8-4-2016

Fidelity to the Cognitive Processing Therapy Protocol: Further Evaluation of Critical Elements

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Doctoral Dissertation

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August 2015

A Dissertation Submitted to The Graduate School at the University of Missouri-St. Louis in partial fulfillment of the requirements for the degree Doctor of Philosophy in Clinical Psychology.

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Abstract

Despite advancements in the field of trauma-focused treatment, a close examination of the literature reveals three concerns. First, a significant number of RCT participants either do not respond to treatment or drop out prematurely. Second, despite significant dissemination of evidence-based interventions, fidelity to those interventions beyond trainings is not well understood. And finally, the effectiveness of trauma-focused interventions in the "real-world" community setting remains unclear. Literature suggests that identification of key treatment components could help to address these three concerns. This study focused on one evidence-based treatment in particular, Cognitive Processing Therapy (CPT), and aimed to extend the current literature by first expanding the existing CPT fidelity rating system to assess theorized CPT critical components and second, by examining the influence of treatment fidelity on symptom change and attrition rates. Results showed that overall fidelity to specific treatment components did not predict PTSD symptom change, newly added CPT fidelity rating system items did not add predictive value over the original items, and neither fidelity to individual theorized critical components nor fidelity to nonspecific treatment components predicted symptom change. Additionally, treatment completers and dropouts did not differ significantly on most fidelity scores. Overall fidelity to the CPT protocol was high in this sample. Further exploration of the relationships amongst therapist fidelity, nonspecific factors, and treatment outcome is indicated.

Fidelity to the Cognitive Processing Therapy Protocol: Further Evaluation of Critical Elements

Introduction

Since the introduction of posttraumatic stress disorder (PTSD) into the third version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association, 1980), there has been a concerted effort among psychologists toward the creation of interventions to target its debilitating symptomatology (Resick, Monson, & Rizvi, 2008). Reviews of treatment outcome research for trauma-focused interventions reveal that these efforts have been largely successful (Friedman, Keane, & Resick, 2007). Randomized controlled trials (RCTs) have provided support for the efficacy of various manualized treatments for PTSD, demonstrating that the majority of participants receiving these treatments in controlled settings realize significant symptom and psychosocial gains (Foa, Keane, Friedman, & Cohen, 2008; Resick, Monson, & Gutner, 2007). As a result, dissemination initiatives have intensified and trauma survivors increasingly have access to short-term therapies that may help to significantly reduce or remediate their PTSD and depressive symptom severity.

Despite the evident gains made within the field of trauma-focused treatment research, there remains room for improvement. The continuum of psychotherapy outcome research involves both efficacy research, defined as "treatment outcomes obtained in controlled psychotherapy studies that are conducted under laboratory conditions," and effectiveness research, defined as "treatment outcomes obtained in clinic settings where the usual control procedures are not implemented" (Kazdin, 2003, p. 142). For some time, researchers have focused on establishing efficacy through RCTs.

However, even within the strictly controlled settings of RCTs, the overall success rates of trauma-focused interventions are unsatisfactory. Up to one-third of treatment completers retain their PTSD diagnosis following administration of evidence-based practices (EBPs); furthermore, on average 18% of participants are found to drop out of treatment prior to completion (Bradley, Greene, Russ, Dutra, & Westen, 2005; Imel, Laska, Jakupcak, & Simpson, 2013; Schottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008). Additionally, because of the tight experimental control that RCTs maintain in order to ensure internal validity, some argue that results may not generalize well to the "real-world" community setting, leaving the effectiveness of these treatments less well understood (Friedman et al., 2007, p. 223). Therefore, the current focus of the field has begun to migrate from intervention development, or efficacy research, toward improving the effectiveness of established trauma-focused treatments.

The momentum for improving intervention effectiveness is fueled not only by the appeal for greater treatment success rates, but also by current national dissemination efforts. Widespread dissemination of trauma-focused evidence-based practices is currently underway in the United States at both the state and federal level (Cook, Schnurr, & Foa, 2004; Karlin et al., 2010). Thus, there is a significant amount of time and financial resources being funneled into training clinicians at every level of care to ensure the successful administration of trauma-focused EBPs. Despite continued efforts, reports reveal that many front-line community clinicians still do not regularly implement EBPs for PTSD (Cook et al., 2004). Therefore, it is increasingly crucial to strive for treatments that not only benefit a greater number of individuals across a wider variety of settings, but also are more readily and effectively disseminated. The goal of successful

dissemination of evidence-based trauma-focused treatments further energizes the overall goal of improving treatment effectiveness.

Given the desire for enhanced treatment success rates and the substantial resources fueling dissemination efforts, the aim of improving the existing trauma-focused treatments is fundamental. One suggested approach of targeting treatment effectiveness is to further examine existing interventions so as to better understand their mechanisms of action and "key ingredients" (Resick et al., 2007). In doing so, researchers may be able to determine the essential and non-essential components of intervention protocols. Understanding which treatment components facilitate symptom change is a step toward creating more effective interventions and could simultaneously benefit dissemination efforts.

We take the following methodological approach to examining essential intervention components. First, we examine the theoretical basis and supporting literature to identify the *proposed* critical elements. Second, we attempt to accurately measure the implementation of those elements. Measurement of whether these components are implemented as designed would be the only way to subsequently examine whether or not they are indeed critical to treatment outcome. Measurement of adherence to a protocol is typically carried out through an assessment of treatment fidelity. Thus, we first need to ensure the adequacy of current fidelity measurement tools and make any modifications necessary so that purported critical elements are adequately represented. And finally, once the proposed critical elements have been identified and accurately measured with updated fidelity rating systems, we examine whether implementation of those components was indeed predictive of treatment outcome. Theoretically, a more rigorous

understanding of the treatment components that are responsible for creating symptom change could contribute to theory, current clinical practice, and intervention training and dissemination initiatives.

Posttraumatic Stress Disorder Scope and Criteria

Exposure to an extreme life stressor is relatively common in the United States, with the lifetime prevalence of trauma exposure reported as 51.2% for women and 60.7% for men (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). While the majority of trauma survivors proceed through a natural recovery process, many individuals experience adverse consequences of the event, including occupational difficulties, medical costs, overall functional impairment, and psychological burden (Kessler, 2000). Adverse emotional and psychological reactions have been found to develop following exposure to a variety of life events, including military combat (Rosenheck & Fontana, 2007; Schnurr, Lunney, Bovin, & Marx, 2009), physical or sexual assault (Foa, Dancu, et al., 1999; Resick, Nishith, Weaver, Astin, & Feuer, 2002; Schumm, Briggs-Phillips, & Hobfoll, 2006), natural disasters (Hussain, Weisaeth, & Heir, 2011; Madakasira & O'Brien, 1987), motor vehicle accidents (Blanchard et al., 1996), and criminal victimization (Kilpatrick & Resnick, 1992). PTSD is the most common psychiatric diagnosis following trauma exposure (Resick, Monson, et al., 2008), with an estimated overall lifetime prevalence rate of 6.8% for the general population (Kessler, Berglund, Demler, Jin, & Walters, 2005).

The diagnostic criteria for PTSD in the DSM-IV-TR require that a person is exposed to a traumatic event and subsequently responds with intense fear, helplessness, or horror (American Psychiatric Association, 2000). The three symptom clusters of

PTSD include re-experiencing the traumatic event, avoidance of stimuli associated with the trauma and numbing of general responsiveness, and increased arousal (American Psychiatric Association, 2000). The DSM-IV-TR requires a 1-month duration of symptoms to meet the criteria for PTSD, and if symptoms persist for 3 months or longer, the disorder is specified as chronic (American Psychiatric Association, 2000). Research suggests that untreated PTSD tends to run a persistent and chronic course (Perkonigg et al., 2005) and often co-occurs with other psychiatric disorders such as depression, generalized anxiety disorder, and panic disorder (Kessler et al., 1995). The debilitating effects of PTSD clearly extend beyond core symptomatology as research consistently displays impairment in both psychosocial functioning and quality of life among individuals with PTSD (Kuhn, Blanchard, & Hickling, 2003; Schnurr et al., 2009). Notably, PTSD diagnostic criteria changed slightly (e.g., further emphasizing the cognitive nature of the disorder) with the publication of the 5th edition of the DSM but this study utilized DSM-IV-TR criteria.

Cognitive Processing Therapy is an EBT for PTSD

As a group, cognitive behavioral therapies (CBTs) have demonstrated the strongest empirical support for the treatment of PTSD (Resick et al., 2007). Within this group, cognitive processing therapy (CPT; Resick & Schnicke, 1992) is one example of an evidence-based trauma-focused therapy that is currently being disseminated on a national level. CPT was designed as a 12-session predominantly cognitive intervention that targets the aforementioned symptoms of PTSD as well as comorbid depressive symptomatology and related clinical correlates such as guilt, anger, and overall psychosocial functioning. In the first session, clients are provided with psychoeducation

related to the symptoms and etiology of PTSD, cognitive theory, types of trauma-related emotions, and the treatment rationale. Clients are also given an assignment in the first session to write an impact statement about the meaning of their traumatic experience including why they believe it occurred and how it has impacted their beliefs about themselves, others, and the world. In session two, therapists introduce the A-B-C worksheet as a tool to educate clients about the connection between events, thoughts, feelings, and behaviors. Clients and therapists together begin to identify "stuck points," or maladaptive trauma-related cognitions, that have developed as a result of the client's interpretation of their traumatic experience (Resick, Monson, & Chard, 2010).

When a trauma occurs, individuals can respond by integrating new trauma-related information into their existing belief systems in many ways. Stuck points can arise if this information is integrated in a maladaptive way, through either assimilation or over-accommodation. Assimilation occurs when trauma information is altered to fit preexisting beliefs and typically involves self-blame and attempts at "undoing" the event (e.g., "Bad things only happen when you do something wrong, so it must be my fault that I was abused."). Over-accommodation involves changing preexisting beliefs in an extreme way with the goal of avoiding future traumas (e.g., "This person betrayed me, therefore I can never trust anyone again."). Ideally, the individual is able to integrate this new information into their existing belief systems in an adaptive way (e.g., accommodation). Starting in the early sessions and continuing throughout the course of therapy, a primary goal of CPT is to challenge stuck points and develop more realistic, evidence-based beliefs that accommodate new trauma information into existing belief

systems without altering them completely (e.g., "Although I didn't use good judgment in that situation, most of the time I make good decisions").

In session four, clients are invited to directly experience and process previously avoided trauma-related emotions by writing and subsequently reading over detailed accounts of their traumatic experience, including sensory details, thoughts and feelings (Resick et al., 2002). During sessions five through seven, clients are taught the core cognitive therapy skills related to identifying and challenging stuck points. As they learn these new skills, clients begin to take on the role of independently challenging and restructuring their own maladaptive beliefs. The final five sessions provide an opportunity for clients to focus on specific domains of beliefs commonly affected by trauma (e.g., safety, trust, power/control, esteem, and intimacy; McCann, Sakheim, & Abrahamson, 1988) and continue honing cognitive restructuring skills using the Challenging Beliefs Worksheet. In the final session, clients rewrite their impact statement based on current interpretations of the trauma. This document is compared to the initial impact statement so that clients and clinicians can identify and process the changes in thoughts, feelings, and behaviors that have occurred over the course of therapy. As part of the final session, goals for the future are identified, and the client is encouraged to continue practicing newly acquired CPT skills.

Theoretical Support for CPT

CPT is based in part on Lang's (1977) information processing theory, which Foa, Steketee, and Rothbaum (1989) adapted for PTSD with emotional processing theory. These theories explain the development and maintenance of PTSD; they suggest that following a traumatic experience, individuals with PTSD develop a fear network which

consists of stimuli (i.e., trauma-cues), responses (i.e., fear, avoidance, escape), and meaning (i.e., trauma-cues = necessary fear; Resick, 2001). When trauma-cues activate the fear network, information in the network is brought into consciousness and the individual "re-experiences" the trauma. Efforts to avoid this activation lead to escape and avoidance behavior. Emotional processing theory suggests that repeated exposure to memories of the trauma in a safe environment will allow for habituation of the fear and ultimately result in a change in the fear network (Foa et al., 1989). CPT posits that this fear, among other emotions such as sadness and anger, are part of a set of emotions called *natural* emotions. These are thought to be a hard-wired response that occurred during the trauma. These emotions recur in PTSD when trauma affected schema are activated by trauma-cues. When activated, if those natural emotions are fully experienced and processed, they will subsequently diminish.

CPT also posits that a second subset of emotions, termed *manufactured* emotions, are equally important in preventing recovery from PTSD. These emotions, which can include guilt, shame, and anger among others, are termed manufactured because CPT holds that they are directly caused by the individual's interpretation of the traumatic event, rather than based on facts. With the understanding that manufactured emotions prevent recovery from PTSD, social cognitive theories further inform CPT by focusing on the impact of trauma on the individual's existing belief system and addressing the meaning that individuals with PTSD attribute to the trauma in a social context (Resick, 2001; Resick et al., 2010). CPT posits that maladaptive beliefs, or conflicts between prior schema and new trauma information, need to be directly targeted through cognitive restructuring in order for the related manufactured emotions to diminish. CPT also

targets beliefs about the self, others, and the world in five domains of functioning that are often affected and disrupted by trauma (e.g., safety, trust, power/control, esteem, and intimacy; McCann et al., 1988).

Empirical Support for CPT

CPT has been shown to be effective in leading to statistically significant and clinically meaningful reductions in PTSD and depressive symptomology among a range of trauma survivors (Resick et al., 2002). These include interpersonal violence survivors (Chard, 2005; Galovski, Blain, Mott, Elwood, & Houle, 2012; Resick, Galovski, et al., 2008; Resick et al., 2002), foreign born refugees living in the United States (Schulz, Resick, Huber, & Griffin, 2006), military veterans (Forbes et al., 2012; Monson et al., 2006; Surís, Link-Malcolm, Chard, Ahn, & North, 2013), incarcerated males (Ahrens & Rexford, 2002), and "multiple trauma" samples (Falsetti, Resnick, Davis, & Gallagher, 2001). Improvements in more global outcomes, including psychosocial impairment and quality of life, have also been reported (Galovski, Sobel, Phipps, & Resick, 2005). Further, CPT has been associated with gains in other clinical correlates of PTSD, such as anger (Galovski, Elwood, Blain, & Resick, in press; Resick, Galovski, et al., 2008), guilt (Galovski et al., 2012; Nishith, Nixon, & Resick, 2005; Resick, Galovski, et al., 2008), perceived physical health (Galovski et al., 2012; Galovski, Monson, Bruce, & Resick, 2009), and sleep impairment (Galovski et al., 2009). Importantly, the majority of treatment completers appear to maintain gains in the long-term (Resick, 2010).

In addition to the success realized through the use of the original CPT 12-session protocol, researchers have adapted the manual and demonstrated the efficacy of varying formats of the intervention. Most notably, a dismantling trial compared the original, full

12-session CPT protocol with its two main components, cognitive therapy only (CPT-C) and written trauma accounts only (WA). Findings illustrated that compared to CPT, CPT-C was equally effective in reducing PTSD, depressive, and comorbid symptoms (Resick, Galovski, et al., 2008). As a result, CPT-C, which eliminates the two written account sessions in an effort to spend increased time on cognitive restructuring, is now often used in cases when written trauma accounts may be contraindicated (e.g., clients with high dropout risk), in group format, and when otherwise indicated (Resick et al., 2010). Additionally, recent research reveals that a variable length course of CPT (i.e., between 4 and 18 sessions depending on client progress) allows for significant treatment gains and eliminates the necessity of the standard 12 sessions (Galovski et al., 2012). CPT has also been effectively implemented in group format (Alvarez et al., 2011; Resick & Schnicke, 1992) and combined individual and group format (Walter, Bolte, Owens, & Chard, 2012).

The CPT training program and treatment protocol has recently been adapted for use with special populations including US-based Bosnian refugees (Schulz et al., 2006) and Iraqi torture survivors in Kurdistan (Kaysen et al., 2011). Researchers have successfully modified the CPT training program through changes such as the use of simplified training material and the addition of population specific case examples and increased therapy scripts in lay language (Kaysen et al., 2011). Likewise, adaptations to the protocol based on culture specific needs have been made. These include the opportunity for home-based treatment, lengthier session time (e.g., 1.5 to 2 hour sessions), change in the order of sessions, the use of interpreters in session, reduced amount of out-of-session practice assignments, modified practice assignments for illiterate clients, and

module content revised to fit culturally appropriate themes (Kaysen et al., 2011; Schulz et al., 2006). Despite these and other modifications, researchers have attempted to preserve the "essential elements" of CPT (Kaysen et al., 2011; Schulz et al., 2006). Finally, CPT has been used in combination with other interventions, including sleep directed hypnosis for sleep impairment (Galovski; NCCAM 1R21AT004079), CBT for chronic pain (Otis, Keane, Kerns, Monson, & Scioli, 2009), and panic control treatment for panic attacks (Falsetti et al., 2001). Clearly, a great deal of literature supports the efficacy of CPT. However, researchers and clinicians alike acknowledge the necessity of making CPT available and effective for a greater percentage of trauma survivors suffering from PTSD.

Dissemination of CPT

Based on the accumulated evidence in support of CPT, efforts are currently underway to disseminate the intervention at the federal and state level. This dissemination is part of a larger effort to train clinicians throughout the mental health community to implement evidence-based practices (Cook et al., 2004; Schnurr, 2007). Since 1999 when the Expert Consensus Guideline Series on the Treatment of PTSD advertised cognitive therapy and exposure as the most beneficial trauma-focused interventions (Foa, Davidson, & Frances, 1999), national and international organizations have released clinical practice guidelines encouraging the implementation of evidence-based trauma-focused therapies as first-line treatments for PTSD (American Psychiatric Association, 2004; Foa et al., 2008; VA/DoD, 2010). These guidelines facilitate the dissemination process by providing specific recommendations regarding trauma focused assessment and treatment to researchers, clinicians, and consumers in diverse settings.

Over the past decade, CPT has consistently been included in these guidelines as a first-line treatment approach.

Prompted by the publicized practice guidelines and the substantial numbers of returning war veterans suffering from PTSD, the US Department of Veterans Affairs (VA) began a national dissemination effort in 2006. The primary aim was to train mental health workers in the VA health care system in evidence-based therapies for PTSD (Karlin et al., 2010). CPT, along with prolonged exposure (PE; Foa, Rothbaum, Riggs, & Murdock, 1991), is one of the EBTs currently being disseminated in the VA system. Recent surveys indicate some initial success of the VA training and implementation initiatives. As of August, 2011, over 3,000 VA and over 2,400 Department of Defense (DoD) mental health providers had received CPT training (Chard, Ricksecker, Healy, Karlin, & Resick, 2012). The majority of clinicians who participate in CPT training through the VA system report that they subsequently implement the intervention and that their clients appear to make significant treatment gains (Chard et al., 2012). Actual patient outcome data, however, shows that approximately half of veterans fully recover from PTSD following completion of a full course of CPT (Chard et al., 2012). Therefore, while these training and implementation initiatives are increasingly successful, there remains room for growth with regards to treatment effectiveness. Likewise, dissemination methods are continually being enhanced to increase availability of EBTs and quality care for veterans (Chard et al., 2012; Karlin et al., 2010).

CPT training initiatives outside of the VA system are currently in place as well. These initiatives typically utilize certified CPT trainers who travel to provide workshops in private and public mental health care settings. The South Texas Research

Organizational Network Guiding Studies on Trauma And Resilience (STRONG STAR) program, funded by the National Institute of Mental Health and the DoD, consists of multiple studies examining the efficacy of different formats of CPT delivered in diverse treatment settings to individuals with a variety of comorbid conditions (Peterson, Luethcke, Borah, Borah, & Young-McCaughan, 2011). Training initiatives focused on providing services to the civilian population are growing as well. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) recently awarded a grant to the Children's Advocacy Center at the University of Missouri – St. Louis that will allow for the training of community clinicians in the provision of CPT to the PTSD-positive caregivers of traumatized children who are also receiving treatment (Missouri Institute of Mental Health, 2012). Thus, it is clear that a great deal of time and resources are being funneled into the dissemination of CPT and other trauma-focused interventions.

Barriers to Successful Dissemination of EBTs

Despite reports of some initial success within the VA dissemination efforts, it is clear that the process of disseminating EBTs is not without obstacles. Unfortunately, there appears to be a gap between what is understood as effective and what is implemented in practice (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). Despite well-documented empirical support for these interventions, front-line clinicians are still relatively unlikely to utilize evidence-based treatments for PTSD (Jameson, Chambless, & Blank, 2009; Rosen et al., 2004; van Minnen, Hendriks, & Olff, 2010). This holds true even after clinicians receive training in specific EBTs (Becker, Zayfert, & Anderson, 2004). Likewise, even when community clinicians do adopt evidence-based treatments,

they are not always implemented as designed (Perepletchikova, 2011). The growth of training and dissemination efforts over the past few years has illuminated some of the barriers to successful dissemination of EBTs.

Clinicians have consistently endorsed obstacles related to the implementation of evidence-based manualized interventions (Peterson et al., 2011). Concerns often relate to the perceived complexity and inflexibility of manualized interventions (Ruzek & Rosen, 2009). Likewise, concerns about sacrificing the therapeutic relationship, reducing therapist autonomy, and minimizing the importance of individual client variables are common (Addis, Wade, & Hatgis, 1999; H. M. Levitt, Neimeyer, & Williams, 2005)(Addis & Krasnow, 2000). Beliefs about the artificiality of RCTs also contribute to under-utilization of evidence-based treatments. Specifically, clinicians report they believe patients in RCTs are not equivalent to patients in general clinical practice due to the strict inclusion and exclusion criteria of treatment outcome trials (Addis et al., 1999; Cook et al., 2004; Seligman, 1995). Additionally, therapists cite logistical and organizational concerns noting that clinicians in RCTs have many more resources (e.g., increased supervision, more opportunities and support for training, reduced client caseload, organizational support for the implementation of manualized protocols, and mechanisms for identifying best practices) compared to community clinicians (Addis, 2002; Addis et al., 1999; Becker et al., 2004; Berwick, 2003; Gray, Elhai, & Schmidt, 2007; Gunter & Whittal, 2010; Ruzek & Rosen, 2009; Shafran et al., 2009).

Although dissemination efforts in the VA appear able to transcend these organizational barriers, such obstacles continue to contribute significantly to the widespread difficulty associated with successfully disseminating evidence-based trauma-

focused interventions. It is clear that dissemination efforts will need to address current logistical and organizational barriers while also propagating research findings that debunk existing myths that prevent clinicians from implementing trauma-focused EBTs. Importantly, it has also been suggested that the identification of the most critical components of manualized interventions may facilitate more successful dissemination efforts (Fixsen et al., 2005).

Benefits Associated with Identifying Critical Components of EBTs

The primary aim of dissemination efforts should be to train providers to implement only those components of an intervention that are "necessary and sufficient for effective behavior change" (Fixsen et al., 2005; Ruzek & Rosen, 2009, p. 985). Considering this goal, identifying the critical components of trauma-focused interventions could strengthen current dissemination efforts. Specific dissemination barriers for trauma-focused EBTs were discussed above. Some of those barriers could be further addressed through identification of critical intervention components. Specifically, barriers related to the perceived complexity of evidence-based protocols, the perceived lack of flexibility inherent in manualized interventions, and the burden associated with monitoring adherence to extant EBTs, could all be addressed through greater understanding of essential therapy elements. The ways in which identifying critical intervention components would be beneficial for the goal of improving dissemination, and consequently for the goal of improving effectiveness, are reviewed in detail below.

First, part of the difficulty with dissemination is that EBTs are typically perceived as overly complex (Ruzek & Rosen, 2009). Identifying the most critical therapy components may simplify the process of learning and implementing an evidence-based

protocol. Likewise, by focusing on the "core competencies" that are related to successful treatment outcome, dissemination efforts can increase in both feasibility and efficiency (Roth & Pilling, 2007; Ruzek & Rosen, 2009). Ultimately, this may help to solve the conflict between the call for more user-friendly protocols and the recognized necessity of adherence to evidence-based practices (Ruzek & Rosen, 2009).

In part because EBTs are perceived as complex, and in part because clinical work in the "real-world" setting requires flexibility, programs and practitioners in the community are known to modify EBPs based on their local patient population's needs and circumstances (Rosenheck, 2001a; Roy-Byrne et al., 2003; Ruzek & Rosen, 2009). These practices suggest an increasing need for manualized treatments that allow for modification and flexibility. In support of this movement, some research suggests that allowing for a more flexible implementation of CBT for PTSD yields positive treatment outcomes (Galovski et al., 2012; H. M. Levitt et al., 2005; J. T. Levitt, Malta, Martin, Davis, & Cloitre, 2007). For example, allowing for optional "stressor sessions" and giving clients and therapists the opportunity to either shorten or lengthen the typical 12-session CPT protocol depending on individual client needs yielded a smaller percentage of treatment non-responders compared to previous CPT treatment trials (Galovski et al., 2012). Determining the most critical therapy components may generate interventions that allow for the desired flexibility in implementation while remaining effective in diverse community settings.

A third factor driving the goal of identifying and disseminating the most essential therapy components relates to the current perception that monitoring treatment fidelity is overly burdensome for EBTs. Because therapist self-report of treatment adherence has

been deemed inadequate, independent observations of clinician behavior through videotape review are necessary (Ruzek & Rosen, 2009). Consequently, monitoring adherence can become both costly and time-consuming. Despite the burden associated with assessing treatment adherence, it is thought that this practice remains crucial in maintaining the efficacy of the intervention (Durlak & DuPre, 2008; McHugh, Murray, & Barlow, 2009; Rosenheck, 2001a, 2001b). If critical components of interventions are identified, monitoring adherence to only the key components of the therapy would be possible and the fidelity measurement process may become more feasible. Greater feasibility of treatment fidelity monitoring could then contribute to more successful dissemination of EBTs.

With the clarification of core intervention components, it may be possible to address current dissemination barriers including the perceived complexity and inflexibility of EBTs as well as the burdensome fidelity monitoring process. Gaining the knowledge of which therapy elements are most critical could facilitate more streamlined implementation and dissemination of trauma-focused EBTs. Likewise, both the efficacy (e.g., treatment outcomes in controlled settings) and effectiveness (e.g., treatment outcomes in "real-world" settings) could be improved with the knowledge of key treatment components. That is, by understanding not only that a treatment works, but also how it works, it may be possible to improve psychotherapy success rates.

In order to meet the goal of disseminating the elements of therapy essential for behavior change, it is necessary to first identify which protocol components are indeed critical. Despite the large body of trauma-focused treatment outcome research, extant literature has not adequately examined the specific critical components of PTSD

interventions (Ruzek & Rosen, 2009). Therefore, it is clear that an examination of the individual treatment components and clinician behaviors that are crucial to treatment success is an important next step in enhancing dissemination efforts and efficacy research, both of which contribute to the overarching movement toward improving effectiveness.

Purported Critical Elements of CPT

There is currently a dearth of research examining the critical components for PTSD interventions (Ruzek & Rosen, 2009). Despite this lack of empirical research, it has been suggested that there are critical elements of CPT that enable the success of the intervention (Resick, 2001). While these treatment elements are informed by the theory behind PTSD and CPT, they are also clearly identified in the current CPT treatment manual (Resick et al., 2010), heavily emphasized in CPT training workshops (Galovski, 2011; Resick, 2012), and are described in detail below.

The first suggested critical element of CPT is the use of Socratic questioning in challenging maladaptive trauma-related beliefs. Socratic questioning involves asking clients questions that they have the knowledge to answer and that draw their attention to information that is relevant but previously was not considered. Through this process, the clinician engages the client in a "guided discovery" process to help them identify stuck points, reevaluate this negative, distorted thinking, and finally develop alternative, balanced beliefs (J. S. Beck, 2011; Padesky, 1993, p. 3; Virues-Ortega, Montaño-Fidalgo, Froján-Parga, & Calero-Elvira, 2011). Rather than taking a more directive challenging style, therapists utilize Socratic questions to aid the client in coming to an awareness of their dysfunctional thinking on their own. Teaching clients to question their own thoughts and beliefs creates more meaningful and lasting change, encourages clients to

take more credit for their progress, and fosters the skills necessary to continue challenging maladaptive cognitions independently once treatment concludes (Resick et al., 2010).

The current CPT manual refers to Socratic dialogue as a "cornerstone" of CPT practice and provides historical and practical information on the topic (Resick et al., 2010, p. 7). CPT training workshops also emphasize the use of Socratic questioning as crucial to the success of CPT (Galovski, 2011; Resick, 2012). Significant time during training is devoted to discussing the history and principles of Socratic dialogue. Clinicians are instructed on how to identify and hone stuck points, or maladaptive trauma-related beliefs. CPT trainers encourage clinicians to consistently phrase challenges to stuck points in question form rather than "telling the client the answer," and organize role-play exercises to practice the method of Socratic dialogue (Galovski, 2011; Resick, 2012). Considering the emphasis placed on Socratic questioning in both the CPT manual and training workshops, it is clear that this component is considered to be critical to the success of the therapy.

Challenging of assimilated beliefs prior to over-accommodated beliefs is a second treatment component thought to play a critical role in the success of CPT. Therapists work with clients to identify stuck points, which can be categorized as either assimilation (e.g., self-blame; undoing of the event) or over-accommodation (e.g., extreme, over-generalizations). According to the treatment manual, clinicians are encouraged to focus on identifying and challenging assimilated stuck points prior to moving on to the cognitive restructuring of over-accommodated beliefs (Resick et al., 2010). This is done in an effort to prevent clients from using assimilated beliefs as evidence for the validity

of over-accommodated beliefs during the cognitive restructuring process. For example, it is suggested that if the assimilated stuck point "It is my fault that I was raped because I chose to walk home alone at night" has not been adequately challenged, it may be used as evidence to support the validity of the over-accommodated stuck point "I cannot trust myself to make good decisions."

When informing clinicians about this treatment component, CPT training workshops instruct clinicians to "go after these [assimilated stuck points] first in therapy" (Galovski, 2011) and to "make sure that the client has resolved the trauma (e.g., assimilated stuck points) before moving on to challenge over-generalized beliefs" (Resick, 2012). Additionally, clinicians are encouraged to look through practice assignment worksheets that clients bring to session in order to identify and focus first on addressing assimilation (Galovski, 2011). Therefore, the focus on assimilation prior to over-accommodation is proposed to be a critical element of CPT.

A third purported critical component of CPT relates to the use of out-of-session practice assignments. It is suggested that clients will realize more efficient gains from therapy if they practice the skills that they learn in session during daily life (Resick et al., 2010). The treatment manual describes the use of the "patient contract" form at the start of treatment to define the work that is expected and the use of the "Practice Assignment Review" form at the beginning of each session to emphasize the importance of homework and increase compliance (Resick et al., 2010). CPT training workshops instruct clinicians to "start all sessions by asking about the [home]work they did over the past week" (Galovski, 2011) and stress the importance of discussing homework completion with clients who are non-compliant with assignments (Resick, 2012).

Despite the emphasis on homework, missing assignments are not cause for delaying treatment. Instead, the therapist encourages the client to do the assignment in session (orally or using a worksheet) and reassigns the uncompleted assignment along with the next assignment (Resick et al., 2010). Finally, when introducing a new practice assignment, clinicians are encouraged to always "problem solve any barriers to assignment completion" (Galovski, 2011). The emphasis placed on assigning and reviewing out-of-session practice work in both the CPT manual and training workshops demonstrates the purported critical nature of this component of the therapy.

The final proposed critical component of CPT is the emphasis placed on the expression of natural affect. The treatment manual states that "emotional processing" contributes to a smooth recovery from PTSD and that one of the four primary goals of CPT is to "feel your emotions about the event" (Resick et al., 2010; p. 28). During treatment, different types and intensity levels of emotions are discussed and clients are encouraged to allow themselves to fully experience their "natural" emotions. Clients are provided psychoeducation related to how allowing oneself to feel trauma-related emotions will lead to a reduction in the frequency and intensity of negative feelings over time (Resick et al., 2010). This treatment component derives from CPT theory which explains that natural emotions should diminish through adequate processing and manufactured emotions should fade following restructuring of the related maladaptive beliefs.

The CPT manual notes that if clients do not appear to be experiencing trauma-related emotions during the reading of their trauma account, the therapist should stop the client, ask whether and why they might be avoiding feelings, and provide

psychoeducation to encourage clients to fully experience natural emotions (Resick et al., 2010). If the client continues to avoid experiencing trauma-related emotions, the therapist should assign a more detailed trauma account and confirm that the client is reading the account regularly outside of session (Resick et al., 2010). In addition to the treatment manual's emphasis on affect expression, clinicians at CPT training workshops learn that the goal with natural emotions is to "feel them and let them run their course." When re-assigning the trauma account, therapists are encouraged to explain to the client that they should be allowing themselves to "really feel their feelings" (Galovski, 2011; Resick, 2012). Finally, the manual also notes that therapists administering CPT-C need to make a specific effort to "draw out natural emotions" and should not ignore the "processing of emotions" despite the exclusion of the trauma account (Resick et al., 2010, p. 186). Thus, the supposed importance of the expression of natural affect as a CPT treatment component is apparent in both the full CPT and modified CPT-C protocols.

As is evident through the above examination of the current CPT treatment manual and CPT training workshop proceedings, these four intervention components (i.e., Socratic questioning, challenging assimilation before over-accommodation, out-of-session practice assignments, and emphasis on expression of natural affect) are clearly proposed as critical to treatment success. However, despite the emphasis on these four elements as cornerstone components of CPT, it remains unclear whether they are implemented in session as designed. Further, it is yet to be determined whether it is specifically the accurate implementation of these intervention components that yields successful treatment outcome for CPT.

Importance of Treatment Fidelity Measurement for EBTs

It is generally assumed that good treatment outcome is a result of the successful implementation of critical intervention components. That is, high fidelity to an EBT protocol should yield good outcome (Bond, Becker, & Drake, 2011). While evidence supports this hypothesis for some interventions (Guydish et al., 2014; Henggeler, Pickrel, & Brondino, 1999; Jahoda et al., 2013; Ogden, Hagan, Askeland, & Christensen, 2009; Oxman et al., 2006; Strang & McCambridge, 2004) and not for others (Bond & Salyers, 2004; Norberg et al., 2014; Tschuschke et al., 2014), this relationship must be confirmed for each intervention individually. In order to do so, it is first crucial to demonstrate that the purported critical therapy components are being implemented as intended. Only when treatment fidelity rating systems adequately assess adherence to specific intervention components can there be an examination of whether the implementation of those specific elements is indeed related to treatment outcome.

Fidelity measurement is important for a number of reasons. First, establishing fidelity to a protocol is a crucial step in treatment outcome research that allows for an interpretation of the results as indicative of the efficacy of the intervention rather than other nonspecific factors (Barber, Triffleman, & Marmar, 2007; Perepletchikova, 2011; Schnurr, 2007; Waltz, Addis, Koerner, & Jacobson, 1993). Monitoring treatment fidelity also plays an important role in dissemination by providing a way to investigate whether training of clinicians was successful and a way to ensure that the intervention remains intact despite being implemented in diverse settings by a wide range of mental health providers (Barber et al., 2007; Perepletchikova, 2011; Schnurr, 2007; Waltz et al., 1993). Assessing treatment fidelity could also be used to inform future alterations to the manual. That is, if clinicians routinely perform certain treatment components incorrectly or

inadequately, or if clients regularly struggle to grasp particular concepts, then those portions of the protocol may need to be clarified or modified either generally or for specific populations (Perepletchikova, 2011; Peterson et al., 2011). Finally, by helping to establish treatment efficacy, improve dissemination methods, and contribute to modification of protocols based on community needs, fidelity measurement also benefits efforts to improve treatment effectiveness.

Given the established importance of monitoring treatment fidelity, it has been suggested that this process become a regular part of treatment outcome research (Perepletchikova, 2011; Waltz et al., 1993). Treatment fidelity is traditionally measured through the use of adherence and competence assessment techniques. *Adherence* to a treatment protocol is defined as how closely a therapist follows the intervention components and the extent to which they avoid proscribed procedures (Waltz et al., 1993). C*ompetence* is understood to be the skill with which the therapist delivers the appropriate intervention (Waltz et al., 1993).

For years researchers either inadequately assessed treatment fidelity, ignored the issue altogether, or provided explanations of the measurement process that were insufficient, unclear, and consequently not replicable (Waltz et al., 1993). Although guidelines for assessment of adherence and competence were eventually developed (Moncher & Prinz, 1991) and propelled an increased focus on sufficient and meaningful measurement of treatment integrity, for some time afterward adherence and competence measures differed with regards to complexity, detail, amount of expertise necessary to use the measure, type of material being rated (e.g., transcripts, video tapes), and amount

and number of therapy sessions coded (Waltz et al., 1993). Such variation made comparisons between studies difficult.

Although more sophisticated versions of fidelity rating systems have been developed, a great deal of variability in both assessment methods and reporting style still exists. Various suggestions have been made for how researchers can develop a uniform method of tracking treatment fidelity (Barber et al., 2007; Bond et al., 2011). For example, adherence and competence should consistently be measured using continuous instead of dichotomous or categorical variables in order to facilitate a more feasible examination of the relationship between fidelity and treatment outcome (Barber et al., 2007). Other suggestions include having available video recordings of treatment sessions, using objective raters who have been trained to use the rating system and are blind to the patient's treatment outcome, coding a random sample of tapes (typically 20-40%), and establishing interrater reliability (Barber et al., 2007; Perepletchikova, 2011).

