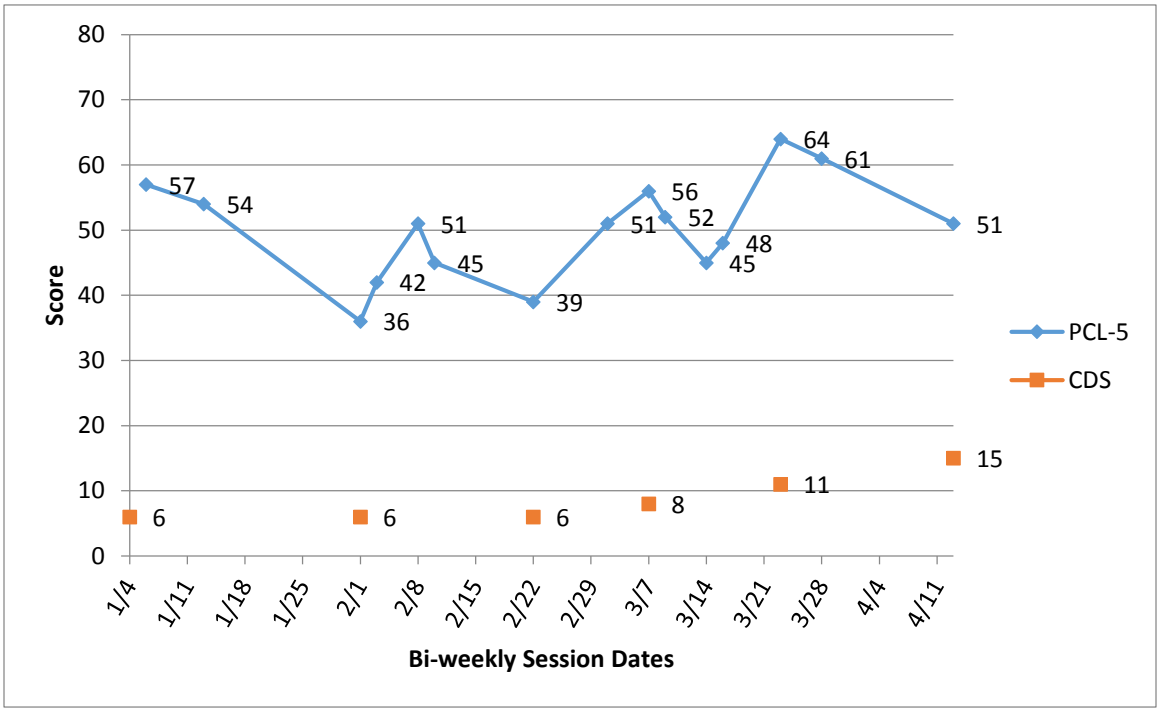
that he is worried that "someone will say something bad and I will snap" or that the leaders will "point me out and I'll have to talk about personal stuff." Socratic questioning was used with Mr. Brown in session for these thoughts and he was able to generate some alternatives, but still remains hesitant. He has been encouraged to use Challenging Questions on these issues but has yet to do so.

Mr. Brown's measures of PTSD, depression, and functioning changed over treatment and are presented in Figure 1. Mr. Brown's PCL-5 scores have been variable during treatment, although mostly clinically significant. The lowest PCL-5 was attributed to client providing statements such as "it is not my fault" or "there's nothing I could have done" in relation to trauma. These did not last as client stated he did not always believe those thoughts. The spiked score of 56 was during reported stressors including having his radio stolen, the cable for his TV breaking, and not receiving a package he had ordered and had funds removed for. Measure scores started to go down with continued treatment and identifying the maladaptive thoughts attached to the stressor and working on challenging it.

Mr. Brown also has shown some depression during treatment. At the beginning, CDS scores were low, although still indicating that depression was present. However, when stressors were present, his depression also increased. It is also noted that Mr. Brown also had more negative cognitions during this time such as stating "I am a monster" and "there is nothing good here for me" in this current facility. These maladaptive cognitions increased during around the time of the anniversary of the traumatic fire and client identified that during this time he was being "hard on myself" which included telling himself that he was "a nobody."

