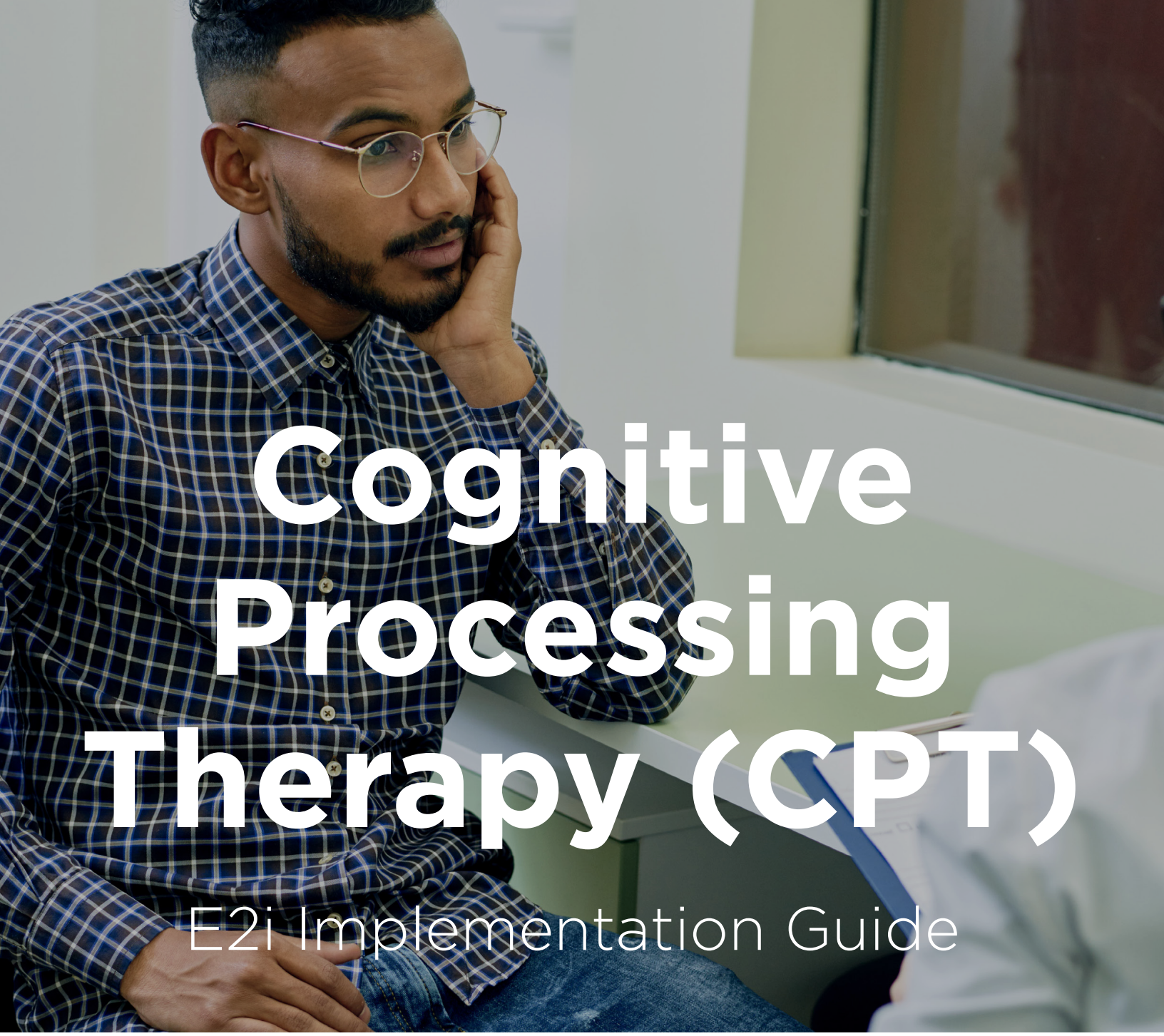

Cognitive Processing Therapy (CPT)

E2i Implementation Guide

An evidence-based intervention, adapted for the Health Resources and Services Administration's Ryan White HIV/AIDS Program, that focuses on reducing symptoms of posttraumatic stress disorder (PTSD) among people with HIV.

FALL 2021

RYAN WHITE E2i HIV/AIDS PROGRAM

A SPECIAL PROJECT OF NATIONAL SIGNIFICANCE

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Acknowledgments

We would like to thank the following organizations for piloting the implementation of CPT. We are especially grateful to the following people who led the implementation for their organization and provided their stories, experiences, and feedback to this Implementation Guide.

Positive Impact Health Centers
Gwen Davies, Victoria Leftridge, Eileen Pagan, Lucero Morse, Brace Arnette, Danielle Wright

Western North Caroline Community Health Services
Nivee Roy, Lindsey Phillips, Scott Parker, Todd Wallenius, Monica Olsen, Sierra Lohman

Thank you also to Anna Laurence and Rachel Kohn, John Snow, Incorporated; and Erica Sawyer, Jordan Hutensky and Katie Burkhart of Fenway Health for designing the Implementation Guide.

Suggested citation: *Cognitive Processing Therapy: E2i Implementation Guide*. Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau; 2021.

Funding statement: This product was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of Ryan White HIV/AIDS Program (RWHAP) Part F - Special Projects of National Significance (SPNS) Program awards totaling $20,307,770 with 0% financed with non-governmental sources, and $2,200,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS, RWHAP SPNS, or the U.S. Government. For more information, please visit HRSA.gov.

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EXECUTIVE SUMMARY

Cognitive Processing Therapy (CPT) is an evidence-based intervention adapted by HIV experts in collaboration with community members to improve health outcomes among people with HIV. CPT provides cognitive behavioral treatment to reduce posttraumatic stress symptoms among people with HIV diagnosed with posttraumatic stress disorder. Through CPT sessions delivered by a behavioral health therapist, clients learn to recognize and address the effects of trauma on their thoughts and feelings.

This Implementation Guide was developed for *Using Evidence-Informed Interventions to Improve Health Outcomes among People Living with HIV (E2i)*, which tested CPT within Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program (RWHAP) settings and evaluated its impact. Additional easy-to-use implementation tools, tips, and resources to support replication of CPT in the RWHAP and other HIV service organizations can be found in the ***CPT E2i Toolkit***.

INTRODUCTION TO THE IMPLEMENTATION GUIDE

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What is Cognitive Processing Therapy?

Cognitive Processing Therapy (CPT) is an evidence-based, cognitive behavioral treatment for posttraumatic stress disorder (PTSD). Through individual or group sessions of CPT, clients learn to recognize and challenge unhelpful thoughts and beliefs related to trauma. CPT is delivered by a behavioral health therapist who follows the protocol and worksheets available in ***Cognitive Processing Therapy for PTSD: A Comprehensive Manual*** (CPT Manual) available from Guilford Press.[1]

Purpose of the Implementation Guide

The purpose of this Implementation Guide is to orient users to the delivery of CPT, and to provide essential information and tools for planning and implementing CPT in the Ryan White HIV/AIDS Program (RWHAP) and other HIV service organizations. This Guide is part of the ***CPT E2i Toolkit***, a collection of helpful resources for implementing CPT. Additional essential information is available in the ***CPT Manual***.

Implementation Guide Background

This Guide was developed as part of the RWHAP Part F Special Projects of National Significance (SPNS) Program *Using Evidence-Informed Interventions to Improve Health Outcomes among People Living with HIV (E2i)*, a four-year initiative (2017-2021) funded by the Health Resources and Services Administration's HIV/AIDS Bureau (HRSA HAB) of the U.S. Department of Health and Human Services. E2i was designed to improve HIV health outcomes for people with HIV who experience persistent gaps along the HIV care continuum, such as engagement in care, retention in care, adherence to antiretroviral therapy (ART), and viral suppression. Because PTSD is associated with adverse effects on HIV health outcomes, people with HIV who have PTSD are among those most in need of interventions that address trauma.

E2i chose to pilot the implementation of CPT within HIV service organizations because of its demonstrated efficacy in reducing symptoms of PTSD. Through a competitive request for proposals, two HIV service organizations in the RWHAP were selected to implement CPT between 2018 and 2020. These sites reported program and client outcome data to a team of evaluators who then analyzed these data. The stories, experiences, and evaluation outcomes of the two sites are integrated and highlighted throughout this Guide.

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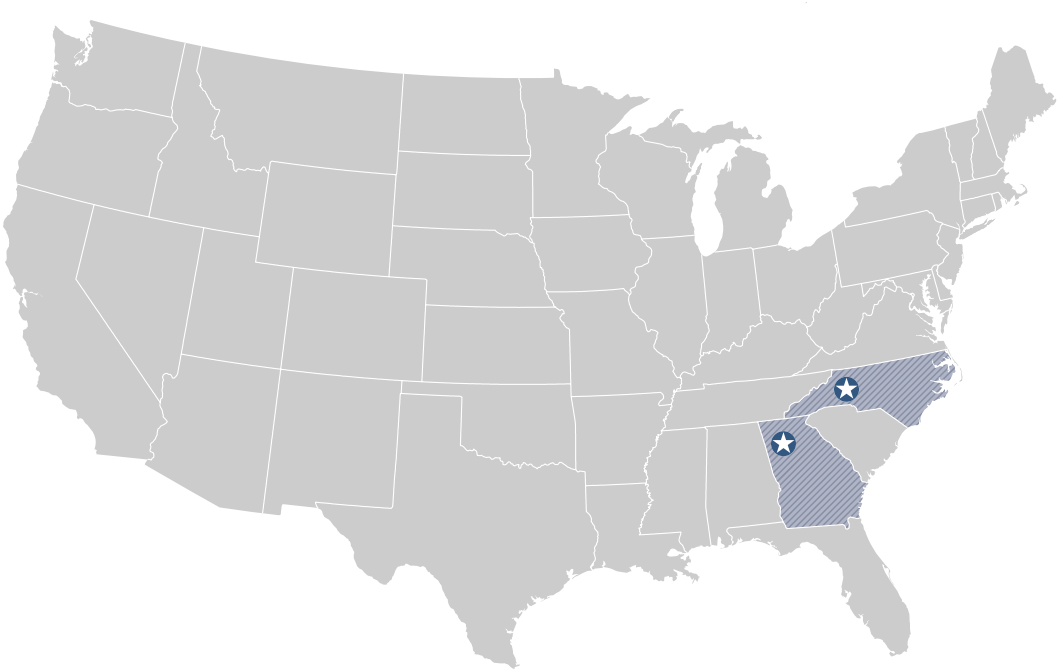
[1] Resick PA, Monson CM, Chard KM. Cognitive Processing Therapy for PTSD: A Comprehensive Manual. New York, NY: Guilford Press; 2016. Available at: https://www.guilford.com/books/Cognitive-Processing-Therapy-for-PTSD/Resick-Monson-Chard/9781462528646

The E2i Implementation Sites

FIGURE 1. Locations of the two sites that implemented CPT through the E2i initiative.



Positive Impact Health Centers (Decatur, Duluth, and Marietta, Georgia)

- HIV primary care and specialty care clinic
- RWHAP Parts A,B, and C recipient
- 2,860 clients with HIV a year
- 95 employees provide HIV services
- Most common non-medical services accessed by clients with HIV: medical/support referrals (82%), medical transport (77%), outreach (23%)

Western North Carolina Community Health Services (Asheville, North Carolina)

- Federally qualified health center
- RWHAP Parts B, C, and D recipient
- 750 clients with HIV a year
- 45 employees provide HIV services
- Most common non-medical services accessed by clients with HIV: non-medical case management (100%), health education (100%), psychosocial support (100%)

Implementation Science Evaluation

E2i used an implementation science approach to evaluate CPT. The evaluation aimed to answer the following questions:

- "What does it take to implement this intervention in an HIV service organization?"
- "To what extent is successful implementation related to better HIV outcomes for the clients?"

E2i evaluators collected CPT client data from the E2i sites throughout the initiative to measure engagement in care, prescription of ART, retention in care, and viral suppression. They also collected and reviewed site staff surveys, client encounter forms, site visit reports, and meeting notes in order to learn more about the key factors for: successful implementation; challenges encountered by the interventionists; and adaptations made to meet the needs of local settings and priority populations. The major findings from the evaluation are reported throughout this Guide. For more detail on E2i's theoretical approach and evaluation methods, see ***Appendix A***. See also the ***CPT E2i Toolkit*** for additional evaluation findings reported in manuscripts.

CPT OVERVIEW

CPT OVERVIEW

Goal

The primary goals of implementing CPT in an HIV service organization are:

- To reduce symptoms of PTSD and related disorders (e.g., depression)
- To help people with HIV stay engaged in HIV care

Description

CPT is an evidence-based, cognitive behavioral treatment for PTSD. A behavioral health therapist delivers approximately 12 weekly or biweekly individual or closed group sessions using the protocol and worksheets from the ***CPT Manual***. CPT for people with HIV guides clients to recognize how traumatic experiences, as well as other factors such as intersectional identities, experiences of bias and social discrimination, and HIV status, may influence their thoughts about themselves, others, and the world. As part of CPT, clients complete worksheets to help them challenge thoughts related to trauma, called "stuck points," that prevent recovery from PTSD.

