

Cognitive Processing Therapy – Cognitive Therapy Only for Treatment of Complex Post-Traumatic Stress Disorder

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Keywords

Posttraumatic stress disorder · Trauma ·
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Summary

Background: Complex posttraumatic stress disorder (PTSD) is often found after repeated experiences of violence in childhood and adolescence, and it includes, additional to PTSD core symptoms, emotion regulation difficulties, instable relationships, and a high rate of comorbidity. Many therapists have concerns about the use of exposure-based treatments in this patient group. Cognitive Processing Therapy (CPT; [Resick et al., 2007]) in its cognitive-only version (CPT-C) represents an effective alternative method, which does not need formal exposure. Besides presenting this method, the authors give an overview of evaluative studies and describe the application of this technique by a case example. **Case Report:** The patient sought out treatment after childhood sexual abuse. Besides PTSD, she was diagnosed with borderline personality disorder. The authors describe the use of CPT-C interventions, the course of treatment, treatment results, and demonstrate special features in the treatment of complex PTSD. **Conclusions:** The cognitive version of CPT, the CPT-C, allows quitting formal exposure and is as effective as exposure-based methods. Therefore, CPT-C should be broader implemented in PTSD treatment, especially in the treatment of complex PTSD.

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Schlüsselwörter

Posttraumatische Belastungsstörung · Trauma ·
Emotionale Instabilität · Kognitive Therapie ·
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Zusammenfassung

Hintergrund: Das Störungsbild der komplexen Posttraumatischen Belastungsstörung (PTBS) tritt häufig nach wiederholten Gewalterfahrungen in der Kindheit und Jugend auf und zeichnet sich neben den Kernsymptomen der PTBS durch Störungen der Emotionsregulation, instabile Beziehungen sowie hohe Komorbiditäten aus. Viele Behandler haben Bedenken, bei dieser Patientengruppe expositionsbasierte Methoden anzuwenden. Die Cognitive Processing Therapy (CPT; [Resick et al., 2007]) stellt in ihrer rein kognitiven Variante (CPT-C) eine wirksame alternative Methode dar, die ohne formale Expositionselemente auskommt. Neben der Vorstellung dieser Behandlung wird ein Überblick über Evaluationsstudien gegeben sowie die Anwendung anhand eines Fallbeispiels beschrieben. **Fallbericht:** Die Patientin kam nach sexueller Gewalt im Kindesalter in die Behandlung. Neben einer PTBS wurde eine emotional instabile Persönlichkeitsstörung (Borderline-Typus) diagnostiziert. Die durchgeführten CPT-C-Interventionen, der Therapieverlauf sowie das Behandlungsergebnis werden beschrieben und Besonderheiten bei der Behandlung der komplexen PTBS aufgezeigt. **Schlussfolgerungen:** Die kognitive Variante der CPT, die CPT-C, ermöglicht es, auf eine formale Exposition zu verzichten, und zeigt dennoch eine genauso gute Wirksamkeit wie expositionsbasierte Methoden. Sie sollte deshalb in der Versorgung traumatisierter Patientinnen und Patienten und besonders auch zur Behandlung der komplexen PTBS eine größere Beachtung und Verbreitung finden.

Introduction

Many patients who experienced physical or sexual violence over a long period of time in childhood and adolescence develop complex post-traumatic stress disorder (PTSD) in the course of their lives, with emotion regulation difficulties, feelings of inferiority, unstable relationships, and dissociative symptoms additional to the core symptoms of PTSD [Maercker, 2013]. Often these patients also meet the criteria for comorbid disorders such as substance abuse, affective disorders, or emotionally unstable personality disorder [Green et al., 2010; Pagura et al., 2010].

Despite the intense suffering and treatment needs of this patient group, they are often underrepresented in treatment studies [Priebe et al., 2012]. Furthermore, many therapists are concerned that treating these patients in an outpatient setting with trauma-focused exposure methods could make the symptoms worse and cause suicidal crises [Neuner, 2008]. Along with treatment methods that integrate emotion regulation training for dealing with intense stress, such as Dialectical Behavior Therapy for PTSD (DBT-PTSD) [Steil et al., 2011], cognitive treatment methods represent a possible alternative. Cognitive Processing Therapy (CPT; [Resick et al., 2007; German manual by König et al., 2012]), which combines cognitive therapy with a written trauma account, is particularly relevant.