Figure 1

Change in Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) and Calgary Depression Scale (CDS) Scores During Treatment



Mr. Brown was also given the WHODAS again after thirteen sessions in which he reported the most disability in participating in society (65.63% disability). He indicates having extreme difficulty with joining in community activities and spending more time and being emotionally affected by his mental health problems. The next affected area was in communication (33.33% disability) in which he feels severe difficulty in analyzing and finding solutions to problems and moderate difficulty in concentrating and generally understanding what others are saying to him.

Self-Evaluation

The transcript provided was the sixth treatment session. At this point in treatment, Mr. Brown had been provided with psychoeducation and asked to work identifying his thoughts and

feelings, especially around the trauma. The plan for the session was to begin with homework review which consisted of ABC worksheets and reworking Impact Statement. Since Mr. Brown had thus far shown limited identification in thoughts and how they related to feelings and current symptoms, his ABC sheet was gone over more thoroughly during this session so as to foster further understanding and model how to identify this information. At this point in treatment, Mr. Brown's goal of being more involved in the unit and treatment was going to be implemented. In order to begin this, a hierarchy needed to be conducted to determine how anxious Mr. Brown was about being involved in different activities and to determine what might be easier for him. Clinician wanted Mr. Brown to experience success through smaller steps so that he would not be overwhelmed and would be more likely to maintain and continue gains.

The clinician demonstrated some strengths in the course of the transcript. The first was to clarify if Mr. Brown was using past experiences to monitor his thoughts and feelings or using a current focus. The current focus was helpful for him to identify thoughts and feelings as he can monitor them in the moment rather than searching his memory for something that has happened in the past. The clinician redirected the reworking of the ABC sheet to a present event or near present event which then became the focus. Another strength was following Mr. Brown's flow and identifying the emotions that he feels first. Then, the clinician used his strength of identifying emotions to foster identification of cognitions. With this discussion, the clinician was modeling for him the way to fill out these sheets and also how to begin to identify thoughts that were more difficult for him as well as modeling how cognitions and emotions are associated to one another.

There are also areas that can continue to be improved upon. One of those areas is to provide Mr. Brown with more support and encouragement in completing homework assignments

to the best of his ability. Reinforcement could have been given for him completing more than one sheet as he previously had only done one in-between sessions. Praise could also be given when he is able to identify emotions. More support could also have been given after going over the hierarchy for being on Treatment Unit. Going over this material is anxiety provoking because the talk is about doing things that he typically avoids. The clinician should have checked in more with him and asked him more about his feelings about doing this and where he was at right now about it rather than just accepting the non-committal mutter that Mr. Brown did provide. By doing this, the clinician could have addressed more concerns and allowed Mr. Brown to feel more secure in these steps.

During the course of the session, the clinician could have also engaged Mr. Brown more when providing additional psychoeducation to him. The clinician provided psychoeducation but then did not fully follow up on checking in with him to assess his complete understanding of the topic being discussed and how it applies to him. It could be helpful to assess this so that he understands more about what the treatment is doing for him and how symptoms arise so that he can have a better idea on how to handle those symptoms in the future.

There were also missed opportunities to elicit more maladaptive cognitions. One such example was when client provided the cognition “he’s going to die.” The clinician could have used the downward arrow technique in order to elicit the core beliefs or the beliefs that are more strongly associated with PTSD symptoms. For example, by using the downward arrow technique with the current cognition, clinician could have then obtained thoughts as “I should have been able to save him” and to the core belief “I’m a nobody” because I could not help my friend. By using the downward arrow technique, the clinician could have obtained additional

maladaptive cognitions to work on and would have provided an important core cognition to work on during the CPT modules of safety, trust, power/control, self-esteem, and intimacy.

The clinician also identified that the use of Socratic Questioning, which is important within the CPT protocol, was not utilized during this session. The use of Socratic Questioning allows the clinician to model for the client how to challenge the maladaptive cognitions that they identify during that particular session. Mr. Brown in later sessions would then be introduced to using the challenging questions themselves. After he identified maladaptive thoughts, it would have been beneficial for the clinician to have done some initial challenging of the cognitions in order to model and to assess how strong that belief was held by that client. As this session was being split with identifying the hierarchy for being on TUA, Socratic Questioning was not utilized as it should be to save time within the session.