In addition to increasing the uniformity of the treatment fidelity measurement process, it may be necessary to further examine the content of fidelity rating systems. Compared to fidelity measurement of treatments for other disorders, ratings of adherence and competence within the trauma-focused treatment field are unusually high (i.e., between 85 and 100% in most RCTs; Barber et al., 2007). Considering this, it has been suggested that perhaps current tracking systems are measuring only those variables that are readily definable and, therefore, tracking systems may need to evolve to include more nuanced parts of the interventions (Barber et al., 2007). Another words, fidelity rating systems must adequately represent the prescribed intervention elements with clear operationalization of variables (Barber et al., 2007; Perepletchikova, 2011).

Specific suggestions have been made with regards to reporting treatment fidelity results as well. It is possible to report results in a number of formats including the percentage of prescribed treatment elements that were completed, the percentage of sessions in which adherence was adequate or better, and the average adherence across all sessions coded (Barber et al., 2007; Cloitre, Koenan, Cohen, & Han, 2002). Information related to the number of therapy tapes coded, the portions of sessions coded, the percentage of sessions from each phase of therapy coded, and whether choosing sessions to code was random should be reported as well (Perepletchikova, 2011). The detail provided when describing the procedures used for assessing and evaluating fidelity allows for an accurate appraisal of the study as well as the ability for future researchers to replicate and compare findings.

It is clear that while efforts to improve treatment fidelity measurement have significantly advanced the field, many researchers still either fail to assess fidelity or fail to include those results in the publication of their findings (Goense, Boendermaker, van Yperen, Stams, & van Laar, 2014; Miller & Rollnick, 2014). Addressing the aforementioned concerns and suggestions could be beneficial. Specifically, this may 1) further enable replicability and comparability of studies, 2) allow more rigorous evaluation of the accuracy with which treatments are implemented, and 3) facilitate further examination of the relationship between treatment fidelity and treatment outcome.

Fidelity Measurement for CPT

The history of CPT fidelity measurement is relatively brief. The CPT adherence and competence manual was first created in 1997 for use during the original randomized controlled trial for CPT (Nishith & Resick, 1997; Resick et al., 2002). It consists of three

sections and is completed by an individual rater viewing videotaped therapy sessions. In part one, between five and eight "essential and unique" treatment elements are listed for each session and raters are asked to record whether or not the clinician implemented each component (i.e., adherence) and how well the clinician carried out the particular component (i.e., competence) using a rating scale that ranges from 1 (*poor*) to 7 (*excellent*). In part two, the rater completes the same adherence and competence ratings for a list of "essential but not unique" treatment elements (i.e., rapport-related) that are designed to be implemented throughout the protocol rather than being specific to any particular session. Finally, in part three the rater gives a rating of the clinician's "overall skills" using the same 1 to 7 rating scale and has the opportunity to record any additional comments regarding departures from the protocol.

This same fidelity manual has been used consistently through subsequent RCTs of CPT. Six of the eight published RCTs of CPT report assessing treatment fidelity using this manual (Forbes et al., 2012; Galovski et al., 2012; Monson et al., 2006; Resick, Galovski, et al., 2008; Resick et al., 2002; Surís et al., 2013). One trial with childhood sexual assault survivors reported using an "adapted" form of the original fidelity manual (Chard, 2005, p. 967), while another stated only that sessions were recorded and would be assessed for adherence to the protocol at a later date (Falsetti et al., 2001). RCTs of CPT have established and reported adequate fidelity (e.g., 85-93% adherence) to the treatment protocol using the current fidelity-rating system (Forbes et al., 2012; Galovski et al., 2012; Monson et al., 2006; Resick, Galovski, et al., 2008; Resick et al., 2002). However, it is important to note that although the CPT protocol itself has evolved and the entire CPT training and dissemination program has been developed since the first RCT,

the fidelity-rating system does not appear to have been updated since its creation. Therefore, it is unclear whether it is adequately assessing treatment integrity in its current state. This is an important shortfall to address considering that maintaining treatment integrity is a necessary part of treatment outcome research (Schnurr, 2007), important in ensuring successful dissemination (Perepletchikova, 2011), and a crucial initial step in the effort to identify critical therapy elements and thereby increase the effectiveness of existing interventions (Barber et al., 2007; Kazdin, 2003).

Inadequate Representation of Purported CPT Critical Components in Fidelity System

If adherence to the purported critical components of CPT is accurately assessed and deemed adequate, it would be possible to determine whether or not their implementation is significantly associated with treatment outcome, thus confirming or disconfirming their legitimacy as essential components of CPT. Although adequate fidelity to the current CPT manual has been established in completed outcome trials (Forbes et al., 2012; Galovski et al., 2012; Monson et al., 2006; Resick, Galovski, et al., 2008; Resick et al., 2002), close examination of the current fidelity rating system reveals that some of the purported critical elements of CPT may not be adequately represented. Without adequate representation in the fidelity-rating system (i.e., adherence and competence form), it remains unclear whether these elements are reliably being implemented in treatment. Identifying and remedying the existing fidelity rating inadequacies would enable a more accurate measurement of the adherence to these treatment components and subsequently allow for an examination of the relationship between the implementation of those components and treatment outcome.

The first proposed critical component, the use of Socratic questioning to challenge maladaptive trauma-related beliefs, does not appear to be adequately represented in the fidelity rating system. During early CPT sessions, the clinician is meant to aid the client in identifying stuck points. In later sessions, the therapist is intended to engage the client in cognitive restructuring and challenge stuck points using Socratic dialogue in order to help the client generate balanced, alternative beliefs. Although words such as "challenge" are included multiple times throughout the fidelity-rating form, the phrase "Socratic questioning" is included only once in the entire form (within Session #3: *Identification of Thoughts and Feelings*) (Nishith & Resick, 1997). Challenging a cognition can be accomplished in multiple ways and does not necessarily imply a Socratic nature to the dialogue. Since CPT theory holds that Socratic questioning is the critical method through which clinicians should engage clients in cognitive restructuring, the measurement of this stated CPT cornerstone is insufficient.

The second critical component of CPT, challenging assimilation before over-accommodation, also appears to be insufficiently tracked in the current fidelity-rating system. During early sessions, clinicians are instructed to challenge stuck points with a specific focus on statements around self-blame or undoing, which are likely assimilated stuck points. However, the adherence and competence form does not directly query whether the therapist is focused on resolving assimilated stuck points prior to challenging over-accommodated cognitions. It is possible that clinicians are challenging both types of beliefs in the same session, or that they are tackling some over-accommodated beliefs prior to addressing all of the existing assimilation. Therefore, the assessment of this purported critical component as it exists presently in the fidelity form is inadequate.

The third purported critical component of CPT, out-of-session practice assignments, is perhaps the best represented. The adherence and competence form satisfactorily tracks some factors of this intervention element. For example, the form measures whether the therapist reviews the homework assigned during the previous session at the beginning of each session. It also measures whether the therapist assigns homework for the following week at the end of each session. Additionally, the form asks generally whether the therapist assigned homework in a clear manner and engaged the client in problem solving techniques related to homework completion.

Despite these inclusions, some key parts of the out-of-session practice assignment component are missing from the adherence and competence form. Specifically, the fidelity-rating system falls short in measuring issues related to homework non-compliance. The fidelity form does not measure whether the therapist has a conversation about the importance of homework completion with a client who is consistently non-compliant with practice assignments. Also missing is an assessment of whether or not the therapist re-assigns uncompleted homework to be completed the following week along with the current week's assignment. Finally, the form does not assess whether the therapist is able to navigate the session protocol even in the absence of the client bringing in a completed homework assignment. These are all supposedly important parts of out-of-session practice assignments that are emphasized heavily in the CPT manual and training workshops. Therefore, the current assessment of this treatment component within the CPT fidelity-rating system requires improvement.

The fourth and final purported critical element of CPT discussed here, the emphasis on expression of natural affect, is also ineffectively represented in the fidelity-

rating system. There is one requirement in the entire adherence and competence form (within Session # 5: *Second Trauma Account*) where the therapist is supposed to involve the client in cognitive restructuring after "processing affect" (Nishith & Resick, 1997). Therefore, it seems that the only way that this component is being measured is through this single item. In reality, the CPT protocol repeatedly emphasizes more time "processing affect" than is indicated by this fidelity form. However, the time that the therapist helps the client to spend on this component, in this one session or any other session, remains difficult to measure with the current state of the fidelity-rating system.

This review of the four purported critical components of CPT and their representation in the existing fidelity-rating system demonstrates the need for an updated adherence and competence form, which better reflects the proposed critical elements of the therapy. The importance of updating this rating system lies not only in ensuring accurate fidelity to the CPT protocol, but also in the ability to subsequently measure the relationship between the implementation of these components and treatment outcome. If it is possible to ensure accurate measurement of whether supposed critical components are implemented, then it would be possible to examine the connection between those components and treatment outcome. So far, the examination of whether the implementation of these treatment components is directly related to outcome has been largely ignored.

Current State of Research on Purported CPT Critical Components

In order to demonstrate the critical nature of individual therapy components, it is necessary to examine the relationship of those components to treatment outcome. Establishing this relationship has been difficult due to the time-consuming nature,

financial burden, and methodological complexities associated with conducting research that examines critical intervention components (Kazdin, 2007). While some recent work has addressed the importance of the four CPT components reviewed above, there remains a dearth of evidence to support the conclusion that these elements are crucial to the success of the intervention.

To date, no study has directly examined the specific effect of the first purported critical element of CPT, therapist use of Socratic dialogue, on treatment outcome. In the general psychotherapy literature, Socratic questioning has been suggested as the primary mechanism through which cognitive restructuring techniques achieve the goal of helping clients to develop adaptive beliefs (A. T. Beck, Rush, Shaw, & Emery, 1979; Froján-Parga, Calero-Elvira, & Montaño-Fidalgo, 2011). The extant literature describes the purpose of Socratic dialogue in psychotherapy and provides example dialogue to aid therapists in determining what types of questions to ask and the mindset with which to approach the Socratic questioning process (Padesky, 1993). Additionally, recent research aimed to analyze and describe the specific components of Socratic questioning in an effort to move towards greater understanding of how those components might function to create cognitive change (Froján-Parga et al., 2011). However, while there is some literature demonstrating the effectiveness of cognitive restructuring in reducing various types of psychological distress (Cooper & Steere, 1995; Harvey, Inglis, & Espie, 2002; Taylor et al., 1997), researchers have yet to conduct a clear examination of the effectiveness of Socratic questioning specifically.

With regards to CPT specifically, some literature has examined the effect of elements that are related to Socratic questioning. For example, a dismantling study was

conducted in which CPT-C (i.e., version of CPT without the written accounts) was compared with a written account only version of CPT (WA) as well as the original version that includes both the cognitive therapy and written account components (Resick, Galovski, et al., 2008). Results revealed that the CPT-C group realized gains in PTSD and depressive symptomatology more efficiently compared to the WA group. It was suggested that the removal of the written account component in CPT-C allowed for increased therapy time spent on cognitive restructuring. Because CPT was designed such that cognitive restructuring is accomplished primarily through Socratic dialogue, CPT-C was assumed to involve increased Socratic questioning compared to WA. Therefore, these results could be interpreted as demonstrating the importance of Socratic questioning in yielding efficient symptom change. However, despite the suggestion that more time was necessarily spent on Socratic questioning in CPT-C, the authors do not present any analyses related to the effect of Socratic questioning on outcome. That is, it is unclear whether some other component of CPT-C might have been responsible for the efficiency of change. Additionally, inadequate representation of Socratic questioning in the existing fidelity rating system translates into an inability to accurately assess the relationship between Socratic questioning and symptom change. No further examination of the importance of Socratic questioning exists within the CPT literature. Thus, it is clear that additional research is necessary to confirm the critical nature of Socratic dialogue in yielding successful treatment outcome for CPT.

There is also a dearth of literature examining the importance of the second purported critical element of CPT, cognitive restructuring of assimilated stuck points prior to over-accommodated stuck points. Existing research has described the

information processing model that posits the development of assimilated and over-accommodated beliefs following trauma (Hollon & Garber, 1988; Janoff-Bulman, 1989; Resick, 2001; Resick & Schnicke, 1990) and examined the validity of that information processing model following trauma (Littleton, 2007). Researchers have also demonstrated the negative consequences (e.g., psychological distress, increased likelihood of PTSD development, risk for revictimization, and presence of trauma-related schemas) that can be associated with assimilation and over-accommodation following trauma (Ali, Dunmore, Clark, & Ehlers, 2002; Littleton & Grills-Taquechel, 2011). However, no clear examination of this component has emerged in the literature on cognitive therapy or trauma-focused treatment.

Within the CPT literature, treatment outcome studies reveal improvement in maladaptive trauma-related cognitions (e.g., assimilation and over-accommodation) following CPT (Owens, Pike, & Chard, 2001; Resick, Galovski, et al., 2008). Additionally, two studies specifically examined the change in the number of assimilated and over-accommodated beliefs over the course of CPT (Jones & Galovski, 2011; Sobel, Resick, & Rabalais, 2009). While results revealed that the number of assimilated and over-accommodated beliefs decreased significantly and the number of accommodated beliefs (e.g., more balanced, evidence-based self-statements) increased significantly, analyses were not aimed at examining the order in which types of beliefs were addressed in treatment or the order in which they changed (Jones & Galovski, 2011; Sobel et al., 2009). Thus, while it is clear that maladaptive beliefs can develop following trauma and can be transformed into more adaptive beliefs through trauma-focused therapy, no research to date has clearly examined the order in which types of beliefs (e.g., assimilated,

over-accommodated) were addressed in treatment, the order in which they changed, or the effect that this order might have on treatment outcome. These specific questions must be addressed to confirm the critical nature of challenging assimilation prior to over-accommodation. The current CPT fidelity rating system will require modification in order to accurately conduct such research.

Compared to the two purported CPT critical components reviewed thus far, there is a greater accumulation of research related to the importance of out-of-session practice assignments in leading to symptom change during therapy. Meta-analytic reviews suggest that homework completion predicts increased symptom reduction and better treatment outcome for cognitive behavioral treatments (Kazantzis, Deane, & Ronan, 2000; Kazantzis, Whittington, & Dattilio, 2010; Mausbach, Moore, Roesch, Cardenas, & Patterson, 2010; Mueser et al., 2008). As it is now generally accepted that homework assignments are an integral part of CBT, more nuanced factors are being examined. For example, recent research finds that it is the quality, rather than the quantity, of homework completed that is the better predictor of treatment outcome (Cammin-Nowak et al., 2013).

Although the effect of homework completion has not been examined for CPT specifically, out-of-session practice work may have a similar influence on treatment outcome for individuals participating in CPT. Notably, there exists a dearth of research examining the clinical importance of the more nuanced homework-related factors for CPT. These include factors such as the clarity with which the therapist introduces homework assignments and engages clients in problem solving around homework completion, time spent in session reviewing completed homework assignments, time spent addressing homework non-compliance and the competence with which the therapist

can encourage future compliance, and the ability of the therapist to navigate structured protocol sessions in the absence of completed homework assignments. Clearly, further research is needed to examine the role of out-of-session practice assignments in creating symptom change during CPT. As is the case with the previously discussed components of CPT, the current fidelity-rating system will require modification to adequately capture these factors before any such research questions can be examined.

There is also a great deal of existing research related to the fourth and final suggested critical element of CPT, the emphasis on expression of natural affect. However, the effect of this component on treatment outcome, specifically within CPT, has not been directly examined. The understanding of the role of emotional expression in leading to positive psychological outcomes has changed over time. For centuries, it has been assumed that the expression of negative emotions related to traumatic experience is necessary for their dissipation (Littrell, 2008). This assumption is related to the idea that expression of an emotion decreases the strength of that emotion whereas unexpressed emotions are contained within the self and result in psychological problems (Breuer & Freud, 1957; Foa & Kozak, 1986; Freud, 1895). Empirical support is relatively scarce for the notion that only through a cathartic release of negative trauma-related emotions can individuals be healed (Littrell, 2008). Despite this, researchers and clinicians alike maintain the importance of emotional expression, and research has explored its role in trauma-focused treatment in a variety of ways.

The most prevalent research has examined the role of habituation as the mechanism by which emotional expression is beneficial. Specifically related to trauma, Foa and colleagues' (1989) emotional processing theory of PTSD states that through

repeated exposure to a trauma memory and simultaneous introduction of new information that is incompatible with the existing fear network, habituation of negative trauma-related emotions will occur over time. One study showed support for the role of habituation by demonstrating that individuals who participated in repeated imaginal exposures of trauma memories, expressed high initial emotionality, and experienced habituation (as measured by decreased SUDS ratings), realized significantly greater PTSD improvement than individuals who engaged in the imaginal exposures but did not demonstrate habituation (Jaycox, Foa, & Morral, 1998). Other more recent research has demonstrated that repeated written exposure to a trauma memory is associated with reduction of PTSD symptoms (Hirai, Skidmore, Clum, & Dolma, 2012; Sloan, Marx, & Epstein, 2005). Additionally, one study examining mechanisms of change determined that habituation, operationalized as the decrease in SUDS scores over the course of treatment, occurred over the course of PE and was significantly associated with PTSD symptom reduction (Gallagher & Resick, 2011).

Some research has examined the effect of exposure-based trauma-focused treatments or treatment components as compared to cognitive interventions on treatment outcome. Results are mixed with some demonstrating that the interventions focused primarily on processing natural affect are equally as effective (Foa et al., 2005; Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998; Paunovic & Öst, 2001), and others showing that purely cognitive interventions (Resick, Galovski, et al., 2008) or combined cognitive and exposure-based interventions (Bryant, Moulds, Guthrie, Dang, & Nixon, 2003) are more efficient. Despite the conclusion that interventions designed to promote emotional processing of a trauma memory are efficacious, these studies do not directly

examine the effect of processing natural affect on outcome. That is, it cannot be assumed that because an intervention's *purported* mechanism of change is the processing of emotion, the outcome is necessarily a result of that emotional processing. Indeed, there could be other factors contributing to treatment outcome. In order to make this claim, the presence of emotional processing must clearly be displayed, and there must be a clear examination of the effect of that emotional processing on symptom change.

The role of emotional processing in CPT may have multiple purposes. As previously noted, the treatment manual states that clients simply allowing themselves to feel trauma-related emotions will experience a reduction in the frequency and intensity of negative feelings over time (Resick et al., 2010). However, experiencing trauma-related emotions in CPT may be important for another reason. When emotions are uncovered during the process of writing and reading trauma accounts, clients and therapists may be able to identify additional maladaptive cognitions that are preventing the individual from recovering fully. Identification and subsequent restructuring of those stuck points will theoretically result in further dissipation of negative emotions. Clearly, the importance of affect expression in CPT is integrally related to the cognitive basis of the intervention. Although the review of the literature above reveals that some research has examined the role of physiological arousal and habituation in participants receiving trauma-focused treatment, the clinical importance of the expression of natural affect in CPT remains unclear. An accurate representation of this CPT treatment component in the fidelity-rating system will be required for future examination of its relation to symptom change.

Despite these attempts in the literature to examine the structure and function of the four CPT components discussed in this paper, the relationship between these

intervention elements and treatment outcome remains unclear. A modification of the existing CPT fidelity-rating system will facilitate further examination of the critical nature of these components by enabling a more accurate assessment of adherence to the treatment protocol. In order for these four elements to be accepted and ultimately disseminated as critical components of CPT, researchers must demonstrate that the implementation of these components is directly associated with the success of the intervention. Clearly, additional research is required to answer questions related to which components are most crucial during CPT and how the knowledge of these components could facilitate the goals of bettering treatment outcome rates, enhancing dissemination efforts, and ultimately improving overall treatment effectiveness.

Suggestions for Addressing CPT Fidelity and Critical Component Concerns

Given the call for improved effectiveness of established evidence-based trauma-focused interventions, as well as the significant time and financial resources being funneled into the dissemination of these interventions, it would be beneficial to clarify the critical components of the CPT protocol. Such clarification could enable greater understanding of mechanisms of change for treatments targeting PTSD and depression, more feasible assessment of treatment integrity in research and clinical settings, and increased efficiency and effectiveness of dissemination efforts. By understanding the intervention components that are most responsible for treatment gains, it will be possible to improve the rates and efficiency of therapeutic change in both controlled and more "real-world" settings (Kazdin, 2007).

Treatment fidelity rating systems can be utilized in the process of identifying and confirming the critical components of established interventions (Barber et al., 2007). In

order to achieve a better understanding of which therapy components are essential to the success of CPT, it will be necessary to first update the existing CPT fidelity-rating system. The adherence and competence form must more clearly and adequately represent the purported critical components of CPT so that analysis of the relationship between accurate implementation of these components and treatment outcome can be accomplished. One approach to identifying CPT's critical components may be to modify the existing CPT fidelity-rating system as previously discussed, code existing CPT session tapes using this updated fidelity system, determine whether purported CPT critical elements are indeed implemented as designed, and analyze whether implementation of those specific components is related to treatment outcome.

The insufficient treatment success rates and gross under-utilization of evidence-based treatments in community settings are two of the most important concerns facing scientists in the field of trauma-focused intervention development. In order to address these concerns, it is important to understand not just that the existing interventions work, but how and why they work. Identifying the critical components of established trauma-focused interventions will enable us to improve the effectiveness of the interventions themselves as well as the methods utilized to disseminate them. Enhancing the existing fidelity-rating systems is one step in the direction of achieving these timely goals. While we must acknowledge that decades of rigorous research have yielded efficacious trauma-focused interventions, it is now time to make strides toward bridging the enduring gap between research and practice.

Current Study

The present study aimed to assess the functionality of revisions to the existing CPT fidelity rating system. Revisions included adding specific assessment of theorized critical elements of CPT as identified by the current national CPT training program and as dictated by theoretical underpinnings informing the CPT intervention. Additionally, this study aimed to examine the association between successful implementation of these purported critical elements and treatment outcome variables (e.g., PTSD and depressive symptom change). As a tertiary goal, the current study seeks to examine the role of nonspecific treatment factors (e.g., warmth, empathy, genuineness) in moderating the relationship between fidelity to specific treatment factors and treatment outcome variables. Finally, this study aims to assess the relationship of the revised and original fidelity rating systems as well as the relative predictability of each system for treatment outcome and treatment completer status (e.g., completer versus dropout). Data (e.g., pre- and post-assessment measure results, weekly symptom monitoring data, and session video tapes) from two previous NIH-funded randomized controlled treatment trials (RCTs) were used as part of the current project. A brief description of those RCTs follows.

Parent Studies

Two NIH funded trials examining CPT were recently completed at the Center for Trauma Recovery at the University of Missouri – St. Louis (Galovski, 1R34-MH-074937; Galovski, 1R21AT004079-01). The first trial, the Variable Treatment Study, was specifically designed to test the efficacy of a variable form of CPT across male and female interpersonal violence survivors (Galovski et al., 2012). Participants received a more flexible form of CPT, Modified Cognitive Processing Therapy (MCPT). The

therapy manual was modified such that treatment end was dictated by progress. That is, treatment was terminated based on the requirement of having met specific end state criteria on measures of PTSD and Depression [PDS $\leq$ 20 (M = 9.0); BDI-II $\leq$ 18 (M = 9.1)], as well as the agreement between the clinician and client. Participants could potentially terminate prior to receiving the standard 12 sessions if indicated or receive up to 50% more therapy (e.g., 6 more sessions after the standard 12). Additional sessions consisted of continued work toward cognitive restructuring or exposure work if necessary. Thus, participants received between 4 and 18 therapy sessions.

The second trial, the Hypnosis Treatment Study, was designed to address sleep impairment among individuals with PTSD who participate in trauma-focused interventions. Thus, researchers aimed to examine the potential influence of completing a course of sleep-directed hypnotherapy prior to beginning CPT. Participants were female interpersonal violence survivors who received either 3 weeks of sleep-directed hypnosis followed by a standard 12 session course of CPT (i.e., hypCPT group) or 3 weeks of symptom monitoring followed by standard CPT (i.e., CPT only group). Thus, all participants received a full course of trauma-focused treatment.

Analysis of the Variable Treatment study data suggests that there were significant main effects of time from the pre-assessment to post-assessment on measures of PTSD and depression (Galovski et al., 2012). There was no significant interaction of number of sessions, suggesting that both early and long treatment completers were able to reach good end state functioning, but did so at variable rates (Galovski et al., 2012). Likewise, data from the Hypnosis Treatment study suggests that there were significant main effects of time from pre- to post-assessment on PTSD and depressive symptom measures

(Galovski & Blain, 2013). There were no significant differences found between the hypCPT and the CPT only group for primary treatment outcome measures (Galovski & Blain, 2013).

Both the Variable Treatment study and the Hypnosis Treatment study utilized the existing CPT fidelity rating system to determine adherence and competence ratings for the CPT protocol. In the Variable Treatment study, independent raters coded a total of 103 sessions (17% of the total 609 sessions conducted) with an additional outside rater coding 25 (24%) of these sessions to ensure reliability among independent raters. For the Hypnosis Treatment study, independent raters coded a total of 61 sessions (8.6% of the 710 sessions conducted) with an additional outside rater coding 14 (23%) of these sessions to ensure reliability among independent raters. For both trials, raters determined that adequate treatment fidelity was achieved based on traditional fidelity rating system developed for previous trials (Nishith & Resick, 1997; Resick et al., 2002). This study seeks to significantly expand the rating system to more accurately reflect the purported critical components of CPT and to assess the value in doing so. Additionally, although findings from these two trials confirm the efficacy of CPT, the intervention components that are primarily responsible for symptom improvement remain unclear. As an extension to these two parent studies, the present study aims to address some of these concerns. Specific aims and hypotheses are stated below.

Specific Aims and Hypotheses

Aim 1. The primary aim of the current study was to examine the influence of treatment fidelity, using the revised CPT fidelity rating system, on trauma-focused treatment

outcomes (e.g., improvement in PTSD and depressive symptoms over the course of treatment).

Hypothesis 1. It was hypothesized that fidelity rating scores on the revised CPT fidelity rating system (i.e., including both original and newly added items) would predict a significant portion of the variance in PTSD change scores from the pre-treatment assessment to the post-treatment assessment. As fidelity ratings improve, it was expected that change in PTSD symptoms over the course of treatment would increase.

Hypothesis 2. It was hypothesized that fidelity rating scores on the revised CPT fidelity rating system (i.e., including both original and added items) would predict a significant portion of the variance in depression change scores from the pre-treatment assessment to the post-treatment assessment.

Aim 2. Second, this study aimed to examine the influence of fidelity to purported CPT critical components on trauma-focused treatment outcomes.

Hypothesis 3. It was hypothesized that the successful implementation of purported CPT critical components (e.g., skill in Socratic questioning; focus on challenging assimilation prior to over-accommodation; use of out-of-session practice assignments and ability to successfully navigate CPT sessions without completed assignments; emphasis on the expression of natural affect) throughout CPT would predict a significant portion of the variance in PTSD change scores. It was expected that as fidelity ratings improve, change in PTSD would increase.

Hypothesis 4. It was also hypothesized that the successful implementation of purported CPT critical components (e.g., skill in Socratic questioning; focus on

challenging assimilation prior to over-accommodation; use of out-of-session practice assignments and ability to successfully navigate CPT sessions without completed assignments; emphasis on the expression of natural affect) throughout CPT would predict a significant portion of the variance in depression change scores. It was expected that as fidelity ratings improve, change in depression would increase.

Aim 3. Third, this study sought to examine the role of nonspecific treatment factors (e.g., empathy) in moderating the relationship between fidelity ratings and trauma-focused treatment outcome variables.

Hypothesis 5. It was hypothesized that fidelity to nonspecific treatment elements would significantly moderate the relationship between fidelity ratings (i.e., using the revised fidelity rating system excluding nonspecific factors) and PTSD change scores. That is, the impact of fidelity ratings on PTSD change scores would vary according to the level of the fidelity to nonspecific factors. Specifically, it is thought that higher fidelity to nonspecific factors would be a moderating variable in that the relationship between fidelity to specific factors and PTSD change scores would be stronger when there is higher fidelity to nonspecific factors and less strong when there is lower fidelity to nonspecific factors.

Hypothesis 6. It was also hypothesized that fidelity to nonspecific treatment elements would significantly moderate the relationship between fidelity ratings (i.e., using the revised fidelity rating system excluding nonspecific factors) and depression change scores. That is, the impact of fidelity ratings on depression change scores would vary according to the level of the fidelity to nonspecific

factors. Specifically, it is thought that higher fidelity to nonspecific factors would be a moderating variable in that the relationship between fidelity to specific factors and depression change scores would be stronger when there is higher fidelity to nonspecific factors and less strong when there is lower fidelity to nonspecific factors.

Aim 4. Finally, this study aimed to compare the original fidelity scores gathered for the parent study with the fidelity scores gathered for the current study using the revised fidelity rating system. The relative predictability of original and newly added item fidelity ratings for treatment outcome variables were assessed. Relatedly, the influence of these fidelity ratings on treatment completer status (i.e., completer versus drop-out) were examined.

Hypothesis 7. It was hypothesized that original fidelity ratings would be significantly correlated with fidelity ratings for newly added items generated using the revised fidelity rating system.

Hypothesis 8. It was hypothesized that fidelity ratings from the newly added items would predict variance in PTSD and depression treatment outcome variables over and above the original fidelity system scores.

Hypothesis 8a. Newly added item fidelity ratings will predict variance in PTSD change scores over and above the variance predicted by the original fidelity ratings.

Hypothesis 8b. Newly added item fidelity ratings will predict variance in depression change scores over and above the variance predicted by the original fidelity ratings.

Hypothesis 9. It was hypothesized that fidelity ratings, adherence and competence scores taken from the revised fidelity rating system, would differ significantly for treatment completers and dropouts such that treatment completers would experience greater treatment fidelity compared to dropouts.

Methods

Participants

The current study is an extension of two larger treatment-outcome studies that examined the efficacy of Cognitive Processing Therapy for male and female interpersonal assault survivors. To be eligible for the studies, participants needed a current diagnosis of PTSD, needed to be at least three months post-crime at the time of their participation, and were at least 18 years of age. The following were exclusion criteria: mental retardation, current substance dependence, current parasuicidal behavior or suicidal intent, and currently being stalked or in a violent relationship. Additionally, participants had to keep medication usage stable for at least one month prior to the onset of treatment and throughout the duration of treatment. Finally, participants were allowed to have received any past therapy with the exception of CPT, and were allowed to continue with current therapy as long as it was not trauma-focused.

Treatment participants for the current study include men and women from the two previously described RCTs who were randomized to a treatment condition and completed at least 1 session of CPT. Thus, both CPT completers and dropouts were included. Initially, participants were excluded if any of their video recorded session tapes were unavailable or lacking adequate audio or video quality. However, this exclusion criterion yielded a severely underpowered sample size as some of these participants were missing

their post treatment outcome data. Thus, the final sample included all participants who were not missing any session tapes, all participants who were missing only one session tape, and a random sample of participants who were missing only two session tapes. Additionally, to stay consistent with the 12 session protocol used in the Hypnosis Treatment trial, only tapes for Variable treatment sessions 1 through 12 were included. The final sample included 21 treatment completers and 8 dropouts from the Variable Treatment study (200 total session tapes). Likewise, tapes from 25 treatment completers and 14 dropouts were included from the Hypnosis Treatment study (333 total session tapes). Combining tapes from both the Variable Treatment and Hypnosis Treatment studies yielded a total of 68 CPT participants and 533 session tapes coded in the current study (see Table 1 below for a summary). Therapists for the Variable Treatment study included six master's level clinicians (master of arts and licensed clinical social worker) who had never treated a CPT case before this study. Therapists for the Hypnosis Treatment study included two of the same master's level clinicians, one additional master's level clinician, and one postdoctoral fellow. Therapists for both studies attended a training workshop conducted by the principal investigator, read the CPT manual and relevant readings, and received weekly supervision on CPT cases.

Table 1.
Summary of Study Sample CPT Session Tapes

		CPT Sessions												
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**Total Tapes**
Variable	Completer Tapes	20	18	21	20	20	18	14	12	13	10	7	7	180
	Drop-out Tapes	6	6	1	1	1	1	1	1	1	1	0	0	20
Hypnosis	Completer Tapes	25	24	24	21	24	25	23	25	24	25	25	24	289
	Drop-out Tapes	14	10	7	6	5	2	0	0	0	0	0	0	44
Total Completer Tapes		45	42	45	41	44	43	37	37	37	35	32	31	469
Total Drop-Out Tapes		20	16	8	7	6	3	1	1	1	1	0	0	64
Overall Total Tapes		65	58	53	48	50	46	38	38	38	36	32	31	**533**

Measures

Clinician Administered PTSD Scale (CAPS). The Clinician Administered PTSD Scale (Blake et al., 1990) is a 30-item structured clinical interview that assesses core symptoms and associated features of PTSD (Blake et al., 1995). The frequency and intensity of each DSM-IV PTSD symptom are rated on a scale ranging from 0 – 4 (Blake et al., 1995). The CAPS also rates subjective distress related to PTSD symptoms, occupational and social functioning, validity of the participant's responses, and the overall severity of PTSD symptoms. Research reveals that the CAPS has excellent psychometric properties (Weathers, Keane, & Davidson, 2001). Inter-rater reliability on both the frequency and intensity ratings is reported as ranging from .92 to .99 for each of

the three subscales (re-experiencing, numbing and avoidance, and hyperarousal) (Blake et al., 1990). Internal consistency for the three subscales is also high, with alpha coefficients ranging from .73 to .85 (Blake et al., 1990). The CAPS shows strong convergent validity as demonstrated by correlations with the following measures: Mississippi Scale for PTSD, .91, MMPI-2 PTSD scale, .77, and SCID PTSD, .89 (Weathers et al., 1992). This measure was administered at each time point of the parent studies (pre-assessment, post-assessment, and 3-month follow-up assessment). Pre- and post-assessment CAPS scores were utilized for the present study. Internal consistency was high in the current study (α = .840).

Beck Depression Inventory, Second Edition (BDI-II). The Beck Depression Inventory (A. T. Beck, Steer, & Brown, 1996) is a 21-item self-report measure of depressive symptoms. The depressive symptoms are rated on a 4-point severity scale and correspond to the DSM-IV criteria for major depressive disorder (*DSM-IV-TR*, 2000). The items are summed to obtain a total score, which can range from zero to 63. The total score can be clinically evaluated using the following guidelines: 0 – 13 = minimal depression, 14 – 19 = mild depression, 20 – 28 = moderate depression, and 29 – 63 = severe depression. The BDI-II was administered at each assessment time point of the parent studies as well as at each CPT session to track symptom change over the course of treatment. BDI-II session data and pre- and post-assessment scores were utilized for the present study. Internal consistency was high in the current study (α = .897).

Cognitive Processing Therapy (CPT): Therapist Adherence and Competence Protocol. The CPT: Therapist Adherence and Competence Protocol (Nishith & Resick, 1997) was developed to assess treatment adherence and therapist competence during the

original randomized controlled trial for CPT (Resick et al., 2002). Individual raters use this fidelity rating system to code the implementation of predetermined treatment components when reviewing session videotapes. The form includes sections on unique and essential elements specific to each session, essential but not unique elements, and overall skill ratings. To track adherence, the component is checked if it occurs; for competence, the coder provides a rating on a 7-point scale (*poor* to *excellent,* with *satisfactory* at the midpoint). At the end of the form, the rater has the opportunity to give an overall skill rating on the same 7-point scale and make any additional comments about the rationale for their ratings (see Appendix A). A total adherence score is calculated by determining the percentage of elements that were implemented. Likewise, a competence score has traditionally been calculated by determining the percentage of items judged to be satisfactory (i.e., 4 on the competence scale) or higher.

Procedure

CPT sessions were videotaped during the two parent studies. These videotapes are stored in a locked data room and viewed only by project staff. All existing tapes were checked for adequate audio and video. Tapes with adequate audio and video quality were coded using the *Cognitive Processing Therapy (CPT): Therapist Adherence and Competence Protocol – Revised Version* (see Appendix B). The revised version of the CPT: Therapist Adherence and Competence Protocol was expanded specifically for this project by the authors. All items from the original fidelity rating system were included. For each session, items were added such that the form now specifically and consistently assesses the therapist's implementation of purported CPT critical components (e.g., skill in Socratic questioning, identifying and challenging assimilation before over-

accommodation, therapist use and encouragement of client use of out-of session practice assignments, emphasis on expression of natural affect). The majority of these new items were rated similarly to the original items. When new items required a different type of rating, instructions were provided. The "essential but not unique elements" section was included in the item list for each session (as opposed to only once in the original version). Other additions included a brief description of Socratic dialogue in the instructions section of the form, a "proscribed elements" item for each session to assess for the consistency of a cognitive approach, a series of "client variable" items for each session, and an expanded "additional considerations" section at the end of the form. See Appendix B for the full, revised manual.