Here, we present the purely cognitive variant of CPT (Cognitive Processing Therapy – Cognitive Therapy Only; CPT-C) as an intervention for treatment of patients with complex PTSD, illustrated by a case study. The effectiveness of this intervention, which does not use formal exposure, is currently subject to a large, randomized controlled study (RELEASE study) funded by the Bundesministerium für Bildung und Forschung (BMBF; Federal Ministry of Education and Research), comparing it with the effectiveness of DBT-PTSD for the treatment of women who experienced sexual or physical violence in childhood or adolescence (www.traumatherapie-verbund.de).

Symptoms of PTSD and Special Features of Complex PTSD

A prerequisite for the diagnosis of PTSD according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; [American Psychiatric Association, 2013]) is that the person was confronted by death, a mortal threat, serious injury, or sexual violence. The main symptoms of PTSD are defined in the DSM-5 as intrusion (e.g., unwanted memories), avoidance, negative changes in cognitions and mood (thoughts like ‘My life is totally destroyed’), and hyperarousal (e.g., irritability).

Victims of interpersonal violence and in particular sexual violence in childhood, with a lifetime prevalence of 35.4% [Kessler et al., 1995], have a very much higher risk of developing PTSD than victims of other traumatic experiences, such as traffic accidents (7.6%). Specific additional symptoms of complex PTSD are found in individuals who have experienced extreme or prolonged stress,

as is often the case with interpersonal violence in childhood and adolescence [Maercker, 2013; Van der Kolk et al., 2005]. This group of patients, besides the core symptoms of PTSD, have difficulties in emotion regulation, feelings of inferiority or worthlessness, difficulties maintaining relationships, as well as long-lasting and deep impairments in affective self-functions and relational functions [Maercker, 2013]. To better address the consequences of such complex trauma history and the associated symptoms, a new disorder will be introduced in the International Classification of Diseases 11 (ICD-11) – complex PTSD [Maercker et al., 2013].

Therapeutic Approaches and Guidelines for the Treatment of PTSD

Psychotherapeutic approaches have been proven very effective in the treatment of PTSD, showing high pre-post effect sizes (from Hedges $g = 1.01$ to 1.63 , depending on the method), and a medium effect size of $g = 1.14$ compared to control conditions such as a waiting list control group [Watts et al., 2013]. Psychotherapy is greatly superior to pharmacotherapy, which shows only small effects compared with placebo [Watts et al., 2013]. Cognitive therapies, exposure-based therapies, and Eye Movement Desensitization and Reprocessing (EMDR) have proven to be effective methods of treatment [Watts et al., 2013]. National as well as international guidelines for the treatment of PTSD [e.g., Flatten et al., 2011 for Germany; NCCMH, 2005 for the UK] therefore recommend a trauma-focused psychotherapy as the method of choice. Many outpatient practitioners, however, fear that these mostly exposure-based psychotherapy methods could aggravate the symptoms or provoke crises in patients who suffer from severe forms of PTSD [Neuner, 2008]. In addition, concerns on the part of the therapist that formal exposure to traumatic memories could lead to relapses, e.g., of pre-existing dependencies, or to discontinuation of therapy, often prevent the use of exposure-based methods [Becker et al., 2004]. The result is that these patients are often treated without their traumatic experiences ever being specifically discussed [Rosner et al., 2010].

More cognitively-oriented psychotherapies have proven in recent years to be a very good alternative to exclusively exposure-based methods, allowing – as recommended in the guidelines – a focus on the trauma, but without formal exposure. In the most up-to-date meta-analyses, these methods show large average effects in countering the symptoms of PTSD [Watts et al., 2013]. CPT-C plays a pioneering role here; its development and application for complex PTSD are described below.

Development and Effectiveness of CPT

CPT was developed in the USA for the treatment of rape victims [Resick and Schnicke, 1993]. It originally consisted of 12 sessions, which combined a cognitive treatment approach to change trauma-related dysfunctional beliefs with an exposure element in the form of a written trauma account [German manual by König et al., 2012].

