APPENDIX 1 Treatment Manuals

Psychologist Training

Trauma-Focused CBT Manual

Contents

INTRODUCTION

The purpose of this manual is to guide the administration of the cognitive behaviour therapy intervention arm of a randomised control trial (RCT) investigated the effectiveness of combined trauma focused cognitive behavioural therapy (TF-CBT) and exercise for chronic whiplash. Material in this manual is largely adapted from the following resources:

1. Blanchard, E. B. and E. J. Hickling (2004). After the crash: Psychological assessment and treatment of survivors of motor vehicle accidents, American Psychological Association. Chapter 18: The Treatment Manual: An in-depth look at the Albany MVA Project's Cognitive Behavioural Therapy

2. Bryant RA & Harvey AG. Acute Stress Disorder: A Handbook of Theory, Assessment, and Treatment. Washington DC: American Psychological Association.

1. Rationale and description of intervention

Persistent pain and disability following whiplash injury as a consequence of a road traffic crash (RTC) is common and incurs substantial personal and economic costs. To date no conservative treatment approach has been shown to be very effective for those who develop chronic pain following whiplash injury. Psychological responses related to the traumatic event itself, posttraumatic stress symptoms, are emerging as an important additional psychological factor in the whiplash condition. Research has demonstrated that individuals with chronic whiplash associated disorders (WAD) and moderate posttraumatic stress disorder (PTSD) symptoms do not respond well to a physical rehabilitation based intervention as those without PTSD symptoms (Jull, Sterling, Kenardy, & Beller, 2007). A recent pilot study has shown TF-CBT has a beneficial effect on both psychological status and pain and disability (Dunne, Kenardy, & Sterling, 2012). The current research is conducting a RCT to determine the effects of adding TF-CBT to exercise for individuals with chronic WAD and PTSD.

TF-CBT will be combined with exercise and compared to supportive therapy (ST) also combined with exercise. The TF-CBT component will be conducted over ten 60 minute weekly sessions.

The main goals of the TF-CBT intervention are to:

- provide psycho-education on PTSD;
- manage anxiety symptoms using relaxation strategies;
- utilise cognitive restructuring to identify and challenge negative thoughts;
- use exposure therapy to manage ongoing anxiety and intrusive thoughts and feelings;
- provide relapse prevention to manage possible setbacks post-therapy;

2. Theoretical background

TF-CBT is one of the most commonly recommended treatments for PTSD. TF-CBT is a combination of cognitive and behavioural therapy and includes exposure to help reduce symptomology and improve a person's quality of life. It is proposed that through repeated exposure to memories of the event, the individual is able to overcome some of the debilitating effects of the trauma. Effective techniques include psycho-education, anxiety management, cognitive restructuring, exposure and relapse prevention (Bryant & Harvey, 2000).

Psycho-education is important as it provides a framework for the client to understand and normalise their symptoms. Using a TF-CBT structure the client is able to recognise how their trauma is experienced in a behavioural, cognitive, and emotional perspective.

Anxiety management is helpful as it provides the client with some initial control over their distress. Giving the client some tools to assist mastery over anxiety can provide both a sense of relief and a motivation to comply with more demanding therapy tasks.

Cognitive restructuring aims to help the client recognise their maladaptive perceptions of their trauma and replace it with more rational thoughts and feelings. By learning to identify and challenge faulty thoughts and feelings, the client can start to think and act differently.

Exposure is an important component of therapy and is based on the principles of habituation and information processing. Exposure is undertaken both imaginally and in vivo. It is thought that through continued exposure the client will habituate to the trauma and subsequently experience less anxiety and distress.

Relapse prevention is a critical component of the intervention as it is quite common for clients to experience setbacks once treatment has completed. Identifying possible high risk situations where relapse might occur and developing appropriate strategies to deal with these can lead to longer-term treatment gains.

3. Exclusions

To maintain the integrity of the treatment, this manual should be followed as closely as possible. Only the strategies discussed should be implemented. Other techniques such as eye movement desensitisation and reprocessing (EMDR) and non TF-CBT should not be used.

4. Special issues

Please see Appendix A for potential issues which may arise during therapy. These include excessive avoidance, dissociation, anger, grief, extreme anxiety, catastrophic beliefs, prior trauma, comorbidity, substance abuse, depression and suicide risk, poor motivation, ongoing stressors, cultural issues, appropriate versus inappropriate avoidance, multiple trauma survivors, and when exposure should not be used.

Legal issues

Clients may be involved in current legal proceedings in relation to the traumatic event. Therapists may listen to client concerns but ultimately are not experts in the law and should remind clients of this fact if asked for advice. Exacerbated symptoms of anxiety may occur around court dates and therapists should be supportive and assure the client that this emotional experience is normal.

Cancellation policy

If a client cannot attend a prearranged appointment then the therapist needs to attempt to organise another appointment within the week to ensure continuity of care. If that is not possible then the therapist can organise an additional appointment to ensure that all ten sessions are completed. If more than two appointments over the trial period are cancelled and unable to be rescheduled within the week, therapists should contact the research team to discuss. The ten sessions should not extend beyond a 12 week period.

Client wellbeing and duty of care

If a client's safety and wellbeing requires additional care[1] beyond the conditions of the trial, therapists are to contact the research team as soon as possible. Therapists will not be asked to disseminate information beyond what is necessary for adhering to research ethics protocols.

[1] including hospitalisation, suicide prevention plans, emergency sessions etc.

5. Structure and format of sessions

- 10 sessions
- 60 minutes each; up to a maximum of 90 minutes
- One session per week

Session	Overview
1	Initial interview/history taking, psycho-education on PTSD, collaborative formulation, description and rational for treatment, confidentiality, homework
2	Review of homework, relaxation training, breathing control, isometric relaxation, homework
3	Review of homework, relaxation training, introduction of cognitive therapy, homework
4	Review of homework, continue with cognitive challenging, introduction of prolonged exposure, homework
5	Review of homework, continue with cognitive challenging, prolonged exposure, homework
6	Review of homework, prolonged exposure, rational and implementation of in vivo exposure, exposure hierarchy development, homework
7	Review of homework, prolonged exposure, review of in-vivo exposure, homework
8	Review of homework, prolonged exposure, review of in-vivo exposure, homework
9	Review of homework, relapse prevention, homework
10	Review of homework, review relapse prevention, termination and end of treatment

SESSION 1

(90 mins)

Objectives

The main goals of this session are to begin to establish rapport with the client, gather important historical information, provide a description and rationale for treatment, discuss confidentiality issues, and to emphasise the importance of homework completion.

Outline of session

1. Initial Interview
2. Psycho-education on PTSD
3. Collaborative formulation
4. Description and rationale for treatment
5. Confidentiality
6. Support person
7. Homework
8. Complete WAI & CEQ

Handouts for Psychologist

A. Initial interview pro forma
B. Checklist for Session 1
C. Therapist WAI

Handouts for Client

1. PSTD fact sheet
2. Helping a friend or family member after a traumatic event
3. Triggers
4. Avoidance and safety behaviours
5. Homework diary
6. Client WAI and CEQ

1. Initial interview

The initial interview has two purposes. Firstly, as the treating therapist was not involved in the screening and baseline data collection, it allows the therapist to gain a good understanding of the presenting problem and to gather important background information that will be useful throughout the duration of treatment. A summary of the client's baseline score for the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) and the Depression, Anxiety and Stress Scale (DASS-21) will also be provided to the therapist. Secondly, it is a great way to develop rapport with the client and begin building the therapeutic alliance.

During the initial interview, it will be essential to identify the pattern of PTSD symptoms for the client, including:

- Intrusive thoughts or feelings (flashbacks, dreams, memories)
- Avoidance of situations
- Avoidance of thoughts or feelings
- Hyperarousal symptoms (e.g. trouble sleeping, concentrating, restlessness, irritability, hypervigilance etc.)

It will also be important to ascertain the strategies the client is currently using to cope with his or her symptoms. Please see **handout A** for the initial interview pro forma.

2. Psycho-education on PTSD

The aims of this education are to give the client a framework in which she or he can understand current symptoms and develop some mastery over her or his reactions and to lay the foundations for participating in CBT. Education can commence by presenting the following information to the client.

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

First, intrusive thoughts or feelings may come in the form of flashbacks, dreams, or memories of the trauma popping into your mind when you do not want them. They can be very upsetting. It is important to be aware that these sorts of memories serve the purpose of allowing the mind to process the trauma by playing it over repeatedly. Because the

experience you have had is so important to you, your mind has a need to keep thinking about it, so that it can understand and resolve it. This may seem strange to you, but these sorts of memories and feelings can be useful because they give us plenty of occasions to learn about our experiences and to sort through them.

It is very common after a traumatic experience to avoid all thoughts and reminders of the trauma. People often do this because thinking about it is so distressing that it seems much better to simply put it all aside. In fact, doing this often makes people feel a little better for that moment because they can distract themselves from the distress associated with the experience. What we need to be aware of here, however, is that this sort of avoidance can actually prevent you from getting over the experience.

One of the ways that people try to avoid the distress associated with the trauma is to block the feelings that they have about it. Often people can feel emotionally flat or detached from things. Sometimes people feel like everything seems strange or dreamlike. Other people report feeling that they are not their normal selves. All these reactions might be happening because people are distancing themselves from what has happened. In a sense, it is a way of turning your back on the whole experience. Although this form of avoidance can reduce the distress in the short term, it eventually gets in the way of resolving this experience because it does not allow people to connect with and resolve what they have been through.

Finally, many people who have suffered a traumatic experience report problems with sleeping, concentration, feeling restless and irritable, or being very sensitive to what is going to happen next. These problems occur because after the trauma, the body is in a state of heightened physical arousal. Physical arousal is a sign that even though the trauma is over, the body is still in the "alert" mode and is still prepared to deal with the threat. This elevated arousal can be very distressing for people because it leads to all these problems that can interfere with daily functioning. What we need to do is learn some ways to reduce this arousal. That is, we need to teach the body that the trauma is now over and it can relax a bit more. When we do this, some of these problems caused by the arousal will ease off.

During this initial discussion, it is important to illustrate each point with examples from the client's own experience. This will increase the relevance of the information for the client and their confidence that the therapist has heard and understood their experience. It is very important to allow opportunities for the client to ask questions and clarify the ideas presented because this initial information forms the basis for the subsequent treatment rationale. After hearing the therapist's account of trauma reactions, therapists should ask clients to explain to them their new understanding of how their trauma has affected them. This practice can be useful because it highlights to the therapist educational issues that need to be clarified before proceeding to therapy.

3. Collaborative formulation

Using the information gathered in the initial interview, as well as from the pre-treatment questionnaires, discuss with the client their specific presentation/symptoms, particular memories/emotions/thoughts and situations they may be avoiding, and discuss together how these coping strategies that may be helpful in the short-term seem to be not helping in the long-term. Be sure to empathise and validate the client’s symptoms, as well as their attempted coping

strategies. These are natural responses to a traumatic situation. However they are not working, otherwise the client would not be here with us. We need to try something different.

4. Description and rationale for treatment

Understanding the rationale of treatment is critical for therapeutic success. Clients require a thorough understanding of the treatment rationale if they are to overcome the ambivalence that they feel about approaching traumatic material that they have previously avoided. Providing a written summary of the rationale can be useful because many clients have difficulty absorbing information soon after the trauma. Provide the client with **handout 1** PTSD fact sheet. An overview of the treatment rationale can be presented in the following way:

As we discussed before, a major problem at the moment is that although we do not really need these stress reactions anymore, your body and mind think that we do still need them. We discussed before how you have responded to this experience in a number of ways that are contributing to your current problems. First, your body has responded with elevated arousal because it is still expecting to have to deal with a threatening event. Second, you are frequently thinking about the trauma and feeling distressed because your mind is still trying to process what you have been through. Third, you are often avoiding thoughts or feelings about the trauma because you want to reduce the distress you feel about it. As we discussed earlier, this response brings short-term benefits, but in the long run, it prevents you from really dealing with the experience. I would like to introduce you to the components of our treatment so you can understand why we are going to do each one. Each part of the treatment is going to target one of these problems. That means our goal is to reduce all the symptoms that you have told me about here.

Treatment will aim to teach you the following strategies to reduce your symptoms:
==>Strategies to manage arousal symptoms (e.g. relaxation and breathing techniques).
==>Strategies to manage problematic thoughts and thinking patterns about the event.
==>Learning how to confront the painful memories in a safe environment, so that you are able to understand and process the memory effectively.
==>Learning how to confront other situations that you may be avoiding such as those that may remind you of your traumatic event.
==>Learning how to maintain any progress we have made into the future.

This treatment will take ten sessions, and each session will last about 60 minutes. We will meet once a week. The overall aim of this program is to tackle these problems before they become entrenched. However, sometimes this will mean that there may be some residual problems still existing at the end of the ten sessions. Don't be concerned about that because recovering from a traumatic experience is often an ongoing process. What we are doing here is teach you the basic skills that you require to help you resolve your experience. Moreover, these skills will help you deal with any problems that might resurface in the coming months. Our main goal at this stage is to reduce the distress that you are feeling and to reduce the sorts of problems that have been getting in the way of you living the way you want to.

During treatment, I would prefer us to work as a team. I cannot "cure" you in the way that a pill might cure an illness. Rather, I would like to share with you some techniques that research has shown can overcome the sorts of problems that you have been experiencing.

That's my side of the process. The other side of the process will involve you doing a range of exercises that I will ask you to practice between sessions. What that means is that doing this sort of therapy requires considerable work on your part. I will be here to help and support you with every step along the way. So after each session we will set some homework to be completed between sessions. I am feeling hopeful that if we can work together in this way, we can make some headway in dealing with these problems. It's best that we have the chance to tackle these problems as early as possible. It often happens that if we leave these problems untreated, they can be trickier to treat in the future.

5. Confidentiality

It is also important to have an explicit discussion about confidentiality. This could be along the lines of the following:

I know you have read an information sheet and signed a consent form with the research team. I wanted to talk to you about what this means about the confidential nature of our sessions.

Firstly, psychologists are ethically obligated to disclose confidential information under a number of different circumstances. These are:
(a) with your consent;
(b) where there is a legal obligation to do so;
(c) if there is an immediate and specified risk of harm to an identifiable person or persons that can be averted only by disclosing information; or
(d) when consulting colleagues, or in the course of supervision or professional training.

This last point is particularly relevant. To ensure the integrity of the treatment procedures, I may need to discuss our therapy session during supervision to make sure I have not deviated from the study's protocol. Also, all of our sessions will be recorded. This is so the research team can randomly select one of our sessions to listen to make sure I am following the study protocol. This would have been explained to you by the research team.

6. Support person

It will be important for the client to have someone to support them throughout therapy, particularly when it comes to the in vivo exposure sessions. Have a discussion with the client about the benefit of having support around them. Ask them to decide on who would be the most appropriate person, whether it is their spouse, relative or friend. Encourage them to discuss this session with their support person and go through the PTSD fact sheet (handout 1) so their support person has some understanding of PTSD. Also provide the client with handout 2, Helping a friend or family member after a traumatic event and ask them to give this to their chosen support person.

7. Homework

It is important to emphasise to the client the importance of homework. The following points can be used:

- *The time between sessions is when most of therapy takes place, so practice and mastery of therapy skills will help to provide systematic guidance on coping with anxiety.*
- *Consistent and frequent practice of techniques is the key to recovery.*
- *Self-monitoring forms help us to keep track of your progress and will be used by me to tailor the treatment to your specific needs.*
- *Your homework will be used as a basis for each session.*
- *Please complete the homework diary and bring it with you to therapy each week and so we can check on your progress.*

- ♦ Read PTSD fact sheet **(handout 1)**
- ♦ The client is to choose an appropriate support person and discuss handout 1 with. They are to give **handout 2** Helping a friend or family member after a traumatic event to their support person and discuss with them.
- ♦ Instruct the client to read **handout 3** Triggers and **handout 4** Avoidance and safety behaviours and complete the worksheets. This will help to identify specific situations for in vivo exposure in future sessions
- ♦ Complete homework diary **(handout 5)**

8. Complete WAI and CEQ

At the end of the session, the therapist is to complete the therapist Working Alliance Inventory (WAI, **handout C**) and the client is to complete the client WAI and the Credibility/Expectancy Questionnaire (CEQ, **handout 6**). Please get the client to complete before they leave the session. These forms are to be returned to the research team at the completion of therapy.

PSYCHOLOGIST'S HANDOUTS

HANDOUT A

INITIAL INTERVIEW

(this is for the therapist to keep on file and does not need to be returned to the research team)

Date: _____

1. Demographic information:

Name:_____ **Age:** _____**years**

Sex: F □ M □ **Race/Ethnicity:** _____

Relationship Status:

☐ Single
☐ In a relationship
☐ De Facto
☐ Married
☐ Divorced/Separated
☐ Widowed/er
☐ Other _____

Highest level of Education attained:

☐ Year 10
☐ Year 12
☐ Trade/certificate _____
☐ Bachelor degree _____
☐ Postgraduate education _____
☐ Other _____

Current Employment Status:

☐ Employed for wages
☐ Out of work more than 1year
☐ Out of work for 1 year or less
☐ Homemaker
☐ Student
☐ Self-employed
☐ Unable to work
☐ Other, please describe: _____

2. **Presenting problem and current symptoms:** (biological, cognition, behaviour, mood/affect)

3. **History of presenting problem:** (onset/course, severity, stressors)

4. **Family history:** (illnesses, substance use, behaviours and intellectual disability, current family situation)

Genogram Key: include three generations Male  Female  Unknown  Married Defacto - - - - Separated  Divorced  Adopted  Death X	

5. **Developmental history:** (problems in school; school performance; history of childhood mental illness; child abuse, traumas/and or losses during childhood)

6. **Educational history:** (highest level of education, other training e.g. vocational, apprenticeship)

7. **Work history:** (current employment, length of employment; previous employment, length of employment, reasons for leaving; periods of unemployment)

8. **Relationship history:** (Describe relationships with others, problems developing/maintaining friendships and/or intimate relationships; childhood relationships, adult relationships, current relationships, history of domestic violence, identified support persons)

9. **Medical history:** (current, overall health; chronic illness; serious medical illness or injury; hospitalised for medical problems; medications for medical problem; family history of heritable medical problems)

10. **Psychiatric history:** (previous diagnoses; previously attended with a mental health professional; history of self-harm/suicide attempts; previous psychiatric admission)

11. **Psychiatric medication:** (current and previous)

12. **Substance use and gambling history:** (cigarette, alcohol, prescription and illicit substance use)

13. Legal history: (past or current involvement with legal system, e.g. warrants, arrests, detentions, convictions, probation or parole; past or current involvement with the court system, e.g. criminal/civil/family)

14. Current social situation: (Social support/social relationships; social activity, daily living skills/work/leisure/education/financial situation/housing)

15. Other/notes:

HANDOUT B

CHECKLIST FOR SESSION 1

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

_____ Please indicate length of session, i.e. 60 mins, 90 mins

PLEASE TICK

_____ 1. Session audio taped; commence with date, client no, session no

_____ 2. Complete initial interview

_____ 3. Introduce psycho-education on PTSD

_____ 4. Provide client with PTSD fact sheet

_____ 5. Discuss collaborative formulation with client

_____ 6. Discuss description and rationale for treatment

_____ 7. Discuss confidentiality

_____ 8. Discuss the importance of a support person and provide with handout

_____ 9. Homework assigned to:

(a) write out triggers,

(b) write out avoidance and safety behaviours.

_____ 10. Give homework diary to client and explain it

_____11. Therapist complete the WAI and return to research team

_____12. Client complete the WAI and CEQ and return to research team

Comments:

HANDOUT C

WORKING ALLIANCE INVENTORY
Short Form (Therapist)
Return to Research Team

Therapist _____ Participant ID _____ Date _____

Measurement Point (circle one): 1st week Last Week

Instructions:

On the following page there are sentences that describe some of the different ways you might think or feel about your client.

As you read the sentences mentally insert the name of your client in place of _____in the text.

Below each statement there is a seven point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you *always* feel (or think) circle the number 7; if it never applies to you, circle the number 1. Use the numbers in between to describe the variations between these extremes.

Work quickly; your first impressions are the ones we would like to see.

PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.

Thank You!

1. _____ and I agree about the steps to be taken to improve his/her situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. My client and I both feel confident about the usefulness of our current activity in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. I believe _____ likes me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. I have doubts about what we are trying to accomplish in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. I am confident in my ability to help _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. We are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I appreciate _____ as a person.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8 We agree on what is important for _____ to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. _____ and I have built a mutual trust.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. _____ and I have different ideas on what his/her real problems are.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. We have established a good understanding between us of the kind of changes that would be good for _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

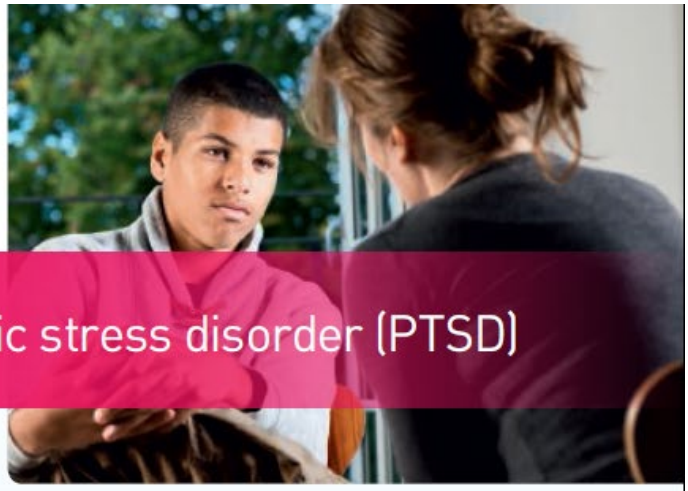
12. _____ believes the way we are working with his/her problem is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

CLIENT HANDOUTS

HANDOUT 1

beyondblue
Depression. Anxiety.



Post-traumatic stress disorder (PTSD)

Post-traumatic stress disorder (PTSD) is a particular set of reactions that can develop in people who have been through a traumatic event. That is, they have experienced or witnessed an event which threatened their life or safety, or that of others around them, and led to feelings of intense fear, helplessness or horror.

This can be a car or other serious accident, physical or sexual assault, war or torture, or disasters such as bushfires or floods. Other life-changing situations such as being retrenched, getting divorced or the expected death of an ill family member are very distressing and may cause mental health problems, but are not events that can cause PTSD.

Signs and symptoms

People with PTSD often experience feelings of panic or extreme fear, which may resemble those sensations that were felt during the traumatic event. A person with PTSD has four main types of difficulties.

1. **Re-living the traumatic event:** Through unwanted and recurring memories, often in the form of vivid images and nightmares. There may be intense emotional or physical reactions, such as sweating, heart palpitations or panic when reminded of the event.
2. **Being overly alert or wound up:** Sleeping difficulties, irritability, lack of concentration, becoming easily startled and constantly being on the lookout for signs of danger.
3. **Avoiding reminders of the event:** Deliberately avoiding activities, places, people, thoughts or feelings associated with the event because they bring back painful memories.
4. **Feeling emotionally numb:** Losing interest in day-to-day activities, feeling cut off and detached from friends and family, or feeling emotionally flat and numb.

A health professional may diagnose PTSD if a person has a number of symptoms in each of these areas for one month or more. The symptoms usually lead to significant distress and interfere with the person's ability to work or study, as well as his/her social relationships.

It's not unusual for people with PTSD to experience other mental health conditions at the same time. These may have developed directly in response to the traumatic event or have followed the PTSD. These additional problems – most commonly depression, anxiety and alcohol or drug use – are more likely to occur if PTSD has persisted for a long time.

Talk to your doctor or another health professional at any time if you feel very distressed or your reactions are interfering with your relationships, work or study and ability to participate in day-to-day activities.

How common is PTSD and who experiences it?

Anyone can develop PTSD following a traumatic event, but people are at greater risk if the event involved deliberate harm (such as physical or sexual assault) or they have had repeated traumatic experiences (such as childhood sexual abuse or living in a war zone). Apart from the event itself, risk factors for developing PTSD include a past history of trauma or previous mental health problems, as well as ongoing stressful life events after the trauma and an absence of social supports.

Around one million Australians experience PTSD in any one year, and 12 per cent of Australians will experience PTSD in their lifetime.[1] Serious accidents are one of the leading causes of PTSD in Australia.

What treatments are available for PTSD?

Many people experience some of the symptoms of PTSD in the first couple of weeks after a traumatic event, but most recover on their own or with the help of family and friends. For this reason, treatment does not usually start until about two weeks after a traumatic experience. Even though formal treatment may not commence, it is important during those first few days and weeks to get whatever help is needed. This might include simple information and advice on self care. Support from family and friends is very important for most people.

Trying, as far as possible, to minimise other stressful life experiences allows the person to focus more on his/her recovery.

If a person feels very distressed at any time after a traumatic event, he/she should talk to a doctor or other health professional. If a person experiences symptoms of PTSD that persist beyond two weeks, a doctor or a mental health professional may recommend starting treatment for PTSD.

Effective treatments are available. Most involve psychological treatment (talking therapy), but medication can also be prescribed in some cases. Generally, it's best to start with psychological treatment rather than use medication as the first and only solution to the problem.

The cornerstone of treatment for PTSD involves confronting the traumatic memory and working through thoughts and beliefs associated with the experience. Trauma-focused psychological treatments can reduce PTSD symptoms, lessen anxiety and depression, and improve a person's quality of life. They are also effective for people who have experienced prolonged or repeated traumatic events, but more time may be needed in these circumstances.

Drug treatments are not recommended within four weeks of symptoms appearing unless the severity of the person's distress cannot be managed by psychological means alone.

Helping yourself to recover from PTSD

There are also many ways in which the person can assist in his/her recovery. It's important to remember that recovery is not something that happens all at once, nor is it straightforward. Symptoms of PTSD can be manageable for a while, then return at times of stress. Anniversary dates, news coverage of similar events or going through a major change like a new job or relationship breakdown can lead to problems coming back or getting worse for a time. For most people, however, the following "DOs and DON'Ts" will help:

Do

- ✓ Spend time with people who care
- ✓ Give yourself time
- ✓ Find out about the impact of trauma and what to expect
- ✓ Try to keep a routine going (e.g. work, study)
- ✓ Return to normal activities
- ✓ Talk about how you feel or what happened when ready
- ✓ Do things that help you relax
- ✓ Do things that you enjoy

Other tips to promote recovery

- Set realistic goals – don't take on too much, but try to find goals that keep you motivated.
- Review and reward progress – notice even the small steps.
- Talk about the ups and downs of recovery with friends, family and the health professionals involved in your care.
- Have a plan to maintain positive changes and plans to deal with times of stress or reminders of the trauma.

Don't

- × Use alcohol or drugs to try to cope
- × Keep yourself busy and work too much
- × Engage in stressful family or work situations
- × Withdraw from family and friends
- × Stop yourself from doing things that you enjoy
- × Avoid talking about what happened
- × Take risks

Anniversaries and other stressful times

Anniversaries of traumatic events like the September 11 terrorist attacks in America, a battle in the Vietnam War, major bushfires and floods, and tragedies may trigger some unpleasant emotions in people, even if they were not directly affected or involved. Seeing images in the media again, or recalling your reaction at the time, may be upsetting. You may also find other times difficult, especially when you are experiencing other stress in your life such as financial, work, health, or relationship problems. At those times, it is especially important that you look after yourself in the ways discussed in this fact sheet.