Three coders (i.e., two masters-level graduate students, including the principle investigator of this project, and one independent, doctoral-level, national CPT expert rater) comprised the team that established inter-rater reliability and coded the session tapes. The tape coding process occurred in two phases: one phase to establish reliability and a second phase to gather the data by coding the entire sample of tapes. First, phase one was aimed at establishing inter-rater reliability between the two primary raters (doctoral candidates with 3 years treating PTSD patients with CPT) for the updated CPT fidelity rating system. The two raters viewed and coded CPT session tapes (not included in this study sample) until they were trained to an inter-rater reliability of at least 80% agreement (Landis & Koch, 1977). Cohen's kappa was used to determine inter-rater reliability for adherence and Intraclass Correlations (ICC) were produced to ensure that competence ratings were adequately related between raters. In the second phase, the team of raters coded the study sample session tapes using the finalized version of the

updated fidelity rating system. The two fidelity raters each rated 50% of the available tapes (266 tapes each). To establish continued inter-rater reliability for the study sample, each of the fidelity raters also rated 14% of the other rater's sample (36 tapes each). Finally, the independent CPT expert rater coded 9.5% of the total available tapes (50 tapes) as an additional check on rater reliability. The two primary raters regularly engaged in reliability meetings with a second CPT expert to prevent rater drift.

Data Analysis

Descriptive statistics were conducted on gender, age, ethnicity, education, and income level for the entire sample and compared by completer status (treatment completer vs. drop-out; see Table 2). Comparative statistics were applied and any significant differences detected were used as covariates in subsequent relevant analyses (i.e., Hypothesis 9; see Table 3).

Traditional adherence and competence percentage scores were calculated using data from the *CPT: Therapist Adherence and Competence Protocol – Revised Version*. Because this project involved watching the complete set of tapes for each participant, mean scores for adherence and competence across the entire course of therapy were calculated. That is, scores on relevant items for each variable were summed and averaged in each session. The averages for all sessions were then summed and averaged to create an overall mean adherence or competence score for each case. Overall mean adherence and competence scores were calculated for 1.) the group of original fidelity items, 2.) the group of revised fidelity items, 3.) the group of nonspecific fidelity items, and 4.) each of the four theorized critical components (i.e., skill in Socratic questioning; assimilation before over-accommodation, use of out-of-session practice assignments;

emphasis on expression of natural affect). Appendices C-F at the end of this document provide details as to exactly which fidelity items were included in the creation of each variable. Multiple linear regressions were used to examine the influence of adherence and competence on change in PTSD and depression across treatment. A priori power analyses were computed using G-Power (Faul, Erdfelder, Lang, & Buchner, 2007). Several of the proposed analyses were limited by a small sample size and are thus considered exploratory in nature and interpreted with caution. Finally, variables were tested for the violation of any relevant assumptions with results included within each individual hypothesis section.

Results

Inter-rater Reliability

First, inter-rater reliability statistics were conducted for a random sample of the session tapes. The two primary raters coded a total of 72 overlapping sessions (14% of the total 533 sessions coded, including drop-outs). Inter-rater agreement across sessions was acceptable on both adherence to session elements (kappa = .67, $p < .001$) and competence rating of session elements (r = .89, $p < .001$). An outside expert rater coded 50 overlapping sessions (~10% of the total 533 sessions coded). Inter-rater agreement across sessions was acceptable on both adherence to session elements (kappa = .64, $p < .001$) and competence rating of session elements (r = .92, $p < .001$). Raters appeared to disagree more on adherence than on competence.

Study Sample

The sample consisted of 58 female and 10 male participants (46 treatment completers and 22 drop-outs). The participants ranged in age from 19 years old to 68 years old. The group was split with 50% describing themselves as Caucasian, 47%

describing themselves as African American, 1.5% as American Indian or Alaska Native, and 1.5% chose not to identify one racial category. A total of 6% described themselves as Hispanic. Most of the sample was single or unmarried (81%) and 19% were married or living with someone. Complete demographic data is displayed for the full sample and by responder type in Table 2.

Table 2.
Demographic Characteristics of Participants (N = 68)*

	Full Sample	Completers	Drop-outs
Gender			
Female	58 (85%)	40 (87%)	18 (82%)
Male	10 (15%)	6 (13%)	4 (18%)
Age	M = 37.75 SD = 11.59	M = 39.70 SD = 12.58	M = 33.68 SD = 7.97
Race			
Caucasian	34 (50%)	23 (50%)	11 (50%)
African American	32 (47%)	22 (48%)	10 (46%)
American Indian or Alaska Native	1 (1.5%)	1 (2%)	
Other	1 (1.5%)		1 (4%)
Ethnicity			
Non-Hispanic/Latino	60 (94%)	41 (98%)	19 (86%)
Hispanic	4 (6%)	1 (2%)	3 (14%)
Years of Education	M = 13.91 SD = 2.62	M = 14.35 SD = 2.78	M = 13.00 SD = 2.05
Annual Income			
< $20,000	45 (66%)	25 (54%)	20 (95%)
> $20,000	22 (32%)	21 (46%)	1 (5%)
Marital Status			
Single	37 (54%)	20 (44%)	17 (77%)
Married/cohabitating	13 (19%)	12 (26%)	1 (5%)
Separated/Divorced/Widowed	18 (27%)	14 (30%)	4 (18%)

*Sample size is less than 68 for some variables because of missing demographic data.

Completer Status Descriptives and Comparisons: Treatment completers and drop-outs were compared using ANOVAs and chi squares with respect to age, gender, race, ethnicity, annual income, marital status, and years of education (see Table 3). The two groups (completers and drop-outs) significantly differed in a number of these variables including income, marital status, age, years of education, such that drop-outs were more likely to have lower income, be single, be of younger age, and have fewer years of formal education. Due to the significant differences across completer status, these variables were used as covariates in relevant analyses (i.e., Hypothesis 9).

Table 3
*Between-Group Comparisons for Participant Demographics (*N = 68)*

	Completers	**Drop-outs**	**Statistic**	***p* value**
Gender				
Female	40 (87%)	18 (82%)	Fisher's Exact Test	.717
Male	6 (13%)	4 (18%)		
Age	M = 39.70 SD = 12.58	M = 33.68 SD = 7.97	F (1, 67) = 4.202**	.044
Race				
Caucasian	23 (50%)	11 (50%)	Fisher's Exact Test	1.00
Not Caucasian	23 (50%)	11 (50%)		
Ethnicity				
Non-Hispanic/Latino	41 (98%)	19 (86%)	Fisher's Exact Test	.113
Hispanic	1 (2%)	3 (14%)		
Years of Education	M = 14.35 SD = 2.78	M = 13.00 SD = 2.05	F (1, 67) = 4.107**	.047
Annual Income				
< $20,000	25 (54%)	20 (95%)	Fisher's Exact Test**	.001
> $20,000	21 (46%)	1 (5%)		
Marital Status				
Single	20 (44%)	17 (77%)	F (2, 66) = 7.580**	.023
Married/cohabitating	12 (26%)	1 (5%)		
Separated/Divorced/Widowed	14 (30%)	4 (18%)		

*Sample size is less than 68 for some variables because of missing data.
**$p < .05$

CPT Adherence Rates: Mean rates of adherence for CPT components are displayed in Table 4, including adherence scores for specific CPT items as measured by the original fidelity manual, the newly added components of the revised manual, and the total revised manual (including new and original specific CPT items). Mean percent adherence for the nonspecific components of the manual is included as well. The average percent of items adhered to in each category for the entire sample is displayed in the first row of data in Table 4. Subsequent rows in Table 4 display the percentage of the sample for whom less than 50% of the CPT items were adhered to, the percentage of the sample for whom between 51 and 60% of the items were adhered to, and so on. Adherence for this sample was generally high such that on average, 94.12% of the specific CPT elements were judged to be present using the original rating system and 85.97% of the specific CPT elements were judged to be present using the revised rating system. A paired samples t-test revealed that average adherence for original fidelity items (M = .9412) was significantly higher than average adherence for revised fidelity items (M = .8597; $t(67) = 9.530$, $p < .001$).

Table 4
Mean Rates of Adherence to CPT Components (N = 68)

	Combined CPT Fidelity Rating Manual			
	Original Specific Fidelity Items	**New Specific Fidelity Items**	**Revised Specific Fidelity Items (Original + New)**	**Nonspecific Fidelity Items**
Mean % Items Present for Total Sample	94.12%	83.43%	85.97%	91.02%

% Items Present	% of Sample			
≤50	0	0	0	0
51-60	0	0	0	0
61-70	2	2	2	2
71-80	4	35	16	21
81-90	16	40	52	22
91-99	32	7	13	35
100	40	7	5.9	15

Mean rates of adherence for the four theorized critical CPT components are displayed in Table 5. The average percent of items adhered to in each category for the entire sample is displayed in the first row of data in Table 5. Subsequent rows in Table 5 display the percentage of the sample for whom less than 50% of the CPT items were adhered to, the percentage of the sample for whom between 51 and 60% of the items were adhered to, and so on. Adherence for the four theorized critical CPT components in this sample was generally high. The highest average rate of adherence was found for the use of Socratic questioning with 99.67% of these items being judged as present. The lowest average rate of adherence out of these four components was found for the reliance on homework with 84.05% of these items being judged as present.

Table 5
Mean Rates of Adherence to CPT Components (N = 68)

	Cornerstones of CPT			
	Use of Socratic Questions	**Assimilation 1st**	**Reliance on HW**	**Expression of Affect**
Mean % Items Present for Total Sample	99.67%	93.89%	84.05%	93.72%

% Items Present	**% of Sample**			
≤50	0	3	2	3
51-60	0	0	3	0
61-70	0	3	21	6
71-80	0	6	13	6
81-90	0	9	9	4
91-99	7	0	21	2
100	93	68	28	78

CPT Competence Rates: Mean rates of competence for CPT components are displayed in Table 6, including competence scores for specific CPT items as measured by the original fidelity manual, the newly added components of the revised manual, and the total revised manual (including new and original specific CPT items). Mean rate of competence for the nonspecific components of the manual is included as well. The average competence rating of present items in each category is displayed in the first row of data in Table 6. Subsequent rows in Table 6 display the percentage of the sample with average competence ratings that are below satisfactory, satisfactory and above, satisfactory, good, very good, and excellent. The average competence rating of present elements across therapists for the original specific fidelity items was 4.56, which is between the "satisfactory" range and the "good" range. The average competence rating of present elements across therapists for the revised specific fidelity items was 4.38. A paired samples t-test revealed that average competence for original specific fidelity items

(M = .456) was significantly higher than average competence for revised specific fidelity items (M = .438; $t(67) = 3.220$, $p < .01$).

Table 6.
Mean Rates of Competence for CPT Components (N = 68)

	Original Specific Fidelity Items	**New Specific Fidelity Items**	**Revised Specific Fidelity Items (Original + New)**	**Nonspecific Fidelity Items**
Average Competence Score	4.56	4.23	4.38	4.60
	% of Sample			
Below Satisfactory (1-3.99)	38	32	33	32
Satisfactory & Above (4-7)	62	68	67	68
Satisfactory (4-4.99)	22	53	40	31
Good (5-5.99)	25	15	25	34
Very good (6-6.99)	15	0	2	3
Excellent (7)	0	0	0	0

Note: Competence ratings are on a 7-point scale (*poor* to *excellent,* with *satisfactory* at the midpoint).

Mean rates of competence for the four theorized critical CPT components are displayed in Table 7. The average competence rating of present items in each category is displayed in the first row of data in Table 7. Subsequent rows in Table 7 display the percentage of the sample with average competence ratings that are below satisfactory, satisfactory and above, satisfactory, good, very good, and excellent. Average competence for the four theorized critical CPT components in this sample was satisfactory or above. Similar to adherence findings, the highest average rate of competence was found for the use of Socratic questioning (M = 5.03) and the lowest

average rate of competence out of these four components was found for the reliance on homework ($M = 4.28$).

Table 7.
Mean Rates of Competence for CPT Components (N = 68)

	Use of Socratic Questions	Assimilation 1st	Reliance on HW	Expression of Affect
Average Competence Score	5.03	4.67	4.28	4.75
	% of Sample			
Below Satisfactory (1-3.99)	13	22	43	19
Satisfactory & Above (4-7)	87	78	57	81
Satisfactory (4-4.99)	25	29	21	21
Good (5-5.99)	43	27	24	43
Very good (6-6.99)	16	12	13	16
Excellent (7)	3	2	0	0

Note: Competence ratings are on a 7-point scale (*poor* to *excellent,* with *satisfactory* at the midpoint).

CPT Fidelity Scores According to Session: Mean adherence and competence scores by session are displayed in bar graph format below (see Figures 1-16). These figures are designed to visually display both the adherence and competence ratings across the entire protocol. Fidelity scores are displayed as measured by the original fidelity manual, the total revised fidelity manual, the new components only of the revised manual, the nonspecific components of the manual, and each of the four theorized critical components of CPT. Bar graphs for adherence scores are presented first, followed by bar graphs for competence scores.

Figure 1.
Mean Adherence Ratings for Original Fidelity Items in Each CPT Session

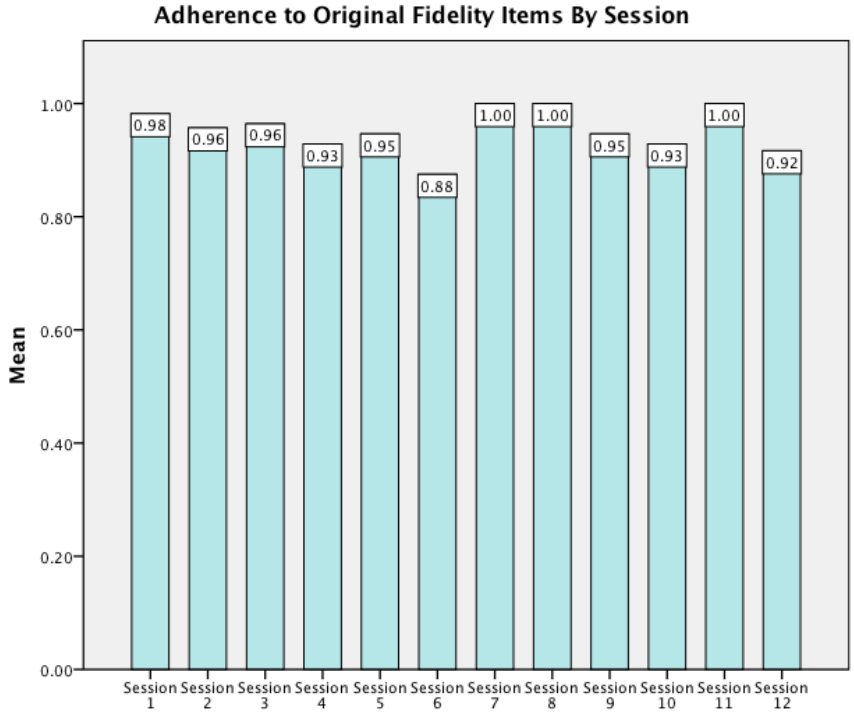


Figure 2.
Mean Adherence Ratings for Revised Fidelity Items in Each CPT Session

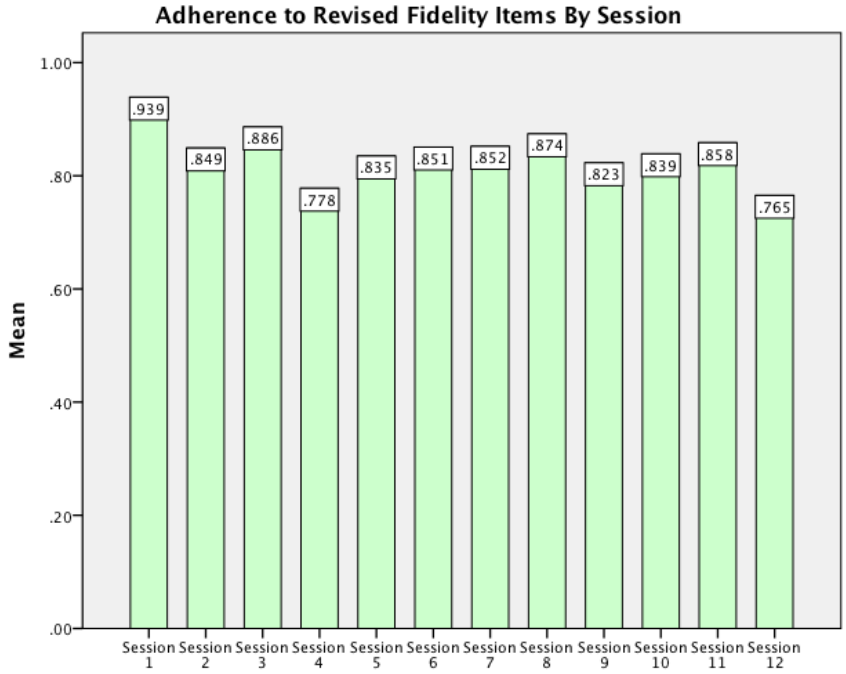


Figure 3.
Mean Adherence Ratings for New Fidelity Items in Each CPT Session

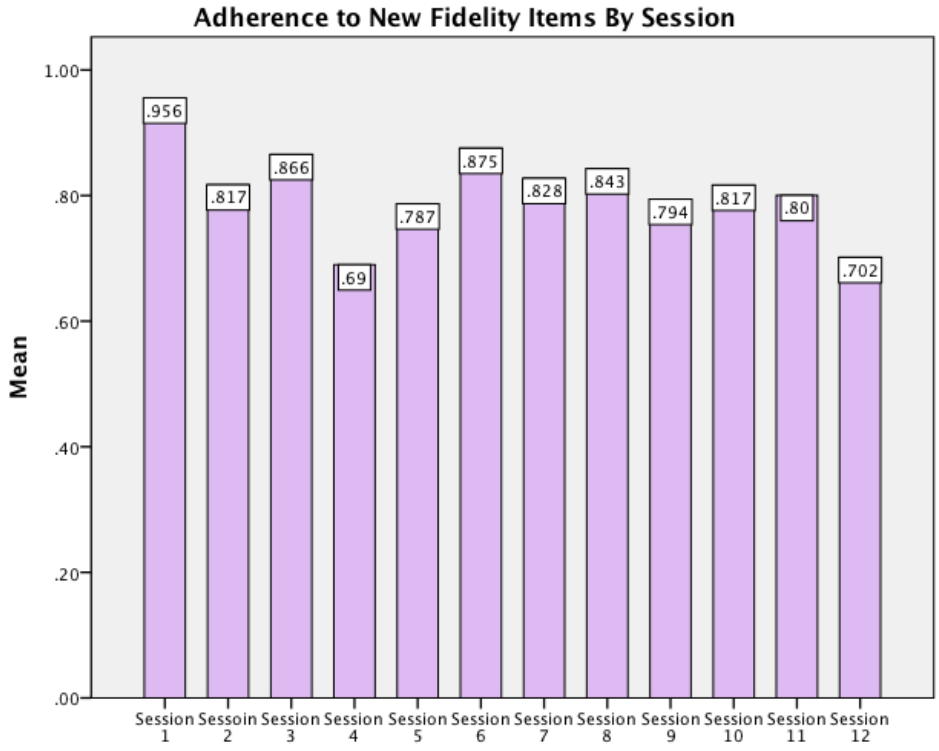


Figure 4.
Mean Adherence Ratings for Nonspecific Fidelity Items in Each CPT Session

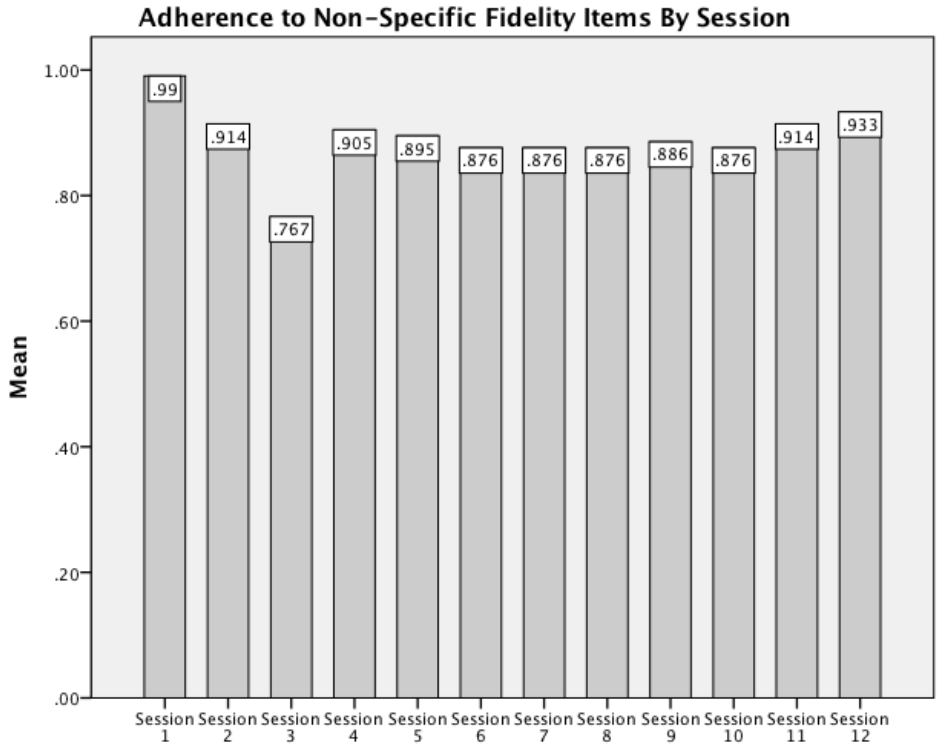


Figure 5.
Mean Adherence Ratings for Socratic Dialogue Items in Each CPT Session

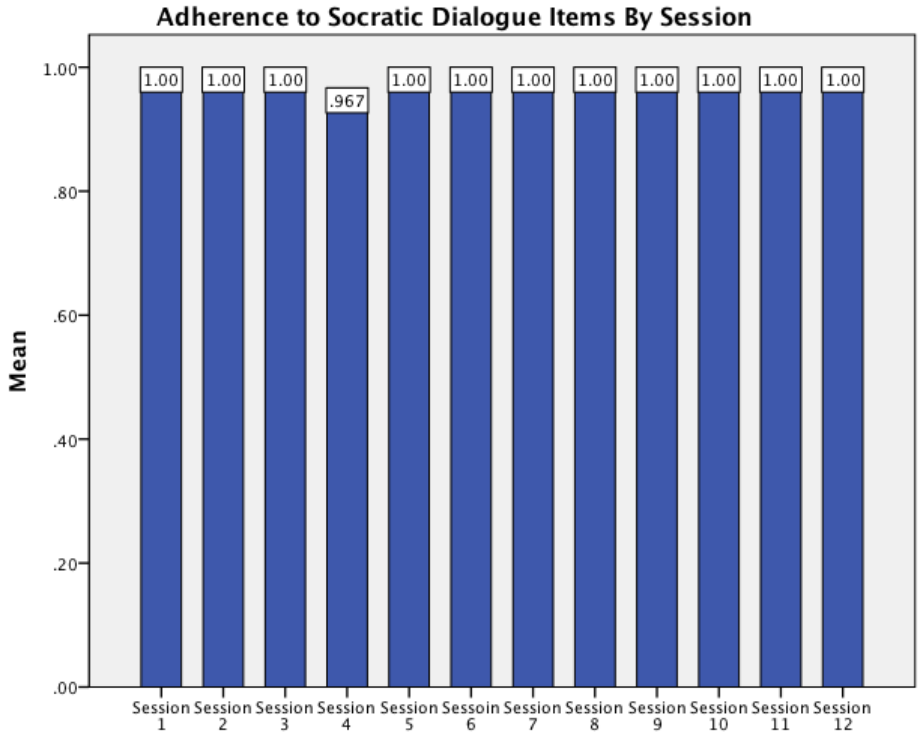


Figure 6.
Mean Adherence Ratings for Assimilation First Items in Each CPT Session

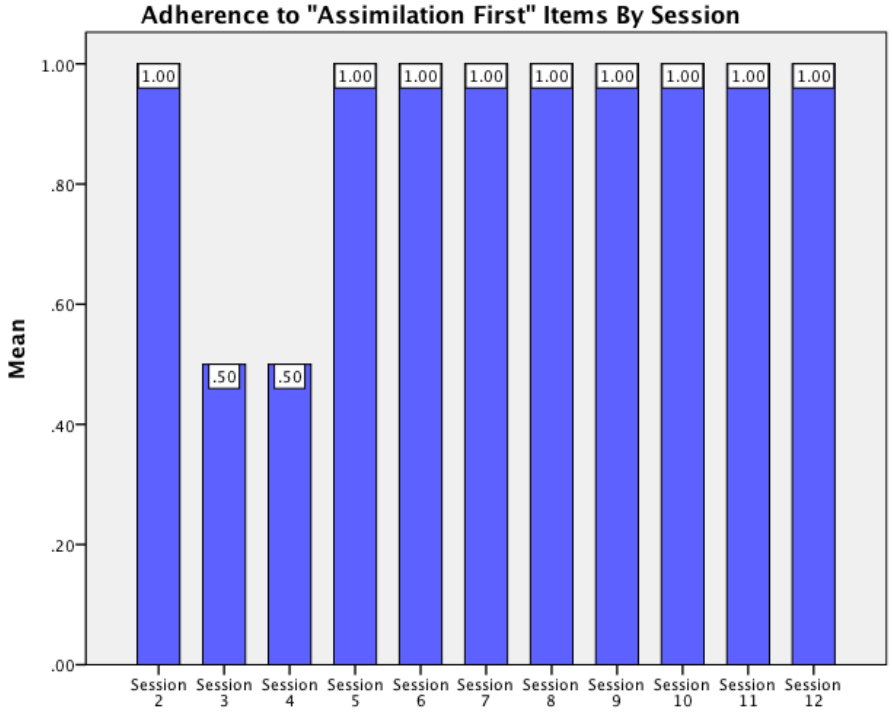


Figure 7.
Mean Adherence Ratings for Homework Items in Each CPT Session

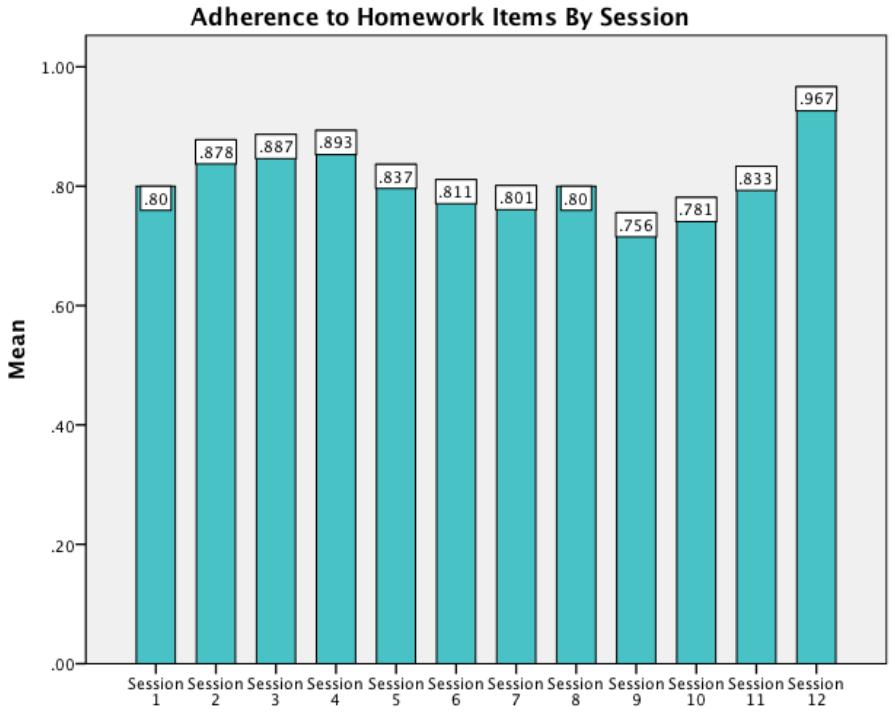


Figure 8.
Mean Adherence Ratings for Emphasis on Affect Items in Each CPT Session

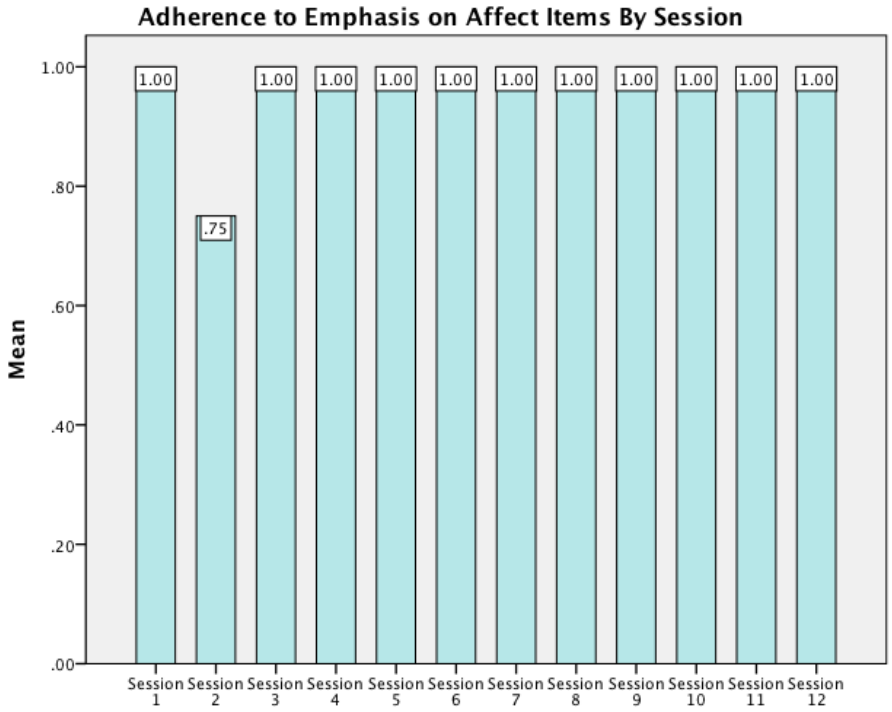


Figure 9.
Mean Competence Ratings for Original Fidelity Items in Each CPT Session

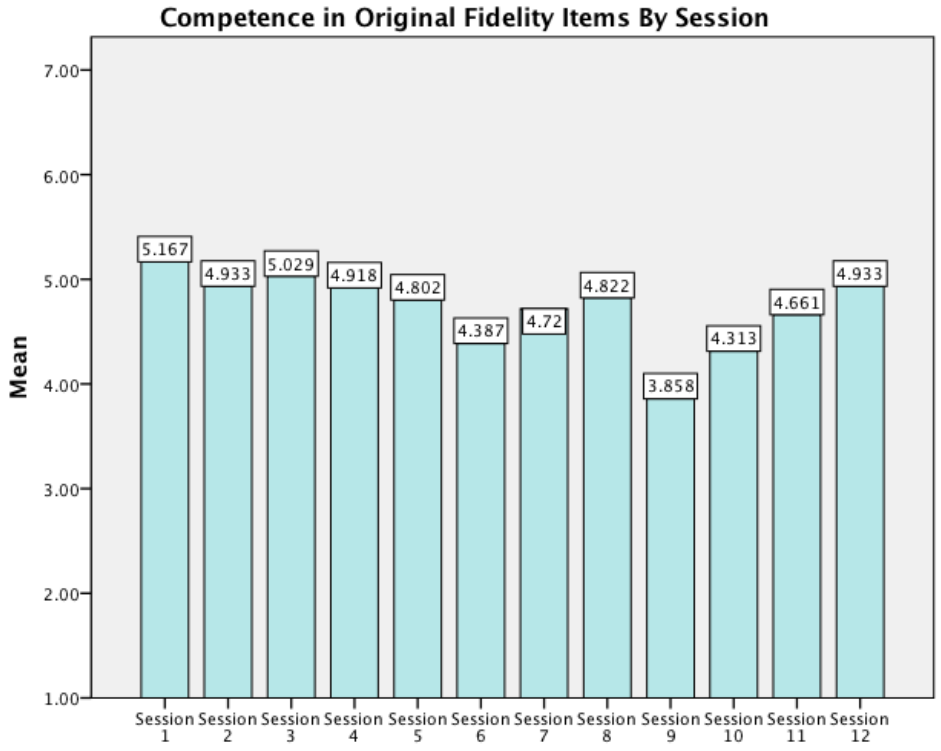


Figure 10.
Mean Competence Ratings for Revised Fidelity Items in Each CPT Session

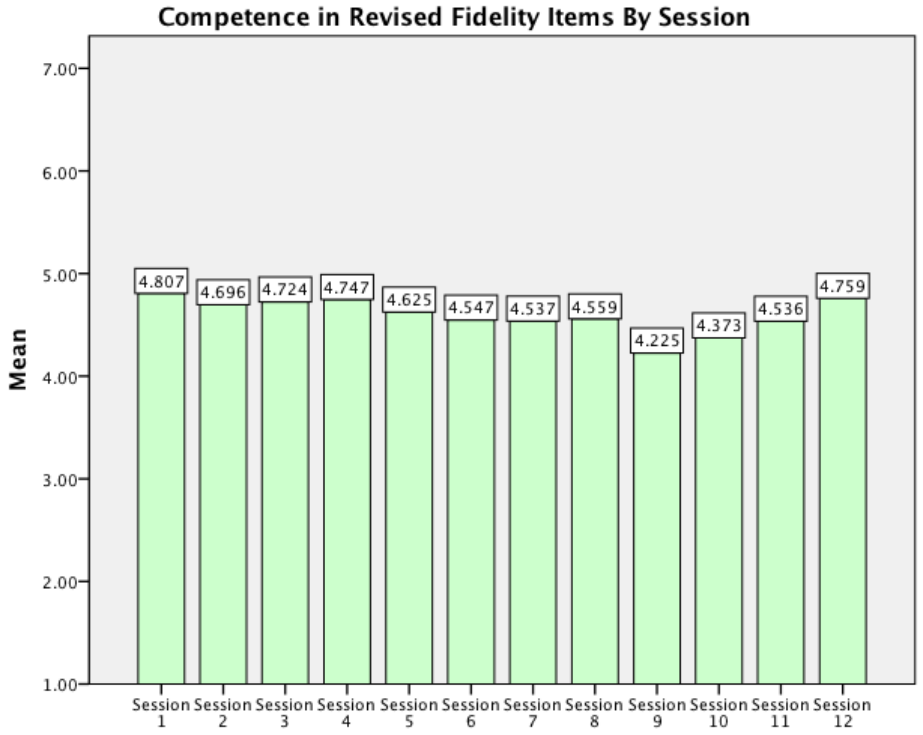


Figure 11.
Mean Competence Ratings for New Fidelity Items in Each CPT Session

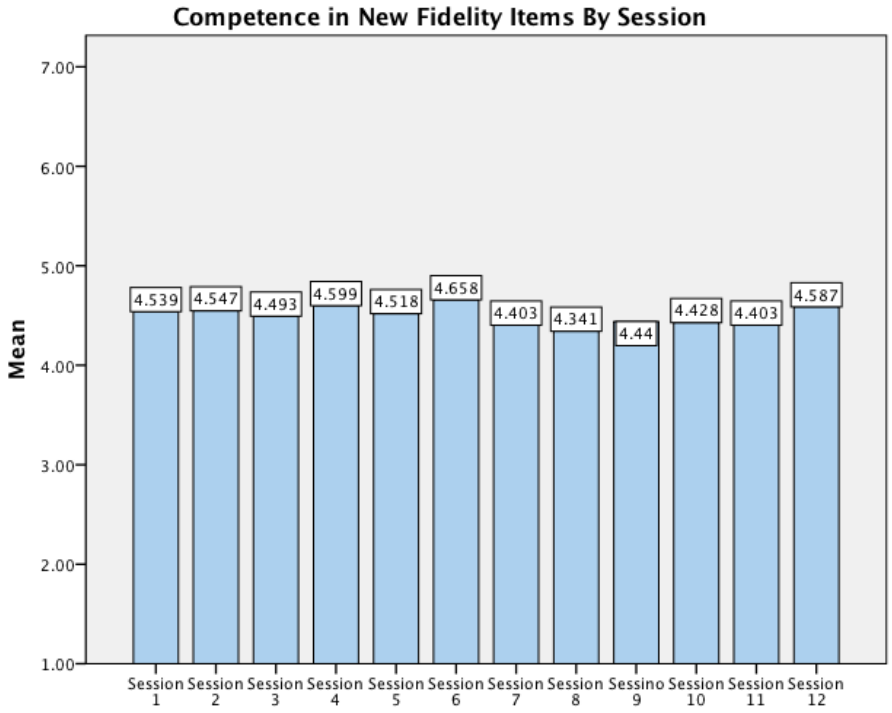


Figure 12.
Mean Competence Ratings for Nonspecific Fidelity Items in Each CPT Session

