CBT for ASD manual

SESSION 1 (60 mins)

Agenda
- Review week (5 mins)
- Psychoeducation (15 mins)
- Rationales for CBT treatment components (25 mins)
- Breathing control (10 mins)
- Assign homework (5 mins)

Materials
- "Common reactions to trauma" handout
- "Slow breathing exercise" handout
- "Breathing control monitoring form"

Review week (5 mins)
- Review week and obtain SUDS rating:

> *When you think back over the past week, how distressed have you generally felt (where 0 = no distress, and 100 = extremely distressed)? Take a couple of minutes to think about your response.*

- Explain that today we will be giving you some feedback about your difficulties and providing some detailed information about the treatment program.

Psychoeducation and feedback (15 mins)
Education about ASD symptoms
- Provide client with a formulation of the information gathered during the assessment.
- Normalise their symptoms.

> *Following a trauma, people often experience the sorts of problems you have told me about. We call this posttraumatic stress. It means that after you have been through a traumatic experience you tend to feel very scared, on edge, and uncertain about things. This happens because when you go through a trauma you can learn that things around you can be harmful and you tend to be on the lookout for other things that might hurt you again. It is common for people to have upsetting memories of their trauma, to dream about it, and to feel very distressed when they are reminded of it. People can get very upset after a trauma because they are on the alert for harmful things to happen again. These are all common and understandable responses to an event that has taught you to be wary of things around you. I want you to understand that all the sorts of problems that you are having are very common considering what you have been through.*

- Provide an outline and brief explanation of the types common reactions in ASD.

Let's talk about each of these reactions in detail:

<u>Intrusions</u> may come in the form of flashbacks, dreams, or memories of the trauma popping into your mind when you don't want them. They can be very upsetting. It's important to be aware that these sorts of memories serve the purpose of allowing the mind to process the trauma by playing it over repeatedly. Because the experience you have had is so important to you, your mind has a need to keep thinking about it so that it can understand and resolve it. This may seem strange to you but these sorts of memories and feelings can be useful because they give us plenty of occasions to learn about our experiences and to sort through them.

<u>Avoidance</u> of thoughts, activities, places and anything else that reminds you of the trauma is another common reaction. People often do this because thinking about it is so distressing that it seems much better to simply put it all aside. In fact, doing this often makes people feel a little better for that moment because they can distract themselves from the distress associated with the experience. What we need to be aware of here, however, is that this sort of avoidance is actually preventing you from getting over the experience.

<u>Emotional numbing</u> is another way people try to avoid the distress associated with the trauma. It refers to feeling emotionally flat, feeling like you are in a daze, feeling the world is not real, or feeling like you are looking at yourself from the outside. These are often signs that you are trying to block the feelings that they have about it. All these reactions might be happening because you are distancing yourself from what has happened. In a sense, it's a way of turning your back on the whole experience. Although this form of avoidance can reduce the distress in the short-term, it eventually gets in the way of resolving this experience because it does not allow people to connect with and resolve what they have been through.

<u>Physical arousal</u> refers to the body being in a heightened state of arousal. This causes problems with sleeping, concentration, feeling restless and irritable, or being very sensitive to what is going to happen next. Physical arousal is a sign that even though the trauma is over, the body is still in the 'alert' mode and is still prepared to deal with the threat. This elevated arousal can be very distressing for people because it leads to all these problems that can interfere with daily functioning. What we need to do is learn some ways to reduce this arousal. That is, we need to teach the body that the trauma is now over and it can relax a bit more. When we do this, some of these problems caused by the arousal will ease off.

- Illustrate each point with examples from the client's own experience. This will increase the relevance of the information for the client and will increase their confidence that the therapist has heard and understood their experience.
- Allow opportunities for the client to ask questions and clarify the ideas presented.
- Ask the client to explain their new understanding of how the trauma has affected them. Clarify any misunderstandings as required.

Treatment rationales (25 mins)

- Provide rationales for each component of treatment:

> *So it is clear that these post-traumatic stress symptoms are normal and common. The problem is that you don't really need these stress reactions anymore because the trauma is over. However your body and mind think that you still do. We discussed before how some of these normal responses actually contribute to your current problems. Let's go through each reaction and think about how this happens.*

- Discuss the effects of cognitive avoidance and introduce rationale for prolonged exposure.

> *First, intrusive memories and nightmares are a sign that the trauma is "unfinished business". When people go through a trauma, their mind automatically tries to process it. However, this process is often so distressing that the person tries to avoid thinking about it. Unfortunately, this means the trauma never gets processed, and it keeps on bothering you through dreams and memories. Even worse, the more you try and avoid thinking about it, the more they come back to you. To illustrate this process I'd like you to sit back, relax, close your eyes and picture a big white polar bear for a moment. Tell me when you have that image clearly in your mind.....Okay, now I would like you to spend the next couple of minutes trying to suppress that image of the white polar bear. Don't let the thought enter your mind for a second..... Okay, what happened when you tried to suppress it?..... [The client will typically report thoughts of the bear]. Right, this is exactly what happens with your memories of the trauma. If you try and suppress the memories, they will usually pop into your mind. And because they haven't properly been processed, they are normally very intense and upsetting. What we need to do then, is to help your mind process these memories. In treatment, you will learn to expose yourself to the memories of the trauma in a controlled manner until these memories no longer cause overwhelming distress.*

- Provide brief rationale for breathing control exercise.

> *Secondly, your body has responded with elevated arousal because it is still expecting to have to deal with a threatening event. There are now all sorts of things that can remind you of the trauma, and your body responds to these reminders [use examples] as if it is back in that dangerous situation. This leaves you feeling pretty stressed, irritable, hyperaware and unable to sleep. We will be practicing a strategy today that targets this arousal. This is a breathing control strategy.*

- Discuss effects of behavioural avoidance and introduce rationale for in vivo exposure.

Thirdly, it is also important to understand why this arousal is still bothering you. It is understandable that you try to avoid anything that reminds you of the trauma, because they trigger off the symptoms of physical arousal. Unfortunately though, this avoidance actually worsens the anxiety. Your body never gets to learn that these things no longer signal danger, and your anxiety gets reinforced over and over again. In therapy, we will be teaching your body that these situations are safe. We do this by gradually confronting these situations, and staying there long enough that you learn that nothing bad will happen. As your body learns this, your anxiety reduces and these tasks get easier and easier.

- Discuss the effects of trauma on beliefs, and introduce rationale for cognitive therapy.

  Lastly, having experienced a traumatic event that was out of your normal experience, the way you view yourself and the world in general would necessarily change, perhaps without your being aware of it. Trauma survivors often perceive the world as dangerous, other people as untrustworthy, and themselves as incapable of coping with their reactions and daily stress. Survivors may also believe that they are in some way at fault for the event and that they deserve to be traumatised. These thoughts can lead a person to feeling more anxious, and pretty bad and down about themselves. To help you get back to feeling like you did before the trauma, we need to have a look at these new thoughts and beliefs and check out how realistic and helpful they are.

- Provide summary. Elicit client's comments and address any misunderstandings.

  So in summary, the skills that we will teach you in therapy will be:
  2) *Processing the memories of the trauma*
  3) *Breathing control strategy*
  4) *Exposure to situations and things that remind you of the trauma*
  5) *Identifying and challenging unhelpful or negative thoughts or beliefs.*

  Have I explained this OK? Do you have any questions?

- Explain the structure of treatment.

  This treatment will take five sessions, and each session will last about 90 minutes. The overall aim of this program is to tackle these problems before they become entrenched. However, sometimes this will mean that there may be some residual problems still existing at the end of the five sessions. Don't be concerned about that because recovering from a traumatic experience is often an ongoing process. What we are doing here is teach you the basic skills that you require to help you resolve your experience. Moreover, these skills will help you deal with any problems that might resurface in the coming

months. Our main goal at this stage is to reduce the distress that you are feeling and to reduce the sorts of problems that have been getting in the way of you living the way you want to.

- Orient client to collaborative skills-based approach and identify avoidance as a potential obstacle. Problem-solve ways of dealing with avoidance. Suggested process:

  During treatment I would prefer us to work as a team. I cannot "cure" you in the way that a pill might cure an illness. Rather, I would like to share with you some techniques that research has shown can overcome the sorts of problems that you have been experiencing. That's my side of the process. The other side of the process will involve you doing a range of exercises that I will ask you to practice between sessions. What that means is that doing this sort of therapy requires considerable work on your part. I will be here to help and support you with every step along the way. So after each session we will set some homework to be completed between sessions. I am feeling hopeful that if we can work together in this way, we can make some headway in dealing with these problems.

  Often the hardest obstacle to overcome is 'avoidance'. It makes a lot of sense that you have tended to avoid reminders of the trauma so far. And it's likely that you will sometimes want to avoid sessions or homework. However, this is going to get in the way of treatment and and in the way of your recovery. We need to work together to face this avoidance. What could you do if you felt like avoiding treatment sessions?

Breathing control (10 mins)

- Provide rationale for breathing control exercise. Suggested process:

  The first thing I will be teaching you is to learn how to reduce the arousal that your body has been experiencing. The sooner we can do this, the more you will notice that some of the problems caused by this arousal will ease. As we have discussed, it is common for the body to be very aroused following a trauma. This arousal can make your anxiety feelings worse. So by learning how to reduce your arousal, you will have an ability to reduce some of your anxiety. This will involve you learning to do to control your breathing. This strategy can be very useful for you in the coming weeks because they will help you cope with the distress that you will periodically experience.

- Explain the role of breathing in anxiety. Elicit common breathing-related symptoms of anxiety. Suggested process:

  Breathing is a very simple, but critical, mechanism that influences how relaxed we feel. We typically breathe very quickly when we are frightened or upset. What sort of breathing-related reactions do you notice when you're getting anxious?