Tips to help you cope with anniversaries and other difficult times

- Recognise that an anniversary can be a difficult period. Give yourself permission to feel some distress; it is perfectly normal and understandable.
- Try to limit your exposure to media coverage about the anniversary, as well as your conversations about it with other people.
- Keep your normal routine going, but allow yourself some time out if you need it.
- Plan your days and build in plenty of relaxing and enjoyable activities.
- Spend time with other people – especially those you care about – and don't be afraid to ask for support if you need it.
- Look after yourself. Get plenty of rest and exercise and eat sensibly; cut back on stimulants such as tea, coffee, chocolate, cola and cigarettes.
- If you drink alcohol, keep an eye on how much you drink.
- Try to relax. Listen to soothing music, go for a walk, take a hot bath, or do whatever works for you.

HANDOUT 2

Australian Centre for Posttraumatic Mental Health

Helping a friend or family member after a traumatic event

Traumatic events involve situations that are either life-threatening or have the potential for serious injury, such as physical or sexual assault, natural disaster, war or a serious accident. Most people will experience at least one of these types of events during their lives.

After a traumatic event, many people experience strong feelings of fear, sadness, guilt, anger, or grief. They might find it hard to cope and it might take a while to come to terms with what has happened. These feelings will usually become less intense after a few weeks. The support of family and friends is particularly important during this time, and this fact sheet will provide you with some ideas of things you can do to help.

Provide practical support

After someone has been through a traumatic experience, re-establishing a normal routine can help to restore a sense of order and control in their life. Some of the ways you can help them return to their normal routine include:

- **Recognise that they have been through an extremely stressful event** and may need time and space to deal with it. You can help them to find that time and space by providing practical support, such as offering to take care of the kids or do the weekly shopping.
- **Encourage them to limit their exposure to media coverage of the event.** You might offer to keep track of the news and inform them of new or important information so that they don't feel the need to monitor it continuously.
- **Encourage them to look after themselves** by getting plenty of rest, eating well, exercising regularly, making time for relaxation and cutting back on coffee, cigarettes, drugs, and alcohol.
- **Join them in doing enjoyable things** and encourage them to plan to do at least one enjoyable thing each day. You may need to help the person come up with ideas of things they can do, for example, ask what activities they used to enjoy before the traumatic event.
- **Acknowledge their achievements.** Sometimes it's hard to see that things are improving, and the person may need you to point out when they have achieved a goal, no matter how small.
- **Encourage them to seek professional help** if they are still finding it hard to cope more than two weeks after the traumatic event.

A centre of excellence supported by the Australian Government

THE UNIVERSITY OF MELBOURNE

Provide emotional support

Your friend or family member may or may not want to talk about their experience or feelings. If they do want to talk, the following tips may be helpful.

- **Choose a time to talk** when you won't be interrupted, or feel rushed or tired.
- **Provide reassurance** that distress is to be expected after an experience like theirs.
- **Understand that talking about trauma can be painful** and the person may get upset. This is a natural part of coming to terms with their experience. Don't feel that you have to make their distress go away.
- **Make another time to talk** if it seems like the person is too distressed to continue.

Listening is very important, but it can sometimes be hard to know what to say. Don't worry about having to say 'the right thing'. There is no right thing to say, but here are a few pointers:

- **Try to put yourself in their shoes**, don't interrupt, offer examples from your own life, or talk about yourself.
- **Avoid offering simple reassurances** such as, *"I know how you feel"* or *"You'll be OK"*.
- **Acknowledge their distress** with statements like, *"It's really tough to go through something like this"*, *"This is such a tough time for you"*, or *"Sometimes it's hard to see a light at the end of the tunnel"*.
- **Ask leading questions** like, *"Would it be helpful to talk about (the event)?"*, *"You've had a rough time, how are you going?"*, or *"How's Sarah going?"*
- **Show that you understand** by re-phrasing the information they give you. Try starting with something like, *"You seem really…"*, *"It sounds like…"*, *"Did I understand right that you…"*, *"No wonder you feel…"*

If they don't want to talk, you can still show your support by spending time with them, talking about other things, and doing practical things to help. Let them be alone for a while if that's what they want, but encourage them to have company for some time each day. Becoming isolated or cutting themselves off from other people is likely to make matters worse rather than better.

For more information

- Download a copy of *Recovery after Trauma – A Guide for People with Posttraumatic Stress Disorder* from www.acpmh.unimelb.edu.au.

HANDOUT 3

TRIGGERS

A trigger is an event, object, or cue that elicits feelings of anxiety, fear, anger, or other types of distress. Triggers are often harmless, but have become associated with the original trauma. For most people with PTSD, triggers are not inherently dangerous, but remind them of their traumatic experiences. The brain recognises the similarity and - not realising that the danger is over – produces a surge of anxiety.

Certain sights, sounds, smells, physical sensations, places, activities, and situations can be triggers for people with PTSD and can produce a surge of anxiety and a strong urge to escape or avoid. Common examples of triggers include:

- Hearing stories of other traumatic events
- Driving in a car
- Hearing an ambulance
- Hearing glass break
- Hearing a car horn
- Unexpected loud noises

Learning to recognise your triggers is an important part of PTSD treatment. Below is a worksheet that will help you start monitoring your triggers this week.

My Triggers

Instructions: Try to notice what triggers feelings of fear, threat, anger, or general discomfort in you this week. Some things will be obvious (e.g., listening to the evening news), but other things may be more subtle (e.g., the sight of rain, or a certain smell).

Triggers:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

HANDOUT 4

AVOIDANCE AND SAFETY BEHAVIOURS

When an activity, place, thing, or situation makes you uncomfortable, a natural impulse is to avoid it altogether or escape from it as quickly as possible. When you have PTSD, behaviour often changes as you try to avoid the triggers in your environment.

Common examples of ***avoidance behaviours*** include:

- Avoiding driving altogether
- Avoiding driving on certain roads
- Refusing to ride in the passenger seat
- Avoiding watching the news
- Staying at home
- Avoiding hearing a certain song

It is also common to develop safety behaviours, which are rituals and habits intended to reduce distress. Safety behaviours may make you feel better, but they don't actually make you any safer.

Common examples of ***safety behaviours*** include:

- Constant visual scanning for threats
- Constant checking behaviour
- Needing to have someone else in the car, or only driving alone

Learning to recognise your avoidance and safety behaviours is an important aspect of treatment for PTSD. The worksheet below will help you start monitoring these behaviours this week.

Instructions: Pay attention this week and try to notice the situations, places, things, people, and activities you intentionally avoid. Also notice safety behaviours you use to try to protect yourself or control your distress. List them in the spaces below.

What I avoid:

1. _____
2. _____
3. _____
4. _____

Safety Behaviours:

1. _____
2. _____
3. _____
4. _____

HANDOUT 5

HOMEWORK DIARY
RETURN TO RESEARCH TEAM

Participant ID _____

Your psychologist will provide list of exercises below for you to complete at home. Please indicate with a tick the number of times you complete your exercises each week.

Session 1 .../.../...	
TASK	✓
Read: PTSD fact sheet Triggers handout Avoidance and safety behaviours handout Discuss: PTSD fact sheet with appropriate support person Helping a friend or family member after a traumatic event handout with support person	

HANDOUT 6

WORKING ALLIANCE INVENTORY
Short Form (Client)
Return to research team

Therapist _____ Participant ID _____ Date _____

Measurement Point (circle one): 1st week Last Week

Instructions:

On the following page there are sentences that describe some of the different ways you might think or feel about your psychologist.

As you read the sentences mentally insert the name of your therapist in place of _____in the text.

Below each statement there is a seven point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you *always* feel (or think) circle the number 7; if it never applies to you, circle the number 1. Use the numbers in between to describe the variations between these extremes.

Work quickly; your first impressions are the ones we would like to see.

PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.

Thank You!

1. _____ and I agree about the things I will need to do in therapy to help improve my situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. What I am doing in therapy gives me new ways of looking at my problem.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. I believe _____ likes me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. _____ does not understand what I am trying to accomplish in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. I am confident in _____'s ability to help me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. _____ and I are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I feel that _____ appreciates me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8. We agree on what is important for me to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. _____ and I trust one another.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. _____ and I have different ideas on what my problems are.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. We have established a good understanding of the kind of changes that would be good for me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. I believe the way we are working with my problem is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

Credibility/Expectancy Questionnaire (CEQ)

Set I

1. At this point, how logical does the therapy offered to you seem?

1	2	3	4	5	6	7	8	9
not at all logical				somewhat logical				very logical

2. At this point, how successfully do you think this treatment will be in reducing your trauma symptoms?

1	2	3	4	5	6	7	8	9
not at all useful				somewhat useful				very useful

3. How confident would you be in recommending this treatment to a friend who experiences similar problems?

1	2	3	4	5	6	7	8	9
not at all confident				somewhat confident				very confident

4. By the end of the therapy period, how much improvement in your trauma symptoms do you think will occur?

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Set II

For this set, close your eyes for a few moments, and try to identify what you really feel about the therapy and its likely success. Then answer the following questions.

1. At this point, how much do you really feel that therapy will help you to reduce your trauma symptoms?

1	2	3	4	5	6	7	8	9
not at all				somewhat				very much

2. By the end of the therapy period, how much improvement in your trauma symptoms do you really feel will occur?

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

SESSION 2

(60 mins)

Objectives

The main goal for this session is to introduce anxiety management training and teach breathing control.

Outline of session

1. Review of homework
2. Relaxation training
3. Breathing control
4. Isometric relaxation
5. Homework

Handouts for Psychologist

D. Relaxation Transcript - 16 muscle groups
E. Checklist for Session 2

Handouts for Client

7. Progressive muscle relaxation
8. Calming technique
9. Steps for isometric relaxation
10. Homework diary

1. Review of homework

Always start the session with a review of the client's homework. Reinforce how important and valuable completion is to treatment, and/or problem solve non-completion. Assess the client's views about the process; whether he/she perceives it as a valuable experience, how practical it was, if had any difficulties etc. Review the Triggers, and Avoidance and safety behaviours worksheets. Discuss any new information gathered by the client, and how this will fit with the treatment plan. Take a copy of the client's homework diary, to be given to the research team.

2. Relaxation training

It can be useful to commence with anxiety management because it provides clients with some initial control over their distress. Be aware that most clients experience considerable distress during the initial sessions because they are confronting and expressing upsetting memories. Giving the client some tools to assist mastery over anxiety can provide both a sense of relief and a motivation to comply with more demanding therapy tasks.

It is important for therapists to be aware of and alert to potential problems prior to the commencement of anxiety management techniques:

Several problems can arise when teaching anxiety management to traumatised clients. First, requesting clients to close their eyes can be a threatening experience if they have concerns about losing control. It is not uncommon for PTSD clients to feel an immediate sense of distress when they close their eyes in the context of therapy. It is wise to always ask clients if they feel comfortable closing their eyes and to reassure them that they can open their eyes at any time during the exercise. Second, a proportion of PTSD clients may suffer hyperventilation and panic during muscle relaxation or breathing exercises. The therapist should carefully assess for the presence of panic symptoms before commencing treatment.

If a PTSD client reports panic, the therapist should address the panic response before proceeding to other therapy components. Specifically, the therapist should teach the client to identify catastrophic interpretations of physical sensations and ensure that panic responses are controlled before proceeding with more demanding tasks (for a detailed review of managing panic, see Craske & Barlow, 1993). Third, it is common for clients to report an increase in anxiety during the initial stages of anxiety management.

These clients should be told that this is a common response and that this perceived increase in arousal simply reflects their heightened awareness of their internal states. Clients should be informed that this is an important step because perceiving their bodily tension will permit them to start re-clueing their tension levels. Finally, many clients

will complain that they cannot reduce their anxiety levels. These concerns should be addressed by reassurance that their high levels of muscle tension will require daily practice and that only after a sustained period of rehearsal will they reap the benefits.

The general rationale for anxiety management training is as follows:

The first thing I will be teaching you in this program is to learn how to reduce the arousal that your body has been experiencing. The sooner we can do this, the more you will notice that some of the problems caused by this arousal will ease. As we have discussed, it is common for the body to be very aroused after a trauma. This arousal can make your anxiety feelings worse. So by learning how to reduce your arousal, you will have an ability to reduce some of your anxiety. This will involve you learning to do two things. First, you will practice relaxing your muscles, and then you will learn how to control your breathing. These strategies can be very useful for you in the coming weeks because they will help you cope with the distress that you will periodically experience. We are going to go through three different techniques: Progressive Muscle Relaxation, Breathing Control, and Isometric Relaxation. We will go through and explain and practice each strategy today, and then we will talk about how to practice these to get the best effects.

The major steps in anxiety management training are as follows:

1. Provide a clear rationale.
2. Identify problems that the client may have with these techniques.
3. Ensure that the setting is conducive to relaxation.
4. Inform the client of possible side effects.
5. Demonstrate the technique to the client.
6. Observe the client's completion of the strategy.
7. Identify the client's difficulties with the strategy.
8. Clarify rehearsal schedule.
9. Commence homework and monitoring.

**** Therapists will be provided with a CD with the relaxation exercises on it to give to the client. Please check with the client that they are able to play this at home. If not, the client may wish to record the exercise on their mobile phone so they are able to practice at home.**

A 16 muscle group relaxation that is easy to learn and easy to demonstrate is introduced in this session. The procedures used are consistent with those described in *New Directions in Progressive Relaxation Training : A Guidebook for Helping Professionals* (Bernstein, Borkovec, & Hazlett-Stevens, 2000). Explain to the client that the relaxation training is a skill that will take some time to learn. Therefore, we want to get started as soon as possible. A transcript of the relaxation is provided in **handout D**.

When presenting the rationale for progressive muscle relaxation training to clients, it is

important to emphasise that muscle relaxation can (a) alleviate anxiety, (b) assist sleep, (c) reduce pain resulting from muscle tension, and (d) assist coping with later therapy tasks. It is also important to warn the client that learning to relax muscles is a gradual process that requires daily practice. Be aware that progressive muscle relaxation may not be appropriate for all clients. For example, burns patients may not be able to tense muscles because of pain associated with skin contraction. Factors contradicting muscle relaxation should be explored before commencement of any training. This part of the session is introduced in the following way:

You mentioned that since the trauma, you have noticed that your body is always on edge and alert. This bodily arousal probably makes it difficult for you to sleep and concentrate and may make you more irritable. In order to reduce your arousal, I suggest that we start with muscle-relaxation training. The best way to learn this skill is for us to go through it here in the session. I will give you a CD of the relaxation so you can take this home and practice the relaxation technique.

Often people think that they will derive immediate benefit from a relaxation tape. In reality, relaxation is like any skill because it takes practice before it is mastered. Just like no one is an expert tennis player when they first start learning the game, no one is an expert at being able to relax without practice. You should remember that your body has had quite a bit of time to learn to be tense. It is not reasonable to expect your body to unlearn that tension overnight. It will take a lot of practice. As you teach your body to become more relaxed, it will gradually let go of the tension it has developed in recent times. Relaxing your muscles requires that you can notice when you are tense. Most people get used to their tension and cannot easily identify which muscles are excessively tense. This means that we will need to do some exercises to get you more aware of the tension that exists in your muscles. The way we will do that is by tensing muscles more than you usually do and then relaxing them. This procedure will both draw your attention to the tension and also help your muscles to loosen up.

Before we start, I want you to be aware of some responses that people may have to relaxation. First, some people report feeling strange sensations. Maybe some different sensations in your stomach or chest. These may be physical signs that you were not expecting. I don't want you to worry about these because they simply reflect your increased awareness of what is happening in your body. It may also occur that you will unexpectedly have some thoughts about your trauma. This is common because you are quietly focusing on yourself and it may be at these times that you have memories of what happened. Again, I don't want you to be concerned about the fact that memories pop into your mind. You can let them come and let them go again. Don't force them out of your mind. Rather, allow yourself to come back to the job of tensing and relaxing your muscles. Finally, you may think that you are experiencing more tension as you do this exercise. This is also common but you are not actually getting tenser. Instead, you have become more aware of the tension that exists in your body, which means that you are doing your job here very well. As you continue to practice the exercise, the level of tension that you perceive will reduce.

It's important when you do relaxation exercises to make sure that you are as comfortable as possible. I suggest that you keep the following points in mind. First, always relax in a comfortable chair or lounge that supports your back and neck. This way you can experience full relaxation because you don't have to support yourself. Second, it's a good idea to loosen any clothes that are particularly tight or uncomfortable. Third, if you wear contact lenses

you might like to take them out, so your eyes can fully relax. Fourth, it's a good idea to not tense muscles that are injured or prone to cramping. If there are muscles that may be a problem, you can tell me about them now and we can work with them in an appropriate way.

Then demonstrate the muscle groups used in the exercise for the client. If applicable, show the client how to adapt the tense-release step for possible physical injuries. Explain what they should be doing (and thinking) during the exercise and, that if there are physical injuries, to use flexibility and adaptation in using the skill. Try to focus on the contrast between tension and subjective relaxation after the muscle is released. Tell the client, "*You don't need to strain or aggravate a muscle to get benefit. It is the contrast and focus we are after during this first exercise*." Remind clients to pay attention as they will be keeping their eyes closed initially during the training session so they can better attend to the internal changes as they occur.

The sequence of muscle tension used for the 16-muscle group exercise is hand and lower arm (right, left, then both together); upper arm (right, left, then both together); lower leg and foot (right, left, then both together); thighs and hips (both simultaneously); abdomen (drawn in); chest and breathing; shoulders, upper neck, back of neck, lips, eyes, lower forehead, and upper forehead. Have the client remove glasses and loosen any tight clothing. Demonstrate the tension-release cycle with the right arm. Inform the client that he or she needs to pay attention to the sensations when they are first tensing and relaxing various muscle groups, again focusing on the contrast between the two sensations. Caution them not to tense too hard because that could possibly cause more pain to any physical injury. Rather, they should tense enough to create tension so that they will demonstrate to themselves a clear difference and be able to remember the difference between muscle tension and relaxation.

At the end of the relaxation, have the client rate how relaxed they feel using a 10-point scale (O = *not relaxed*, 10 = *extremely relaxed*). Give the client **handout 7 and a CD copy of the exercise**.

3. Breathing control

The next step in anxiety management is to teach breathing control. This should commence by modelling appropriate breathing to the client. It is important that the client is instructed to not take too deep a breath initially because this may elicit an anxiety response in traumatised clients. Clients with PTSD can be very sensitive to physiological responses that occurred during their traumatic experience, and taking a very large breath may be overly reminiscent of their initial trauma reaction. Therapists should be careful when using breathing control techniques with clients who have been traumatised by attempted suffocation or choking or who have suffered injuries in which their breathing was impaired. Therapists can present breathing control to the client with the following rationale:

Breathing is a very simple, but very critical, mechanism that influences how relaxed we feel. We typically breathe very quickly when we are frightened or upset. You can probably recall times when something has scared you and you immediately responded with a gasp. These experiences can literally "take our breath away." Breathing too fast can bring on a number of physiological reactions that we associate with feeling anxious. These include breathlessness, a feeling of choking, chest pains, and light-headedness. Fast breathing is also called hyperventilation. This occurs when people are frightened because they feel they need to breathe more air in. In fact, at times like this, we need to actually take in less air because hyperventilation actually disrupts the balance between oxygen and carbon dioxide in our bodies. It is this imbalance that causes the symptoms like light-headedness and dizziness. Because of this, the way out of this situation is to slow down our breathing and ensure that we are taking less air into our bodies. We can also make sure we breathe into our abdomen rather than our chest. The result of this will be a feeling of greater relaxation and control.

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

Now, to show you what this is like, I'd like you to sit comfortably with your back straight. Put one hand on your diaphragm (just below the belly button) and the other on your upper chest. In a moment, I am going to ask you to take a normal breath in. Not a deep breath but just a normal one and inhale through your nose. I want you to try and make the hand on your abdomen rise, while keeping the hand on your chest still. Okay, now take a normal breath in through your nose. That's good. Now, I want you to breathe out slowly and easily. The hand on your stomach should move in as you exhale, but your other hand should move very little. And as you breathe out, I want you to say the word "relax" [or a comparable cue word that the client is comfortable with] to yourself. Okay, and again. And say "r-e-l-a-x" to yourself as you slowly breathe out. Now keep breathing in and out. To help you get the timing right, try saying to yourself, "1 ... 2 ... 3 ... in" and then as you exhale: "1 ... 2 ...3 ... out." And say the word "relax" every time you breathe out. This procedure should produce a breathing rate of 10 breaths per minute, which is a good rate to help you remain relaxed and steady.

The client should rehearse this procedure as the therapist observes her or his progress. During this rehearsal, the therapist can count out loud as the client breathes in and out. For example, the therapist can lead the client's breathing by saying, "*Now breathe in . . . 1 and 2 and 3 ... and exhale, relax*." It is useful to have the client continue this exercise for approximately 5 minutes. This period allows ample opportunity to observe the client's breathing rate.

Discuss with clients that with practice, they should be able to slow their breathing rate down even further. The handout (**see handout 8**) on abdominal breathing suggests a rate of breathing in for 4, pause for 2, and out for 6 seconds, giving a rate of 5 breaths per minute. Emphasise to clients that this would be a goal, but it may be quite hard or even uncomfortable at first. They can start with 10 breaths per minute, and work from there.

4. Isometric relaxation

PTSD clients can be taught isometric relaxation because it provides them with a brief technique than can quickly interrupt an anxiety response and facilitate relaxation. Isometric relaxation involves briefly tensing and subsequently relaxing muscles that are not actually moved. This procedure can result in rapid reduction of muscle tension and has the additional advantage of allowing clients to do a muscle relaxation exercise in public settings where they do not wish to be observed as they attempt relaxation.

The following rationale and instructions can be provided for clients.

Isometric relaxation is another technique I want you to learn because it is a simple strategy that can help you relax very quickly without drawing attention to yourself. Isometric relaxation refers to the process when you tense muscles without actually moving them and then relax them. The useful thing about this exercise is that it allows you to relax your muscles in places where it is not appropriate for you to do your full muscle relaxation exercise. For example, imagine that you are in a doctor's waiting room and you suddenly felt very anxious. You would not be able to stretch out and do your progressive muscle relaxation exercise because of all the people around you. Isometric relaxation allows you to briefly tense and relax your muscles in a way that nobody need see you doing it.

The therapist should then walk through the steps with the client:

Let's go through the steps of isometric relaxation. First, decide on a set of muscle groups that you can tense without moving them. We can try this just now. In a moment I will ask you to clench the muscles in the top half of your leg, your quadriceps [point this area out on your own body]. *So, without sticking your legs out in front of you, tighten this muscle. Can you feel it? You need to tighten them as much as you can. And this bit is important. Tighten them for about 7 seconds. If you tighten them for more that, the muscles will tire, and it will be difficult for you to relax them. When you do relax the muscles, just say "r-e-l-a-x" to yourself, slowly, and notice the muscles loosening up. And keep letting them loosen up for about 30 seconds. Okay, let's try it. Tighten your muscles now .... Feel the tension .... 1 ... 2 ...3 ... 4 ... 5 ... 6 ... And relax. Breathe out and let ALL the tension flow out of those muscles. That's it. Just take your time, and let the muscles loosen up and remember to say "relax" to yourself as you breathe out… Good. Keep letting the muscles relax. More and more. Okay, that was good. Now often you will still feel tense after doing this. If you do, you can simply repeat the exercise several times. It is much better to do this than try to continue the tension for longer than 7 seconds. And there are many muscle groups that you can use to do this exercise.*

It is then important to discuss with clients the options for exercises that can be done in public. **Handout 9** can outline these for the client.

5. Homework

The client is encouraged to practice the assigned homework - practice each of the relaxation techniques as least once per day (a CD is provided for home practice of the relaxation exercises or they have recorded the exercises on their mobile phone).

To encourage completion of these tasks, a homework diary is given to each client. Clients are asked to record how often they practiced the relaxation techniques, and to record on a 0-10 scale how relaxed they were by the end of the exercise (0 = *not relaxed*, 10 = *extremely relaxed*).

It is very important to clarify with clients how they should practice relaxation between sessions. Specifying the time and location in which the exercise will be conducted is important. Each client is questioned about the availability of a CD player for using the relaxation CD, and if there are any possible obstacles, such a place to practice, child care, and so forth. These are problem-solved before the end of the session. To facilitate compliance, provide clients with **handouts 7, 8 and 9** to take home. In preparation for their use, you might state:

These techniques will only work if you can practice them every day. It will be important for you to take these handouts and CD home and practice them daily. There are a couple of important things to remember when you are practicing relaxation at home (e.g. for the progressive muscle relaxation and breathing control techniques). The first is that you need to find a place where no one will disturb you. For example, you need to turn your phone off and tell others not to disturb you. Then you need to get yourself comfortable. Doing relaxation lying down on your bed is often not ideal because many people just fall asleep. It is better to use a reclining chair much like the one you are using now, to sit in. It is important that your neck and back are fully supported and your legs should not be crossed. It is usually good to not do it just before you go to bed because you may simply fall asleep. Remember, these techniques are trying to teach you to be relaxed when you are awake. Also, you need to make sure that you can give yourself sufficient time to do the entire exercise. Try to allow 30- 45 minutes for progressive muscle relaxation, and 10-15 minutes for breathing control, so you can complete the exercise with lots of practice, and also enjoy some of the relaxation at the end of it. How realistic is it for you to find a quiet, comfortable place to do the exercise?"

[Discuss with the client the exact details about how relaxation will be conducted between sessions]

-When might you do it?

- How will you remember? (e.g. external cues, internal cues)

- Read progressive muscle relaxation handout **(handout 7)**
- Read the calming technique handout **(handout 8)**
- Read the isometric relaxation handout **(handout 9)**
- Practice each of the relaxation techniques at least once per day
- Complete homework diary **(handout 10)**

PSYCHOLOGIST HANDOUTS

HANDOUT D

TRANSCRIPT OF 16 GROUPS MUSCLE RELAXATION

This is the CD to assist you with your home practice of relaxation. You will be going through the same exercises we practiced in the clinic. You should be comfortably seated in a recliner or upholstered chair or lying on a bed. Be sure to remove your glasses if you wear them. Also, loosen any tight or restrictive clothing that you have on.

Now begin to let yourself relax, close your eyes, and we will go through the relaxation exercises . . .

I want you to begin by tensing the muscles in your right lower arm and right hand. Study the tensions in the back of your hand and your right, lower arm . . . Study those tensions and now relax the muscles . . . Study the difference between the tension and the relaxation . . . Just let yourself become more and more relaxed. If you feel yourself becoming drowsy, that will be fine too. As you think of relaxation and of letting go of your muscles they will become more loose and heavy and relaxed . . . Just let your muscles go as you become more and more deeply relaxed.

Next, I want you to tense the muscles in your left hand and left lower arm. Tense those muscles and study the tensions in the back of your left hand and in your left lower arm . . . Study those tensions and now relax the muscles . . . Study the difference between the tension and the relaxation . . . This time I want you to tense both hands and both lower arms by making fists, tensing the muscles in both hands and both lower arms. Study those tensions . . . and now relax them . . . Study the difference between the tension and the relaxation. You are becoming more and more relaxed. Drowsy and relaxed . . . As you become more relaxed you feel yourself settling deep into the chair. All your muscles are becoming more and more comfortably relaxed. Loose and heavy and relaxed.

This time I want you to tense the muscles in your right upper arm by bringing your right hand up toward your shoulder and tensing the biceps muscle. Study the tensions there in your right upper arm . . . study those tensions . . . and now relax your arm . . . Study the difference between the tension and the relaxation.