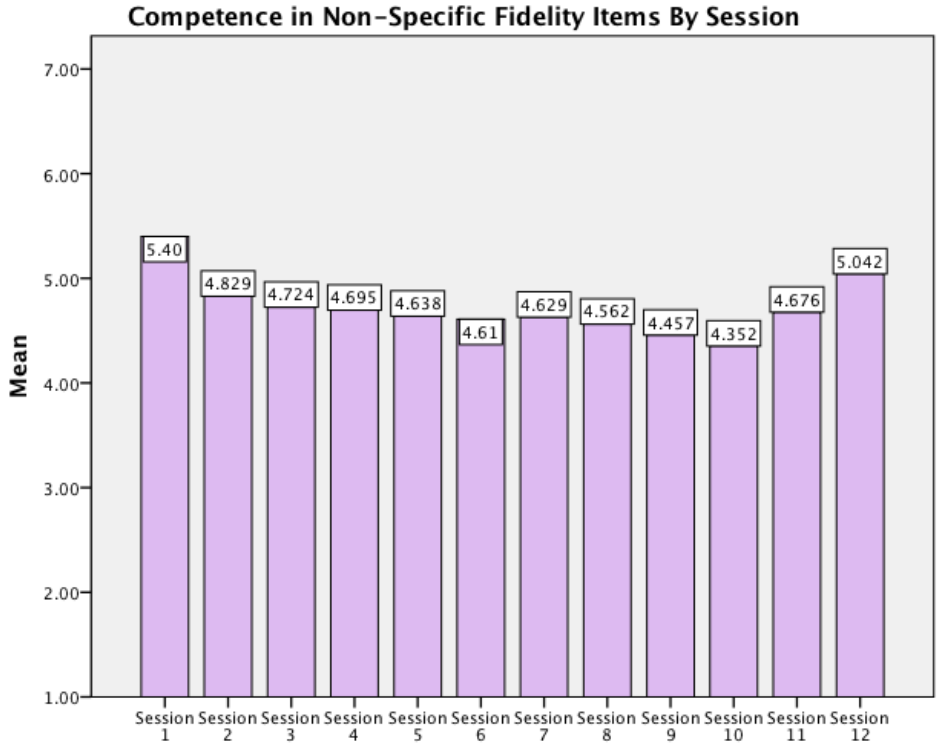


Figure 13.
Mean Competence Ratings for Socratic Dialogue Items in Each CPT Session

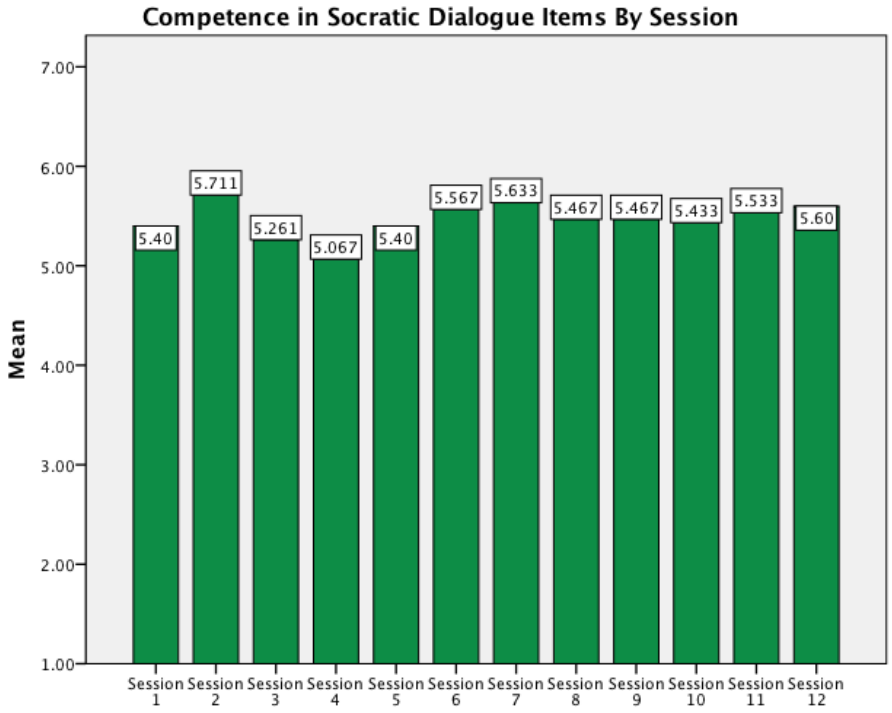


Figure 14.
Mean Competence Ratings for Assimilation First Items in Each CPT Session

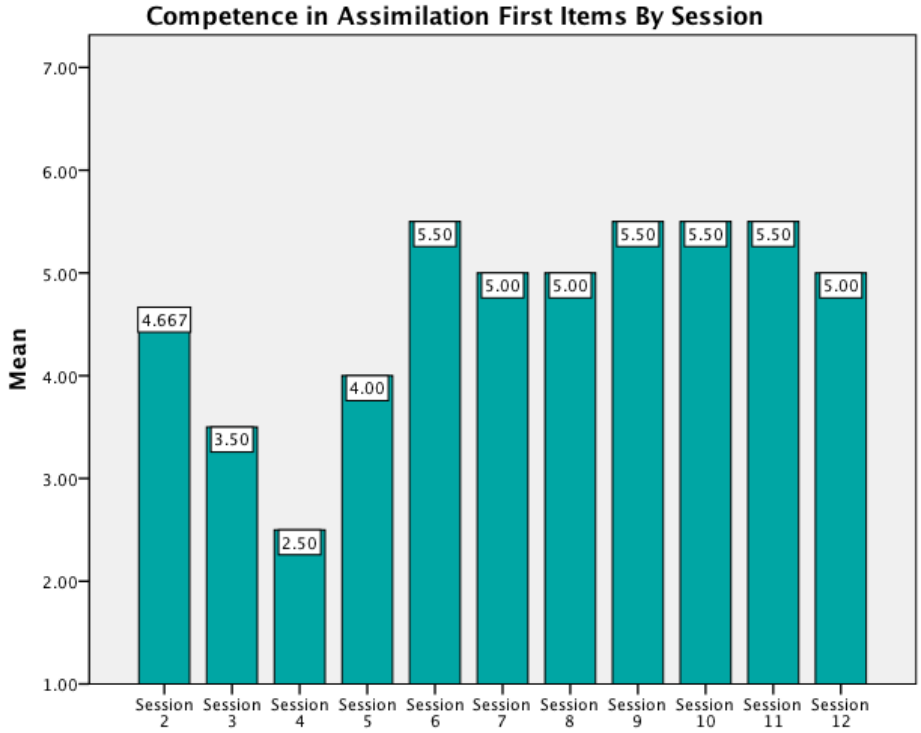


Figure 15.
Mean Competence Ratings for Homework Items in Each CPT Session

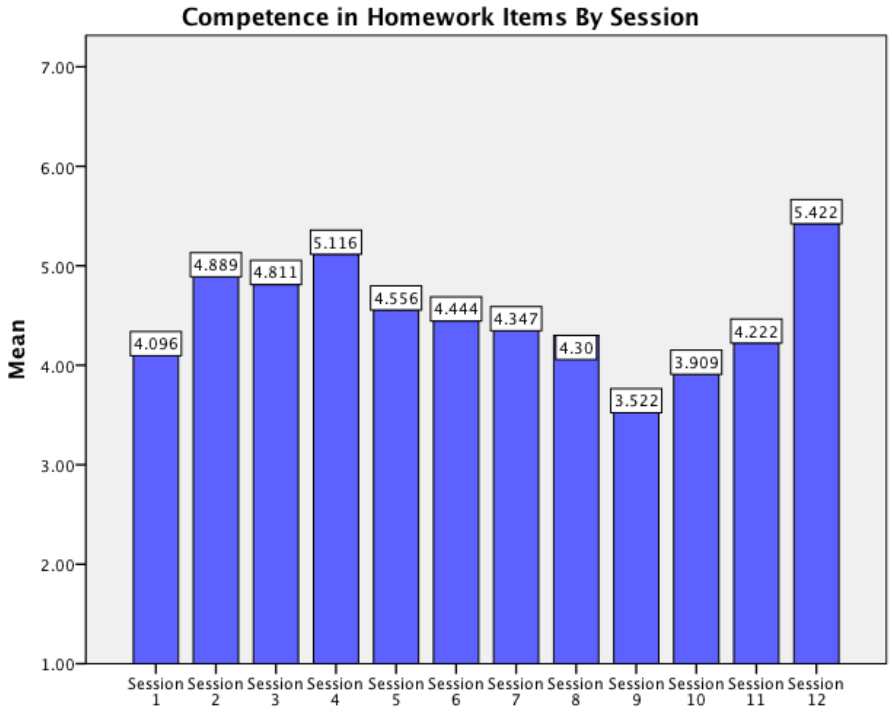
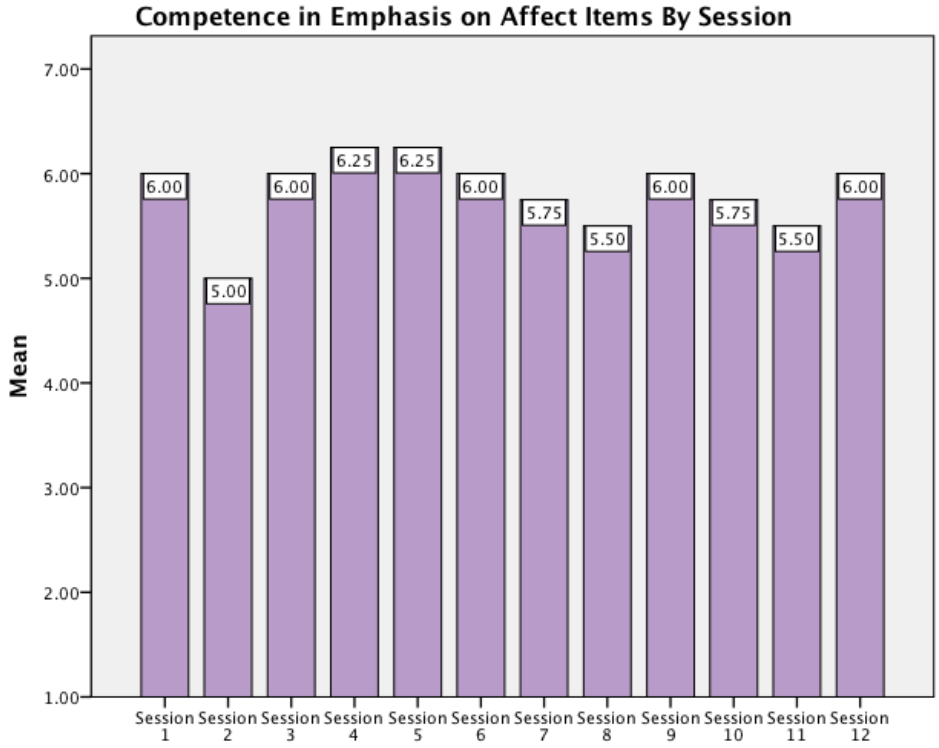


Figure 16.
Mean Competence Ratings for Emphasis on Affect Items in Each CPT Session



Aim 1 Results

Aim 1. Examine the influence of treatment fidelity, using the total revised CPT fidelity rating system, on trauma-focused treatment outcomes (e.g., improvement in PTSD and depressive symptoms over the course of treatment). The following analyses were completed with treatment completers only and excluded participants who dropped out of treatment prematurely. Dropouts were excluded because, by definition, they had not completed the therapy and we were specifically interested in the effect of fidelity on outcomes. Hypothesis 9 results below (see Table 34) reveal that treatment completers and dropouts did not have significantly different fidelity rating scores for most relevant variables.

Sample characteristics for Aim 1

A Shapiro-Wilk's test ($p > .05$) (Razali & Wah, 2011; Shapiro & Wilk, 1965) and a visual inspection of their histograms, normal Q-Q plots, and box plots showed that the dependent variables (CAPS change score and BDI change score) were approximately normally distributed. A Shapiro-Wilk's test ($p > .05$) (Shapiro & Wilk, 1965; Razali & Wah, 2011) and a visual inspection of their histograms, normal Q-Q plots, and box plots showed that the independent variables were approximately normally distributed as well (Cramer, 1998; Cramer & Howitt, 2004; Doane & Seward, 2011).

Hypothesis 1 Results

Standard multiple regression was conducted with the CAPS pre to post change score (CAPSchange) as the dependent variable and the revised adherence score (RevisedADH) and revised competence score (RevisedCOMP) as independent variables.

As can be seen in Table 8, the independent variables were not significantly correlated with the dependent variable.

Table 8.
Means, Standard Deviations, and Intercorrelations for CAPS Pre to Post Change Score and Treatment Adherence and Competence Predictor Variables (N = 45)

Variable	*M*	*SD*	1	2
Change in CAPS	47.64	22.24	.014	.125
Predictor variable				
1. RevisedADH	.86	.08		
2. RevisedCOMP	4.42	.85		

*p < .05

Regression results are summarized in Table 9. Multiple regression analyses revealed that the overall model was not significant ($F(2, 44) = .870$, $p = .426$), with RevisedADH and RevisedCOMP accounting for less than 1% (Adjusted R^2) of the variance in CAPSchange. Within this model, neither RevisedADH nor RevisedCOMP was a unique predictor of CAPSchange.

Table 9.
Regression Analysis Summary for Treatment Adherence and Competence Variables Predicting CAPS Pre to Post Change Score (N = 45)

Predictor Variables	*F*	*p*	*Adjusted R^2*	*B*	*t*	*p*
Hypothesis 1	.870	.426	-.006			
RevisedADH				-.272	-1.028	.310
RevisedCOMP				.349	1.316	.195

*$p < .05$

Hypothesis 2 Results

Standard multiple regression was conducted with BDI pre to post change score (BDIchange) as the dependent variable and the revised adherence score (RevisedADH)

and revised competence score (RevisedCOMP) as independent variables. As can be seen in Table 10, the independent variables were not significantly correlated with the dependent variable.

Table 10
Means, Standard Deviations, and Intercorrelations for BDI Pre to Post Change Score and Treatment Adherence and Competence Predictor Variables (N = 45)

Variable	*M*	*SD*	1	2
Change in BDI	17.87	13.28	.154	.122
Predictor variable				
1. RevisedADH	.86	.07		
2. RevisedCOMP	4.43	.85		

*p < .05

Regression results are summarized in Table 11. Multiple regression analyses revealed that the overall model was not significant ($F(2, 44) = .529$, $p = .593$), with RevisedADH and RevisedCOMP accounting for -2.2% (Adjusted R^2) of the variance in BDIchange. Within this model, neither RevisedADH nor RevisedCOMP was a unique predictor of BDIchange.

Table 11
Regression Analysis Summary for Treatment Adherence and Competence Variables Predicting BDI Pre to Post Change Score (N = 45)

Predictor Variables	*F*	*p*	*Adjusted* R^2	*B*	*t*	*p*
Hypothesis 2	.529	.593	-.022			
RevisedADH				.214	.645	.522
RevisedCOMP				-.068	-.206	.838

*p < .05

Aim 2 Results

Aim 2. Examine the relative influence of theorized CPT critical components on trauma-focused treatment outcomes. Again, these analyses were conducted with treatment completers only and individuals who dropped out of treatment prematurely were excluded.

Sample Characteristics for Aim 2

A Shapiro-Wilk's test ($p < .05$) (Shapiro & Wilk, 1965; Razali & Wah, 2011) and a visual inspection of their histograms, normal Q-Q plots, and box plots showed that all of the adherence independent variables for hypotheses 3 and 4 violated the assumption of normality. All of these variables demonstrated very high skewness and kurtosis. Close examination reveals that there was very limited range in the sample. Despite multiple attempts at transforming these variables to increase normality (logarithmic transformation, square root transformation, arcsine transformation, reciprocal transformation, exponential transformation, etc.), data remained in significant violation of the assumption of normality. Therefore, relevant results should be interpreted with caution. Tests for normality revealed that all of the competence independent variables for hypotheses 3 and 4 were approximately normally distributed.

Hypothesis 3 Results

Hypothesis 3a: Standard multiple regression was conducted with CAPSchange as the dependent variable and the four critical component adherence variables as independent variables. These four critical component adherence variables are as follows: adherence to use of Socratic dialogue (SocraticADH), adherence to targeting assimilated before over-accommodated beliefs (AssimilationADH), adherence to utilization of homework assignments (HomeworkADH), and adherence to emphasis on the expression

of affect (AffectADH). As can be seen in Table 12, the independent variables were not significantly correlated with the dependent variable.

Table 12
Means, Standard Deviations, and Intercorrelations for CAPS Pre to Post Change Score and Adherence Critical Component Predictor Variables (N = 45)

Variable	*M*	*SD*	1	2	3	4
Change in CAPS	47.64	22.24	-.08	.16	.03	.23
Predictor variable						
1. SocraticADH	.995	.02				
2. AssimilationADH	.939	.11				
3. HomeworkADH	.850	.16				
4. AffectADH	.907	.17				

*p < .05.

Regression results are summarized in Table 13. Multiple regression analyses revealed that the overall model was not significant ($F(4, 44) = 1.019$, $p > .05$), with independent variables accounting for less than 1% (Adjusted R^2) of the variance in CAPSchange. Within this model, none of the independent variables were unique predictors of CAPSchange.

Table 13
Regression Analysis Summary for Adherence Critical Component Variables Predicting CAPS Pre to Post Change Score (N = 45)

Predictor Variables	*F*	*p*	*Adjusted R^2*	*β*	*t*	*p*
Hypothesis 3a	1.019	.409	.002			
1. SocraticADH				-.129	-.838	.407
2. AssimilationADH				.128	.786	.436
3. HomeworkADH				-.140	-.793	.432
4. AffectADH				.282	1.566	.125

*p < .05. **p < .01.

Hypothesis 3b: Standard multiple regression was conducted with CAPSchange as the dependent variable and the four critical component competence variables as independent variables. These four critical component competence variables are as follows: competence in the use of Socratic dialogue (SocraticCOMP), competence in targeting assimilated before over-accommodated beliefs (AssimilationCOMP), competence in utilization of homework assignments (HomeworkCOMP), and competence in emphasis on the expression of affect (AffectCOMP). As can be seen in Table 14, the independent variables were not significantly correlated with the dependent variable.

Table 14
Means, Standard Deviations, and Intercorrelations for CAPS Pre to Post Change Score and Competence Critical Component Predictor Variables (N = 45)

Variable	*M*	*SD*	1	2	3	4
Change in CAPS	47.64	22.24	.16	.12	.07	.24
Predictor variable						
1. SocraticCOMP	5.12	.95				
2. AssimilationCOMP	4.62	1.04				
3. HomeworkCOMP	4.32	1.28				
4. AffectCOMP	4.63	1.42				

*p < .05.

Regression results are summarized in Table 15. Multiple regression analyses revealed that the overall model was not significant ($F(4, 44) = 1.137$, $p = .353$), with independent variables accounting for 1.2% (Adjusted R^2) of the variance in CAPSchange. Within this model, none of the independent variables uniquely predicted CAPSchange.

Table 15
Regression Analysis Summary for Competence Critical Component Variables Predicting CAPS Pre to Post Change Score (N = 45)

Predictor Variables	*F*	*p*	*Adjusted* R^2	*β*	*t*	*p*
Hypothesis 3b	1.137	.353	.012			
1. SocraticCOMP				.094	.345	.732
2. AssimilationCOMP				-.033	-.150	.881
3. HomeworkCOMP				-.354	-1.331	.191
4. AffectCOMP				.472	1.767	.085

*p < .05

Hypothesis 4 Results

Hypothesis 4A: Standard multiple regression was conducted with BDIchange as the dependent variable and the four critical component adherence variables as independent variables. As can be seen in Table 16, AssimilationADH was positively significantly correlated with BDIchange (r = .27, p < .05). None of the other independent variables were significantly correlated with the BDIchange score.

Table 16
Means, Standard Deviations, and Intercorrelations for BDI Pre to Post Change Score and Adherence Critical Component Predictor Variables (N = 45)

Variable	*M*	*SD*	1	2	3	4
Change in BDI	17.87	13.28	-.12	.27*	.14	.17
Predictor variable						
1. SocraticADH	.995	.015				
2. AssimilationADH	.938	.114				
3. HomeworkADH	.851	.156				
4. AffectADH	.911	.171				

*p < .05

Regression results are summarized in Table 17. Multiple regression analyses revealed that the overall model was not significant and within this model, none of the independent variables uniquely predicted BDIchange.

Table 17
Regression Analysis Summary for Adherence Critical Component Variables Predicting BDI Pre to Post Change Score (N = 45)

Predictor Variables	*F*	*p*	*Adjusted* R^2	*β*	*t*	*p*
Hypothesis 4A	1.158	.344	.014			
1. SocraticADH				-.161	-1.053	.299
2. AssimilationADH				.247	1.538	.132
3. HomeworkADH				.030	.174	.863
4. AffectADH				.102	.576	.568

*p < .05

Hypothesis 4B: Standard multiple regression was conducted with BDIChange as the dependent variable and the four critical component competence variables as independent variables. As can be seen in Table 18, none of the independent variables were significantly correlated with the BDIchange.

Table 18
Means, Standard Deviations, and Intercorrelations for BDI Pre to Post Change Score and Competence Critical Component Predictor Variables (N = 45)

Variable	*M*	*SD*	1	2	3	4
Change in BDI	17.87	13.28	.03	.06	.20	.18
Predictor variable						
1. SocraticCOMP	5.12	.94				
2. AssimilationCOMP	4.61	1.06				
3. HomeworkCOMP	4.33	1.28				
4. AffectCOMP	4.66	1.40				

*p < .05.

Regression results are summarized in Table 19. Multiple regression analyses revealed that the overall model was not significant and within this model, none of the independent variables uniquely predicted BDIchange.

Table 19
Regression Analysis Summary for Competence Critical Component Variables Predicting BDI Pre to Post Change Score (N = 45)

Predictor Variables	*F*	*p*	*Adjusted R^2*	*β*	*t*	*p*
Hypothesis 4B	.967	.436	-.003			
1. SocraticCOMP				-.365	-1.333	.190
2. AssimilationCOMP				-.001	-.005	.996
3. HomeworkCOMP				.304	1.144	.260
4. AffectCOMP				.219	.825	.415

*p < .05. **p < .01.

Aim 3 Results

Aim 3. Examine the role of nonspecific treatment factors (e.g., empathy) in moderating the relationship between fidelity ratings and trauma-focused treatment outcome variables. Again, these analyses were conducted with treatment completers only and individuals who dropped out of treatment prematurely were excluded.

Sample Characteristics for Aim 3

A Shapiro-Wilk's test (p > .05) (Shapiro & Wilk, 1965; Razali & Wah, 2011) and a visual inspection of their histograms, normal Q-Q plots, and box plots showed that two of the independent variables for hypotheses 5 and 6 were approximately normally distributed. These two variables were the adherence score for the revised fidelity rating system excluding nonspecific items (Revised_WithoutNonSpecADH) and the competence score for the revised fidelity rating system excluding nonspecific items (Revised_WithoutNonSpecCOMP). Conversely, the remaining two independent variables,

the adherence score for the nonspecific items (NonSpecADH) and the competence score for the nonspecific items (NonSpecCOMP), violated the assumption of normal distribution, with a significant Shapiro-Wilk's test ($p < .05$), high skewness, and high kurtosis (Cramer, 1998; Cramer & Howitt, 2004; Doane & Seward, 2011). Data remained in violation of normality despite transformations.

Hypothesis 5 Results

Hypothesis 5A: Multiple regression analysis was conducted with CAPSchange as the dependent variable and Revised_WithoutNonSpecADH, NonSpecADH, and an interaction variable as independent variables. As can be seen in Table 20, none of the independent variables were significantly correlated with the CAPSchange score.

Table 20
Means, Standard Deviations, and Intercorrelations for CAPS Pre to Post Change Score and Adherence Critical Component Predictor Variables (N = 45).

Variable	*M*	*SD*	1	2	3
Change in CAPS	47.64	22.24	.098	-.130	.102
Predictor variables					
1. Revised_WithoutNonSpecADH	-.017	.066			
2. NonSpecADH	-.010	.175			
3. InteractionRevised_WithoutNonSpecADH xNonSpecADH	.004	.012			

*p < .05

Regression results are summarized in Table 21. Multiple regression analyses revealed that the overall model was not significant and within this model, none of the independent variables uniquely predicted CAPSchange. Therefore, there was no significant moderation.

Table 21
Moderation Effect of Adherence to Nonspecific Components on the Relationship between Adherence to Specific Components and Change in CAPS Pre to Post (N = 45).

Predictor Variables	*F*	*p*	*Adj. R^2*	*β*	*t*	*p*
Hypothesis 5A	.587	.627	-.029			
MeanRevised_WithoutNonSpecADH				.169	1.012	.318
MeanNonSpecADH				-.18	-.587	.561
MeanInteractionRevised_WithoutNonSpecADHxNonSpecADH				.018	.060	.953

*p < .05

Hypothesis 5B: Multiple regression analysis was conducted with CAPSchange as the dependent variable and Revised_WithoutNonSpecCOMP, NonSpecCOMP, and an interaction variable as independent variables. As can be see in Table 22, none of the independent variables were significantly correlated with the CAPSchange.

Table 22
Means, Standard Deviations, and Intercorrelations for CAPS Pre to Post Change Score and Competence Critical Component Predictor Variables (N = 45).

Variable	*M*	*SD*	1	2	3
Change in CAPS	47.64	22.24	.145	.072	.114
Predictor variables					
1. Revised_WithoutNonSpecCOMP	3.50	.87			
2. NonSpecCOMP	3.73	.86			
3. InteractionRevised_WithoutNonSpecCOMPxNonSpecCOMP	13.71	6.28			

*p < .05

Regression results are summarized in Table 23. Multiple regression analyses revealed that the overall model was not significant and within this model, none of the independent variables uniquely predicted CAPSchange. Therefore, there was no significant moderation.

Table 23
Moderation Effect of Competence for Nonspecific Components on the Relationship between Competence for Specific Components and Change in CAPS Pre to Post (N = 45).

Predictor Variables	*F*	*p*	*Adj.* R^2	*β*	*T*	*p*
Hypothesis 5B	.536	.661	-.033			
Revised_WithoutNonSpecCOMP				.220	.290	.77
NonSpecCOMP				-.44	-.56	.58
InteractionRevised_WithoutNonSpecCOMP xNonSpecCOMP				.331	.241	.81

*p < .05

Hypothesis 6 Results

Hypothesis 6A: Multiple regression analysis was planned with BDIchange as the dependent variable and Revised_WithoutNonSpecADH, NonSpecADH, an interaction variable as independent variables. As can be seen in Table 24, none of the independent variables were significantly correlated with the BDIchange score. Because the independent variables were not significantly correlated with the BDIchange score, multiple regression analyses were not examined for a significant moderation.

Table 24
Means, Standard Deviations, and Intercorrelations for BDI Pre to Post Change Score and Adherence Critical Component Predictor Variables (N = 45).

Variable	*M*	*SD*	1	2	3
Change in BDI	17.87	13.28	.122	.156	-.057
Predictor variables					
1. Revised_WithoutNonSpecADH	-.017	.066			
2. NonSpecADH	-.032	.100			
3. InteractionRevised_WithoutNonSpecADH xNonSpecADH	.006	.007			

*p < .05

Hypothesis 6B: Multiple regression analysis was planned with BDIchange as the dependent variable and Revised_WithoutNonSpecCOMP, NonSpecComp, and an interaction variable as independent variables. As can be see in Table 26, none of the independent variables were significantly correlated with the BDIchange score. Because the independent variables were not significantly correlated with the BDIchange score, multiple regression analyses were not examined for a significant moderation.

Table 26
Means, Standard Deviations, and Intercorrelations for BDI Pre to Post Change Score and Competence Critical Component Predictor Variables (N = 45).

Variable	*M*	*SD*	1	2	3
Change in BDI	17.87	13.28	.111	.132	.122
Predictor variables					
1. Revised_WithoutNonSpecCOMP	3.51	.87			
2. NonSpecCOMP	3.74	.86			
3. InteractionRevised_WithoutNonSpecCOMP xNonSpecCOMP	13.77	6.25			

*p < .05

Aim 4 Results

Aim 4. Compare the original fidelity scores gathered for the parent study with the fidelity scores gathered for the current study using the revised fidelity rating system. The relative predictability of original and revised fidelity ratings for treatment outcome variables will be assessed. Relatedly, the influence of these fidelity ratings on treatment completer status (i.e., completer versus drop-out) will be examined. Analyses for hypotheses 7 and 8 were conducted with treatment completers only and individuals who

dropped out of treatment prematurely were excluded. Hypothesis 9 analyses included both treatment completers and dropouts as the two groups were being compared.

Sample Characteristics for Hypotheses 7 and 8

A Shapiro-Wilk's test ($p > .05$) (Shapiro & Wilk, 1965; Razali & Wah, 2011) and a visual inspection of the histogram, normal Q-Q plot, and box plot showed that two of the variables for hypothesis 7 and 8, adherence to the newly added fidelity items (NewOnlyADH) and competence for the newly added fidelity items (NewOnlyCOMP) were normally distributed. Conversely, the remaining two variables for hypotheses 7 and 8, adherence to the original fidelity items excluding the nonspecific items (Original_WithoutNonSpecADH) and competence for the original fidelity items excluding the nonspecific items (Original_WithoutNonSpecCOMP), violated the assumption of normal distribution, with a significant Shapiro-Wilk's test ($p < .05$), high skewness, and high kurtosis (Cramer, 1998; Cramer & Howitt, 2004; Doane & Seward, 2011). Data remained in violation of normality despite attempted transformations.

Hypothesis 7 Results

Hypothesis 7A (with ITT sample): A simple Pearson product-moment correlation revealed that Original_WithoutNonSpecADH and NewOnlyADH were not significantly correlated ($r(66) = .069$, $p > .05$). Conversely, Original_WithoutNonSpecCOMP and NewOnlyCOMP were significantly and strongly correlated ($r(66) = .772$, $p < .001$; see Table 28).

Table 28
Means, Standard Deviations, and Intercorrelations for Original Fidelity Scores and Revised Fidelity Scores (ITT sample, N = 66).

Variable	*M*	*SD*	*r*
Original_WithoutNonSpecADH	.941	.076	.069

NewOnlyADH	.834	.084	
Original_WithoutNonSpecCOMP	4.559	1.185	.772*
NewOnlyCOMP	4.249	.714	

*p < .001

Hypothesis 7B (with treatment completers only): Results were the same using only the treatment completers. A simple Pearson product-moment correlation revealed that Original_WithoutNonSpecADH and NewOnlyADH were not significantly correlated ($r(46) = .021$, $p > .05$). Conversely, Original_WithoutNonSpecCOMP and NewOnlyCOMP were significantly and strongly correlated ($r(46) = .856$, $p < .001$; see Table 29).

Table 29
Means, Standard Deviations, and Intercorrelations for Original Fidelity Scores and Revised Fidelity Scores (Completer sample, N = 46).

Variable	*M*	*SD*	*r*
Original_WithoutNonSpecADH	.925	.083	.021
NewOnlyADH	.813	.064	
Original_WithoutNonSpecCOMP	4.464	1.211	.856*
NewOnlyCOMP	4.275	.658	

*p < .001

Hypothesis 8 Results

Hypothesis 8A: Hierarchical regression was conducted with CAPSchange as the dependent variable and Original_WithoutNonSpecADH, Original_WithoutNonSpecCOMP, NewOnlyADH, and NewOnlyCOMP as independent variables. As can be seen in Table 30, none of the independent variables were significantly correlated with the CAPSchange.

Table 30
Means, Standard Deviations, and Intercorrelations for CAPS Pre to Post Change Score and Original and Revised Fidelity Predictor Variables (N = 45).

Variable	*M*	*SD*	1	2	3	4
Change in CAPS	47.64	22.24	.18	.14	-.03	.15
Predictor variables						
1. Original_WithoutNonSpecADH	.93	.08				
2. Original_WithoutNonSpecCOMP	4.48	1.22				
3. NewOnlyADH	.81	.07				
4. NewOnlyCOMP	4.28	.66				

*p < .05

Regression results are summarized in Table 31. The hierarchical regression model revealed that the overall model did not significantly predict CAPSchange.

Table 31
Hierarchical Regression Analysis Summary for Original and Revised Fidelity Variables Predicting Change in CAPS Pre to Post (N = 45).

Predictor Variables	*F*	*p*	*Adj. R^2*	*β*	*t*	*p*
Hypothesis 8A	.446	.78	-.05			
STEP 1						
Original_WithoutNonSpecADH				.18	.66	.51
Original_WithoutNonSpecCOMP				-.12	-.30	.77
STEP 2						
NewOnlyADH				-.07	-.36	.72
NewOnlyCOMP				.18	.57	.58

*p < .05

Hypothesis 8B: Hierarchical regression was conducted with BDIchange as the dependent variable and Original_WithoutNonSpecADH, Original_WithoutNonSpecCOMP, NewOnlyADH, and NewOnlyCOMP as independent

variables. As can be seen in Table 32, none of the independent variables were significantly correlated with the BDIchange.

Table 32
Means, Standard Deviations, and Intercorrelations for BDI Pre to Post Change Score and Original and Revised Fidelity Predictor Variables (N = 45).

Variable	*M*	*SD*	1	2	3	4
Change in BDI	17.87	13.28	.19	.18	-.02	.02
Predictor variables						
1. Original_WithoutNonSpecADH	.93	.08				
2. Original_WithoutNonSpecCOMP	4.49	1.21				
3. NewOnlyADH	.81	.06				
4. NewOnlyCOMP	4.28	.66				

*p < .05

Regression results are summarized in Table 33. The hierarchical regression model revealed that the overall model did not significantly predict BDIchange.

Table 33
Hierarchical Regression Analysis Summary for Original and Revised Fidelity Variables Predicting Change in BDI Pre to Post (N = 45).

Predictor Variables	*F*	*p*	*Adj.* R^2	*β*	*t*	*p*
Hypothesis 8B	1.17	.34	.02			
STEP 1						
Original_WithoutNonSpecADH				-.02	-.07	.94
Original_WithoutNonSpecCOMP				.64	1.62	.11
STEP 2						
NewOnlyADH				-.04	-.24	.82
NewOnlyCOMP				-.50	-1.64	.11

*p < .05

Hypothesis 9 Results

An analysis of covariance (ANCOVA) was completed for each of the study variables to determine whether treatment completers and dropouts differed significantly. The four demographic variables (i.e., Years of Education, Age, Income, Marital Status) previously determined to significantly differ according to group were used as covariates in these analyses. Means, standard deviations, and ANCOVA results are presented in Table 34. Treatment completers had significantly lower adherence scores compared to dropouts for the following variables: Original_WithoutNonSpecADH ($\eta_p^2 = .14$), RevisedADH ($\eta_p^2 = .07$), Revised_WithoutNonSpecADH ($\eta_p^2 = .13$), NewOnlyADH ($\eta_p^2 = .07$), and AffectADH ($\eta_p^2 = .07$). There were no significant differences between treatment completers and dropouts on the other adherence variables or on any competence variables (see Table 34). Notably, some of the variables used in the following analyses violated the assumption of normal distribution and results should therefore be interpreted with caution.

Table 34
Means, Standard Deviations, and Analysis of Covariance Results for CPT Fidelity Variables

Variable	Group	*M*	*SD*	*F*
OriginalADH	completer	.89	.10	2.07
	dropout	.94	.07	
Original_WithoutNonSpecADH	completer	.93	.08	9.53**
	dropout	.98	.04	
RevisedADH	completer	.86	.08	4.85*
	dropout	.92	.06	
Revised_WithoutNonSpecADH	completer	.84	.07	8.75**
	dropout	.90	.07	
NonSpecADH	completer	.90	.17	.001
	dropout	.94	.07	
NewOnlyADH	completer	.82	.07	4.48*

	dropout	.87	.10	
SocraticADH	completer	.10	.02	2.18
	dropout	1.00	.00	
AssimilationADH	completer	.94	.11	.26
	dropout	.94	.15	
HomeworkADH	completer	.85	.16	.02
	dropout	.84	.17	
AffectADH	completer	.91	.17	4.70*
	dropout	1.00	.00	
Rating of therapist overall CPT skills	completer	5.22	1.03	.01
	dropout	5.10	1.30	
Rating of therapist overall ability to rely on Socratic dialogue	completer	5.33	1.10	1.49
	dropout	4.86	1.32	
Rating of therapist overall ability to prioritize assimilation over over-accommodation	completer	5.13	.98	.36
	dropout	4.87	1.41	
Rating of therapist overall ability to effectively utilize and navigate HW	completer	4.98	1.22	.00
	dropout	4.80	1.24	
Rating of therapist overall ability to appropriately encourage and emphasize expression of natural affect	completer	4.85	1.32	.11
	dropout	4.81	1.12	
RevisedCOMP	completer	4.42	.84	.47
	dropout	4.55	.82	
Revised_WithoutNonSpecCOMP	completer	4.35	.86	.21
	dropout	4.45	.89	
OriginalCOMP	completer	4.51	.98	1.25
	dropout	4.77	.89	
Original_WithoutNonSpecCOMP	completer	4.46	1.21	1.55
	dropout	4.80	1.14	
NonSpecCOMP	completer	4.54	.85	1.25
	dropout	4.75	.73	
NewOnlyCOMP	completer	4.28	.66	.15

	dropout	4.18	.85	
SocraticCOMP	completer	5.11	.94	.88
	dropout	4.86	1.17	
AssimilationCOMP	completer	4.59	1.05	.58
	dropout	4.88	1.52	
HomeworkCOMP	completer	4.31	1.27	.10
	dropout	4.24	1.44	
AffectCOMP	completer	4.63	1.40	.65
	dropout	4.99	.95	

*p < .05. **p < .01.

Discussion

Average adherence for this sample, using the revised CPT fidelity rating manual, was high for specific CPT components and higher for nonspecific factors. Average adherence using the original fidelity rating system was higher than with the revised system, indicating that newly added items involved more nuanced or complex components of the intervention and were less likely to be performed. Average competence using the revised fidelity rating system was between "satisfactory" and "good" for both CPT specific and nonspecific factors. Again, average competence for the revised fidelity rating system was significantly lower than with the original system, indicating that newly added items were perhaps more difficult to implement. One possible explanation for lower fidelity for the newly added items is that they were generally more specific compared to original items. Increased specificity may have allowed for more decisive coding judgments about whether or not treatment components were present and how well they were implemented. These findings indicate that it may be

relatively simple to implement the treatment components in a basic format but more skillful implementation could require additional training.