- Explain the consequences of hyperventilation. Suggested process.

  Although being scared brings on fast breathing or hyperventilation. Hyperventilation actually brings on a number of other reactions that we associate with being anxious. These include breathlessness, a feeling of choking, chest pains, and light-headedness.

  Hyperventilation also disrupts the balance between oxygen and carbon dioxide in our bodies. It is this disruption that causes symptoms like feeling light-headed and dizziness.

  The way out of this situation is to learn to slow down our breathing and ensure that we are taking less air into our bodies. The result of this will be a feeling of greater relaxation and control.

- Explain breathing control as a skill. Suggested process.

  The technique that we are going to learn, like any other skill needs to be practiced. The more you practice it the better you will become at using it. So don't be concerned if initially you have difficulty applying it. It does take time. It's important that you practice it twice daily, and its best if you try to practice it at times when you are not very anxious or uptight. By doing this you will be better prepared to use it effectively when you are feeling anxious.

- Demonstrate and rehearse procedure:

  Now in a moment I am going to ask you to take a normal breath in. Not a deep breath but just a normal one and inhale through your nose. Okay, now take a normal breath in through your nose. That's good. Now, I want you to breathe out slowly and easily. As you breathe out, I want you to say the word "relax" to yourself. Okay, and again. And say r-e-l-a-x to yourself as you slowly breathe out. Now keep breathing in and out. To help you get the timing right, try saying to yourself: "1….2….3….in" and then as you exhale: "1….2….3….out". And you say the word "relax" every time you breathe out.

- The client should rehearse this procedure for approximately 10 minutes as the therapist observes their progress. During this rehearsal the therapist can count out loud as the client breathes in and out.

Possible Problems:

- It is important that the therapist instructs the client not to take too deep a breath initially because this may elicit an anxiety response in acutely traumatised clients.
- Therapists should also be cautious using breathing control techniques with clients who have been traumatised by attempted suffocation, choking, or suffered injuries where their breathing was impaired.
- It is common for clients to report an increase in anxiety during the initial stages of anxiety management. These clients should be told that this is a common

response, and this perceived increase in arousal simply reflects their heightened awareness of their internal states.

- It is also common for clients to report that this has no effect on their level of anxiety or is “too difficult”. It should be explained that this is a skill that requires daily practice, and it is only after sustained period of rehearsal that they will reap the benefits.

Homework (5 mins)

- Provide handout “Common reactions to trauma”. Ask the client to read through it during the week and ask if there are any family members that they would like to discuss it with.
- Twice-daily practice of breathing control exercise when not anxious. Provide and explain “Breathing control monitoring form”.

SESSION 2 (90 mins)

Agenda
- Review week and homework (10 mins)
- Cognitive therapy: Rationale, identification of trauma-related unhelpful thoughts, ABC model and unhelpful thinking patterns (25 mins)
- Prolonged exposure: Rationale and session (50 mins)
- Assign Homework (5 minutes)

Materials
- "PE monitoring – in session" form
- "PE monitoring- homework" form
- "Cognitive therapy" handout
- "ABC monitoring form"

Review week and homework (10 mins)
- Review week and obtain SUDS rating:

> *When you think back over the past week, how distressed have you generally felt (where 0 = no distress, and 100 = extremely distressed)? Take a couple of minutes to think about your response.*

- Review homework. Discuss any questions that were raised by the handout. Review monitoring of breathing control, and address any difficulties.

Cognitive Therapy (25 mins)
- Review rationale for cognitive therapy.

> *We all have a constant stream of thoughts running through our minds – we call this self-talk. These thoughts are automatic. We don't try to have these particular thoughts, they just come to us and they reflect our beliefs and attitudes about the world, other people and ourselves. Occasionally something happens that makes us change our way of thinking. The recent trauma you have been through may have resulted in a marked change to the way you see yourself and the world. For example, some people suddenly see the world as much more dangerous, uncontrollable and unpredictable. As a result, they feel scared and unsafe a lot of the time. They believe that they should always be on guard to protect themselves from further trauma. This can leave a person feeling constantly on edge and at risk. Or perhaps a person might be feeling very guilty about something that happened, and they feel extremely responsible for the unpleasant things that have occurred. This can lead a person to feeling very down and bad about themselves. These sorts of thoughts can also lead a person to feeling that they may not overcome their recent trauma because they feel that the world and their future is too overwhelming.*
>
> *For example [modify accordingly] before your recent trauma you probably felt that you could drive your car and feel pretty safe as you drove to wherever you needed to go. That is, you believed that the roads were*

basically a safe place if you drove sensibly. After your accident, however, you are now feeling very unsafe on the road and do not want to drive again because you feel that you might be harmed again. You now believe that every time you get behind the wheel of your car you are putting yourself at risk of being seriously hurt. Whereas you previously thought that you were safe, you now think that the world is dangerous and you are vulnerable. Of course, when you think this you feel scared, nervous, cannot sleep properly, and want to avoid all the things that may put you in places where you are at risk. What I want you to understand is that all these reactions are occurring because of your new belief that the world is a dangerous place and that you are very vulnerable.

These new beliefs can be hard to change unless you become aware of them and recognize that this way of thinking is unhelpful and unrealistic. I want you to understand that my goal here is not to change the way you think about things. The trauma that you have been through is a very personal experience, and the things that you are thinking about since that time are entirely understandable considering what you have been through. What we need to do here is to work out what beliefs are realistic and what are not. I appreciate that what you believe at the moment is real for you and I don't want you to think that I am doubting how strongly you feel about what you have experienced. We are just going to explore the sorts of thoughts that you have so that any that are not helpful for you can be understood in a different light. For example, if you believe at the moment that you can never feel safe again..... for the rest of your life...., then you are most probably going to feel pretty hopeless about the future. On the other hand, if you can consider that you feel very unsafe now but that some things may happen in the future that might make things safer for you, then you may feel a bit more optimistic. Does that make sense?

So what we are going to do here is learn how to interrupt the automatic thought process and become aware of your automatic thoughts. Once we've done that we are going to learn how to challenge any unrealistic thoughts with more realistic and positive thoughts. We will do this at a comfortable pace, and its something that we will be doing together. Probably the best way for you to think of this exercise is to imagine that we are both experimenters, and we are testing available evidence to see whether a particular theory fits or not. That is, we look at your thoughts, test them against whatever evidence we have at that time, and work out how valid these thoughts are.

Identifying automatic negative thoughts

- Explain that first step involved in this process is learning to identify the automatic thought process.
- Demonstrate this exercise to the client, utilising the client's own thoughts. Use examples from daily life (e.g., you ran into a colleague in the corridor and he/she didn’t say hello, or coming to the first treatment session). Often it is preferable to begin with a benign thought because it allows the client to learn the process without the distress associated with trauma-related issues.

- Illustrate the relationship between thoughts and feelings using the ABC model, where "A" is the activating event, "B" is the beliefs or thoughts, and "C" is the emotional consequences. Emphasise that one event can result in a many different interpretations, and these have important implications for the way we feel.
- Below is an example of an interaction that attempts to identify a negative thought. Notice that wherever possible ask questions that allow the client to learn, for themselves, the irrational nature of the target thought and to draw their own conclusions on the basis of this insight.

CASE EXAMPLE
THERAPIST: As we discussed before, the way you feel about anything is going to be strongly influenced by what you think. For example, imagine that you are walking down the road and you hear a sound in the bushes. You immediately think that there's a thug hiding in the bushes. What would you be feeling?
CLIENT: Petrified.
THERAPIST: Sure, that's how I'd feel too. Most people would be very scared if they thought a crook was hiding in bushes as they passed by. But what if you found out that it was only a cat in the bushes. What would you be feeling then?
CLIENT: Oh, that's no problem. I would just say to myself that it's a cat and keep on walking.
THERAPIST: What different reactions did you notice within your self to these different perceptions? Although it's the same noise, did you feel different depending on what you believed was making the noise?
CLIENT: Well, yeah, when it was a thug in the bushes I felt very scared but there was no problem when I thought it was a cat.
THERAPIST: Okay, so it looks like it is what you believe about an event that matters. It is not the noise that makes you scared but rather the belief that there is a thug in the bushes. So what we need to do first is to learn to identify your thoughts, particularly the unrealistic ones. For example, a lot of people who have experienced a trauma think things like "it is only a matter of time before I have another accident", "no one can be trusted", "no place is safe", "I was probably asking for it", "I have no control over what is going to happen to me", "there is no point planning for the future anymore". I want you to think of some of the thoughts that you have had since the trauma. Can you think of any examples of negative thoughts that you have had since the trauma? [Prompt the client to discuss this issue with you]

- Introduce thought monitoring (using ABC form), using above examples:

> *Thought monitoring is a way of learning to catch these automatic thoughts as they happen. You will need to write down what you were doing at the time you had the thought, what the actual thought is, and how you were feeling at the time. It's best to complete this diary each time you notice that you are feeling down or anxious. Try to write it down as soon as possible because if you leave it till later, you may forget what you are actually thinking.*

Unhelpful thinking patterns
- Explain that the second step is to start to identify unhelpful thinking patterns that might be operating.

- Work through the following thinking patterns. Where appropriate, use trauma-related thoughts identified during client's assessment or above examples to illustrate the different unhelpful thinking patterns.