This time I want you to tense the muscles in your left upper arm by bringing your left hand up to your shoulder, tensing the muscle in your left biceps area. Study those tensions in your left biceps . . . study those tensions . . . and now relax the arm . . . Study the difference between the tension and the relaxation . . . The relaxation in going deeper and still deeper. You are relaxed, drowsy and relaxed. Your breathing is regular and relaxed . . . With each breath you take in, your relaxation increases. Each time you exhale, you spread the relaxation throughout your body.

This time I want you to tense both upper arms together by bringing both hands up to your

shoulders, tense the muscles in both upper arms, both biceps areas. Study those tensions . . . and now relax the muscles . . . Study the difference between the tension and the relaxation . . . Just continue to let your muscles relax . . .

Next, I want you to tense the muscles in your right lower leg. Tense the muscles in your right lower leg, particularly in your calf and study the tensions there in your right lower leg. Study those tensions . . . and now relax the muscles . . . Study the difference between the tension and the relaxation. Note the pleasant feelings of warmth and heaviness that are coming into your body as your muscles relax completely . . . You will always be clearly aware of what you are doing and what I am saying as you become more deeply relaxed.

Next, I want you to tense the muscles in your left lower leg, in the left calf area. Study the tensions in your left lower leg. Study those tensions . . . now relax the muscles . . . Study the difference between the tension and the relaxation . . . Just continue to let your leg relax.

Now, this time I want you to tense both lower legs together. Tense the muscles in both lower legs, both calf muscles. Study those tensions . . . and now relax your legs . . . Study the difference between the tension and the relaxation . . . Just continue to let those muscles relax. Let them relax . . .

Now the very deep state of relaxation is moving through all the areas of your body. You are becoming more and more comfortably relaxed . . . drowsy and relaxed. You can feel the comfortable sensations of relaxation as you go into a deeper . . . and deeper state of relaxation.

Next, I want you to tense the muscles in your thighs by pressing your legs together from the knees upward. Press your upper legs against each other and study the tensions throughout your thighs. Study those tensions . . . now relax the muscles . . . Study the difference between the tension and the relaxation . . . Just let those muscles continue to relax.

This time I want you to tense the muscles in the abdominal area by drawing your abdominal muscles in tightly. Draw them in tightly and study the tensions across the entire abdominal region . . . Study those tensions . . . and now relax the muscles . . . Just let them relax and study the difference between the tension and the relaxation. Just let yourself become more and more relaxed . . . As you think of relaxation, and of letting go of your muscles, they will become more loose and heavy and relaxed . . . Just let your muscles go as you become more and more deeply relaxed.

This time I want you to tense the muscles in your chest by taking a deep breath and holding it. Hold it, hold it . . . and now relax . . . Study the difference between the tension and the relaxation . . . The relaxation is growing deeper and still deeper. You are relaxed, your breathing is regular and relaxed . . . With each breath you take in your relaxation increases. Each time you exhale, you spread the relaxation throughout your body.

This time, I want you to tense the muscles in your shoulders and upper back by hunching your shoulders and drawing your shoulders upward toward your ears . . . Study those tensions across your upper back . . . study those tensions . . . and now relax your muscles . . . Study the

difference between the tension and the relaxation . . . Note the pleasant feelings of warmth and heaviness that are coming into your body as your muscles relax completely . . . You will always be clearly aware of what you are doing and of what I am saying as you become more deeply relaxed.

Next, I want you to tense the muscles in the back of your neck by pressing your head backward against the rest or against the bed. Study the tensions in the back of your neck, across your shoulders, and the base of your scalp . . . Study those tensions . . . and now relax the muscles . . . Study the difference between the tension and the relaxation.

Next, I want you to tense the muscles in the region around your mouth by pressing your lips together tightly. Press your lips together tightly without biting down and study the tensions in the region around your mouth . . . Study those tensions . . . and now relax the muscles . . . Study the difference between the tension and the relaxation . . . You are becoming more and more relaxed . . . Drowsy and relaxed . . . As you become more relaxed, feel yourself settling deep into the chair. All your muscles are becoming more and more comfortably relaxed . . . . Loose and heavy and relaxed.

This time I want you to tense the muscles in the region around your eyes by closing your eyes tightly. Just close your eyes tightly and study the tensions all around your eyes and upper face . . . Study those tensions . . . and now relax the muscles . . . Just continue to let them relax and study the difference between the tension and the relaxation . . . The very deep state of relaxation is moving through all of the areas of your body . . . You are becoming more and more comfortably relaxed. Drowsy and relaxed . . . You can feel the comfortable sensations of relaxation as you go into a deeper and deeper state of relaxation.

Next I want you to tense the muscles in your lower forehead by frowning and lowering your eyebrows downward. . . . Study the tensions there in your lower forehead and the region between your eyes. Study those tensions . . . and now relax the muscles. . . . Study the difference between the tension and the relaxation.

This time I want you to tense the muscles in your upper forehead by raising your eyebrows upward and wrinkling your forehead . . . Raise them up and wrinkle your forehead . . . Study the tension in the upper part of your forehead. Study those tensions . . . now relax the muscles . . . Study the difference between the tension and the relaxation . . .

Now I want you to relax all the muscles of your body . . . Just let them become more and more relaxed. I am going to help you to achieve a deeper state of relaxation by counting from 1 to 5 . . . and as I count you feel yourself becoming more and more deeply relaxed, farther and farther down into a deep restful state of deep relaxation. 1 . . . You are going to become more deeply relaxed. 2 . . . Down, down into a very relaxed state. 3 . . . 4 . . . More and more relaxed. 5 . . . Deeply relaxed . . .

Now I want you to remain in your very relaxed state. I want you to begin to attend just to your breathing. Breathe through your nose. Notice the cool air as you breathe in, and the warm moist air as you exhale. Just continue to attend to your breathing. Each time you exhale mentally

repeat the word *relax.* Inhale . . . exhale . . . relax. Inhale . . . exhale . . . relax.

Now I am going to help you to return to your normal state of alertfulness. In a little while I shall begin counting backward from 5 to 1. You will gradually become alert. When I reach 2, I want you to open your eyes. When I get to 1, you will be entirely aroused, back to your normal state of alertfulness.

Ready? 5 . . . 4 . . . You are becoming more and more alert, you feel very refreshed. 3 . . . 2 . . . Now your eyes are open and you are beginning to feel very alert, returning to your normal state of alertfulness. 1 . . . This is the end of your relaxation CD.

HANDOUT E

CHECKLIST FOR SESSION 2

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

_____ Please indicate length of session, i.e. 60 mins, 90 mins

PLEASE TICK

_____ 1. Session audio taped; commence with date, client no, session no

_____ 2. Review homework and photocopy homework diary

_____ 3. Introduce 16-muscle group relaxation (progressive muscle relaxation)

_____ 4. Discuss breathing control

_____ 5. Client rating of relaxation completed

_____ 6. Run through isometric relaxation exercise

_____ 7. Provide client with CD of 16-muscle group relaxation

_____ 8. Homework assigned to practice and rate relaxation

_____ 9. Give homework diary to client and explain it

_____ Client completed homework

_____ Client completed homework diary

Comments:

CLIENT HANDOUTS

HANDOUT 7

progressive muscle relaxation

One of the body's reactions to fear and anxiety is muscle tension. This can result in feeling "tense", or can lead to muscle aches and pains, as well as leaving some people feeling exhausted. Think about how you respond to anxiety. Do you "tense up" when you're feeling anxious? Muscle relaxation can be particularly helpful in cases where anxiety is especially associated to muscle tension. This information sheet will guide you through a common form of relaxation designed to reduce muscle tension.

Muscle tension

Muscle tension is commonly associated with stress, anxiety and fear as part of a process that helps our bodies prepare for potentially dangerous situations. Even though some of those situations may not actually be dangerous, our bodies respond in the same way. Sometimes we don't even notice how our muscles become tense, but perhaps you clench your teeth slightly so your jaw feels tight, or maybe your shoulders become. Muscle tension can also be associated with backaches and tension headaches.

Progressive Muscle Relaxation

One method of reducing muscle tension that people have found helpful is through a technique called Progressive Muscle Relaxation (PMR). In progressive muscle relaxation exercises, you tense up particular muscles and then relax them, and then you practise this technique consistently.

preparing for relaxation

When you are beginning to practice progressive muscle relaxation exercises keep in mind the folloing points.

- **Physical injuries.** If you have any injuries, or a history of physical problems that may cause muscle pain, always consult your doctor before you start.
- **Select your surroundings.** Minimise the distraction to your five senses. Such as turning off the TV and radio, and using soft lighting.
- **Make yourself comfortable.** Use a chair that comfortably seats your body, including your head. Wear loose clothing, and take off your shoes.
- **Internal mechanics.** Avoid practicing after big, heavy meals, and do not practice after consuming any intoxicants, such as alcohol.

general procedure

1 Once you've set aside the time and place for relaxation, slow down your breathing and give yourself permission to relax.
2 When you are ready to begin, tense the muscle group described. Make sure you can feel the tension, but not so much that you feel a great deal of pain. Keep the muscle tensed for approximately 5 seconds.
3 Relax the muscles and keep it relaxed for approximately 10 seconds. It may be helpful to say something like "Relax" as you relax the muscle.
4 When you have finished the relaxation procedure, remain seated for a few moments allowing yourself to become alert.

Relaxation sequence

1. **Right hand and forearm.** Make a fist with your right hand.
2. **Right upper arm.** Bring your right forearm up to your shoulder to "make a muscle".
3. **Left hand and forearm.**
4. **Left upper arm.**
5. **Forehead.** Raise your eyebrows as high as they will go, as though you were surprised by something.
6. **Eyes and cheeks.** Squeeze your eyes tight shut.
7. **Mouth and jaw.** Open your mouth as wide as you can, as you might when you're yawning.
8. **Neck. !!!** Be careful as you tense these muscles. Face forward and then pull your head back slowly, as though you are looking up to the ceiling.
9. **Shoulders.** Tense the muscles in your shoulders as you bring your shoulders up towards your ears.
10. **Shoulder blades/Back.** Push your shoulder blades back, trying to almost touch them together, so that your chest is pushed forward.
11. **Chest and stomach.** Breathe in deeply, filling up your lungs and chest with air.
12. **Hips and buttocks.** Squeeze your buttock muscles
13. **Right upper leg.** Tighten your right thigh.
14. **Right lower leg. !!!** Do this slowly and carefully to avoid cramps. Pull your toes towards you to stretch the calf muscle.
15. **Right foot.** Curl your toes downwards.
16. **Left upper leg.** Repeat as for right upper leg.
17. **Left lower leg.** Repeat as for right lower leg.
18. **Left foot.** Repeat as for right foot.

Practice means progress. Only through practice can you become more aware of your muscles, how they respond with tension, and how you can relax them. Training your body to respond differently to stress is like any training – practising consistently is the key.

Centre for Clinical Interventions
• Psychotherapy • Research • Training

HANDOUT 8

calming technique

Everyone knows that breathing is an essential part of life, but did you know that breathing plays an essential role in anxiety? This information sheet will briefly discuss the role of breathing in anxiety and guide you through a simple calming technique that uses breathing patterns to help you relax.

Breathing is a powerful determinant of physical state. When our breathing rate becomes elevated, a number of physiological changes begin to occur. Perhaps you've noticed this yourself when you've had a fright; you might suddenly gasp, feel a little breathless and a little light-headed, as well as feeling some tingling sensations around your body. Believe it or not, the way we breathe is a major factor in producing these and other sensations that are noticeable when we are anxious.

Anxious breathing

You might already know that we breathe in oxygen – which is used by the body – and we breathe out carbon dioxide. In order for the body to run efficiently, there needs to be a **balance** between oxygen and carbon dioxide, and this balance is maintained through how fast and how deeply we breathe. Of course, the body needs different amounts of oxygen depending on our level of activity. When we exercise, there is an *increase* in both oxygen *and* carbon dioxide; in relaxation there is a *decrease* in both oxygen *and* carbon dioxide. In both cases the balance is maintained.

When we are anxious though, this balance is disrupted. Essentially, we take in more oxygen than the body needs – in other words we overbreathe, or *hyperventilate*. When this imbalance is detected, the body responds with a number of chemical changes that produce symptoms such as dizziness, light-headedness, confusion, breathlessness, blurred vision, increase in heart rate to pump more blood around, numbness and tingling in the extremities, cold clammy hands and muscle stiffness.

The normal rate of breathing is 10-12 breaths per minute – what's your breathing rate?

The Calming Technique

While overbreathing and hyperventilation are not specifically dangerous (it's even used in medical testing!), continued overbreathing can leave you feeling exhausted or "on edge" so that you're more likely to respond to stressful situations with intense anxiety and panic.

Gaining control over your breathing involves both slowing your rate of breathing and changing your breathing style. Use the calming technique by following these steps and you'll be on your way to developing a better breathing habit.

1. Ensure that you are sitting on a comfortable chair or laying on a bed
2. Take a breath in for 4 seconds (through the nose if possible
3. Hold the breath for 2 seconds
4. Release the breath taking 6 seconds (through the nose if possible)., then pause slightly before breathing in again.
5. Practise, practise, practise!

Breathing tips

- When you first begin changing your breathing, it may be difficult to slow your breathing down to this rate. You may wish to try using a 3-in, 1-hold, 4-out breathing rate to start off with.
- When you are doing your breathing exercises, make sure that you are using a stomach breathing style rather than a chest breathing style. You can check this by placing one hand on your stomach and one hand on your chest. The hand on your stomach should rise when you breathe in.
- Try to practise at least once or twice a day at a time when you can relax, relatively free from distraction. This will help to develop a more relaxed breathing habit. The key to progress really is practise, so try to set aside some time each day.

By using the calming technique, you can slow your breathing down and reduce your general level anxiety. With enough practice, it can even help to reduce your anxiety when you are in an anxious situation.

Centre for Clinical Interventions
• Psychotherapy • Research • Training

HANDOUT 9

STEPS FOR ISOMETRIC RELAXATION

1. Tense a muscle group for 7 seconds
2. Relax the muscles fully
3. Say "Relax" to yourself as you exhale
4. Continue to relax for at least 30 seconds
5. Repeat the exercise if you still feel tense

Isometric Relaxation Options

Situation	Exercise
Sitting in public	Clench your fists in your lap
Sitting in public	Lock your fingers together and tense
Standing in public	Tense your legs by straightening your knees
Standing in public	Pretend to stretch and tighten your arm muscles
Standing in public	Lock your fingers behind your neck and push forward as you force your neck back
Sitting in the car	Clench the steering wheel as tight as you can (when the car is stationary)

HANDOUT 10

HOMEWORK DIARY
RETURN TO RESEARCH TEAM

Participant ID _____

Your psychologist will provide list of exercises below for you to complete at home. Please indicate with a tick the number of times you complete your exercises each week.

Session 2 .../.../...	
TASK	✓
Read: Progressive muscle relaxation Calming technique Isometric relaxation	

	Day						
	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
ACTIVITY Date							
Progressive muscle relaxation practice Number of times completed							
How relaxed? (0-10)							
Breathing practice Number of times completed							
How relaxed? (0-10)							
Isometric relaxation practice Number of times completed							
How relaxed? (0-10)							

SESSION 3

(60 mins)

Objectives

The main goal of this session is to introduce cognitive therapy to the client and begin the development of skills to challenge negative cognitions.

Outline of session

1. Review of homework
2. Rational for cognitive therapy
3. Identifying negative thoughts
4. Challenging negative thoughts
5. Homework

Handouts for Psychologist

F. Checklist for Session 3

Handouts for Client

11. Thought record form
12. Useful questions for assessing realistic thoughts
13. Homework diary

1. Review of homework

Every session begins with a review of the homework that the client had been asked to complete up to this point. This session begins with checking in on how the client is going with the relaxation exercises. As with the previous session, reinforce how important and valuable completion is to treatment, and/or problem solve non-completion. Assess the client's views about the process; whether he/she perceives it as a valuable experience, how practical it was, if had any difficulties etc. Check that the client has completed their diary. Take a copy of the client's homework diary, to be given to the research team. Therapists may wish to practice a relaxation technique with the client, time-permitting, to consolidate learning.

2. Rationale for cognitive therapy

It can be helpful to introduce the rationale and practice of cognitive therapy to allow clients to apply it when undertaking the exposure component of treatment. Based on the notion that emotional dysfunction results from maladaptive interpretations of events, this approach aims to correct clients' unrealistic perceptions of their trauma and their current environment (Beck, Rush, Shaw, & Emery, 1979). There are two major levels of cognitive dysfunction that are targeted by cognitive therapy. The first is automatic maladaptive thoughts, which are thoughts that elicit a negative emotional reaction. The second is more pervasive beliefs, which underlie automatic thoughts. That is, a person's belief that he or she will never be safe again may lead them to an automatic thought about the threatening intentions of other drivers on the road. A range of studies have indexed the types of cognitive distortions that traumatised people display. Epstein (1993) pointed to four central themes that are modified by a traumatic experience: (a) The world is benign, (b) the world is meaningful, (c) the traumatised individual is worthy, and (d) other people can be trusted. Similarly, Janoff-Bulman (1992) focused on beliefs about the worth of the individual and the trustworthiness of others. McCann and Pearlman (1990) cited beliefs about safety, trust, power, esteem, and intimacy. Foa, Ehlers, et al. (1999) extended this list of beliefs to include beliefs about initial post-traumatic stress symptoms and permanent changes of one's belief about the self. Table 1 provides some common (but not exhaustive) problematic beliefs that traumatised clients report.

TABLE 1
Examples of dysfunctional thoughts and beliefs

Emotion	Belief	Automatic Thought
Fear	I will never be safe again	This bus will hit me
	Only crazy peoples have flashbacks	I will be locked away
	All roads are dangerous	I might have an accident
Anger	I never get what I deserve	These cops don't care
	I didn't deserve this	I hate this world
	No one can be trusted	I can't stand this
Depression	Only weak people think like this	My partner doesn't love me
	I attract disaster	I would rather be dead
	I have no control	Everything is hopeless

Issues to recognise when applying cognitive therapy to PTSD populations:
First, it should be acknowledged that many of the beliefs that traumatised clients present with are based on recent and threatening experiences. Accordingly, their beliefs that they are not safe or that the world is inherently dangerous appear to them valid in the context of their recent trauma. Therapists need to be cautious that they are not perceived by their clients as invalidating their perceptions of the threat they have survived. The possible price of invalidating the traumatised client's perception of her or his vulnerability is that the client may reject any form of cognitive therapy and may even become hostile to all therapeutic interventions. To avoid this situation, it is useful for the therapist to carefully explain the rationale for cognitive therapy in terms of learning how to think about one's traumatic experience in a way that does not exaggerate the event or compound the negative emotional responses. The therapist should suggest that although the client's reactions are perfectly understandable in the wake of his or her experience, the client needs to distinguish between realistic and unrealistic perceptions. Moreover, one particular focus of cognitive therapy in the is to encourage the client to recognise that the perceptions that she or he currently holds may change with time. It is sometimes unrealistic to expect someone who has recently been traumatised to modify his or her threat related beliefs within weeks of the trauma. It can be very helpful for the client to recognise that the beliefs he or she holds may not be permanent and that they can change as time lapses. This recognition can pave the way for clients to explore other interpretations of their experience.

Therapists should commence cognitive therapy by ensuring that the client has a clear understanding of the rationale of this technique. Below is an example of a rationale given to a client:

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

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

These new beliefs can be hard to change unless you become aware of them and recognise that this way of thinking is unhelpful and unrealistic. I want you to understand that my goal here is not to change the way you think about things. The trauma that you have been through is a very personal experience, and the things that you are thinking about since that time are entirely understandable considering what you have been through. What we need to do here is to work out which beliefs are realistic and which are not. I appreciate that what you believe at the moment is real for you, and I don't want you to think that I am doubting how strongly you feel about what you have experienced. We are just going to explore the sorts of thoughts that you have, so that any that are not helpful for you can be understood in a different light. For example, if you're believing at the moment that you can never feel safe again ... for the rest of your life ... , then you are most probably going to feel pretty hopeless about the future. On the other hand, if you can consider that you feel very unsafe now but that some things may happen in the future that might make things safer for you, then you may feel a bit more optimistic. Does that make sense? So what we are going to do here is learn how to interrupt the automatic thought process and become aware of your automatic thoughts. Once we've done that, we are going to learn how to challenge any unrealistic thoughts with more realistic and positive thoughts. We will do this at a comfortable pace, and it's something that we will be doing together. Probably the best way for you to think of this exercise is to imagine that we are both experimenters and that we are testing available evidence to see whether a particular theory fits or not. That is, we look at your thoughts, test them against whatever evidence we have at that time, and work out how valid these thoughts are.

3. Identifying negative thoughts

It is important to demonstrate this exercise to the client because identifying negative thoughts is an unfamiliar task for most people. This demonstration should use the client's own thoughts and should encourage the client to adopt an active role in this discussion. We typically commence this process with a benign thought because it allows the client to learn the process without the distress associated with trauma related issues. Below is an example of an interaction that attempts to identify a negative thought. Notice that wherever possible, the therapist asks questions that allow the client to learn, for themselves, the irrational nature of the target thought and to draw his or her own conclusions on the basis of this insight.

***Therapist**: As we discussed before, the way you feel about anything is going to be strongly influenced by what you think. For example, imagine that you are walking down the road and you hear a sound in the bushes. You immediately think that there's a thug hiding in the bushes. What would you be feeling?*

***Client**: Petrified.*

***Therapist**: Sure, that's how I'd feel too. Most people would be very scared if they thought a crook was hiding in bushes as they passed by. But what if you found out that it was only a cat in the bushes? What would you be feeling then?*

***Client**: Oh, that's no problem. I would just say to myself that it's a cat and keep on walking.*

***Therapist**: What different reactions did you notice within yourself to these different perceptions? Although it's the same noise, did you feel different depending on what you believed was making the noise?*

***Client**: Well, yeah, when it was a thug in the bushes, I felt very scared, but there was no problem when I thought it was a cat.*

***Therapist**: Okay, so it looks like it is what you believe about an event that matters. It is not the noise that makes you scared but rather the belief that there is a thug in the bushes. So what we need to do first is to learn to identify your thoughts, particularly the unrealistic ones. For example, a lot of people who have experienced a trauma think things like "it's only a matter of time before I have another accident", "no one can be trusted", "no place is safe", "I was probably asking for it", "I have no control over what is going to happen to me", "there is no point planning for the future anymore." I want you to think of some of the thoughts that you have had since the trauma. Can you think of any examples of negative thoughts that you have had since the trauma?* [Prompt the client to discuss this issue with you.]

Next introduce the idea of monitoring thoughts that the client has, using the Thought Record Form (**handout 11**)

Okay, that's the idea. Now what I am going to ask you to do during the week is to complete a diary that records the negative thoughts that you have. This diary will ask you to write down what you were doing at the time you had the thought, what the actual thought is, and how you were feeling at the time. It's best to complete this diary each time you notice that you are feeling down or anxious.

[Talk through example on the form]

Try to write it down as soon as possible because if you leave it till later, you may forget what you are actually thinking. What you write down is important because this is the material that we will work with in our next session. I want you to bring along to our sessions examples of what you have felt and thought. Then we can work on these thoughts together and evaluate the extent to which these thoughts are realistic or not. We will also work out the ways to think about these things that may be more helpful for you. If we look at the Thought Record Form (see ***handout 11****), we can see that it asks you to write down the situation in which the thought occurred to you. In the next column, you can write down what the thought actually is. I want you to also write down how strongly you believe that thought on a scale of 0 (not at all) to 100 (completely). In the next column, I want you to write what you feel and how strongly you feel that emotion on a scale of 0 (not at all) to 100 (extremely intense).*

Let's have a go at working through an example using one of your recent thoughts.
[Select recent example from client and work through client example]

You can see that in the other columns there is room to write down how you challenge the thought, that's what we will talk about now.

4. Challenging negative thoughts

The next step in this process is to help the client to modify negative thoughts and to compare them with available evidence. Through systematic questioning, the therapist can direct the client's attention to incongruities between her or his thoughts and available evidence. It is important to remember that the traumatised client has only recently developed many trauma related beliefs and that it would be detrimental to challenge beliefs in a dogmatic fashion. It is also important to tell the client that cognitive therapy is not identical to positive thinking because the goal of therapy is to lead the client to perceiving events in a realistic fashion. This is particularly true of acutely traumatised clients who are still experiencing stressful events in the acute post traumatic phase. The therapist can begin to challenge thoughts in the following way:

The second step involves challenging these thoughts. We find that one of the best ways to do this is to ask yourself a series of questions that draw your attention to the evidence underlying these thoughts. Remember that the point of these exercises is not to change all your thoughts. It is simply to test these thoughts against reality. These sorts of questions may help you. [Provide **handout 12** with sample questions on it to facilitate the client's challenging.]

Below is an example of an interaction between therapist and client as they work on challenging a recent irrational thought that the client has had recently.

Therapist*: Okay, Martin, on your Thought Record Form, you've mentioned that you were very frightened the other day when your wife was 30 minutes later than usual in arriving home from work. According to your form, you say you thought that she must have had a serious car accident. Is that what*

you thought?

***Client**: Yes. I was expecting her home from work and I hadn't heard from her to say she was going to be late. I was just overcome with fear.*

***Therapist**: Okay. On a scale of 0 to 100, how scared were you?*

***Client**: I was pretty terrified. I'd say about 90.*

***Therapist**: Okay, now could you tell me what thoughts were running through your head at this time*

***Client**: Well, I figured she must have had a car accident, or something really bad had happened. It was raining too which made me more worried.*

***Therapist**: How strongly did you believe this?*

***Client**: Well, I would say about 90. I felt pretty sure about it. It wasn't like her not to let me know if she was late.*

***Therapist**: Okay. And looking back now, could you think of any other reason why she may be home late from work, besides an accident?*

***Client**: Well, looking back now, another possibility was that she was held up at work.*

***Therapist**: Good. What other reasons?*

***Client**: Maybe there was bad traffic, maybe she had stopped at the supermarket... And maybe her phone battery went flat so she couldn't contact me.*

***Therapist**: Okay, so it sounds like you think there are a bunch of reasons why she may be late: traffic, being stuck at work, stopping to get something... When you adopt one of these alternative interpretations of the situation, how scared do you feel then?*

***Client**: Well, not that scared. Probably only about 50.*

***Therapist**: Okay, so what conclusions do you draw from the change in how anxious you feel? It was 90 when you thought she had an accident, and 50 when you adopted one of the alternative possibilities.*

***Client**: Well, I guess that when I considered the less harmful possibilities, I felt less anxious.*

***Therapist**: So it looks like simply altering the way you interpret things make a huge difference to how you feel.*

***Client**: Okay, but I still can't be sure that an accident isn't going to happen.*

***Therapist**: Sure, it is not possible to be 100% sure. I wonder if you could tell me more about what happened that night?*

***Client**: Well I tried to call her phone but it was off. And then I waited.*

***Therapist**: What happened?*

***Client**: Well, she eventually came home, and had her hands full of grocery bags.*

***Therapist**: Ah, grocery shopping?*

***Client**: Yeah, at that point, I laughed at myself for getting my knickers in a knot unnecessarily.*

***Therapist**: Okay, this is really interesting ... What did you do next?*

***Client**: I asked her why she'd been late and she'd mentioned that her phone had gone flat at work but she'd decided to stop to get some groceries on the way home.*

***Therapist**: Okay, so let's take a moment to pull it all together. You were sitting at home and were expecting your wife home from work but she was not there at the expected time. It was raining outside, and you hadn't heard from her to say she was going to be late. It sounds like you automatically assumed that something terrible like a car accident had happened. But instead you found that her phone battery had gone flat and she'd stopped to pick up some groceries on her way home. Have I got that right?*

***Client**: Yes, that's right.*

***Therapist**: I can appreciate why you jumped to your conclusion because it's only a few months since you were in an accident. It's very common for people to assume that they are going to get into trouble again when something happens that even remotely resembles what you experienced when you had your accident. What I want you to understand here is that you can slow your thoughts down and evaluate them in the light of objective evidence. As you do that now, how scared do you feel by that event?*

***Client**: Well, it's probably dropped to about 10. I guess it shouldn't even be that high, but I*

still feel a bit nervous about it.