Examining rates of fidelity for the four theorized critical components, we saw that adherence was very high for "use of Socratic dialogue" and high for "assimilation first" and "emphasis on expression of affect." Despite high adherence indicating that therapists almost always implemented these items, competence scores reveal that therapists varied in their skill level. Notably, "reliance on homework" had the lowest average adherence of the four components and almost half of the competence scores for this variable were on average between "mediocre" and "poor." Attention to the role of practice work in session appears to be a more difficult CPT component to implement skillfully. Therapists may struggle to utilize homework given the other necessary agenda items for each session. Therapists may also be hesitant to reassign incomplete work given that each session brings new assignments. Finally, therapists may choose to avoid potentially uncomfortable conversations about homework noncompliance.

An examination of fidelity ratings in each session revealed consistency across sessions with a few interesting deviations. For example, using the revised fidelity rating system, sessions 4 and 12 had the lowest adherence ratings for CPT specific items. For session 4, lower adherence may be due to therapists' difficulty in adhering to the protocol specifically around the writing of the trauma narrative. This difficulty may be due to the patient displaying more affect in this component of the protocol. It may also be due to heightened patient avoidance of this portion of the protocol (perhaps not completing the trauma narrative outside session, requiring the therapist to navigate this within session). Poor fidelity at session 4 may also be due to therapist discomfort with the detailed trauma

information provided in this session. For session 12, low adherence may be due to therapists feeling less tied to the protocol given that the treatment is essentially concluded. Alternatively, by session 12 clients may be successfully identifying and challenging their own stuck points and thus therapists may take a less active role. Overall competence for specific CPT components using the revised fidelity rating system appears to be consistent across sessions indicating that therapist skill level holds constant during a course of treatment.

The finding that fidelity for the "use of Socratic dialogue" variable was generally high and consistent across sessions indicates that therapists understand it as an essential component. It is unclear why fidelity for the "reliance on homework" variable was lowest in session 9 as any potential problem areas (e.g., failure to review homework) would theoretically be consistent throughout the last few sessions. Further exploration of individual homework items is necessary to determine which components therapists struggle with during session 9. The finding that fidelity for the "assimilation first" variable was significantly lower in sessions 3 and 4 compared to other sessions is interesting given that 3 and 4 are focused specially on challenging assimilated beliefs. Perhaps therapists have difficulty spending time on assimilated stuck points given the time consuming tasks of reviewing ABC worksheets in session 3 and processing the first trauma account in session 4. Alternatively, therapists may gravitate toward over-accommodated stuck points since they are generally more apparent and identifying assimilated beliefs can require additional processing. More time spent training therapists to identify and hone assimilated stuck points may be indicated. Finally, the finding that fidelity for the "emphasis on expression of affect" variable was lowest in session 2

suggests that therapists may be fearful of exacerbating symptoms or pushing clients early in therapy. Therapists may benefit from additional training or supervision to address the unfounded fear that expressing affect will negatively impact clients.

The primary hypothesis, that treatment fidelity using the revised CPT fidelity rating system would predict change scores, was not supported such that overall adherence and competence to the CPT treatment manual did not account for significant variance in the change in PTSD symptoms over the course of treatment. Despite this surprising finding, participants did experience significant decrease in PTSD scores over the course of treatment. One potential explanation for this finding is that the variables as they were created for this study encompass such a wide variety of intervention components that it would be necessary to separate them to better understand the relationship between fidelity and outcome. Moreover, small sample size and a lack of range in data make these results difficult to interpret. These findings add to the inconclusive existing literature on whether treatment fidelity is associated with treatment outcome. One potential explanation for the variation in findings within this area could be the variation in measurement method used to assess treatment fidelity. Further research is necessary to better understand the true impact of CPT fidelity on PTSD symptoms during treatment.

While change in depressive symptoms was significantly correlated with change in PTSD symptoms, none of the fidelity predictor variables throughout the study hypotheses significantly influenced depression change scores. Literature has repeatedly shown that depressive symptoms typically decrease alongside PTSD remediation (Foa et al., 2005; Galovski et al., 2012; Resick, Galovski, et al., 2008). However, extant literature does not appear to have explored the relationship between fidelity to specific trauma-focused

intervention components and change in depressive symptoms. This finding may suggest that clients with PTSD can experience a reduction in depressive symptoms when engaged in a course of CPT regardless of the level of therapist fidelity to specific components of the protocol.

A secondary aim of this project was to examine the influence of fidelity to the four theorized CPT critical components on symptom change. The finding that fidelity to these components did not influence PTSD symptom change may speak to the robustness of the protocol as a whole. That is, it may be more important to deliver the entire treatment rather than individual intervention components being responsible for symptom change. Alternatively, different operationalization of the four critical components may have yielded different results. For example, the variable for "reliance on homework" was created by taking an average of multiple items from each session and across the entire course of treatment. This included items that asked specifically about reviewing homework in session, an item that involved increasing homework compliance, an item that involved re-assigning incomplete homework, an item that involved assigning homework clearly, and an item that involved engaging in problem solving strategies for homework completion. Taking an average of fidelity for all of these items across sessions may be problematic if the therapist performs differently on certain items. Examining these items independently or in smaller groups may have revealed a significant relationship with treatment outcome. Since fidelity to some treatment components varied according to session, taking an average of fidelity across all sessions also may have impacted the findings. Examining individual session performance may be a more fruitful

endeavor. Importantly, interpretations are once again limited by small sample size and limited range in data.

It may also be possible that some unknown factors, rather than fidelity to these four treatment components, could be contributing to symptom change. Possibilities for such factors include specific CPT components measured in this fidelity rating system but not examined for this project (e.g., whether therapist remains trauma-focused in session), nonspecific therapist components not specifically measured in this fidelity rating system (e.g., therapeutic alliance – factors such as warmth and empathy were measured but the actual relationship and level of collaboration were not), client and treatment match, or other specific client variables. Further examination of treatment fidelity to specific treatment components, nonspecific components, and client variables is necessary to better understand the critical components of CPT.

There are multiple potential explanations for the finding that fidelity to nonspecific factors was not related to PTSD symptom change. First, the items included in this variable are distinct and would perhaps be better examined individually or in different groupings. The fidelity variables for nonspecific components included the following items: genuineness, warmth, empathy, professionalism, setting an agenda, structuring the session efficiently, and eliciting feedback from the client. Clearly some of these items are closely related (e.g., warmth and empathy). However, therapists may have been skilled in the areas of genuineness and empathy while exhibiting poor performance on efficiently structuring the session. More individualized examination of these variables may help us to better understand their relationship with treatment outcome. Alternatively, insufficient range in therapist fidelity to nonspecific factors may have contributed to non-

significant findings. Future research should examine the role of nonspecific factors with greater therapist variability perhaps by using therapists with a varied range of skill level (e.g., novice therapists, advanced graduate students, and expert clinicians).

There is no consensus within empirical literature as to whether nonspecific factors are significantly related to treatment outcome. Much of the literature on the influence of nonspecific factors in outcome has focused specifically on the concept of therapeutic alliance, defined as "the collaborative bond between the therapist and patient" (DeRubeis, Brotman, & Gibbons, 2005). Some posit that a strong therapeutic alliance is the key factor in good outcome while others fail to find a significant relationship between them. Findings from a large scale, multi-site study on the role of therapeutic alliance in the treatment of depression showed that therapeutic alliance significantly influenced outcome for all of the treatment conditions (interpersonal psychotherapy, CBT, imipramine with clinical management, and placebo with clinical management; Krupnick, Sotsky, Elkin, Watkins, & Pilkonis, 1996). Interestingly, ratings of client contribution to the alliance, but not therapist contribution to the alliance, were significantly related to treatment outcome (Krupnick et al., 1996). This suggests that client factors are crucial to consider when examining the role of nonspecifics in predicting treatment outcome. Of course, therapeutic alliance is not simply a therapist factor or a client factor, but rather the combination of those and the interaction between them. Future fidelity rating studies for CPT would benefit from assessing therapeutic alliance, as well as therapist and client contributions to that alliance. Ultimately, it is likely a combination of factors, including specific factors, nonspecific factors, therapist factors, and client factors, that leads to

treatment outcome. The goal should be to further examine these components to determine their relative importance in creating meaningful change.

Multiple conclusions can be drawn from the results of the final hypothesis. First, the finding that dropouts had higher overall adherence to specific treatment components compared to completers may be explained by session 1 involving more straightforward material (e.g., psycho-education about PTSD). Many treatment dropouts attended only session 1 and therefore had scores based solely on therapist performance in that session. Second, the finding that completers and dropouts do not differ significantly on competence for specific or nonspecific components suggests that therapist skill level may not be a contributing factor in whether clients prematurely terminate a course of CPT. Overall, completers and dropouts did not differ significantly on the majority of the fidelity variables suggesting that client factors (e.g., life stressors, avoidance), rather than therapist factors, may play a large part in determining whether clients complete CPT.

Some limitations should be considered in interpretation of these results. First, reflection on the revised fidelity rating system reveals that it may not have fully captured some key variables. These include factors such as therapeutic alliance, interpersonal effectiveness, collaboration, and a measure of therapist overall rigidity to the protocol. The fidelity rating system for Dialectical Behavior Therapy measures components such as “flexibility, movement, speed, and flow” (Linehan). Perhaps integrating such items in the CPT fidelity-rating manual would improve the measurement of nonspecific treatment components. A second limitation relates to the limited range in fidelity scores. Therapists were generally adherent to the protocol and competent in their implementation of treatment components. The data thus violated the assumption of normality and made

interpretation difficult. Similar questions should be examined in the context of greater range of therapist fidelity. This could be achieved through use of therapists with varying levels of clinical experience (e.g., very novice therapists to expert clinicians) and varying levels of CPT training (e.g., read the manual on own versus participated in multiple workshops and received weekly consultation). Future research should examine differences across therapists to examine potential therapist effects on treatment outcome.

There are a number of other possible future directions to consider. First, it may be beneficial to operationalize fidelity variables differently to ensure that individual items are related (e.g., warmth and efficiency are both nonspecific items but should be examined separately to determine their true value in predicting treatment outcome). Second, this study utilized a primarily female IPV survivor sample. Future research could expand these findings by examining different trauma types, samples with more male participants, samples with greater racial and ethnic diversity, and using other evidence based treatment protocols. Third, given that therapist fidelity was not a predictor of outcome, future research should examine the role of client variables. Finally, these study analyses were underpowered to detect significance indicating that future research would benefit from examining these relationships with a larger sample size.

Despite the named limitations, this study is an important step in the direction of higher quality implementation research. Despite consistent calls for fidelity measurement in all treatment outcome studies, many researchers either fail to assess fidelity or fail to include those results in the publication of their findings (Goense et al., 2014; Miller & Rollnick, 2014). While the studies that do report fidelity measurements typically show very high fidelity (Barber et al., 2007; Listug-Lunde, Vogeltanz-Holm, & Collins, 2013;

Rossello, Bernal, & Rivera-Medina, 2008), most studies fail to extend analyses to the critical question of whether fidelity was associated with outcome (Schoenwald & Garland, 2013). Examining the role of fidelity is a crucial component to better understanding and improving our trauma-focused treatment options. Under-utilization of evidence-based treatments and persistent rates of treatment non-responders still remain as important concerns. This study began to address these concerns by adding to our understanding of how and why CPT creates meaningful change for trauma survivors with PTSD. Continued work toward the identification of critical treatment components will enable us to improve our already effective interventions and better facilitate the dissemination process.

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Appendix A

Cognitive Processing Therapy (CPT): Therapist Adherence and Competence Protocol

Pallavi Nishith, Ph.D and Patricia A. Resick, Ph.D

University of Missouri at St. Louis
Department of Psychology
Center for Trauma Recovery

Cognitive Processing Therapy:
Therapist Adherence and Competence Protocol

Therapist:_____ TapeType(Audio/Video)_____
Subject#:_____
Rater: _____ Rating Date: _____

Instructions (Part I – Part IV):

Adherence: For each item, assess **if the therapist demonstrated the particular behavior** described in the item. If so, put a check (X) on the first line next to the item. For e.g., in session 1, item 1, if the therapist educated the client about PTSD, the rated item would look like:

__X_ ____ 1. Therapist educated the client about PTSD.

Competence: For each item, assess **how well the therapist carried out the particular behavior** described in the item. Use the rating scale described below to assign a number on the second line next to the item. For e.g., in session 1, item 1, if you think the therapist did a barely adequate job in educating the client about PTSD, then you would assign the number 2 on the second line next to the item. The rated item would now look like:

__X_ __2__ 1. Therapist educated the client about PTSD.

Rating Scale for Assessing Competence:

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

Please don't leave any items blank. For all items assess therapist competency, taking into account client's presenting problems, their difficulty level, and the stage of therapy. **Use N/A for Not Applicable ratings of Adherence/Competence.**

Part I. Unique and Essential Elements specific to each session:

SESSION 1: Introduction and Education Phase:

____ ____1. Therapist educated the client about PTSD.
____ ____2. Therapist asked the client for a 5-minute account of the trauma and asked for clarifications based on information presented in this account and the information presented in the trauma interview.
____ ____3. Therapist presented the treatment rationale using the Information Processing Theory and gave the handout on stuck points.
____ ____4. Therapist presented the client with an overview of the 12-session treatment.
____ ____5. Therapist gave the client the Therapy Expectancy Questionnaire.
____ ____6. Therapist asked client to write an Impact statement for homework.

SESSION 2: The Meaning of the Event:

____ ____1. Therapist reviewed homework using the CPT Homework Review form.
____ ____2. Therapist reviewed concepts from the first session: PTSD, information processing theory, and treatment rationale.
____ ____3. Therapist had client read her impact statement.
____ ____4. If the client did not do the homework, the therapist had client describe meaning of events orally.
____ ____5. Therapist discussed the meaning of the impact statement with the client and introduced the handout on four basic emotions.
____ ____6. Therapist helped client differentiate between thoughts and feelings and introduced the ABC sheet to help client with this.
____ ____7. Therapist asked client to fill out at least one ABC sheet a day with examples, past or current, related to the trauma, for homework.

SESSION 3: Identification of Thoughts and Feelings:

____ ____1. Therapist reviewed homework using the CPT Homework Review form.
____ ____2.Therapist reviewed ABC sheets with client, and helped her further differentiate between thoughts and feelings.
____ ____3. Therapist helped client identify stuck points and offered alternative hypotheses for client's explanation of the event, in a tentative way.
____ ____4. Therapist discussed the labeling of rape and further explored the stuck point of self blame, using Socratic questioning.
____ ____5. Therapist asked client to write an account of rape, with sensory details, and read over daily for homework.

SESSION 4: Remembering the Traumatic Event:

____ ____1. Therapist reviewed the homework using the CPT homework review form.
____ ____2. Therapist had client read the rape account aloud.
____ ____3. If the client did not write the rape account, therapist had the client recount the rape during session.
____ ____4. Therapist used client's expression of affect or lack thereof to identify stuck points.
____ ____5. Therapist continued to challenge client's stuck point related to self-blame using cognitive techniques.
____ ____6.Therapist asked the client to rewrite the rape account not as a police report, but in more detail, including all the sensory aspects, for homework.

SESSION 5: Identification of Stuck Points:

____ ____1. Therapist reviewed the homework using the CPT homework review form.
____ ____2. Therapist had client read the second rape account out loud and helped client identify differences between the first and second write ups of the account.
____ ____3. Therapist involved client in challenging assumptions and conclusions, which the client had made after processing affect, with particular focus on self blame.
____ ____4. Therapist introduced Challenging Questions Sheet to help client challenge stuck points (Handout).
____ ____5. Therapist asked the client to challenge at least one stuck point a day, using the Challenging Questions Sheet, for homework.

SESSION 6: Challenging Questions:

____ ____1. Therapist reviewed homework using the CPT homework review form.
____ ____2. Therapist reviewed the Challenging Questions Sheet to address stuck point of self blame.
____ ____3. Therapist introduced the Faulty Thinking Patterns sheet (Handout).
____ ____4. Therapist helped client generate possible examples of faulty thinking patterns using the faulty thinking patterns sheet.
____ ____5. Therapist asked the client to identify stuck points and find examples for each faulty thinking pattern for homework.

SESSION 7: Faulty Thinking Patterns:

____ ____1. Therapist reviewed homework using the CPT homework review form.
____ ____2. Therapist and client reviewed the faulty thinking patterns sheet to address rape related stuck points.
____ ____3. Therapist introduced the Challenging Beliefs Worksheet with a rape example.

____ ____4. Therapist introduced the first of five problem areas: Safety issues related to Self and Others (Handout).
____ ____5. Therapist asked the client to identify stuck points, of which one had to relate to safety, and confront them using the challenging beliefs worksheet for homework.

SESSION 8: Safety Issues:

____ ____1. Therapist reviewed homework using the CPT homework review form.
____ ____2. Therapist reviewed the Challenging Beliefs Worksheet with the client to address rape related stuck points.
____ ____3. Therapist helped client confront faulty cognitions using the challenging beliefs worksheet and generate alternative beliefs.
____ ____4. Therapist introduced the second of five problem areas: Trust issues related to Self and Other (Handout).
____ ____5. Therapist asked the client to identify stuck points, of which one had to relate to trust, and confront them using the challenging beliefs worksheet for homework.

SESSION 9: Trust Issues:

____ ____1. Therapist reviewed homework using the CPT homework review form.
____ ____2. Therapist reviewed the Challenging Beliefs Worksheet with the client to challenge traumatic event related trust stuck points and generate alternative beliefs.
____ ____3. Therapist discussed judgment issues that may arise from stuck point related to trust, and discussed client's social support systems.
____ ____4. Therapist introduced the third of the five problem areas: Power/Control issues related to Self and Others (Handout).
____ ____5. Therapist asked the client to identify stuck points, of which one had to relate to power/control issues, and confront them using the challenging beliefs worksheet for homework.

SESSION 10: Power/Control Issues:

____ ____1.Therapist reviewed homework using the CPT homework review form.
____ ____2.Therapist discussed the connection between power/control and self blame, and helped client challenge faulty cognitions related to this area using the Challenging Beliefs Worksheet.
____ ____3.Therapist introduced the fourth of the five problem areas: Esteem issues related to self and others (Handout).
____ ____4.Therapist introduced the Identifying Assumptions sheet, and determined which assumptions were applicable to the client.
____ ____5a. Therapist asked the client to identify stuck points, of which one had to relate to esteem issues, and confront them using the challenging beliefs worksheet, for homework.

____ ____5b. Therapist asked the client to confront assumptions checked on the Identifying Assumptions sheet, using the Challenging Beliefs Worksheet for homework.
____ ____5c. Therapist asked the client to practice giving and receiving compliments for homework.
____ ____5d. Therapist asked the client to do at least one nice thing for herself each day for homework.

SESSION 11: Esteem Issues:

____ ____1.Therapist reviewed homework using the CPT homework review form.
____ ____2.Therapist helped client identify esteem issues and assumptions and challenge them using Challenging Beliefs Worksheet.
____ ____3.Therapist discussed clients' reactions to giving and receiving compliments and engaging in a pleasant activity.
____ ____4.Therapist introduced the fifth of the five problem areas: Intimacy issues related to self and others (Handout).
____ ____5a. Therapist asked the client to identify stuck points, one of which had to relate to intimacy issues, and confront them using the challenging beliefs worksheet for homework.
____ ____5b. Therapist asked the client to rewrite the impact statement for homework.
____ ____5c. Therapist asked the client to continue to give and receive compliments for homework.
____ ____5d. Therapist asked the client to continue to do at least one nice thing for herself each day for homework.

SESSION 12: Intimacy Issues:

____ ____1. Therapist reviewed homework, using the CPT homework review form.
____ ____2. Therapist helped client identify any remaining stuck points and confront them using the Challenging Beliefs Worksheet.
____ ____3. Therapist had client read the rewritten impact statement.
____ ____4. Therapist involved the client in reviewing therapy and progress.
____ ____5. Therapist helped client identify goals for the future, and helped her/him delineate strategies for meeting them.

Part II: Essential but not Unique Elements:

1. Therapist established good rapport by demonstrating:

____ ____1a. Genuineness
____ ____1b. Warmth
____ ____1c. Accurate Empathy
____ ____2. Therapist engaged with the client in a professional manner.
____ ____3. Therapist set an agenda at the beginning of the session, in an atmosphere of

collaboration and mutual understanding.
____ ____4. Therapist reviewed the homework with the client, using the CPT homework review form.
____ ____5. Therapist structured therapy time efficiently, and was able to keep the focus of the session on issues decided upon in setting the agenda.
____ ____6. Therapist elicited feedback about the client's reactions to the therapy and/or the therapist as part of the closing portion of the session.
____ ____7. Therapist assigned homework in a clear and specific manner.
____ ____8. Therapist asked the client about anticipated problems with completing homework, and problem solved to resolve them.

Part III: Additional Considerations:

1. Please give a rating of the therapist's overall CPT skills as demonstrated throughout the course of CPT.

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

2. Please write down any additional comments that you may have regarding the ratings on this tape including any departures from the protocol and the adequacy with which the therapist dealt with the problems that led to the departure.

Appendix B

Cognitive Processing Therapy (CPT): Therapist Adherence and Competence Protocol

Original Authors: Pallavi Nishith, Ph.D and Patricia A. Resick, Ph.D
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10-24-13

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Cognitive Processing Therapy:
Therapist Adherence and Competence Protocol

Therapist:_____ TapeType(Audio/Video)_____
Subject#:_____
Rater: _____ Rating Date: _____

Instructions

Adherence: For each item, assess **if the therapist demonstrated the particular behavior** described in the item. If so, put a check (✓) on the first line next to the item. If the therapist did not demonstrate the behavior, put an **X**. For e.g., in session 1, item 1, if the therapist educated the client about PTSD, the rated item would look like:

_✓_ ____ 1. Therapist educated the client about PTSD.

Competence: For each item, assess **how well the therapist carried out the particular behavior** described in the item. Use the rating scale described below to assign a number on the second line next to the item. For e.g., in session 1, item 1, if you think the therapist did a barely adequate job in educating the client about PTSD, then you would assign the number 2 on the second line next to the item. The rated item would now look like:

_✓_ __2__ 1. Therapist educated the client about PTSD.

Rating Scale for Assessing Competence:

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

Please don't leave any items blank. For all items assess therapist competency, taking into account client's presenting problems, their difficulty level, and the stage of therapy. **Use N/A for Not Applicable ratings of Adherence/Competence.**

***Description of Socratic Dialogue:** Therapist asks questions (e.g., clarifications, probing assumptions, requesting evidence, questioning perspectives, etc.) as part of a "guided discovery" process to assist the client in challenging the accuracy of thought processes and rectifying maladaptive beliefs that have prevented recovery.

SESSION 1: Introduction and Education Phase:

PID:_____ Date of session (if known): _____
Session #: _____ Duration of session (round to nearest minute): _____ min

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

1. ____ ____ Therapist educated the client about PTSD.
2. ____ ____ Therapist asked the client for a 5-minute account of the trauma and asked for clarifications based on information presented in this account and the information presented in the trauma interview.
3. ____ ____ Therapist presented the treatment rationale using the Information Processing Theory and gave the handout on stuck points.
4. ____ ____ Therapist presented the client with an overview of the 12-session treatment.
5. ____ ____ Therapist asked client to write an Impact statement for homework.

Identifying Stuck Points:

6. ____ ____ The therapist elicits examples of stuck points (verbally or written on the stuck point log).

7. ____ ____Therapist hones stuck points (i.e., identifies stuck points accurately).

Socratic Questioning:

8. ____ ____ Therapist uses Socratic questions.

9. ____ What percentage of dialogue was Socratic in nature (use the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

10. ____ What percentage of dialogue was authoritative/directive in nature (use the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

Out-of-Session Practice Assignments:

11. ____ ____ Therapist introduces the idea of out-of-session practice assignments and emphasizes the importance of homework compliance.

Emphasis on the Expression of Natural Affect:

12. ____ ____ Therapist **encourages** the expression of natural affect.

Remaining Trauma Focused:

13. ____ ____ Therapist remains trauma focused (Note: trauma focused = topics included in the treatment protocol and any challenging of maladaptive assimilated or over-accommodated cognitions).

Essential but not Unique Elements:

14. Therapist established good rapport by demonstrating:
    a. ____ ____Genuineness
    b. ____ ____Warmth
    c. ____ ____Accurate Empathy
15. ____ ____Therapist engaged with the client in a professional manner.
16. ____ ____Therapist set an agenda at the beginning of the session, in an atmosphere of collaboration and mutual understanding.
17. ____ ____Therapist structured therapy time efficiently, and was able to keep the focus of the session on issues decided upon in setting the agenda.
18. ____ ____Therapist elicited feedback about the client's reactions to the therapy and/or the therapist as part of the closing portion of the session.
19. ____ ____Therapist assigned homework in a clear and specific manner.
20. ____ ____Therapist asked the client about anticipated problems with completing homework, and problem solved to resolve them.

Proscribed Elements:

21. ____ Therapist implemented an intervention not specifically included in the protocol (e.g., mindfulness exercise, behavioral intervention, relaxation training, fear/avoidance hierarchy, SUDS ratings). Please write Y or N.
    a. If Yes, what type of intervention?
    _____

Client Behaviors Section

Note: Some of the scales in the client section are modified from the therapist section!

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22. _____ **Is client <u>avoiding</u> engagement with the therapist?**

Examples (high score): client appeared to lack participation via having minimal responses, repeatedly saying "I don't know," having nonverbal gestures of disinterest (e.g., checking phone, looking repeatedly at the clock, etc.)
Examples (0/low score)-answered questions, interacted regularly with the therapist, appeared to put effort & interest into the session

0	1	2	3	4	5	6	7
Not at all	Barely	Very Minimal	Minimal	Moderate	Strongly	Very	Completely

23. _____ **Is client <u>avoiding</u> engagement with the trauma memory?**

Examples (high score): client appeared to effortfully avoid the memory (e.g., changed the topic away from the trauma)
Examples (0/low score): client appeared open to discuss/engage with trauma memory (e.g., remained trauma-focused)

0	1	2	3	4	5	6	7
None	Barely	Very Minimal	Minimal	Moderate	Much	A lot	Extreme

24. _____ **Client appears to understand concept of stuck point.**

Examples (high score): client able to generate own stuck point, discuss concept/definition of stuck point
Examples (0/low score): client unable to identify examples of his/her own stuck points, unable to explain/define stuck point
*Note: Insert N/A if no opportunity for client to demonstrate understanding.

0	1	2	3	4	5	6	7
Not at all	Poorly	Barely	Mediocre	Somewhat	Mostly	Quite well	Completely

25. _____ **Rate the level of client cognitive flexibility in the space using the scale below.**

Examples (high score): client is able to integrate new information to alter existing stuck point, can come up with alternative, more flexible beliefs
Examples (0/low score): client continues to believe stuck point and does not appear to take into account new information or evidence (e.g, they hold tightly to their stuck point)

0	1	2	3	4	5	6	7
Completely Rigid	Poor	Mediocre	Somewhat	Mostly	Very	Open Mind	

Resistant

26. **Rate how much client expresses <u>all</u> the following emotions based on Client Emotional Arousal Scale-III ratings (1-7).**

Modal rating= overall/average amount of that emotion for the session
Peak rating= most extreme amount of that emotion the client exhibits in session
Estimated % of session= approximate % of session the client exhibited that emotion
Example: If client cries throughout the entire session, sadness would be 100% duration
*Note: Please only rate the amount of emotion the client <u>exhibits</u>, not what he/she verbally reports.
*Note- If any other emotions that are not listed are expressed, please list/rate them in Other column(s).

	Sadness (crying, shaky voice, long pause)	Anger (yelling, loud tone of voice, physical movements)	Anxiety/Fear (hunch over, crying, shaking)	Other _____ (insert name of emotion)	Other _____ (insert name of emotion)	Did client appear num (express n emotions)
Modal rating						Y or N
Peak rating						
Estimated % of session						_____ % session

<u>Client Emotional Arousal Scale-III</u>

1	Person does not express emotions. Voice or gestures **do not** disclose any emotional arousal
2	Person may acknowledge emotions, but there is **very little** arousal in voice or body ▪ there is no disruption of usual speech patterns ▪ any arousal is almost **completely restricted**
3	At this level of arousal as well as higher levels, the person acknowledges emotions Arousal is **mild** in voice and body ▪ very little emotional overflow ▪ any arousal is still **very restricted** ▪ usual speech patterns are only **mildly disrupted**
4	Arousal is **moderate** in voice and body ▪ emotional voice is present: ordinary speech patterns are **moderately** disrupted by emotional overflow as represented by changes in accentuation patterns, unevenness of pace, changes in pitch ▪ although there is some freedom from control and restraints, arousal may still be **somewhat restricted**
5	Arousal is **fairly intense and full** in voice and body ▪ emotion overflows into speech pattern to a great extent: speech patterns deviate

	markedly from the client's baseline, and are fragmented or broken ▪ elevated loudness and volume ▪ arousal seems **fairly unrestricted**
6	Arousal is **very intense and extremely full** as the person is freely expressing emotion, with voice and body. ▪ usual speech patterns are **extremely disrupted** as indicated by changes in accentuation patterns, unevenness of pace, changes in pitch, and volume or force of voice ▪ spontaneous expression of emotion and there is **almost no sense of restriction**
7	Arousal is **extremely intense and full** in voice and body ▪ usual speech patterns are **completely disrupted** by emotional overflow ▪ the expression is **completely spontaneous and unrestricted** ▪ arousal appears uncontrollable and enduring. ▪ falling apart quality: although arousal can be a completely unrestricted therapeutic experience, it may also be a disruptive negative experience in which the clients feels like they are falling apart **control = containment vs control = restriction** * The distinguishing feature between level 6 and level 7 is that in level 6 there is the sense that although a person's expression may be fairly unrestricted, this individual would be able to contain or control his or her arousal, whereas in level 7, a person's expression is completely unrestricted and there is the sense that emotional arousal would not be within this person's control.

SESSION 2: The Meaning of the Event:

PID:_____ Date of session (if known): _____
Session #: _____ Duration of session (round to nearest minute): _____ min

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

27. ____ ____Therapist reviewed homework using the CPT Homework Review form.
28. ____ ____Therapist reviewed concepts from the first session: PTSD, information processing theory, and treatment rationale.
29. ____ ____Therapist had client read her impact statement.
30. ____ ____If the client did not do the homework, the therapist had client describe meaning of events orally.
31. ____ ____Therapist discussed the meaning of the impact statement with the client and introduced the handout on four basic emotions.
32. ____ ____Therapist helped client differentiate between thoughts and feelings and introduced the ABC sheet to help client with this.
33. ____ ____Therapist asked client to fill out at least one ABC sheet a day with examples, past or current, related to the trauma, for homework.

Identifying Stuck Points:

34. ____ ____The therapist elicits examples of stuck points (verbally or written on the stuck point log).
35. ____ ____Therapist hones stuck points (i.e., identifies stuck points accurately).

Socratic Questioning:

36. ____ ____ Therapist uses Socratic questions.
37. ____ What percentage of dialogue was Socratic in nature (choose 1-5 on the scale below).

1	2	3	4	5
_____ 0-20%	21-40%	41-60%	61-80%	81-100%

38. ____ What percentage of dialogue was authoritative/directive in nature (use the scale below).

1	2	3	4	5
_____ 0-20%	21-40%	41-60%	61-80%	81-100%

Challenging Assimilation before Over-Accommodation:

39. ____ ____Therapist helps the client to identify <u>assimilated</u> stuck points.
40. ____ ____Therapist helps the client to identify <u>over-accommodated</u> stuck points.
41. ____ ____Therapist prioritizes challenging assimilated stuck points over over-accommodated stuck points.

Out-of-Session Practice Assignments:

42. ____ ____If the client did not complete the practice assignment, the therapist employs an intervention strategy aimed at increasing compliance (e.g., conversation about the rationale for homework compliance; discussion about the role of avoidance in maintaining PTSD, etc.)
43. ____ ____If the client did not complete the practice assignment, the therapist reassigns it in addition to the current week's assignment.

Emphasis on the Expression of Natural Affect:

44. ____ ____ Therapist encourages the expression of natural affect.

Remaining Trauma Focused:

45. ____ ____ Therapist remains trauma focused (Note: trauma focused = topics included in the treatment protocol and any challenging of maladaptive assimilated or over-accommodated cognitions).

Use of Worksheets in Session:

46. ____ Did the therapist write anything on a worksheet? Write Y or N.
47. ____ Did the client write anything on a worksheet? Write Y or N.
48. ____ Did the therapist and client review a worksheet? Write Y or N.

Essential but not Unique Elements:

49. Therapist established good rapport by demonstrating:
    a. ____ ____Genuineness
    b. ____ ____Warmth
    c. ____ ____Accurate Empathy
50. ____ ____Therapist engaged with the client in a professional manner.
51. ____ ____Therapist set an agenda at the beginning of the session, in an atmosphere of collaboration and mutual understanding.
52. ____ ____Therapist structured therapy time efficiently, and was able to keep the focus of the session on issues decided upon in setting the agenda.
53. ____ ____Therapist elicited feedback about the client's reactions to the therapy and/or the therapist as part of the closing portion of the session.
54. ____ ____Therapist assigned homework in a clear and specific manner.
55. ____ ____Therapist asked the client about anticipated problems with completing homework, and problem solved to resolve them.

Proscribed Elements:

56. ____ Therapist implemented an intervention not specifically included in the protocol (e.g., mindfulness exercise, behavioral intervention, relaxation training, fear/avoidance hierarchy, SUDS ratings). Please write Y or N.
    a. If Yes, what type of intervention?
       _____

Client Behaviors Section

Note: Some of the scales in the client section are modified from the therapist section!

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57. _____ **Is client <u>avoiding</u> engagement with the therapist?**

Examples (high score): client appeared to lack participation via having minimal responses, repeatedly saying "I don't know," having nonverbal gestures of disinterest (e.g., checking phone, looking repeatedly at the clock, etc.)
Examples (0/low score)-answered questions, interacted regularly with the therapist, appeared to put effort & interest into the session

0	1	2	3	4	5	6	7
Not at all	Barely	Very Minimal	Minimal	Moderate	Strongly	Very	Completely

58. _____ **Is client <u>avoiding</u> engagement with the trauma memory?**

Examples (high score): client appeared to effortfully avoid the memory (e.g., changed the topic away from the trauma)
Examples (0/low score): client appeared open to discuss/engage with trauma memory (e.g., remained trauma-focused)

0	1	2	3	4	5	6	7
None	Barely	Very Minimal	Minimal	Moderate	Much	A lot	Extreme

59. _____ **Client appears to understand concept of stuck point.**

Examples (high score): client able to generate own stuck point, discuss concept/definition of stuck point
Examples (0/low score): client unable to identify examples of his/her own stuck points, unable to explain/define stuck point
*Note: Insert N/A if no opportunity for client to demonstrate understanding.

0	1	2	3	4	5	6	7
Not at all	Poorly	Barely	Mediocre	Somewhat	Mostly	Quite well	Completely

60. _____ **Client returned to session bringing ATTEMPTED practice assignment <u>due at this session</u> <u>(Session 2: impact statement)</u>.**

*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home/ Lost	None mentioned	Other reason (please write in box b

61. _____ **Rate the level of client cognitive flexibility in the space using the scale below.**

Examples (high score): client is able to integrate new information to alter existing stuck point, can come up with alternative, more flexible beliefs
Examples (0/low score): client continues to believe stuck point and does not appear to take into account new information or evidence (e.g, they hold tightly to their stuck point)

0 1 2 3 4 5 6 7

Completely Resistant Rigid Poor Mediocre Somewhat Mostly Very Open Mind

62. **Rate how much client expresses <u>all</u> the following emotions based on Client Emotional Arousal Scale-III ratings (1-7).**

Modal rating= overall/average amount of that emotion for the session
Peak rating= most extreme amount of that emotion the client exhibits in session
Estimated % of session= approximate % of session the client exhibited that emotion
Example: If client cries throughout the entire session, sadness would be 100% duration
*Note: Please only rate the amount of emotion the client <u>exhibits</u>, not what he/she verbally reports.
*Note- If any other emotions that are not listed are expressed, please list/rate them in Other column(s).

	Sadness (crying, shaky voice, long pause)	Anger (yelling, loud tone of voice, physical movements)	Anxiety/Fear (hunch over, crying, shaking)	Other _____ (insert name of emotion)	Other _____ (insert name of emotion)	Did client appear num (expresses emotions)
Modal rating						Y or N
Peak rating						
Estimated % of session						_____ % session

SESSION 3: Identification of Thoughts and Feelings:

PID:_____ Date of session (if known): _____
Session #: _____ Duration of session (round to nearest minute): _____ min

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

63. ____ ____Therapist reviewed homework using the CPT Homework Review form.
64. ____ ____Therapist reviewed ABC sheets with client, and helped her further differentiate between thoughts and feelings.
65. ____ ____Therapist helped client identify stuck points and offered alternative hypotheses for client's explanation of the event, in a tentative way.
66. ____ ____Therapist further explored the stuck point of self-blame, using Socratic questioning.
67. ____ ____Therapist asked client to write an account of the trauma, with sensory details, and read over daily for homework.

Identifying Stuck Points:

68. ____ ____Therapist hones stuck points (i.e., identifies stuck points accurately).