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Session Transcript

T: Ok, so, um, what was some of the things you did for homework from last time?

C: Um, I did them two.

T: Ok, the ABC sheets?

C: Yah.

T: K. Uh, did work anymore on doing the Impact Statement?

C: Uh, I uh forgot to do that.

T: Ok

C: You just got to bear with me, I'm not really…able to concentrate all that well from the lack of sleep from nightmares and stuff

T: So you had a lot of nightmares last night that kept you up so you didn't get a whole lot of sleep? That's ok, we'll just, if we need to slow down or anything tell me and we'll just kinda work through that ok?

C: K.

T: Alright. So how did doing the ABC sheets work go then?

C: Both of them were rough.

T: What do you mean by rough?

C: While I was doing them it brought back a lot of bad memories.

T: So going through them, just writing those things down brought back memories.

C: Mhmm

T: K. Which is understandable seeing as these are things that you've tried to avoid in the past, not wanting to think about them and so right now, having to think about them might bring back some of those memories again. But people have found that the more that they try to do these things and they go through it that tends to decrease.

C: Mhmm

T: So, um, you know a lot of people explain that it is kinda rough it is difficult to begin the treatment because those things that you tried not to have, not to think about before you are. Um,

but, a lot of people do find that it gets better. Ok, so, um, I just kinda want you to walk me through the sheets that you did.

C: Uh, um, I said on the activating event, A "something happens" I said "I watched the house burn down with my friend inside." K

T: Ok so that was a past event that had happened.

C: K. Now a Belief/Stuck Point, B "I tell myself something" "He's going to die." You know, I'm watching the house burn down with him inside and I was like "whoever's in there is going to die," which he did.

T: Right

C: Um, consequence C "I feel something:" anguish, sadness, sick to my stomach.

T: Mhmm. Ok, so that was on something that had happened in the past right?

C: Back then yes. In fact the anniversary is coming up on April 15, '95 is when it happened.

T: Ok, so is that something that reminded you of that event? (Client nonverbal response) Ok, so lets go through that. So what I'm wanting with these sheets is to be more…what's been happening now with you that leads to some of these thoughts and these feelings.

C: Oohh

T: So a lot of what you've been giving me is something happened in the past. And you're right, you did think "he is going to die" because he was still in the fire. Um, so right now what I'm wanting you to do these sheets on is what currently has happened that you've been having these, because you said you have these feelings first, what happened right now that brought back some of those feelings and those thoughts, k?

C: (mumble)

T: So you said that the anniversary is coming up right? So you thought about the anniversary (writing) of the fire coming up next month, no in two months.

C: Yah, in two.

T: Ok.

C: There have been some times during the anniversary of the fire, right at 1:30 in the morning when the fire happened, when I'm in my room, I'll wake up either screaming or I'll panic a little bit, so.

T: So you're saying, like, you wake up right at 1:30 when the fire happened?

C: (Nod)

T: And you're saying that you, lately, you've been thinking about the anniversary coming up.

C: Right.

T: So when you think about that what happens?

C: Um, stress level goes up, can't sleep. Uh, I physically feel sick. I sweat, so.

T: K, uh, you physically feel sick and you sweat. So what are you noticing first? The thoughts that you have or the feelings you have?

C: Feelings.

T: Ok, what kind of feelings come up when you think about the anniversary?

C: Uh…jealousy.

T: Ok, so let's follow that ok?

C: Ok.

T: What are your thoughts that are connected to that feeling?

C: I don't know. It's hard to follow up.

T: It's hard to identify the thoughts that you're having?

C: Yah.

T: Ok

C: It's just mixed emotions.

T: Ok so what are some of the other emotions that you've had? When you think about the anniversary coming up? Because you said those are the things that you identify the most first is the feelings.
C: Um, the heart races.

T: Mhmm

C: Um, adrenaline. So

T: And what are some of those emotions? Because you're giving me a lot of physical symptoms that you do have when you start to feel these things. What are some of the emotions that are coming with those feelings?