Priority Population

- People with HIV who have a diagnosis of PTSD
- Clients can be of various ages, races, ethnicities, genders, and literacy levels

CPT Enrollment at the E2i Sites

34 clients

36-55 years old

79% male

56% White

38% Black/African American

Rationale

An estimated 30% to 50% of people with HIV meet criteria for PTSD.[2,3] Among people with HIV, PTSD negatively affects HIV disclosure, medication adherence,[4] and physical health.[5] By reducing symptoms of PTSD, CPT may help clients with HIV have better HIV health outcomes.

[2] Gonzalez A, Locicero B, Mahaffey B, Fleming C, Harris J, Vujanovic AA. Internalized HIV stigma and mindfulness: Associations with PTSD symptom severity in trauma-exposed adults with HIV/AIDS. Behav Modif. 2016;40(1-2):144-163.

[3] Kessler RC, Sonnega A, Bromet E, Hughes M, Nelson CB. Posttraumatic stress disorder in the National Comorbidity Survey. Arch Gen Psychiatry. 1995;52(12):1048-1060.

[4] Safren SA, Gershuny BS, Hendriksen E. Symptoms of posttraumatic stress and death anxiety in persons with HIV and medication adherence difficulties. AIDS Client Care STDS. 2003;17(12):657-66.

[5] Brownley JR, Fallot RD, Wolfson Berley R, Himelhoch SS. Trauma history in African-American women living with HIV: Effects on psychiatric symptom severity and religious coping. AIDS Care. 2015;27(8):964-971.

Intervention Background

CPT has demonstrated efficacy for treating PTSD among a variety of populations and in a variety of treatment settings.[6-11]

Intervention Duration

- The length of CPT treatment is determined by monitoring the client's PTSD symptoms in response to intervention.
- The course of treatment is typically 12 weekly or bi-weekly sessions; however, some clients respond as early as six sessions, while others require additional sessions.
- Depending upon a client's progress, CPT can be extended for up to 24 sessions.
- CPT experts *highly recommend* delivering a minimum of six sessions per client or group.

[6] Asmundson GJG, Thorisdottir AS, Roden-Foreman JW, et al. A meta-analytic review of cognitive processing therapy for adults with posttraumatic stress disorder. Cogn Behav Ther. 2019;48(1):1-14.

[7] Chard KM. An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse. J Consult Clin Psychol. 2005;73(5):965-971.

[8] Galovski TE, Blain LM, Mott JM, Elwood L, Houle T. Manualized therapy for PTSD: Flexing the structure of cognitive processing therapy. J Consult Clin Psychol. 2012;80(6):968-981.

[9] Resick PA, Nishith P, Weaver TL, Astin MC, Feuer CA. A comparison of cognitive-processing therapy with prolonged exposure and a waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims. J Consult Clin Psychol. 2002;70(4):867-879.

[10] Resick PA, Galovski TE, Uhlmansiek MO, Scher CD, Clum GA, Young-Xu Y. A randomized clinical trial to dismantle components of cognitive processing therapy for posttraumatic stress disorder in female victims of interpersonal violence. J Consult Clin Psychol. 2008;76(2):243-258.

[11] Resick PA, Wachen JS, Dondanville KA, et al. Effect of group vs individual cognitive processing therapy in active-duty military seeking treatment for posttraumatic stress disorder: A randomized clinical trial. JAMA Psychiatry. 2017;74(1):28-36.

Settings

CPT can be delivered in any organization that serves people with HIV and employs a behavioral health therapist. Settings can include:

- Primary care
- Behavioral health care
- Telehealth
- Inpatient
- Criminal justice settings

The two E2i sites that implemented CPT were an HIV medical and specialty care clinic, and a federally qualified health center that provides comprehensive medical care to people with HIV.

Staffing

CPT staffing will vary based on the unique structure of each organization.

Core staff

At minimum, CPT requires:

- **Behavioral health therapist(s):** To deliver CPT sessions to clients with HIV.

Additional recommended staff

Additional support from existing staff depends on each clinic's local context and needs. Programs may need help from:

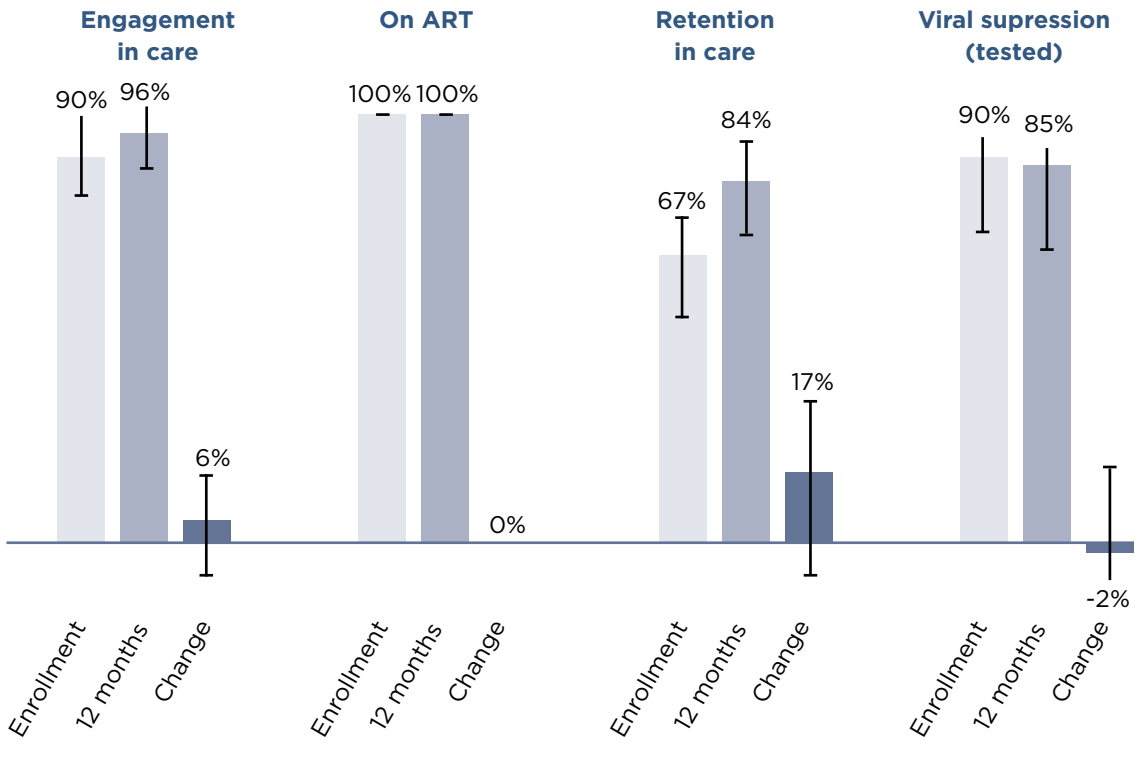
- **Program manager:** To oversee screening, referrals, and integration within the behavioral health and medical departments.
- **RN care manager(s):** To help with screening and referrals.

In addition to having a behavioral health therapist on their CPT team, one of the E2i sites also included a nurse care coordinator and primary care physician who met with clients during CPT intake to help reinforce treatment and appointment adherence. The other E2i site trained behavioral health therapy interns to support clients and deliver CPT sessions.

E2i EVALUATION:
CPT HIV CARE CONTINUUM OUTCOMES

- **Enrollment:** During a 9 to 13 month period, the E2i sites enrolled 34 clients in CPT (10 clients at one site, and 24 at the other site). Clients were 36 to 55 years old. Most clients were male (79%), 18% were female, and 3% were transgender women. Clients identified as White (56%), Black/African American (38%), and Hispanic/Latinx (11%).
- **Outcomes:** The E2i initiative measured HIV care continuum outcomes at time of enrollment and 12 months later. Among the clients enrolled in CPT, there were no statistically significant changes in outcomes. Given that CPT clients already had high levels of engagement, prescription of ART, and viral suppression at time of enrollment, it is likely that there was not a sufficient sample size to observe statistically significant changes.

FIGURE 2. HIV care continuum outcomes among the 34 clients enrolled in CPT as part of the E2i initiative.



Note: E2i used the following HRSA definitions for HIV care continuum outcomes:

- *Engagement in care* = At least one primary HIV care visit in the previous 12 months
- *On ART (adherence)* = Having been prescribed ART in the past 12 months
- *Retention in care* = At least two HIV care visits in the past 12 months
- *Viral suppression* = Having an HIV viral load test in the past 12 months AND having a result of less than 200 copies/mL at the last viral load test




CORE ELEMENTS

CORE ELEMENTS

Core elements are the "active ingredients" essential to achieving the desired outcomes of an intervention strategy. It is critical to follow the core elements when implementing an intervention in an HIV service organization; otherwise, the intervention may not work as intended.[12] All other activities, such as staffing arrangements and clinical workflows, can be adapted to fit the unique circumstances of an organization. However, adaptations should not compete with or contradict the core elements of CPT. **CPT has four core elements:**

1. PTSD Assessment and Symptom Monitoring

- All clients with HIV are universally screened for PTSD with a standard validated screening tool.
- Clients who screen positive receive further assessment for PTSD from a behavioral health therapist using validated assessment tools.
- Clients with a PTSD diagnosis engage in shared decision-making with the therapist to determine whether CPT is the best plan for treatment.
- During treatment, clients are monitored weekly for symptoms of PTSD and depression. Clients who no longer meet criteria for PTSD may be ready to complete CPT treatment.

2. CPT Sessions

CPT sessions are delivered by a behavioral health therapist who is trained in CPT and follows the protocol and worksheets in the ***CPT Manual***.

The number of CPT sessions is determined by monitoring the client's PTSD symptoms in response to intervention.

Sessions can be delivered:

- One-on-one or in a closed group
- For 50 to 60 minutes (individual sessions) or 90 minutes (group sessions)

[12] Psihopaidas D, Cohen SM, West T, et al. Implementation science and the Health Resources and Services Administration's Ryan White HIV/AIDS Program's work towards ending the HIV epidemic in the United States. PLoS Med. 2020;17(11):e1003128.

3. Socratic Dialogue

Socratic dialogue is a technique that values clients coming to know something for themselves, rather than the therapist telling them what to do. This technique is helpful when addressing clients' thoughts regarding their personal experiences with trauma.

In CPT, Socratic dialogue techniques include:

- Questions to clarify (e.g., "What do you mean when you say…?")
- Questions to probe for assumptions (e.g., "How did you come to this conclusion?")
- Questions to explore evidence (e.g., "How do you know this?")
- Questions to explore deeper beliefs (e.g., "What does this mean about you that the trauma happened to you?")

4. Identifying and Challenging "Stuck Points"

"Stuck points" are unrealistic or unhelpful thoughts related to trauma that prevent recovery from PTSD. Clients learn to identify, evaluate, and challenge stuck points in order to change their thoughts and feelings about their trauma(s). Common trauma-related stuck points include:

- "It's my fault the trauma happened."
- "If I had done something differently, I could have prevented the trauma."
- "It's going to happen again."

The therapist uses a series of worksheets to teach the client to challenge their own stuck points. Clients are also asked to complete daily practice assignments between sessions.

"For some clients there can be trauma around their HIV diagnosis itself. Stuck points may arise about what their HIV status means." —E2i site CPT therapist

PLANNING ACTIVITIES

PLANNING ACTIVITIES

This section provides recommended activities for planning to implement CPT.

For additional helpful planning tools, see:

Appendix B: General Best Practices for Planning to Implement an Intervention Strategy

Appendix C: CPT "Go Live" Worksheet

Obtain the CPT Manual

- To deliver CPT, each therapist must have a copy of the ***CPT Manual*** available from Guilford Press.
- ***Translations of the CPT Manual and patient handouts*** are available in several languages.

Train Staff

To become a Rostered Provider of CPT, therapists must first:

- Participate in a live, two-day CPT Workshop from an approved training or consultant company.
- Enroll in post-workshop consultation of 7.5 individual hours or 20 group hours to develop competency and confidence in delivering CPT. The consultant helps to ensure that the therapist is delivering CPT according to best practices.

For more information on CPT Consultation and Training, visit:

- ***CPT for PTSD Consultation***
- ***STRONG STAR Training***

It is also recommended, but not required, to train all organizational staff in using a trauma-informed approach to the care of clients with HIV. Information on trauma-informed care can be found in the ***TIA/CHANGE E2i Toolkit***.

Identify Space

Find a space to conduct CPT sessions that is:

- Comfortable
- Safe
- Private
- Welcoming and affirming

Consider decorating the space with calming colors and comfortable furniture. Virtual telehealth sessions may also be possible for clients who cannot attend every session in person.