Note that in this excerpt the therapist did not engage in an argument with the client when he maintained his belief in his and his family's vulnerability. The therapist responded to this response by recognising the client's position and then evaluating the evidence for the objections that were raised by the client. Furthermore, the therapist explicitly communicated to the client that his interpretations were understandable in the light of his recent accident. That is, the distinction was drawn between the legitimacy and the irrationality of the client's perception.

5. Homework

Homework for this session includes relaxation practice; reading **handout 12**: Useful questions for assessing how realistic your thought is, and monitoring automatic negative thoughts. Thoughts are recorded using **handout 11**, and clients practice generating alternative thoughts, recording the impact this has on belief and emotion strength.

When booking the next session, let the client know that 90 minutes will be required (as prolonged exposure will be commenced). The prolonged exposure exercise will also need to be audiotaped. Check with the client whether they have the facilities to do this on their phone or other device, i.e the client may prefer to bring in their iPad.

- Read Useful questions for assessing how realistic your thought is **(handout 12)**
- Complete thought record form **(handout 11)**, using handout 12 as guidance
- Complete homework diary **(handout 13)**

PSYCHOLOGIST HANDOUTS

HANDOUT F

CHECKLIST FOR SESSION 3

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

_____ Please indicate length of session, i.e. 60 mins, 90 mins

PLEASE TICK

_____1. Session audio taped; commence with date, client no, session no

_____ 2. Review homework and photocopy homework diary

_____ 3. Introduce rationale for cognitive therapy

_____ 4. Give handouts for:

a) Thought record form

b) Useful questions for assessing realistic thoughts

_____ 5. Practice identifying and challenging negative thoughts

_____ 6. Give homework diary to client

_____ Client completed homework

_____ Client completed homework diary

Comments:

CLIENT HANDOUTS

HANDOUT 11

THOUGHT RECORD FORM

Situation	**Thought**	**Belief in thought** (0= not at all, 100= completely)	**Emotion**	**Rating of emotion** (0= not at all, 100= extremely intense)	**Evidence of thought**	**Evidence against thought**	**Rating of emotion** (0= not at all, 100= extremely intense)
e.g. Wife isn't home from work	"She's had an accident"	90	Terrified	95	She would usually call	There might be other explanations, she might be stuck in traffic and her phone might be flat.	50

HANDOUT 12
USEFUL QUESTIONS FOR ASSESSING REALISTIC THOUGHTS

- ***What did I think about this issue before the trauma?***
- ***Has anything in the world really changed except for my perception?***
- ***What is the evidence?*** Here we want you to become a scientist and really think about the objective evidence for and against the thought. Is it really true? Are you 100% sure? Do the facts of the situation back up what you think or contradict it? Write out all the evidence you can think of for and against the thought. In most cases, you will find that it is not completely true. (Indeed, it may turn out to be completely false).
- ***What alternative views are there?*** How do other people think about this? Would other people agree with you? How would I respond to someone else who had this thought? Is there another way of looking at it? Are there other explanations? Try to generate as many alternative explanations as you can and review the evidence for and against them. When you look at it objectively, which explanation is most likely to be correct?
- ***Am I thinking in all-or-nothing, black-and-white terms?*** Am I using terms like all, always, never? Is my thought extreme? Nothing is all bad or all good, no person is either perfect or worthless. Try to look for a more balanced view, with a more realistic assessment of the situation.
- ***Am I overestimating my responsibility?*** Things happen for all sorts of complex reasons, many of which we may never understand. Be very careful not to take too much responsibility for things over which you do not have control.
- ***Are my judgements based on how I feel, rather than what is actually happening?*** If you feel guilty, you are likely to assume things must have been your fault. If you feel frightened, you may assume that you are not safe. If you feel depressed, you may assume that things will never get better. Feelings are not a good basis on which to make rational judgements. Put the feelings to one side for a moment and look for objective evidence.
- ***Am I over-focusing on one aspect and forgetting other aspects?*** Am I looking only at the negative side and ignoring the neutral or positive things? If we focus only on small parts of the whole picture, we will end up with a very distorted view of reality.
- ***How likely is it?*** Am I confusing a low probability with a high probability? How likely is it that what you fear will actually happen? Understandably, many trauma survivors fear a recurrence of the event but, realistically, how likely is it.
- ***Am I underestimating what I can do about it?*** Am I putting myself in the role of helpless victim? What can I do to make things better or safer for myself? Taking some control - doing something about it - is an important part of recovery.
- ***What will happen if I continue to think like this?*** Is this kind of thinking helping me to recover? Will it help me to live a happy and relaxed life? Are there any benefits to thinking this way? If not, it is worth working hard to try and let go of the irrational negative thoughts.

HANDOUT 13

HOMEWORK DIARY
RETURN TO RESEARCH TEAM

Participant ID _____

Your psychologist will provide list of exercises below for you to complete at home. Please indicate with a tick the number of times you complete your exercises each week.

Session 3 .../.../...	
TASK	✓
Read: Useful questions for assessing realistic thoughts Write: Thought record form	✓

	Day						
	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
ACTIVITY Date							
Relaxation practice Number of times completed							
How relaxed? (0-10)							
Breathing practice Number of times completed							
How relaxed? (0-10)							
Isometric relaxation practice Number of times completed							
How relaxed? (0-10)							
Completed thought record form How many times?							

SESSION 4

(90 mins)

Objectives

The main goal of this session is to further develop cognitive challenging skills and introduce imaginal (prolonged) exposure.

Outline of session

1. Review of homework
2. Continue with cognitive challenging
3. Introduce imaginal (prolonged) exposure
4. Conduct imaginal (prolonged) exposure
5. Debrief
6. Use cognitive challenging
7. Homework

Handouts for Psychologist

G. Checklist for Session 4

Handouts for Client

14. SUDS
15. Prolonged exposure monitoring form
16. Thought record form 2
17. Homework diary

In this session, you will need to audiotape the full session for the research team. You will also need to audiotape the prolonged exposure exercise for the client to use for their homework.

1. Review of homework

Review how the homework assignments went. Up to this point the homework will include relaxation training, and monitoring automatic negative thoughts and practicing generating alternative thoughts. Each of these needs to be reviewed and any problems discussed and clarified. Take a copy of the client's homework diary, to be given to the research team.

6. Continue with cognitive challenging

Explore the thoughts noted by the client on the Thought Record Form, and discuss the alternatives generated by the client. Discuss the effect noted on belief and emotion strength. Work through some additional examples with client.

7. Introduce imaginal (prolonged) exposure

Perhaps the most critical component of therapy is prolonged exposure (PE). The major steps in PE are as follows:

1. Assess the client's suitability for PE.
2. Provide the rationale for PE.
3. Establish a contract for conducting PE.
4. Obtain a narrative in the present tense and ensure emotional engagement.
5. Continue exposure to the narrative for at least 50 minutes.
6. Obtain Subjective Units of Distress Scale (SUDS) ratings throughout PE.
7. Discuss the client's experience after PE.
8. Implement cognitive restructuring with thoughts elicited in PE.
9. Initiate PE as daily homework after habituation is observed.

The first stage in considering PE is determining the client's suitability for this procedure. It is very important to clarify the rationale of PE with the client to engage the client in the exercise. The therapist should keep in mind that clients are being asked to confront those memories and emotions that they are trying to avoid with extreme effort. A clear understanding of the rationale for PE will assist the client in persevering with PE even when she or he is feeling distressed. A clear rationale also is important because clients need to make an informed decision about proceeding with PE. A commitment to PE is essential to reduce poor motivation. Therapists can provide the following rationale for PE:

As we discussed earlier, people who go through a trauma tend to avoid thinking about their painful experience because it eases some of the distress they feel. Although this is an understandable response, it does not usually help in dealing with the trauma because it prevents you from understanding and processing the memory. In fact, no matter how hard you try to push away thoughts about the trauma, they come back to you in distressing ways, such as nightmares or flashback memories. These symptoms are a sign that the trauma is still unfinished business. To illustrate this process, I'd like you to sit back, relax, close your eyes, and picture a big white polar bear for a moment. Tell me when you have that image clearly in your mind .... Okay, now I would like you to spend the next couple of minutes trying to suppress that image of the white polar bear. Don't let the thought enter your mind for a second ... Okay, what happened when you tried to suppress it? [The client will typically report thoughts of the bear] Right, this is exactly what happens with your memories of the trauma. If you try and suppress the memories, they will usually pop into your mind. Instead of letting these memories pop into your head and distress you, we are going to tackle them head on, by having you focus your attention on them. I am going to ask you to think about your memories in a way that I don't think you normally do. From the discussion we have had, I think we agree that like most people who have suffered a trauma, you typically respond to trauma memories by attempting to avoid them. That is, you think of something else, distract yourself, or do something to take your mind away from the distress. The problem with this approach is that it prevents you from ever processing and resolving these memories and feelings effectively. It takes time for the mind to get used to things. Have you ever got into a hot bath or shower? When you first get in, it feels really hot, and you feel that you can't handle it. If you stay there for a few minutes, however, your body gets used to the temperature, and it actually feels comfortable. If you got out of the bath straight away, your mind would never get the chance to get used to the heat. It's a bit like that with your memories. You are not giving your mind a chance to get used to these memories because you're avoiding them every chance you get. By focusing attention on these memories, you will actually find that they do not distress you as much as they do now. Moreover, people typically report that as they do this exercise, they get to understand the experience in a way that makes a lot more sense. To use another example, have you ever walked out of a very dark room into bright sunlight? It's virtually impossible to see anything because it all seems so bright. After a few moments, however, you are seeing normally because your eyes and brain have adapted to what's around you. It's the same with your memories. When you first think about them, they will cause great distress, but after you stay with them for a while, your mind will get used to them, and you will see them more clearly and understand them with less distress.

Obtaining a narrative from the client is very important because this represents the stimuli that is the focus of exposure. It is important to the client that they are not being asked to recount what occurred. Many clients will have done this repeatedly to police, doctors, or other authorities in the wake of their traumatic experience. The therapist needs to emphasise that the client is required to relive the experience by narrating the trauma in the first person and present tense. Emphasis should be placed on engagement with the range of emotions experienced during the trauma. The client should be informed that the exposure will continue for at least 50 minutes. The therapist should explain the SUDS rating scale and tell the client that he or she will be asked to describe the level of distress regularly throughout the exposure by providing a SUDS rating. **It is useful to obtain a SUDS rating every 5 minutes.**

Provide clients with **handout 14**, to show them the SUDS rating scale, and establish some

anchor points with the client.

8. Conduct imaginal (prolonged) exposure

Tell the client that if he or she completes the narrative in less than 50 minutes, to simply repeat the exercise until 50 minutes have expired. **The narrative should be audiotaped, which permits the client to listen to it in a structured manner during homework exercises.** Below is an example of instructions given to a client in the first exposure session.

I am now going to ask you to focus on your memories for a prolonged period, about 50 minutes. This is different from thinking back to something in the past. I am going to ask you to walk me through exactly what happened by being as fully aware of your experience as you can. I want you to feel everything that you felt at the time and be aware of everything that you thought. In a sense, I want you to relive the experience because this is the most effective way for you to process the event and resolve it. We will do this over and over until you feel more comfortable and less anxious about the trauma. I realise that this sounds like a demanding task, but we are doing this because we know that this approach leads to less distress and fear. We are going to record it so that at a later time, once you feel comfortable, you can practice more at home as well. Now what questions would you like to ask before we start?..... Okay, let's begin. I would like you to describe your trauma to me. I don't want you to tell me about it in the past tense. Instead, I want you to tell me about it as if it were happening now. So tell me about it talking from your position. Use the words "I am" and "he is" to put us there in the here and now. And remember to focus on how you are feeling. Close your eyes if you feel comfortable. It will help you focus on what happened. And as you are telling me what's happening, try to focus on the details of the experience. Tell me about your surroundings, what you can see and hear, as well as what you are doing. I also want you to tell me how you are feeling emotionally, what is going through your mind, and also what your body is feeling. As we do this, I want you to be able to tell me how distressed you feel. Let's use the SUDS scale, on which 0 means that you do not feel at all anxious and 100 means that you feel extremely anxious. So when I ask you how you are feeling, you can just tell me a number that best describes how you are feeling. Okay, you can start now.

CASE EXAMPLE

Background

Martin and his wife had been involved in a car accident. He and his wife, Marge, had been out shopping and were on their way home when they had been involved in a four car pile-up on the M1. Just before the accident had occurred, Martin had been distracted and had been arguing with Marge. Martin was referred to a therapist by his local doctor, whom he had consulted after the accident. When Martin initially presented 2 weeks after the accident, he displayed marked numbing and denial. He reported that he was reluctant to discuss the event but felt that he needed help because he had not slept much since the accident, had terrifying nightmares about it, and was frequently distressed by intrusive memories of it. He reported marked avoidance of any reminders of the accident and stated that he had not spoken to anyone about it. It was eventually revealed that his response to the trauma was compounded by the fact that the he blamed himself for the accident because he had been distracted and felt severe guilt about arguing with his wife just before it happened. Martin admitted to pervasive avoidance

behaviours since the trauma, including actively trying to suppress thoughts and conversation of them. He reported that he had not spoken to his wife much since that night. Martin cancelled two appointments before actually attending his first appointment. On the first session, he admitted that he feared attending because he could not bear the thought of revealing the traumatic experience to anybody.

Imaginal Exposure Transcript

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

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

Therapist: *I think it might help.*

Martin: *Okay. Marge and I are leaving the shop. We've bought some takeaway chicken, which we took back to the car. We then got into the car and drove out of the carpark.*

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

Martin: *Oh yeah. Okay. Sorry …. Well, we're walking back to the car. We get in the car and I drive out of the carpark. Marge is talking to me. I am only half listening. I am distracted by a message that has just appeared on my phone. Marge is asking me if I am listening to her. She is getting angry and is raising her voice at me. I am just coming up to the turnoff for the M1. I put my blinker on and look over at Marge….. I look down at my phone again…..The next thing I am merging with traffic. There's a car coming towards me…. It's all happening so fast….. I can't go on …. I want to stop.*

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

Martin: *It's about 95. It's pretty bad.*

Therapist: *Okay. We're just beginning here. I know it's tough, but if you can, I want you to continue telling me.*

Martin: *Okay …. I'll try …. Everything's a blur…. It's weird, it seems like I am not in the car, but I am. It seems like I am watching what is happening from a long way away. I don't know what is happening. I am driving and….. it's a blur….. I can hear screaming…..but I don't know if it is me or Marge or someone else…..It's so loud and shrill…..I see lights everywhere……in front of me…..behind me……it's all happening so fast…… I feel a tremendous blow to the front of the car……or is it the back……I think it is both…….My neck……it's snapped back……and then I am pushed forward…..against the steering wheel……I can't breathe……I see more lights……more screaming……I don't want to remember this……I can't talk about this, no way.*

Therapist: *That's okay, maybe move on to what happened next.*

Martin: *I don't remember what happened…. I must have blacked out ……. I don't know ……. I feel like I am on autopilot … I don't remember anything …. There is screaming ……. the car rolling over and over …… I thought I was going to die ……The next thing I remember is everything is still……..there is no noise…… I look over at Marge ……. she's not moving. I am screaming now….. It sounds like it is coming from somewhere else …. but it is definitely me ….. I feel like I am watching this from outside of the car…… I feel intense pain ……. I feel like I want to die…..but Marge….. I am screaming out her name….. I can't move….I can't get to her….there's blood everywhere…..I feel like we have been trapped like this for hours….It's horrible. Why won't she move? Why isn't she answering me……we had been fighting, and now she is not moving…. Why can't I help her? I can't see anything outside. It's all black. My whole body is hurting. The next thing I know, there is someone at the window. I roll down the window. Someone is asking me if I am alright. I can't speak…I try but nothing comes out. Someone is saying they are going to try to open the door. They can't open it. Nothing is happening… I feel panicky and trapped. I hear the person say that they have called an ambulance and it is on its way. I want to ask how Marge is….I can't look at her. I hear a siren. It's getting closer. There is a groaning sound….it's Marge….she's alive. The next thing I remember is I am lying on a stretcher in the ambulance. Someone is speaking to me. I feel so much pain…. Marge….where is Marge……I scream ….. Marge ….. Marge …. where is Marge ….. The man is telling me she is ok …. She is in another ambulance ….. He tells me the car was a mess but we are both going to be ok……*

Therapist: *Martin, how are you feeling? Maybe rate how you are feeling now on that scale?*

Martin: *About 90 … 95. It's still bad. I thought you said I would feel better. I don't think this is going to work.*

Therapist: *It takes time. Most people don't find relief after doing this just once. We are going to have to do this again and again. I can't make you any promises, but I think it will get better as we do this more often. What's most important at this stage is that you felt as distressed as you did and you stayed with it. That's critical. The fact that you could do that is a great sign for how you are going to cope with this program.*

Martin: *I can't believe how real it was. I haven't done that before. Thought about it like that, I mean. It was all happening again. I could see cars coming at me. I can still smell the blood that was everywhere. Is that normal?*

Therapist: *Yes. It's very common for people to be very aware of all those sorts of details. And to feel the same emotions that you had at the time. Was there any point that was particularly difficult for you?*

Martin: *Yeah. Two things mainly. When the first car hit us. I really thought we were going to die. I hate thinking about it. The other when I looked over at Marge and I thought she was dead and there was nothing I could do. I will never get over that.*

Therapist: *Did you allow yourself to think about those things just now?*

Martin: *To be honest, I didn't. They're too bad. I thought about them, but I wanted to skip over them and get to other things.*

Therapist: *That's okay. Being able to focus on the things that you did was fine for now. We've got time to focus on those other aspects as we move on. I think you will feel more comfortable in tackling them after we've done this a bit more. How are you feeling now that it's over?*

Martin: *Relieved. I really didn't think that I would cope with it.*

Therapist: *But you did cope with it. In fact, you did very well …. You have been able to focus on this whole event, and you have survived it. You are now sitting here with me, in one piece, and have been able to discuss it with me. That's really important because it tells us that thinking about these memories doesn't really hurt you. You can think about them and be okay after it.*

Case Example Analysis

This narrative is noteworthy because it not only illustrates the process of imaginal exposure but also highlights a number of features of the PTSD client's response to the trauma. Note that Martin presented with several dissociative symptoms. His report of perceiving the accident from outside the car in which he was seated represents an example of depersonalisation. He also reports dissociative amnesia of much of the time after the car was hit. It is difficult to know if Martin was actually amnesic of this event or whether he intentionally did not focus attention on it during this stage of therapy. Subsequent therapy indicated that this phase of the accident was particularly threatening for Martin because he felt severe helplessness for not being able to assist Marge. He also described emotional numbing when he referred to being on "automatic pilot" and not feeling anything. This narrative also highlights the importance of encouraging the client to describe his or her feelings and thoughts during the trauma. Martin's admission that he expected himself to be able to help Marge indicated to the therapist a potentially important area that would require attention in therapy. It is common for clients to want to withhold certain aspects of the traumatic experience because it is excessively distressing. It is worthwhile to encourage the client to continue with the narrative if it is within her or his capacity. It is important to communicate to the client that experiencing the narrative is important, although focusing on the most distressing details of the experience is not essential in the early sessions. Some clients may not disclose the most distressing features of their experience until the second or third exposure session. It is preferable for the client to be able to participate in exposure to a limited extent as opposed to being overwhelmed by the experience and subsequently avoid this exercise. It is equally important to ensure that all features of the narrative are eventually addressed within exposure.

Martin's initial exposure to the narrative took approximately 15 minutes. Accordingly, the therapist requested him to repeat the procedure for a second time. This exposure took about 20 minutes because Martin focused in more detail on some aspects and was visibly more distressed as he allowed himself to engage with the narrative. The therapist then asked Martin to repeat the procedure for a third time, which again took approximately 20 minutes. In total, the initial exposure session lasted for 55 minutes. Martin's anxiety levels did not decrease over this time. This is not uncommon in a proportion of acutely traumatised clients. In such cases, it is important to communicate to the client that his or her capacity to cope with the distress is important and that habituation will occur in future sessions. Clients should not be instructed to continue with exposure as homework until they have demonstrated a capacity for habituation in the presence of the therapist.

9. Debrief prolonged exposure

After the initial exposure session, the therapist should engage the client in a detailed and frank discussion about the exercise. The therapist should focus on any particular difficulties that the client experienced. Special attention should be directed to any features of the narrative that were avoided in some manner. Many clients will prefer to give less attention to more distressing aspects of the experience. The therapist should be sensitive to these sorts of strategies because

they may develop into persistent avoidance that can undermine the effectiveness of the exposure. If the client does not report habituation during the initial exposure exercise, the therapist should reassure the client that it is common for habituation to occur only after several sessions.

10. Use cognitive challenging

Use cognitive challenging techniques with the client for any salient negative/catastrophic thoughts identified in the story that can be gently challenged.

Once habituation has commenced and the therapist feels confident that the client is able to conduct exposure independently, exposure should be commenced as daily homework using the audio recording. The client should complete a Prolonged Exposure Monitoring Form each time exposure is done (see **handout 15**). The client records (a) starting and finishing times, (b) the scene that was the subject of exposure, (c) the SUDS rating soon after commencing exposure, (d) the SUDS rating at the completion of exposure, and (e) any salient thoughts that occurred during or after the exposure. Monitoring is important because it allows the therapist and client to note patterns of habituation, compliance, and trauma related cognitions. The latter is important because exposure usually results in many irrational beliefs that can be usefully addressed with cognitive therapy. Accordingly, cognitive therapy needs to be integrated into sessions after each exposure session.

11. Homework

Homework for this session is the same as the previous session and includes relaxation practice, and completing the thought record form (**handout 16**). Clients will monitor automatic negative thoughts, and practice generating alternative thoughts, recording the impact this has on belief and emotion strength. If the client is able to conduct prolonged exposure independently, also have the client commence exposure daily, completing **handout 15.**

When scheduling the next session, again allow 90 minutes for the prolonged exposure.

- Read SUDS handout (**handout 14**)
- Complete prolonged exposure monitoring form (**handout 15)**
- Complete thought record form 2 **(handout 16)**
- Complete homework diary **(handout 17)**

PSYCHOLOGIST HANDOUT

HANDOUT G

CHECKLIST FOR SESSION 4

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

_____ Please indicate length of session, i.e. 60 mins, 90 mins

PLEASE TICK

_____1. Session audio taped; commence with date, client no, session no

_____ 2. Review homework and photocopy homework diary

_____ 3. Continue cognitive therapy

_____ 4. Conduct prolonged exposure

_____ 5. Audiotape prolonged exposure

_____ 6. Debrief prolonged exposure

_____ 7. Give homework diary to client

_____ Client completed homework

_____ Client completed homework diary

Comments:

CLIENT HANDOUTS
HANDOUT 14

SUDS

(Subjective Units of Distress)

SUDS ratings are a way of communicating the level of distress you feel. The term "distress" is intentionally very broad, so it can refer to feeling anxious, angry, scared, upset, jumpy, or any other negative emotional state.

We use a scale from 0 to 100.

0 represents no distress at all (i.e., completely calm, relaxed). 100 represents very extreme distress, fear, or anxiety – the most upset you have ever been in your life. Usually when people say they have a SUDS of 100 they are experiencing physical reactions (e.g., sweating, heart pounding, trouble breathing, dizziness), as well as intense emotional distress.

SUDS ratings are a good way to notice when your distress is going up. Keep in mind distress related to fear and anxiety always comes down eventually.

0----------25----------50----------75----------100

No Distress	Moderate Distress	Maximum Distress

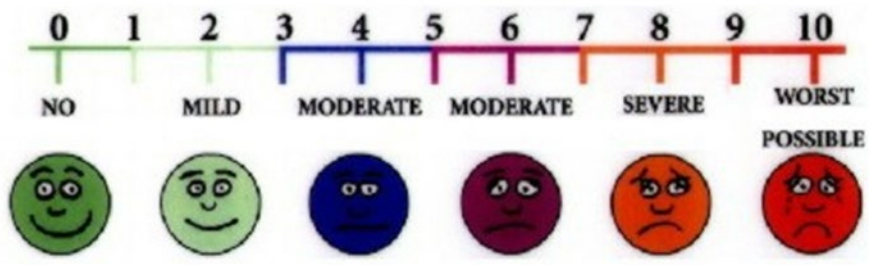
SUDS ratings are subjective. One person may rate a situation as a 100 on the SUDS scale, while another person may rate the same situation as a 50. It will be helpful to identify some situations that correspond with different SUDS ratings for you.

SUDS Anchor Points:

0 - _____

50 - _____

100 - _____



HANDOUT 15

PROLONGED EXPOSURE MONITORING FORM

Start Time	End Time	Describe the Scene	SUDS at start of exposure	SUDS at end of exposure	Thoughts during exposure and general comments
e.g. 10.45	11.30	The crash, hearing my kids in the back seat of the car crying	95	65	It was pretty hard to stick with the image, it made me feel very upset initially. I kept thinking “why me?” and “why don’t they get us out quicker?”

HANDOUT 16

THOUGHT RECORD FORM 2

Situation	**Thought**	**Belief in thought** (0= not at all, 100= completely)	**Emotion**	**Rating of emotion** (0= not at all, 100= extremely intense)	**Evidence of thought**	**Evidence against thought**	**Rating of emotion** (0= not at all, 100= extremely intense)
e.g. Wife isn't home from work	"She's had an accident"	90	Terrified	95	She would usually call	There might be other explanations, she might be stuck in traffic and her phone might be flat.	50

HANDOUT 17

HOMEWORK DIARY
RETURN TO RESEACH TEAM

Participant ID _____

Your psychologist will provide list of exercises below for you to complete at home. Please indicate with a tick the number of times you complete your exercises each week.

Session 4 .../.../...

	Day						
	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
ACTIVITY Date							
Relaxation practice Number of times completed							
How relaxed? (0-10)							
Breathing practice Number of times completed							
How relaxed? (0-10)							
Isometric relaxation practice Number of times completed							
How relaxed? (0-10)							
Completed thought record form How many times?							
Completed prolonged exposure monitoring form How many times?							

SESSION 5

(90 mins)

Objectives

The main goal of this session is to continue prolonged exposure and develop cognitive challenging.

Outline of session

1. Review of homework
2. Continue with cognitive challenging
3. Continue with prolonged exposure
4. Debrief from prolonged exposure
5. Cognitive challenging
6. Homework

Handouts for Psychologist

H. Checklist for Session 5

Handouts for Client

18. Prolonged exposure monitoring form 2
19. Thought record form 3
20. Homework diary

In this session, you will need to audiotape the full session for the research team. You will also need to audiotape the prolonged exposure exercise for the client to use for their homework.