In 1992, the effectiveness of CPT was studied for the first time in a group setting for the treatment of women who were raped as adults, and demonstrated good results in the reduction of PTSD and depressive symptoms compared to a waiting list control group [Resick and Schnicke, 1992].

In a randomized controlled trial, CPT proved to be as effective as a pure exposure treatment in reducing the symptoms of PTSD [Resick et al., 2002]. The effectiveness of CPT was subsequently verified in a large number of studies with patients who had suffered various traumas [e.g., Monson et al., 2006].

To examine in more detail the differential effectiveness of both elements of CPT (cognitive restructuring of trauma-related dysfunctional beliefs and written trauma account), a dismantling study compared the full 12-session CPT with both CPT without the written trauma account (Cognitive Therapy Only), and written trauma accounts only [Resick et al., 2008]. In all 3 groups there was a significant improvement of PTSD symptoms, and the groups did not differ significantly. CPT-C, however, showed the fastest improvement in symptoms, with the fewest dropouts. This result suggests that CPT-C is a good alternative to the full CPT program, as confirmed in a more recent study comparing CPT-C with CPT [Walter et al., 2014].

CPT for Treatment of Complex PTSD

So far, there have been only a few studies on CPT for the treatment of patients with complex trauma history who experienced violence in childhood and adolescence.

The research up to now suggests, however, that victims of sexual abuse in childhood and patients with comorbid borderline personality symptomatology benefit equally from CPT as compared to other patient groups, assuming that they suffer in general from more severe symptoms both before and after treatment [Resick et al., 2003; Chard, 2005; Clarke et al., 2008].

Moreover, a comparison of randomized controlled trials for treatment of adult victims of sexual abuse in childhood showed that cognitive methods such as CPT were superior in this particular patient group to exposure-based methods, both in their effectiveness and in the smaller number of dropouts [Neuner, 2008].

Overall, these results suggest that CPT is also applicable for patients with complex PTSD who were traumatized early in life; however, due to their more severe symptomatology, some adjustments would be indicated, such as a larger number of sessions and the development of an emergency plan. Such changes for example were incorporated in the Developmentally Adapted Cognitive Processing Therapy (D-CPT; [Matulis et al., 2014]), a special variant of CPT for adolescents and young adults with PTSD after interpersonal violence.

CPT-C is particularly useful for the treatment of patients with complex PTSD, since the lack of formal exposure is less distressing for the patients and yet achieves just as good effects as classical CPT or purely exposure-based methods [Resick et al., 2008], which are not well accepted in clinical practice [Becker et al., 2004].

CPT-C for Treatment of Patients with Complex PTSD

Treatment Format

In the following we are going to describe CPT-C, as it is currently being applied in the RELEASE study funded by the BMBF, for the treatment of patients with complex PTSD after sexual or physical violence in childhood and adolescence. The study is being directed by Martin Bohus and implemented in 3 centers: Mannheim (led by Martin Bohus), Frankfurt (led by Regina Steil), and Berlin (led by Thomas Fydrich). This study is using an adapted version of CPT-C by Resick et al. [2008]. 4 probatory sessions were added to the original CPT-C, with the aim of recording the case history and formulating emergency plans for suicidal or other crises in addition to relationship building. These probatory sessions are combined with the 12 CPT-C core sessions, which are described below in greater detail. Then additional individually relevant topics are addressed with a flexible treatment duration of up to 29 additional sessions.

Model of PTSD

To explain the development of PTSD symptoms, CPT-C uses a social-cognitive model according to which successful treatment depends on whether and how the traumatic event can be integrated into the person's existing schemas. The symptoms of PTSD arise when the event is contrary to the person's previous beliefs or confirms or strengthens existing negative beliefs. A traumatic experience such as rape, for example, shatters most people's expectation that there is a just world in which 'good people' experience goodness and transgressions are punished. According to the CPT-C PTSD model, a traumatic event can lead to various attempts of integration. One of them is assimilation, by which the memory or interpretation of the traumatic event is changed so that it fits into pre-existing assumptions. Concretely, this can mean that a woman who has been raped blames herself and assumes that she could have prevented the assault. Self-blame here often has the function of maintaining the illusion that one can control events and maintaining the just world belief.