Develop a Delivery Plan

A trained CPT provider can start delivering CPT with clients at any point. General guiding questions to consider when planning CPT include:

- Will your organization be delivering individual sessions, closed-group sessions, or both?
- How often will sessions run?
- How many therapists do you need?
- Will you include peers as support staff?
- Can you identify a private, comfortable space to accommodate sessions?
- Will sessions be offered virtually?
- What time(s) of day are best for your clients to have sessions?
- What is your budget to accommodate all core elements of CPT?
- Will you need to provide childcare, transportation, or other services to help clients attend regularly?
- Will you offer financial incentives for attendance?
- How will you engage clients in between sessions?
- How will therapists prepare for sessions?

Develop a Sustainability Plan

Sustainability refers to the ability to maintain programming and its benefits over time. A helpful resource for building capacity for sustainability is the ***Program Sustainability Assessment Tool*** developed by the Center for Public Health Systems Science at the Brown School, Washington University in St. Louis.

This tool helps program planners achieve the following:

1. Understand the factors that influence a program's capacity for sustainability
2. Assess the program's capacity for sustainability
3. Review results from the Assessment
4. Plan to increase the likelihood of sustainability by developing an Action Plan

Achieving sustainability typically involves both applying for grants and accessing available reimbursement options. For reimbursement by third party payors, Outpatient Mental Health Current Procedural Terminology Codes for individual psychotherapy (90834 for 45 minutes with a client) or group psychotherapy (code 90853) are appropriate billing codes for CPT. Mental health counseling is an allowable core medical service under RWHAP funding, and RWHAP-funded organizations can receive technical assistance on health coverage options from the ***Access, Care, and Engagement Technical Assistance (ACE TA) Center***.

E2i EVALUATION: CPT IMPLEMENTATION OUTCOMES

To learn more about how CPT was viewed by the leadership and staff members at the E2i sites, E2i collected data from the people implementing the intervention. The data included: (1) an organizational survey completed by site leadership once during the planning period, and every six months during implementation; and (2) a review of site documents created by staff during implementation, including site visit reports, meeting notes, and cost workbooks (see *Appendix A*).

Measure (definition)	Results at the E2i sites
Acceptability: how well staff and leadership regard the intervention	Both of the E2i sites found the intervention highly acceptable for the duration of the initiative. Each site believed that the intervention was a good fit for their organization's mission and goals.
Adoption: the intention, initial decision, or action to implement the intervention	One site reported consistently high adoption throughout the initiative. The other site reported lower adoption at first, and then high adoption within a year.
Appropriateness: the compatibility of the intervention to address a particular issue or problem	Both sites reported that CPT was highly appropriate and filled a service need. The site staff considered a trauma intervention appropriate because many of their clients had been affected by trauma in their lives.
Feasibility: the extent to which the intervention can be successfully carried out	Both sites found CPT highly feasible within one year of implementation.
Fidelity: the degree to which a site felt able to (a) implement the intervention as it was intended by the program developers, and (b) monitor progress	One site gradually increased their ability to have a full implementation team, and therefore became able to assess and maintain fidelity. The other site reduced their rating of fidelity over time, likely because of challenges in recruiting and retaining clients.
Penetration: the integration of the intervention within the organization	Although one site perceived integration of CPT activities as declining over time, the other site reported an increase in integration of CPT over time. Integration appeared to be facilitated by making trauma screening a standard of care for clients, and by providing trainings about trauma-informed care for all staff, and trainings about CPT for medical providers.
Cost: the costs associated with planning and implementation, such as personnel, training, supplies, incentives, and outreach activities	Costs included both direct and in-kind expenses. The average expenditures for each site were: • *Planning period:* $265,855 (the high cost was related to one site taking a long time to start the implementation phase) • *Recruitment:* $3,815 per client enrolled • *Implementation activities:* $7,109 per client enrolled • *Supervision and management of intervention:* $4,329 per client enrolled These numbers do not necessarily reflect what it would cost to implement CPT at other HIV service organizations. Costs per client would be lower in settings where more clients could be enrolled into the intervention.

IMPLEMENTATION ACTIVITIES

IMPLEMENTATION ACTIVITIES

Activity 1. Client Recruitment, Referral, and Screening

» To identify existing clients with diagnosed or suspected PTSD who may benefit from CPT, organizations can review medical records and ask providers for referrals.

» It is recommended to also universally screen all clients with HIV for possible PTSD in order to identify potential candidates for CPT or other evidence-based treatments.

- Universal screening can be delivered at intake and annually by front desk staff, case workers, nurse care managers, or primary care providers.
- The recommended screening measure for PTSD is the ***Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)***.[13] Clients who answer "Yes" to three or more questions should receive further assessment for PTSD from a behavioral health therapist using a validated assessment tool (see Activity 2: Pre-treatment Assessment).

» To find other eligible clients, organizations can partner with agencies that serve people with HIV.

Activity 2. Pre-Treatment Assessment & Engagement

Prior to beginning CPT treatment, therapists first meet with clients to further assess for PTSD, identify an index event to focus on during treatment, and engage in shared decision-making to determine whether CPT is the best plan for treatment.

Assessment

To assess clients for CPT eligibility, therapists can use the following validated measures:

» ***Post-Traumatic Stress Disorder Checklist (PCL-5) with Life Events Checklist-5 (LEC-5) and Criterion A***[14,15]

» ***Patient Health Questionnaire (PHQ-9)*** for depression symptoms[16]

» Optional: ***Brief Inventory of Psychosocial Functioning*** to assess PTSD-related functional impairment in the prior 30 days

[13] Prins A, Bovin MJ, Smolenski DJ, et al. The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5): Development and evaluation within a veteran primary care sample. J Gen Intern Med. 2016;31(10):1206-1211.

[14] Blevins CA, Weathers FW, Davis MT, Witte TK, Domino JL. The Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5): Development and initial psychometric evaluation. J Trauma Stress. 2015;28(6):489-498.

[15] Gray M, Litz B, Hsu J, Lombardo T. Psychometric properties of the Life Events Checklist. Assessment. 2004;11(4):330-341.

[16] Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. J Gen Intern Med. 2001;16(9):606-613.

Shared decision-making

For clients that meet diagnostic criteria for PTSD, the therapist and client should next engage in shared decision-making to discuss CPT and other treatment options. The ***PTSD Treatment Decision Aid*** is a tool that can aid in this discussion.

Engagement in CPT

If the client decides to move forward with CPT, the therapist should orient the client to how CPT works, build rapport, and discuss the client's goals for treatment. When the client feels ready, the therapist can conduct the **Trauma History and Psychosocial Interview** (***Appendix D***). Pre-treatment sessions are *critical* for engaging clients, many of whom may mistrust healthcare providers and experience complex barriers to care.

During pre-treatment sessions, it is important to:

- Normalize and de-stigmatize treatment for PTSD
- Provide education about PTSD and the roles that avoidance and substance use often play in coping with symptoms
- Discuss how treatment will help the client reach their goals
- Address and plan for barriers that may impede a client's ability to come to sessions and complete the practice assignments
- Plan for and communicate with clients about the availability of additional check-ins and ASAP sessions (i.e., crisis sessions)

Social Support Session(s)

People with PTSD vary along a continuum from wanting their family, friends, and partners to know nothing about their trauma-related experiences, diagnosis, and treatment to expecting others to "understand" or "know" everything. Because social support is essential for people with HIV who suffer from PTSD, therapists may need to conduct an informational session with a client's selected friends, partners/spouses, or other family members. Alternatively, a session could focus on how clients can talk with partners, friends, and family members about PTSD and treatment. If the client intends to discuss the trauma, the therapist should give direct guidance regarding the appropriate level of detail to disclose to each recipient of the story.

The E2i sites reported that clients most ready to engage in CPT were:

- *More established and stabilized in their case management needs, and*
- *Already engaged in HIV primary care at their clinic.*

Additionally, clients who had an ongoing relationship of trust with their behavioral health therapist were more likely to be ready and willing to engage in a new and intensive protocol.

Activity 3. CPT Treatment Sessions

CPT treatment sessions are led by a behavioral health therapist and cover various topics related to recovery from trauma. Sessions follow the structured protocol laid out in the CPT Manual. Every week, clients complete the PCL-5 and PHQ-9 for symptom monitoring. It is recommended that therapists who are still in the CPT training period complete the **CPT Fidelity Monitoring Checklist** (see ***Appendix E***) during or after each session.

To support their CPT treatment, clients can use the free ***CPT Coach mobile application (app)*** that includes:

- All practice assignments and handouts
- Information about CPT therapy
- PTSD symptom tracking
- CPT session reminders

For other helpful mobile apps, see ***Appendix F***.

CPT Sessions 1-7: Focusing on the Trauma

The first seven CPT sessions focus on reflecting on the impact of PTSD on daily life and learning to identify, evaluate, and challenge stuck points through daily practice. Below are some of the topics covered during these sessions.

Impact of PTSD on Daily Life

People who are living with PTSD are often not aware of how PTSD symptoms impair their responses to everyday situations. The CPT therapist begins the first session by gathering information on the impact of PTSD symptoms on the client's daily life, while educating the client on PTSD symptoms, recovery, and treatment. Together, the client and therapist begin to identify concrete goals.

Below are four clusters of symptoms associated with PTSD that affect quality of life:

- *Intrusive thoughts:* People with PTSD may re-experience reactions to the traumatic event through repeated, involuntary memories, distressing dreams, or flashbacks. Dreams and flashbacks may be so vivid that people feel they are re-living the traumatic experience.

- *Avoidance:* People with PTSD may try to prevent reminders of the traumatic event by avoiding people, places, activities, objects, and situations that bring on distressing memories. People may also try to avoid remembering or thinking about the traumatic event, and may resist talking about what happened or how they feel about it.
- *Negative thoughts and feelings:* People with PTSD may have ongoing and distorted beliefs about oneself or others (e.g., "I am bad," "No one can be trusted"); ongoing fear, horror, anger, guilt or shame; much less interest in activities previously enjoyed; or feelings of detachment from others.
- *Arousal and reactive symptoms:* People with PTSD may become irritable; have angry outbursts; behave recklessly or self-destructively; be easily startled; or have problems concentrating or sleeping.

Redirecting Blame

Much of the first half of CPT focuses on helping the client challenge stuck points related to self-blame, erroneously blaming others, or the belief that the world is always fair, known as the "just-world" belief. Therapists explore a range of common themes including blame/responsibility, erroneous blame of others, the just-world belief, traumatic loss, fear of being harmed, fear of intimacy, stigma associated with HIV/AIDS, and mistrust of health care providers.

People with HIV who identify as a sexual minority may report stuck points like, "I'm to blame for the sexual assault because I'm different," or, "If I wasn't gay, I wouldn't have been molested as a child." Socratic dialogue and practice assignment worksheets can help the client explore all possible alternatives, with the goal of arriving to the conclusion that the client is not to blame for other peoples' actions.

During CPT, the therapist uses gentle questioning to explore the meaning that underlies the client's position. For example, they may ask: "If friends and family 'understood,' what would that mean to you? If they never know anything, then what?" A view into the client's personalized meaning will help the therapist identify the level of engagement and possible stuck points.

Worksheets

Each CPT session has an accompanying worksheet to support clients in challenging their stuck points. Worksheets are introduced and reviewed in-session and assigned for daily practice between sessions. The worksheets can be found in the CPT Manual.

There are four types of worksheets:

1. **ABC Worksheet**

   When using the ABC Worksheet, the client fills out spaces under sections A, B, and C:

   - *A = Activating Event:* an event that triggers anxiety or another reaction. "Something happens"
   - *B = Belief/Stuck Point:* the belief or thoughts associated with that event. "I tell myself something"
   - *C = Consequence:* the feelings associated with the event and belief/stuck point. "I feel something"

   For example, a client may write "grocery shopping" under A, "I will get assaulted again" under B, and "scared and angry" under C.

   The client then decides whether their thoughts, located under section B, are realistic or helpful. For example, in response to the question: "Are my thoughts in section B realistic or helpful?" the client would write: "No, they are not helpful. I have never been assaulted at a grocery store."

   The client then can change their beliefs and generate more realistic thoughts. For example, in response to the question: "What can I tell myself on such occasions in the future?" the client would write: "It is okay to go to the grocery store. I have never been attacked there. People do not even look at me."

2. **Challenging Questions Worksheet**

   Clients receive a list of questions to help challenge a stuck point or problematic belief. Examples of questions include:

   - What is the evidence for this stuck point?
   - What is the evidence against this stuck point?
   - Is your stuck point a habit or based on facts?
   - In what ways is your stuck point not including all of the information?

3. Patterns of Problematic Thinking Worksheet

Clients receive a list of several different patterns of problematic thinking that people use habitually in different life situations, but that often cause people to engage in self-defeating behavior. Clients write examples for each of these patterns based on their own stuck points, describe how it fits that pattern, and how that pattern affects them. Examples of patterns include:

- Jumping to conclusions or predicting the future
- Exaggerating or minimizing a situation (blowing things way out of proportion or shrinking their importance inappropriately)
- Ignoring important parts of a situation
- Oversimplifying things as "good–bad" or "right–wrong"
- Overgeneralizing from a single incident (e.g., a negative event is seen as a never-ending pattern)
- Mind reading (assuming that people are thinking negatively of you when there is no definite evidence for this)
- Emotional reasoning (using your emotions as proof)

4. Challenging Beliefs Worksheet

With this worksheet, clients are asked to re-evaluate their stuck points.