C: …. Sad that he's gone.

T: Mhmm. So sad and "he's gone" is the thought right?

C: Yah

T: And that's linked to being sad. Do you see how those lead from one to the other? And they can interact so you may be feeling sad and you recognize that what your thought is is "he's gone." K? What are some other feelings or thoughts that you recognize around the anniversary coming up?

C: … I know I question God about it.

T: You question a lot about it?

C: I question God about it.

T: Oh, you question *God* about it. Ok, so how are you questioning God? Like what are you saying to yourself?

C: Why

T: Just why? Ok why… what?

C: Why me or why him.

T: Ok. (Writing) Why me … why him. And what do you feel when you say that to yourself?

C: … Um, I don't know.

T: Ok. So when you're doing these, let's focus on some of the current things that are happening right now. That are leading to thoughts and feelings such as like this, K? That's, that's what I'm going over right now is the current example. And you may notice the feelings first which is ok because some people do. They are, it's easier for them to recognize how they're feeling than what they're thinking. So when you know that you have those thoughts, or I mean those feelings, it would be a good idea to try to sit down right away and do one of these sheets and stop and think about what thoughts you were having right before you started having those feelings, ok? So how, how does that sound to you?

C: Sounds good.

T: Yah, cuz, I mean are you doing these at night or something? Kind of picking or doing them together?

C: (Nod)

T: So one way for us to work on it so that we get some of these specific and it's easier for us to identify the thoughts might be to try to do one of these sheets right after you have an event that leads to some of these thoughts and feelings. Um, because the quicker you do one of these sheets after it happens the easier it is to remember these things and get them down on the sheet than if you wait you know at night or do them the night before you come to session or whatever. Um, which then you may not remember as clearly what was going on and it may be harder to identify those thoughts.

C: Even right now I feel sick to my stomach cuz…

T: We're talking about it.

C: Ya.

T: Ya. Which is understandable its bringing back some of those things that you haven't wanted to talk about.

C: And thoughts about the funeral and his casket was going past me. I nearly fainted, my girlfriend had to catch me. So…

T: K. Ya, so I understand that it can be hard but what is the benefit of going through this?

C: It's making me stronger I know that.

T: K

C: As each year goes it's not as bad, but during the anniversary it's pretty rough.

T: Right.

C: A few months before it's pretty rough. Cuz I remember the times we had together all the way before that up to that.
T: Right. And that's understandable anniversaries can be very hard for a lot of people just because that's a reminder of what you have lost and the things you've had to go through.

C: Right.

T: So it's understandable that the anniversary would be more difficult. That can also give you, um, points to write about and what may be difficult for you still at this time. K?

C: Alright.

T: So what questions do you have about doing this then?

C: … Right now I don't got none.

T: K. And I see this other one was more of a different kind of abuse right?

C: Yah.

T: So for right now what I'm going to have you focus on is the fire.

C: K

T: And not, if you want to do some of the other ones, um I mean I would suggest we start doing those later. If you want to start working through them on your own that's ok, um, but I want to focus on the fire. And then I had also asked you about filling out one of those sheets for being on Treatment Status. Did you get to one of those?

C: Nuh-uh

T: Ok. So remember right now we're going to do one of these ABC worksheets on the trauma specifically

C: Ok

T: And we're going to do it on whats currently been happening and do your thoughts and feelings on something that's happened recently.

C: Right

T: And we're going, I'm going to have you fill out these same sheets for being on Treatment Status and your thoughts and feelings around that, k? So like you came up today again without having to be cuffed or anything so what are some thoughts and feelings around that. K? Um, alright, so I said last time because we're just starting this treatment and the program you know where you're not fully Restrictive Housing anymore, it's kind of a weird in-between phase we were going to go over some of the things that you've been anxious about or that you avoid doing. So I want to go over that. K? So we've talked about avoidance with the trauma reminders. So there are things that you avoid because you start to feel anxious if you do them. So for example some people it's, you know, if they were attacked outside on a walking trail they get anxious going around walking trails anymore. They don't, they don't want to go out and walk. So that is something that you can feel anxious and stuff about things that you're doing now and you don't do them anymore. So what are some things that you've avoided?