  - OVERGENERALIZING: You tend to see a single negative event as a never-ending pattern that will happen again and again. Examples include the thought: "I'm going to be attacked again" or "bad things keep happening to me so I must be a bad person"
  - ALL OR NOTHING THINKING: You tend to see the world as black or white, and you try to fit information into all or nothing categories. For example, if your performance falls short of perfect, you see yourself as a failure. Similarly, the world is seen as either completely safe or dangerous.
  - CATASTROPHIZING: This type of thinking happens when you focus on the most negative aspects of a situation. You may expect disaster to happen or focus on the danger aspects of a situation, and ignore other important evidence showing a situation isn't dangerous. Most catastrophising thoughts are triggered by "what if" thoughts like "what if I were attacked?" "If I let my guard down someone will attack me" and they can increase your fear and anxiety.
  - EMOTIONAL REASONING: This happens when what you feel determines how you think. While it's important to be aware of your feelings, they can lie to you. If you are anxious most of the time your feelings are almost certainly lying to you. An example might be "I feel scared, the world must be dangerous.
  - MUST, SHOULD OR NEVER STATEMENTS: These are expectations you have of yourself based on myths or rules rather than facts. They are often inflexible rules with unrealistic standards, for example: "I should be able to handle this."

Prolonged Exposure (50 mins)

- Review rationale for PE:

  As we discussed earlier, people who go through a trauma tend to avoid thinking about their painful experience because it eases some of the distress they feel. Although this is an understandable response, it does not usually help in dealing with the trauma because it prevents you from understanding and processing the memory. In fact, no matter how hard you try to push away thoughts about the trauma, they come back to you in distressing ways, such as nightmares or flashback memories. These symptoms are a sign that the trauma is still unfinished business.

  Instead of letting these memories pop into your head and distress you, we are going to tackle them head-on, by having you focus your attention on them. I am going to ask you think about your memories in a way that I don't think you normally do. From the discussion we have had I think we agree that like most people who have suffered a trauma, you typically

respond to trauma memories by attempting to avoid them. That is, you think of something else, distract yourself, or do something to take your mind away from the distress. The problem with this approach is that it prevents you from ever processing and resolving these memories and feelings effectively. It takes time for the mind to get used to things. Have you ever got into a hot bath or shower? When you first get in, it feels really hot and you feel that you can't handle it. If you stay there for a few minutes, however, your body gets used to the temperature and it actually feels comfortable. If you got out of the bath straight away, your mind would never get the chance to get used to the heat. It's a bit like that with your memories. You are not giving your mind a chance to get used to these memories because you're avoiding them every chance you get. By focusing attention on these memories you will actually find that they do not distress you as much as they do now. Moreover, people typically report that as they do this exercise they get to understand the experience in a way that makes a lot more sense. To use another example, have you ever walked out of a very dark room into bright sunlight? It's virtually impossible to see anything because it all seems so bright. After a few moments, however, you are seeing normally because your eyes and brain have adapted to what's around you. It's the same with your memories. When you first think about them, they will cause great distress but after you stay with them for a while your mind will get used to them, and you will see them more clearly and understand them with less distress.

- Ask the client if that makes sense in terms of their experience? Answer questions as appropriate.
- Explain the process to the client.

I *am going to ask you to walk me through exactly what happened by being as fully aware of your experience as you can. I want you to feel everything that you felt at the time, and be aware of everything that you thought. In a sense, I want you to re-live the experience because this is the most effective way for you to process the event and resolve it. We will do this over and over until you feel more comfortable and less anxious about the trauma. I realize that this sounds like a demanding task but we are doing this because we know that this approach leads to less distress and fear.*

- Explain that the exposure will continue for at least 40 minutes. Tell the client that if they complete their narrative in less than 40 minutes, they will simply need to repeat the exercise until 40 minutes have expired.
- Explain SUDS ratings

It is important for me to understand how you are feeling while you are doing exposure. From time to time, I will ask you to indicate how anxious you are feeling. You do this by giving me a number on a scale of 0 to 100. On this scale, "0" means no anxiety, i.e. feeling extremely calm and relaxed, whereas "100" means feeling extremely tense and anxious, or extremely angry. For example, if you feel quite anxious, you may give me an anxiety rating of 70 Do you understand how to use the scale? How much anxiety are you feeling at this moment?

- Ask the client to identify automatic thoughts about the consequences of thinking and talking about the trauma. For example, it is very normal for clients to think that they will "go crazy" if they let themselves think about the trauma. Make sure you elicit specific predictions (e.g. what would happen if you "didn't cope").

  What do you think will happen if your think about the trauma? What sorts of things are you most afraid of?
  Normalise these fears and explain that we will review this after the PE session.
  I imagine the thought of doing this is very frightening. Remember how we talked about processing the trauma. Initially it is going to be difficult. But it is going to become easier over time and I am going to be here to help you get through it.

- Ask if the client has any questions and then proceed with 40 min PE:

  Okay, let's begin. I would like you to describe your trauma to me. I don't want you to tell me about it in the past tense. Instead, I want you to tell me about it as if it were happening now. So tell me about it talking from your position. Use the words "I am" and "he is" to put us there in the here and now. And remember to focus on how you are feeling. Close your eyes if you feel comfortable. It will help you focus on what happened. And as you are telling me what's happening, try to focus on the details of the experience. Tell me about your surroundings, what you can see and hear, as well as what you are doing. I also want you to tell me how you are feeling emotionally, what is going through your mind, and also what your body is feeling.

- If the narrative doesn't take 40 minutes, ask the client to begin the narrative again, encouraging him/her to slow down and focus on the details. Alternatively, if the narrative appears to be taking much longer than 40 minutes, you may need to encourage the client to focus on the most anxiety-provoking parts of the narrative.

CASE EXAMPLE

Martin was the victim of an assault. Martin had taken a girl out for their first date, and as they left a restaurant, they were accosted and assaulted by two men. Martin was referred to us by his local doctor, who Martin had consulted after the assault. When Martin initially presented two weeks after the assault, he displayed marked numbing and denial. He reported that he was reluctant to discuss the event but felt that he needed help because he had not slept much since the assault, had terrifying nightmares about the incident, and was frequently distressed by intrusive memories of it. He reported marked avoidance of any reminders of the night, and stated that he had not spoken to anyone about the assault. It was eventually revealed that his response to the trauma was compounded by the fact that the girl that he was with that night had been sexually assaulted by one of the men. Martin admitted to pervasive avoidance behaviors since the trauma, including actively trying to suppress thoughts and conversation of them. He reported that he had not spoken to his girlfriend since that night. Martin canceled two appointments before actually attending his first appointment. On the first session he admitted that he feared attending because he could not bear the thought of revealing the traumatic experience to anybody.

Client-Therapist Exchange

THERAPIST: Now Martin, tell me exactly what's happening. Remember, I don't want you to describe to me what happened as if you're telling a story. I want you to re-live the experience by telling me what is happening in the here and now. I want you to talk in the present tense. Use words like "is" and "am" rather than "did" or "was". And I want you to talk in the first person. That means I want you to keep using the word "I" because this will help you engage with all the feelings and concerns that you have about this event. As we discussed before, this can be distressing but we need to tackle this problem head-on so we can get a hold on these memories. During this exercise I am going to ask you how you are feeling. As we agreed on earlier, I want you to tell me how distressed you feel on that scale of 0 to 100, where 0 means that you don't feel at all distressed and 100 means that you feel extremely distressed. You can tell me a number on that scale that describes how distressed you are at any particular time. Is that okay? As we discussed earlier, you might be able to connect with these things better if you close your eyes and are not distracted by things around you here. Would that be okay if you closed your eyes?

MARTIN: Ummm, I don't know. If you want me to.

THERAPIST: I think it might help.

MARTIN: Okay. Marge and I are leaving the shop. We've bought some take-away chicken which we took back to the car.

THERAPIST: Wait a moment, Martin. Remember to talk in the present tense. Try to remember to say "we are now taking it back to the car"

MARTIN: Oh yeah. Okay. Sorry…. Well, we're walking back to the car. I am just putting the keys in the car door and I feel a terrific blow to my back. I am thrown against the car door. I can't say anything because I'm winded. When I turn around there are two guys in front of me. What are they doing?… They've got knives and they're pushing me against the car. I don't know where they've come from. There was nobody here a minute ago. They're laughing…They're big… The knives are enormous… I can't speak. I am terrified… I don't know what Marge is doing. All I am thinking about is these guys. This has never happened before…. What am I meant to do?…The darker one is telling me to open the door… I am trying to open it. I am scared…. I can't get the damn keys in the lock. He is pushing me and telling me to hurry up. He's yelling at me to get it open or he'll put my head through the window. He grabs my hair and he is shoving my face up against the door window. I can't open the door like this… He shoves me to the ground and opens the door himself. My mouth is full of gravel and I think a tooth is chipped. I can taste blood in my mouth. He is forcing me behind the wheel… He's pointing the knife at the back of my neck. I am trying to get in the car as fast as possible because he's pushing the knife harder against my skin. I'm begging him to let me go… I think he's going to kill me… The other guy is getting in the back with Marge. They stink of beer. He sticks his face right in front of me and breathes right in my face. Why is he doing this? What does he want me to do?…I am closing my eyes. I don't want to see him… He laughs again and tells me to look into his eyes. I do as he says… I think this is it… He is looking right at me and asks me if I'm scared… I nod because I can't speak… He then backs away and tells me to drive… He is holding the knife against my throat. Its just resting against my skin… He is telling me that I better drive carefully because if I don't, his knife might slip… I know that if we go over a hole or I do something dumb it'll cut my throat… He is making some joke about getting blood off the car seat. I can feel the knife scraping against my skin… He is telling me to drive faster but I don't want to. I have to do what he says. I don't even know if I'm bleeding yet or not. … I can't go on… I want to stop.

THERAPIST: I know its tough but you're doing very well. Just stay with this Martin. This is how we are going to deal with all this. Can you tell me how you are feeling just now on that scale we mentioned?