- *Situation:* Describe the event, thought, or belief leading to the unpleasant emotion(s).
- *Thought/Stuck point:* Write a thought/stuck point related to the situation in section A. Rate your belief in this thought/stuck point from 0 to 100%. How much do you believe this thought?
- *Emotion(s):* Specify your emotion(s) (sad, angry, etc.), and rate how strongly you feel each emotion from 0 to 100%.
- *Challenging thoughts:* Use the Challenging Questions Worksheet to examine your automatic thought from section B. Consider whether the thought is balanced and factual, or extreme.
- *Problematic patterns:* Use the Patterns of Problematic Thinking Worksheet to decide whether this is one of your problematic patterns of thinking.
- *Alternative thought(s):* What else can I say instead of the thought in section B? How else can I interpret the event instead of the original stuck point? Rate your belief in the alternative thought(s) from 0 to 100%.
- *Re-rate old thought/stuck point:* Re-rate how much you now believe the original thought/stuck point in section B, from 0 to 100%.
- *Emotion(s):* Now what do you feel? Rate it from 0 to 100%.

At the E2i sites, some clients completed their CPT worksheets at home before their sessions, while other clients could not because they lacked privacy or safety at home. The staff accommodated clients by scheduling time before or after sessions to complete assignments.

CPT Sessions 8+: Facing Forward

From session 8 onward, CPT treatment focuses on the impact of the trauma on clients' thoughts about themselves, others, and their general worldview across five themes: safety, trust, power and control, esteem, and intimacy.[17]

By this point in the treatment, clients may experience a reduction in symptoms and an expanded sense of their own safety and security, which enhances their ability to participate in everyday life. The therapist should continue to encourage and support the client's engagement in their personal and professional lives. If the client's scores on the PCL-5 are 19 or below, the therapist and client may discuss the option of completing CPT early or before session 12.

Those who continue to experience difficulty participating in social situations and personal events may find the themes of safety, trust, power and control, esteem, and intimacy to be most helpful. For example, clients may connect challenges in social settings to the themes of safety and trust (e.g., "I cannot trust anyone not to harm me"), and esteem (e.g., "I'm damaged"). Deeper examination of core beliefs, values, and traditions relating to the five themes can facilitate important cognitive movement beyond stuck points.

Safety

The safety theme explores the belief that people have the ability to control events and protect themselves or others from harm and the dangerous intentions of others. People with HIV and PTSD often report stuck points about the safety of the world. They may also engage in safety behaviors. A safety behavior is an action that is used to attempt to prevent fears from coming true and to feel more comfortable in situations where they experience anxiety. For instance, a client may spend a considerable amount of money on home security systems in addition to frequent checking of locks and windows to ensure their physical safety. Checking the locks, windows, and security footage are examples of safety behaviors.

[17] McCann IL, Pearlman LA Vicarious traumatization: A framework for understanding the psychological effects of working with victims. Journal of Traumatic Stress, 1990; 3(1):131-149.

When evaluating stuck points, clients can consider the effects of stuck points on daily functioning. Questions to explore include:

- When did the checking (e.g., safety behavior) start?
- If you don't check, then what are you worried about/how do you feel?
- What is the probability of the fear happening?
- How is the safety behavior helping you?
- Are there any costs to the checking?
- How does your partner feel when you are highly anxious?
- How does this fear impact your physical health?

Decreasing anxiety and fear responses will help clients to distinguish between objectively safe and dangerous situations.

Trust

The trust theme explores trust in one's own judgments and the reliability of others' promises, intentions, and behaviors. People with HIV and PTSD often have difficulty trusting their own safety and the safety of their family.

Other stuck points may stem directly from the incident in which the client became infected with HIV (e.g., "I should not have trusted this person" or "I should not have trusted myself in that situation"). For many clients, sexual and physical assault can generate stuck points about their general level of trust in others (e.g., "No one can be trusted with anything"). Together, the client and therapist can explore beliefs about trust in themselves and others. CPT uses a "Trust Star" to facilitate a discussion around different types of trust and different levels of trust both for trusting other people and themselves. Questions to ask the client may include:

- When you meet someone for the first time, where do they start with regards to trust: negative, positive, neutral?
- If you loan someone $5.00, and they don't pay you back, what do you learn about trusting that person with money?
- Is there someone in your life you can trust will be late?
- If you tell someone a secret, and they keep it, what does that tell you about trusting them with information?

Therapists can also explore ways in which the client can evaluate the trustworthiness of a person in their personal and professional lives, such as their roles as a student, volunteer, parent or caretaker, and client. For example, a client can aim to transform the stuck point of "No one can be trusted" to "Some people can be trusted with some things, some of the time."

Power and Control

The power and control session explores beliefs about the client's capacity to control emotions and behavior, meet challenges, and maintain a balance between giving and taking power and control in interpersonal relationships. For people with HIV and PTSD, trauma often includes childhood physical and sexual assault, with limited control considering their age at the time. As a result, these clients commonly desire to have complete power and control over external and internal experiences.

Unfortunately, complete control is not feasible. The attempt to exert complete control often results in chaotic interpersonal relationships and avoidance of other people and situations. Therapists should ask Socratic questions to help clients understand what they can control about themselves, while recognizing the uncontrollable aspects of certain situations. Questions to ask the client include:

- What do you mean by control? Control of exactly what?
- What kinds of decisions have you made just today?
- What, about yourself, do you have control over?

In addition, therapists should explore the worst-case scenario in situations where the client does not have complete control, or times when they may refrain from exerting control. Questions include:

- If you don't have complete control, what do you think will happen?
- What does complete control look like?
- What would happen if you tried to exert control in a specific situation?

People with HIV may have anxiety about dying, which can influence PTSD symptoms. They may have the impression that they cannot control their health status. These concerns have implications when discussing power and control. Therapists can use Socratic questions about how the client might take some control back, such as by adhering to prescribed medications and following the advice of their medical therapists.

Esteem

Esteem explores beliefs of self-worth and worth of others. The thought "I am damaged" is one example of a common stuck point. The therapist can explore with the client what it means to be damaged with questions like:

- What does it mean to you to be a good or bad person?
- Do good people sometimes make bad decisions?
- Are all bad decisions equally as important?

The goal of this line of questioning is to help the client contextualize the meaning of being a good or bad person and to understand that it is not an either/or set of categories.

Given both the trauma and the stigma associated with HIV, therapists should address a client's feelings about approval from others. People with HIV who have PTSD may have stuck points such as, "Other people are uncaring and self-serving," and "Other people will just reject me." Socratic questions can address these stuck points:

- Who in your life has not rejected you?
- How do you know that this specific person will reject you because you have HIV?
- What does it mean if they do reject you?

Support groups or a strong social support system can help combat stigma, provide clients with a sense of acceptance, and challenge beliefs regarding others.

Intimacy

Intimacy explores beliefs about the ability to be alone without feeling lonely, the ability to soothe oneself when experiencing distress, and the ability to connect with others. People with HIV and PTSD may have difficulty with intimacy, and may use drugs and alcohol to avoid thinking or experiencing feelings. At times, they may have stuck points concerning their ability to manage difficult emotions. Questions to encourage self-management and increase self-efficacy to manage unpleasant emotions include:

- What is so wrong or bad about these emotions?
- What do you think would happen if you felt these emotions?
- How do you know that they would last indefinitely?

Intimacy with others can also lead to feelings of emptiness or loneliness, especially among people with HIV who have had interpersonal or sexual trauma. These individuals may have stuck points about how other people will eventually hurt them if they become too close, and about how they will never be able to be sexually intimate with anyone else.

Additionally, if clients still experience emotional numbing, they may misinterpret a lack of joy or happiness with others as meaning that they are not caring or loving. When clients present these thought patterns, therapists can ask questions such as:

- Why might it be important to get close to others?
- Who in your life is most important to you?
- How do you know that if you get close to someone, that they would hurt you?
- How might you determine if you could trust another person to be intimate with?

Activity 4. ASAP "Crisis" Sessions

Adherence to the CPT protocol is critical. However, many clients at some point during CPT present in significant distress that warrants a departure from the protocol. The client and therapist should identify crises appropriately and sparingly, and return to the CPT protocol as quickly as possible.

Defining Crisis

During assessment, therapists should inform their clients that they can receive up to two additional sessions in the event of a crisis. Clients and therapists should use a collaborative process in deciding what constitutes a "crisis" and whether to use an additional session for an Adjunctive Services and Attrition Prevention (ASAP) session. Generally, therapists will want to discuss in advance the difference between a crisis and general distress (i.e., an issue that can be addressed using a regular CPT session).

Often, crises that need an extra session include:

- Life events that prevent a client from attending therapy
- Health concerns of self and family members
- Death within the family
- Significant relationship problems such as pending separation or divorce
- Experiencing another trauma
- Suicidality

In comparison, general heightened distress usually arises from less severe events, such as:

- Having a fight with a significant other/partner
- A child who is failing in school
- Concerns about possibly losing a job

General increased distress occurs more often than crises. In cases of distress, therapists should consider moving forward with CPT and address stuck points that limit the clients' ability to cope with the additional stress.

For example, if a client has had a fight with their significant other, they may state that they are in crisis and would like to use one of their ASAP Sessions. However, the therapist may help the client conceptualize the behavior as distress in the context of PTSD; by addressing the PTSD symptoms, the client can learn to cope with the stress, decrease their anger and irritability, and prevent extreme arguments in the future. Therapists can leave an additional five minutes near the end of the session to address the cause of the heightened distress, while maintaining a CPT framework by using the practice assignment worksheets associated with the distress.

Deciding to Use an ASAP Session

If a crisis does occur, a therapist should not immediately assume the client would like to use one of their ASAP Sessions. Rather, a therapist should ask for the client's opinion. As the experts in their own lives, clients need the therapist to respect their ability to make this decision on their own; this can foster a sense of self-efficacy. Clients may even prove they can utilize the skills and techniques that they have learned throughout therapy and can develop alternative ways of interpreting the stressful event(s). At the same time, therapists should use their clinical judgment in determining whether clients are capable of making a reasonable decision. For example, if a client experienced another trauma in between sessions and is in shock, the therapist may decide for them and use an ASAP Session.

During an ASAP Session, therapists should continue to help the client identify thoughts and feelings, and gently challenge those thoughts. Therapists should use the worksheet within the ASAP session that corresponds to their last practice assignment. The goal at the end of the ASAP session is to return to CPT. Therefore, at the end of the ASAP session, therapists should re-explain the practice assignment that corresponds with the next CPT session.

Activity 5. Symptom Monitoring, Reassessment, and Treatment Planning

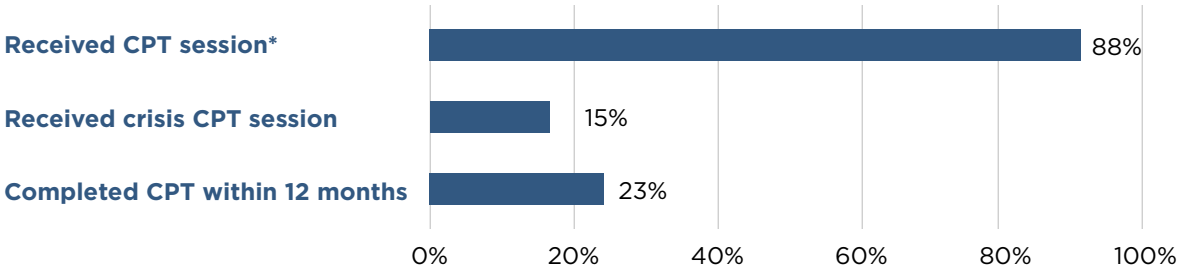
During CPT treatment, clients should complete the PCL-5 and PHQ-9 weekly for symptom monitoring. Scores of 19 or lower on the PCL-5 indicate that a client is likely no longer meeting criteria for PTSD and may be ready to complete CPT.

After completing a course of CPT treatment, the therapist and client should review progress towards the client's goals and PTSD and depression symptom change to inform next steps. The following may be outcomes to consider:

- **Discharge:** The client may no longer require behavioral health treatment. Some clients may benefit from scheduling a one-month follow-up appointment to check-in with their therapist. This follow-up appointment is often cancelled when clients are doing well, but it also gives the option to re-assess progress and schedule future appointments as needed.
- **Maintenance:** Clients with additional problem areas or case management needs may benefit from stepping down from weekly psychotherapy appointments. This may be transitioning care to a case manager, scheduling two appointments per week, or monthly maintenance appointments.
- **Active treatment:** The therapist and client may determine that more treatment is needed to address PTSD, depression, or other co-morbid conditions. Clients who did not respond as desired to one course of CPT may benefit from additional CPT sessions or a second course of CPT treatment.

E2i EVALUATION: CPT PARTICIPATION OUTCOMES

FIGURE 3. Participation outcomes among the 34 clients enrolled in CPT as part of the E2i initiative.