C: …

T: What are some things that you've avoided? Or situations that make you feel really anxious so you don't go into those situations?

C: Try not to think about it.

T: You're not thinking about … about what?

C: About the fire.

T: Ok. What are some other things you try not to do?

C: Try to avoid reminders of it. Like the TV when it shows fires.

T: What other kind of reminders?

C: Um … I can't think right now.

T: Ok. That's ok. We can go over this again to in later sessions. I'm just trying to get an idea right now. So what are some activities? Or there's a lot of people who avoid places or going um into certain things or being around certain people after a trauma. What are some places or activities things like that that you avoid?

C: … Being around large groups of people.

T: Mhmm. And what do you mean by large groups? Like how many people?

C: Like 5 or more

T: Like 5 plus. So what would be easier than a large group? How many people would make that easier?

C: 3

T: Ok, so it would be easier with 3 people. So you're still a little anxious around 3 people but not as bad as with 5 people or more.

C: Right

T: And what would make it really hard?

C: Oh in a small room and there is a clutter of us.

T: Ok, so (writing) harder, small room with like how many people?

C: 5 or more

T: So if you had like 5 people in a bigger room it's not as bad. If it was in a smaller room with 5 people it would be bad. So what is a smaller room? Is it like this room or the group rooms?

C: Something like this.

T: Ok so what are some other things that you avoid?

C: … I can't think about anything.

T: Ok. Um, and another thing we had talked about is, I remember you said quite a few times that, um, one of the reasons that you were wanting to go to Larned other than to be closer to your family was because you wanted more treatment options right? You felt like they did more there and you got more out of it. And so remember I was talking about that is part of the reason your coming up to see me is we're trying to get you into more things like your wanting. Right? Ok, so um, what are some things, some goals some things that you don't get to do know that you would like to be able to do?

C: (Cough) Um … art therapy or something.

T: Some what?

C: Art therapy

T: Art therapy, ok. What else?

C: Activity

T: Activity, like activity therapy stuff?

C: Yah. Probably in a mental health group (mumbling). And a Mr. (omitted name) was talking about getting me back into the music group.
T: Ok. And that is something that you've done in the past that you've enjoyed?

C: (Nod)

T: K. So those are some things that you would like to be able to do. Get involved in some groups. Sounds like a mental health group would probably be a good thing um, music therapy, art therapy um, maybe some more activities and things depending on what groups are available. Right? K. So getting into some of those things would be something to look forward to.

C: Right

T: Um, and, alright, and so are there, what other goals do you have. Getting involved in groups is kinda this (writing).

C: (silence)

T: What other goals?

C: … Um, I can't think of any.

T: Uh, and how would you feel about um, being like being able to go to the pill line on your own?

C: I'm still paranoid about that.

T: K. Um, k. So going to the pill line is still hard. So if you had to say on a scale from 1-10 on how anxious it made you feel with 1 being not at all anxious and 10 being the most anxious I've ever been. So 5 would be I'm kinda anxious, I'm somewhere in-between. How anxious would going to the pill line?

C: Probably an 8

T: An 8. Ok. And let's say you had to go to chow.

C: 10

T: So that's even worse than going to pill line?

C: Yah

T: K. Um, alright. How, and your still up on the Restrictive Housing side right?

C: Mhmm
T: What … so what about being out in one of the regular cells around this unit?

C: Right now it would probably be an 8.

T: (Writing) So not being on RH run would be 8. So those are things you're still pretty anxious about, they still make you uncomfortable. What, what are some reasons that they are making you uncomfortable?

C: There's a lot of new people in here.

T: Mhmm

C: I'm afraid we may not get along or someone will say something that will make me snap.

T: K. Alright so "people might make me snap." Or "people may say something that might make me angry and then I'll snap." Ok. Um, and how anxious would you be on that same scale to go to some of these groups?

C: 5/6

T: For all of them or is some groups harder than others?

C: Um, activity therapy would be easier.

T: Ok, then what mental health group?

C: Um yah.

T: K. So what would you rate getting involved in activity groups?

C: 3

T: And the mental health group or groups, whichever?