MARTIN: Its about 95. Its pretty bad.
THERAPIST: Okay. We're just beginning here. I know its tough but if you can, I want you to continue telling me.
MARTIN: Okay… I'll try… This guy is just laughing. He thinks it's a real joke. He tells me to drive up to some park that's in the middle of nowhere. I haven't been there before. He tells me to stop the car… Now I'm really scared… I am stopping the car and just looking straight ahead. I think he's going to cut my throat… He's letting the knife slide up and down my throat…Why is he doing this?… He's making jokes about what I'd look like without a head… I am crying like a baby… I don't know what to do… I don't know what Marge is thinking of me. A part of me tells me that I should be doing something to stop all this… But I can't. I can't do anything… I just want to close my eyes and not be here. Now the guy in the back seat is pulling my hair back and he is putting his knife to my throat…I can hardly breathe. He is bending my neck back over the seat. Now he is leaning over the seat and talking into my ear. He's telling me he wants to get to know Marge better… He is asking me all the sorts of questions about Marge's body… Disgusting things… I don't want to remember this… I can't talk about this, no way.....
THERAPIST: That's okay, maybe move on to what happened next.
CLIENT: Now he lets go of me… Marge starts screaming…He's pulling her out of the car. I don't dare turn around. She's calling out to me… But there's nothing I can do....I feel so guilty, I should be trying to save her.....I knew what was about to happen to her..... I just keep staring straight ahead. I close my eyes again…I don't know where they are going… I can't see them… Its weird but I can see all this happening. I can see him pulling her out of the car but I am not here. I mean I am not in the car… But I am… But its like I am seeing it from the other side of the park. I don't know what's happening next. It's a blur… I am sitting in the car with the other guy. He keeps talking about Marge and is asking me personal things about sex. I don't remember these things. The next thing I know is that Marge is back in the car…I turn around and look at her… She looks terrible. Her clothes are ripped and she is not talking… I think she's bleeding. She's just staring at her lap… I can't look at her…There's nothing I can do to help…
The guy in the front seat is now leaning over to me with his knife. He is whispering in my ear: "We've had our fun. Now what will we do?" And then he puts the knife in my mouth… I stretch my mouth as wide as I can. I can feel it against my tongue as he turns it around… He's pressing it right to the back of my mouth. I can't push back any more. The knife is getting further down my throat… I want to scream out to him to stop but I can't move my mouth… And then he just stops. He takes the knife out of my mouth. He is laughing at me. He grabs my chin and he is forcing me to look at him. Now he looks at Marge and tells her she has a "chicken shit boyfriend" because I didn't do anything to help her… Then he laughs, gets out of the car, and walks off with his mate… That's it. I then drive the car to the police station. I don't look at Marge. Neither of us say a word. I am in automatic pilot now. I don't feel anything. I don't think anything. That's it. There's nothing more.
THERAPIST: Martin, how are you feeling? Maybe rate how you feeling now on that scale?
MARTIN: About 90…95. Its still bad. I thought you said I would feel better. I don't think this is going to work.
THERAPIST: It takes time. Most people don't find relief after doing this just once. We are going to have to do this again and again. I can't make you any promises but I think it will get better as we do this more often. What's most important at this stage is that you felt as distressed as you did and you stayed with it. That's critical. The fact that you could do that is a great sign for how you are going to cope with this program.

MARTIN: I can't believe how real it was. I haven't done that before. Thought about it like that, I mean. It was all happening again. I could see his face. I can still smell the beer on his breath. Is that normal?
THERAPIST: Yes. Its very common for people to be very aware of all those sorts of details. And to feel the same emotions that you had at the time. Was there any point that was particularly difficult for you?
MARTIN: Yeah. Two things mainly. When he made me drive faster and the knife is against my throat. I really thought I was going to die then. I hate thinking about that. The other one was when they took Marge out of the car. They shouldn't have done that. Its not right. I should have done something to stop them. I will never get over that.
THERAPIST: Did you allow yourself to think about those things just now?
MARTIN: To be honest, I didn't. They're too bad. I thought about them but I wanted to skid over them and get to another things.
THERAPIST: That's okay. Being able to focus on the things that you did was fine for now. We've got time to focus on those other aspects as we move on. I think you will feel more comfortable in tackling them after we've done this a bit more. How are you feeling now that its over?
MARTIN: Relieved. I really didn't think that I would cope with it.
THERAPIST: But you did cope with it. In fact, you did very well..... You have been able to focus on this whole event and you have survived it. You are now sitting here with me, in one piece, and have been able to discuss it with me. That's really important because it tells us that thinking about these memories doesn't really hurt you. You can think about them and be okay after it.

- Ask for SUDS ratings throughout the PE. On the monitoring form "SUDS Level During PE", record SUDS ratings of anxiety (1) prior to, (2) peak anxiety, and (3) at the end of PE.
- Provide encouraging comments during the PE. For example:
    - "You are doing fine. Stay with the image."
    - "You've done very well. It took some courage to stick it out even though you were afraid."
    - "Stay with your feelings."
    - "I know this is difficult. You are doing a good job."
    - "Feel safe and let go of the feelings."
- Discuss the experience with the client. Focus on any difficulties that the client experienced. Special attention should be directed to any features of the narrative that were avoided in some manner.
- Reinforce the bravery of the client and point out the decrease in SUDS over time (if there is no decrease in SUDS, explain that over time the amount of distress will decrease).
- Re-evaluate the thoughts regarding the consequences of thinking and talking about the trauma articulated by the client prior to PE. Compare what they predicted would happen, with the outcome of the PE. Highlight that the client "didn't go crazy" and "coped" whilst doing PE. Reinforce how these predictions probably increased the anxiety and encourage more realistic predictions of future PE sessions.
- Explain that it is normal for a increase in intrusive thoughts and nightmares after initial PE sessions, but this is a short-term effect on beginning to process the trauma.

Potential problems

- Many clients will have recounted the story many times to police, doctors, or other authorities in the wake of their traumatic experience, and may lapse into "giving a statement" (i.e., emotional avoidance). This can be limited by using first person and present tense during the PE. It is also important to review the rationale in this case, and discuss the importance of engagement with the range of emotions experienced during the trauma.
- Many clients do not habituate during the first PE session. In such cases, it is important to communicate to the client that their capacity to cope with distress is important and that habituation will occur in future sessions.
- It is very normal that the client experiences high levels of distress and high levels of anxiety during the PE. In this case, it is important that the therapist remains calm and supportive and expresses confidence that you will be able to handle, and help the client to hand, whatever comes up. Provide encouraging comments throughout and strongly encourage the client to continue with the narrative. Allow sufficient time for debriefing afterwards. It can also be helpful to plan a pleasant and rewarding activity for after the session.
- The client may also attempt to discontinue the PE when they become distressed. This can be minimized by initially presenting a very clear rationale and explanation of the procedure. However, if they do stop in the middle of the PE, normalize their distress and encourage them to return to the narrative. If they still refuse, PE may be "titrated" in various ways. For example, they may agree to continue if they have their eyes open but focusing on a spot on the floor, or if they are permitted to take a break and practice their slow breathing until they are ready to continue.
- Similarly, clients often express hesitation to practice PE for homework. Again, briefly reiterate the rationale, and encourage them to "try it out". Also explain that you will phone them mid-week to check their progress. If they continue to refuse, collaboratively work on "titrating" the PE. They may agree to a written version of PE or listening to the tape. Once their confidence increases, encourage them to use PE in the oral form.
- The client may become very angry and begin to ruminate on aspects of the narrative. It should be noted that PE may not be as effective when the primary response is anger or rumination. Encourage the client to focus on the parts of the narrative which primarily elicit fear responses. The ruminative anger aspects of the response need to be targeted within the cognitive component of the treatment.
- Occassionally, clients exhibit dissociative reactions (e.g., lose awareness of their current surroundings/ experience severe flashback episodes). Remain calm and "reground" them by asking them to focus their attention on something tangible in your office. Once they can attend to something in your room, discuss the experience with them and identify the triggers to the episode, e.g., a very distressing aspect of the trauma ("hotspot") Collaboratively develop a plan for titrating exposure at these stages of the narrative. Also identify early warning signs for the dissociative episode (e.g., physical symptoms, feeling hot, derealisation) and use these signs to "reground" the client when identified.
- Some clients will be amnesic to some events or aspects of the trauma. De-emphasise the importance of remembering all of the trauma perfectly, and prompt the client to move to the next part that they remember.

Assign Homework (5 mins)

- Daily PE: Explain procedure and monitoring (provide “PE monitoring- homework” form). Explain that you will phone them mid-week to check their progress with the initial PE homework.

  Pick a time and place where you have as much privacy as possible. Do the PE as closely to what we have done today as possible, i.e., talk the trauma through out loud. Remember to include what you were thinking, how you felt, what you saw and heard… in fact everything that you can remember. Don’t be afraid if any feelings arise, this is part of process. Stick with it for at least 40 mins. When and where do you think you will start doing this assignment?

- Cognitive therapy: Provide “Cognitive therapy” handout and review use of “ABC monitoring form”. Encourage client to note the type of unhelpful thinking pattern that may be operating. Both thoughts in everyday situations or trauma-related thoughts may be recorded.
- Daily breathing control practice.

SESSION 3 (90 mins)

Agenda
- Review week and homework (10 mins)
- In Vivo Exposure: Rationale and hierarchy development (15 mins)
- Cognitive therapy: Challenging thoughts (15 mins)
- Prolonged Exposure (45 mins)
- Assign Homework (5 mins)

Materials
- ”ABCDE” monitoring form
- Blank sheet for in vivo hierarchy

Review week and homework (10 mins)
- Review week and obtain SUDS rating:

> *When you think back over the past week, how distressed have you generally felt (where 0 = no distress, and 100 = extremely distressed)? Take a couple of minutes to think about your response.*

Review PE practice.
- Ask them to walk you through the procedure, and discuss any differences between doing the exposure at home versus in session. Be mindful of the following possible difficulties:
  - Use of distraction strategies (e.g., having the TV on)
  - “Skimming” and/or other emotional avoidant strategies
  - Allowing insufficient time for habituation.
- Review SUDS ratings, emphasise any reductions in anxiety and reinforce efforts.
- If client failed to do daily PE practice remind him/her of the importance of not avoiding and help client problem-solve around homework completion. For example, set specific times for PE, organise “self-rewards” etc.