Another option for dealing with the contradiction posed by the trauma is to change and adapt one's pre-existing assumptions. If this happens to a degree corresponding to reality, it is called accommodation, which is associated with successful processing. Often, people who have experienced traumatic events develop, however, extreme, rigid assumptions that are associated with negative expectations about the present and the future. This mechanism is referred to CPT-C as over-accommodation. It includes assumptions such as that something terrible could happen at any moment or that nobody can be trusted.

For people who have confronted stressful events in childhood, or have experienced emotional violence from their caregivers, the traumatic event may confirm earlier dysfunctional assumptions and lead to their further chronification, e.g., by treating the event as proof that one deserves nothing good.

Treatment Goals

The goal of CPT-C is to use the mechanisms described below to uncover and modify dysfunctional beliefs, which are referred to as 'stuck points'. In this context an important distinction is made by CPT-C between 'natural' and 'manufactured' emotions. While natural emotions, such as fear, helplessness and disgust, relate directly to the traumatic event, manufactured emotions depend on one's interpretation of it. For example, the assumption by the victim that she is responsible for the rape because she visited the perpetrator that day (assimilation) leads to manufactured emotions such as guilt and shame. The goal of treatment in CPT-C is to counteract the patient's tendencies to avoid dealing with the traumatic event and to support the patient in feeling their natural trauma-related emotions, to reduce manufactured emotions through modification of the underlying stuck points, and to adapt one's own belief system to reality (accommodation).

Course of Treatment

Probatory Sessions

In addition to building an effective therapeutic alliance, the first 4 sessions contain a detailed case history, explore the patient's specific problematic behavior, and work out emergency plans. Concrete strategies are developed that the patient can use in emergency situations, e.g., reorientation toward the present and physical activity in the case of dissociative symptoms. In the 4th session, the patient is informed about the CPT-C therapeutic procedure, and a specific treatment contract is concluded. In this session at the latest, if there are several traumatic experiences, the most stressful events for the patient is identified as the focus of treatment. The patient is asked about problematic behavior, such as self-injury, high-risk behavior, or dissociation, at the beginning of each session, and if necessary, these are also addressed by cognitive strategies.

CPT-C Core Sessions

The sequence of the following 12 sessions is precisely set by CPT-C (fig. 1).

They start with psychoeducation about the symptoms of PTSD, the model of PTSD and the treatment rationale. Next, the patient is asked to write a report about the causes and effects of the event ('Impact Statement'), in which she addresses the question why she thinks the traumatic event (e.g., the sexual abuse) occurred and how this experience has influenced her thinking about 'safety', 'trust', 'control', 'self-esteem', and 'intimacy'. In the subsequent session, stuck points are derived from this report and recorded in a stuck point log. As the treatment proceeds, these will be analyzed with the help of consecutively introduced worksheets. The worksheets are introduced step by step and are intended to support the patient in questioning her own dysfunctional beliefs. It starts with ABC worksheets ('activating event', 'belief/stuck point', 'consequence'), in order to help the patient to develop an awareness of the relationships of thoughts and feelings. This will be supplemented in the next step, with the introduction of 'Challenging Questions', which help the patient to question her own stuck points. For

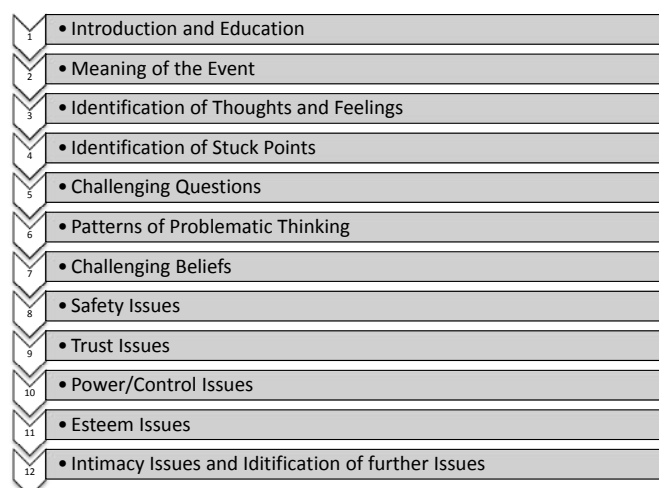


Fig. 1. The 12 CPT-C core sessions.