C: Probably a 7

T: K. Ok, and so if you were to say this being around large groups of people is something you avoid doing. And you said it's easier if you're around like 3 people. Um, would the room size make a difference with three people?

C: (nonverbal response)

T: Ok, so if you were in a large room and a small room, how anxious would you be if there were 3 people in a large room?
C: Probably a 1

T: And how about 3 people in a small room?

C: Probably an 8.

T: An 8? So being in a small room with 3 people is just as bad as going to pill line or not being on the RH run?

C: Mhmm

T: And, so what if you were around a bigger group of people in a large room, how bad would your anxiety be?

C: … Pretty bad. Probably about an 8.

T: About an 8? And how about in a small room with 5 people?

C: I don't know. Oh nevermind. Being around large groups of people in a large room?

T: Yep

C: It's like a 2. In a small room it would be an 8.

T: Oh, ok. Alright.

C: I had to go over that again.

T: That's ok. So really it sounds like being in a small room with people in general is more anxiety producing than it is if you're in a large room with people. Being around more people in a large room is still a little bit harder than being around a smaller amount of people but it's not as bad as being in a small room.

C: Right.

T: K. So I think, um, with this treatment program thing that we're doing we're going to see how it goes. And that's why I'm having you do this. And we'll see, you know, I, we're not going to jump right into doing what is going to make you really anxious like right in the beginning. We don't just want to throw you in.

C: Mhmm

T: We want to step you up into things, because you have some goals. You would like to be involved in more activities and do some things and get out more. Um, so stepping you up and then each step we'll sit for a little while and see how it goes before going to the next. K? How does that sound to you?

C: Yah (hesitant). I just don't like being in groups or going to chow hall or something like that.

T: But the groups you said were a little easier than going to chow hall right?

C: Right.

T: K. And activity therapy is even easier than being in a mental health group.

C: Right

T: Right. So it would be something uh, like right now you're coming up to see me without any cuffs on or anything.

C: Right

T: Your still on the RH run uh you're just, it's just a little bit different from being on RH. We'll figure out the next small step would be that, I mean I'd talk with Supervisor and see what they would think would be the next step. If the next step might be getting into some activity therapy groups. K? Not right now. Not right away. I'm not saying that. I don't want to just push you

into it. But at some point we can discuss it and see and then try it. Um, and then we would sit for a little while after doing that and see how it goes and we can talk about it and discuss if there are problems and how to deal with them. You know, we're not just going to sit you in there and leave you, leave you to be right? We'll help you through it, k? And I know it can be anxiety provoking just to do those next steps, um, so I understand. We'll take it slow, k. These are just things to think about and I wanted to get an idea of the goals and things you wanted to do such as being involved in the groups like you had said so that we can try to work those things into you and get you where you want to be. How does that sound?

C: Mmm

T: Yah? Alright. Um, let me see where we're at. Ok, we've got just a little bit of time left. Well and you you said you were kinda sleepy so would you even want to try to learn some of the Challenging stuff or do you feel like you're not…in the right frame of mind today?

C: I'm not in the frame of mind right now.

T: So let's work some more on what we had been discussing. Uh, so what are some of the, you know we've been talking about the feelings. You feel more feelings than you do the thoughts. What are some of the strong feelings that you find a pattern for you? That you've had these same feelings over and over again based on the trauma of whats happened?

C: Um … when the flashbacks get real severe

T: Mhmm

C: Um …

T: So the flashbacks get real severe and when you have the flashback… so what's a flashback that you've had recently?

C: Um, um, let's see here… Um … too many people out there (several people talking loudly outside the door to the office)

T: Yep, yep, and it sounds like other people are having problems with their anniversaries too right? (Based on conversation in the hall)

C: Yah

T: You're not the only one… Would you like me to repeat what we were talking about?

C: Yah

T: It kinda got distracting in the hallway right?

C: Yah

T: Ok, so we were talking about you're having flashbacks and you said the flashbacks were getting kinda hard. What, what was one of the flashbacks you've had recently?

C: Uh, let's see. What I went through that night. What I seen, what I smelt.

T: (Writing on ABC sheet) So, you had a flashback. Describe that flashback for me.