1. Review of homework

Review how the homework assignments went. Up to this point the homework will include relaxation training, and monitoring automatic negative thoughts and practicing generating alternative thoughts. Also if the client has commenced prolonged exposure at home, check on their progress. Each of these needs to be reviewed and any problems discussed and clarified. Take a copy of the client's homework diary, to be given to the research team.

2. Continue with cognitive challenging

Use cognitive challenging techniques with the client for any negative/catastrophic thoughts identified in their monitoring this week.

After the client has become familiar and rehearsed in the practice of identifying and challenging automatic thoughts, it is timely to proceed to understanding and correcting the beliefs that mediate these thoughts. Many clients find identification of these beliefs difficult because they are more abstract than automatic thoughts. Consequently, these beliefs require some degree of insight to perceive the attitudes or beliefs that are contributing to the PTSD. The most common means of comprehending the underlying belief is repeated questioning about the significance of an automatic thought for the client (Burns, 1980). Asking questions that probe the client to further explore their reasoning for their automatic thought typically leads to greater awareness of the underlying belief (Clark, 1989; Foa & Rothbaum, 1997).

The following are useful questions:
1. If this were true, what would it mean for me?
2. What does this say about me?
3. What would happen if this event did occur?
4. What would be so bad if this thing did happen?

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

***Therapist**: M, you have talked about how, when you leave the safety of your neighbourhood, you find the busy highway that you need to travel to work as very threatening and dangerous. In fact, you had never been in an accident up until the accident that brought you into treatment. You, therefore, were able to make that trip many times without anything negative happening. Now, when you get on the highway, you see the speed and amount of traffic, especially during rush hour, as very dangerous. Is it possible that you might be magnifying or overemphasising the amount of danger that you are actually in?*

***M** : It's possible, but again, if I'm going to have an accident, it is more likely that people are going to mess up at exactly this time!*

***Therapist**: M, is that true? Are you certain that most accidents occur on highways or, in fact, that more accidents occur at slower speeds for a variety of other reasons?*

***M**: I don't really know, it seems that way to me.*

***Therapist**: So at least it is possible that what you have thought about the situation, that may not be the case.*

***M**: It's possible.*

***Therapist**: In fact, we can look back on your life and say you've driven this road thousands and thousands of times and never had a mishap or that you had seen very few accidents. Is that true, M?*

***M**: Yes, that's true.*

***Therapist**: So, again, if we can help you address the distortions here in your thinking, I think we will be able to help you find ways of helping to modify the amount of anxiety.*

Then go on to explain the following ways:

***Therapist**: There are several maladaptive ways of thinking; some may be more characteristic or true of you than others. Subsequently, we are going to have you pay close attention and learn patterns of how your thinking affects your life.*

Okay, on the basis of the evidence that you have available at this time, it sounds like you have concluded that it's not justified to feel unsafe all the time. So it looks like it's the case that if you apply this line of reasoning to this belief, you are able to change that belief. So by entertaining these other options and balancing your belief with the evidence you are beginning to put a more realistic slant on your outlook. Let's turn to the Thought Record Form and fill out the final columns. I want you to write down the reality-based response to each of your beliefs and rate how strongly you believe that at the moment. This is what I want you to do each time you have one of these thoughts that make you feel bad. Think about the evidence, weigh it up with an open mind, and record the outcome. The more you do this, the more you will be able to have conviction in the realistic beliefs.

3. Continue with prolonged exposure

Ask the client to repeat the same process for prolonged exposure as in Session 4. Tell the client that if he or she completes the narrative in less than 50 minutes, to simply repeat the exercise until 50 minutes have expired. Audiotape this exercise so the client can use this for homework.

4. Debrief from prolonged exposure

After the exposure session, the therapist should engage the client in a detailed and frank discussion about the exercise. The therapist should focus on any particular difficulties that the client experienced. Special attention should be directed to any features of the narrative that were avoided in some manner. Many clients will prefer to give less attention to more distressing aspects of the experience. The therapist should be sensitive to these sorts of strategies because they may develop into persistent avoidance that can undermine the effectiveness of the exposure. If the client does not report habituation during the initial exposure exercise, the therapist should reassure the client that it is common for habituation to occur only have several sessions.

5. Cognitive challenging

Use cognitive challenging techniques with the client for any salient negative/catastrophic thoughts identified in the story that can be gently challenged.

Once habituation has commenced and the therapist feels confident that the client is able to conduct exposure independently, exposure should be commenced as daily homework using the audio recording. The client should complete a Prolonged Exposure Monitoring Form each time exposure is done (see **handout 18**). The client records (a) starting and finishing times, (b) the scene that was the subject of exposure, (c) the SUDS rating soon after commencing exposure, (d) the SUDS rating at the completion of exposure, and (e) any salient thoughts that occurred during or after the exposure. Monitoring is important because it allows the therapist and client to note patterns of habituation, compliance, and trauma related cognitions. The latter is important because exposure usually results in many irrational beliefs that can be usefully addressed with cognitive therapy. Accordingly, cognitive therapy needs to be integrated into sessions after each exposure session.

6. Homework

Homework for this session includes relaxation practice, and monitoring automatic negative thoughts and beliefs using **handout 19**. The client is to practice generating alternative thoughts, recording the impact this has on belief and emotion strength. If the client is able to conduct exposure independently, exposure can be conducted on a daily basis. Have the client complete the Prolonged Exposure Monitoring Form each time exposure is completed (see **handout 18**).

When scheduling the next session, again allow 90 minutes for prolonged exposure and exposure hierarchy development.

- Complete prolonged exposure monitoring form (**handout 18**)
- Complete thought record form 3 **(handout 19)**
- Complete homework diary **(handout 20)**

PSYCHOLOGIST HANDOUT

HANDOUT H

CHECKLIST FOR SESSION 5

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

_____ Please indicate length of session, i.e. 60 mins, 90 mins

PLEASE TICK

_____1. Session audio taped; commence with date, client no, session no

_____ 2. Review homework and photocopy homework diary

_____ 3. Continue cognitive therapy

_____ 4. Conduct prolonged exposure

_____ 5. Audiotape prolonged exposure

_____ 6. Debrief prolonged exposure

_____ 7. Give homework diary to client

_____ Client completed homework

_____ Client completed homework diary

Comments:

CLIENT HANDOUTS

HANDOUT 18

PROLONGED EXPOSURE MONITORING FORM 2

Start Time	End Time	Describe the Scene	SUDS at start of exposure	SUDS at end of exposure	Thoughts during exposure and general comments
e.g. 10.45	11.30	The crash, hearing my kids in the back seat of the car crying	95	65	It was pretty hard to stick with the image, it made me feel very upset initially. I kept thinking “why me?” and “why don’t they get us out quicker?”

HANDOUT 19

THOUGHT RECORD FORM 3

Situation	**Thought**	**Belief in thought** (0= not at all, 100= completely)	**Emotion**	**Rating of emotion** (0= not at all, 100= extremely intense)	**Evidence of thought**	**Evidence against thought**	**Rating of emotion** (0= not at all, 100= extremely intense)
e.g. Wife isn't home from work	"She's had an accident"	90	Terrified	95	She would usually call	There might be other explanations, she might be stuck in traffic and her phone might be flat.	50

HANDOUT 20

HOMEWORK DIARY
RETURN TO RESEARCH TEAM

Participant ID _____

Your psychologist will provide list of exercises below for you to complete at home. Please indicate with a tick the number of times you complete your exercises each week.

Session 5 .../.../...

	Day						
	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
ACTIVITY Date							
Relaxation practice Number of times completed							
How relaxed? (0-10)							
Breathing practice Number of times completed							
How relaxed? (0-10)							
Isometric relaxation practice Number of times completed							
How relaxed? (0-10)							
Completed thought record form How many times?							
Completed prolonged exposure monitoring form How many times?							

SESSION 6

(90 mins)

Objectives

The main goal of this session is the introduction of in vivo exposure. Avoidance hierarchies are developed and clients begin their in vivo exposure.

Outline of session

1. Review of homework
2. Continue with prolonged exposure
3. Debrief from prolonged exposure
4. Provide rationale for in vivo exposure
5. Exposure hierarchy development
6. Implementing in vivo exposure
7. Support person
8. Homework

Handouts for Psychologist

I. Checklist for Session 6

Handouts for Client

21. Avoidance hierarchy
22. List of typically avoided situations for MVA survivors
23. In vivo exposure form
24. Guide for support people for exposure hierarchy
25. Prolonged exposure monitoring form 3
26. Thought record form 4
27. Homework diary

In this session, you will need to audiotape the full session for the research team. You will also need to audiotape the prolonged exposure exercise for the client to use for their homework.

1. Review of homework

Review how the homework assignments went. This includes relaxation training, monitoring automatic negative thoughts and practicing generating alternative thoughts. By now the client should have commenced prolonged exposure at home. Check in on how this has gone. Each of these needs to be reviewed and any problems discussed and clarified.

2. Continue with prolonged exposure

Ask the client to repeat the same process for prolonged exposure as in Session 4 and 5. The time can now be reduced from 50 minutes to 30 minute if appropriate. It is important to not reduce the exposure time until the client has habituated to the exercise. Audiotape this exercise so the client can use this for homework.

3. Debrief from prolonged exposure

As in session 4 and 5, debrief with the client about the exercise. Monitor how the client is progressing to determine if the exercise can be reduced.

4. Provide rationale for in vivo exposure

In vivo exposure is initiated toward the end of therapy because it is hoped that clients' ambivalence about participating in in vivo exposure is reduced after completing the other treatment components. The reluctance that many clients have in approaching feared events requires that a clear rationale be given. Although the rationale for in vivo exposure is the same as that for imaginal exposure, it needs to be explained to clients in the context of in vivo procedures. Therapists can provide the following rationale for clients:

As we have discussed before, one outcome of your traumatic experience is that you have learned that things that remind you of your trauma make you anxious. Whereas before the accident you felt that you could drive on the roads and feel safe, however since your accident you have felt that your car and roads are no longer safe. There are now all sorts of things that remind you of the experience. Things that you see every day, or noises that you hear, or smells that you notice. All these things remind you of what happened when you had the accident. What you need to realise is that before the accident, all these things were there but they did not cause you to feel anxious. What we will need to do in therapy is to teach you that these things are no longer dangerous. We can do this by gradually confronting these situations and learning that nothing bad will happen to you. Another way of thinking about this is that your body has learned to respond to many of the cues that remind you of the trauma. That is, your body becomes tense because it associates these cues with danger signals. In therapy, we must give your body and your mind the chance to learn that these things do NOT necessarily signal

danger. This means exposing you to some situations that may remind you of the trauma. By remaining in these situations, you can learn that your initial anxiety will decrease, and you can develop confidence in those situations.

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

This is the basic principle to treat all fears. We need to face our fears and stay in the situations that we are afraid of long enough to learn that nothing bad will happen. In fact, we need to repeat this over and over until the anxiety diminishes. Avoiding the situations that we are afraid of actually strengthens our belief that they are scary because this avoidance teaches us that staying away from these things makes us feel better. In effect, avoiding the situations that scare you makes it even harder to face them the next time. A very important part of in vivo exposure is to try and predict what will happen before you go into the situation. For example, let's say a woman has had a motor vehicle accident and she has decided to go back to where the accident happened. I would ask her to make a specific prediction about what is likely to happen. She may say that she predicts that she will have another car accident. Then I would get her to rate the probability of having another accident during the exposure exercise. Let's say she said 80%. Then when she goes into the situation she can experience for herself whether the prediction she made was realised. Also I would ask her to prepare a series of strategies to help her cope with being in this situation. For example, she may ask herself what the evidence is that she will be the victim of another accident. Finally, I would ask her to rehearse these strategies before going into that situation, so that she is very familiar with them when she actually has to use them. The most important point of this exercise is that you only leave the feared situation after you have felt relief. Remember, leaving before the anxiety subsides only reinforces the belief that it is a fearful scene.

5. Exposure hierarchy development

After explaining the rationale, the next step in in vivo exposure is to develop a hierarchy of feared or avoided situations. This procedure involves having the client determine a graded series of situations that elicit varying degrees of anxiety. The most effective way to create a hierarchy is to have the client evaluate avoided situations in terms of subjective units of distress (SUDS) ratings. That is, the therapist asks the client to allocate a rating of 0 (*not at all distressing*) to 100 (*the most distressing I have ever felt*) to a series of events or situations. This exercise requires a joint effort by the client and therapist because most clients have some difficulty in determining gradations of anxiety eliciting situations. This difficulty can be especially evident in the acute phase, when many clients perceive all trauma related situations as being extremely aversive.

There are several options available to facilitate hierarchy development. The client can be given an Avoidance Hierarchy Form, which requires the client to write down 10 to 15 situations which he or she avoids (see **handout 21**). Each situation is given a SUDS rating, and this permits development of a graded hierarchy. Alternately, the client can write down each

situation that is avoided on a small card. When 10 or 15 cards have been completed, the client can sort the cards in a graded fashion, and this allows a hierarchy to be established and SUDS ratings to be allocated to each situation. This method has the advantage of allowing the client to repeatedly shuffle the order of situations so that it most accurately reflects the levels of anxiety that the situations elicit. Whatever method is chosen; the client should be encouraged to focus on events that are realistic and can be practically integrated into an exposure program. The therapist and client need to identify situations that are avoided in a maladaptive way and that impede the client's functioning. The therapist should also be aware that the hierarchy nearly always needs to be modified once exposure has commenced because traumatised clients often have difficulty accurately perceiving the level of fear that certain situations will evoke.

A list of common situations that are frequently avoided can be found at the end of the session (**handout 22**). This list can be provided to the clients as a prompt, which may or may not be appropriate for them to look over and maybe add some examples to their personal list.

Therapist can introduce the hierarchy in the following manner:

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

Client: *That's hard. There are lots. I definitely will not drive past where I had the accident. There is no way I will do that.*

Therapist: *Ok, that would be hard I agree. What SUDS rating would you give where you have to drive past the scene of the accident?*

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

Therapist: *What do you think about driving to the scene of the accident and getting out of the car?*

Client: *There is no way I could do that. I haven't even considered that. That would be much worse than driving past.*

Therapist: *I agree, it would be very difficult and a really hard thing for you to do. Should we rate that as 100 and maybe put driving past the scene of the accident as a 95?*

Client: *Wait, you are not going to ask me to do that, are you? I couldn't possibly do that.*

Therapist: *Yes, it will be very hard for you to do but remember we are approaching this in a gradual way so you won't be expected to do this straight away. Let's write these two down so we can remember them.*

Client: *Ok*

Therapist: *What do you think might go next on your hierarchy? What about driving alone?*

Client: *Oh yes, that's definitely a hard one for me to do.*

Therapist: *Is your fear of driving alone the same whether it's during the day or night?*

Client: *Oh, it's much worse at night. I won't drive at night.*

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

Client: *It's worse on my own. I panic more when I am on my own*

Therapist: *What SUDS rating would you give a situation involving driving at night when you're by yourself?*
Client: *Oh, probably 90. It is not as bad as the other two.*
Therapist: *What about driving with someone else at night?*
Client: *That would also be scary but not so bad. Maybe 85.*
Therapist: *Okay, how would it be driving in bad weather?*
Client: *I hate that. I don't feel safe driving in bad weather.*
Therapist: *How does it compare to driving at night?*
Client: *I feel a bit safer driving in bad weather than at night. I would say about 80.*
Therapist: *Okay, so let's write these situations down on the cards. We've got driving to the scene of the accident and getting out of the car, driving past the scene of the accident, driving alone at night, driving with a friend at night, and driving in bad weather. Can you put these in the order that you feel is most to least scary?*
Client: *Driving to where I had the accident and getting out is definitely worst. That's 100 ... without a doubt. Then it would be driving past the scene of the accident. I'd say that's 95. Then it would be driving alone at night... say 90. And then driving with a friend at night. That would be 85. Driving in bad weather, that would be 80.*
Therapist: *Excellent. Now what other situations do you think we need to put on the hierarchy?*
Client: *Driving on the highway. I despise the highway. You never know what's going to happen there, what other drivers will do. You've got no control.*
Therapist: *So driving on the highway is difficult. Do you think that is worse than driving in bad weather?*
Client: *No driving in bad weather is worse.*
Therapist: *Ok so you gave driving in bad weather a rating of 80. What SUDS rating would you give driving on the highway?*
Client: *About 75.*
Therapist: *Good, now what do you think might be next on your hierarchy? How do you find driving during the day?*
Client: *Oh I find driving by myself especially difficult. I also hate being a passenger in a car.*
Therapist: *Ok which one do you think would be worse out of those two?*
Client: *I think driving by myself during the day is worse.*
Therapist: *Good, what rating would you give that?*
Client: *I think, 60.*
Therapist: *Great, now you mentioned you don't like being a passenger in a car. Tell me more about that.*
Client: *I don't like being a passenger. I don't have any control over what is happening. It makes me feel very anxious. I don't like sitting in the passenger seat or the back seat.*
Therapist: *So what SUDS rating would you give riding in the back seat.*
Client: *I think that is worse than being a passenger. I get really scared being in the backseat so I guess I would give that 50.*
Therapist: *And what about being in the passenger seat?*
Client: *It would be about 45.*
Therapist: *Okay. Now what would be the thing that you would find least scary?*
Client: *I guess, I don't like hearing about accidents on television but it doesn't scare me as much as other things.*
Therapist*: Great, so what SUDs rating would you give hearing about an accident on television.*
Client: *Maybe that would be the lowest, a 10.*
Therapist: *Okay, so let's put those situations on the cards and sort them in the right order.*

6. Implementing in vivo exposure

After the hierarchy is complete, the therapist should ask the client to commence with the situation that is lowest on the hierarchy. It is advisable to start with a situation that the client can cope with relatively easily because this can facilitate confidence in her or his ability and enhance compliance with more demanding items. Many in vivo exposure exercises do not work effectively because they are not structured in a regimented manner. Therapists can follow a number of guidelines to ensure that the client remains in the situation for at least 30 to 40 minutes, or less if the anxiety has fully subsided. Second, we can operationalise habituation by requiring that the SUDS rating decrease by 50% before leaving the situation. To recognise reduction in anxiety, have the client use the in vivo exposure form (see **handout 23**) to monitor progress by describing (a) the situation, (b) the time spent in the situation, (c) SUDS ratings at the beginning and end of the exercise, and (d) his or her thoughts during the exercise. Third, it is extremely useful to have someone accompany the client during exposure, especially in the early stages. This can assist the client because (a) many situations on a hierarchy initially involve the presence of a supportive person, (b) the person can encourage the client to remain in the situation, and (c) the person can remind the client to engage in adaptive strategies to assist coping with the situation. The person assisting the client may be a therapist or a friend or partner of the client. It is crucial that the additional person participating in the exposure is fully aware of the rationale and techniques of exposure. Fourth, it is essential to expose the client to all situations that elicit anxiety and contribute to avoidance behaviour. This requires the therapist to be sensitive to covert means of avoidance during exposure. For example, a MVA victim may agree to be a passenger in a car but not open their eyes and have headphones on listening to music. Such safety behaviours serve to minimise full exposure to the situation and should be removed from the exposure exercise.

7. Support person

In session one, the client was asked to choose an appropriate support person to help them throughout therapy. The client may need the support person to help them with their avoidance hierarchy. The client is to take home handout 24 and discuss this with their relevant support person. If the therapist thinks it is necessary to have the support person attend a session, the therapist needs to contact the research team to discuss further.

8. Homework

Homework for this session includes relaxation practice. The client also needs to continue to monitor automatic negative thoughts and beliefs using **handout 26**, and practice generating alternative thoughts, recording the impact this has on belief and emotion strength. The client is to attempt in vivo exposure to the first situation on their hierarchy (lowest SUDS), and record on the in vivo exposure form (**handout 23**). The client is also to continue with the prolonged exposure and record their progress using **handout 25**. The client is to take **handout 24** home and discuss with an appropriate support person.

Remind clients that the goal of treatment is the application of these techniques as they have been learned. This means that they may be driving in a car trying to master those situations that are now provoking them. Often as a bridge, you can provide clients a brief imaginal situation

drawn from their hierarchy, and use the muscle relaxation exercise as a method to counter anxiety as it is provoked. This helps reinforce the cognitive stimulus (of the imagined scene) as the provocation, and is a way to show that they hold tools (challenging negative thoughts and relaxation) that can be applied to counter the anxiety as it is provoked. The imaginal exposure is gently introduced at this time to illustrate the method. MVA victims are given the suggestion to try this method as they gain sufficient skill to reduce any anxiety that occurs.

Depending on where the client is up to with their prolonged exposure, you may need to schedule another 90 minutes for the next session. If the client is progressing well and is completing the exercise at home, the prolonged exposure can be shortened next session and the session can be the usual 60 minutes.

- Practice each of the relaxation techniques
- Complete avoidance hierarchy **(handout 21)**
- Read list of typically avoided situations for MVA survivors **(handout 22)**
- Complete in vivo exposure form **(handout 23)**
- Discuss in vivo exposure with support person and provide support person with handout (**handout 24)**
- Complete prolonged exposure monitoring form 3 (**handout 25**)
- Complete thought record form 4 **(handout 26)**
- Complete homework diary **(handout 27)**

PSYCHOLOGIST HANDOUTS

HANDOUT I

CHECKLIST FOR SESSION 6

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

_____ Please indicate length of session, i.e. 60 mins, 90 mins

PLEASE TICK

_____1. Session audio taped; commence with date, client no, session no

_____ 2. Review homework and photocopy homework diary

_____3. Continue with prolonged exposure, audiotaping exercise for homework

_____ 4. Develop exposure hierarchy

_____ 5. Provide new handouts

a) Avoidance hierarchy

b) List of typically avoided situations for MVA survivors

d) In vivo exposure form

e) Guide for support person for exposure therapy

_____ 6. Assign homework

_____ Client completed homework

_____ Client completed homework diary

Comments:

CLIENT HANDOUTS

HANDOUT 21

AVOIDANCE HIERARCHY

SUDS RATING

_____	1. _____
_____	2. _____
_____	3. _____
_____	4. _____
_____	5. _____
_____	6. _____
_____	7. _____
_____	8. _____
_____	9. _____
_____	10. _____

Subjective Units of Discomfort Scale (SUDS) rating, 0 = *no discomfort*; 100 = *great discomfort*.

HANDOUT 22

LIST OF TYPICALLY AVOIDED SITUATIONS FOR MVA SURVIVORS

1. Driving past the scene of the accident
2. Riding as a passenger in a car
3. Seeing a MVA on TV or in the movies
4. Seeing a photo of an accident in the newspaper
5. Hearing an accident described on television
6. Having acquaintances ask about the MVA or how you're doing since the accident
7. Going through a deposition related to the MVA
8. Driving on highways
9. Driving in congested areas
10. Driving in bad weather (snow, dark, rain, etc.)
11. Riding in the back seat of a car

HANDOUT 23

IN VIVO EXPOSURE FORM

Name: _____ Date: _____

Situation:_____
_____
_____
_____
_____

Expected SUDS:_____ /100

BEFORE

Time Commenced: _____ Initial SUDS: :_____ /100

What do you predict will happen in the situation?

_____
_____
_____
_____

AFTER

Time Finalised: _____ Final SUDS: :_____ /100

Did your predictions come true?

_____
_____

Additional Problems/Comments:

_____
_____

OBSERVER'S RATING (please tick one of the choices below)

☐ Task fully completed	☐ Task partially completed
☐ Task not completed	☐ Observer not present

HANDOUT 24

GUIDE FOR SUPPORT PERSON

EXPOSURE THERAPY

Many people who experience PTSD avoid situations, places and activities that remind them of their trauma because they feel scared. However, while avoiding these things can help in the short term, it can actually make the problem worse in the long run, because it stops them overcoming their fear. The exposure hierarchy works by exposing the person to their own fears. It may sound strange, to expose someone to what they are most afraid of. However, when these situations are confronted in a graded way under relatively safe circumstances, the person learns they can handle their fear and anxiety and feel better about themselves.

The person you are supporting has developed a list of feared or avoided situations associated with their motor vehicle accident (MVA). This list is hierarchical, advancing from situations that cause low levels of distress to situations that cause higher levels of distress. The process will be like climbing a ladder one step at a time. Eventually the person will be able to enter situations without being scared and upset. The more they practice each situation on their list, the less fear and avoidance they will experience.

The person you are supporting and their therapist will decide what is appropriate for them to do. They will need your help to support them with their graded exposure list developed during therapy. The person may feel anxious or fearful at the beginning. It is important that you be supportive and encouraging. You can help them stay in the situation by making supportive, encouraging comments like, “you are doing a great job facing your fear” and “I know it’s hard, but it will help you feel better in the long run”. If the person makes excuses about not practicing, it’s better to discuss this with them than to simply agree with them. An example of this is, “You don’t want to do your exposure today. What do you think is getting in the way of you doing this?”

During therapy, the person you are supporting and their therapist will define the goals of an exposure session. It is important that you support them rather than telling them what to do. Before commencing an exposure session where they will begin to face the situations on their list, ask the person to communicate clearly what is expected of you. For example, do they want you to talk to them a great deal? Stay with them the whole time? Hold their hand? If the person is easily overwhelmed, help them to break each situation down into small, incremental steps. Whilst they are conducting the exposure, don’t be afraid to ask how they are doing. Encourage the person to use the strategies they have been practicing with their therapist and at home, i.e., relaxation, breathing, cognitive challenging.
You may need to be present when the person you are supporting first commences their

hierarchy, but you will need to gradually decrease your involvement so that they can do it entirely by themselves. Their hierarchy list will indicate which situations require a support person. Be careful that you are not contributing to the person's avoidance by taking over a number of roles that they used to do before the MVA but are now not doing. Examples of this might include avoiding doing the shopping, driving children to activities, driving to work. It will be helpful if you can be supportive and encouraging, and avoid trying to step in and do it all for the person. The person must retain responsibility for their recovery. By encouraging their independence it will help decrease their dependence on you for the activities they have been avoiding since the MVA.

If the person you are supporting becomes distressed during the exposure, remain calm, be present, maybe offering your hand or other physical touch that will help to relieve their distress. Try not to minimise the person's distress with statements such as there is no reason to be afraid. It is important to try to see things from the person's perspective while they are trying to overcome their fear/avoidance of these specific activities. Things that might seem insignificant may involve a great deal of work and courage for them to achieve. Praise them for whatever they accomplish. There will also be times when they may regress (i.e., avoiding certain situations related to their MVA). At these times it will be beneficial for you to be understanding and encouraging. Express confidence in the person. When the person expresses doubts about overcoming their fear/avoidance, let them know you believe they can succeed if they keep persisting. At the same time, know and express your limits. You can maintain your involvement without doing more than you can handle.

Adapted from Bourne, 2000 and Foa, Chrestman and Gilboa-Schechtman, 2008

HANDOUT 25

PROLONGED EXPOSURE MONITORING FORM 3

Start Time	End Time	Describe the Scene	SUDS at start of exposure	SUDS at end of exposure	Thoughts during exposure and general comments
e.g. 10.45	11.30	The crash, hearing my kids in the back seat of the car crying	95	65	It was pretty hard to stick with the image, it made me feel very upset initially. I kept thinking "why me?" and "why don't they get us out quicker?"

HANDOUT 26

THOUGHT RECORD FORM 4

Situation	**Thought**	**Belief in thought** (0= not at all, 100= completely)	**Emotion**	**Rating of emotion** (0= not at all, 100= extremely intense)	**Evidence of thought**	**Evidence against thought**	**Rating of emotion** (0= not at all, 100= extremely intense)
e.g. Wife isn't home from work	"She's had an accident"	90	Terrified	95	She would usually call	There might be other explanations, she might be stuck in traffic and her phone might be flat.	50

HANDOUT 27

HOMEWORK DIARY
RETURN TO RESEARCH TEAM

Participant ID _____

Your psychologist will provide a list of exercises below for you to complete at home. Please indicate with a tick the number of times you complete your exercises each week.