example, gathering evidence for and against a certain belief, and the question of whether the chosen source of information is trustworthy; this question aims to counter the perpetrator's accusations that the victim is to blame. In the following step, the patient learns about typical 'Patterns of Problematic Thinking' and is encouraged to find them in her stuck point log. These include, for example, the tendency to disregard important aspects of a situation, which can lead the patient to ignore her vulnerability as a child to the perpetrator, who is clearly more powerful than she. Another 'Pattern of Problematic Thinking' is the emotional reasoning that occurs when the patient's judgement is based on her feelings rather than on facts. Finally, the 'Challenging Beliefs Worksheet' is introduced, which integrates all the techniques that have been taught, and will be used throughout the whole treatment to challenge the patient's stuck points and to develop alternative thoughts. For this purpose, the patient is asked from the beginning to use the worksheets daily on her own, to analyze both trauma-related beliefs and relevant everyday situations. Thereby the therapeutic focus is at the beginning of the treatment on challenging self-blame and feelings of guilt (assimilation).

The next 5 sessions are devoted to specific topics that often contain stuck points of patients with PTSD: safety, trust, power/control, esteem, and intimacy.

The corresponding worksheets help the patient to understand how the trauma, depending on her previous experiences, could have affected her thinking in this areas. Hereby, the patient's individual stuck points are examined in relation to herself ('I'm not safe anywhere') and to other people ('The world is dangerous, I should keep away from other people'), as well as possible alternative assumptions ('There are people in the world who are dangerous, but not everyone wants to harm me'). Specific cognitive techniques are used for each module. For example, calculating probabilities can help to develop a realistic assessment of risk in future situations.

Variable Design of Treatment after the 16th session

Starting with the 17th session, the choice of topics is guided by the patient's stuck point log. In this phase, individual outstanding

issues from the previous 12 sessions can be addressed more intensively. If, with regard to the worst event (or the worst class of events) that was addressed up to then, no relevant topics are left and the PTSD symptomatology related to it has diminished, other traumatic events can be worked on, if indicated. Before, a new Impact Statement must be written, about the implications of the worst event, that is compared with the first statement to precisely analyze the achieved changes.

Towards the end of the therapy, questions of life choices (activities, social relations, career prospects, etc.) become central. These are also addressed using cognitive techniques.

Case Study

The application of CPT-C for treatment of complex PTSD is illustrated below with a specific case study.

Spontaneously Reported Symptoms

Ms. A., age 26, suffered, as a result of years of almost daily sexual and physical abuse by her stepfather when she was between the ages of 4 and 12, from intrusions in form of distressing images and strong physical reactions related to the abuse. She further told that she had been emotionally neglected by her mother when she was a child. The patient reported that she quickly became irritable and angry. She experienced strong inner tension and sudden mood swings. These had already begun in childhood and adolescence, and in an intimate relationship in adulthood these emotions were so strong that aggressive outbursts also occurred. At the start of therapy, the patient reported significant concentration problems and being easily startled – there were ‘months where she ‘could not motivate myself to anything’. She slept only a few hours and was therefore often exhausted. Ms. A. described it as difficult to ‘stand intimacy’ in close social relations. Intrusive memories often lead to feelings of shame, guilt, and disgust. She suppressed thoughts about what had happened to her as quickly as possible. Since adolescence she had resorted to frequent alcohol and drug consumption to do that. Ms. A. also suffered from dissociative symptoms and memory gaps. Following the Axis-II diagnostics of the International Personality Disorder Examination (IPDE; [Loranger et al., 1994]), the patient met the following criteria for emotionally unstable personality disorder: excessive efforts to avoid abandonment, unstable relationships, identity disorder, affective instability, chronic feelings of emptiness, as well as intense rage and dissociations.