*CPT sessions do not include crisis or pre-treatment sessions.

- **Session attendance:**
  - 30 clients participated in at least one CPT session. The other four clients participated in pre-treatment or crisis sessions, but not regular CPT sessions.
  - Clients participated in a median of four CPT sessions, which is below the recommended 6-12+ sessions.
- **Completion:** The E2i sites defined completion of CPT as having participated in at least six CPT sessions and having a reduction in symptoms. Symptom reduction was assessed by the CPT provider on a client-by-client basis. Only 8 clients completed CPT within one year.

E2i EVALUATION: CHALLENGES, SUCCESSES, ADAPTATIONS, AND LESSONS LEARNED

The E2i sites shared barriers and facilitators to implementing CPT. They also made changes to the original intervention to meet the specific needs of their clients and staff members. Here is a summary of adaptations and lessons learned. Additional information about the sites' experiences can be found in the Program Spotlights below.

- **Challenges with recruiting and retaining clients:** Clients with HIV often present with unmet basic needs related to housing, employment, and transportation. Clients may also have co-occurring mental health and substance use disorders requiring treatment. The E2i sites found that clients who had unmet needs were typically not interested in CPT, could not commit the time, or were not stable enough to start or remain in CPT. Likewise, clients with a recent diagnosis of HIV needed more time to adjust to their new medication regimen and to familiarize themselves with HIV-related information before being able to start CPT.
- **Preparing clients for CPT:** The E2i site therapists noted the importance of CPT pre-treatment and other means of preparing clients for engaging in time intensive and trauma-focused sessions. One of the sites would provide clients with general counseling/psychotherapy to improve their readiness for CPT. Both sites allowed for multiple pre-treatment sessions in order to build trust and rapport with the therapist and increase comfort with the idea of discussing their trauma.
- **"Meet and greet" recruitment:** One of the E2i sites included a "meet and greet" team of a medical provider and a behavioral health therapist during intake appointments for newly diagnosed clients and previously diagnosed clients who are new to the clinic. The "meet and greet" team reinforces for clients the clinic's emphasis on team-based care and integration of physical and behavioral health care. As part of the "meet and greet," clients learn about trauma screening, how trauma can affect health, and CPT and other therapy options at the clinic.
- **Routine trauma screening:** Both sites found that the implementation of routine, standard of care screening for PTSD and trauma greatly facilitated their ability to identify patients for CPT.

E2i EVALUATION: CHALLENGES, SUCCESSES, ADAPTATIONS, AND LESSONS LEARNED

- **Waiving fees/copays:** To incentivize participation in CPT, one site waived fees for every clinic visit.
- **Training commitment:** The staff at one of the sites could not become certified CPT trainers within the timespan of the intervention because of the time commitment involved in that training.
- **Spanish translation of CPT manual:** The staff at one site noted that the Spanish version of the CPT Manual lacked some of the worksheets, and that the language was oversimplified for some clients, but too complicated for low literacy clients.

E2i PROGRAM SPOTLIGHTS

PROGRAM SPOTLIGHT

Positive Impact Health Centers

Organizational Background

Positive Impact Health Centers (PIHC) provides client-centered HIV primary and specialty care, along with mental health care, substance use disorder treatment, gender-affirming care, case management, and prevention services for clients in the Atlanta, Georgia metropolitan area. PIHC operates sites in rural, urban, and suburban areas, including Decatur, Duluth, Marietta and Covington, and is a recipient of RWHAP Parts A, B, and C.

Implementation Goals and Context

PIHC implemented CPT as part of its organization-wide effort to adopt a trauma-informed care approach. PIHC builds trauma awareness by training all clinic staff about the impact of trauma on people with HIV, and by instituting universal trauma screening and referrals. PIHC integrated CPT into their behavioral health department in order to add a "gold standard" evidence-based treatment for clients diagnosed with PTSD.

Recruitment and Delivery

As part of their intake protocol, all behavioral health clients complete the PC-PTSD-5 screener which identifies people with probable PTSD. In addition, clients with a new HIV diagnosis or who are re-entering care are screened for PTSD by a case manager or social work intern. Clients who screen positive meet with a clinician, who further assesses the client using the PHQ-9 and the PCL-5 with LEC-5 and Criterion A. Clients diagnosed with PTSD are then given the option to enroll in CPT or another appropriate service. Clients can continue seeing their regular therapist in addition to the CPT therapist, if appropriate.

PIHC aims to provide clients with six to 14 sessions of CPT, depending on individual client needs. CPT is offered in both English and Spanish, including a CPT workbook translated into Spanish. In general, PIHC has found that clients with an established and trusting relationship with their therapists are able to engage in CPT quickly, and to complete it in fewer sessions. However, clients new to therapy, or newly diagnosed with HIV, may need additional sessions, often in the form of pre-treatment sessions, in order to feel safe enough with their therapist to disclose and work on their post-traumatic stress symptoms. Additionally, clients who have competing life obligations, such as those without stable housing or food security, are typically unable to prioritize CPT until their most pressing life needs are met.

Adaptations and Innovations

- **Training all providers in CPT:** All of PIHC's behavioral health therapists are trained in CPT in order to minimize gaps in care, support sustainability, and enable them to offer CPT to clients at all of their sites. Although most therapists do not provide CPT with their clients on a regular basis, they are available to immediately fill in if a CPT therapist leaves the practice. Therapists say that their CPT training also enables them to apply aspects of CPT to clients who are coping with traumatic stress, but do not have a PTSD diagnosis. Though training all therapists is expensive, PIHC has found it worth the cost.
- **Champions:** CPT champions train and encourage all staff to complete screenings and engage in trauma-informed care. After successfully implementing CPT at the Decatur site, the CPT champions facilitated the launch of CPT in two additional sites.
- **COVID-19 pandemic:** During the COVID-19 pandemic, providers transitioned most existing clients to telehealth delivery. To support the CPT sessions, providers also mailed/emailed out worksheets and encouraged clients to use the CPT phone app. PIHC had planned to start an in-person CPT group in March 2020, but the organization had to postpone this service due to COVID-19 safety protocols.

"Our clients who complete CPT no longer have symptoms of PTSD. It is a cure!" —PIHC therapist

Program Integration

PIHC has successfully integrated CPT into its behavioral health department and continues to maintain strong institutional buy-in of universal screening and referral to CPT and other behavioral health services. With encouragement from their leadership, PIHC staff have shared their CPT experience by presenting at local and national conferences. Although CPT is a reimbursable service, many clients do not have insurance, making it necessary to seek additional funding. PIHC has been able to find grant money from federal programs that will support the program's staff training and salary needs for CPT moving forward.

Contact Information

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PROGRAM SPOTLIGHT

Western North Carolina Community Health Services

Organizational Background

Western North Carolina Community Health Services (WNCCHS), located in Asheville, NC, is a federally qualified health center providing primary care and other healthcare services for approximately 16,000 clients from the 18 western-most counties in NC. As the only RWHAP-funded medical provider in the region (RWHAP Parts B, C, and D), WNCCHS serves about 780 people with HIV (65% White, 25% Black) who are geographically dispersed across mostly rural areas. WNCCHS's HIV program is a fully integrated model of primary care, medical and non-medical case management, and behavioral health; other key WNCCHS services include a transgender health program, dental care, and a pharmacy.

Implementation Goals and Context

While WNCCHS already had a high degree of integration of behavioral health services when they began CPT, they had not yet integrated a trauma-informed approach to care. To that end, WNCCHS's goal has been to implement organization-wide training on trauma, screening for PTSD, and referral to CPT for clients motivated to seek therapy to stabilize PTSD symptoms and increase their capacity to engage in HIV care. WNCCHS's CPT program includes a project director who oversees program administration, and three CPT therapists, including one who also acts as a project administrator and clinical supervisor. CPT staff also receive in-kind support from nurse care managers who work closely with all HIV clients. These staff all serve as "champions" of trauma-informed care and CPT across the agency, and have worked hard to gain institutional buy-in for universal PTSD screening. The WNCCHS CPT team noticed a positive shift in staff response to the program once they educated staff about how CPT can treat PTSD in a primary care setting.

Recruitment and Delivery

The CPT team initially focused on recruiting clients who had fallen out of medical care, believing that addressing trauma along with basic needs would help these clients stay in care. They next expanded recruitment to all new HIV clients; however, many clients with newly diagnosed HIV were too overwhelmed with new medical treatments and information to also engage in CPT. The WNCCHS team therefore decided to open up recruitment to all established HIV clients. Medical, behavioral health, and additional clinical front-line staff have been trained to administer and score all new clients with the PTSD screening tool. These staff also have received training to use the electronic medical record to refer eligible and motivated clients to a CPT trained therapist.

Referred clients are connected to the CPT team often on the same day as screening. A CPT team member explains to the client the effects of trauma and PTSD on health, and how the behavioral health services team can help. WNCCHS staff report that letting the client know what to expect from the beginning is an important component in the trauma-informed process.

The initial CPT visit involves further assessment with the PCL-5 with LEC-5 and Criterion A, Brief Inventory of Psychosocial Functioning, PHQ-9, and WNCCHS's own psychosocial assessment. The CPT provider uses these assessments to help create a tailored CPT care plan for the client.

CPT therapists at WNCCHS seek to complete from six to 12 sessions with clients. Depending on the client's readiness to begin treatment, the therapist might first provide several pre-treatment sessions to further explain concepts and build rapport. Therapists have found that many clients report feeling significantly better by session 7 or 8, and are able to end treatment at that time. To engage clients of all health literacy levels, the CPT therapists take time during the session to explain the language in the worksheets, as needed.

"Talking about trauma as a part of a whole person care plan really changed the game for us. CPT is a gift. We owe it to our patients to give them this resource." —CPT provider at WNCCHS

Adaptations and Innovations

- **Flexible timing of sessions:** Many of WNCCHS's clients live in remote rural areas that are two to four hours from the clinic. Rather than expect clients to drive for hours every week, WNCCHS allows clients to schedule sessions further apart, or to align visits with their medical appointments. Clients may also receive some CPT sessions as telehealth services, as long as they have access to reliable internet service.
- **Communications:** WNCCHS created a new website ***www.thehive828.org*** that enables the organization to promote information on all of their services, including CPT.
- **COVID-19 pandemic:** Due to the COVID-19 pandemic, WNCCHS increased its capacity to provide telehealth services after being initially delayed by technical issues. CPT therapists have mailed homework assignments or emailed the worksheets so clients can be consistent with the expected practice assignment for each session. Although the pandemic has made it challenging to recruit new clients into CPT, the CPT team at WNCCHS has managed to retain most existing clients.

Program Integration

Trauma screening and the CPT intervention have been successfully integrated across WNCCHS thanks to the systems developed by the CPT team, as well as their efforts to educate medical staff about trauma and CPT. In fact, organizational leadership has noted an increase in interdepartmental collaboration due to the work of the CPT champions. To further sustain the intervention, WNCHHS has begun screening clients of any HIV status for PTSD and training other staff therapists in CPT. Organizational leadership is looking to identify innovative funding opportunities to support staff salaries and utilize RWHAP funds to help cover costs of staff involved in CPT, and to pay for clients' transportation, food, dental support, and integration of services.

Contact Information

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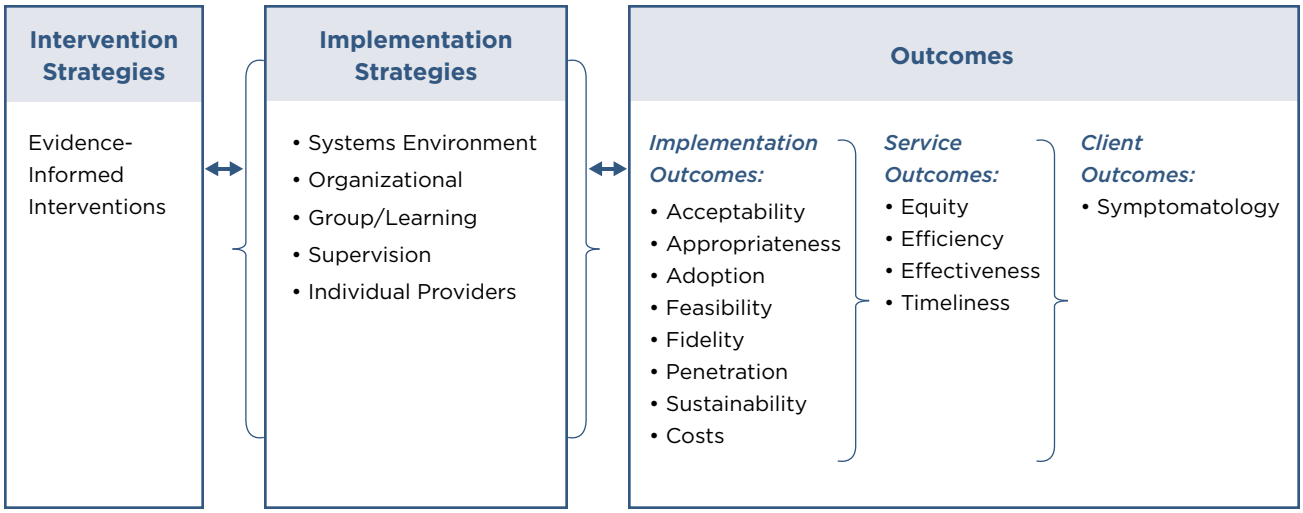
APPENDICES

APPENDIX A. IMPLEMENTATION SCIENCE AND EVALUATION: FRAMEWORK AND METHODS

The Center for AIDS Prevention Studies (CAPS) at the University of California San Francisco conducted the evaluation of the E2i program implementation. The evaluation used the Proctor Model Framework for Implementation Research.[18] This approach suggests that program assessment should include an understanding of the process of implementation and its impact on all people and systems that are involved in the implementation:

1. The core elements of the program (intervention strategies).
2. The efforts to put the program into place (implementation strategies).
3. How the program is viewed by the people involved (implementation outcomes).
4. How the program is delivered (service outcomes).
5. The impact on the participants (client outcomes).