Session 6 .../.../...	
TASK	✓
Read: List of typically avoided situations for MVA survivors Write: Avoidance hierarchy In vivo exposure form Discuss: Guide for support person exposure therapy with your support person	

	Day						
	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
ACTIVITY **Date**							
Relaxation practice Number of times completed							
How relaxed? (0-10)							
Breathing practice Number of times completed							
How relaxed? (0-10)							
Isometric relaxation practice Number of times completed							
How relaxed? (0-10)							
Completed thought record form How many times?							
Completed prolonged exposure monitoring form How many times?							
Commenced avoidance hierarchy (complete in vivo exposure form) How many times?							

SESSION 7

(60-90 mins)

Objectives

The main goal of this session is to continue with the prolonged exposure and plan next steps for in vivo exposure.

Outline of session

1. Review of homework
2. Continue with prolonged exposure
3. Debrief from prolonged exposure
4. Cognitive challenging
5. Review in vivo exposure and plan next step
6. Homework

Handouts for Psychologist

J. Checklist for Session 7

Handouts for Client

28. In vivo exposure form 2
29. Prolonged exposure monitoring form 4
30. Thought record form 5
31. Homework diary

In this session, you will need to audiotape the full session for the research team. You will also need to audiotape the prolonged exposure exercise for the client to use for their homework.

1. Review of homework

Begin the session with review of all homework assignments. Cognitive techniques to deal with experiences are reviewed and improved and encouraged.

The largest portion of session time is spent in discussing the real-life encounters that the client is going through and how the client is coping and dealing with the tasks in the avoidance hierarchy and the changes in his or her life. The focus of treatment becomes more and more the application of cognitive-behavioural skills. All homework needs to be reviewed carefully. The hierarchy of avoidance situations needs to be attended to, as does any success with the exposure that uses behavioural and cognitive techniques. The use of self-talk, challenging catastrophic thinking, and misinterpretations of situations need to be dealt with appropriately. Multiple repetitions are often helpful and provide the opportunity to praise the client for success as well as to help with modifications of technique. Encourage clients to bring their homework records to each session. This ensures both the completion of the task and provides the opportunity to check to make sure the client is applying the cognitive and relaxation skills as instructed. Notes by the client on the homework sheet can help the client remember specific thoughts from driving hierarchy items.

As the client goes through new and related situations, remind the client to use coping and cognitive strategies for managing any provoked anxiety or planning for the future. As previously discussed, it is often useful to use imaginal exposure for feared situations that are either difficult to complete or rarely occur (e.g., close calls while driving, rapid stops, etc.). Cognitive-behavioural techniques are reviewed and relaxation techniques applied as appropriate. Self-talk, addressing cognitive distortions, and problem-solving often take place during much of the session. If the client is not completing the homework record or forgets to bring it in, remind him or her that the record can often facilitate recall of thoughts and feelings associated with difficult, anxiety-provoking situations.

2. Continue with prolonged exposure

Ask the client to repeat the same process for prolonged exposure as in previous sessions. The time for this exercise can now be reduced to 15 minutes if appropriate. This will also depend on how much the client is completing this at home. It is important to not reduce the exposure time until the client has habituated to the exercise. Audiotape this exercise so the client can use this for homework.

3. Debrief from prolonged exposure

As in previous sessions, debrief with the client about the exercise. Monitor how the client is progressing to determine if the exercise can be reduced.

4. Cognitive challenging

Use cognitive challenging techniques with the client for any salient negative/catastrophic thoughts identified in the story that can be gently challenged.

5. Review in vivo exposure and plan next step

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

***Therapist**: Looking at your record form, it seems that you had problems driving in the day by yourself. What happened?*
***Client:** I just panicked. A few days before, I had driven during the day with a friend and I coped okay. I mean it was pretty distressing, but I was able to hang in there. But yesterday, I tried it on my own, and I just lost it. I put the key in the ignition and felt that I was going to handle it. But then it all went haywire. I started to panic, my heart went wild.... I thought my chest was going to explode. I just felt that something bad would happen.*
***Therapist:** What did you do?*
***Client:** I jumped out of the car. I know I wasn't meant to but I had to get out. To be honest, I really didn't think it would be as bad as that.*
***Therapist:** Okay, how about we build in a few more steps so you can handle this. As we have discussed before, the most important thing here is that you can stay in these situations that cause you distress. Leaving them will only reinforce the belief that they are scary and you can feel better if you leave them. Tell me more about what scared you when you put the key in the ignition.*
***Client:** Well, it was late in the day, and there seemed to be a lot of traffic around.*
***Therapist:** So you were going to drive when it was peak hour traffic?*
***Client:** Yes.*
***Therapist:** Do you think it would have been easier if you went earlier during the day?*
***Client:** Probably. Now you mention it, I was worried about the traffic because there had been a lot of traffic when I had my accident.*
***Therapist**: Okay. How about going for a drive in the middle of the day? Would that make it easier?*
***Client:** Yes, that would be better. But I have to tell you, I am not looking forward to this.*
***Therapist:** Well, you say that you coped last week with it when you went with your friend. How about we try it initially with your friend waiting in the driveway for you?*
***Client:** That would be much better.*
***Therapist:** What do you predict will happen when you go for a drive during the middle of the day with your friend waiting in the driveway?*
***Client:** I reckon there is a good chance I will have an accident.*
***Therapist:** How much of a chance?*
***Client:** Well ... I would say 50%.*

Therapist: *Okay, how does this sound for a plan? The next step is for you to go for a drive during the middle of the day and with your friend waiting in the driveway. After you've managed that, you can try going for a drive by yourself during the middle of the day without your friend being there. After you've managed that, you can then try going later or earlier in the day. You're predicting that you will have an accident driving, so you will get to check that out. How does that sound?*

Client: *Much better.*

6. Homework

The client is to continue with relaxation practice. The client is also to continue with homework introduced in previous sessions. This includes completing the thought record form, continuing with the prolonged exposure and with in vivo exposure to the situations on their hierarchy.

Depending on where the client is up to with their prolonged exposure, you may need to schedule another 90 minutes for the next session. If the client is progressing well and is completing the exercise at home, the prolonged exposure can be shortened next session and the session can be the usual 60 minutes.

- Practice each of the relaxation techniques
- Complete in vivo exposure form 2 **(handout 28)**
- Complete prolonged exposure monitoring form 4 (**handout 29**)
- Complete thought record form 5 **(handout 30)**
- Complete homework diary **(handout 31)**

PSYCHOLOGIST HANDOUTS

HANDOUT J

CHECKLIST FOR SESSION 7

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

_____ Please indicate length of session, i.e. 60 mins, 90 mins

PLEASE TICK

_____1. Session audio taped; commence with date, client no, session no

_____ 2. Review homework and photocopy homework diary

_____ 3. Continue with prolonged exposure, audiotaping exercise for homework

_____ 4. Provide handouts

a) In vivo exposure form

b) Prolonged exposure form

c) Thought record form

_____ 5. Assign homework

_____ Client completed homework

_____ Client completed homework diary

Comments:

CLIENT HANDOUTS
HANDOUT 28
IN VIVO EXPOSURE FORM 2

Name: _____ Date: _____

Situation:_____
_____
_____
_____
_____

Expected SUDS:_____ /100

BEFORE

Time Commenced: _____ Initial SUDS: :_____ /100

What do you predict will happen in the situation?

_____
_____
_____
_____

AFTER

Time Finalised: _____ Final SUDS: :_____ /100

Did your predictions come true?

_____
_____

Additional Problems/Comments:

_____
_____

OBSERVER'S RATING (please tick one of the choices below)

☐ Task fully completed	☐ Task partially completed
☐ Task not completed	☐ Observer not present

HANDOUT 29

PROLONGED EXPOSURE MONITORING FORM 4

Start Time	End Time	Describe the Scene	SUDS at start of exposure	SUDS at end of exposure	Thoughts during exposure and general comments
e.g. 10.45	11.30	The crash, hearing my kids in the back seat of the car crying	95	65	It was pretty hard to stick with the image, it made me feel very upset initially. I kept thinking “why me?” and “why don’t they get us out quicker?”

HANDOUT 30

THOUGHT RECORD FORM 5

Situation	**Thought**	**Belief in thought** (0= not at all, 100= completely)	**Emotion**	**Rating of emotion** (0= not at all, 100= extremely intense)	**Evidence of thought**	**Evidence against thought**	**Rating of emotion** (0= not at all, 100= extremely intense)
e.g. Wife isn't home from work	"She's had an accident"	90	Terrified	95	She would usually call	There might be other explanations, she might be stuck in traffic and her phone might be flat.	50

HANDOUT 31

HOMEWORK DIARY
RETURN TO RESEARCH TEAM

Participant ID _____

Your psychologist will provide a list of exercises below for you to complete at home. Please indicate with a tick the number of times you complete your exercises each week.

Session 7 .../.../...

	Day						
	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
ACTIVITY Date							
Relaxation practice Number of times completed							
How relaxed? (0-10)							
Breathing practice Number of times completed							
How relaxed? (0-10)							
Isometric relaxation practice Number of times completed							
How relaxed? (0-10)							
Completed thought record form How many times?							
Completed prolonged exposure monitoring form How many times?							
Avoidance hierarchy (complete in vivo exposure form) How many times?							

SESSION 8

(60-90 mins)

Objectives

The main goal of this session is similar to previous session, continue with the prolonged exposure and in vivo exposure.

Outline of session

1. Review of homework
2. Continue with prolonged exposure
3. Debrief from prolonged exposure
4. Cognitive challenging
5. Review in vivo exposure and plan next step
6. Homework

Handouts for Psychologist

K. Checklist for Session 8

Handouts for Client

32. In vivo exposure form 3
33. Prolonged exposure monitoring form 5
34. Thought record form 6
35. Homework diary

In this session, you will need to audiotape the full session for the research team. You will also need to audiotape the prolonged exposure exercise for the client to use for their homework.

1. Review of homework

Following review of all homework assignments and cognitive techniques to deal with any reactions and experiences triggered by tasks on the driving hierarchy are applied or discussed. The avoidance hierarchy continues to be the focus for most clients, and cognitive-behavioural intervention is primarily the treatment provided. Some supportive counselling and encouragement may also be helpful in aiding the client's confidence as they challenge the more difficult tasks from their personal hierarchy of feared travel situations. Here, it is important to guide the pace and the direction of treatment.

By this point some clients have understood the basic ideas of graduated in vivo exposure and can correct their negative self-talk and even spot and correct cognitive fallacies. These clients need more of the same with support and occasional guidance. Primarily, it is important to continue to supply gentle but firm pressure for the client to continue up the hierarchy. These can be critical steps, such as for one client whose car had gone off the road and tumbled down a hillside. For this woman, it was revisiting the accident site, getting out of her car and looking down to the place where she had been trapped for more than two hours, suffering from cracked vertebrae and other serious injuries. It was as if visiting the site removed a cloud from her brain and her emotions.

Other clients will take longer, in part because they have difficulty with the correction of self-talk or even understanding logical fallacies. It is also possible that they are able to progress up the hierarchy only at a slow pace.

The important part of the session is the discussion of driving hierarchy tasks and the cognitions the approach behaviour elicits. These discussions also provide opportunity to reinforce the client for successful progress.

The remainder of this session is the same as previous sessions.

2. Continue with prolonged exposure

Ask the client to repeat the same process for prolonged exposure as in previous sessions. The time for this exercise can now be reduced to 15 minutes if appropriate. This will also depend on how much the client is completing this at home. It is important to not reduce the exposure time until the client has habituated to the exercise.

3. Debrief from prolonged exposure

As in previous sessions, debrief with the client about the exercise. Monitor how the client is progressing to determine if the exercise can be reduced. Audiotape this exercise so the client

can use this for homework.

4. Cognitive challenging

Use cognitive challenging techniques with the client for any salient negative/catastrophic thoughts identified in the story that can be gently challenged.

5. Review in vivo exposure and plan next step

As in the previous session, review the previous week's exposure homework, and make plans for the next step. Keep in mind that the hierarchy may need to be altered based on client experiences with exposure tasks.

6. Homework

It is important to encourage the client to continue with their relaxation practice as this is a something the client should continue once therapy has stopped. The client is also to continue with other homework introduced in previous sessions. Depending on the client's needs, the thought record form and the prolonged exposure can be stopped. The client should be nearing the end of their in vivo exposure to the situations on their hierarchy.

- Practice each of the relaxation techniques
- Complete in vivo exposure form 3 (**handout 32**)
- Complete prolonged exposure monitoring form 5 **(handout 33**)
- Complete thought record form 6 **(handout 34)**
- Complete homework diary **(handout 35)**

PSYCHOLOGIST HANDOUTS

HANDOUT K

CHECKLIST FOR SESSION 8

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

_____ Please indicate length of session, i.e. 60 mins, 90 mins

PLEASE TICK

_____ 1. Session audio taped; commence with date, client no, session no

_____ 2. Review homework and photocopy homework diary

____ 3. Continue with prolonged exposure, audiotaping exercise for homework

_____ 4. Provide handouts

a) In vivo exposure form

b) Prolonged exposure form

c) Thought record form

_____ 5. Assign homework

_____ Client completed homework

_____ Client completed homework diary

Comments:

CLIENT HANDOUTS
HANDOUT 32
IN VIVO EXPOSURE FORM 3

Name: _____ Date: _____

Situation:_____
_____
_____
_____
_____

Expected SUDS:_____ /100

BEFORE

Time Commenced: _____ Initial SUDS: :_____ /100

What do you predict will happen in the situation?

_____
_____
_____
_____

AFTER

Time Finalised: _____ Final SUDS: :_____ /100

Did your predictions come true?

_____
_____

Additional Problems/Comments:

_____
_____

OBSERVER'S RATING (please tick one of the choices below)

☐ Task fully completed	☐ Task partially completed
☐ Task not completed	☐ Observer not present

HANDOUT 33

PROLONGED EXPOSURE MONITORING FORM 5

Start Time	End Time	Describe the Scene	SUDS at start of exposure	SUDS at end of exposure	Thoughts during exposure and general comments
e.g. 10.45	11.30	The crash, hearing my kids in the back seat of the car crying	95	65	It was pretty hard to stick with the image, it made me feel very upset initially. I kept thinking “why me?” and “why don’t they get us out quicker?”

HANDOUT 34

THOUGHT RECORD FORM 6

Situation	**Thought**	**Belief in thought** (0= not at all, 100= completely)	**Emotion**	**Rating of emotion** (0= not at all, 100= extremely intense)	**Evidence of thought**	**Evidence against thought**	**Rating of emotion** (0= not at all, 100= extremely intense)
e.g. Wife isn't home from work	"She's had an accident"	90	Terrified	95	She would usually call	There might be other explanations, she might be stuck in traffic and her phone might be flat.	50

HANDOUT 35

HOMEWORK DIARY
RETURN TO RESEARCH TEAM

Participant ID _____

Your psychologist will provide a list of exercises below for you to complete at home. Please indicate with a tick the number of times you complete your exercises each week.

Session 8 .../.../...

	Day						
	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
ACTIVITY Date							
Relaxation practice Number of times completed							
How relaxed? (0-10)							
Breathing practice Number of times completed							
How relaxed? (0-10)							
Isometric relaxation practice Number of times completed							
How relaxed? (0-10)							
Completed thought record form How many times?							
Completed prolonged exposure monitoring form How many times?							
Avoidance hierarchy (complete in vivo exposure form) How many times?							

SESSION 9

(60 mins)

Objectives

The main goal of this session is to review homework and skills and then introduce relapse prevention.

Outline of session

1. Review of homework
2. Relapse prevention
3. Homework

Handouts for Psychologist

L. Checklist for Session 9

Handouts for Client

36. Homework diary

1. Review of homework

As with previous sessions, the session begins with a review of the homework. Check how the client is going with their relaxation strategies. At this point of therapy, the client should have habituated to the prolonged exposure exercise and have already or be close to stopping the exercise. They should also be near completion of their avoidance hierarchy and becoming skilled in completing their thought record form. Depending on the needs of the client, these can be stopped. However, reinforce the importance of continuing to use these strategies, even though they now no longer have to complete the handouts.

2. Introduce relapse prevention

The final component of treatment is relapse prevention (for a review, see P. H. Wilson, 1992). This is a critical component because it is very common for traumatised clients to experience numerous setbacks in the months following treatment. Identifying likely problems and rehearsing means to overcome them can assist the client's longer term adaptation to the trauma. This component is particularly important because many PTSD clients have ongoing stressors, including legal proceedings, ongoing medical complaints, and social difficulties that can directly compound their posttraumatic stress.

The steps for relapse prevention are as follows:

1. Identify areas of poor therapeutic gain.
2. Initiate remedial steps to enhance therapy gains.
3. Predict possible situations when relapse may occur.
4. Develop strategies to deal with expected difficulties.
5. Rehearse strategies to increase familiarity with problem solving.
6. Initiate relapse prevention steps
   (a) before expected difficult situations and
   (b) when symptoms increase.

First, the therapist should begin relapse prevention by asking the client to identify the aspects of therapy he or she have found most beneficial. This allows the therapist to determine (a) areas that may not have been given enough attention during therapy and (b) areas that match with the client's coping abilities. The therapist and client can use this information to decide whether further sessions are required to enhance the client's skills. Second, the therapist assists the client to identify foreseeable situations that may exacerbate his or her condition. For example, anniversaries of the trauma, appearing in court, or surgical procedures may be nominated as possible situations in which the client may experience a resurgence of symptoms. Third, the therapist should identify those particular therapeutic skills that will assist the client to manage these expected difficulties. Inherent in this work is the assumption that the client will not need therapeutic support each time she or he experiences problems. Instead, it is important to convey to clients that they have learnt important skills that they will be able to use at problematic times to master symptoms that may arise. Fourth, the therapist should encourage clients to rehearse the particular skills necessary to cope with foreseeable problems. This stage

of therapy may involve role-playing with the client the expected difficult situations and assisting the client to refine his or her coping strategies. Therapists can explain relapse prevention in the following way:

Therapist: *Well, we are coming toward the end of therapy, and so it is probably a good time to look back to the progress you have made and look forward to the next few weeks and months. As I am sure you are aware, the end of therapy is not the end of the process of dealing with your trauma. There will inevitably be ups and downs. Sometimes the memories of the trauma will bother you, and sometimes they won't. During therapy, you have developed a collection of coping strategies and ideas for managing the trauma. Each of the strategies is fairly new, so it will be important to keep practicing them. Then, if ever you do come across a period when the memories of your trauma are bothering you, you will be able to go back to these strategies and continue your own therapy. In your sessions, we have learnt a number of strategies to deal with your trauma. Which ones do you find most useful?*

Client: *I think I probably benefited most from the relaxation and the imaginal exposure.*

Therapist*: What were your thoughts about the cognitive therapy?*

Client: *Well, I guess it was an eye opener. I feel like I am doing that pretty automatically now in all situations.*

Therapist: *What part of therapy do you think is still a bit difficult?*

Client: *Well, I guess the real life exposure is tough. I know I've managed the early steps, but some of these later ones are not easy.*

Therapist: *So perhaps our immediate plan should focus on real life exposure. What areas still cause you some distress?*

Client: *Well, none really cause me a huge amount of distress. But there are still one or two that cause me a little bit of discomfort. Like on my way to work I can take one of two routes. One goes past where I had the accident. This is the most direct route. But I still take another way that doesn't go past the accident site, even though it's 20 minutes longer.*

Therapist: *Well, I am pleased that you are aware when you are avoiding. This ability will serve you well. As soon as you detect avoidance, you will be able to work out what you are fearful of in the situation and then go into the situation to test out if your feared outcome occurs. So what do you think you should do about your driving to work?*

Client: *I guess make a plan to drive there every day. But I know what you'll say next. You think I should stay there for half an hour until I am not edgy about it anymore. Am I right?*

Therapist: *Absolutely. We are starting to think alike. I know it won't be pleasant but by staying there for prolonged periods, I think you'll be surprised how quickly this anxiety will subside. If there are any things that still cause you distress and you are doing things to avoid them, now is the time to tackle them. If you deal with them in the near future, it is less likely that they will be problems later.*

Client: *Do you think I will have more problems?*

Therapist: *I don't know. Most people have some hiccups at some time or another. That doesn't mean they go back to where they started. It just means that you need to apply the skills that you have learned here to master the situation. What helps is if you can plan for those occasions in advance. Can you think of any situations in the coming months that will be stressful for you?*

Client: *Definitely. In a couple of months I have to go to court and give evidence against the men who ran me over. The cops have told me that I can do it so I won't be recognised. But I am terrified. I know it's going to bring it all back.*

Therapist: *Well, Ed, I think you're right. It will be a tough time, but you have the advantage of planning for it now. What sorts of things are you worrying about? How do you think they will affect you?*

Client: *It's hard to know at this stage. To be honest with you, I have been considering leaving town so the cops can't find me. I think if I can just get away from that whole scene, I will feel better. Since I have been thinking about it over the last week, I've stopped reading papers and watching the news so I don't get confronted by it all.*

Therapist: *What I hear you saying, Ed, is that you want to avoid the reminders of the experience. I would agree with you if I thought that you were in any danger. But it seems to me that you are trying to avoid things because they are stirring up memories of what happened in the past. Now we have spoken often about how important it is for you to not allow avoidance to develop. I suggest that you use the opportunity of this court episode to deal with your avoidance more effectively. I suggest that you make a plan to intentionally watch the news and read the papers until you notice that your anxiety has subsided. I think you should also return to your imaginal exposure in the period before going to court because this will help to reassure you that you don't need to be afraid of these memories. There are also a range of practical strategies you can use to help you cope with your stress. Your relaxation techniques will be very helpful at that stage. In fact, I suggest that we actually make a detailed plan about the strategies you will use to deal with this period. Then we can rehearse them here in our last session, so you can feel confident in using them when the time arrives.*

3. Homework

Depending on the client's needs most homework can now be stopped. After the discussion of relapse prevention, ask the client if there is anything specifically he or she would like to focus on before the final session. Tailor the homework accordingly.

PSYCHOLOGIST HANDOUTS

HANDOUT L

CHECKLIST FOR SESSION 9

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

_____ Please indicate length of session, i.e. 60 mins, 90 mins

PLEASE TICK

_____ 1. Session audio taped; commence with date, client no, session no

_____ 2. Review homework and photocopy homework diary

_____ 3. Review avoidance hierarchy; discuss cognitive strategies used; assist in application of cognitive-behavioural strategies as necessary

_____ 4. Introduce relapse prevention

_____ 5. Assign homework if required

_____ Client completed homework

_____ Client completed homework diary

Comments:

CLIENT HANDOUTS

HANDOUT 36

HOMEWORK DIARY
RETURN TO RESEARCH TEAM

Participant ID _____

Your psychologist will provide a list of exercises below for you to complete at home. Please indicate with a tick the number of times you complete your exercises each week.

Session 9 .../.../...

	Day						
	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
ACTIVITY Date							
Relaxation practice Number of times completed							
How relaxed? (0-10)							
Breathing practice Number of times completed							
How relaxed? (0-10)							
Isometric relaxation practice Number of times completed							
How relaxed? (0-10)							
Completed thought record form How many times?							
Completed prolonged exposure monitoring form How many times?							
Avoidance hierarchy (complete in vivo exposure form) How many times?							

SESSION 10

(60 mins)

Objectives

The main goal of this session is conclude treatment. The client's relapse prevention plan is reviewed and overview of the treatment is provided.

Outline of session

1. Review of homework
2. Review relapse prevention
3. Termination and end of treatment

Handouts for Psychologist

M. Checklist for Session 10
N. Therapist WAI

Handouts for Client

37. Client WAI and CEQ

1. Review of homework

Depending on the client, there may or may not be any homework to review. Check in on the discussion from last session around relapse prevention and see if there is anything the client may need assistance with.

2. Review relapse prevention

Review any plans that the client came up with for foreseeable high-risk times. Role-play with client any expected difficulties if appropriate. Discuss and refine plan if necessary.

3. Termination and review of program

In the last session, therapist should include a general review of skills learned and progress made over the ten sessions. Clients can be reassured of progress they have made so far and reassured of the potential gains they can continue to make. This conversation should be interactive and solicit the client's perceptions of their progress, and their sense of readiness to continue the work begun in therapy. Ask the patient what he or she has learned and whether they feel able to handle difficult situations better than prior to treatment. Therapist should encourage clients to continue using the strategies that they have learnt.

- Provide general review of skills learnt
- Review client's progress
- Encourage client to continue using coping strategies
- Encourage client to continue to engage in anxiety eliciting activities
- Complete WAI and CEQ and return to research team
- If they have any questions, concerns or difficulties about the treatment, they should feel free to contact the research team at any time

PSYCHOLOGIST HANDOUTS

HANDOUT M

CHECKLIST FOR SESSION 10

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

_____ Please indicate length of session, i.e. 60 mins, 90 mins

PLEASE TICK

_____ 1. Session audio taped; commence with date, client no, session no

_____ 2. Review homework and photocopy homework diary if required

_____ 3. Review all treatment procedures

_____ 4. Review approach/avoidance behaviour

_____ 5. Review relaxation techniques learned

_____ 6. Review coping self-statements

_____ 7. Review cognitive restructuring techniques

_____ 8. Review relapse prevention

_____ 9. Therapist complete the WAI and return to research team

_____ 10. Client complete the WAI and CEQ and return to research team

_____ Client completed homework

_____ Client completed homework diary

Comments:

HANDOUT N

WORKING ALLIANCE INVENTORY
Short Form (Therapist)
Return to research team

Therapist _____ Participant ID _____ Date _____

Measurement Point (circle one): 1st week Last Week

Instructions:

On the following page there are sentences that describe some of the different ways you might think or feel about your client.

As you read the sentences mentally insert the name of your client in place of _____in the text.

Below each statement there is a seven point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you *always* feel (or think) circle the number 7; if it never applies to you, circle the number 1. Use the numbers in between to describe the variations between these extremes.

Work quickly; your first impressions are the ones we would like to see.

PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.

Thank You!

1. _____ and I agreed about the steps to be taken to improve his/her situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. My client and I both felt confident about the usefulness of our current activity in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. I believe _____ liked me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. I had doubts about what we were trying to accomplish in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. I was confident in my ability to help _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. We worked towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I appreciated _____ as a person.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8 We agreed on what was important for _____ to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. _____ and I built a mutual trust.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. _____ and I had different ideas on what his/her real problems were.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. We established a good understanding between us of the kind of changes that were good for _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. _____ believed the way we worked with his/her problem were correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

CLIENT HANDOUTS

HANDOUT 37

WORKING ALLIANCE INVENTORY
Short Form (Client)
Return to research team

Therapist _____ Participant ID _____ Date _____

Measurement Point (circle one): 1st week Last Week

Instructions:

On the following page there are sentences that describe some of the different ways you might think or feel about your psychologist

As you read the sentences mentally insert the name of your counsellor in place of _____in the text.

Below each statement there is a seven point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you *always* feel (or think) circle the number 7; if it never applies to you, circle the number 1. Use the numbers in between to describe the variations between these extremes.

Work quickly; your first impressions are the ones we would like to see.

PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.

Thank You!