C: Seeing the fire blocking my way on the staircase so I couldn't get out. Then I could have sworn I was going to die.

T: So you had a flashback, um … and when you said um, it felt like I was going, you felt for sure you were going to die, you meant like right now? You didn't feel like you were going to die in the past when it was happening, you felt like right now you were going to die?

C: Right. During the fire.

T: During the flashback? Did it feel like, because this flashback is happening to you

C: Uh-huh
T: Where you feel like your back in the fire. Did you feel like you were going to die that night? That moment that you were having the flashback? Or were you remembering having that thought in the fire?

C: I was remembering having that thought.

T: Ok. So, you had a flashback and during this flashback you were seeing the fire block the way

C: Uh-huh

T: On the staircase

C: Right

T: Did you feel like that was happening to you in the moment or was that a memory?

C: Uh, I'd say both.

T: K. What did you notice first? Thoughts or feelings?

C: Feelings

T: What were you feeling?

C: My heart was pounding. Um, adrenaline was rushing real strong. Adrenaline

T: What does that feel like?

C: Um… let's see. My heart was pounding … I (inaudible) to the point of dry heaving.

T: Ok, so dry heaving, it was hard to breath then (writing). K, so when you're feeling these things your heart pounding, it's getting hard to breath, at some points you might dry heave.

C: Mhmm

T: There's a big adrenaline rush. When you think about all of those physical symptoms, what emotion is associated with those physical symptoms?

C: … My heart's broken. So that makes me feel sad.

T: K. You're sad. Sad doesn't really fit with an adrenaline rush and your heart pounding and hard, having a hard time breathing.

C: Oh.
T: What kind of emotion fits in with those feelings?

C: Scared

T: Yah. That sounds about right to me. You were really scared. And it felt like those, what had happened to you in the past was happening to you again.

C: Mhmm

T: So it makes sense that you would feel scared in the moment when remembering about those things or experiencing those things again. But you were also feeling sad. Were there any other emotions that you remember having?

C: (Head shake)

T: Ok, well let's work with those. So, which would you like to feel, or work with first? Scared or sad?

C: Scared.

T: Ok. So you were scared. What were some of the thoughts you had before that feeling?

C: Uh shoot. Uh, I'm sorry I can't concentrate today.

T: Ok

C: Uh

T: Maybe it would be easier to work with sad first. Because you did give me, you said "I feel sad because my heart is broken," right? So what are some of those thoughts that you have around "my heart is broken?"

C: Um… Um

T: So help me explain why your heart is broken.

C: Um, because I lost him

T: K.

C: I lost (omitted name).

T: Mhmm. So that is a thought. My heart is broken, I lost him, and so I feel sad. What else does it mean that your heart is broken?
C: … (Sigh)

T: Ok. So I think we kinda went over this one last time, we've followed that path last time. So ok, so now you see what I'm talking about when I'm trying to get those thoughts based on what you're feeling. I know these can be a little harder for you to think of and to, to remember and bring up, which is why I want you to do them right when it happens because it's easier to write them down. And to think of even the more specific ones. And I'm wanting you to look and figure out where this feeling is coming from which is what I'm trying to do. Because you feel this first and I'm trying to get you to, ok well what led to that? What kinda thoughts are you having. Uh, so when you're doing these and you start to feel that thought, I want you to try to think, "ok now what am I thinking about? What is leading to this feeling." K? I want us to work on being able to identify that because once we can identify those things we can work on them and work through them. Ok? That's what I'm trying to get at here. And this takes practice, which is just fine and why we are doing it in here. K?

C: Alright

T: So now you said you felt scared. What are some things that led you to feel scared? What are some of the thoughts that you had?

C: … Um. Let's see here (mumbling). The black smoke I was choking on. Um, I have memories of that.

T: Mhmm

C: And I have memories about being trapped in the basement.

T: And how did it feel to you in that moment?

C: Like I said, I felt like I was going to die. Just…

T: K. So, and those are some of the things when you're having those flashbacks and those memories um, you do feel that automatic scare response again. Because those memories are, you know, they're based on the fire which you experienced being scared, feeling like you were going to die, the fear of losing other people. And now when you have those memories it brings back those same feelings and you remember those thoughts. So, and they're uncomfortable and you don't want to think about them anymore so what was one thing, that, is one thing that I've asked you not to do?