The E2i Proctor Model



[18] Proctor E, Silmere H, Raghavan R, et al. Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. Adm Policy Ment Health. 2011;38(2):65-76.

Six types of information were gathered over the three years of E2i program implementation. These include:

Organizational Assessment: Every six months, the site program director completed a survey. This survey had questions about the organization (e.g., number of patients, types of services provided, and staffing). It also included questions about program delivery and how the staff views the program.

Proctor Concepts

- Implementation strategies (systems environment, organizational, group/learning, supervision)
- Implementation outcomes (acceptability, appropriateness, adoption, feasibility, fidelity, penetration, sustainability, costs)

Document Review: Evaluators reviewed documents that were created during implementation and technical assistance activities. Documents were created by either the sites themselves or by The Fenway Institute/AIDS United and included: E2i funding applications, site visit reports, quarterly reports, monitoring call notes, cohort call notes, and presentations in meetings.

Proctor Concepts

- Implementation Strategies (systems environment, organizational, group/learning, supervision, individual providers, individual clents)
- Implementation Outcomes (acceptability, appropriateness, adoption, feasibility, fidelity, penetration, sustainability)

Observations: Sites participated in two Learning Session Meetings each year. Evaluators took notes on discussions and presentations. These notes focused on barriers and facilitators to implementation.

Proctor Concepts

- Implementation Strategies (systems environment, organizational, group/learning, supervision, individual providers, individual clients)

Costing Data: Program managers and financial administrative staff completed two cost workbooks. One was for the three-month preparation/planning period and the first year of program implementation. The other was for the second year of program implementation. Costs included personnel and expenses paid for by E2i as well as in-kind donations.

Proctor Concepts

» Implementation Outcomes (costs)

Intervention Exposure: Information was collected on clients who participated in the intervention between September 2018 and December 2020. Demographic information was collected on enrollment forms. Intervention exposure forms were collected whenever staff had program-related interactions with participants. These forms included information such as: date of the interaction, the staff person who had contact, type of interaction, activities completed, and outcomes of the activities.

Proctor Concepts

» Service Outcomes (fidelity, penetration, equity, efficiency, effectiveness, timeliness)

Medical Records: Medical records were collected on participants for the 12 months before enrollment in the program and for the 12 months after enrollment in the program. The information was specific to HIV-related medical care, such as: appointment dates; prescription of ART; viral load test dates; and viral load test results.

Proctor Concepts

» Client Outcomes (symptomatology)

Quantitative Analysis: Organizational assessment data was used to describe organization characteristics and readiness for implementation based on Proctor Concepts. Client level enrollment and intervention exposure data was analyzed using descriptive statistics to understand client demographics, proportions of clients receiving intervention services, and frequencies of exposures. When appropriate, proportion of clients completing the intervention was included. Repeated measures modeling methods were used to assess changes in HIV care continuum outcomes for clients enrolled in the intervention. This compared data from 12 months prior to enrollment to 12 months following enrollment. Costing data was analyzed to provide information on cost of intervention implementation per client enrolled.

Qualitative Analysis: Documents and observations were thematically analyzed using the Proctor Concepts. The intervention was the primary unit of analysis.

APPENDIX B. GENERAL BEST PRACTICES FOR PLANNING TO IMPLEMENT AN INTERVENTION STRATEGY

The following are general recommendations for planning an intervention in an HIV service organization.

Create a Planning Team

» Assemble a team of staff "champions" who are invested in the success of the intervention; who will meet regularly to drive planning, implementation, and sustainability; and who will remain committed to overcoming hurdles and moving implementation forward.

» Consider how to meaningfully involve at least one peer (a person who represents the priority population) in the planning and implementation of the intervention (see AIDS United's resources on ***meaningful involvement of people with HIV***).

» Hold weekly team meetings or daily "huddles" (i.e., short meetings at the beginning of the day to review client status and discuss recruitment and retention issues, etc.).

Engage Leadership and Staff

Implementing a new service into an established program may require changes in routines, job duties, and administrative procedures. It is essential to obtain buy-in and a firm commitment from the entire organization as early in the planning process as possible.

» Meet with executive leadership to discuss:

- How the intervention will support the organization's mission and goals
- The benefits of the intervention for clients and the organization as a whole
- The resources needed to implement the intervention
- The organizational systems and procedures that will be affected by implementation
- The importance of leadership communicating their commitment to the intervention to all staff
- How the intervention team will regularly share the status of the intervention with regard to planning, implementation, enrollment, and client outcomes

» Meet with staff members directly and indirectly affected by the intervention to discuss:

- The benefits of the intervention for clients and the organization as a whole
- How staff can help with recruitment and referrals
- Suggestions for outreach and implementation processes
- How the intervention team will regularly share the status of the intervention with regard to planning, implementation, enrollment, and client outcomes

Assess Community Needs

Early in the planning process, organizations should consider conducting an informal or formal needs assessment to better understand the needs of the priority population(s) and how to best tailor the intervention to their needs. Engaging with the local community also helps to establish trust, build recruitment visibility, and grow your referral networks. Community needs assessment strategies include:

» Reviewing existing data on PTSD among clients with HIV.

- What does the data tell you about the needs of your client population?

» Holding discussions and focus groups with staff, clients, and community leaders, residents, and neighborhood associations to learn about gaps in health services and the needs of people with PTSD, and to receive input and answer questions on the proposed program.

Train All Staff

When implementing an intervention for people with HIV, it is important to train all organizational staff in reducing stigma, providing trauma-informed care, enhancing cultural humility, and providing affirming, culturally-responsive care to all people with HIV, including Black, Indigenous, and other people of color, and including lesbian, gay, bisexual, queer, transgender, and gender diverse people. Training and resources are available from ***TargetHIV***, ***AIDS Education and Training Center Program***, ***National LGBTQIA+ Health Education Center***, and the ***Black AIDS Institute***.

Conduct a Pilot Test

Prior to full implementation, conduct a pilot test under "real world" conditions to evaluate the feasibility and acceptability of the process flow, forms, and procedures.

- Consider piloting with one provider's client panel.
- Use a validated ***quality improvement method*** to guide your pilot test.
- After the pilot, communicate to all staff the results of the pilot: what worked, what did not work, and what changes were made to improve operations.

APPENDIX C. CPT "GO LIVE" WORKSHEET

Purpose

The purpose of the "Go Live" Worksheet is to:

1. Guide organizations in carrying out the intervention's planning and implementation activities
2. Monitor progress in meeting implementation goals

Instructions

The team that is leading the intervention should identify a team member to complete this worksheet over time. Use the worksheet to:

- Develop and drive team meeting agendas
- Document decisions made by the team
- Track progress towards goals

Name of organization	
Name (Who is completing this worksheet?)	
Intervention goals	• To reduce symptoms of PTSD and related disorders (e.g., depression) • To help people with HIV stay engaged in HIV care
Core elements	**1.** PTSD assessment and symptom monitoring **2.** CPT sessions **3.** Socratic dialogue **4.** Identifying and challenging "stuck points"
Planning Steps	
Planning Team (Who is on the planning team?)	**1.**
	2.
	3.
	4.
	5.
Eligibility criteria	• People who have a diagnosis of PTSD, including people with HIV • People of various ages, races, ethnicities, genders, and literacy levels
Priority population(s) (Who will you recruit for the intervention?)	**1.**
	2.
	3.
	4.

Geographic catchment area(s) (From which communities will you recruit clients?)	**1.**
	2.
	3.
Language(s) (In what languages will you deliver the intervention?)	**1.**
	2.
Engaging stakeholders (What strategies will you use to gain "buy-in" and feedback?)	**1.** Organizational leadership:
	2. Relevant staff:
	3. Local community members:
	4. Clients:
Recruitment and outreach (What are your recruitment strategies?)	**1.**
	2.
	3.
	4.

<table>
<tr><td rowspan="6">Intervention staff
(Who will do what?)</td><td>Role/Task</td><td>Staff Responsible</td></tr>
<tr><td>Recruitment</td><td></td></tr>
<tr><td>Screening and referral</td><td></td></tr>
<tr><td>Intake/Enrollment</td><td></td></tr>
<tr><td>Scheduling</td><td></td></tr>
<tr><td>Therapy</td><td></td></tr>
<tr><td>Staff training requirements (Check each box when completed)</td><td colspan="2">☐ Inform all staff about CPT processes
☐ Train providers in CPT from certified trainers
☐ Purchase CPT manual(s)
☐ Train all staff on trauma-informed care
☐ Train all staff on culturally affirming care for the priority population(s)</td></tr>
<tr><td>Staff training plan
(When, where, and how will staff be trained?)</td><td colspan="2"></td></tr>
<tr><td>Incentives (What incentives, if any, are you giving participants?)</td><td colspan="2"></td></tr>
</table>

Assessment tools (What screening instruments and assessments will you use?)	**1.**
	2.
	3.
	4.
	5.
Additional tools (e.g., enrollment forms, referral forms, client satisfaction)	**1.**
	2.
	3.
Referrals (Who will you partner with for services not offered by your organization?)	**1.**
	2.
	3.
	4.
CPT process flow (Describe or draw the process from recruitment/referral through first CPT visit. Consider: who, when, what, and where)	
Sustainability (What are you doing to make your program sustainable?)	

Pilot the intervention (When and how will you pilot test the intervention?)	
After pilot (What worked, what did not work? What changes will you make?)	
SMART goals (Specific, Measurable, Achievable, Relevant, Time-Bound goals)	**1.**
	2.
	3.
	4.
	5.

APPENDIX D. TRAUMA HISTORY AND PSYCHOSOCIAL INTERVIEW

Note that clients may not be ready to answer all of these questions during their first pre-treatment assessment and engagement session. Prior to asking these questions, it is important to first build rapport and trust with the client. Therapists may skip questions that have already been addressed in other assessments.

I. Childhood History

Family of origin (Where did you grow up? Who did you live with? Parental marital status? Siblings?)

Childhood abuse history (probe for physical, emotional, sexual abuse, without using the word "abuse")

What was the household environment like growing up? How were you punished as a child? Were you ever injured by a parent or caretaker?

Education (How far did you go in school? Learning disabilities/Conduct issues? Grades?)

II. Current Functioning

Current psychosocial situation (Can confirm from initial assessment)

Current family and living situation (marital/partner status, children, where living, with whom)

Daily routine (How do you spend your time during the day?)

(If relevant) How are your PTSD symptoms impacting your relationship with your children? Your parenting?

Leisure activities (What do you do for fun? Hobbies?)

Significant current stressors (What are the most stressful things in your life right now?)

Social support (Do you have someone you can turn to for help? Talk about your thoughts and feelings with? How is your relationship with your significant other?)

III. Confirmation of Target Trauma

Now I would like to review with you the information that you provided on the measures you filled out.

You indicated the trauma that was the worst event was (read from LEC-5). Can you describe what happened?

In the last month, have you had nightmares about it or thought about it when you did not want to? Can you give me an example of the last time this happened?

In the last month, have you tried hard not to think about it or went out of your way to avoid situations that reminded you of it? Can you give me an example of the last time this happened?

In the last month, were you constantly on guard, watchful, or easily startled? Can you give me an example of the last time this happened?

In the last month, have you felt numb or detached from others, activities, or your surroundings? Can you give me an example of the last time this happened?

(If more than one trauma was endorsed) You also indicated that you experienced a number of other traumatic events. Are there other events that are still bothering you? Can you describe what happened?

In the last month, have you had nightmares about it or thought about it when you did not want to? Can you give me an example of the last time this happened?

In the last month, have you tried hard not to think about it or went out of your way to avoid situations that reminded you of it? Can you give me an example of the last time this happened?

In the last month, were you constantly on guard, watchful, or easily startled? Can you give me an example of the last time this happened?

In the last month, have you felt numb or detached from others, activities, or your surroundings? Can you give me an example of the last time this happened?

Unfortunately, what we know is most people experience multiple traumas like yourself (IF TRUE), but working with people who have experienced trauma, there is usually one or two traumas that stick out and drive the symptoms of PTSD. Sometimes patients say, everything changed after that day, or I started having nightmares or not liking to go out after that. I wonder for you what trauma has been bothering you the most in the last month?