Personal History

The patient reported that she, her younger brother, and her much younger and physically disabled sister grew up with her mother, and after she reached the age of 2, also with her stepfather. He screamed at her and beat her; one day he wrapped her hands in paper and set it on fire. Starting at the age of 4, he sexually abused her almost every day if her mother was not at home. If she misbehaved, she would have to sleep in the kitchen, for example, or

would not be permitted to eat. The parents were not giving emotional support to her; in the morning, she had to get ready alone to go to school, where she was almost continuously bullied. After earning an advanced technical certificate, she started an apprenticeship, and at the beginning of her treatment she was working full-time and doing a correspondence course. She had never previously undergone either outpatient or inpatient psychotherapy.

Diagnoses According to the International Classification of Diseases (ICD-10)

F43.1 Post-traumatic stress disorder

F60.31 Emotionally unstable personality disorder, borderline type

Course of Treatment

Probatory Sessions

In the first 4 sessions, in addition to building an effective therapeutic alliance, both a biographical and trauma case history were compiled. Despite her initial distrust, the patient was able to engage quickly in the therapeutic alliance. To be able to respond in a timely manner to symptoms of emotionally unstable personality disorder, potentially harmful problem behavior patterns (alcohol consumption, not looking before crossing the street, dissociation) was identified and an emergency plan for situations of strong emotional stress and suicidality was worked out. Here the lack of sleep was determined to be a vulnerability factor, with reference to the tendency toward dissociation. The coping strategies incorporated into the emergency plan included contacting close friends, sports, and the phone number of the relevant hospital.

Afterwards Ms. A. was informed of the steps by which CPT-C proceeds, and she and her therapist signed the therapy agreement, which included a non-suicide commitment.

CPT-C Core Sessions

The patient audio-recorded the therapy sessions and was asked to listen to these before each subsequent session. At the beginning of the treatment, she was given detailed psychoeducation about PTSD, as well as about the relevant maintaining factors and the cognitive treatment rationale of CPT-C, discussing in detail the problem of cognitive avoidance, which needs to be abandoned for an effective treatment. Already at the very beginning of the therapy, the patient stopped by herself the practice of listening to an excessive amount of music, which she had used as an avoidance strategy. Ms. A. wrote a report on the effects of the most stressful event (sexual abuse by her stepfather). She reported that at first she had put off writing it, but then she noticed that dealing with the traumatic experiences had already ‘helped a bit’. The first stuck points were derived from this Impact Statement, with an emphasis on assimilation (‘I am responsible for the abuse because I didn’t tell anyone’). Then the first worksheet (ABC Sheet) was introduced, with a focus on the clear distinction between thoughts and feelings. Since the patient had identified confrontation with men who look like the perpetrator as a trigger, a trauma-associated everyday situation

A. Situation	B. Thought/Stuck Point	D. Challenging Thoughts	E. Problematic Patterns	F. Alternative Thought(s)
Describe the event, thought or belief leading to the unpleasant emotion(s).	Write thought related to Column A. Rate belief in each thought/stuck point below from 0-100%. (How much do you believe this thought?)	Use the 'Challenging Questions' to examine your automatic thought from Column B. Consider if the thought is balanced and factual or extreme.	Use the Patterns of Problematic Thinking Worksheet to decide if this is one of your problematic patterns of thinking.	What else can I say instead of Column B? How else can I interpret the event instead of Column B? Rate belief in alternative thought(s) from 0-100%
<i>Ring the neighbor's bell to pick up a parcel.</i> <i>A dark-skinned man opens the door.</i>	<i>All dark-skinned men only want sex.</i> <i>100%</i>	Evidence For? / Evidence Against? <i>Not all men are the same.</i> Habit or fact? <i>Habit</i> All or none? <i>Yes</i> Extreme or exaggerated? <i>Thought is worded extremely: „all“.</i> Out of context? <i>Dark-skinned men do not necessarily have something in common with the perpetrator.</i> Source unreliable? <i>Me.</i> Low versus high probability? / Based on feelings or facts? <i>Feelings</i>	Jumping to conclusions: <i>Because the men remind me of him, I presume that they are like him.</i> Exaggerating or minimizing: <i>Exaggerating</i> Disregarding important aspects: <i>Human beings are individuals and cannot be categorized.</i> Oversimplifying: / Mind reading: <i>When he looks at me I think he wants me naked.</i> Emotional reasoning: <i>Because it feels dangerous, there has to be danger.</i>	<i>The neighbor is not my stepfather. I'm just thinking this way because he reminds me of him.</i> <i>80%</i>
	C. Emotion(s)			G. Re-rate Old Thought/Stuck Point
	Specify sad, angry, etc., and rate how strongly you feel each emotion from 0–100% <i>Anger – 80%</i> <i>Disgust – 70%</i>			Re-rate how much you now believe the thought/stuck point in Column B from 0-100% <i>30%</i>
				H. Emotion(s)
				Now what do you feel? 0-100% <i>Anger – 20%</i> <i>Disgust – 20%</i>