Socratic Questioning:

69. ____ ____ Therapist uses Socratic questions.
70. ____ What percentage of dialogue was Socratic in nature (choose 1-5 on the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

71. ____ What percentage of dialogue was authoritative/directive in nature (use the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

Challenging Assimilation before Over-Accommodation:

72. ____ ____Therapist prioritizes challenging assimilated stuck points over over-accommodated stuck points.

Out-of-Session Practice Assignments:

73. ____ ____If the client does not bring in attempted practice assignment, the therapist then proceeds with completing the assignment together in session (either verbally or using a worksheet).
74. ____ ____If the client did not complete the practice assignment, the therapist employs an intervention strategy aimed at increasing compliance (e.g., conversation about the rationale for homework compliance; discussion about the role of avoidance in maintaining PTSD, etc.)
75. ____ ____If the client did not complete the practice assignment, the therapist reassigns it in addition to the current week's assignment.

Emphasis on the Expression of Natural Affect:

76. ____ ____ Therapist encourages the expression of natural affect.

Remaining Trauma Focused:

77. ____ ____ Therapist remains trauma focused (Note: trauma focused = topics included in the treatment protocol and any challenging of maladaptive assimilated or over-accommodated cognitions).

Use of Worksheets in Session:

78. ____ Did the therapist write anything on a worksheet? Write Y or N.
79. ____ Did the client write anything on a worksheet? Write Y or N.
80. ____ Did the therapist and client review a worksheet? Write Y or N.

Essential but not Unique Elements:

81. Therapist established good rapport by demonstrating:
    a. ____ ____Genuineness
    b. ____ ____Warmth
    c. ____ ____Accurate Empathy
82. ____ ____Therapist engaged with the client in a professional manner.
83. ____ ____Therapist set an agenda at the beginning of the session, in an atmosphere of collaboration and mutual understanding.
84. ____ ____Therapist structured therapy time efficiently, and was able to keep the focus of the session on issues decided upon in setting the agenda.
85. ____ ____Therapist elicited feedback about the client's reactions to the therapy and/or the therapist as part of the closing portion of the session.
86. ____ ____Therapist assigned homework in a clear and specific manner.
87. ____ ____Therapist asked the client about anticipated problems with completing homework, and problem solved to resolve them.

Proscribed Elements:

88. ____ Therapist implemented an intervention not specifically included in the protocol (e.g., mindfulness exercise, behavioral intervention, relaxation training, fear/avoidance hierarchy, SUDS ratings). Please write Y or N.

a. If Yes, what type of intervention?

_____

Client Behaviors Section

Note: Some of the scales in the client section are modified from the therapist section!

---

89. _____ **Is client <u>avoiding</u> engagement with the therapist?**

Examples (high score): client appeared to lack participation via having minimal responses, repeatedly saying "I don't know," having nonverbal gestures of disinterest (e.g., checking phone, looking repeatedly at the clock, etc.)
Examples (0/low score)-answered questions, interacted regularly with the therapist, appeared to put effort & interest into the session

0	1	2	3	4	5	6	7
Not at all	Barely	Very Minimal	Minimal	Moderate	Strongly	Very	Completely

90. _____ **Is client <u>avoiding</u> engagement with the trauma memory?**

Examples (high score): client appeared to effortfully avoid the memory (e.g., changed the topic away from the trauma)
Examples (0/low score): client appeared open to discuss/engage with trauma memory (e.g., remained trauma-focused)

0	1	2	3	4	5	6	7
None	Barely	Very Minimal	Minimal	Moderate	Much	A lot	Extreme

91. _____ **Client appears to understand concept of stuck point.**

Examples (high score): client able to generate own stuck point, discuss concept/definition of stuck point
Examples (0/low score): client unable to identify examples of his/her own stuck points, unable to explain/define stuck point
*Note: Insert N/A if no opportunity for client to demonstrate understanding.

0	1	2	3	4	5	6	7
Not at all	Poorly	Barely	Mediocre	Somewhat	Mostly	Quite well	Completely

92. _____ **Client returned to session bringing ATTEMPTED practice assignment due at this session (Session 3: ABC sheets).**

*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home/ Lost	None mentioned	Other reason (please write in box b

93. _____ **Client returned to session bringing ATTEMPTED re-assigned practice assignment.**
Insert name of assignment _____.

*Note: This will only be applicable if therapist re-assigned homework from previous session to be completed in this session (e.g., if they did not complete impact statement from previous session, and therapist asked client to bring it to this session). Write N/A if not applicable.
*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.
*Note: If more than 1 task are re-assigned, if the client brings both, mark Y, if he/she brings none, mark N, if they bring 1, but not both, mark P (partial). If Y or P, check appropriate box below.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home/ Lost	None mentioned	Other reason (please write in box b

94. **Estimation of the # of total number of worksheets client brought to session (if possible): _____**

*Note: If no way to tell, please insert 666 (missing)

95. _____ **Rate the level of client cognitive flexibility in the space using the scale below.**

Examples (high score): client is able to integrate new information to alter existing stuck point, can come up with alternative, more flexible beliefs
Examples (0/low score): client continues to believe stuck point and does not appear to take into account new information or evidence (e.g, they hold tightly to their stuck point)

0 1 2 3 4 5 6 7

Completely Resistant Rigid Poor Mediocre Somewhat Mostly Very Open Mind

96. **Rate how much client expresses <u>all</u> the following emotions based on Client Emotional Arousal Scale-III ratings (1-7).**

Modal rating= overall/average amount of that emotion for the session
Peak rating= most extreme amount of that emotion the client exhibits in session
Estimated % of session= approximate % of session the client exhibited that emotion
Example: If client cries throughout the entire session, sadness would be 100% duration
*Note: Please only rate the amount of emotion the client <u>exhibits</u>, not what he/she verbally reports.
*Note- If any other emotions that are not listed are expressed, please list/rate them in Other column(s).

	Sadness (crying, shaky voice, long pause)	Anger (yelling, loud tone of voice, physical movements)	Anxiety/Fear (hunch over, crying, shaking)	Other _____ (insert name of emotion)	Other _____ (insert name of emotion)	Did client appear num (expresses emotions)
Modal rating						Y or N
Peak rating						
Estimated % of session						_____ % session

SESSION 4: Remembering the Traumatic Event:

PID:_____ Date of session (if known): _____
Session #: _____ Duration of session (round to nearest minute): _____ min

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

97. ____ ____Therapist reviewed the homework using the CPT homework review form.
98. ____ ____Therapist had client read the trauma account aloud.
99. ____ ____If the client did not write the traumatic event account, therapist had the client recount the traumatic event during session.
100. ____ ____Therapist used client's expression of affect or lack thereof to identify stuck points.
101. ____ ____Therapist continued to challenge client's stuck point related to self-blame using cognitive techniques.
102. ____ ____Therapist asked the client to rewrite the traumatic event account not as a police report, but in more detail, including all the sensory aspects, for homework.

Identifying Stuck Points:

103. ____ ____Therapist hones stuck points (i.e., identifies stuck points accurately).

Socratic Questioning:

104. ____ ____ Therapist uses Socratic questions.
105. ____ What percentage of dialogue was Socratic in nature (choose 1-5 on the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

106. ____ What percentage of dialogue was authoritative/directive in nature (use the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

Challenging Assimilation before Over-Accommodation:

107. ____ ____Therapist prioritizes challenging assimilated stuck points over over-accommodated stuck points.

Out-of-Session Practice Assignments:

108. ____ ____If the client did not complete the practice assignment, the therapist employs an intervention strategy aimed at increasing compliance (e.g., conversation about the rationale for homework compliance; discussion about the role of avoidance in maintaining PTSD, etc.)
109. ____ ____If the client did not complete the practice assignment, the therapist reassigns it in addition to the current week's assignment.

Emphasis on the Expression of Natural Affect:

110. ____ ____ Therapist **emphasizes** the expression of natural affect.

Remaining Trauma Focused:

111. ____ ____ Therapist remains trauma focused (Note: trauma focused = topics included in the treatment protocol and any challenging of maladaptive assimilated or over-accommodated cognitions).

Use of Worksheets in Session:

112. ____ Did the therapist write anything on a worksheet? Write Y or N.
113. ____ Did the client write anything on a worksheet? Write Y or N.
114. ____ Did the therapist and client review a worksheet? Write Y or N.

Essential but not Unique Elements:

115. Therapist established good rapport by demonstrating:
    a. ____ ____Genuineness
    b. ____ ____Warmth
    c. ____ ____Accurate Empathy
116. ____ ____Therapist engaged with the client in a professional manner.
117. ____ ____Therapist set an agenda at the beginning of the session, in an atmosphere of collaboration and mutual understanding.
118. ____ ____Therapist structured therapy time efficiently, and was able to keep the focus of the session on issues decided upon in setting the agenda.
119. ____ ____Therapist elicited feedback about the client's reactions to the therapy and/or the therapist as part of the closing portion of the session.
120. ____ ____Therapist assigned homework in a clear and specific manner.
121. ____ ____ Therapist asked the client about anticipated problems with completing homework, and problem solved to resolve them.

Proscribed Elements:

122. ____ Therapist implemented an intervention not specifically included in the protocol (e.g., mindfulness exercise, behavioral intervention, relaxation training, fear/avoidance hierarchy, SUDS ratings). Please write Y or N.
    a. If Yes, what type of intervention?
    _____

Client Behaviors Section

Note: Some of the scales in the client section are modified from the therapist section!

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123. _____ **Is client <u>avoiding</u> engagement with the therapist?**

Examples (high score): client appeared to lack participation via having minimal responses, repeatedly saying "I don't know," having nonverbal gestures of disinterest (e.g., checking phone, looking repeatedly at the clock, etc.)
Examples (0/low score)-answered questions, interacted regularly with the therapist, appeared to put effort & interest into the session

0	1	2	3	4	5	6	7
Not at all	Barely	Very Minimal	Minimal	Moderate	Strongly	Very	Completely

124. _____ **Is client <u>avoiding</u> engagement with the trauma memory?**

Examples (high score): client appeared to effortfully avoid the memory (e.g., changed the topic away from the trauma)
Examples (0/low score): client appeared open to discuss/engage with trauma memory (e.g., remained trauma-focused)

0	1	2	3	4	5	6	7
None	Barely	Very Minimal	Minimal	Moderate	Much	A lot	Extreme

125. _____ **Client appears to understand concept of stuck point.**

Examples (high score): client able to generate own stuck point, discuss concept/definition of stuck point
Examples (0/low score): client unable to identify examples of his/her own stuck points, unable to explain/define stuck point

*Note: Insert N/A if no opportunity for client to demonstrate understanding.

0	1	2	3	4	5	6	7
Not at all	Poorly	Barely	Mediocre	Somewhat	Mostly	Quite well	Completely

126. _____ **Client returned to session bringing ATTEMPTED practice assignment due at this session (Session 4: trauma account).**

*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home/ Lost	None mentioned	Other reason (please write in box b

127. _____ **Client returned to session bringing ATTEMPTED practice assignment due at this session (Session 4: ABC sheets).**

*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home/ Lost	None mentioned	Other reason (please write in box b

128. _____ **Client returned to session bringing ATTEMPTED re-assigned practice assignment.**
Insert name of assignment _____.

*Note: This will only be applicable if therapist re-assigned homework from previous session to be completed in this session (e.g., if they did not complete impact statement from previous session, and therapist asked client to bring it to this session). Write N/A if not applicable.

*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)

Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.

*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.

*Note: If more than 1 task are re-assigned, if the client brings both, mark Y, if he/she brings none, mark N, if they bring 1, but not both, mark P (partial). If Y or P, check appropriate box below.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home/ Lost	None mentioned	Other reason (please write in box b

129. **Estimation of the # of total number of worksheets client brought to session (if possible):** _____

*Note: If no way to tell, please insert 666 (missing)

130. _____ **Rate the level of client cognitive flexibility in the space using the scale below.**

Examples (high score): client is able to integrate new information to alter existing stuck point, can come up with alternative, more flexible beliefs
Examples (0/low score): client continues to believe stuck point and does not appear to take into account new information or evidence (e.g, they hold tightly to their stuck point)

0 1 2 3 4 5 6 7

Completely Rigid Resistant Poor Mediocre Somewhat Mostly Very Open Mind

131. **Rate how much client expresses <u>all</u> the following emotions based on Client Emotional Arousal Scale-III ratings (1-7).**

Modal rating= overall/average amount of that emotion for the session
Peak rating= most extreme amount of that emotion the client exhibits in session
Estimated % of session= approximate % of session the client exhibited that emotion
Example: If client cries throughout the entire session, sadness would be 100% duration

*Note: Please only rate the amount of emotion the client <u>exhibits</u>, not what he/she verbally reports.

*Note- If any other emotions that are not listed are expressed, please list/rate them in Other column(s).

	Sadness (crying, shaky voice, long pause)	Anger (yelling, loud tone of voice, physical movements)	Anxiety/Fear (hunch over, crying, shaking)	Other _____ (insert name of emotion)	Other _____ (insert name of emotion)	Did client appear num (expresses emotions)
Modal rating						Y or N
Peak rating						
Estimated % of session						_____ % session

SESSION 5: Identification of Stuck Points:

PID:_____ Date of session (if known): _____
Session #: _____ Duration of session (round to nearest minute): _____ min

1 2 3 4 5 6 7

Poor Barely Adequate Mediocre Satisfactory Good Very Good Excellent

132. ____ ____Therapist reviewed the homework using the CPT homework review form.
133. ____ ____Therapist had client read the second traumatic event account out loud and helped client identify differences between the first and second write ups of the account.
134. ____ ____Therapist involved client in challenging assumptions and conclusions, which the client had made after processing affect, with particular focus on self blame.
135. ____ ____Therapist introduced Challenging Questions Sheet to help client challenge stuck points (Handout).
136. ____ ____Therapist asked the client to challenge at least one stuck point a day, using the Challenging Questions Sheet for homework.

Identifying Stuck Points:

137. ____ ____Therapist hones stuck points (i.e., identifies stuck points accurately).

Socratic Questioning:

138. ____ ____ Therapist uses Socratic questions.
139. ____ What percentage of dialogue was Socratic in nature (choose 1-5 on the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

140. ____ What percentage of dialogue was authoritative/directive in nature (use the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

Challenging Assimilation before Over-Accommodation:

141. ____ ____Therapist prioritizes challenging assimilated stuck points over over-accommodated stuck points.

Out-of-Session Practice Assignments:

142. ____ ____If the client does not bring in attempted practice assignment, the therapist then proceeds with completing the assignment together in session (either verbally or using a worksheet).
143. ____ ____If the client did not complete the practice assignment, the therapist employs an intervention strategy aimed at increasing compliance (e.g., conversation about the rationale for homework compliance; discussion about the role of avoidance in maintaining PTSD, etc.)
144. ____ ____If the client did not complete the practice assignment, the therapist reassigns it in addition to the current week's assignment.

Emphasis on the Expression of Natural Affect:

145. ____ ____ Therapist **emphasizes** the expression of natural affect.

Remaining Trauma Focused:

146. ____ ____ Therapist remains trauma focused (Note: trauma focused = topics included in the treatment protocol and any challenging of maladaptive assimilated or over-accommodated cognitions).

Use of Worksheets in Session:

147. ____ Did the therapist write anything on a worksheet? Write Y or N.
148. ____ Did the client write anything on a worksheet? Write Y or N.
149. ____ Did the therapist and client review a worksheet? Write Y or N.

Essential but not Unique Elements:

150. Therapist established good rapport by demonstrating:
    a. ____ ____Genuineness
    b. ____ ____Warmth
    c. ____ ____Accurate Empathy
151. ____ ____Therapist engaged with the client in a professional manner.
152. ____ ____Therapist set an agenda at the beginning of the session, in an atmosphere of collaboration and mutual understanding.
153. ____ ____Therapist structured therapy time efficiently, and was able to keep the focus of the session on issues decided upon in setting the agenda.
154. ____ ____Therapist elicited feedback about the client's reactions to the therapy and/or the therapist as part of the closing portion of the session.
155. ____ ____Therapist assigned homework in a clear and specific manner.
156. ____ ____Therapist asked the client about anticipated problems with completing homework, and problem solved to resolve them.

Proscribed Elements:

157. ____ Therapist implemented an intervention not specifically included in the protocol (e.g., mindfulness exercise, behavioral intervention, relaxation training, fear/avoidance hierarchy, SUDS ratings). Please write Y or N.
    a. If Yes, what type of intervention?
    _____

Client Behaviors Section

Note: Some of the scales in the client section are modified from the therapist section!

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158. _____ **Is client <u>avoiding</u> engagement with the therapist?**

Examples (high score): client appeared to lack participation via having minimal responses, repeatedly saying "I don't know," having nonverbal gestures of disinterest (e.g., checking phone, looking repeatedly at the clock, etc.)
Examples (0/low score)-answered questions, interacted regularly with the therapist, appeared to put effort & interest into the session

0	1	2	3	4	5	6	7
Not	Barely	Very Minimal	Minimal	Moderate	Strongly	Very	Completely

at all

159. _____ **Is client <u>avoiding</u> engagement with the trauma memory?**

Examples (high score): client appeared to effortfully avoid the memory (e.g., changed the topic away from the trauma)
Examples (0/low score): client appeared open to discuss/engage with trauma memory (e.g., remained trauma-focused)

0	1	2	3	4	5	6	7
None	Barely	Very Minimal	Minimal	Moderate	Much	A lot	Extreme

160. _____ **Client appears to understand concept of stuck point.**

Examples (high score): client able to generate own stuck point, discuss concept/definition of stuck point
Examples (0/low score): client unable to identify examples of his/her own stuck points, unable to explain/define stuck point
*Note: Insert N/A if no opportunity for client to demonstrate understanding.

0	1	2	3	4	5	6	7
Not at all	Poorly	Barely	Mediocre	Somewhat	Mostly	Quite well	Completely

161. _____ **Client returned to session bringing ATTEMPTED practice assignment <u>due at this session</u> <u>(Session 5: trauma account)</u>.**

*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home	None mentioned	Other reason (please write in box b

162. _____ **Client returned to session bringing ATTEMPTED practice assignment due at this session (Session 5: ABC sheets).**

*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home	None mentioned	Other reason (please write in box b

163. _____ **Client returned to session bringing ATTEMPTED re-assigned practice assignment.**
Insert name of assignment _____.

*Note: This will only be applicable if therapist re-assigned homework from previous session to be completed in this session (e.g., if they did not complete impact statement from previous session, and therapist asked client to bring it to this session). Write N/A if not applicable.
*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.
*Note: If more than 1 task are re-assigned, if the client brings both, mark Y, if he/she brings none, mark N, if they bring 1, but not both, mark P (partial). If Y or P, check appropriate box below.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home	None mentioned	Other reason (please write in box b

164. **Estimation of the # of total number of worksheets client brought to session (if possible): _____**

*Note: If no way to tell, please insert 666 (missing)

165. _____ **Rate the level of client cognitive flexibility in the space using the scale below.**

Examples (high score): client is able to integrate new information to alter existing stuck point, can come up with alternative, more flexible beliefs
Examples (0/low score): client continues to believe stuck point and does not appear to take into account new information or evidence (e.g, they hold tightly to their stuck point)

0 1 2 3 4 5 6 7

Completely Resistant Rigid Poor Mediocre Somewhat Mostly Very Open Mind

166. **Rate how much client expresses <u>all</u> the following emotions based on Client Emotional Arousal Scale-III ratings (1-7).**

Modal rating= overall/average amount of that emotion for the session
Peak rating= most extreme amount of that emotion the client exhibits in session
Estimated % of session= approximate % of session the client exhibited that emotion
Example: If client cries throughout the entire session, sadness would be 100% duration
*Note: Please only rate the amount of emotion the client <u>exhibits</u>, not what he/she verbally reports.
*Note- If any other emotions that are not listed are expressed, please list/rate them in Other column(s).

	Sadness (crying, shaky voice, long pause)	Anger (yelling, loud tone of voice, physical movements)	Anxiety/Fear (hunch over, crying, shaking)	Other _____ (insert name of emotion)	Other _____ (insert name of emotion)	Did client appear nun (expresses emotions)
Modal rating						Y or N
Peak rating						
Estimated % of session						_____ % session

SESSION 6: Challenging Questions:

PID:_____ Date of session (if known): _____
Session #: _____ Duration of session (round to nearest minute): _____ min

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

167. ____ ____Therapist reviewed homework using the CPT homework review form.
168. ____ ____Therapist reviewed the Challenging Questions Sheet to address stuck point of self blame.
169. ____ ____Therapist introduced the Faulty Thinking Patterns sheet (Handout).
170. ____ ____Therapist helped client generate possible examples of faulty thinking patterns using the faulty thinking patterns sheet.
171. ____ ____Therapist asked the client to identify stuck points and find examples for each faulty thinking pattern for homework.

Identifying Stuck Points:

172. ____ ____Therapist hones stuck points (i.e., identifies stuck points accurately).

Socratic Questioning:

173. ____ ____ Therapist uses Socratic questions.
174. ____ What percentage of dialogue was Socratic in nature (choose 1-5 on the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

175. ____ What percentage of dialogue was authoritative/directive in nature (use the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

Challenging Assimilation before Over-Accommodation:

176. ____ ____If assimilation is evident, therapist prioritizes challenging assimilated stuck points over over-accommodated stuck points (if no assimilation evident, write n/a).

Out-of-Session Practice Assignments:

177. ____ ____If the client does not bring in attempted practice assignment, the therapist then proceeds with completing the assignment together in session (either verbally or using a worksheet).
178. ____ ____If the client did not complete the practice assignment, the therapist employs an intervention strategy aimed at increasing compliance (e.g., conversation about the rationale for homework compliance; discussion about the role of avoidance in maintaining PTSD, etc.)
179. ____ ____If the client did not complete the practice assignment, the therapist reassigns it in addition to the current week's assignment.

Emphasis on the Expression of Natural Affect:

180. ____ ____ Therapist **encourages** the expression of natural affect (if no longer applicable, write n/a).

Remaining Trauma Focused:

181. ____ ____ Therapist remains trauma focused (Note: trauma focused = topics included in the treatment protocol and any challenging of maladaptive assimilated or over- accommodated cognitions).

Use of Worksheets in Session:

182. ____ Did the therapist write anything on a worksheet? Write Y or N.
183. ____ Did the client write anything on a worksheet? Write Y or N.
184. ____ Did the therapist and client review a worksheet? Write Y or N.

Essential but not Unique Elements:

185. Therapist established good rapport by demonstrating:
    a. ____ ____Genuineness
    b. ____ ____Warmth
    c. ____ ____Accurate Empathy
186. ____ ____Therapist engaged with the client in a professional manner.
187. ____ ____Therapist set an agenda at the beginning of the session, in an atmosphere of collaboration and mutual understanding.
188. ____ ____Therapist structured therapy time efficiently, and was able to keep the focus of the session on issues decided upon in setting the agenda.
189. ____ ____Therapist elicited feedback about the client's reactions to the therapy and/or the therapist as part of the closing portion of the session.
190. ____ ____Therapist assigned homework in a clear and specific manner.
191. ____ ____Therapist asked the client about anticipated problems with completing homework, and problem solved to resolve them.

Proscribed Elements:

192. ____ Therapist implemented an intervention not specifically included in the protocol (e.g., mindfulness exercise, behavioral intervention, relaxation training, fear/avoidance hierarchy, SUDS ratings). Please write Y or N.

a. If Yes, what type of intervention?

_____

Client Behaviors Section

Note: Some of the scales in the client section are modified from the therapist section!

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193. _____ **Is client <u>avoiding</u> engagement with the therapist?**

Examples (high score): client appeared to lack participation via having minimal responses, repeatedly saying "I don't know," having nonverbal gestures of disinterest (e.g., checking phone, looking repeatedly at the clock, etc.)
Examples (0/low score)-answered questions, interacted regularly with the therapist, appeared to put effort & interest into the session

0	1	2	3	4	5	6	7
Not at all	Poorly	Barely	Mediocre	Somewhat	Mostly	Quite well	Completely

194. _____ **Is client <u>avoiding</u> engagement with the trauma memory?**

Examples (high score): client appeared to effortfully avoid the memory (e.g., changed the topic away from the trauma)
Examples (0/low score): client appeared open to discuss/engage with trauma memory (e.g., remained trauma-focused)

0	1	2	3	4	5	6	7
None	Barely	Very Minimal	Minimal	Moderate	Much	A lot	Extreme

195. _____ **Client appears to understand concept of stuck point.**

Examples (high score): client able to generate own stuck point, discuss concept/definition of stuck point
Examples (0/low score): client unable to identify examples of his/her own stuck points, unable to explain/define stuck point
*Note: Insert N/A if no opportunity for client to demonstrate understanding.

0	1	2	3	4	5	6	7
Not at all	Poorly	Barely	Mediocre	Somewhat	Mostly	Quite well	Completely

196. _____ **Client returned to session bringing ATTEMPTED practice assignment <u>due at this session</u> <u>(Session 6: challenging questions worksheet)</u>.**

*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home	None mentioned	Other reason (please write in box bel

197. _____ **Client returned to session bringing ATTEMPTED <u>re-assigned practice assignment</u>.**

Insert name of assignment _____.

*Note: This will only be applicable if therapist re-assigned homework from previous session to be completed in this session (e.g., if they did not complete impact statement from previous session, and therapist asked client to bring it to this session). Write N/A if not applicable.
*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.
*Note: If more than 1 task are re-assigned, if the client brings both, mark Y, if he/she brings none, mark N, if they bring 1, but not both, mark P (partial). If Y or P, check appropriate box below.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home	None mentioned	Other reason (please write in box b

198. **Estimation of the # of total number of worksheets client brought to session (if possible): _____**

*Note: If no way to tell, please insert 666 (missing)

199. _____ **Rate the level of client cognitive flexibility in the space using the scale below.**

Examples (high score): client is able to integrate new information to alter existing stuck point, can come up with alternative, more flexible beliefs
Examples (0/low score): client continues to believe stuck point and does not appear to take into account new information or evidence (e.g, they hold tightly to their stuck point)

0 1 2 3 4 5 6 7

Completely Resistant Rigid Poor Mediocre Somewhat Mostly Very Open Mind

200. **Rate how much client expresses <u>all</u> the following emotions based on Client Emotional Arousal Scale-III ratings (1-7).**

Modal rating= overall/average amount of that emotion for the session
Peak rating= most extreme amount of that emotion the client exhibits in session
Estimated % of session= approximate % of session the client exhibited that emotion
Example: If client cries throughout the entire session, sadness would be 100% duration
*Note: Please only rate the amount of emotion the client <u>exhibits</u>, not what he/she verbally reports.
*Note- If any other emotions that are not listed are expressed, please list/rate them in Other column(s).

	Sadness (crying, shaky voice, long pause)	Anger (yelling, loud tone of voice, physical movements)	Anxiety/Fear (hunch over, crying, shaking)	Other _____ (insert name of emotion)	Other _____ (insert name of emotion)	Did client appear num (expresses emotions)
Modal rating						Y or N
Peak rating						
Estimated % of session						_____ % session

SESSION 7: Faulty Thinking Patterns:

PID:_____ Date of session (if known): _____
Session #: _____ Duration of session (round to nearest minute): _____ min

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

201. ____ ____Therapist reviewed homework using the CPT homework review form.
202. ____ ____Therapist and client reviewed the faulty thinking patterns sheet to address traumatic event related stuck points.
203. ____ ____Therapist introduced the Challenging Beliefs Worksheet with a traumatic event example.
204. ____ ____Therapist introduced the first of five problem areas: Safety issues related to Self and Others (Handout).
205. ____ ____Therapist asked the client to identify stuck points, of which one had to relate to safety, and confront them using the challenging beliefs worksheet for homework.

Identifying Stuck Points:

206. ____ ____Therapist hones stuck points (i.e., identifies stuck points accurately).

Socratic Questioning:

207. ____ ____ Therapist uses Socratic questions.
208. ____ What percentage of dialogue was Socratic in nature (choose 1-5 on the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

209. ____ What percentage of dialogue was authoritative/directive in nature (use the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

Challenging Assimilation before Over-Accommodation:

210. ____ ____If assimilation is evident, therapist prioritizes challenging assimilated stuck points over over-accommodated stuck points (if no assimilation evident, write n/a).

Out-of-Session Practice Assignments:

211. ____ ____If the client does not bring in attempted practice assignment, the therapist then proceeds with completing the assignment together in session (either verbally or using a worksheet).
212. ____ ____If the client did not complete the practice assignment, the therapist employs an intervention strategy aimed at increasing compliance (e.g., conversation about the rationale for homework compliance; discussion about the role of avoidance in maintaining PTSD, etc.)
213. ____ ____If the client did not complete the practice assignment, the therapist reassigns it in addition to the current week's assignment.

Emphasis on the Expression of Natural Affect:

214. ____ ____ Therapist **encourages** the expression of natural affect (if no longer applicable, write n/a).

Remaining Trauma Focused:

215. ____ ____ Therapist remains trauma focused (Note: trauma focused = topics included in the treatment protocol and any challenging of maladaptive assimilated or over-accommodated cognitions).

Use of Worksheets in Session:

216. ____ Did the therapist write anything on a worksheet? Write Y or N.
217. ____ Did the client write anything on a worksheet? Write Y or N.
218. ____ Did the therapist and client review a worksheet? Write Y or N.

Essential but not Unique Elements:

219. Therapist established good rapport by demonstrating:
    a. ____ ____Genuineness
    b. ____ ____Warmth
    c. ____ ____Accurate Empathy
220. ____ ____Therapist engaged with the client in a professional manner.
221. ____ ____Therapist set an agenda at the beginning of the session, in an atmosphere of collaboration and mutual understanding.
222. ____ ____Therapist structured therapy time efficiently, and was able to keep the focus of the session on issues decided upon in setting the agenda.
223. ____ ____Therapist elicited feedback about the client's reactions to the therapy and/or the therapist as part of the closing portion of the session.
224. ____ ____Therapist assigned homework in a clear and specific manner.
225. ____ ____Therapist asked the client about anticipated problems with completing homework, and problem solved to resolve them.

Proscribed Elements:

226. ____ Therapist implemented an intervention not specifically included in the protocol (e.g., mindfulness exercise, behavioral intervention, relaxation training,

fear/avoidance hierarchy, SUDS ratings). Please write Y or N.

a. If Yes, what type of intervention?

_____

Client Behaviors Section

Note: Some of the scales in the client section are modified from the therapist section!

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227. _____ **Is client <u>avoiding</u> engagement with the therapist?**

Examples (high score): client appeared to lack participation via having minimal responses, repeatedly saying "I don't know," having nonverbal gestures of disinterest (e.g., checking phone, looking repeatedly at the clock, etc.)
Examples (0/low score)-answered questions, interacted regularly with the therapist, appeared to put effort & interest into the session

0	1	2	3	4	5	6	7
Not at all	Barely	Very Minimal	Minimal	Moderate	Strongly	Very	Completely

228. _____ **Is client <u>avoiding</u> engagement with the trauma memory?**

Examples (high score): client appeared to effortfully avoid the memory (e.g., changed the topic away from the trauma)
Examples (0/low score): client appeared open to discuss/engage with trauma memory (e.g., remained trauma-focused)

0	1	2	3	4	5	6	7
None	Barely	Very Minimal	Minimal	Moderate	Much	A lot	Extreme

229. _____ **Client appears to understand concept of stuck point.**

Examples (high score): client able to generate own stuck point, discuss concept/definition of stuck point
Examples (0/low score): client unable to identify examples of his/her own stuck points, unable to explain/define stuck point
*Note: Insert N/A if no opportunity for client to demonstrate understanding.

0	1	2	3	4	5	6	7
Not at all	Poorly	Barely	Mediocre	Somewhat	Mostly	Quite well	Completely

230. _____ **Client returned to session bringing ATTEMPTED practice assignment due at this session (Session 7: patterns of problematic thinking).**

*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home	None mentioned	Other reason (please write in box b

231. _____ **Client returned to session bringing ATTEMPTED re-assigned practice assignment.**
Insert name of assignment _____.

*Note: This will only be applicable if therapist re-assigned homework from previous session to be completed in this session (e.g., if they did not complete impact statement from previous session, and therapist asked client to bring it to this session). Write N/A if not applicable.
*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If more than 1 task are re-assigned, if the client brings both, mark Y, if he/she brings none, mark N, if they bring 1, but not both, mark P (partial). If Y or P, check appropriate box below.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home	None mentioned	Other reason (please write in box b

232. **Estimation of the # of total number of worksheets client brought to session (if possible): _____**

*Note: If no way to tell, please insert 666 (missing)

233. _____ **Rate the level of client cognitive flexibility in the space using the scale below.**

Examples (high score): client is able to integrate new information to alter existing stuck point, can come up with alternative, more flexible beliefs
Examples (0/low score): client continues to believe stuck point and does not appear to take into account new information or evidence (e.g, they hold tightly to their stuck point)

0 1 2 3 4 5 6 7

Completely Rigid Poor Mediocre Somewhat Mostly Very Open Mind Resistant

234. **Rate how much client expresses <u>all</u> the following emotions based on Client Emotional Arousal Scale-III ratings (1-7).**

Modal rating= overall/average amount of that emotion for the session
Peak rating= most extreme amount of that emotion the client exhibits in session
Estimated % of session= approximate % of session the client exhibited that emotion
Example: If client cries throughout the entire session, sadness would be 100% duration
*Note: Please only rate the amount of emotion the client <u>exhibits</u>, not what he/she verbally reports.
*Note- If any other emotions that are not listed are expressed, please list/rate them in Other column(s).

	Sadness (crying, shaky voice, long pause)	Anger (yelling, loud tone of voice, physical movements)	Anxiety/Fear (hunch over, crying, shaking)	Other _____ (insert name of emotion)	Other _____ (insert name of emotion)	Did client appear num (expresses emotions)
Modal rating						Y or N
Peak rating						
Estimated % of session						_____ % session

SESSION 8: Safety Issues:

PID:_____ Date of session (if known): _____
Session #: _____ Duration of session (round to nearest minute): _____ min

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

235. ____ ____Therapist reviewed homework using the CPT homework review form.
236. ____ ____Therapist reviewed the Challenging Beliefs Worksheet with the client to address traumatic event related stuck points.
237. ____ ____Therapist helped client confront faulty cognitions using the challenging beliefs worksheet and generate alternative beliefs.
238. ____ ____Therapist introduced the second of five problem areas: Trust issues related to Self and Other (Handout).
239. ____ ____Therapist asked the client to identify stuck points, of which one had to relate to trust, and confront them using the challenging beliefs worksheet for homework.

Identifying Stuck Points:

240. ____ ____Therapist hones stuck points (i.e., identifies stuck points accurately).

Socratic Questioning:

241. ____ ____ Therapist uses Socratic questions.
242. ____ What percentage of dialogue was Socratic in nature (choose 1-5 on the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

243. ____ What percentage of dialogue was authoritative/directive in nature (use the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

Challenging Assimilation before Over-Accommodation:

244. ____ ____If assimilation is evident, therapist prioritizes challenging assimilated stuck points over over-accommodated stuck points (if no assimilation evident, write n/a).

Out-of-Session Practice Assignments:

245. ____ ____If the client does not bring in attempted practice assignment, the therapist then proceeds with completing the assignment together in session (either verbally or using a worksheet).
246. ____ ____If the client did not complete the practice assignment, the therapist employs an intervention strategy aimed at increasing compliance (e.g., conversation about the rationale for homework compliance; discussion about the role of avoidance in maintaining PTSD, etc.)
247. ____ ____If the client did not complete the practice assignment, the therapist reassigns it in addition to the current week's assignment.

Emphasis on the Expression of Natural Affect:

248. ____ ____ Therapist **encourages** the expression of natural affect (if no longer applicable, write n/a).

Remaining Trauma Focused:

249. ____ ____ Therapist remains trauma focused (Note: trauma focused = topics included in the treatment protocol and any challenging of maladaptive assimilated or over-accommodated cognitions).

Use of Worksheets in Session:

250. ____ Did the therapist write anything on a worksheet? Write Y or N.
251. ____ Did the client write anything on a worksheet? Write Y or N.
252. ____ Did the therapist and client review a worksheet? Write Y or N.

Essential but not Unique Elements:

253. Therapist established good rapport by demonstrating:
    a. ____ ____Genuineness
    b. ____ ____Warmth
    c. ____ ____Accurate Empathy
254. ____ ____Therapist engaged with the client in a professional manner.
255. ____ ____Therapist set an agenda at the beginning of the session, in an atmosphere of collaboration and mutual understanding.
256. ____ ____Therapist structured therapy time efficiently, and was able to keep the focus of the session on issues decided upon in setting the agenda.
257. ____ ____Therapist elicited feedback about the client's reactions to the therapy and/or the therapist as part of the closing portion of the session.
258. ____ ____Therapist assigned homework in a clear and specific manner.
259. ____ ____Therapist asked the client about anticipated problems with completing homework, and problem solved to resolve them.

Proscribed Elements:

260. ____ Therapist implemented an intervention not specifically included in the protocol (e.g., mindfulness exercise, behavioral intervention, relaxation training,

fear/avoidance hierarchy, SUDS ratings). Please write Y or N.

a. If Yes, what type of intervention?

_____

Client Behaviors Section

Note: Some of the scales in the client section are modified from the therapist section!