1. _____ and I agreed about the things I needed to do in therapy to help improve my situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. What I have done in therapy has given me new ways of looking at my problem.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. I believe _____ liked me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. _____ did not understand what I was trying to accomplish in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. I was confident in _____'s ability to help me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. _____ and I worked towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I felt that _____ appreciated me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8. We agreed on what was important for me to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. _____ and I trusted one another.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. _____ and I had different ideas on what my problems were.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. We established a good understanding of the kind of changes that were be good for me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. I believe the way we worked with my problem was correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

Credibility/Expectancy Questionnaire (CEQ)

Set I

1. At the completion of therapy, how logical did the therapy offered to you seem?

1	2	3	4	5	6	7	8	9
not at all logical				somewhat logical				very logical

2. At the completion of therapy, how successfully do you think this treatment has been in reducing your trauma symptoms?

1	2	3	4	5	6	7	8	9
not at all useful				somewhat useful				very useful

3. How confident would you be in recommending this treatment to a friend who experiences similar problems?

1	2	3	4	5	6	7	8	9
not at all confident				somewhat confident				very confident

4. At the completion of therapy, how much improvement in your trauma symptoms do you think has occurred?

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Set II

For this set, close your eyes for a few moments, and try to identify what you really feel about the therapy and its success. Then answer the following questions.

1. At the completion of therapy, how much do you really feel that therapy has helped you to reduce your trauma symptoms?

1	2	3	4	5	6	7	8	9
not at all				somewhat				very much

2. At the completion of therapy, how much improvement in your trauma symptoms do you really feel has occurred?

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

References

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guildford Press.

Bernstein, D. A., Borkovec, T. D., & Hazlett-Stevens, H. (2000). *New Directions in Progressive Relaxation Training : A Guidebook for Helping Professionals*. Westport, Connecticut: Greenwood Press.

Bourne, E. J. (2000). T*he anxiety & phobia workbook*. Oakland, California: New Harbinger Publications.

Bryant, R. A., & Harvey, A. G. (2000). *Acute stress disorder: a handbook of theory, assessment, and treatment*. Washington, DC: American Psychological Association.

Burns, D. D. (1980). *Feeling good: The new mood therapy*. New York: Morrow.

Clark, D. M. (1989). Anxiety states: Panic and generalised anxiety. In K. Hawton, P. Salkovskis, J. Kirk & D. M. Clark (Eds.), *Cognitive behaviour therapy for psychiatric problems: A practical guide*. Oxford, England: Oxford University Press.

Craske, M. G., & Barlow, D. H. (1993). Panic disorder and agoraphobia. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (pp. 1-47). New York: Guildford Press.

Dunne, R. L., Kenardy, J., & Sterling, M. (2012). A randomized controlled trial of cognitive-behavioural therapy for the treatment of PTSD in the context of chronic whiplash. *The Clinical journal of pain, 28*(9), 755-765.

Epstein, R. S. (1993). Avoidant symptoms cloaking the diagnosis of PTSD in patients with severe accidental injury. *Journal of Traumatic Stress, 6*(4), 451-458. doi: 10.1007/BF00974316

Foa, E.B., Chrestman, K.R., and Gilboa-Schechtman, E. (2008). *Prolonged exposure therapy for adolescents with PTSD therapist guide*. Cary, North Carolina: Oxford University Press.

Foa, E. B., Ehlers, A., Clark, D. M., Tolin, D. F., & Orsillo, S. M. (1999). The Posttraumatic Cognitions Inventory (PTCI): Development and validation. *Psychological Assessment, 11*(3), 303-314. doi: 10.1037/1040-3590.11.3.303

Foa, E. B., & Rothbaum, B. O. (1997). *Treating the trauma of rape: Cognitive behaviour therapy for PTSD*. New York: Guildford Press.

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: Free Press.

Jull, G., Sterling, M., Kenardy, J., & Beller, E. (2007). Does the presence of sensory hypersensitivity influence outcomes of physical rehabilitation for chronic whiplash?--A preliminary RCT. *Pain, 129*(1-2), 28-34. doi: 10.1016/j.pain.2006.09.030

Keane, T. M., Zimering, R. T., & Cadell, J. M. (1985). A behavioural formulation of Post Traumatic Stress disorder. *Behaviour Therapist, 8*, 9-12.

McCann, I. L., & Pearlman, L. A. (1990). *Psychological trauma and the adult survivor: Theory, tharapy, and transformation*. New York: Brunner/Mazel.

Meichenbaum, D. (1985). *Stress inoculation training*. Elmsford, NY: Pergamon Press.

Mowrer, O. H. (1947). On the dual nature of learning—a re-interpretation of "conditioning" and "problem-solving.". *Harvard Educational Review, 17*, 102-148.

Wilson, P. H. (1992). *Principles and practice of relapse prevention*. New York: Guildford Press.

APPENDIX A

POTENTIAL ISSUES

The treatment of traumatised individuals often can be difficult. The particular symptoms of PTSD, the social upheaval associated with the recent trauma, and the presence of ongoing stressors all can contribute to problems in the therapy process. Although the treatment protocol outlines treatment strategies that have been proven to be successful, it is unusual for any treatment of PTSD to proceed as neatly as a treatment manual would suggest. Accordingly, this section presents some of the difficulties that can arise in treating PTSD and discusses a range of options for overcoming these obstacles. These obstacles are taken from Chapter 8 of the following book (note that they were written for Acute Stress Disorder, however largely apply to PTSD as well):

> Bryant RA & Harvey AG. *Acute Stress Disorder: A Handbook of Theory, Assessment, and Treatment.* Washington DC: American Psychological Association.

EXCESSIVE AVOIDANCE

A common obstacle to treating PTSD is the extent to which the person actively avoids confronting his or her traumatic memories or feared situations. Although strong avoidance tendencies will be present in nearly all clients with PTSD, in a proportion of individuals, avoidance impedes any form of exposure-based therapy. Avoidance is frequent during therapy for a number of reasons. First, many people feel they have lost control over their responses to events, and they attempt to regain some control by avoiding those things that will threaten that control. Second, avoidant styles are common in individuals with PTSD and may even be a predisposing factor to the development of PTSD (Guthrie & Bryant, in press). Third, the distress elicited by exposure often evokes further avoidance in clients because they feel they cannot cope with the resulting anxiety. Fourth, disclosing details about one's traumatic experience to a therapist often can be difficult because of fears about how the information will be used or how the therapist will react. Many traumatised people have already been forced to disclose details about the trauma to police, organisational authorities, or legal counsel before seeing a therapist. These earlier experiences can result in avoidance of disclosing personal experiences when working with a therapist.

When confronted with extreme avoidance of traumatic memories, the therapist should first consider the utility of this avoidance. A client's extreme avoidance is sometimes an important warning sign to the therapist that the client needs support and containment rather than exposure-based intervention that may further compound his or her elevated anxiety. Pushing an acutely traumatised client to surrender her or his avoidance in the acute phase

may precipitate further crises. In such cases, more active therapeutic intervention may be more appropriate several months later.

If the therapist determines that the client can cope with exposure, several strategies can be implemented to minimise the avoidance. First, the therapist can repeat the rationale for exposure in a way that clarifies the need for habituation of anxiety. Second, one can use motivational techniques that compare the benefits and disadvantages of proceeding with therapy. Third, more attention to cognitive therapy can assist the client in perceiving his or her response to exposure more realistically. Fourth, it is often useful to implement a graded exposure regime that commences with less distressing aspects of the traumatic experience. For example, although one client we worked with could focus attention on two men beating him around the head during an assault, he was resistant to thinking about the assailants stabbing his younger brother. After contracting with him that his brother's assault would not be the focus of exposure, he was compliant to completing exposure to his own assault. After initial habituation of his anxiety about his own assault, he suggested that we proceed with exposure to the features of the assault that involved his brother's experience. When therapists initiate graded exposure because of a client's stated reluctance to confront critical aspects of the trauma, it is imperative that all features of the narrative are eventually integrated into the exposure.

DISSOCIATION

The emotional detachment associated with dissociative responses can impede engagement with traumatic memories (Foa & Hearst-Ikeda, 1996). A person may be able to relate the events that happened to him or her but will not feel the distress associated with the experience. This problem can occur commonly in PTSD because of the prevalence of dissociation in this condition. Therapists should be sensitive to the presentation of marked dissociation because it may indicate a defense against overwhelming distress that the person may not be able to manage in the acute phase.

Acute dissociation is more evident in very severe or prolonged traumas (Zatzick et al., 1994). This pattern suggests that dissociative responses may reflect reactions to particularly disturbing experiences. Breaching dissociative responses in the acute phase may often be unwarranted because it may reduce the individual's control in this period. Therapists should be sensitive to the defensive and potentially protective role that dissociative responses can play in the acute phase. Respecting this function of dissociation, therapists should consider clients' psychological resources and their capacity to tolerate the distress from which they are distancing themselves. Those individuals who display signs of not being psychologically robust may fare better with supportive therapy that allows them to stabilise their acute reaction before more direct therapeutic intervention. Those dissociative individuals who are considered capable of managing their distress may require modified exposure techniques. For example, clients who do not feel anxiety when recalling their traumatic experience may be able to experience distress when imagining a loved one

suffering the same traumatic event. Alternately, directing clients to imagine a scene that they can feel emotional about and then switching to the traumatic memory can facilitate emotional engagement. It has been suggested that hypnosis can facilitate breaching acute dissociative reactions because it allegedly involves dissociative techniques (Spiegel, 1996). It should be recognised, however, that there are no outcome studies concerning the use of hypnosis with ASD.

ANGER

Anger is a very common response after a traumatic experience (Hyer et al., 1986; Yassen & Glass, 1984). Anger responses are particularly prevalent in victims of violent crime (Riggs, Dancu, Gershuny, Greenberg, & Faa, 1992). There is convergent evidence that anger responses to a trauma do not respond effectively to exposure treatments. Factor analyses of PTSD indicate that anger responses are more associated with numbing than anxiety (Foa, Riggs, & Gershung, 1995). It has been suggested that anger may serve to inhibit anxiety after a trauma, especially when effortful avoidance is unsuccessful (Riggs, Hearst-Ikedo, & Perry, 1995). Furthermore, both self-reported anger before treatment and facial expressions of anger during the initial exposure session are associated with poor therapeutic gain (Foa, Riggs, & Gershung, 1995; Jaycox, Perry, Freshman, Stafford, & Foa, 1995). These findings suggest that exposure may not be the optimal treatment for those acutely traumatised individuals whose primary presentation is anger. Recent CBT programs that have specifically addressed posttraumatic anger have demonstrated that integrating anxiety management and cognitive therapy into treatment can be effective (Chemtob, Novaco, Hamada, & Gross, 1997).

GRIEF

Grief is a very common condition after a traumatic experience (Raphael & Martinek, 1997). Moreover, posttraumatic stress and grief interact to compound the clinical presentation (Goenjian et al., 1995; Horowitz, Weiss, & Marmor, 1987). The use of exposure in the acute trauma phase should be exercised cautiously with people who present with grief issues. Acute grief reactions are often characterised by intrusive symptoms, numbing, and a degree of avoidance. The bereavement process requires time, however, and it may not be appropriate to provide the acutely grieving client with exposure when she or he is coming to terms with her or his loss. For example, a woman was referred to us after a motor vehicle accident in which her 2-year-old child died. She was trapped in the car for several hours with her dead child lying on her lap. This scene represented the primary content of her intrusive memories. The referral expressly asked us to use an exposure-based approach to help this client manage her distressing images of this scene. We decided that requesting this woman to complete exposure to this image several weeks after the loss would have placed excessive strains on her at a time when she was only just managing to

grieve for her lost child. Therapists need to be aware that whereas ASD can be considered a psychopathological condition because it leads to ongoing disorder, acute grief reactions are normal and not necessarily indicative of later psychopathology. Recognising the need for people to proceed through the grieving process often involves not overburdening clients with exposure in the acute phase.

EXTREME ANXIETY

Recent commentaries have noted that exposure can be impeded by a participant's excessive anxiety because the experience can be perceived as overwhelming (Jaycox & Foa, 1996). Activating traumatic memories can result in an anxiety state that will not be managed by the individual if he or she lacks the necessary resources to cope with the distress. Any individual who suffers panic attacks in the acute phase should be monitored carefully because exposure can elicit a panic that can be perceived as further traumatisation. Such a response often results in poor compliance with subsequent therapeutic attempts.

Individuals who display extreme anxiety require instruction in anxiety management before any exposure therapy. Following Meichenbaum's (1974) SIT program, we teach the client relaxation, breathing control, self-talk, and, if required, panic control. Only when the anxiety is manageable should exposure be considered. It is not uncommon for exposure to result in extreme anxiety and requests by the client to cease exposure. In such a situation, the therapist has two options. One is to give more attention to cognitive therapy to assist the client to appraise the exposure in a more adaptive way. The alternative is to cease exposure. The latter option is problematic because it can reinforce to the client that avoidance of the memories is associated with fear reduction. If the client cannot tolerate the anxiety, however, it is wiser to temporarily suspend exposure and return to it at a later time when the distress of the acute phase has stabilised. We emphasise that the decision to suspend exposure should be based on the client's inability to tolerate anxiety rather than the therapist's own discomfort with administering exposure. Many therapists avoid exposure because they are reluctant to elicit strong anxiety reactions in traumatised clients. Although this tactic may be more comfortable for the clinician, it may be depriving the client of a therapeutic intervention with proven efficacy.

CATASTROPHIC BELIEFS

Clients who complete exposure but continue to ruminate on catastrophic thoughts about their experience often do not benefit from exposure. A recent study found that exposure was not successful if the person's narrative of the trauma was characterised by mental defeat or lack of mastery over the situation (Ehlers, Clark, et al., 1998). This situation highlights the need for exposure to be accompanied by cognitive restructuring. Clients who manifest entrenched beliefs arising from their experience should receive substantive cognitive

therapy. Proceeding with exposure without addressing their interpretations of the recalled memories may simply reinforce their maladaptive beliefs.

PRIOR TRAUMA

It is likely that many people who develop PTSD have a history of previous traumas. It is common for people who have suffered unresolved traumatic experiences before the recent trauma to be confronted with both the recent stressor and a resurgence of the earlier memories. For example, a woman who survived a recent motor vehicle accident had seen her mother commit suicide 20 years earlier. Soon after the motor vehicle accident, she began experiencing severe posttraumatic stress symptoms relating both to the motor vehicle accident and to her mother's death. In terms of network theory, the two sets of memories are stored within associated networks that promote merging of the multiple traumas. This scenario is especially common in populations that are frequently exposed to traumatic events, such as police, ambulance workers, and military personnel. Therapists need to decide whether the longer term traumatic experience will disturb the acutely traumatised individual to an extent that is beyond her or his tolerance. We have decided to not treat a proportion of ASD individuals in the acute phase because the distress associated with memories of longer term traumas was excessively upsetting in the context of the recent trauma. Allowing the posttraumatic upheaval to settle before addressing the traumatic memories can lead to a better outcome. If the therapist decides that a client who presents with symptoms relating to multiple traumas is able to manage therapy, it is useful to prioritise the memories that will be addressed. The therapist and client can mutually agree on compartmentalising the intrusive memories into an order that the client feels comfortable addressing. In most cases, we would address memories of the recent trauma first because they tend to be more accessible and were the reason for the presentation.

COMORBIDITY

Depression, substance abuse, anxiety disorders, and other disorders are common comorbid diagnoses in posttraumatic stress populations (Barton et al., 1996; Davidson & Fairbank, 1993; Davidson, Hughes, & Blazer, 1991; Keane & Wolfe, 1990; Southwick, Yehuda, & Giller, 1993). Individuals who suffer a psychiatric disorder at the time of being exposed to a traumatic event are likely to respond in a more complicated manner than those who had no prior disorder. Therapists need to be particularly aware of disorders that may be exacerbated by the distress elicited by exposure. Some of the more problematic preexisting disorders include borderline personality disorder and psychosis. People with these backgrounds can experience marked deterioration, including psychotic episodes, severe dissociative states, and self-destructive tendencies when confronted with exposure to traumatic memories in the acute phase. Caution is required with these vulnerable people, and it is probably wiser to offer

support to contain their preexisting disorder than to resolve their traumatic experience in the acute phase.

SUBSTANCE ABUSE

Substance abuse is also a common posttraumatic response (Keane & Wolfe, 1990; Kulka et al., 1990) that is conceptualised as a form of avoidance behaviour that assists distraction from distressing intrusive symptoms (Keane, Gerardi, Lyons, & Wolfe, 1988). There are several reasons to index the level of substance abuse in any traumatised client before treatment. First, marked substance abuse can result in poor ability to engage with anxiety during exposure. Second, people who have a tendency toward substance abuse may increase their reliance on the substance as a means of coping with the distress associated with exposure. Third, reliance on substances is often a sign of one's inability to cope with the posttraumatic stress and a tendency to use avoidant coping mechanisms. These are poor prognostic signs for exposure. It is common in exposure programs to require sobriety of several months before commencing exposure (Foa & Rothbaum, 1997). Accordingly, we typically do not provide exposure therapy to someone in the acute phase who presents with substance abuse because we need evidence of prolonged sobriety. This typically results in treatment being offered several months after the trauma.

DEPRESSION AND SUICIDE RISK

Depression and suicidal ideation are prevalent risks after a trauma. Studies of rape victims have indicated that over 40% of victims have contemplated suicide and at least 17% have actually attempted suicide since the rape (Kilpatrick et al., 1985; Resick, 1988). It is for this reason that the level of depression needs to be assessed carefully both before treatment and throughout the therapy process. Although there is some evidence that posttraumatic depression can be reduced through treatment of the primary posttraumatic stress symptoms (Bryant, Harvey, Dang, Sackville, & Basten, 1998; Nishith, Hearst, Mueser, & Foa, 1995), there is also evidence that depression can coexist independently of posttraumatic stress (Shalev, Freedman, et al., 1998). Individuals who are considered a suicide risk in the acute phase require support, containment, and possibly antidepressant medication or hospitalisation. The risk of providing suicidal clients with exposure is that it may enhance their attention toward the negative aspects of their experience. There is considerable evidence that depressed people have poor retrieval of specific positive memories (Williams, 1996), and so they may have difficulty reinterpreting their traumatic memories after exposure. Our practice is to ensure that acutely traumatised clients who are also severely depressed are provided with the appropriate assistance to stabilise their depression before exposure therapy.

POOR MOTIVATION

Poor motivation to engage in treatment is often a feature of individuals who are traumatised. This is particularly prevalent in the acute phase because many individuals are referred for therapy by other people. This practice can place considerable strain on therapy because often the client is not adequately motivated to participate in therapy. Therapists should always try to ascertain the level of motivation that a client has for therapy, and when there is clear ambivalence, there should be attempts to educate the client about the advantages of proceeding with therapy. Proceeding with therapy when the client is not motivated can be counterproductive because unsuccessful attempts at therapy can sabotage the possibility of subsequent effective therapy. It may be better to not proceed with therapy if the client is not willing. In postponing therapy, however, the therapist should attempt to have the client own responsibility for the decision to not proceed with therapy and to realise the merits of considering therapy when she or he is more motivated. It is common for other events to distract the client from giving therapy priority, and in such cases, the chances of therapeutic success may be better after the disruptions of the acute phase settle.

ONGOING STRESSORS

The presence of ongoing stressors, particularly in the acute phase, also can represent an obstacle for effective therapy. Severe pain or other medical problems, financial losses, criminal investigations, property loss, and media attention are some of the stresses that are demanding on traumatised individuals. Accordingly, therapists need to evaluate the client's available resources that can be allocated to therapy, especially in the acute phase. Asking a client to complete exposure exercises when he or she is attempting to manage many other demands can result in insufficient attention being given to therapy or unnecessarily high levels of distress. Furthermore, the demands of therapy can result in the person experiencing further distress that impedes her or his capacity to deal with the ongoing stressors. For example, a burn patient who is attempting to cope with the severe pain of daily debridements and physiotherapy may require psychological support to assist her or him through these procedures. Attempting exposure may create additional distress at a time when the individual requires all available energy for managing his or her medical condition.

It is also common for acutely traumatised clients to perceive that there are still threats to their safety. For example, it is not uncommon for assailants to inform victims of home invasions, assaults, and domestic violence that they will be harmed again. The therapist needs to decide whether the actual risk to the client is *likely* to impede that client benefiting from therapy. For example, one of our clients who was stuck with a hypodermic filled with possibly contaminated blood during an assault was preoccupied with the possibility that he would contract AIDS. Because final pathology evidence indicating his health status would be available after a short delay, it was decided to delay active treatment until he was aware of his condition. In another case, however, a client was terrified that an assailant would be released on bail and kill him before he could testify against him. Considering that the issue of bail was not going to be finally determined for a long time, we decided that therapy needed to proceed immediately with a strong focus on his appraisals of future harm.

CULTURAL ISSUES

Therapists need to be aware that a traumatic experience can differentially affect people from different cultural backgrounds (Manson, 1997). Moreover, one's cultural perspective can influence response to therapeutic interventions (Lee & Lu, 1989). Exposure can be interpreted differentially by people from different cultures. For example, one Buddhist client complained that she did not want to participate in exposure because she believed that focusing on a negative memory would be detrimental to her future prosperity. Similarly, a Taoist client reported that he believed that the assault that he suffered was a result of fate and it was not appropriate through exposure to challenge or modify the events that had happened to him. In such cases, the rationale for exposure needs to be integrated into the client's value system in a way that is congruent with his or her view of recovery. Cognitive restructuring that attempts to reconcile therapy techniques with the client's epistemology can be useful. If there is a persistent discrepancy, however, the therapist needs to recognise that a client's culturally driven outlook must be recognised and validated.

APPROPRIATE VERSUS INAPPROPRIATE AVOIDANCE

One of the difficulties in working with acutely traumatised clients is deciding when avoidance behaviour is maladaptive. In cases of longer term trauma, the identification of avoidance behaviours that need to be targeted in treatment is more straightforward. There are many instances in the initial period after a trauma when avoidance behaviour may be regarded as reasonable because of the recency of the trauma. For example, one client we treated came to us after a home invasion. The invader had viciously attacked our client for several hours, leaving him with multiple knife wounds and burns. As the invader left, he told our client that he would return one day and "finish the job." Our client was reluctant to return to his house because he feared future attacks, every room in the house was bloodstained, and the assailant had not been apprehended. We considered that to urge the client to return to the house through a graded *in vivo* regime in the initial weeks after such an ordeal was not constructive. In a case such as this, there are realistic concerns and understandable reasons to avoid very salient reminders of the trauma. This client was willing to participate in a range of other *in vivo* exercises that actively encouraged him to confront certain other situations. Alternately, another client who was also the victim of a home invasion was adamant in therapy that she wanted to sell her house, leave the city, and impulsively engage in a wide range of avoidance behaviours. In this case, we encouraged the client to commence *in vivo* exercises on a selected number of situations and persuaded her to restrict her avoidance to a temporary change of residence until her acute stress symptoms stabilised. Therapists should recognise the functional, and sometimes safety-enhancing, roles of some avoidance behaviours in the acute phase. Avoidance behaviours that need to be targeted are those that clearly contribute to ongoing anxiety and a longer term pattern of phobic avoidance.

MULTIPLE TRAUMA SURVIVORS

It is common for a client's adjustment to be directly influenced by the responses of others who were also involved in the traumatic event. The individual's perceptions of the event, appraisals of future harm, and compliance with therapeutic aims can often depend on how other trauma survivors are coping with their own experiences. One of our clients, who had been assaulted with her husband, had significant difficulties in responding to treatment because her husband repeatedly expressed his catastrophic concerns about their vulnerability and the need for pervasive avoidance strategies. Other clients have displayed considerable difficulty in allocating sufficient attention to therapy for themselves because they are preoccupied by caring for their loved ones who have also suffered the experience. We have seen many parents who are reluctant to participate in exposure because they believe they must contain their emotional responses to the trauma so they do not communicate fear to their children. Therapists need to index the impact of others' traumatic responses on the client and to integrate this factor into the treatment plan. In some cases, it is appropriate to involve others in therapy. In other cases, it may be more appropriate to directly work with the client on strategies for managing the impact of others' reactions. In rare cases, we have suggested that clients remove themselves from their environments because they are contributing to their posttraumatic stress. One client, who was a member of a street gang, was very disturbed in the weeks after a very violent assault because the gang insisted that our client rehearse a planned revenge attack. Although leaving the gang involved its own risks, our client agreed that he could not resolve the recent assault as long as he remained in this environment.

Therapists should also be careful when treating more than one person who has survived the same traumatic event. It is often difficult for the therapist to keep the multiple clients' narratives and interpretations of the trauma separate. Whenever possible, we allocate clients from the same traumatic event to different therapists. If this is not possible, the therapist needs to be aware of the ease with which details and attributions reported by different clients can be confused. In these situations, the therapist needs to keep detailed notes concerning each client's idiosyncratic response to the traumatic experience.

WHEN EXPOSURE SHOULD NOT BE USED

Although exposure can be a powerful therapeutic tool, it is clear that this intervention can cause a number of problems in trauma survivors. Kilpatrick and others have criticised exposure for rape victims because (a) in aiming to reduce anxiety it may focus on symptom change rather than modifying irrational thoughts, (b) it may contribute to excessive noncompliance with therapy because of its distressing nature, (c) it may inappropriately reduce anxiety to nonconsensual sex, and (d) it does not directly teach coping strategies (Kilpatrick et al., 1985; Kilpatrick, Veronen, & Resick, 1982). Although others have countered these criticisms (see Foa & Meadows, 1997; Rychtarik, Silverman, Van Landingham, & Prue, 1984), therapists do need to be aware that exposure can exacerbate a number of problems. Note that Pitman et al. (1991) have reported that they terminated a study that used imaginal exposure because of the significant adverse effects it had on their participants. Similarly, Vaughan and Tarrier (1992) have reported that one of their sample of 7 participants suffered a marked deterioration after exposure. We suggest that caution

be exercised and the use of exposure be seriously questioned when the acutely traumatised client presents with one of the following problems:

- Extreme anxiety
- Panic attacks
- Marked dissociation
- Borderline personality disorder
- Psychotic illness
- Anger as primary trauma response
- Unresolved prior traumas
- Severe depression or suicide risk
- Complex comorbidity
- Substance abuse
- Marked ongoing stressors

Although these types of presentations are seen in relatively few acutely traumatised clients, clinicians should be sensitive to their presence prior to commencing any therapy. In cases where exposure is contraindicated, other techniques, including anxiety management, cognitive therapy, or pharmacological intervention, may be effective.

Supportive Therapy Manual

Contents

INTRODUCTION

The purpose of this manual is to guide the administration of the supportive therapy intervention arm of a randomised control trial (RCT) investigated the effectiveness of combined trauma focused cognitive behavioural therapy (TF-CBT) and exercise for chronic whiplash. Material in this manual is largely adapted from the following resources:

1. Winston, A., Rosenthal, R.N., & Pinsker, H. (2012). *Learning supportive psychotherapy: An illustrated guide.* Washington DC: American Psychiatric Association.
2. Blanchard, E., & Hickling, E. (2004). *After the crash: Psychological assessment and treatment of survivors of motor vehicle accidents*. Washington, DC: American Psychological Association.
3. Schnurr, P., Friedman, M., Engel, C., Foa, E., Shea, M., Chow, B., ... & Bernardy, N. (2007). Cognitive behavioral therapy for posttraumatic stress disorder in women: a randomized controlled trial. *Jama, 297*(8), 820-830. doi: 10.1016/s0084-3970(08)70746-1

1. Rationale and description of intervention

Persistent pain and disability following whiplash injury as a consequence of a road traffic crash (RTC) is common and incurs substantial personal and economic costs. To date no conservative treatment approach has been shown to be very effective for those who develop chronic pain following whiplash injury. Psychological responses related to the traumatic event itself, posttraumatic stress symptoms, are emerging as an important additional psychological factor in the whiplash condition. Research has demonstrated that individuals with chronic whiplash associated disorders (WAD) and moderate posttraumatic stress disorder (PTSD) symptoms do not respond well to a physical rehabilitation based intervention as those without PTSD symptoms (Jull, Sterling, Kenardy, & Beller, 2007). A recent pilot study has shown TF-CBT has a beneficial effect on both psychological status and pain and disability (Dunne, Kenardy, & Sterling, 2012). The current research is conducting a RCT to determine the effects of adding TF-CBT to exercise for individuals with chronic WAD and PTSD.