Fig. 2. Completed 'Challenging Beliefs Worksheet'.

was addressed using the ABC schema, and she and the therapist jointly questioned the stuck point 'If I'm not attentive, something bad will happen to me' (e.g., using probability calculations). Ms. A. said that it was difficult for her 'to let go of the thoughts', but that the reprocessing gave her 'hope by seeing that one can perhaps think differently'. At this point, she was able to independently develop alternative, more functional thoughts ('Not all [men] are the same. Just because it happened to me, doesn't mean it happens/happened to all other [children].'). Then, the Challenging Questions and the concept of Patterns of Problematic Thinking were introduced for questioning and changing the stuck points. During the treatment session, the patient often became tense and got into mildly dissociative states if the stresslevel increased. A short break to 'get some air' as well as reorienting questions ('Where are we? How old are you today? What is different now than it was then?') were used as 'groundings' to stop the dissociative episodes. The previously used cognitive tools were then incorporated into the 'Challenging Beliefs Worksheet', which was utilized in the whole further course of treatment for intensive challenging of dysfunctional beliefs. By this point, the patient had already become well able to distance herself independently from the stuck point 'I am to blame for the abuse' ('I was a child, I was afraid, and there was nothing I could do against him. I am in no way to blame, but he is.'). Regarding the topics 'Safety' and 'Control', it became clear that the patient was anxious that she would not be able to deal with her feelings. This was reduced by Socratic questioning and thera-

pist-assisted exploration of the corresponding stuck points ('I have already resisted so much and have to summon up the courage to engage with my own feelings, so that I can get better'). This enabled the patient to deal with strong anxiety-provoking issues. Ms. A. began, on her own initiative, to examine her thought patterns also between sessions on the behavioral level; she asked her friends, for example, about the thought 'I must do something to make people like me'.

Variable Sessions

Following the 12 structured CPT-C sessions, the therapist and patient together created a goal hierarchy, with the still-to-be-processed dysfunctional beliefs and updated the stuck point log. The focus was then on topics of self-esteem that are typical for emotionally unstable patients ('I don't deserve to be complimented'), as well as the belief that all men who look like the perpetrator abuse children. In everyday life, this stuck point triggered strong intrusive re-experiencing, disgust, and anxiety, and the patient was ambivalent for a long time about addressing it. Her commitment, however, deeply increased after clarifying the protective function behind this belief ('Then this can't happen to me again'), so that Ms. A. was also able to successfully work through this belief ('This man is not my stepfather. I have this fear because of the things my stepfather did to me.'). Figure 2 shows a worksheet completed by the patient in this context. The challenging of this stuck point led to a significant reduction of stress and of the whole PTSD symptomatology.

Towards the end of treatment, she challenged the fear that other people could see that she was abused, and addressed her anxiety about overwhelming memories. The experience of sexual arousal caused by intrusions gave Ms. A. a distinct feeling of shame and the thought that this could mean that she had wanted it [the abuse, transl.]. In the context of reality testing, however, the patient was able to successfully modify this stuck point. Ms. A. then wrote a second Impact Statement, which was used to compare together her beliefs before the therapy ('They feel so strange now') with those at the end. This enabled the patient to acknowledge her great progress, and she felt proud of her success.