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261. _____ **Is client <u>avoiding</u> engagement with the therapist?**

Examples (high score): client appeared to lack participation via having minimal responses, repeatedly saying "I don't know," having nonverbal gestures of disinterest (e.g., checking phone, looking repeatedly at the clock, etc.)
Examples (0/low score)-answered questions, interacted regularly with the therapist, appeared to put effort & interest into the session

0	1	2	3	4	5	6	7
Not at all	Barely	Very Minimal	Minimal	Moderate	Strongly	Very	Completely

262. _____ **Is client <u>avoiding</u> engagement with the trauma memory?**

Examples (high score): client appeared to effortfully avoid the memory (e.g., changed the topic away from the trauma)
Examples (0/low score): client appeared open to discuss/engage with trauma memory (e.g., remained trauma-focused)

0	1	2	3	4	5	6	7
None	Barely	Very Minimal	Minimal	Moderate	Much	A lot	Extreme

263. _____ **Client appears to understand concept of stuck point.**

Examples (high score): client able to generate own stuck point, discuss concept/definition of stuck point
Examples (0/low score): client unable to identify examples of his/her own stuck points, unable to explain/define stuck point
*Note: Insert N/A if no opportunity for client to demonstrate understanding.

0	1	2	3	4	5	6	7
Not at all	Poorly	Barely	Mediocre	Somewhat	Mostly	Quite well	Completely

264. _____ **Client returned to session bringing ATTEMPTED practice assignment <u>due at this session</u> <u>(Session 8: challenging beliefs worksheets)</u>.**

*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home/ Lost	None mentioned	Other reason (please write in box b

265. _____ **Client returned to session bringing ATTEMPTED <u>re-assigned practice assignment</u>.**
Insert name of assignment _____.

*Note: This will only be applicable if therapist re-assigned homework from previous session to be completed in this session (e.g., if they did not complete impact statement from previous session, and therapist asked client to bring it to this session). Write N/A if not applicable.
*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If more than 1 task are re-assigned, if the client brings both, mark Y, if he/she brings none, mark N, if they bring 1, but not both, mark P (partial). If Y or P, check appropriate box below.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home/ Lost	None mentioned	Other reason (please write in box b

266. **Estimation of the # of total number of worksheets client brought to session (if possible):** _____

*Note: If no way to tell, please insert 666 (missing)

267. _____ **Rate the level of client cognitive flexibility in the space using the scale below.**

Examples (high score): client is able to integrate new information to alter existing stuck point, can come up with alternative, more flexible beliefs
Examples (0/low score): client continues to believe stuck point and does not appear to take into account new information or evidence (e.g, they hold tightly to their stuck point)

0 1 2 3 4 5 6 7

Completely Resistant Rigid Poor Mediocre Somewhat Mostly Very Open Mind

268. **Rate how much client expresses <u>all</u> the following emotions based on Client Emotional Arousal Scale-III ratings (1-7).**

Modal rating= overall/average amount of that emotion for the session
Peak rating= most extreme amount of that emotion the client exhibits in session
Estimated % of session= approximate % of session the client exhibited that emotion
Example: If client cries throughout the entire session, sadness would be 100% duration
*Note: Please only rate the amount of emotion the client <u>exhibits</u>, not what he/she verbally reports.
*Note- If any other emotions that are not listed are expressed, please list/rate them in Other column(s).

	Sadness (crying, shaky voice, long pause)	Anger (yelling, loud tone of voice, physical movements)	Anxiety/Fear (hunch over, crying, shaking)	Other _____ (insert name of emotion)	Other _____ (insert name of emotion)	Did client appear num (expresses emotions)
Modal rating						Y or N
Peak rating						
Estimated % of session						_____ % session

SESSION 9: Trust Issues:

PID:_____ Date of session (if known): _____
Session #: _____ Duration of session (round to nearest minute): _____ min

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

269. ____ ____Therapist reviewed homework using the CPT homework review form.
270. ____ ____Therapist reviewed the Challenging Beliefs Worksheet with the client to challenge traumatic event related trust stuck points and generate alternative beliefs.
271. ____ ____Therapist discussed judgment issues that may arise from stuck point related to trust, and discussed client's social support systems.
272. ____ ____Therapist introduced the third of the five problem areas: Power/Control issues related to Self and Others (Handout).
273. ____ ____Therapist asked the client to identify stuck points, of which one had to relate to power/control issues, and confront them using the challenging beliefs worksheet for homework.

Identifying Stuck Points:

274. ____ ____Therapist hones stuck points (i.e., identifies stuck points accurately).

Socratic Questioning:

275. ____ ____ Therapist uses Socratic questions.
276. ____ What percentage of dialogue was Socratic in nature (choose 1-5 on the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

277. ____ What percentage of dialogue was authoritative/directive in nature (use the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

Challenging Assimilation before Over-Accommodation:

278. ____ ____If assimilation is evident, therapist prioritizes challenging assimilated stuck points over over-accommodated stuck points (if no assimilation evident, write n/a).

Out-of-Session Practice Assignments:

279. ____ ____If the client does not bring in attempted practice assignment, the therapist then proceeds with completing the assignment together in session (either verbally or using a worksheet).
280. ____ ____If the client did not complete the practice assignment, the therapist employs an intervention strategy aimed at increasing compliance (e.g., conversation about the rationale for homework compliance; discussion about the role of avoidance in maintaining PTSD, etc.)
281. ____ ____If the client did not complete the practice assignment, the therapist reassigns it in addition to the current week's assignment.

Emphasis on the Expression of Natural Affect:

282. ____ ____ Therapist **encourages** the expression of natural affect.

Remaining Trauma Focused:

283. ____ ____ Therapist remains trauma focused (Note: trauma focused = topics included in the treatment protocol and any challenging of maladaptive assimilated or over-accommodated cognitions).

Use of Worksheets in Session:

284. ____ Did the therapist write anything on a worksheet? Write Y or N.
285. ____ Did the client write anything on a worksheet? Write Y or N.
286. ____ Did the therapist and client review a worksheet? Write Y or N.

Essential but not Unique Elements:

287. Therapist established good rapport by demonstrating:
    a. ____ ____Genuineness
    b. ____ ____Warmth
    c. ____ ____Accurate Empathy
288. ____ ____Therapist engaged with the client in a professional manner.
289. ____ ____Therapist set an agenda at the beginning of the session, in an atmosphere of collaboration and mutual understanding.
290. ____ ____Therapist structured therapy time efficiently, and was able to keep the focus of the session on issues decided upon in setting the agenda.
291. ____ ____Therapist elicited feedback about the client's reactions to the therapy and/or the therapist as part of the closing portion of the session.
292. ____ ____Therapist assigned homework in a clear and specific manner.
293. ____ ____Therapist asked the client about anticipated problems with completing homework, and problem solved to resolve them.

Proscribed Elements:

294. ____ Therapist implemented an intervention not specifically included in the protocol (e.g., mindfulness exercise, behavioral intervention, relaxation training, fear/avoidance hierarchy, SUDS ratings). Please write Y or N.

a. If Yes, what type of intervention?

_____

Client Behaviors Section

Note: Some of the scales in the client section are modified from the therapist section!

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295. _____ **Is client <u>avoiding</u> engagement with the therapist?**

Examples (high score): client appeared to lack participation via having minimal responses, repeatedly saying "I don't know," having nonverbal gestures of disinterest (e.g., checking phone, looking repeatedly at the clock, etc.)
Examples (0/low score)-answered questions, interacted regularly with the therapist, appeared to put effort & interest into the session

0	1	2	3	4	5	6	7
Not at all	Barely	Very Minimal	Minimal	Moderate	Strongly	Very	Completely

296. _____ **Is client <u>avoiding</u> engagement with the trauma memory?**

Examples (high score): client appeared to effortfully avoid the memory (e.g., changed the topic away from the trauma)
Examples (0/low score): client appeared open to discuss/engage with trauma memory (e.g., remained trauma-focused)

0	1	2	3	4	5	6	7
None	Barely	Very Minimal	Minimal	Moderate	Much	A lot	Extreme

297. _____ **Client appears to understand concept of stuck point.**

Examples (high score): client able to generate own stuck point, discuss concept/definition of stuck point
Examples (0/low score): client unable to identify examples of his/her own stuck points, unable to explain/define stuck point
*Note: Insert N/A if no opportunity for client to demonstrate understanding.

0	1	2	3	4	5	6	7
Not at all	Poorly	Barely	Mediocre	Somewhat	Mostly	Quite well	Completely

298. _____ **Client returned to session bringing ATTEMPTED practice assignment due at this session (Session 9: challenging beliefs worksheets).**

*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home/ Lost	None mentioned	Other reason (please write in box b

299. _____ **Client returned to session bringing ATTEMPTED re-assigned practice assignment.**
Insert name of assignment _____.

*Note: This will only be applicable if therapist re-assigned homework from previous session to be completed in this session (e.g., if they did not complete impact statement from previous session, and therapist asked client to bring it to this session). Write N/A if not applicable.
*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If more than 1 task are re-assigned, if the client brings both, mark Y, if he/she brings none, mark N, if they bring 1, but not both, mark P (partial). If Y or P, check appropriate box below

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home/ Lost	None mentioned	Other reason (please write in box b

300. **Estimation of the # of total number of worksheets client brought to session (if possible): _____**

*Note: If no way to tell, please insert 666 (missing)

301. _____ **Rate the level of client cognitive flexibility in the space using the scale below.**

Examples (high score): client is able to integrate new information to alter existing stuck point, can come up with alternative, more flexible beliefs
Examples (0/low score): client continues to believe stuck point and does not appear to take into account new information or evidence (e.g, they hold tightly to their stuck point)

0 1 2 3 4 5 6 7

Completely Resistant Rigid Poor Mediocre Somewhat Mostly Very Open Mind

302. **Rate how much client expresses <u>all</u> the following emotions based on Client Emotional Arousal Scale-III ratings (1-7).**

Modal rating= overall/average amount of that emotion for the session
Peak rating= most extreme amount of that emotion the client exhibits in session
Estimated % of session= approximate % of session the client exhibited that emotion
Example: If client cries throughout the entire session, sadness would be 100% duration
*Note: Please only rate the amount of emotion the client <u>exhibits</u>, not what he/she verbally reports.
*Note- If any other emotions that are not listed are expressed, please list/rate them in Other column(s).

	Sadness (crying, shaky voice, long pause)	Anger (yelling, loud tone of voice, physical movements)	Anxiety/Fear (hunch over, crying, shaking)	Other _____ (insert name of emotion)	Other _____ (insert name of emotion)	Did client appear num (expresses emotions)
Modal rating						Y or N
Peak rating						
Estimated % of session						_____ % session

SESSION 10: Power/Control Issues:

PID:_____ Date of session (if known): _____
Session #: _____ Duration of session (round to nearest minute): _____ min

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

303. ____ ____Therapist reviewed homework using the CPT homework review form.
304. ____ ____Therapist discussed the connection between power/control and self blame, and helped client challenge faulty cognitions related to this area using the Challenging Beliefs Worksheet.
305. ____ ____Therapist introduced the fourth of the five problem areas: Esteem issues related to self and others (Handout).
306. ____ ____Therapist asked the client to identify stuck points, of which one had to relate to esteem issues, and confront them using the challenging beliefs worksheet, for homework.
307. ____ ____Therapist asked the client to practice giving and receiving compliments for homework.
308. ____ ____Therapist asked the client to do at least one nice thing for herself each day for homework.

Identifying Stuck Points:

309. ____ ____Therapist hones stuck points (i.e., identifies stuck points accurately).

Socratic Questioning:

310. ____ ____ Therapist uses Socratic questions.
311. ____ What percentage of dialogue was Socratic in nature (choose 1-5 on the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

312. ____ What percentage of dialogue was authoritative/directive in nature (use the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

Challenging Assimilation before Over-Accommodation:

313. ____ ____If assimilation is evident, therapist prioritizes challenging assimilated stuck points over over-accommodated stuck points (if no assimilation evident, write n/a).

Out-of-Session Practice Assignments:

314. ____ ____If the client does not bring in attempted practice assignment, the therapist then proceeds with completing the assignment together in session (either verbally or using a worksheet).
315. ____ ____If the client did not complete the practice assignment, the therapist employs an intervention strategy aimed at increasing compliance (e.g., conversation about the rationale for homework compliance; discussion about the role of avoidance in maintaining PTSD, etc.)
316. ____ ____If the client did not complete the practice assignment, the therapist reassigns it in addition to the current week's assignment.

Emphasis on the Expression of Natural Affect:

317. ____ ____ Therapist **encourages** the expression of natural affect.

Remaining Trauma Focused:

318. ____ ____ Therapist remains trauma focused (Note: trauma focused = topics included in the treatment protocol and any challenging of maladaptive assimilated or over-accommodated cognitions).

Use of Worksheets in Session:

319. ____ Did the therapist write anything on a worksheet? Write Y or N.
320. ____ Did the client write anything on a worksheet? Write Y or N.
321. ____ Did the therapist and client review a worksheet? Write Y or N.

Essential but not Unique Elements:

322. Therapist established good rapport by demonstrating:
    a. ____ ____Genuineness
    b. ____ ____Warmth
    c. ____ ____Accurate Empathy
323. ____ ____Therapist engaged with the client in a professional manner.
324. ____ ____Therapist set an agenda at the beginning of the session, in an atmosphere of collaboration and mutual understanding.
325. ____ ____Therapist structured therapy time efficiently, and was able to keep the focus of the session on issues decided upon in setting the agenda.
326. ____ ____Therapist elicited feedback about the client's reactions to the therapy and/or the therapist as part of the closing portion of the session.
327. ____ ____Therapist assigned homework in a clear and specific manner.
328. ____ ____Therapist asked the client about anticipated problems with completing homework, and problem solved to resolve them.

Proscribed Elements:

329. ____ Therapist implemented an intervention not specifically included in the protocol (e.g., mindfulness exercise, behavioral intervention, relaxation training, fear/avoidance hierarchy, SUDS ratings). Please write Y or N.

a. If Yes, what type of intervention?

_____

Client Behaviors Section

Note: Some of the scales in the client section are modified from the therapist section!

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330. _____ **Is client <u>avoiding</u> engagement with the therapist?**

Examples (high score): client appeared to lack participation via having minimal responses, repeatedly saying "I don't know," having nonverbal gestures of disinterest (e.g., checking phone, looking repeatedly at the clock, etc.)
Examples (0/low score)-answered questions, interacted regularly with the therapist, appeared to put effort & interest into the session

0	1	2	3	4	5	6	7
Not at all	Barely	Very Minimal	Minimal	Moderate	Strongly	Very	Completely

331. _____ **Is client <u>avoiding</u> engagement with the trauma memory?**

Examples (high score): client appeared to effortfully avoid the memory (e.g., changed the topic away from the trauma)
Examples (0/low score): client appeared open to discuss/engage with trauma memory (e.g., remained trauma-focused)

0	1	2	3	4	5	6	7
None	Barely	Very Minimal	Minimal	Moderate	Much	A lot	Extreme

332. _____ **Client appears to understand concept of stuck point.**

Examples (high score): client able to generate own stuck point, discuss concept/definition of stuck point
Examples (0/low score): client unable to identify examples of his/her own stuck points, unable to explain/define stuck point
*Note: Insert N/A if no opportunity for client to demonstrate understanding.

0	1	2	3	4	5	6	7
Not at all	Poorly	Barely	Mediocre	Somewhat	Mostly	Quite well	Completely

333. _____ **Client returned to session bringing ATTEMPTED practice assignment <u>due at this session</u> <u>(Session 10: challenging beliefs worksheets)</u>.**

*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home/ Lost	None mentioned	Other reason (please write in box b

334. _____ **Client returned to session bringing ATTEMPTED <u>re-assigned practice assignment</u>.**
Insert name of assignment _____.

*Note: This will only be applicable if therapist re-assigned homework from previous session to be completed in this session (e.g., if they did not complete impact statement from previous session, and therapist asked client to bring it to this session). Write N/A if not applicable.
*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.
*Note: If more than 1 task are re-assigned, if the client brings both, mark Y, if he/she brings none, mark N, if they bring 1, but not both, mark P (partial). If Y or P, check appropriate box below.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home/ Lost	None mentioned	Other reason (please write in box b

335. **Estimation of the # of total number of worksheets client brought to session (if possible): _____**

*Note: If no way to tell, please insert 666 (missing)

336. _____ **Rate the level of client cognitive flexibility in the space using the scale below.**

Examples (high score): client is able to integrate new information to alter existing stuck point, can come up with alternative, more flexible beliefs
Examples (0/low score): client continues to believe stuck point and does not appear to take into account new information or evidence (e.g, they hold tightly to their stuck point)

0 1 2 3 4 5 6 7

Completely Rigid Resistant Poor Mediocre Somewhat Mostly Very Open Mind

337. **Rate how much client expresses <u>all</u> the following emotions based on Client Emotional Arousal Scale-III ratings (1-7).**

Modal rating= overall/average amount of that emotion for the session
Peak rating= most extreme amount of that emotion the client exhibits in session
Estimated % of session= approximate % of session the client exhibited that emotion
Example: If client cries throughout the entire session, sadness would be 100% duration
*Note: Please only rate the amount of emotion the client <u>exhibits</u>, not what he/she verbally reports.
*Note- If any other emotions that are not listed are expressed, please list/rate them in Other column(s).

	Sadness (crying, shaky voice, long pause)	Anger (yelling, loud tone of voice, physical movements)	Anxiety/Fear (hunch over, crying, shaking)	Other _____ (insert name of emotion)	Other _____ (insert name of emotion)	Did client appear nun (expresses emotions)
Modal rating						Y or N
Peak rating						
Estimated % of session						_____ % session

SESSION 11: Esteem Issues:

PID:_____ Date of session (if known): _____
Session #: _____ Duration of session (round to nearest minute): _____ min

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

338. ____ ____Therapist reviewed homework using the CPT homework review form.
339. ____ ____Therapist helped client identify esteem issues and assumptions and challenge them using Challenging Beliefs Worksheet.
340. ____ ____Therapist discussed clients' reactions to giving and receiving compliments and engaging in a pleasant activity.
341. ____ ____Therapist introduced the fifth of the five problem areas: Intimacy issues related to self and others (Handout).
342. ____ ____Therapist asked the client to identify stuck points, one of which had to relate to intimacy issues, and confront them using the challenging beliefs worksheet for homework.
343. ____ ____Therapist asked the client to rewrite the impact statement for homework.

Identifying Stuck Points:

344. ____ ____Therapist hones stuck points (i.e., identifies stuck points accurately).

Socratic Questioning:

345. ____ ____ Therapist uses Socratic questions.
346. ____ What percentage of dialogue was Socratic in nature (choose 1-5 on the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

347. ____ What percentage of dialogue was authoritative/directive in nature (use the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

Challenging Assimilation before Over-Accommodation:

348. ____ ____If assimilation is evident, therapist prioritizes challenging assimilated stuck points over over-accommodated stuck points (if no assimilation evident, write n/a).

Out-of-Session Practice Assignments:

349. ____ ____If the client does not bring in attempted practice assignment, the therapist then proceeds with completing the assignment together in session (either verbally or using a worksheet).
350. ____ ____If the client did not complete the practice assignment, the therapist employs an intervention strategy aimed at increasing compliance (e.g., conversation about the rationale for homework compliance; discussion about the role of avoidance in maintaining PTSD, etc.)
351. ____ ____If the client did not complete the practice assignment, the therapist reassigns it in addition to the current week's assignment.

Emphasis on the Expression of Natural Affect:

352. ____ ____ Therapist **encourages** the expression of natural affect.

Remaining Trauma Focused:

353. ____ ____ Therapist remains trauma focused (Note: trauma focused = topics included in the treatment protocol and any challenging of maladaptive assimilated or over-accommodated cognitions).

Use of Worksheets in Session:

354. ____ Did the therapist write anything on a worksheet? Write Y or N.
355. ____ Did the client write anything on a worksheet? Write Y or N.
356. ____ Did the therapist and client review a worksheet? Write Y or N.

Essential but not Unique Elements:

357. Therapist established good rapport by demonstrating:
    a. ____ ____Genuineness
    b. ____ ____Warmth
    c. ____ ____Accurate Empathy
358. ____ ____Therapist engaged with the client in a professional manner.
359. ____ ____Therapist set an agenda at the beginning of the session, in an atmosphere of collaboration and mutual understanding.
360. ____ ____Therapist structured therapy time efficiently, and was able to keep the focus of the session on issues decided upon in setting the agenda.
361. ____ ____Therapist elicited feedback about the client's reactions to the therapy and/or the therapist as part of the closing portion of the session.
362. ____ ____Therapist assigned homework in a clear and specific manner.
363. ____ ____Therapist asked the client about anticipated problems with completing homework, and problem solved to resolve them.

Proscribed Elements:

364. ____ Therapist implemented an intervention not specifically included in the protocol (e.g., mindfulness exercise, behavioral intervention, relaxation training, fear/avoidance hierarchy, SUDS ratings). Please write Y or N.

a. If Yes, what type of intervention?

_____

Client Behaviors Section

Note: Some of the scales in the client section are modified from the therapist section!

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365. _____ **Is client <u>avoiding</u> engagement with the therapist?**

Examples (high score): client appeared to lack participation via having minimal responses, repeatedly saying "I don't know," having nonverbal gestures of disinterest (e.g., checking phone, looking repeatedly at the clock, etc.)
Examples (0/low score)-answered questions, interacted regularly with the therapist, appeared to put effort & interest into the session

0	1	2	3	4	5	6	7
Not at all	Barely	Very Minimal	Minimal	Moderate	Strongly	Very	Completely

366. _____ **Is client <u>avoiding</u> engagement with the trauma memory?**

Examples (high score): client appeared to effortfully avoid the memory (e.g., changed the topic away from the trauma)
Examples (0/low score): client appeared open to discuss/engage with trauma memory (e.g., remained trauma-focused)

0	1	2	3	4	5	6	7
None	Barely	Very Minimal	Minimal	Moderate	Much	A lot	Extreme

367. _____ **Client appears to understand concept of stuck point.**

Examples (high score): client able to generate own stuck point, discuss concept/definition of stuck point
Examples (0/low score): client unable to identify examples of his/her own stuck points, unable to explain/define stuck point
*Note: Insert N/A if no opportunity for client to demonstrate understanding.

0	1	2	3	4	5	6	7

Not at all Poorly Barely Mediocre Somewhat Mostly Quite well Completely

368. _____ **Client returned to session bringing ATTEMPTED practice assignment <u>due at this session</u> <u>(Session 11: challenging beliefs worksheets)</u>.**

*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home/ Lost	None mentioned	Other reason (please write in box b

369. _____ **Client returned to session bringing ATTEMPTED <u>re-assigned practice assignment</u>.**
Insert name of assignment _____.

*Note: This will only be applicable if therapist re-assigned homework from previous session to be completed in this session (e.g., if they did not complete impact statement from previous session, and therapist asked client to bring it to this session). Write N/A if not applicable.
*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If more than 1 task are re-assigned, if the client brings both, mark Y, if he/she brings none, mark N, if they bring 1, but not both, mark P (partial). If Y or P, check appropriate box below.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home/ Lost	None mentioned	Other reason (please write in box b

370. **Estimation of the # of total number of worksheets client brought to session (if possible): _____**

*Note: If no way to tell, please insert 666 (missing)

371. **_____ Rate the level of client cognitive flexibility in the space using the scale below.**

Examples (high score): client is able to integrate new information to alter existing stuck point, can come up with alternative, more flexible beliefs

Examples (0/low score): client continues to believe stuck point and does not appear to take into account new information or evidence (e.g, they hold tightly to their stuck point)

0 1 2 3 4 5 6 7

Completely Rigid Poor Mediocre Somewhat Mostly Very Open Mind Resistant

372. **Rate how much client expresses <u>all</u> the following emotions based on Client Emotional Arousal Scale-III ratings (1-7).**

Modal rating= overall/average amount of that emotion for the session
Peak rating= most extreme amount of that emotion the client exhibits in session
Estimated % of session= approximate % of session the client exhibited that emotion
Example: If client cries throughout the entire session, sadness would be 100% duration
*Note: Please only rate the amount of emotion the client <u>exhibits</u>, not what he/she verbally reports.
*Note- If any other emotions that are not listed are expressed, please list/rate them in Other column(s).

	Sadness (crying, shaky voice, long pause)	Anger (yelling, loud tone of voice, physical movements)	Anxiety/Fear (hunch over, crying, shaking)	Other _____ (insert name of emotion)	Other _____ (insert name of emotion)	Did client appear num (expresses emotions)
Modal rating						Y or N
Peak rating						
Estimated % of session						_____ % session

SESSION 12: Intimacy Issues:

PID:_____ Date of session (if known): _____
Session #: _____ Duration of session (round to nearest minute): _____ min

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

373. ____ ____Therapist reviewed homework, using the CPT homework review form.
374. ____ ____Therapist helped client identify any remaining stuck points and confront them using the Challenging Beliefs Worksheet.
375. ____ ____Therapist had client read the rewritten impact statement.
376. ____ ____Therapist involved the client in reviewing therapy and progress.
377. ____ ____Therapist helped client identify goals for the future, and helped her/him delineate strategies for meeting them.

Identifying Stuck Points:

378. ____ ____Therapist hones stuck points (i.e., identifies stuck points accurately).

Socratic Questioning:

379. ____ ____ Therapist uses Socratic questions.
380. ____ What percentage of dialogue was Socratic in nature (choose 1-5 on the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

381. ____ What percentage of dialogue was authoritative/directive in nature (use the scale below).

1	2	3	4	5
0-20%	21-40%	41-60%	61-80%	81-100%

Challenging Assimilation before Over-Accommodation:

382. ____ ____If assimilation is evident, therapist prioritizes challenging assimilated stuck points over over-accommodated stuck points (if no assimilation evident, write n/a).

Out-of-Session Practice Assignments:

383. ____ ____If the client does not bring in attempted practice assignment, the therapist then proceeds with completing the assignment together in session (either verbally or using a worksheet).

Emphasis on the Expression of Natural Affect:

384. ____ ____ Therapist **encourages** the expression of natural affect.

Remaining Trauma Focused:

385. ____ ____ Therapist remains trauma focused (Note: trauma focused = topics included in the treatment protocol and any challenging of maladaptive assimilated or over-accommodated cognitions).

Use of Worksheets in Session:

386. ____ Did the therapist write anything on a worksheet? Write Y or N.
387. ____ Did the client write anything on a worksheet? Write Y or N.
388. ____ Did the therapist and client review a worksheet? Write Y or N.

Essential but not Unique Elements:

389. Therapist established good rapport by demonstrating:
    a. ____ ____Genuineness
    b. ____ ____Warmth
    c. ____ ____Accurate Empathy
390. ____ ____Therapist engaged with the client in a professional manner.
391. ____ ____Therapist set an agenda at the beginning of the session, in an atmosphere of collaboration and mutual understanding.
392. ____ ____Therapist reviewed the homework with the client, using the CPT homework review form.
393. ____ ____Therapist structured therapy time efficiently, and was able to keep the focus of the session on issues decided upon in setting the agenda.
394. ____ ____Therapist elicited feedback about the client's reactions to the therapy and/or the therapist as part of the closing portion of the session.
395. ____ ____Therapist assigned homework in a clear and specific manner.
396. ____ ____Therapist asked the client about anticipated problems with completing homework, and problem solved to resolve them.

Proscribed Elements:

397. ____ Therapist implemented an intervention not specifically included in the protocol (e.g., mindfulness exercise, behavioral intervention, relaxation training, fear/avoidance hierarchy, SUDS ratings). Please write Y or N.
    a. If Yes, what type of intervention?
    _____

Client Behaviors Section

Note: Some of the scales in the client section are modified from the therapist section!

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398. _____ **Is client <u>avoiding</u> engagement with the therapist?**

Examples (high score): client appeared to lack participation via having minimal responses, repeatedly saying "I don't know," having nonverbal gestures of disinterest (e.g., checking phone, looking repeatedly at the clock, etc.)
Examples (0/low score)-answered questions, interacted regularly with the therapist, appeared to put effort & interest into the session

0	1	2	3	4	5	6	7
Not at all	Barely	Very Minimal	Minimal	Moderate	Strongly	Very	Completely

399. _____ **Is client <u>avoiding</u> engagement with the trauma memory?**

Examples (high score): client appeared to effortfully avoid the memory (e.g., changed the topic away from the trauma)
Examples (0/low score): client appeared open to discuss/engage with trauma memory (e.g., remained trauma-focused)

0	1	2	3	4	5	6	7
None	Barely	Very Minimal	Minimal	Moderate	Much	A lot	Extreme

400. _____ **Client appears to understand concept of stuck point.**

Examples (high score): client able to generate own stuck point, discuss concept/definition of stuck point
Examples (0/low score): client unable to identify examples of his/her own stuck points, unable to explain/define stuck point
*Note: Insert N/A if no opportunity for client to demonstrate understanding.

0	1	2	3	4	5	6	7
Not at all	Poorly	Barely	Mediocre	Somewhat	Mostly	Quite well	Completely

401. _____ **Client returned to session bringing ATTEMPTED practice assignment <u>due at this session</u> <u>(Session 12: impact statement)</u>.**

*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.

*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home	None mentioned	Other reason (please write in box b

402. _____ **Client returned to session bringing ATTEMPTED practice assignment due at this session (Session 12: challenging beliefs worksheets).**

*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home	None mentioned	Other reason (please write in box b

403. _____ **Client returned to session bringing ATTEMPTED re-assigned practice assignment.**
Insert name of assignment _____.

*Note: This will only be applicable if therapist re-assigned homework from previous session to be completed in this session (e.g., if they did not complete impact statement from previous session, and therapist asked client to bring it to this session).
*Note: "attempted" means the client at least began/did some of the assignment (does not have to be complete)
Write Y (if brought assignment) or N (if did not bring assignment) in the blank above and if no, check the box with appropriate explanation.
*Note: If client reports that they did the homework, or attempted it, but did not bring it to session, place N in the blank and check appropriate box.

*Note: If more than 1 task are re-assigned, if the client brings both, mark Y, if he/she brings none, mark N, if they bring 1, but not both, mark P (partial). If Y or P, check appropriate box below.

Lack of understanding/ too difficult	Avoidance/ PTSD	Not seen as worthwhile/helpful/ refusal	Not enough time	Forget/ Left at home	None mentioned	Other reason (please write in box b

404. **Estimation of the # of total number of worksheets client brought to session (if possible): _____**

*Note: If no way to tell, please insert 666 (missing)

405. _____ **Rate the level of client cognitive flexibility in the space using the scale below.**

Examples (high score): client is able to integrate new information to alter existing stuck point, can come up with alternative, more flexible beliefs
Examples (0/low score): client continues to believe stuck point and does not appear to take into account new information or evidence (e.g, they hold tightly to their stuck point)

0	1	2	3	4	5	6	7
Completely Resistant	Rigid	Poor	Mediocre	Somewhat	Mostly	Very	Open Mind

406. **Rate how much client expresses <u>all</u> the following emotions based on Client Emotional Arousal Scale-III ratings (1-7).**

Modal rating= overall/average amount of that emotion for the session
Peak rating= most extreme amount of that emotion the client exhibits in session
Estimated % of session= approximate % of session the client exhibited that emotion
Example: If client cries throughout the entire session, sadness would be 100% duration
*Note: Please only rate the amount of emotion the client <u>exhibits</u>, not what he/she verbally reports.
*Note- If any other emotions that are not listed are expressed, please list/rate them in Other column(s).

	Sadness	Anger	Anxiety/Fear	Other	Other	Did client

	(crying, shaky voice, long pause)	(yelling, loud tone of voice, physical movements)	(hunch over, crying, shaking)	_____ (insert name of emotion)	_____ (insert name of emotion)	appear num (expresses emotions)
Modal rating						Y or N
Peak rating						
Estimated % of session						_____ % session

Additional Considerations

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407. Please give a rating of the therapist's overall CPT skills as demonstrated throughout the course of CPT.

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

408. Please give a rating of the therapist's overall ability to rely on Socratic dialogue throughout the course of CPT.

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

409. Please give a rating of the therapist's overall ability to prioritize assimilation over over-accommodation throughout the course of CPT.

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

410. Please give a rating of the therapist's overall ability to effectively utilize and navigate homework throughout the course of CPT.

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

411. Please give a rating of the therapist's overall ability to appropriately encourage and emphasize the expression of natural affect throughout the course of CPT.

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

412. Please give a rating of the client's avoidance of engagement with the therapist throughout the course of CPT.

0	1	2	3	4	5	6	7
Not at all	Barely	Very Minimal	Minimal	Moderate	Strongly	Very	Completely

413. Please give a rating of the client's avoidance of engagement with the trauma memory throughout the course of CPT.

0	1	2	3	4	5	6	7
None	Barely	Very Minimal	Minimal	Moderate	Much	A lot	Extreme

414. Please give a rating of the client's overall ability to demonstrate understanding of a stuck point throughout the course of CPT.

0	1	2	3	4	5	6	7
Not at all	Poorly	Barely	Mediocre	Somewhat	Mostly	Quite well	Completely

415. Please give a rating of the client's overall compliance with attempting homework assignments throughout the course of CPT.

1	2	3	4	5	6	7
Poor	Barely Adequate	Mediocre	Satisfactory	Good	Very Good	Excellent

416. Please give a rating of the client's overall demonstration of cognitive flexibility throughout the course of CPT.

0	1	2	3	4	5	6	7
Completely Resistant	Rigid	Poor	Mediocre	Somewhat	Mostly	Very	Open Mind

417. Please write down any additional comments that you may have regarding the ratings on this tape including any departures from the protocol and the adequacy with which the therapist dealt with the problems that led to the departure.