- Review breathing control exercises. If the client is competent in the use of the strategy, encourage him/her to begin using it in anxiety provoking situations.

In Vivo Exposure: Rationale and hierarchy development (15 mins)
- Review rationale and procedures of in vivo exposure:

> *As we have discussed before, one outcome of your traumatic experience is that you have learned that things that remind you of your trauma make you anxious. All sorts of places and all sorts of things [use examples) now feel dangerous and remind you of the trauma. Things that you see every day, or noises that you hear, or smells that you notice. All these things remind you of what happened. What you need to realize is that before the trauma, all these things were there but they did not cause you to feel anxious. What we will need to do in therapy is to teach you that these things are no longer dangerous. We can do this by gradually confronting these situations and learning that nothing bad will happen to you. Another way of thinking about this is that your body has learned to respond to*

many of the cues that remind you of the trauma. That is, your body becomes tense because it associates these cues with danger signals. In therapy we must give your body and your mind the chance to learn that these things do NOT necessarily signal danger. This means exposing you to some situations that may remind you of the trauma. By remaining in these situations, you can learn that your initial anxiety will decrease and you can develop confidence in those situations.

Let's take the example of children learning to swim. Some children are very fearful when they initially enter the water. When they go in the shallow end of the pool, however, they learn that the fear subsides a bit. Next time, they have slightly less fear when they enter the water. Each time they enter the water, they go a little further into deeper sections. The decrease in fear continues to occur and becomes more and more rapid as they practice. This continues until they are no longer scared. If children were removed from the water the first time they became scared, it would become even harder for them to go swimming the next time.

This is the basic principle to treat all fears. We need to face our fears and stay in the situations that we are afraid of long enough to learn that nothing bad will happen. In fact, we need to repeat this over and over until the anxiety diminishes. Avoiding the situations that we are afraid of actually strengthens our belief that they are scary because this avoidance teaches us that staying away from these things makes us feel better. In effect, avoiding the situations that scare you makes it even harder to face it the next time.

- Illustrate this by drawing a graph illustrating habituation.
- Relate to client's experience. Answer any questions as appropriate.
  Begin developing a hierarchy, based on SUDS ratings. That is, the therapist asks the client to allocate a rating of 0 ("not at all distressing") to 100 ("the most distressing I have ever felt") to a series of events or situations. This exercise requires a joint effort by the client and therapist because most clients have some difficulty in determining gradations of anxiety-eliciting situations. This difficulty can be especially evident in the acute phase, when many clients perceive all trauma-related situations as being extremely aversive.
- Encourage the client to focus on events that can be practically integrated into an exposure program in the required way. For example, a client who survived a motor-vehicle accident may find a particular intersection very anxiety-provoking. To allow the client sufficient time for their anxiety to habituate, a route in which the client goes through the intersection repeatedly may need to be devised.
- Also highlight the difference between *inappropriate* avoidance behaviour versus *appropriate* "safety" behaviour. *Inappropriate* avoidance behaviour refers to avoidance of situations where the risk of serious harm is objectively minimal or of low probability. This avoidance behaviour can interfere with everyday functioning (e.g. avoiding driving; avoiding supermarkets). In contrast, a*ppropriate* safety behaviour refers to avoiding situations that are objectively associated with a high probability of real danger, or high risk behaviour (e.g. avoiding walking down dark alleys in Kings Cross at 3 am; avoiding speeding in the car on the wrong side of the road). In this sense appropriate safety behaviour does NOT interfere with

everyday functioning. Explain that therapy will be focusing on teaching you to expose yourself to situations that remind you of your trauma, which you are currently avoiding, but are of minimal objective risk. That is, exposure will be to situations which are inappropriately being avoided and which are probably disrupting your usual routine (use examples).

- The therapist should also be aware that the hierarchy nearly always needs to be modified once exposure has commenced because acutely traumatized clients often have difficulty accurately perceiving the level of fear that certain situations will evoke.
- Discuss the idea of a 'support person'. Explain that often the anxiety elicited by items on the hierarchy can be reduced by the presence of a supportive person. It can be especially helpful if that person has some information on what and why the client is attempting. Discuss whether there is an appropriate person that the client can ask to be a 'support person'.

Case Example

THERAPIST: To help you gradually reduce your avoidance of these events, we need to make a list of the things that you do avoid. It's best that you approach each of these things in a gradual manner. So let's make a list of things you avoid that cause you lots of distress, moderate distress, and only a little distress. If we can describe each situation with the SUDS rating that we have used before, it will help us put each situation in a position on the hierarchy relative to other situations. Let's remember that we are going to get you to go into each of these situations, so they need to be realistic ones that you can practically do. How about we start with the hardest ones? What would be the toughest situations for you to approach?

CLIENT: That's hard. There are lots. I definitely will not walk by myself. There is no way I will do that. It's asking for trouble.

THERAPIST: Is your fear of walking alone the same whether it's during the day or night?

CLIENT: Oh, its much worse at night. That's when I was mugged. I won't walk at night?

THERAPIST: Okay, how about if you are with someone or on your own?

CLIENT: It's worse on my own. There's some safety in numbers, you know.

THERAPIST: What SUDS rating would you give a situation involving walking at night when you're by yourself?

CLIENT: Oh, probably 100. I can't think of anything worse.

THERAPIST: Okay, let's write that down so we can remember it.

CLIENT: Wait on, you're not going to ask me to go walking out at night. That's dangerous.

THERAPIST: I agree that its dangerous to go walking downtown at night. I certainly wouldn't want to ask you to do that. But you've told me that you won't go walking anywhere at night. Even in your own neighborhood, where you've told me that the streets are busy until 11.00pm. How about we put at the top of the hierarchy walking at night by yourself in your neighborhood at 7.00pm?

CLIENT: Okay, it sounds reasonable.

THERAPIST: What about walking with someone else at night?

CLIENT: That would also be scary but not so bad. Maybe 95.

THERAPIST: Okay, how would it be driving at night?

CLIENT: I hate that. You're not safe in your car.

THERAPIST: How does it compare to walking?

CLIENT: It's a bit safer than walking. I would say about 90.

THERAPIST: Okay, so walking at night is a bit worse than driving at night. Is it easier driving with someone else than driving alone?
CLIENT: You bet.
THERAPIST: Okay, so let's write these situations down. We've got walking alone at night, walking with a friend at night, driving alone at night, and driving with a friend at night? Can you put these in the order that you feel is most to least scary?
CLIENT: Walking alone at night is definitely worst. That's 100… without a doubt. Then it would be driving alone at night. I'd say that's 95. Then it would be walking with a friend at night… say 90. And then driving with a friend at night. That would be 85.
THERAPIST: Excellent. Now what other situations do you think we need to put on the hierarchy?
CLIENT: Men's restrooms. I despise them. You never know what's going to happen there, and when you've got your back turned, you can't protect yourself.
THERAPIST: So being in a public restroom is difficult. And turning your back on people is difficult, is it?
CLIENT: Oh yeah, I never turn my back on anyone. You never know who might try and get you when your back is turned.
THERAPIST: Does it matter if you're in the restroom on your own or with a friend you can trust?
CLIENT: It's much easier with a friend.
THERAPIST: Okay, and what SUDS rating would you give being in a restroom with a friend?
CLIENT: About 60.
THERAPIST: And being there on your own?
CLIENT: About 75.
THERAPIST: Good. Now you mentioned that it was difficult turning your back on people. Tell me more about that.
CLIENT: Well, I never know if someone is going to hurt me if I turn my back on them. So I never do. If I am in a room or near someone, I always watch them. I always stand next to walls so people can't get behind me.
THERAPIST: Does it make any difference whether the person is male or female?
CLIENT: Oh yes. I am much worse if it's a man.
THERAPIST: So what would the SUDS rating be for you if you had to turn your back on a woman in a shopping mall?
CLIENT: Only about 25.
THERAPIST: And what about turning your back on a man?
CLIENT: Oh, that's worse. I haven't let that happen since I was mugged. It would be about 40.
THERAPIST: Okay. Would it make any difference if you were alone or with a friend?
CLIENT: Yes. It's a bit easier with a friend because I know that someone's there that I can trust. If I was on my own, it would be 45. But if a friend was there, it might be about 40.
THERAPIST: Okay, so let's put those situations on the hierarchy, and sort them in the right order.

Potential problems

- Excessive avoidance can prevent the client from considering placing items on the hierarchy, or later attempting this tasks. Firstly, clarify that the client understands the rationale, and understands the process of habituation. Secondly, consider motivational tools to engage the client. For example, encourage the client to

consider the pros and cons for continuing to avoid particular situations. Finally, ensure that tasks are graded sufficiently, and elicit commitment to each individual task before progressing to more difficult items.