After the successful treatment of the sexual abuse, the focus was on the patient's difficulties in social interactions (e.g., tension in the subway, if other people behave in a way that she thinks is inappropriate, for example, eating or talking loudly to each other) and the subject of 'Self-esteem'. Stuck points in these areas were attributed to the symptoms of emotionally unstable personality disorder (especially difficulties in social relationships, unstable self-image, and intense rage). Here, Ms. A. also attached importance to the topic of empathy, which was still difficult for her to show because of her experiences of violence. The last sessions of the therapy were devoted to review the prior course of therapy and a joint summation of the techniques learned, so that the patient could continue independent work even after the end of the therapy. The emergency plan chosen at the beginning of the treatment was revised and expanded with newly learned techniques ('Challenging Beliefs Worksheet', 'talk to other people about my thoughts/feelings'), in order to prevent a relapse into old patterns of thoughts and behavior.

Treatment Result

In the course of the therapy, the patient reported a significant reduction in stress from intrusions, less tension, and a marked reduction of outbursts of rage. In her everyday life, she reported to feel more seldom helpless and more often in control. Problematic behaviors like crossing the street without looking and the previously described dissociation occurred significantly less. Ms. A. said at the end of the therapy, that she was now in a better position 'to do things for myself' (self-care), and could concentrate much better. Intrusions occurred much less frequently. She explained that she had learned 'to deal with the thoughts'. She reported to be much more relaxed, to be able to tolerate having people around her (e.g., in public transport), and not having to listen to music all the time to distract herself. Within the family, she knew better where to draw the line and had plans for the future (finishing university, changing jobs). She indicated that she could not change what happened, but had learned to deal with it differently. The treatment outcome is also reflected in her scores on the questionnaires she completed. The test scores on the Davidson Trauma Scale [Davidson et al., 1997] at the beginning and end of treatment are shown in figure 3. The sum score of the Beck Depression Inventory (BDI-II; [Hautzinger et al., 2006]) fell from 22 at the beginning to 9 at the end of treatment. Symptom reduction also took place in the severity of borderline symptomatology, as measured by the Borderline Symptom List (BSL-23; [Bohus et al., 2007]), where the percentile rank decreased from 33 to 2 in comparison to other borderline patients.

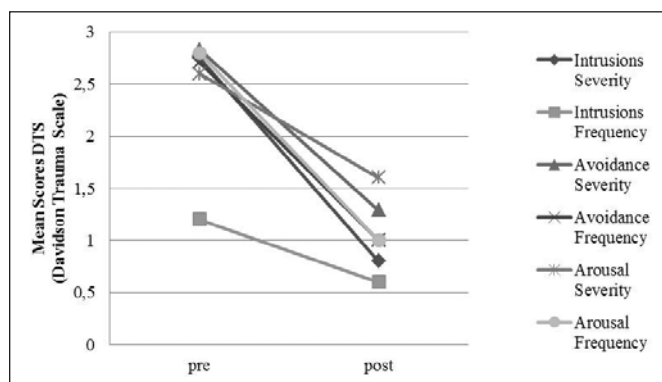


Fig. 3. Ms. A.'s scores on the Davidson Trauma Scale.

Conclusion and Outlook

Many new findings demonstrate the long-term negative effects of violent experiences in childhood on mental as well as physical health [Irish et al., 2009]. Specific intervention strategies that are well accepted by both patients and practitioners can alleviate the symptoms, improve the patients' quality of life, and prevent secondary illnesses.

The purely cognitive variant of CPT (CPT-C), described in this article and presented through the case study, should be given greater attention and dissemination for the treatment of traumatized patients, because it allows the waiver of formal exposure and yet is just as effective as exposure-based methods [Resick et al., 2008].

Especially in care for patients with complex PTSD and comorbid disorders such as emotionally unstable personality disorder, CPT-C offers a great opportunity, because it can counteract the concerns of patients and practitioners regarding possible negative consequences of a formal exposure to the trauma content. The highly structured nature of the individual sessions is seen by patients with relationship difficulties as helpful for building a trusting working relationship.

However, further studies are needed to investigate in more detail the specific efficacy of this treatment in patients with complex PTSD. The results of the RELEASE study will also add further information. Due to the expected inclusion of the new clinical picture of complex PTSD in the ICD-11 [Maercker, 2013], which devotes greater attention to the marked severity and the consequences of experiences of abuse beyond PTSD, attention to the treatment of this particular group of patients will increase.

Disclosure Statement

M. Müller-Engelmann and R. Steil are lecturers in continuing education and vocational training for the treatment of PTSD.

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