Appendix C

Item Lists for Adherence Variables – Original, New, Revised, and Nonspecific

Original Items:	ADeducatePTSD_sn1 ADtreatmentrationale_sn1 ADtreatmentoverview_sn1 ADassignimpact_sn1 ADReviewConcepts_sn2 ADReadImpact_sn2 ADDescribeOrally_sn2 ADDiscussedMeaning_sn2 ADABCsheets_sn2 ADAssignABCsheet_sn2 ADReviewABCsheets_sn3, ADIdentifySP_sn3, ADExploreSelfBlame_sn3, ADAssignTraumaAccount_sn3, ADReadAccount_sn4, ADNoAccountRecount_sn4, ADIdentifyStuckPoints_sn4, ADChallengeSelfBlame_sn4, ADAssignRewriteAccount_sn4, ADRead2ndAccount_sn5, ADChallengingAssumptions_sn5, ADIntroChallengingQuestions_sn5, ADAssignChallengingQuestions_sn5, ADReviewChallengingQuestions_sn6, ADIntroFaultyPatterns_sn6, ADGenerateExamplePatterns_sn6, ADAssignFaultyPatterns_sn6, ADReviewFaultyThinkingPatterns_sn7, ADIntroCBW_sn7, ADIntroSafetyModule_sn7, ADAssignCBWsSafety_sn7, ADReviewCBWs_sn8, ADConfrontFaultyCognitions_sn8, ADIntroTrust_sn8, ADAssignCBWTrust_sn8,

	ADReviewCBWs_sn9, ADDiscussJudgement_sn9, ADIntroPower_sn9, ADAssignCBWsPower_sn9, ADChallengePowerCBW_sn10, ADIntroEsteem_sn10, ADAssignEsteemCBWs_sn10, ADAssignCompliments_sn10, ADAssignPleasurableEvents_sn10, ADChallengeEsteemCBWs_sn11, ADReactionsComplimentsActivities_sn11, ADIntroIntimacy_sn11, ADAssignCBWsIntimacy_sn11, ADAssignFinalImpact_sn11, ADConfrontStuckPointsCWBs_sn12, ADReadNewImpact_sn12, ADReviewProgress_sn12, ADFutureGoals_sn12
New Items:	ADelicitstuckpoints_sn1 ADhonesstuckpoints_sn1 ADuseSocraticQuestions_sn1 ADintroHW_sn1 ADencourageAffect_sn1 ADTraumaFocused_sn1 ADelicitstuckpoints_sn2 ADhonesstuckpoints_sn2 ADuseSocraticQuestions_sn2 ADAssimilatedSP_sn2 ADOverAccommodatedSP_sn2 ADPrioritizeAssim_sn2 ADInterventionforCompliance_sn2 ADTherapistReassigns_sn2 ADencourageAffect_sn2 ADTraumaFocused_sn2 ADTherapistWorksheet_sn2 ADClientWorksheet_sn2 ADReviewWorksheet_sn2 ADhonesstuckpoints_sn3, ADuseSocraticQuestions_sn3, ADPrioritizeAssim_sn3,

	ADCompleteAssignInSession_sn3, ADInterventionforCompliance_sn3, ADTherapistReassigns_sn3, ADencourageAffect_sn3, ADTraumaFocused_sn3, ADTherapistWorksheet_sn3, ADClientWorksheet_sn3, ADReviewWorksheet_sn3, ADhonesstuckpoints_sn4, ADuseSocraticQuestions_sn4, ADPrioritizeAssim_sn4, ADInterventionforCompliance_sn4, ADTherapistReassigns_sn4, ADencourageAffect_sn4, ADTraumaFocused_sn4, ADTherapistWorksheet_sn4, ADClientWorksheet_sn4, ADReviewWorksheet_sn4, ADhonesstuckpoints_sn5, ADuseSocraticQuestions_sn5, ADPrioritizeAssim_sn5, ADCompleteAssignInSession_sn5, ADInterventionforCompliance_sn5, ADTherapistReassigns_sn5, ADencourageAffect_sn5, ADTraumaFocused_sn5, ADTherapistWorksheet_sn5, ADClientWorksheet_sn5, ADReviewWorksheet_sn5, ADhonesstuckpoints_sn6, ADuseSocraticQuestions_sn6, ADPrioritizeAssim_sn6, ADCompleteAssignInSession_sn6, ADInterventionforCompliance_sn6, ADTherapistReassigns_sn6, ADencourageAffect_sn6, ADTraumaFocused_sn6, ADTherapistWorksheet_sn6, ADClientWorksheet_sn6, ADReviewWorksheet_sn6, ADhonesstuckpoints_sn7, ADuseSocraticQuestions_sn7,

	ADPrioritizeAssim_sn7, ADCompleteAssignInSession_sn7, ADInterventionforCompliance_sn7, ADTherapistReassigns_sn7, ADencourageAffect_sn7, ADTraumaFocused_sn7, ADTherapistWorksheet_sn7, ADClientWorksheet_sn7, ADReviewWorksheet_sn7, ADhonesstuckpoints_sn8, ADuseSocraticQuestions_sn8, ADPrioritizeAssim_sn8, ADCompleteAssignInSession_sn8, ADInterventionforCompliance_sn8, ADTherapistReassigns_sn8, ADencourageAffect_sn8, ADTraumaFocused_sn8, ADTherapistWorksheet_sn8, ADClientWorksheet_sn8, ADReviewWorksheet_sn8, ADhonesstuckpoints_sn9, ADuseSocraticQuestions_sn9, ADPrioritizeAssim_sn9, ADCompleteAssignInSession_sn9, ADInterventionforCompliance_sn9, ADTherapistReassigns_sn9, ADencourageAffect_sn9, ADTraumaFocused_sn9, ADTherapistWorksheet_sn9, ADClientWorksheet_sn9, ADReviewWorksheet_sn9, ADhonesstuckpoints_sn10, ADuseSocraticQuestions_sn10, ADPrioritizeAssim_sn10, ADCompleteAssignInSession_sn10, ADInterventionforCompliance_sn10, ADTherapistReassigns_sn10, ADencourageAffect_sn10, ADTraumaFocused_sn10, ADTherapistWorksheet_sn10, ADClientWorksheet_sn10, ADReviewWorksheet_sn10,

	ADhonesstuckpoints_sn11, ADuseSocraticQuestions_sn11, ADPrioritizeAssim_sn11, ADCompleteAssignInSession_sn11, ADInterventionforCompliance_sn11, ADTherapistReassigns_sn11, ADencourageAffect_sn11, ADTraumaFocused_sn11, ADTherapistWorksheet_sn11, ADClientWorksheet_sn11, ADReviewWorksheet_sn11, ADhonesstuckpoints_sn12, ADuseSocraticQuestions_sn12, ADPrioritizeAssim_sn12, ADCompleteAssignInSession_sn12, ADencourageAffect_sn12, ADTraumaFocused_sn12, ADTherapistWorksheet_sn12, ADClientWorksheet_sn12, ADReviewWorksheet_sn12
Revised Items (Original + New):	ADeducatePTSD_sn1 ADtreatmentrationale_sn1 ADtreatmentoverview_sn1 ADassignimpact_sn1 ADelicitstuckpoints_sn1 ADhonesstuckpoints_sn1 ADuseSocraticQuestions_sn1 ADintroHW_sn1 ADencourageAffect_sn1 ADTraumaFocused_sn1 ADReviewConcepts_sn2 ADReadImpact_sn2 ADDescribeOrally_sn2 ADDiscussedMeaning_sn2 ADABCsheets_sn2 ADAssignABCsheet_sn2 ADelicitstuckpoints_sn2 ADhonesstuckpoints_sn2 ADuseSocraticQuestions_sn2 ADAssimilatedSP_sn2 ADOverAccommodatedSP_sn2 ADPrioritizeAssim_sn2 ADInterventionforCompliance_sn2

	ADTherapistReassigns_sn2 ADencourageAffect_sn2 ADTraumaFocused_sn2 ADTherapistWorksheet_sn2 ADClientWorksheet_sn2 ADReviewWorksheet_sn2 ADReviewABCsheets_sn3, ADIdentifySP_sn3, ADExploreSelfBlame_sn3, ADAssignTraumaAccount_sn3, ADhonesstuckpoints_sn3, ADuseSocraticQuestions_sn3, ADPrioritizeAssim_sn3, ADCompleteAssignInSession_sn3, ADInterventionforCompliance_sn3, ADTherapistReassigns_sn3, ADencourageAffect_sn3, ADTraumaFocused_sn3, ADTherapistWorksheet_sn3, ADClientWorksheet_sn3, ADReviewWorksheet_sn3 ADReadAccount_sn4, ADNoAccountRecount_sn4, ADIdentifyStuckPoints_sn4, ADChallengeSelfBlame_sn4, ADAssignRewriteAccount_sn4, ADhonesstuckpoints_sn4, ADuseSocraticQuestions_sn4, ADPrioritizeAssim_sn4, ADInterventionforCompliance_sn4, ADTherapistReassigns_sn4, ADencourageAffect_sn4, ADTraumaFocused_sn4, ADTherapistWorksheet_sn4, ADClientWorksheet_sn4, ADReviewWorksheet_sn4, ADRead2ndAccount_sn5, ADChallengingAssumptions_sn5, ADIntroChallengingQuestions_sn5, ADAssignChallengingQuestions_sn5, ADhonesstuckpoints_sn5, ADuseSocraticQuestions_sn5, ADPrioritizeAssim_sn5,

	ADCompleteAssignInSession_sn5, ADInterventionforCompliance_sn5, ADTherapistReassigns_sn5, ADencourageAffect_sn5, ADTraumaFocused_sn5, ADTherapistWorksheet_sn5, ADClientWorksheet_sn5, ADReviewWorksheet_sn5, ADReviewChallengingQuestions_sn6, ADIntroFaultyPatterns_sn6, ADGenerateExamplePatterns_sn6, ADAssignFaultyPatterns_sn6, ADhonesstuckpoints_sn6, ADuseSocraticQuestions_sn6, ADPrioritizeAssim_sn6, ADCompleteAssignInSession_sn6, ADInterventionforCompliance_sn6, ADTherapistReassigns_sn6, ADencourageAffect_sn6, ADTraumaFocused_sn6, ADTherapistWorksheet_sn6, ADClientWorksheet_sn6, ADReviewWorksheet_sn6, ADReviewFaultyThinkingPatterns_sn7, ADIntroCBW_sn7, ADIntroSafetyModule_sn7, ADAssignCBWsSafety_sn7, ADhonesstuckpoints_sn7, ADuseSocraticQuestions_sn7, ADPrioritizeAssim_sn7, ADCompleteAssignInSession_sn7, ADInterventionforCompliance_sn7, ADTherapistReassigns_sn7, ADencourageAffect_sn7, ADTraumaFocused_sn7, ADTherapistWorksheet_sn7, ADClientWorksheet_sn7, ADReviewWorksheet_sn7, ADReviewCBWs_sn8, ADConfrontFaultyCognitions_sn8, ADIntroTrust_sn8, ADAssignCBWTrust_sn8, ADhonesstuckpoints_sn8,

	ADuseSocraticQuestions_sn8, ADPrioritizeAssim_sn8, ADCompleteAssignInSession_sn8, ADInterventionforCompliance_sn8, ADTherapistReassigns_sn8, ADencourageAffect_sn8, ADTraumaFocused_sn8, ADTherapistWorksheet_sn8, ADClientWorksheet_sn8, ADReviewWorksheet_sn8, ADReviewCBWs_sn9, ADDiscussJudgement_sn9, ADIntroPower_sn9, ADAssignCBWsPower_sn9, ADhonesstuckpoints_sn9, ADuseSocraticQuestions_sn9, ADPrioritizeAssim_sn9, ADCompleteAssignInSession_sn9, ADInterventionforCompliance_sn9, ADTherapistReassigns_sn9, ADencourageAffect_sn9, ADTraumaFocused_sn9, ADTherapistWorksheet_sn9, ADClientWorksheet_sn9, ADReviewWorksheet_sn9, ADChallengePowerCBW_sn10, ADIntroEsteem_sn10, ADAssignEsteemCBWs_sn10, ADAssignCompliments_sn10, ADAssignPleasurableEvents_sn10, ADhonesstuckpoints_sn10, ADuseSocraticQuestions_sn10, ADPrioritizeAssim_sn10, ADCompleteAssignInSession_sn10, ADInterventionforCompliance_sn10, ADTherapistReassigns_sn10, ADencourageAffect_sn10, ADTraumaFocused_sn10, ADTherapistWorksheet_sn10, ADClientWorksheet_sn10, ADReviewWorksheet_sn10, ADChallengeEsteemCBWs_sn11, ADReactionsComplimentsActivities_sn11,

	ADIntroIntimacy_sn11, ADAssignCBWsIntimacy_sn11, ADAssignFinalImpact_sn11, ADhonesstuckpoints_sn11, ADuseSocraticQuestions_sn11, ADPrioritizeAssim_sn11, ADCompleteAssignInSession_sn11, ADInterventionforCompliance_sn11, ADTherapistReassigns_sn11, ADencourageAffect_sn11, ADTraumaFocused_sn11, ADTherapistWorksheet_sn11, ADClientWorksheet_sn11, ADReviewWorksheet_sn11, ADConfrontStuckPointsCWBs_sn12, ADReadNewImpact_sn12, ADReviewProgress_sn12, ADFutureGoals_sn12, ADhonesstuckpoints_sn12, ADuseSocraticQuestions_sn12, ADPrioritizeAssim_sn12, ADCompleteAssignInSession_sn12, ADencourageAffect_sn12, ADTraumaFocused_sn12, ADTherapistWorksheet_sn12, ADClientWorksheet_sn12, ADReviewWorksheet_sn12
Nonspecific Items:	ADGenuineness_sn1 ADWarmth_sn1 ADEmpathy_sn1 ADProfessional_sn1 ADAgenda_sn1 ADStructureEfficient_sn1 ADElicitFeedback_sn1 ADGenuineness_sn2 ADWarmth_sn2 ADEmpathy_sn2 ADProfessional_sn2 ADAgenda_sn2 ADStructureEfficient_sn2 ADElicitFeedback_sn2 ADGenuineness_sn3,

	ADWarmth_sn3, ADEmpathy_sn3, ADProfessional_sn3, ADAgenda_sn3, ADStructureEfficient_sn3, ADElicitFeedback_sn3, ADGenuineness_sn4, ADWarmth_sn4, ADEmpathy_sn4, ADProfessional_sn4, ADAgenda_sn4, ADStructureEfficient_sn4, ADElicitFeedback_sn4, ADGenuineness_sn5, ADWarmth_sn5, ADEmpathy_sn5, ADProfessional_sn5, ADAgenda_sn5, ADStructureEfficient_sn5, ADElicitFeedback_sn5, ADGenuineness_sn6, ADWarmth_sn6, ADEmpathy_sn6, ADProfessional_sn6, ADAgenda_sn6, ADStructureEfficient_sn6, ADElicitFeedback_sn6, ADGenuineness_sn7, ADWarmth_sn7, ADEmpathy_sn7, ADProfessional_sn7, ADAgenda_sn7, ADStructureEfficient_sn7, ADElicitFeedback_sn7, ADGenuineness_sn8, ADWarmth_sn8, ADEmpathy_sn8, ADProfessional_sn8, ADAgenda_sn8, ADStructureEfficient_sn8, ADElicitFeedback_sn8,

	ADGenuineness_sn9, ADWarmth_sn9, ADEmpathy_sn9, ADProfessional_sn9, ADAgenda_sn9, ADStructureEfficient_sn9, ADElicitFeedback_sn9, ADGenuineness_sn10, ADWarmth_sn10, ADEmpathy_sn10, ADProfessional_sn10, ADAgenda_sn10, ADStructureEfficient_sn10, ADElicitFeedback_sn10, ADGenuineness_sn11, ADWarmth_sn11, ADEmpathy_sn11, ADProfessional_sn11, ADAgenda_sn11, ADStructureEfficient_sn11, ADElicitFeedback_sn11, ADGenuineness_sn12, ADWarmth_sn12, ADEmpathy_sn12, ADProfessional_sn12, ADAgenda_sn12, ADReviewHWsheet_sn12, ADStructureEfficient_sn12, ADElicitFeedback_sn12, ADAssignedHWClearly_sn12, ADProblemSolved_sn12

Appendix D

Item Lists for Adherence Variables – Four Critical Components

Skill in Socratic Questioning:	ADelicitstuckpoints_sn1, ADhonesstuckpoints_sn1, ADuseSocraticQuestions_sn1, ADelicitstuckpoints_sn2, ADhonesstuckpoints_sn2, ADuseSocraticQuestions_sn2, ADIdentifySP_sn3, ADhonesstuckpoints_sn3, ADuseSocraticQuestions_sn3, ADhonesstuckpoints_sn4, ADuseSocraticQuestions_sn4, ADhonesstuckpoints_sn5, ADuseSocraticQuestions_sn5, ADhonesstuckpoints_sn6, ADuseSocraticQuestions_sn6, ADhonesstuckpoints_sn7, ADuseSocraticQuestions_sn7, ADhonesstuckpoints_sn8, ADuseSocraticQuestions_sn8, ADhonesstuckpoints_sn9, ADuseSocraticQuestions_sn9, ADhonesstuckpoints_sn10, ADuseSocraticQuestions_sn10, ADhonesstuckpoints_sn11, ADuseSocraticQuestions_sn11, ADhonesstuckpoints_sn12, ADuseSocraticQuestions_sn12
Assimilation before Over-Accommodation:	ADAssimilatedSP_sn2, ADOverAccommodatedSP_sn2, ADPrioritizeAssim_sn2,

	ADPrioritizeAssim_sn3, ADPrioritizeAssim_sn4, ADPrioritizeAssim_sn5, ADPrioritizeAssim_sn6, ADPrioritizeAssim_sn7, ADPrioritizeAssim_sn8, ADPrioritizeAssim_sn9, ADPrioritizeAssim_sn10, ADPrioritizeAssim_sn11, ADPrioritizeAssim_sn12
Use of Out-of-session Practice Assignments:	ADintroHW_sn1, ADAssignedHWClearly_sn1, ADProblemSolved_sn1, ADReadImpact_sn2, ADDescribeOrally_sn2, ADDiscussedMeaning_sn2, ADInterventionforCompliance_sn2, ADTherapistReassigns_sn2, ADAssignedHWClearly_sn2, ADProblemSolved_sn2, ADReviewABCsheets_sn3, ADCompleteAssignInSession_sn3, ADInterventionforCompliance_sn3, ADTherapistReassigns_sn3, ADAssignedHWClearly_sn3, ADProblemSolved_sn3, ADReadAccount_sn4, ADNoAccountRecount_sn4, ADInterventionforCompliance_sn4, ADTherapistReassigns_sn4, ADAssignedHWClearly_sn4, ADProblemSolved_sn4,

	ADRead2ndAccount_sn5, ADCompleteAssignInSession_sn5, ADInterventionforCompliance_sn5, ADTherapistReassigns_sn5, ADAssignedHWClearly_sn5, ADProblemSolved_sn5, ADReviewChallengingQuestions_sn6, ADCompleteAssignInSession_sn6, ADInterventionforCompliance_sn6, ADTherapistReassigns_sn6, ADAssignedHWClearly_sn6, ADProblemSolved_sn6, ADReviewFaultyThinkingPatterns_sn7, ADCompleteAssignInSession_sn7, ADInterventionforCompliance_sn7, ADTherapistReassigns_sn7, ADAssignedHWClearly_sn7, ADProblemSolved_sn7, ADReviewCBWs_sn8, ADCompleteAssignInSession_sn8, ADInterventionforCompliance_sn8, ADTherapistReassigns_sn8, ADAssignedHWClearly_sn8, ADProblemSolved_sn8, ADReviewCBWs_sn9, ADCompleteAssignInSession_sn9, ADInterventionforCompliance_sn9, ADTherapistReassigns_sn9, ADAssignedHWClearly_sn9, ADProblemSolved_sn9, ADChallengePowerCBW_sn10, ADCompleteAssignInSession_sn10, ADInterventionforCompliance_sn10, ADTherapistReassigns_sn10, ADAssignedHWClearly_sn10, ADProblemSolved_sn10, ADChallengeEsteemCBWs_sn11, ADCompleteAssignInSession_sn11, ADInterventionforCompliance_sn11, ADTherapistReassigns_sn11,

	ADAssignedHWClearly_sn11, ADProblemSolved_sn11, ADConfrontStuckPointsCWBs_sn12, ADReadNewImpact_sn12, ADCompleteAssignInSession_sn12
Emphasis on Expression of Natural Affect:	ADencourageAffect_sn1, ADencourageAffect_sn2, ADencourageAffect_sn3, ADencourageAffect_sn4, ADencourageAffect_sn5, ADencourageAffect_sn6, ADencourageAffect_sn7, ADencourageAffect_sn8, ADencourageAffect_sn9, ADencourageAffect_sn10, ADencourageAffect_sn11, ADencourageAffect_sn12

Appendix E

Item Lists for Competence Variables – Original, New, Revised, and Nonspecific

Original Items:	COMPeducatePTSD_sn1, COMPtreatmentrationale_sn1, COMPtreatmentoverview_sn1, COMPassignimpact_sn1, COMPReviewConcepts_sn2, COMPReadImpact_sn2, COMPDescribeOrally_sn2, COMPDiscussedMeaning_sn2, COMPABCsheets_sn2, COMPAssignABCsheet_sn2, COMPReviewABCsheets_sn3, COMPIdentifySP_sn3, COMPExploreSelfBlame_sn3, COMPAssignTraumaAccount_sn3, COMPReadAccount_sn4, COMPNoAccountRecount_sn4, COMPIdentifyStuckPoints_sn4, COMPChallengeSelfBlame_sn4, COMPAssignRewriteAccount_sn4, COMPRead2ndAccount_sn5, COMPChallengingAssumptions_sn5, COMPIntroChallengingQuestions_sn5, COMPAssignChallengingQuestions_sn5, COMPReviewChallengingQuestions_sn6, COMPIntroFaultyPatterns_sn6, COMPGenerateExamplePatterns_sn6, COMPAssignFaultyPatterns_sn6, COMPReviewFaultyThinkingPatterns_sn7, COMPIntroCBW_sn7, COMPIntroSafetyModule_sn7, COMPAssignCBWsSafety_sn7, COMPReviewCBWs_sn8, COMPConfrontFaultyCognitions_sn8, COMPIntroTrust_sn8, COMPAssignCBWTrust_sn8,

	COMPReviewCBWs_sn9, COMPDiscussJudgement_sn9, COMPIntroPower_sn9, COMPAssignCBWsPower_sn9, COMPChallengePowerCBW_sn10, COMPIntroEsteem_sn10, COMPAssignEsteemCBWs_sn10, COMPAssignCompliments_sn10, COMPAssignPleasurableEvents_sn10, COMPChallengeEsteemCBWs_sn11, COMPReactionsComplimentsActivities_sn11, COMPIntroIntimacy_sn11, COMPAssignCBWsIntimacy_sn11, COMPAssignFinalImpact_sn11, COMPConfrontStuckPointsCWBs_sn12, COMPReadNewImpact_sn12, COMPReviewProgress_sn12, COMPFutureGoals_sn12
New Items:	COMPelicitstuckpoints_sn1, COMPhonesstuckpoints_sn1, COMPuseSocraticQuestions_sn1, COMPpercentSocratic_sn1, COMPintroHW_sn1, COMPencourageAffect_sn1, COMPTraumaFocused_sn1, COMPelicitstuckpoints_sn2, COMPhonesstuckpoints_sn2, COMPuseSocraticQuestions_sn2, COMPpercentSocratic_sn2, COMPAssimilatedSP_sn2, COMPOverAccommodatedSP_sn2, COMPPrioritizeAssim_sn2, COMPInterventionforCompliance_sn2, COMPTherapistReassigns_sn2, COMPencourageAffect_sn2, COMPTraumaFocused_sn2, COMPhonesstuckpoints_sn3, COMPuseSocraticQuestions_sn3, COMPpercentSocratic_sn3, COMPPrioritizeAssim_sn3,

	COMPCompleteAssignInSession_sn3, COMPInterventionforCompliance_sn3, COMPTherapistReassigns_sn3, COMPencourageAffect_sn3, COMPTraumaFocused_sn3, COMPhonesstuckpoints_sn4, COMPuseSocraticQuestions_sn4, COMPpercentSocratic_sn4, COMPPrioritizeAssim_sn4, COMPInterventionforCompliance_sn4, COMPTherapistReassigns_sn4, COMPencourageAffect_sn4, COMPTraumaFocused_sn4, COMPhonesstuckpoints_sn5, COMPuseSocraticQuestions_sn5, COMPpercentSocratic_sn5, COMPPrioritizeAssim_sn5, COMPCompleteAssignInSession_sn5, COMPInterventionforCompliance_sn5, COMPTherapistReassigns_sn5, COMPencourageAffect_sn5, COMPTraumaFocused_sn5, COMPhonesstuckpoints_sn6, COMPuseSocraticQuestions_sn6, COMPpercentSocratic_sn6, COMPPrioritizeAssim_sn6, COMPCompleteAssignInSession_sn6, COMPInterventionforCompliance_sn6, COMPTherapistReassigns_sn6, COMPencourageAffect_sn6, COMPTraumaFocused_sn6, COMPhonesstuckpoints_sn7, COMPuseSocraticQuestions_sn7, COMPpercentSocratic_sn7, COMPPrioritizeAssim_sn7, COMPCompleteAssignInSession_sn7, COMPInterventionforCompliance_sn7, COMPTherapistReassigns_sn7, COMPencourageAffect_sn7, COMPTraumaFocused_sn7, COMPhonesstuckpoints_sn8,

	COMPuseSocraticQuestions_sn8, COMPpercentSocratic_sn8, COMPPrioritizeAssim_sn8, COMPCompleteAssignInSession_sn8, COMPInterventionforCompliance_sn8, COMPTherapistReassigns_sn8, COMPencourageAffect_sn8, COMPTraumaFocused_sn8, COMPhonesstuckpoints_sn9, COMPuseSocraticQuestions_sn9, COMPpercentSocratic_sn9, COMPPrioritizeAssim_sn9, COMPCompleteAssignInSession_sn9, COMPInterventionforCompliance_sn9, COMPTherapistReassigns_sn9, COMPencourageAffect_sn9, COMPTraumaFocused_sn9, COMPhonesstuckpoints_sn10, COMPuseSocraticQuestions_sn10, COMPpercentSocratic_sn10, COMPPrioritizeAssim_sn10, COMPCompleteAssignInSession_sn10, COMPInterventionforCompliance_sn10, COMPTherapistReassigns_sn10, COMPencourageAffect_sn10, COMPTraumaFocused_sn10, COMPhonesstuckpoints_sn11, COMPuseSocraticQuestions_sn11, COMPpercentSocratic_sn11, COMPPrioritizeAssim_sn11, COMPCompleteAssignInSession_sn11, COMPInterventionforCompliance_sn11, COMPTherapistReassigns_sn11, COMPencourageAffect_sn11, COMPTraumaFocused_sn11, COMPhonesstuckpoints_sn12, COMPuseSocraticQuestions_sn12, COMPpercentSocratic_sn12, COMPPrioritizeAssim_sn12, COMPCompleteAssignInSession_sn12, COMPencourageAffect_sn12, COMPTraumaFocused_sn12

Revised Items (Original + New):	COMPeducatePTSD_sn1, COMPtreatmentrationale_sn1, COMPtreatmentoverview_sn1, COMPassignimpact_sn1, COMPelicitstuckpoints_sn1, COMPhonesstuckpoints_sn1, COMPuseSocraticQuestions_sn1, COMPpercentSocratic_sn1, COMPintroHW_sn1, COMPencourageAffect_sn1, COMPTraumaFocused_sn1, COMPReviewConcepts_sn2, COMPReadImpact_sn2, COMPDescribeOrally_sn2, COMPDiscussedMeaning_sn2, COMPABCsheets_sn2, COMPAssignABCsheet_sn2, COMPelicitstuckpoints_sn2, COMPhonesstuckpoints_sn2, COMPuseSocraticQuestions_sn2, COMPpercentSocratic_sn2, COMPAssimilatedSP_sn2, COMPOverAccommodatedSP_sn2, COMPPrioritizeAssim_sn2, COMPInterventionforCompliance_sn2, COMPTherapistReassigns_sn2, COMPencourageAffect_sn2, COMPTraumaFocused_sn2, COMPReviewABCsheets_sn3, COMPIdentifySP_sn3, COMPExploreSelfBlame_sn3, COMPAssignTraumaAccount_sn3, COMPhonesstuckpoints_sn3, COMPuseSocraticQuestions_sn3, COMPpercentSocratic_sn3, COMPPrioritizeAssim_sn3, COMPCompleteAssignInSession_sn3, COMPInterventionforCompliance_sn3, COMPTherapistReassigns_sn3, COMPencourageAffect_sn3, COMPTraumaFocused_sn3, COMPReadAccount_sn4,

	COMPNoAccountRecount_sn4, COMPIdentifyStuckPoints_sn4, COMPChallengeSelfBlame_sn4, COMPAssignRewriteAccount_sn4, COMPhonesstuckpoints_sn4, COMPuseSocraticQuestions_sn4, COMPpercentSocratic_sn4, COMPPrioritizeAssim_sn4, COMPInterventionforCompliance_sn4, COMPTherapistReassigns_sn4, COMPencourageAffect_sn4, COMPTraumaFocused_sn4, COMPRead2ndAccount_sn5, COMPChallengingAssumptions_sn5, COMPIntroChallengingQuestions_sn5, COMPAssignChallengingQuestions_sn5, COMPhonesstuckpoints_sn5, COMPuseSocraticQuestions_sn5, COMPpercentSocratic_sn5, COMPPrioritizeAssim_sn5, COMPCompleteAssignInSession_sn5, COMPInterventionforCompliance_sn5, COMPTherapistReassigns_sn5, COMPencourageAffect_sn5, COMPTraumaFocused_sn5, COMPReviewChallengingQuestions_sn6, COMPIntroFaultyPatterns_sn6, COMPGenerateExamplePatterns_sn6, COMPAssignFaultyPatterns_sn6, COMPhonesstuckpoints_sn6, COMPuseSocraticQuestions_sn6, COMPpercentSocratic_sn6, COMPPrioritizeAssim_sn6, COMPCompleteAssignInSession_sn6, COMPInterventionforCompliance_sn6, COMPTherapistReassigns_sn6, COMPencourageAffect_sn6, COMPTraumaFocused_sn6, COMPReviewFaultyThinkingPatterns_sn7, COMPIntroCBW_sn7, COMPIntroSafetyModule_sn7, COMPAssignCBWsSafety_sn7, COMPhonesstuckpoints_sn7,

	COMPuseSocraticQuestions_sn7, COMPpercentSocratic_sn7, COMPPrioritizeAssim_sn7, COMPCompleteAssignInSession_sn7, COMPInterventionforCompliance_sn7, COMPTherapistReassigns_sn7, COMPencourageAffect_sn7, COMPTraumaFocused_sn7, COMPReviewCBWs_sn8, COMPConfrontFaultyCognitions_sn8, COMPIntroTrust_sn8, COMPAssignCBWTrust_sn8, COMPhonesstuckpoints_sn8, COMPuseSocraticQuestions_sn8, COMPpercentSocratic_sn8, COMPPrioritizeAssim_sn8, COMPCompleteAssignInSession_sn8, COMPInterventionforCompliance_sn8, COMPTherapistReassigns_sn8, COMPencourageAffect_sn8, COMPTraumaFocused_sn8, COMPReviewCBWs_sn9, COMPDiscussJudgement_sn9, COMPIntroPower_sn9, COMPAssignCBWsPower_sn9, COMPhonesstuckpoints_sn9, COMPuseSocraticQuestions_sn9, COMPpercentSocratic_sn9, COMPPrioritizeAssim_sn9, COMPCompleteAssignInSession_sn9, COMPInterventionforCompliance_sn9, COMPTherapistReassigns_sn9, COMPencourageAffect_sn9, COMPTraumaFocused_sn9, COMPChallengePowerCBW_sn10, COMPIntroEsteem_sn10, COMPAssignEsteemCBWs_sn10, COMPAssignCompliments_sn10, COMPAssignPleasurableEvents_sn10, COMPhonesstuckpoints_sn10, COMPuseSocraticQuestions_sn10, COMPpercentSocratic_sn10, COMPPrioritizeAssim_sn10,

	COMPCompleteAssignInSession_sn10, COMPInterventionforCompliance_sn10, COMPTherapistReassigns_sn10, COMPencourageAffect_sn10, COMPTraumaFocused_sn10, COMPChallengeEsteemCBWs_sn11, COMPReactionsComplimentsActivities_sn11, COMPIntroIntimacy_sn11, COMPAssignCBWsIntimacy_sn11, COMPAssignFinalImpact_sn11, COMPhonesstuckpoints_sn11, COMPuseSocraticQuestions_sn11, COMPpercentSocratic_sn11, COMPPrioritizeAssim_sn11, COMPCompleteAssignInSession_sn11, COMPInterventionforCompliance_sn11, COMPTherapistReassigns_sn11, COMPencourageAffect_sn11, COMPTraumaFocused_sn11, COMPConfrontStuckPointsCWBs_sn12, COMPReadNewImpact_sn12, COMPReviewProgress_sn12, COMPFutureGoals_sn12, COMPhonesstuckpoints_sn12, COMPuseSocraticQuestions_sn12, COMPpercentSocratic_sn12, COMPPrioritizeAssim_sn12, COMPCompleteAssignInSession_sn12, COMPencourageAffect_sn12, COMPTraumaFocused_sn12
Nonspecific Items:	COMPGenuineness_sn1, COMPWarmth_sn1, COMPEmpathy_sn1, COMPProfessional_sn1, COMPAgenda_sn1, COMPStructureEfficient_sn1, COMPElicitFeedback_sn1, COMPGenuineness_sn2, COMPWarmth_sn2, COMPEmpathy_sn2, COMPProfessional_sn2, COMPAgenda_sn2,

	COMPStructureEfficient_sn2, COMPElicitFeedback_sn2, COMPGenuineness_sn3, COMPWarmth_sn3, COMPEmpathy_sn3, COMPProfessional_sn3, COMPAgenda_sn3, COMPStructureEfficient_sn3, COMPElicitFeedback_sn3, COMPGenuineness_sn4, COMPWarmth_sn4, COMPEmpathy_sn4, COMPProfessional_sn4, COMPAgenda_sn4, COMPStructureEfficient_sn4, COMPElicitFeedback_sn4, COMPGenuineness_sn5, COMPWarmth_sn5, COMPEmpathy_sn5, COMPProfessional_sn5, COMPAgenda_sn5, COMPStructureEfficient_sn5, COMPElicitFeedback_sn5, COMPGenuineness_sn6, COMPWarmth_sn6, COMPEmpathy_sn6, COMPProfessional_sn6, COMPAgenda_sn6, COMPStructureEfficient_sn6, COMPElicitFeedback_sn6, COMPGenuineness_sn7, COMPWarmth_sn7, COMPEmpathy_sn7, COMPProfessional_sn7, COMPAgenda_sn7, COMPStructureEfficient_sn7, COMPElicitFeedback_sn7, COMPGenuineness_sn8, COMPWarmth_sn8, COMPEmpathy_sn8,

	COMPProfessional_sn8, COMPAgenda_sn8, COMPStructureEfficient_sn8, COMPElicitFeedback_sn8, COMPGenuineness_sn9, COMPWarmth_sn9, COMPEmpathy_sn9, COMPProfessional_sn9, COMPAgenda_sn9, COMPStructureEfficient_sn9, COMPElicitFeedback_sn9, COMPGenuineness_sn10, COMPWarmth_sn10, COMPEmpathy_sn10, COMPProfessional_sn10, COMPAgenda_sn10, COMPStructureEfficient_sn10, COMPElicitFeedback_sn10, COMPGenuineness_sn11, COMPWarmth_sn11, COMPEmpathy_sn11, COMPProfessional_sn11, COMPAgenda_sn11, COMPStructureEfficient_sn11, COMPElicitFeedback_sn11, COMPGenuineness_sn12, COMPWarmth_sn12, COMPEmpathy_sn12, COMPProfessional_sn12, COMPAgenda_sn12, COMPReviewHWsheet_sn12, COMPStructureEfficient_sn12, COMPElicitFeedback_sn12

Appendix F

Item Lists for Competence Variables – Four Critical Components

Skill in Socratic Questioning:	COMPelicitstuckpoints_sn1, COMPhonesstuckpoints_sn1, COMPuseSocraticQuestions_sn1, COMPelicitstuckpoints_sn2, COMPhonesstuckpoints_sn2, COMPuseSocraticQuestions_sn2, COMPIdentifySP_sn3, COMPExploreSelfBlame_sn3, COMPhonesstuckpoints_sn3, COMPuseSocraticQuestions_sn3, COMPhonesstuckpoints_sn4, COMPuseSocraticQuestions_sn4, COMPhonesstuckpoints_sn5, COMPuseSocraticQuestions_sn5, COMPhonesstuckpoints_sn6, COMPuseSocraticQuestions_sn6, COMPhonesstuckpoints_sn7, COMPuseSocraticQuestions_sn7, COMPhonesstuckpoints_sn8, COMPuseSocraticQuestions_sn8, COMPhonesstuckpoints_sn9, COMPuseSocraticQuestions_sn9, COMPhonesstuckpoints_sn10, COMPuseSocraticQuestions_sn10, COMPhonesstuckpoints_sn11, COMPuseSocraticQuestions_sn11, COMPhonesstuckpoints_sn12, COMPuseSocraticQuestions_sn12
Assimilation before Over-Accommodation:	COMPAssimilatedSP_sn2, COMPOverAccommodatedSP_sn2, COMPPrioritizeAssim_sn2,

	COMPPrioritizeAssim_sn3, COMPPrioritizeAssim_sn4, COMPPrioritizeAssim_sn5, COMPPrioritizeAssim_sn6, COMPPrioritizeAssim_sn7, COMPPrioritizeAssim_sn8, COMPPrioritizeAssim_sn9, COMPPrioritizeAssim_sn10, COMPPrioritizeAssim_sn11, COMPPrioritizeAssim_sn12,
Use of Out-of-session Practice Assignments:	COMPintroHW_sn1, COMPAssignedHWClearly_sn1, COMPProblemSolved_sn1, COMPReadImpact_sn2, COMPDescribeOrally_sn2, COMPDiscussedMeaning_sn2, COMPInterventionforCompliance_sn2, COMPTherapistReassigns_sn2, COMPAssignedHWClearly_sn2, COMPProblemSolved_sn2, COMPReviewABCsheets_sn3, COMPCompleteAssignInSession_sn3, COMPInterventionforCompliance_sn3, COMPTherapistReassigns_sn3, COMPAssignedHWClearly_sn3, COMPProblemSolved_sn3, COMPReadAccount_sn4, COMPNoAccountRecount_sn4, COMPInterventionforCompliance_sn4, COMPTherapistReassigns_sn4, COMPAssignedHWClearly_sn4, COMPProblemSolved_sn4,

	COMPRead2ndAccount_sn5, COMPCompleteAssignInSession_sn5, COMPInterventionforCompliance_sn5, COMPTherapistReassigns_sn5, COMPAssignedHWClearly_sn5, COMPProblemSolved_sn5, COMPReviewChallengingQuestions_sn6, COMPCompleteAssignInSession_sn6, COMPInterventionforCompliance_sn6, COMPTherapistReassigns_sn6, COMPAssignedHWClearly_sn6, COMPProblemSolved_sn6, COMPReviewFaultyThinkingPatterns_sn7, COMPCompleteAssignInSession_sn7, COMPInterventionforCompliance_sn7, COMPTherapistReassigns_sn7, COMPAssignedHWClearly_sn7, COMPProblemSolved_sn7, COMPReviewCBWs_sn8, COMPCompleteAssignInSession_sn8, COMPInterventionforCompliance_sn8, COMPTherapistReassigns_sn8, COMPAssignedHWClearly_sn8, COMPProblemSolved_sn8, COMPReviewCBWs_sn9, COMPCompleteAssignInSession_sn9, COMPInterventionforCompliance_sn9, COMPTherapistReassigns_sn9, COMPAssignedHWClearly_sn9, COMPProblemSolved_sn9, COMPChallengePowerCBW_sn10, COMPCompleteAssignInSession_sn10, COMPInterventionforCompliance_sn10, COMPTherapistReassigns_sn10, COMPAssignedHWClearly_sn10, COMPProblemSolved_sn10, COMPChallengeEsteemCBWs_sn11, COMPCompleteAssignInSession_sn11, COMPInterventionforCompliance_sn11,

	COMPTherapistReassigns_sn11, COMPAssignedHWClearly_sn11, COMPProblemSolved_sn11, COMPConfrontStuckPointsCBWs_sn12, COMPReadNewImpact_sn12, COMPCompleteAssignInSession_sn12,
Emphasis on Expression of Natural Affect:	COMPencourageAffect_sn1, COMPencourageAffect_sn2, COMPencourageAffect_sn3, COMPencourageAffect_sn4, COMPencourageAffect_sn5, COMPencourageAffect_sn6, COMPencourageAffect_sn7, COMPencourageAffect_sn8, COMPencourageAffect_sn9, COMPencourageAffect_sn10, COMPencourageAffect_sn11, COMPencourageAffect_sn12