If can identify one trauma, SAY: Then that's where we'll get started in treatment, and we will talk about the other traumas too if we find they are also impacting you.

If cannot pick one trauma, SAY: It's hard for a lot of people. For the work that we are going to do, we need to pick one place to start and work on that trauma in a very specific way to help teach you some skills to reduce your PTSD symptoms. Then we'll move to the next trauma, and next, and so on if we need to. We've found that often, when we work on one, we are also working on symptoms and stuck points related to the others too. Where should we get started?

For the trauma you choose, I'm going to ask you some questions now about who, if anyone, you blame for the occurrence of [the event]. I want you to know there are no right or wrong answers to these questions, and we don't think that it is necessary that you place blame. We ask them because it is often helpful to me in our work together to understand how YOU view this event and how you have responded to it. OK?

Who, if anyone, or what, do you blame for the occurrence of [the event]?

- » Myself
- » Assailant(s) or perpetrators
- » The environment
- » Parent
- » Chance
- » The government
- » Friend or acquaintance
- » Other (describe) _____

How so? (i.e., how is the person or organization responsible?)

Have you been feeling guilty about [the event] or your response to it? Shamed? Angry? How much have these feelings been present for you?

IV. Physical And Mental Health Since Trauma

What health problems, if any, are you having? Are these related to [the event]?

How has your mood been since [the event] (or if trauma was long time ago, how has your mood been lately)? Have you been feeling down or depressed? Are you as interested in things as you usually are?

Have you sought psychiatric or psychological help for your feelings and difficulties related to [the event] before you came to us here? Crisis intervention? (not including this treatment):

No Yes

If yes, describe:

V. Identity And Trauma (as applicable)

Do you have any spiritual or religious practices or beliefs? How big or small of a role does your faith/religion/spirituality play in your life?

Have your spiritual/religious beliefs or practices been affected by the trauma?

What is your gender identity? What is your sexual orientation? Has the trauma impacted how you identify?

What is your ethnic or cultural background? What does your cultural background mean to you (e.g., is it a big or small part of who you are as a person)?

Has your connection with your culture been affected by the trauma?

Have you been exposed to racism/discrimination? Did discrimination play a role in your trauma?

Was your HIV status related to your trauma? Have your feelings about your HIV status been affected in any way?

VI. Substance Use History

Do you currently drink alcohol? How often? How much? Have you had problems with alcohol in the past or currently?

Do you currently use any recreational drugs? What type? How often? Have you had problems with drugs in the past or currently?

Are you currently taking any prescription medication? What is the name? Dose? And for what is it prescribed?

[Discuss with the client the role that substance use plays in avoidance, and how alcohol and drug use is discouraged during treatment. Discuss the importance of not using substances before session, and before, during, or after completing practice assignments, as this will impact the effectiveness of the treatment.]

Is there anything else about your life now or about how [the event] is affecting you that you think I should know now?

VI. Treatment Overview

[Give an overview of the treatment and discuss each of the components of the treatment. Discuss how the therapist is like a coach teaching the client specific skills to reduce the PTSD.]

What do you hope to get out of treatment? What would you like to see changed?

[Before ending the session, provide psychoeducation about PTSD and the role of avoidance. Predict that they probably considered cancelling this session and congratulate them on taking the first step to challenge avoidance. Predict that they will also think about cancelling the next session and discuss how important their goals are to them and how the treatment will help them reach their goals.]

APPENDIX E. CPT SESSIONS FIDELITY MONITORING CHECKLISTS

Rater Instructions

- **Fidelity to CPT Session Elements:** For each CPT element, check "Yes" if you completed the task; check "No" if you did not, and explain why under "Additional Comments."
- **Proscribed Elements:** For each item, assess whether any proscribed (disallowed) elements were present. If YES, please provide comments in the "Additional Comments" section on why any proscribed elements were present during the session.

Note: Revisions to the "CPT Sessions Fidelity Monitoring Checklists" made by: John Moring, PhD & Katy Dondanville, PsyD. Original forms (formerly "Variable Length Cognitive Processing Therapy (CPT): Therapist Adherence and Competence Protocol Full-Length Treatment Version) by: Alexandra Macdonald, PhD, Shannon Wiltsey-Stirman, PhD, Jennifer Wachen, PhD, CJ Eubanks Fleming, PhD, and Patricia Resick, PhD which was based on original forms (formerly "Cognitive Processing Therapy Cognitive Only") by: Anna K. Birks, PsyD, Carie Rodgers, PhD, and Leslie A. Morland, PsyD.

Pre-Treatment Assessment

Session Date:_____ Therapist:_____ Client ID:_____

Fidelity: Did you complete the task? If "No," please explain why under "Additional Comments."

Pre-treatment Assessment and Engagement		
	Yes	**No**
1. Screened client for PTSD		
2. Oriented client to the assessment tools		
3. Client completed all assessment tools: • Life Events Checklist-5 • PTSD Checklist-5 • PHQ-9 • Brief Inventory of Psychosocial Functioning (optional) • Additional measures determined by your team		
4. Reviewed client's responses to determine PTSD diagnosis and eligibility for CPT		
5. If client was eligible for CPT: • Engaged in shared decision-making about choosing CPT or another treatment • Used PTSD Treatment Decision Aid Tool (optional)		
6. If client chose to participate in CPT: • Built rapport • Discussed the client's goals for treatment • Addressed and planned for barriers to treatment • Discussed crisis sessions and check-ins		
4. Conducted Trauma History and Psychosocial Interview (Appendix D)		
Additional Comments:		

Session 1

Session Date:_____ Therapist:_____ Client ID:_____

Fidelity: Did you complete the task? If "No," please explain why under "Additional Comments." If you answer "Yes" to any proscribed elements, please explain why under "Additional Comments."

CPT Elements		
	Yes	**No**
1. Educated client on PTSD: • discussed 4 symptom clusters of reexperiencing, cognitions/emotions, arousal, and escape/avoidance symptoms • presented in the context of non-recovery • provided examples for symptoms • facilitated client participation in discussing examples		
2. Educated client about fight-flight response: • easily paired with environmental cues • used relevant examples		
3. Educated client on cognitive theory: • organize world into categories • explained just world myth • described assimilation and over-accommodation • used relevant examples		
4. Provided education on types of emotions: • natural vs. manufactured • examples of different emotions & combination of emotions		
5. Provided treatment rationale: • recognition/modification of unhelpful thoughts and feelings • acceptance of the reality of the traumatic event, to develop more balanced beliefs • feel natural emotions associated with the traumatic event		
6. Explained stuck points: • defined stuck points • discussed how stuck points are formed • introduced stuck point handout • provided examples of stuck points		
7. Clearly and completely assigned practice assignment: completed Impact Statement (hand-written if possible, focus on meaning not detail)		

Essential but Not Unique Elements		
	Yes	**No**
1. Structured the session and used time effectively.		
Proscribed Elements		
1. Significant problems arose that led to a departure from the agenda (please describe in Additional Comments section).		
2. Implemented interventions that are not included in manual or the model of treatment, except as clearly dictated by client safety.		
3. Engaged in more than 15 minutes of off-task discussion.		
Additional Comments:		

Session 2

Session Date:_____ Therapist:_____ Client ID:_____

Fidelity: Did you complete the task? If "No," please explain why under "Additional Comments." If you answer "Yes" to any proscribed elements, please explain why under "Additional Comments."

CPT Elements		
	Yes	**No**
1. Discussed the Impact Statement: • explored impact of traumatic event • praised for completing • if client did not complete, therapist had client describe meaning of events orally and reassign		
2. Assisted client in identifying stuck points from impact statement: • discussed examples of assimilation and over-accommodation using examples from Impact Statements • begin building Stuck Point Log		
3. Discussed relationship between events, thoughts and feelings: • asked for examples of feelings and the associated physical sensations • introduced Identifying Emotions handout (e.g., basic emotions, varied intensity of emotions, secondary emotions) • discussed example of how interpretations of events affect feelings • used relevant examples		
4. Completed A-B-C worksheet with the client on relevant example.		
5. Clearly and completely assigned the practice: daily completion of A-B-C sheet with at least one sheet on trauma.		
Essential but Not Unique Elements		
1. Structured the session and used time effectively.		
Proscribed Elements		
1. Significant problems arose that led to a departure from the agenda (please describe in Additional Comments section).		
2. Implemented interventions that are not included in manual or the model of treatment, except as clearly dictated by client safety.		
3. Engaged in more than 15 minutes of off-task discussion.		
Additional Comments:		

Session 3

Session Date:_____ Therapist:_____ Client ID:_____

Fidelity: Did you complete the task? If "No," please explain why under "Additional Comments." If you answer "Yes" to any proscribed elements, please explain why under "Additional Comments."

CPT Elements		
	Yes	**No**
1. Reviewed A-B-C worksheets: • labeled thoughts versus emotions • highlighted changing thoughts can change intensity and types of feelings • began to challenge assimilated stuck points • pointed out mismatches between thoughts and emotions • identified stuck points		
2. Identified and challenged stuck points used Socratic questioning (i.e., "What else could you have done?"; "What might have happened then?"): • focused on trauma-specific and assimilation stuck points whenever possible • used the Stuck Point Log to track stuck points		
3. Reviewed A-B-C worksheet on trauma-related example.		
4. Clearly explained practice assignment: daily completion of A-B-C sheet with at least one sheet on trauma.		
Essential but Not Unique Elements		
1. Structured the session and used time effectively.		
Proscribed Elements		
1. Significant problems arose that led to a departure from the agenda (please describe in Additional Comments section).		
2. Implemented interventions that are not included in manual or the model of treatment, except as clearly dictated by client safety.		
3. Engaged in more than 15 minutes of off-task discussion.		
Additional Comments:		

Session 4

Session Date:_____ Therapist:_____ Client ID:_____

Fidelity: Did you complete the task? If "No," please explain why under "Additional Comments." If you answer "Yes" to any proscribed elements, please explain why under "Additional Comments."

CPT Elements		
	Yes	**No**
1. Reviewed A-B-C worksheets: • helped further differentiate between thoughts and feelings • highlighted how changing thoughts changes type and intensity of emotions • challenged assimilation stuck points		
2. Identified and challenged stuck points used Socratic questioning (i.e., "What else could you have done?"; "What might have happened then?"): • discussed hindsight bias • focused on trauma-specific and assimilation stuck points whenever possible		
3. Explained difference between responsibility and blame: • provided definition of both concepts • discussed examples relevant to client		
4. Introduced Challenging Questions Worksheet to help challenge stuck points: • used relevant stuck point examples • provided explanation of questions using examples • provided alternative hypotheses		
4. Clearly and completely assigned practice assignment: daily completion of Challenging Questions Worksheet, with one focused on the trauma/ blame.		
Essential but Not Unique Elements		
1. Structured the session and used time effectively.		
Proscribed Elements		
1. Significant problems arose that led to a departure from the agenda (please describe in Additional Comments section).		
2. Implemented interventions that are not included in manual or the model of treatment, except as clearly dictated by client safety.		
3. Engaged in more than 15 minutes of off-task discussion.		
Additional Comments:		

Session 5

Session Date:_____ Therapist:_____ Client ID:_____

Fidelity: Did you complete the task? If "No," please explain why under "Additional Comments." If you answer "Yes" to any proscribed elements, please explain why under "Additional Comments."

CPT Elements		
	Yes	**No**
1. Facilitated discussion while reviewing Challenging Questions Worksheet(s): • discussed questions client had difficulty with • helped analyze and confront stuck points • addressed hindsight bias		
2. Identified and challenged stuck points used Socratic questioning (i.e., "What else could you have done?"; "What might have happened then?"): • discussed hindsight bias • focused on trauma-specific and assimilation stuck points whenever possible • used the Stuck Point Log to track stuck points		
3. Introduced Patterns of Problematic Thinking Worksheet: • discussed each pattern & provided examples • described how patterns become automatic, creating negative feelings (using an example to illustrate) • helped generate trauma and non-trauma examples of problematic thinking patterns		
4. Clearly and completely assigned practice assignment: daily completion of Patterns of Problematic Thinking Worksheet.		
Essential but Not Unique Elements		
1. Structured the session and used time effectively.		
Proscribed Elements		
1. Significant problems arose that led to a departure from the agenda (please describe in Additional Comments section).		
2. Implemented interventions that are not included in manual or the model of treatment, except as clearly dictated by client safety.		
3. Engaged in more than 15 minutes of off-task discussion.		
Additional Comments:		

Session 6

Session Date:_____ Therapist:_____ Client ID:_____

Fidelity: Did you complete the task? If "No," please explain why under "Additional Comments." If you answer "Yes" to any proscribed elements, please explain why under "Additional Comments."