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Cognitive therapy: Challenging trauma-related thoughts (15 mins)

- Review the steps covered last session (e.g., identifying thoughts, and noticing unhelpful thinking patterns).
- Ensure that the client understands the difference between situations, thoughts and emotions.
- Check that the thoughts that they have identified are phrased as statements, and explain the consequential emotion. If they are having difficulty identifying the thoughts, ask "what was running through your head?", "what were you afraid was going to happen?"
- Check that they are able to identify unhelpful thinking patterns.
- Explain that the next step involves learning to challenge thoughts:

> *The third step involves challenging these thoughts. We find that one of the best ways to do this is to ask yourself a series of questions that draw your attention to the evidence underlying these thoughts. Remember that the point of these exercises is not to change all your thoughts. It is simply to test these thoughts against reality.*

- The following questions may help to challenge unhelpful thoughts:

- What did I think about this issue before the trauma?
- Has anything in the world really changed except for my perception?
- How would someone else view this situation?
- How would I respond to someone else who had this thought?
- What is the evidence that my thought is true?
- Is there any evidence that it is not true?
- What effect is this way of thinking having on me?
- Is this thought helpful or harmful to me?
- Is my thought extreme?
- Am I focusing on only the bad things and ignoring the good?
- Am I overestimating the chances of disaster?
- Am I assuming a disaster will take place in a place that is really quite safe?
- Am I assuming responsibility for something that I had no control over?
- Would I blame someone else for the same event?

- Where applicable, help client identify and challenge unhelpful thoughts using the above questions.
- Below is an example of an interaction between therapist and client as they work on challenging an irrational thought.

CASE EXAMPLE

THERAPIST: Okay Martin, on your Thought Record Form you mentioned that you were very frightened when someone knocked on your door the other day. According to your form,

you say you thought that it was an intruder and that he was going to hurt you. Is that what you thought?
CLIENT: Yes. I wasn't expecting anyone to come over. When there was the knock on my door, I was just overcome with fear.
THERAPIST: Okay. On a scale of 0 to 100, how scared were you?
CLIENT: I was pretty terrified. I'd say about 90.
THERAPIST: Okay, now could you tell me what thoughts were running through your head at this time?
CLIENT: Well, I figured it was an intruder and he was going to get me. I had no way of protecting myself.
THERAPIST: How strongly did you believe this?
CLIENT: Well, I would say about 90. I felt pretty sure about it. Why else would someone be knocking on my door? I wasn't expecting anyone.
THERAPIST: Okay. Can you think of any other reason why someone might be knocking at your door other than being an intruder?
CLIENT: Well, I guess they might be lost and asking for directions.
THERAPIST: Good. What other reasons?
CLIENT: They might be knocking on my door by mistake. Or maybe they are collecting for a charity…Or maybe they're selling something.
THERAPIST: Okay, so it sounds like you think there are a bunch of reasons why someone might knock on your door. They might be lost, knocking on the wrong door, collecting for charity, or selling something. When you adopt one of these alternative interpretations of the situation, how scared do you feel then?
CLIENT: Well, not that scared. Probably only about 50.
THERAPIST: Okay, so what conclusion do you draw from the change in how anxious you feel? It was 90 when you thought it was an intruder and 50 when you adopted one of the alternative possibilities.
CLIENT: Well, I guess that when I considered the less harmful possibilities I felt less anxious.
THERAPIST: So it looks like simply altering the way you interpret things makes a huge difference to how you feel.
CLIENT: Okay but I still can’t be sure that there is not an intruder out there.
THERAPIST: Sure, it is not possible to be 100% sure. I wonder if you could tell me more about what happened when you heard the knock on the door.
CLIENT: I immediately went quiet so I wouldn't be heard. And then I waited.
THERAPIST: What happened?
CLIENT: Well, I heard a woman's voice outside the door.
THERAPIST: A woman's voice?
CLIENT: Yeah, at that point I laughed at myself for getting my knickers in a knot unnecessarily.
THERAPIST. Okay, this is really interesting.....are you saying that a woman wouldn’t attack you?
CLIENT: No, not likely.
THERAPIST: What did you do next?
CLIENT: Well, I went to the peephole and looked outside. There was a woman standing there with a man. She looked pregnant.
THERAPIST: So how likely do you think it is that a couple are going to attack someone, especially when one of them is going to have a baby soon?
CLIENT: It’s not very likely.

THERAPIST: So what happened next?
CLIENT: He was helping her lean against a wall. She didn't look well.
THERAPIST: Okay, so let's take a moment to pull it all together. You were sitting at home and heard a knock on the door. It sounds like you automatically assumed that it was an intruder who was going to harm you. But instead you found that it was a couple, one of whom was a pregnant women who was clearly not well. Have I got that right?
CLIENT: Yes, I guess the reasonable conclusion is that they were wanting help because she wasn't feeling well.
THERAPIST: That sounds right to me. But I can appreciate why you jumped to your conclusion because it's only a few weeks since you were badly beaten up. It's very common for people to assume that they are going to get into trouble again when something happens that even remotely resembles what you experienced when you were assaulted. What I want you to understand here is that you can slow your thoughts down and evaluate them in the light of objective evidence. As you do that now, how scared do you feel by that event?
CLIENT: Well, it's probably dropped to about 10. I guess it shouldn't even be that high but I still feel a bit nervous about it.

- Encourage client to compare emotions prior to and following the challenging process.

<u>Potential problems</u>

- It is important to remember that the client has been traumatised and hence the significant changes in belief systems are legitimate. However, whilst it is important to communicate that his/her beliefs are understandable, the distinction should be made between how legitimate and how realistic/helpful these beliefs are.
- It is also important that cognitive therapy does not degenerate into 'arguments', in which the therapist and the client are defending their positions. Rather, use Socratic questioning to encourage the client to consider all of the evidence.
- Clients will often report that they *know* that their thoughts are unrealistic, but they *feel* differently (e.g., I know that it is unlikely that I will be assaulted again, but I feel that I'm always unsafe). Explain that they are confusing 'feeling' with 'strength of belief'. If they don't really believe the challenges then they are still going to feel anxious in these situations. Then, go back and try to challenge the beliefs more convincingly. Also explain it takes time for beliefs to change, and every time they practice challenging their beliefs they are slowly shifting these beliefs. Also encourage them to build up the evidence, or 'test out' these new beliefs, by setting behavioural experiments/in vivo exposure tasks.

Prolonged Exposure (45 mins)

- Reinforce rationale of PE
- Proceed with 40 min PE
- Encourage the client to slow down during the periods of high distress using the following questions:
    - "What are you feeling?"
    - "What are you thinking?"
    - "What is your body feeling?"
    - "What are you smelling/seeing now?"
- Obtain SUDS ratings of anxiety, especially when you notice increases in distress.

- Write down any cognitive distortions or negative thoughts that the client expresses during the recounting of the trauma that you can use in cognitive restructuring.

Assign Homework (5 mins)

- In vivo exposure: Complete hierarchy.
- Daily PE (40 mins)
- Cognitive therapy: Provide “ABCDE” monitoring form and encourage client to monitor and challenge thoughts daily.
- Talk to friend of family member about being a ‘support person’.

SESSION 4 (90 mins)

Agenda
- Review week and homework (10 mins)
- In Vivo Exposure: Hierarchy development continued (15 mins)
- Cognitive Therapy: Challenging thoughts continued (15 mins)
- Prolonged Exposure (45 mins)
- Assign Homework (5 mins)

Materials
- ”ABCDE” monitoring form
- “PE monitoring forms” as needed
- “In vivo monitoring form”
- “Support person letter”

Review week and homework (10 mins)
- Review week and obtain SUDS rating:

  When you think back over the past week, how distressed have you generally felt (where 0 = no distress, and 100 = extremely distressed)? Take a couple of minutes to think about your response.

- Review PE practice. Check the client is not using any avoidance strategies. Review SUDS ratings, emphasise any reductions in anxiety and reinforce efforts. If client failed to do daily PE practice remind him/her of the importance of not avoiding and help client problem-solve around homework completion.
- Review in vivo hierarchy.
- Review breathing control exercises. If the client is competent in the use of the strategy, encourage him/her to begin using it in anxiety provoking situations. Review effectiveness of strategy to manage anxiety if appropriate.
- Review thought monitoring and challenging.
- Discuss support person. Explain that you will write them a letter to explain their role in the program.

In vivo exposure: Set tasks(15 mins)
- Review and complete hierarchy.
- After the hierarchy is complete, set the lowest task on the hierarchy. It is advisable to start with a situation that the client can cope with relatively easily because this can facilitate confidence in their ability and enhance compliance with more demanding items.
- Explain the importance of remaining in the situation for at least 30 to 40 minutes, or earlier if the anxiety has subsided by at least 50%.
- Explain the “In Vivo Exposure Form” including monitoring (a) the situation, (b) the time spent in the situation, (c) SUDS ratings at the commencement and following the exercise, and (d) their thoughts during the exercise.
- It is important to identify potential covert means of avoidance during exposure. For example, an assault victim may agree to remain in a shopping mall but will carry a knife in his pocket as a means of protection. Such safety behaviors serve

to minimize full exposure to the situation and should be removed from the exposure exercise.

- Below is an example of reviewing the previous week's exposure homework and making plans for the next step.

CASE EXAMPLE

THERAPIST: Looking at your record form, it seems that you had problems in going into a public restroom. What happened?

CLIENT: I just panicked. A few days before I had gone in with a friend and I coped okay. I mean it was pretty distressing but I was able to hang in there. But yesterday I tried it on my own and I just lost it. I walked in and felt that I was going to handle it. But then it all went haywire. I started to panic, my heart went wild… I thought my chest was going to explode. I just felt that something bad would happen in there.

THERAPIST: What did you do?

CLIENT: I ran out. I know I wasn't meant to but I had to get out. To be honest, I really didn't think it would be as bad as that.

THERAPIST: Okay, how about we build in a few more steps so you can handle this. As we have discussed before, the most important thing here is that you can stay in these situations that cause you distress. Leaving them will only reinforce the belief that they are scary and you can feel better if you leave them. Tell me more about what scared you when you went in to the restroom?

CLIENT: Well, it was dark and I didn't know who was around.

THERAPIST: So you went at night?

CLIENT: Yes.

THERAPIST: Do you think it would have been easier if you went during the day?

CLIENT: Probably. Now you mention it, I was worried about the dark because that's when those guys got me.