C: Avoid.

T: Yes, very good. That's one of the things I'm wanting you not to avoid as well. Thinking about it and the memories. You don't want to remember it right now, because how does that make you feel if you don't remember it?
C: Um … I mean it's always going to be in my head

T: Mhmm

C: But I can't get better if I don't remember.

T: Right. And I know it can be hard to remember now but that is something you tell yourself when you're trying not to avoid. Having those memories, you know if you just push them out of your head they may go away for the short-term, but they come back. And you still have those, that same response, "I'm scared." Um, when they do come back, k? So when, people have found that when you don't avoid those things and you sit with them and try to work through them that it gets better in that they don't have as strong of that scare response, the adrenaline rush and everything else. They begin to differentiate between that was then, I understand that you were scared when the fire and every, that is a perfectly reasonable response in that situation.

C: Right

T: But, when you're having a memory, does that mean that you're in the fire?

C: I know, being realistic I know that I'm not, but it feels that way.

T: Right. It feels that way because you have that response right?

C: Mhmm

T: And you response is leading you to that and it's, that you'll keep having that response if you keep avoiding having these memories or if uh, you avoid thinking about it or doing those types of things we had just talked about. You're continuing that response. What I'm asking you to do is not avoid, because then you begin to learn to differentiate between that was the fire and these are just memories. It doesn't mean that I'm in the fire, that I'm in danger right now. They are memories. And yes, they may not completely go away but you can learn to deal with them and not have that kind of response. But they should, the ways to do that to decrease the response and

the fear and the feelings of guilt and stuff is to go through this, where I'm going to help you identify those thoughts and feelings and we're going to work on them and not avoiding. Ok? Don't avoid the feelings, don't avoid the memories, try not to avoid the situations. We'll work on those, taking it step by step, but working hard on not avoiding can be helpful as well. And a lot of people do find it helpful to remind themselves what they're doing it for because it can be hard. Ok, so, we're out of time, um next time I want you to keep working on the Impact Statement. What are you going to do with the Impact Statement?

C: Uh … I forgot. Could you write it down?

T: I was just going to ask you if you wanted me to. I'll write it down on this sheet that we did today ok?

C: Alright.

T: (Writing) Tasks for next time. I want you to rewrite the Impact Statement.

C: What do I write it on anyway?

T: Uh,

C: Cuz I ain't got no paper

T: Would writing it on the back of one of these sheets work?

C: Yah.

T: K. If it's one that you've written on a front that's fine. You don't have to use a blank one. Re-write the Impact Statement and write about (writing) how trauma has changed or strengthened beliefs you had before the fire. So safety, trust, power/control, intimacy, and self-esteem. Those are the areas, how did those things change after the fire.

C: K

T: And do the ABC worksheets. One on the fire, and one on … being on Treatment, what do they call it Treatment

C: Treatment Bed

T: Bed. K. Or if you're wanting to avoid, you could fill out a sheet for that as well.

C: Alright

T: How would you fill out a sheet for if you wanted to avoid?

C: … Up top

T: Mhmm. Ya so, you could have, you know, had a memory about whatever it is you had a memory, whatever reminded you about it. And you could, and your thought is, you know, "I don't want to have that thought" and what do you feel? What other thoughts do you have going on, you know maybe, some people are like "I'm going to lose control if I think about it" and how do you feel. So any of the thoughts you have even when wanting to avoid or somehow you get into a room with so many people, you know "I'm in a room with this many people" and I feel scared. Why? What do you think is going to happen being in a room with that many people. Those are the types of things you can write down. Ok? So, any of those situations you can write about.

C: Ok

T: Ok so that's that. These are blank pages for you. Oh, you had asked the visiting this weekend and I had found out it is Saturday.

C: Ok

T: Ok, what questions do you have before you leave?

C: Nothing

T: Then I'll let you go.

C: On Monday I'll let you know how the visit went.

T: Awesome, yah. I'll look forward to hearing about it.