CPT Elements		
	Yes	**No**
1. Facilitated discussion related to Problematic Patterns Worksheet: • discussed patterns client had difficulty with • identified tendencies toward particular patterns • discussed how patterns may have affected reactions to the trauma • used Socratic questions to help replace problematic patterns with more balanced cognitions		
2. Introduced Challenging Beliefs Worksheet: • described outline of worksheet • identified previous pieces presented • completed sheet with stuck point with client, preferably on a trauma-related thought		
3. Clearly and completely assigned the practice assignment: daily challenging of stuck points using the Challenging Beliefs Worksheets.		
Essential but Not Unique Elements		
	Yes	**No**
1. Structured the session and used time effectively.		
Proscribed Elements		
1. Significant problems arose that led to a departure from the agenda (please describe in Additional Comments section).		
2. Implemented interventions that are not included in manual or the model of treatment, except as clearly dictated by client safety.		
3. Engaged in more than 15 minutes of off-task discussion.		
Additional Comments:		

Session 7

Session Date:_____ Therapist:_____ Client ID:_____

Fidelity: Did you complete the task? If "No," please explain why under "Additional Comments." If you answer "Yes" to any proscribed elements, please explain why under "Additional Comments."

CPT Elements		
	Yes	**No**
1. Facilitated client discussion related to Challenging Beliefs Worksheet(s): • discussed successes and/or problems in changing cognitions/stuck points • helped client confront problematic cognitions they were unable to modify on their own • used Socratic questions to challenge beliefs		
2. Introduced Safety Module • reviewed module; defined safety for self and others • explored how the trauma affected beliefs about safety for self (e.g., "I can keep myself safe) and others (e.g., "the world is dangerous") • compared safety beliefs prior to and after the traumatic event		
3. Clearly and completely assigned practice assignment: • read Safety Module • daily completion of Challenging Beliefs Worksheets, with at least one being on a safety-related stuck point		
Essential but Not Unique Elements		
	Yes	**No**
1. Structured the session and used time effectively.		
Proscribed Elements		
1. Significant problems arose that led to a departure from the agenda (please describe in Additional Comments section).		
2. Implemented interventions that are not included in manual or the model of treatment, except as clearly dictated by client safety.		
3. Engaged in more than 15 minutes of off-task discussion.		
Additional Comments:		

Session 8

Session Date:_____ Therapist:_____ Client ID:_____

Fidelity: Did you complete the task? If "No," please explain why under "Additional Comments." If you answer "Yes" to any proscribed elements, please explain why under "Additional Comments."

CPT Elements		
	Yes	**No**
1. Facilitated client discussion related to Challenging Beliefs Worksheet(s): • discussed successes and/or problems in changing cognitions/stuck points • helped client confront problematic cognitions they were unable to modify on their own • used Socratic questions to challenge beliefs • discussed stuck points related to safety (self and others) if possible		
2. Reviewed Safety Module: • discussed any self and other safety beliefs and facilitated discussion on related stuck points • discussed low versus high probability • calculated percentages related to safety related stuck points		
3. Introducing the Trust Module: • reviewed module and defined self-trust and trust of others • explored how the trauma affected beliefs about trust for self and others • compared trust beliefs prior to and after the traumatic event • identified stuck points to be challenged		
4. Clearly and completely assigned practice assignment: • read Trust Module • daily completion of Challenging Beliefs Worksheets, with at least one being on a trust-related stuck point		
Essential but Not Unique Elements		
1. Structured the session and used time effectively.		
Proscribed Elements		
1. Significant problems arose that led to a departure from the agenda (please describe in Additional Comments section).		
2. Implemented interventions that are not included in manual or the model of treatment, except as clearly dictated by client safety.		
3. Engaged in more than 15 minutes of off-task discussion.		
Additional Comments:		

Session 9

Session Date:_____ Therapist:_____ Client ID:_____

Fidelity: Did you complete the task? If "No," please explain why under "Additional Comments." If you answer "Yes" to any proscribed elements, please explain why under "Additional Comments."

CPT Elements		
	Yes	**No**
1. Facilitated client discussion related to Challenging Beliefs Worksheet(s): • discussed successes and/or problems in changing cognitions/stuck points • helped client confront problematic cognitions they were unable to modify on their own • used Socratic questions to challenge beliefs • discussed Stuck Point related to trust (self and others) if possible		
2. Reviewed Trust Module: • discussed trust and facilitated a discussion on related stuck points • focused on clients' self and other trust issues • explained different kinds of trust (i.e., money versus secret), and that trust is not all or none, but lies on a continuum (e.g., Star diagram) • discussed how trust impacts their relationships		
3. Introduced Power/Control Module: • reviewed module & defined self-power and concept of self-efficacy • explored how the trauma affected beliefs about power/control for self and others • compared power/control beliefs prior to and after the traumatic event • identified stuck points to be challenged		
4. Clearly and completely assigned the practice assignment: • read the Power/Control Module • daily completion of Challenging Beliefs Worksheets, with at least one being on a power/control-related stuck point		
Essential but Not Unique Elements		
1. Structured the session and used time effectively.		
Proscribed Elements		
1. Significant problems arose that led to a departure from the agenda (please describe in Additional Comments section).		
2. Implemented interventions that are not included in manual or the model of treatment, except as clearly dictated by client safety.		
3. Engaged in more than 15 minutes of off-task discussion.		
Additional Comments:		

Session 10

Session Date:_____ Therapist:_____ Client ID:_____

Fidelity: Did you complete the task? If "No," please explain why under "Additional Comments." If you answer "Yes" to any proscribed elements, please explain why under "Additional Comments."

CPT Elements		
	Yes	**No**
1. Facilitated client discussion related to Challenging Beliefs Worksheet(s): • discussed successes and/or problems in changing cognitions/stuck points • helped client confront problematic cognitions they were unable to modify on their own		
2. Reviewed Power/Control Module: • identified stuck points (e.g., "I need to be a 'control freak'") and helped client gain more balanced views of power/control • explained that power and control also lie on a continuum (like trust, it's not all or none) • discussed anger in the context of control		
3. Introduced Ways of Giving and Taking Power Handout: • discussed example of each positive/negative ways of giving/taking power • encouraged client to give examples • discussed barriers to positive giving/taking power		
4. Introduced Esteem Module: • reviewed module & defined self-esteem and esteem related to others • compared esteem related to self and others prior to and after the traumatic event • identified stuck points to be challenged		
5. Clearly and completely assigned practice assignment: • Read Esteem Module • Complete Challenging Beliefs Worksheets daily, with at least one being on an esteem-related stuck point • Give and receive compliments daily • do at least one nice thing for self each day		
Essential but Not Unique Elements		
1. Structured the session and used time effectively.		
Proscribed Elements		
1. Significant problems arose that led to a departure from the agenda (please describe in Additional Comments section).		
2. Implemented interventions that are not included in manual or the model of treatment, except as clearly dictated by client safety.		
3. Engaged in more than 15 minutes of off-task discussion.		
Additional Comments:		

Session 11

Session Date:_____ Therapist:_____ Client ID:_____

Fidelity: Did you complete the task? If "No," please explain why under "Additional Comments." If you answer "Yes" to any proscribed elements, please explain why under "Additional Comments."

CPT Elements		
	Yes	**No**
1. Facilitated discussion related to giving/receiving compliments and engaging in pleasant activities: • reinforce behavior & encouraged to continue • explored related stuck points • identified emotional reactions to compliments and engaging in pleasant activities		
2. Facilitated client discussion related to Challenging Beliefs Worksheet(s): • discussed successes and/or problems in changing cognitions/stuck points • helped client confront problematic cognitions they were unable to modify on their own • used Socratic questions to challenge beliefs • discussed stuck points related to esteem (self and others) if possible		
3. Reviewed Esteem Module: • explored self-esteem related beliefs & identified stuck points, such as being permanently damaged or needing to be perfect (perfectionism) • discussed beliefs related to ability to self-soothe (problems with food/alcohol/spending) • explored esteem beliefs related to others and identified over-accommodated beliefs to challenge		
4. Introduced Intimacy Module: • reviewed module & defined self-intimacy and other-intimacy and generate examples • discussed how relationships may have been affected by the trauma • compared self and other intimacy beliefs prior to and after the traumatic event, • identified stuck points to be challenged		
4. Clearly and completely assigned practice assignment: • read Intimacy Module • complete Challenging Beliefs Worksheets daily, with at least one being on an intimacy-related stuck point • give and receive compliments daily • do at least one nice thing for self each day • write a second impact statement		

Essential but Not Unique Elements		
	Yes	**No**
1. Structured the session and used time effectively.		
Proscribed Elements		
1. Significant problems arose that led to a departure from the agenda (please describe in Additional Comments section).		
2. Implemented interventions that are not included in manual or the model of treatment, except as clearly dictated by client safety.		
3. Engaged in more than 15 minutes of off-task discussion.		
Additional Comments:		

Session 12

Session Date:_____ Therapist:_____ Client ID:_____

Fidelity: Did you complete the task? If "No," please explain why under "Additional Comments." If you answer "Yes" to any proscribed elements, please explain why under "Additional Comments."

CPT Elements		
	Yes	**No**
1. Facilitated client discussion on Challenging Beliefs Worksheet(s): • discussed successes and/or problems in changing cognitions/stuck points • helped client confront problematic cognitions they were unable to modify on their own • used Socratic questions to challenge beliefs • discussed stuck points related to intimacy (self and others) if possible • reviewed compliments and engaging in pleasant activities		
2. Reviewed Intimacy Module: • discussed how relationships have been affected by the trauma • helped develop balanced beliefs to help improve current relationships and develop new ones • identified ways to improve self-soothing to improve client's life		
3. Discussed second Impact Statement: • asked client to review their final Impact Statement • compared the first Impact Statement with second, identified changes made in cognitions, praised client for progress and changes made • identified remaining stuck points and instructed client to continue challenging them with their new skill set		
4. Initiated discussion on course of therapy/progress made: • reviewed concepts/skills learned • encouraged client to reflect on progress and changes made; reviewed Stuck Point Log • emphasized that continued success depends on practice of skills learned		
5. Helped client plan for the future: • identified future goals and strategies for meeting goals • reviewed available resources • reiterated treatment plans as necessary • discussed life without PTSD		

Essential but Not Unique Elements		
	Yes	**No**
1. Structured the session and used time effectively.		
Proscribed Elements		
1. Significant problems arose that led to a departure from the agenda (please describe in Additional Comments section).		
2. Implemented interventions that are not included in manual or the model of treatment, except as clearly dictated by client safety.		
3. Engaged in more than 15 minutes of off-task discussion.		
Additional Comments:		

Session 13+

Session Date:_____ Therapist:_____ Client ID:_____

Fidelity: Did you complete the task? If "No," please explain why under "Additional Comments." If you answer "Yes" to any proscribed elements, please explain why under "Additional Comments."

CPT Elements		
	Yes	**No**
1. Facilitated client discussion on Challenging Beliefs Worksheet(s): • discussed successes and/or problems in changing cognitions/stuck points • helped client confront problematic cognitions they were unable to modify on their own • used Socratic questions to challenge beliefs • discussed stuck points related to intimacy (self and others) if possible • reviewed compliments and engaging in pleasant activities		
2. Clearly and completely assigned practice assignment: • read Intimacy Module • complete Challenging Beliefs Worksheets daily, with at least one being on an intimacy-related stuck point • give and receive compliments daily • do at least one nice thing for self each day • write a second Impact Statement		
Essential but Not Unique Elements		
	Yes	**No**
1. Structured the session and used time effectively.		
Proscribed Elements		
1. Significant problems arose that led to a departure from the agenda (please describe in Additional Comments section).		
2. Implemented interventions that are not included in manual or the model of treatment, except as clearly dictated by client safety.		
3. Engaged in more than 15 minutes of off-task discussion.		
Additional Comments:		

ASAP Session

Session Date:_____ Therapist:_____ Client ID:_____

Fidelity: Did you complete the task? If "no," in the Additional Comments section, please describe why items were omitted.

ASAP Session Elements		
	Yes	**No**
1. Facilitated client discussion on current stressor(s): • discussed problems in changing cognitions/stuck points • helped client confront problematic cognitions that might prevent them from engaging in therapy, avoiding practice assignments, or any other barriers • discussed moving forward with CPT		
2. Clearly and completely assigned practice assignment that corresponds to the next session of CPT.		
Essential but Not Unique Elements		
	Yes	**No**
1. Structured the session and used time effectively.		
Additional Comments:		

APPENDIX F. MOBILE APPS FOR CPT CLIENTS

The following free applications (apps) may enhance a client's experience with CPT. All three apps are available for both iPhone and Android users.

CPT Coach

The CPT Coach app helps clients manage their treatment as part of their overall completion of CPT with a behavioral health provider. The app includes between session assignments, reading material, PTSD symptom monitoring, and mobile versions of CPT worksheets.

For more information: ***CPT Coach***

PTSD Coach

PTSD Coach app provides clients with information about PTSD, as well as tools to manage daily life stressors related to their PTSD. Tools include help with relaxation, positive self-talk, and other common self-help strategies. PTSD Coach is available in English and Spanish.

For more information: ***PTSD Coach***

Virtual Hope Box

The Virtual Hope Box (VHB) app contains customizable tools to help clients with coping, relaxation, distraction, and positive thinking.

For more information: ***Virtual Hope Box***