THERAPIST: Okay. How about going into the restroom in the middle of the day? Would that make it easier?

CLIENT: Yes, that'd be better. But I have to tell you, I am not looking forward to this.

THERAPIST: Well, you say that you coped last week with it when you went in with your friend. How about we try it initially with your friend waiting outside the restroom for you?

CLIENT: That's much better.

THERAPIST: What do you predict will happen when you go to the restroom during the day with your friend.

CLIENT: I reckon there is a good chance we will be attacked.

THERAPIST: How much of a chance?

CLIENT: Well....I would say 50%.

THERAPIST: Okay, how does that sound for a plan? The next step is for you to go into the restroom during the day and with your friend waiting outside. After you've managed that, you can try going into the restroom by yourself during the day without your friend being there. After you've managed that, you can then try going in there later in the day. You're predicting that you will be attacked - so by going there you will get to check that out. How does that sound?

CLIENT: Much better.

Cognitive therapy (15 mins)

- Continue challenging unhelpful trauma-related thoughts and beliefs, including thoughts identified in PE.

- Below is an example of challenging thoughts that have been identified in a PE session.

CASE EXAMPLE

THERAPIST: Martin, one of the hardest parts of the reliving is when Marge is pulled out of the car. Is that right?
CLIENT: Yeah, I just feel so guilty.
THERAPIST: Why do you feel guilty?
CLIENT: Because I should have stopped them….there must have been something I could have done.
THERAPIST: It sounds like we should have a look at that belief, because it's making you feel pretty terrible. Let's see if can use the challenging skills to check out how helpful and realistic this thought is.
CLIENT: OK.
THERAPIST: Do you have any evidence that you could have stopped them?
CLIENT: Well no, nothing specific. Just this gut reaction that I should have been able to do something.
THERAPIST: Well I understand that. But to see how realistic this thought is, we need to stick to the evidence. Do you remember what problems there are with using our feelings as evidence?
CLIENT: Yeah, I remember that sometimes our feelings don't always tell the right story.
THERAPIST: Exactly, just like when we use our anxiety to tell us that a situation isn't safe. The problem is that after a trauma nowhere feels safe, even when you are in safe situations….so we need to stick with the evidence we've got. Let's think about the alternatives in this situation. What else could have you done?
CLIENT: I could have tried to wrestle the guy who had me pinned with the knife and tried to help Marge.
THERAPIST: Yes, and what were the most likely consequences if you had tried that?
CLIENT: I think they would have killed me.
THERAPIST: Was it likely, then, that you could have changed the outcome?
CLIENT: Not really, there were two big guys with knives. And I wouldn't have been able to do anything if I was stabbed anyway.
THERAPIST: So it would have been likely if you had tried that, you may have been killed, and couldn't have helped Marge anyway. Could trying to wrestle the guys, actually made the situation worse for Marge?
CLIENT: Well, obviously it's impossible to know, but I suppose it is possible that they could have got more violent.
THERAPIST: OK, so we haven't got much evidence that you could have done something differently that would have made things any better. Let's try seeing this situation from someone else's perspective then. If you had heard this story on the news, who would have you blamed? The boyfriend?
CLIENT: No, the guys that did it, obviously.
THERAPIST: So it's easy to see whose fault it is when it's someone else in the situation, but hard when you were the one who wasn't able to save your girlfriend.
CLIENT: Exactly.
THERAPIST: OK, let me summarise what we've been discussing. You say that, with the luxury of retrospect, you had no options open to you...any other action was likely to cause you or Marge to get further hurt or killed, and that you wouldn't blame someone else if they were in your shoes. Is that a fair summary?

CLIENT: Yes, I just wish I had been able to stop it.
THERAPIST: That's a good point Martin. But there's a big difference between wishing it hadn't happened and blaming yourself. What are the consequences of blaming yourself?
CLIENT: I feel terrible. I feel like I've got a big weight hanging around my neck. I can't face Marge.
THERAPIST: Exactly, and when we challenge that guilt, we can see that there is not much evidence to substantiate it. That's why we've got to continue to challenge that guilt whenever it comes up.
CLIENT: Yeah, OK.

Prolonged exposure (45 mins)

- Proceed with 40 min PE
- Obtain SUDS ratings of anxiety.
- Identify "hotspots" (portions of the memory that still cause anxiety >20 SUDS). They need repeated exposure in order for habituation to occur. Hence slow down the narrative in these areas and review in a repetitive fashion if required (as many as 6-7 times in the one session).
- These hotspots may also be a target of cognitive therapy. Make sure you elicit the thoughts/interpretations and meaning attributed to these hotspots.

Assign Homework (5 mins)

- In vivo exposure: Complete hierarchy.
- PE: daily practice (40 mins)
- CT: daily monitoring and challenging trauma-related unhelpful thoughts.

SESSION 5 (90 mins)

Agenda
- Review week and homework (10 mins)
- In vivo exposure - Moving through the hierarchy (10 mins)
- Cognitive therapy – Core beliefs (20 mins)
- Prolonged exposure (45 mins)
- Assign Homework (5 mins)

Materials
- "Changing beliefs and assumptions" handout
- Monitoring forms as needed

Review week and homework (10 mins)
- Review week and obtain SUDS rating:

> *When you think back over the past week, how distressed have you generally felt (where 0 = no distress, and 100 = extremely distressed)? Take a couple of minutes to think about your response.*

- Review PE practice. Check the client is not using any avoidance strategies. Review SUDS ratings, emphasise any reductions in anxiety and reinforce efforts. If client failed to do daily PE practice remind him/her of the importance of not avoiding and help client problem-solve around homework completion.
- Review in vivo exposure.
- Review thought monitoring and challenging.
- Review breathing control exercises. Review and reinforce the effectiveness of the strategy in anxiety-provoking situations.

In Vivo Exposure: Moving through the hierarchy (10 mins)
- Ensure in vivo steps are being following correctly.
- Discuss reductions in anxiety, relate back to rationale.
- Discuss failures to habituate.

Cognitive therapy – Core beliefs(20 mins)
- Continue challenging unhelpful trauma-related thoughts and beliefs using thoughts and hotspots identified in monitoring and PE.
- Once client is competent in thought challenging, begin to address more core beliefs and assumptions. Many clients find identification of these beliefs difficult because they are more abstract than automatic thoughts.
- Identify core beliefs by noting recurrent themes in thought monitoring. You can also direct the client to ask questions like the following:

- If this were true, what would it mean for me?
- What does this say about me?
- What would happen if this event did occur?
- What would be so bad if this thing did happen?

- These may include beliefs related to:
    - Safety
    - Trust
    - Power and control
    - Esteem issues
    - Intimacy issues

- The following is an example of a therapist-client interaction that attempts to identify and challenge a belief.

CASE EXAMPLE

THERAPIST: Martin, the last little while we have been discussing a number of thoughts that have led you to feel scared. I would like to turn our attention to explore whether there is a common thread between these thoughts.
CLIENT: I just feel scared. All the time.
THERAPIST: Okay, let's take it a bit more slowly. Let's focus on the last example we worked on. The other day you were sitting in your office and you felt very scared when a new client walked in. Tell me more about that.
CLIENT: Well, I was feeling pretty okay and then he walked in. I wasn't expecting him. He just knocked, opened my door, and gave me a terrible fright.
THERAPIST: When you say he gave you a fright, what were you actually scared of?
CLIENT: I thought he was going to beat me. Just like the other guy. He had me cornered.
THERAPIST: Okay, if he actually did that what would it mean for you?
CLIENT: I'd be dead, of course. He'd hurt me…like the other guy did. I feel like this everywhere. I get scared at the office, at home, in the car. Even with the family.
THERAPIST: So you're saying that you can't feel safe anywhere. It doesn't matter where you are or who you are with, you can't feel safe.
CLIENT: What's more, I know that I can't ever feel safe again. Not after what happened.
THERAPIST: Okay, so what you are saying is that the main belief underlying many of these scary thoughts is that "I can't feel safe anywhere, with anyone, ever again". Is that right?
CLIENT: Yes. That's right. And if you had been through what I have, you'd agree with me.
THERAPIST: So are you saying that there is absolutely no place that you can feel safe?
CLIENT: Absolutely.
THERAPIST: Do you feel safe here?
CLIENT: Sure. But that's different. I know nothing can happen to me here.
THERAPIST: Well, what about other places. You mentioned your home?
CLIENT: If those guys got me at home, they'd hurt me there too.
THERAPIST: How often have you been assaulted in your home?
CLIENT: Never…yet.
THERAPIST: How long have you lived there?
CLIENT: Getting onto ten years.
THERAPIST: So you've lived there for ten years but never been assaulted there. How often has someone tried to assault you there?
CLIENT: Never.
THERAPIST: How often has someone you have lived with been assaulted in your home?
CLIENT: I guess never.

THERAPIST: Alright, so how likely is it…just looking at the evidence… that you will get assaulted in your home?
CLIENT: Based on the evidence, I guess it's not likely.
THERAPIST: Alright, let's turn to the next part of your belief. You said that you can't feel safe with anyone. Do you really mean that?
CLIENT: Yes. Nobody can make me safe.
THERAPIST: So you don't feel safe with me?
CLIENT: No, I feel safe with you.
THERAPIST: What about your family?
CLIENT: I don't necessarily feel safe with them.
THERAPIST: How often have you been assaulted when you've been with them? How often have they assaulted you?
CLIENT: Never. And I know your next question…I've known them for thirty years and I've never been assaulted when I have been with them.
THERAPIST: Good, you're getting the idea of this. You need to apply some logic to the way you're thinking? You need to base these conclusions on reason and evidence. What about the third part of that belief? The one where you said that you can never feel safe again.
CLIENT: I can't help that. It's just the way I feel.
THERAPIST: I understand that but let's ask the question, how often have you been assaulted?
CLIENT: Only once, thank God.
THERAPIST: How do you know then that you won't feel different in a few weeks or months? What experience are you basing that on?
CLIENT: None.
THERAPIST: Have you ever felt bad in the past about something for a while but then the feeling passed or changed?
CLIENT: No… I mean I have felt bad about a whole bunch of things but it always passes.
THERAPIST: So is it reasonable to assume that there is a chance that this feeling may pass?
CLIENT: You're right. It probably will pass. Although it doesn't feel as though it will at the moment.
THERAPIST: That's understandable. But let's just sum all this up. You are saying that you can actually feel safe in certain places, feel safe when you are with numerous people, and probably feel safer some time in the future. Is that correct?
CLIENT: Yes, guess so.
THERAPIST: Okay, on the basis of the evidence that you have available at this time, it sounds like you have concluded that it's not justified to feel unsafe all the time. So it looks like it's the case that if you apply this line of reasoning to this belief, you are able to change that belief. So by entertaining these other options and balancing your belief with the evidence, you are beginning to put a more realistic slant on your outlook. Let's turn to the Thought Record Form, and fill out the final column. I want you to write down the reality-based response to each of your beliefs, and rate how strongly you believe that at the moment. This is what I want you to do each time you have one of these thoughts that make you feel bad. Think about the evidence, weigh it up with an open mind, and record the outcome. The more you do this, the more you will be able to have conviction in the realistic beliefs.

Prolonged exposure (45 mins)

- Proceed with 40 min PE
- Obtain SUDS ratings of anxiety

- Identify “hotspots” (portions of the memory that still cause anxiety >20 SUDS) and slow down the narrative in these areas and review in a repetitive fashion if required.

Assign homework (5 mins)

- In vivo exposure tasks from hierarchy & monitoring SUDS ratings.
- PE: daily practice (40 mins)
- CT: daily monitoring and challenging trauma-related unhelpful thoughts and beliefs.

SESSION 5 (90 mins)

Agenda
- Review week and homework (10 mins)
- In vivo exposure: Moving through the hierarchy (10 mins)
- Cognitive therapy (20 mins)
- Prolonged exposure (45 mins)
- Assign homework (5 mins)

Materials
- Monitoring forms as needed

Review week and homework (10 mins)
- Review week and obtain SUDS rating:

> *When you think back over the past week, how distressed have you generally felt (where 0 = no distress, and 100 = extremely distressed)? Take a couple of minutes to think about your response.*

- Review cognitive therapy
- Review in vivo exposure practice: ensure in vivo steps are being followed correctly, reinforce efforts and discuss any reductions in anxiety.
- Review prolonged exposure: address any difficulties (e.g. avoidance/distraction).

In vivo exposure (10 mins)
- Continue to go up the hierarchy, setting in vivo tasks and rehearsing steps in completing tasks.

Cognitive therapy (20 mins)
- Continue challenging unhelpful trauma-related thoughts and beliefs.

Prolonged exposure (45 mins)
- Proceed with 40 min PE
- Obtain SUDS ratings of anxiety
- Identify “hotspots” (portions of the memory that still cause anxiety >20 SUDS) and slow down the narrative in these areas and review in a repetitive fashion if required.

Assign homework (5 mins)
- CT: daily monitoring and challenging trauma-related unhelpful thoughts and beliefs
- In vivo exposure tasks from hierarchy & monitoring SUDS ratings.
- PE: daily practice (40 mins)
- Daily p

SESSION 6 (60 mins)

Agenda
- Review homework (10 mins)
- In vivo exposure (10 minutes)
- Cognitive therapy (20 mins)
- Relapse prevention (15 mins)
- Schedule post-treatment assessment (5 mins)

Materials
- Monitoring forms as needed
- "Preventing relapse" form

Review week and homework (10 mins)
- Review week and obtain SUDS rating:

> *When you think back over the past week, how distressed have you generally felt (where 0 = no distress, and 100 = extremely distressed)? Take a couple of minutes to think about your response.*

- Review cognitive therapy
- Review in vivo exposure practice: ensure in vivo steps are being followed correctly, reinforce efforts and discuss any reductions in anxiety.
- Review prolonged exposure: address any difficulties (e.g. avoidance/distraction).

In vivo exposure (10 mins)
- Continue to go up the hierarchy, setting in vivo tasks and rehearsing steps in completing tasks.

Cognitive therapy (20 mins)
- Continue challenging unhelpful trauma-related thoughts and beliefs.

Relapse prevention (15 mins)
- Review rationale of prolonged exposure, in vivo exposure and cognitive therapy and check client's understanding.
- Identify the areas in which the client has made the most gains or has found the most beneficial. Identify the specific positive changes the client has made since beginning treatment. Also identify areas in which the client has made less progress.
- Identify short-term goals and goals for booster sessions for client. Use this information to plan continuing use of the strategies. For example, emphasise that although this is the second last treatment session, client should continue to practise PE and IV exposure and cognitive therapy.
- Point out that it is not unusual to re-experience the PTSD symptoms even after "recovery", especially on occasions like the anniversary of the trauma. Ask client to anticipate situations in the future that may trigger PTSD symptoms (a "slip") Make a list of potential high-risk situations.
- Discuss "alarms" or early warning signals that could identify slips and therefore trigger relapse prevention strategies. These may be thoughts (e.g., I'm not

safe"), feelings (e.g., panic, depression), physical symptoms (e.g., heart racing, chest pain) and behaviours (e.g., making excuses instead of going out).

- Work out a plan for when the client notices "alarms". This plan may involve, for example, writing and implementing new hierarchies, re-starting cognitive therapy, re-reading resources and forms that they have been using in treatment, and re-contacting the unit. Role-play and rehearse these strategies if necessary.

CASE EXAMPLE

THERAPIST: Well, we are coming towards the end of therapy and so it is probably a good time to look back to the progress you have made and look forward to the next few weeks and months. As I am sure you are aware the end of therapy is not the end of the process of dealing with your trauma. There will inevitably be ups and downs. Sometimes the memories of the trauma will bother you and sometimes they won't. During therapy you have developed a collection of coping strategies and ideas for managing the trauma. Each of the strategies is fairly new so it will be important to keep practicing them. Then, if ever you do come across a period when the memories of your trauma are bothering you, you will able to go back to these strategies, and continue your own therapy. In your sessions we have learned a number of strategies to deal with your trauma. Which ones do you find most useful?
CLIENT: I think I probably benefited most from the breathing control and the imaginal exposure.
THERAPIST: What were your thoughts about the cognitive therapy?
CLIENT: Well I guess it was an eye-opener. I feel like I am doing that pretty automatically now in all situations.
THERAPIST: What part of therapy do you think is still a bit difficult?
CLIENT: Well I guess the real life exposure is tough. I know I've managed the early steps but some of these later ones are not easy.
THERAPIST: So perhaps our immediate plan should focus on real life exposure. What areas still cause you some distress?
CLIENT: Well none really cause me a huge amount of distress. But there are still one or two that cause me a little bit of discomfort. Like on my way to work I can take one of two routes. One goes past where I had the accident. This is the most direct route. But I still take another way that doesn't go past the accident site, even though it's 20 minutes longer.
THERAPIST: Well, I am pleased that you are aware when you are avoiding. This ability will serve you well. As soon as you detect avoidance you will be able to work out what you are fearful of in the situation and then go into the situation to test out if your feared outcome occurs. So what do you think you should do about your driving to work?
CLIENT: I guess make a plan to drive there every day. But I know what you'll say next. You think I should stay there for half an hour until I am not edgy about it anymore. Am I right?
THERAPIST: Absolutely. We are starting to think alike. I know it won't be pleasant but by staying there for prolonged periods, I think you'll be surprised how quickly this anxiety will subside. If there are any things that still cause you distress and you are doing things to avoid them, now is the time to tackle them. If you deal with them in the near future, it is less likely that they will be problems later.
CLIENT: Do you think I will have more problems?
THERAPIST: I don't know. Most people have some hiccups at some time or another. That doesn't mean they go back to where they started. It just means that you need to apply the skills that you have learned here to master the situation. What helps is if you can plan for those occasions in advance. Can you think of any situations in the coming months that will be stressful for you?

CLIENT: Definitely. In a couple of months I have to go to court and give evidence against the men who ran me over. The cops have told me that I can do it so I won't be recognized. But I am terrified. I know it's going to bring it all back.
THERAPIST: Well Ed, I think you're right. It will be a tough time but you have the advantage of planning for it now. What sorts of things are you worrying about? How do you think they will affect you?
CLIENT: It's hard to know at this stage. To be honest with you, I have been considering leaving town so the cops can't find me. I think if I can just get away from that whole scene I will feel better. Since I have been thinking about it over the last week, I've stopped reading papers and watching the news so I don't get confronted by it all.
THERAPIST: What I hear you saying Ed, is that you want to avoid the reminders of the experience. I would agree with you if I thought that you were in any danger. But it seems to me that you are trying to avoid things because they are stirring up memories of what happened in the past. Now we have spoken often about how important it is for you to not allow avoidance to develop. I suggest that you use the opportunity of this court episode to deal with your avoidance more effectively. I suggest that you make a plan to intentionally watch the news and read the papers until you notice that your anxiety had subsided. I think you should also return to your imaginal exposure in the period before going to court because this will help to reassure you that you don't need to be afraid of these memories. There is also a range of practical strategies you can employ to help you cope with your stress. Your relaxation techniques will be very helpful at that stage. In fact, I suggest that we actually make a detailed plan about the strategies you will use to deal with this period. Then we can rehearse them here, so you can feel confident in using them when the time arrives.

Post-treatment Assessment (5 mins)

- Schedule an appointment for 1 week after the completion of treatment with an independent therapist.