Supportive Therapy (ST) will serve as a clinically relevant comparison condition for TF-CBT in the investigation of therapy and exercise impacts for those with chronic whiplash injury. ST will be conducted across ten 60 minute weekly sessions.

This intervention will provide clients with ten sessions of ST which is less structured than TF-CBT, allowing clients greater input in the direction of therapy. ST will not focus on the trauma or contain any elements of exposure, cognitive restructuring or relaxation techniques. Clients in this group will be focusing on present day problems and feelings that have arisen as a result of their trauma symptoms.
There are four main goals of ST:

- To provide education about trauma symptoms to normalise the client's experience
- Provide unconditional empathetic support to the client
- Aid the client to improve their problem solving skills towards current issues
- Restore, maintain or improve the client's self-efficacy, self-esteem and adaptive skills

2. Theoretical background

ST is characterised by the development of a therapeutic relationship that focuses on a person's current life situation looking to address and solve current issues or problems (Winston, Rosenthal & Pinsker, 2012). It aims to help the individual better understand themselves and assist them through the application of practical problem solving and coping strategies to improve well-being, alleviate distress, resolve crises, and increase the ability to live more highly functioning lives (Winston et al., 2012).

An unconditionally supportive environment is created to allow the client to discuss various issues including emotional, social, interpersonal, health-related, educational and vocational concerns (Blanchard & Hickling, 2004; Schnurr, 2007; Winston et al., 2007). The therapist's role is to actively respond to the client in a conversation style indicating understanding (Blanchard & Hickling, 2004; Schnurr, 2007; Winston et al., 2012). Therapists can seek clarification and actively paraphrasing, but must not interpret or provide direction. ST techniques include esteem building, skills building, reducing and preventing anxiety and awareness expanding (Blanchard & Hickling, 2004; Schnurr, 2007; Winston et al., 2012).

The therapeutic alliance is an essential element of effective ST. It can be described as a robust bond between the client and therapist, based on a commitment to common goals, mutual respect and collaboration (Winston et al., 2012). With this relationship, clients may be more willing to discuss sensitive issues as well as accept suggestions from the therapist that may not be accepted from another person in the client's life (Winston et al., 2012).

3. Therapist behaviours

When interacting with the client, therapists should display an attitude of warmth, calmness, empathy and consistency. Therapists can achieve this by normalising the client's responses to trauma, providing unconditional emotional support and working through current problems with the client.

Some examples of this are as follows.

"I want to understand how you are feeling and what you are thinking."

"You are the expert in your life. I am not here to tell you what to do. Rather, I am here to help support you and work together with you to explore some of the issues you are having."

"I want to share with you my perceptions of what you have told me." (i.e. reflections not judgements)

"I am not here to make any judgements, my role is to fully accept you as you are. I will not agree or disagree with what you say. I will only tell you what I perceive that you are expressing and experiencing."

The following behaviours are desirable and appropriate:

1. *Active listening*: The therapist listens to the client without interrupting, provides verbal cues of understanding ("*I see", "Uh-huh", "Mmmm*"), clarifies understanding through paraphrasing or questions and invites the client to say more.

2. *Encourage expression of feelings*: Asking the client how he or she feels currently or commenting on reactions can be a useful tool to redirect discussions to the present moment.

3. *Provide accurate information*: Therapists should ensure the information they provide is useful and relevant to the client and refer the client to appropriate sources of information. This may include medical, legal, sexual, emotional or day to day problems.

4. *Encourage problem-solving and application of formerly used or new coping methods:* Therapists should assist clients to identify and define their problems and then brainstorm potential solutions. Suggestions can be made of other potential solutions (excluding exposure or TF-CBT based solutions) but therapists should not direct clients as to which option to choose (e.g. *have you thought about talking to a friend about it?*). Solutions can be evaluated together for the merits and problems (e.g. *That's a possibility. How do you think it would help?"*). How this solution turns out can be evaluated in the following sessions.

5. *Praise liberally*: Praise the client for expressing their feelings appropriately. Efforts to make independent decisions and any problem solving attempts should also be praised and encouraged. Therapists should discourage excessive dependence.

6. *Encourage contact with supportive others*: Support networks should be explored to help the client think about who they have in their life (e.g. friends, family, teachers and co-workers) who they could seek support, understanding or aid from. Tensions or

communication difficulties with important people (e.g. family) resulting from the trauma is an important topic for discussion and problem solving.

4. Exclusions

To maintain the integrity of the study, ***do not*** utilise any strategies from TF-CBT including:

- relaxation techniques such as progressive muscle relaxation, breathing exercises and isometric relaxation
- imagery
- exposure (imaginal or in-vivo)
- cognitive restructuring
- challenging maladaptive thoughts and core beliefs

This therapy is designed to be supportive and client-focused in nature. Therapists are to provide a safe and supportive environment to discuss issues and problem solve. The focus should be on how the client feels and the acknowledgment and legitimisation of these feelings instead of trying to correct them.

Below are some examples of how you might respond to comments about exposure, flashbacks or cognitive distortions.

(If directly asked about whether to drive again or not)
"You're the best judge of what's best for you; listen to your body and go with your feelings."

(If the client doubts they will ever get over it)
"I hear that this is still hard for you despite the passage of months. If you remember what you were told earlier, people are different in how long it takes to get over the trauma. It takes time to get over the trauma so it may take some time for the memories to fade. You have taken the first step by acknowledging that the problem is present"

(Fear of further accidents)
"I understand you are having some self-doubts and are worried. These are natural reactions to an accident like yours. It may take some time but this will gradually get easier as the memories fade."

(Logical fallacies)
"You continue to feel bad about the accident and its consequences; these are normal reactions to an event like yours."

Please ***refrain*** from giving specific advice to the client. Encourage the client to listen to their own body and feelings and be guided by those as they are the expert on themselves. Therapists are to help clients brainstorm solutions or coping strategies by discussing the costs and benefits of different options but clients must be allowed to make decisions themselves.

Other therapist behaviours which should be **avoided** include:

- passive listening without responding
- a challenging rather than supportive approach to clarifying feelings and making effort to resolve problems
- judgemental statements such as: "*you really shouldn't have*"
- putting words into the mouth of the client (e.g. completing sentences for him or her)
- directing the client to describe, imagine or relive the memory of the traumatic experience

5. Special issues

References to trauma

If the client brings up the trauma in discussion, therapist can politely redirect the conversation to the present and the problems the trauma is causing in his or her life now. Care should be taken to refocus the client in a positive and supportive manner and not interrupt his or her disclosure. It is important to be clear with the client about why the session won't focus on the trauma from the beginning. Therapist should check that clients understand the reasons for focusing on the present instead of the past.

See below for some examples of this.

"So, in what ways does this relate to what's happening in your life now?"

"What's it like for you to talk about this right now? You seem a little [anxious, upset, sad etc.]"

(if the client expresses fear about driving on the same road the accident occurred)
"These feelings are normal given what you have been through. Trauma survivors often respond to such reminders with fear and anxiety"

(If the client continues to talk about the trauma or doesn't understand why the session doesn't focus on trauma)
"Different treatment strategies work for different people. Our strategy here is to reduce the painful experiences and feelings you have by working on the issues you are dealing with in your current life and increasing your ability to cope with these problems."

(If the client complains or is disappointed about being in the supportive therapy group)
"It sounds as if you are disappointed that we're not going to be talking about the traumatic event(s). What do you expect to miss, in not going into the trauma? How do you imagine that trauma-focus would be more helpful to you? Do you feel that the problem-focused approach is less helpful to you?

Legal issues

Clients may be involved in current legal proceedings in relation to the traumatic event. Therapists may listen to client concerns but ultimately are not experts in the law and should remind clients of this fact if asked for advice. Exacerbated symptoms of anxiety may occur around court dates and therapists should be supportive and assure the client that this emotional experience is normal.

Prior relaxation training

If the client has had experience with relaxation or meditation prior to treatment, this should be recorded in the treatment notes. Any direct questions about relaxation techniques should be met with noncommittal responses such as "*It is up to you to decide what is best for you"*. Therapists should avoid making comments of support or direction about the continuation or commencement of such activities. If the client has no experience, therapists are not to introduce the material or suggest it might be beneficial if gained elsewhere.

Cancellation policy

If a client cannot attend a prearranged appointment then the therapist needs to attempt to organise another appointment within the week to ensure continuity of care. If that is not possible then the therapist can organise an additional appointment to ensure that all ten sessions are completed. If more than two appointments over the trial period are cancelled and unable to be rescheduled within the week, therapists should contact the research team to discuss. The ten sessions should not extend beyond a 12 week period.

Client well-being and duty of care

If a client's safety and wellbeing requires additional care[2] beyond the conditions of the trial, therapists are to contact the research team as soon as possible. Therapists will not be asked to disseminate information beyond what is necessary for adhering to research ethics protocols.

[2] including hospitalisation, suicide prevention plans, emergency sessions etc.

6. Structure and format of treatment sessions

- 10 sessions
- 60 minutes each
- One session per week

Session	Overview
1	Outline of the therapeutic approach and housekeeping (e.g. confidentiality, contracting etc.) Psycho-education about trauma symptoms - Provided in a brief manner - Reassurance that the client's problems are not pathological - Therapists should highlight how these symptoms are interfering with the clients life and current functioning - Explain how therapy will help improve the clients coping and problem solving skills History taking – this will provide the client an opportunity to start talking about themselves and their current problems
2-8	Supportive therapy focusing on current problems Development of problem-solving techniques
9-10	Supportive therapy Relapse prevention Termination and review (session ten only)

SESSION 1

(90 mins)

Objectives

The main goal of this session is to provide a description and rationale for treatment, discuss confidentiality issues and to begin to establish rapport with the client.

Outline of session

1. Initial interview
2. Psycho-education
3. Confidentiality
4. Description of supportive therapy approach
5. Contracting
6. Assign home diary
7. Completion of measures

Handouts for Psychologist

G. Initial interview pro forma
H. Therapist WAI
I. Checklist for session 1

Handouts for Client

1. PTSD fact sheet
2. Home diary
3. Client WAI and CEQ

1. Initial interview

The initial interview has two purposes. Firstly, as the treating therapist was not involved in the screening and baseline data collection, it allows the therapist to gain a good understanding of the presenting problem and to gather important background information that will be useful throughout the duration of treatment. A summary of the client's baseline score for the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) and the Depression, Anxiety and Stress Scale (DASS-21) will also be provided to the therapist. Secondly, it is a great way to develop rapport with the client and begin building the therapeutic alliance.

Please see **handout A** for the initial interview pro forma.

2. Psycho-education

The education provided will be limited to a discussion of symptoms and therapists should avoid discussing the meaning of these symptoms. Therapists can explain that people who experience a trauma might also experience subsequent changes in behaviour, thoughts and emotions. Reassurance should be provided so the client does not continue to think they are "going crazy" or "losing their mind" but rather that the changes they are experiencing are an understandable human response to trauma. Provide client with **handout 1**.

Suggested dialogue might be something such as:

"It is normal to have some increased anxiety or apprehension when you are back in a situation that had led to trauma. It is also normal to have some fear and anxiety when confronted with situations in which there is a potential for harm or even threat of death. Although your initial reaction was normal and almost everyone would have some of those feelings and reactions, we believe the symptoms you are now experiencing are of sufficient severity and have continued for a sufficient period of time that they are causing problems in your daily life."

3. Confidentiality

It is also important to have an explicit discussion about confidentiality. This could be along the lines of the following:

I know you have read an information sheet and signed a consent form with the research team. I wanted to talk to you about what this means about the confidential nature of our sessions.

Firstly, psychologists are ethically obligated to disclose confidential information under a number of different circumstances. These are:
(a) with your consent;
(b) where there is a legal obligation to do so;

(c) if there is an immediate and specified risk of harm to an identifiable person or persons that can be averted only by disclosing information; or
(d) when consulting colleagues, or in the course of supervision or professional training.

This last point is particularly relevant. To ensure the integrity of the treatment procedures, I may need to discuss our therapy session during supervision to make sure I have not deviated from the study's protocol. Also, all of our sessions will be recorded. This is so the research team can randomly select one of our sessions to listen to make sure I am following the study protocol. This would have been explained to you by the research team.

4. Description of supportive therapy approach

In discussing the nature of the therapy highlight that everyone is unique and experiences life differently. Re-assure the client that therapy is a vehicle for the client to discover his or her path to healing or recovery from traumatic stress. Ensure the client understands that their path will be unique to them and therapy will be guided by their input.

Therapists might like to ask the client if they have any questions or concerns at this point.

5. Contracting

Nurturing the client's commitment to therapy can be achieved through contracting and making the responsibilities of the therapist and client explicit. Care must be taken to present the notion of the contract in a non-threatening manner so the client does not feel coerced or victimised. Emphasise to the client that improvement depends on he/she being active in therapy, taking on responsibility for active participation and engage in problem solving and doing their homework in between sessions.

6. Home diary

Outside of therapy, the client will be asked to record an event from each day in a diary which will be used as a discussion starter for each session. Clients are asked to record current problems as well as mood states and thoughts in **handout 2**.

"Self-monitoring helps us to keep track of your progress and will be used to tailor each session to your specific needs. Improvement will depend on you being active in therapy, taking on responsibility to work, practice and engage in problem solving and doing your assigned tasks in between sessions"

"Until the next session, I would like you to keep a diary. At the end of each day, pick a time and place where you have some privacy, and write down an event that happened during the day. It is important that you record any difficulties you experienced and what you did to cope with these."

"Starting today, I will ask you to monitor and record your activities and any problems or difficulties that you encounter in a daily diary. It is important that you bring this diary to each session because it will help us focus on the main concerns in your life right now. I will be helping

you to 1) clarify your feelings, 2) figure out useful coping strategies, and 3) problem solve, or help you explore solutions to these problems. Our goal is to help you return to your best level of functioning. How does this sound to you? Any questions?"

To solicit collaboration with the task, therapists can take a number of steps when *requesting* the task to ensure clients are committed and empowered.

1. Relate the diary to the treatment goals so the client understands the purpose of the task and how this can make a difference

2. Inform the client how their improvement requires active participation, taking on responsibility to work, practice and engage in problem-solving

3. Therapists can use examples shared by the client to re-assure the client that they have the skills and strengths to be able to undertake the task

4. Convey that the amount of benefit from therapy depends on the amount of effort the client puts in outside of therapy sessions. Inform the client how the diary task will help provide talking points in each session and the quality of problem-solving discussions will be reflected in the detail provided in writings

5. Be aware that the term "homework" can have negative connotations. Consider the use of terms such as: assignment, tasks, practice

6. Describe the task in simple terms, keeping it meaningful, easy to do and remember

7. Completion WAI and CEQ

At the end of the session, the therapist is to complete the therapist Working Alliance Inventory (WAI, **handout C**) and the client is to complete the client WAI and the Credibility/Expectancy Questionnaire (CEQ, **handout 3**). Please get the client to complete before they leave the session. These forms are to be returned to the research team at the completion of therapy.

PSYCHOLOGIST'S HANDOUTS

HANDOUT C

INITIAL INTERVIEW

(this is for the therapist to keep on file and does not need to be returned to the research team)

Date: _____

16.Demographic information:

Name:_____ **Age:** _____**years**

Sex: F □ M □ **Race/Ethnicity:** _____

Relationship Status:

☐ Single

☐ In a relationship

☐ De Facto

☐ Married

☐ Divorced/Separated

☐ Widowed/er

☐ Other _____

Highest level of Education attained:

☐ Year 10

☐ Year 12

☐ Trade/certificate _____

☐ Bachelor degree _____

☐ Postgraduate education _____

☐ Other _____

Current Employment Status:

☐ Employed for wages

☐ Out of work more than 1year

☐ Out of work for 1 year or less

☐ Homemaker

☐ Student

☐ Self-employed

☐ Unable to work

☐ Other, please describe: _____

17. Presenting problem and current symptoms: (biological, cognition, behaviour, mood/affect)

18. History of presenting problem: (onset/course, severity, stressors)

19. Family history: (illnesses, substance use, behaviours and intellectual disability, current family situation)

Genogram Key: include three generations Male □ Female ○ Unknown △ Married — Defacto - - - - Separated / Divorced // Adopted → Death X	

20. Developmental history: (problems in school; school performance; history of childhood mental illness; child abuse, traumas/and or losses during childhood)

21. Educational history: (highest level of education, other training e.g. vocational, apprenticeship)

22. Work history: (current employment, length of employment; previous employment, length of employment, reasons for leaving; periods of unemployment)

23. Relationship history: (Describe relationships with others, problems developing/maintaining friendships and/or intimate relationships; childhood relationships, adult relationships, current relationships, history of domestic violence, identified support persons)

24. Medical history: (current, overall health; chronic illness; serious medical illness or injury; hospitalised for medical problems; medications for medical problem; family history of heritable medical problems)

25. Psychiatric history: (previous diagnoses; previously attended with a mental health professional; history of self-harm/suicide attempts; previous psychiatric admission)

26. Psychiatric medication: (current and previous)

27. Substance use and gambling history: (cigarette, alcohol, prescription and illicit substance use)

28. Legal history: (past or current involvement with legal system, e.g. warrants, arrests, detentions, convictions, probation or parole; past or current involvement with the court system, e.g. criminal/civil/family)

29. Current social situation: (Social support/social relationships; social activity, daily living skills/work/leisure/education/financial situation/housing)

30. Other/notes:

HANDOUT D

CHECKLIST FOR SESSION 1

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

PLEASE TICK

_____ 1. Session audio taped; commence with date, client no, session no

_____ 2. Complete initial interview

_____ 3. Introduce psycho-education on PTSD

_____ 4. Provide client with PTSD fact sheet

_____ 5. Discuss confidentiality

_____ 6. Discuss treatment parameters and focus of intervention

_____ 7. Discuss contracting

_____ 8. Assign home diary

_____ 9. Therapist complete the WAI and return to research team

_____ 10. Client complete the WAI and CEQ and return to research team

HANDOUT C
WORKING ALLIANCE INVENTORY
Short Form (Therapist)
Return to Research Team

Therapist _____ Participant ID _____ Date _____

Measurement Point (circle one): 1st week Last Week

Instructions:
On the following page there are sentences that describe some of the different ways you might think or feel about your client.

As you read the sentences mentally insert the name of your client in place of _____in the text.

Below each statement there is a seven point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you *always* feel (or think) circle the number 7; if it never applies to you, circle the number 1. Use the numbers in between to describe the variations between these extremes.

Work quickly; your first impressions are the ones we would like to see.

PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.

Thank You!

1. _____ and I agree about the steps to be taken to improve his situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. My client and I both feel confident about the usefulness of our current activity in counselling.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. I believe _____ likes me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. I have doubts about what we are trying to accomplish in counselling.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. I am confident in my ability to help _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. We are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I appreciate _____ as a person.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8 We agree on what is important for _____ to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. _____ and I have built a mutual trust.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. _____ and I have different ideas on what his/her real problems are.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. We have established a good understanding between us of the kind of changes that would be good for _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. _____ believes the way we are working with his/her problem is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

CLIENT HANDOUT

HANDOUT 1

Post-Traumatic Stress Disorder

SANE Factsheet

What is Post-Traumatic Stress Disorder?

Post-Traumatic Stress Disorder (sometimes called PTSD) is a form of anxiety disorder. Some people develop this condition after they have experienced a traumatic event. This event might be a serious accident, physical or sexual assault, war or torture, or a natural disaster such as a bushfire or a flood. Strong reactions such as fear, horror, anger, sadness and hopelessness are natural after events like these, of course. In most cases, these feelings will pass after the normal working-through of emotions and talking things over in your own time with family, friends or colleagues.

When these feelings are intensely distressing and go on for more than four weeks, however, it is important to ask for help from a doctor or other health professional, as they may be symptoms of a more persistent condition such as PTSD. About 25% of people who are exposed to traumatic events develop PTSD. As well as being very upsetting, the symptoms interfere with the person's ability to carry on their everyday life, work and relationships. Treatment helps deal with the symptoms so that people are able to get on with their life again.

What are the symptoms?

Post-Traumatic Stress Disorder is identified by three main groups of symptoms:

- *Flashbacks of the traumatic event through intrusive memories or nightmares.*
  As well as strong emotions, there may be physical symptoms such as sweating, heart palpitations or panic attacks.
- *Feeling emotionally numb and avoiding situations that are reminders of the trauma.*
  Avoiding possible reminders of the trauma can cause someone to lose interest in day-to-day activities and become detached from friends and family. Some people experience 'dissociation' – a feeling of watching from a distance as events unfold.
- *Feeling anxious and 'jumpy' for no reason.*
  Heightened vigilance can mean the affected person is constantly on the lookout for danger, possibly leading to irritability and a lack of concentration.

Someone who has experienced a traumatic event may sometimes feel that they have 'got over' it, until they are confronted with a reminder that triggers symptoms again. Those affected may also develop other anxiety disorders (such as phobias or social anxiety), depression, or problems with alcohol and drug use. These conditions can be present at the same time as the PTSD, and require additional treatment.

What are the treatments?

Treatment usually involves psychological (talking) therapy with the person directly affected (and sometimes their family) by a qualified health professional such as a doctor or psychologist. The sooner someone is diagnosed and receives treatment, the more likely it is they will recover sooner. With help, a person can learn to manage their response in unavoidable situations that previously would have triggered a flashback. Medication can also be helpful for a time. With appropriate treatment and support people with PTSD are able to recover and get on with their lives.

What about friends and family?

Post-Traumatic Stress Disorder can have a big impact on relationships. When a person tries to block out painful memories it can appear that they are irritable or uninterested in others. Help for families and friends to look after themselves as well as the person directly affected is also important.

How do I find out more?

Ask your doctor about any concerns you have, or contact the SANE Helpline on 1800 18 SANE (7263) for information, advice and referral. SANE Australia also produces a range of easy to read publications and multimedia resources on mental illness. Visit the SANE Bookshop at www.sane.org for more information on these and other resources:

- *SANE Guide to Anxiety Disorders*
- *SANE DVD Kit on Anxiety Disorders (includes DVD and Guide)*
- *SANE Guide to Medication and other Treatments*

www.sane.org
Visit the SANE website for information about mental illness and related issues.

www.mindfulemployer.org
Workplace training solution available to all organisations Australia-wide.

saneaustralia
saneaustralia

HANDOUT 2

SUPPORTIVE THERAPY HOME DIARY

Participant **ID** _____

The following space is for you to record any problems you may have during the week. Please record what happened as well as how you felt. Also try to describe how you acted in response.

Week 1 .../.../... to .../.../...

Week 2 .../.../... to .../.../...

Week 3 .../.../... to .../.../...

Week 4 .../.../... to .../.../...

Week 5 .../.../... to .../.../...

Week 6 .../.../... to .../.../...

Week 7 .../.../... to .../.../...

Week 8 .../.../... to .../.../...

Week 9 .../.../... to .../.../...

HANDOUT 3

WORKING ALLIANCE INVENTORY
Short Form (Client)
Return to research team

Therapist _____ Participant ID _____ Date _____

Measurement Point (circle one): 1st week Last Week

Instructions:
On the following page there are sentences that describe some of the different ways you might think or feel about your psychologist.

As you read the sentences mentally insert the name of your counsellor in place of _____in the text.

Below each statement there is a seven point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you *always* feel (or think) circle the number 7; if it never applies to you, circle the number 1. Use the numbers in between to describe the variations between these extremes.

Work quickly; your first impressions are the ones we would like to see.

PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.

Thank You!

1. _____ and I agree about the things I will need to do in therapy to help improve my situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. What I am doing in therapy gives me new ways of looking at my problem.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. I believe _____ likes me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. _____ does not understand what I am trying to accomplish in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. I am confident in _____'s ability to help me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. _____ and I are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I feel that _____ appreciates me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8. We agree on what is important for me to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. _____ and I trust one another.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. _____ and I have different ideas on what my problems are.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. We have established a good understanding of the kind of changes that would be good for me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. I believe the way we are working with my problem is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

CREDIBILITY / EXPECTANCY QUESTIONNAIRE (CEQ)

Set I

1. At this point, how logical does the therapy offered to you seem?

1	2	3	4	5	6	7	8	9
not at all logical				somewhat logical				very logical

2. At this point, how successfully do you think this treatment will be in reducing your trauma symptoms?

1	2	3	4	5	6	7	8	9
not at all useful				somewhat useful				very useful

3. How confident would you be in recommending this treatment to a friend who experiences similar problems?

1	2	3	4	5	6	7	8	9
not at all confident				somewhat confident				very confident

4. By the end of the therapy period, how much improvement in your trauma symptoms do you think will occur?

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Set II

For this set, close your eyes for a few moments, and try to identify what you really feel about the therapy and its likely success. Then answer the following questions.

1. At this point, how much do you really feel that therapy will help you to reduce your trauma symptoms?

1	2	3	4	5	6	7	8	9
not at all				somewhat				very much

2. By the end of the therapy period, how much improvement in your trauma symptoms do you really feel will occur?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

SESSION 2-8

(60 mins)

Objectives

The goals of these sessions is to help the client better understand how their symptoms are related to current problems as well as develop the client's problem solving skills for managing such problems.

Outline of session

1. Review home diary
2. Supportive therapy
3. Reflection and home diary

Handouts for Psychologist

D. Checklist per session

1. Reviewing the home diary

When reviewing the diary it is important to discuss the coping strategies the client used to overcome their emotions/mood episode. This will help identify positive and maladaptive coping mechanisms. Clients may be unaware of the significance of completing the home diary and how client's self-monitoring and engagement in adaptive behaviours in-between sessions can affect their improvement. You may comment that the client should not expect immediate relief from the homework, that this takes time and practice which is aided by completing homework tasks.

If the client consistently does not use the home diary between sessions, therapists should reiterate the importance of the home diary as part of treatment and work with the client to determine the reasons for the client's reluctance/avoidance in using the diary.

2. Supportive therapy

Provide supportive therapy. Ask client to elaborate on events or emotions recorded in the previous week's diary. To build self-efficacy, identify where the client has succeeded in overcoming whatever issue(s) they are struggling with. It does not have to be a huge success, any positive step, no matter how small it is, therapists need to recognise and highlight this and encourage client to 'build' on that success. Maladaptive mechanisms however (e.g. using alcohol to cope with depression) should be discussed so the client can gain an understanding of how these strategies are detrimental to them and discuss better alternatives in such situations (e.g. exercise and social support).

If a client had a problem with anger

"As we have discussed, feelings of anger and difficulty controlling anger are very commonly associated with trauma. Possible explanations for this include the initial adaptiveness of reacting with anger, possible biochemical changes, the experiences of betrayal for many, and so on. So we can certainly understand where the anger comes from. The challenge for you is to work on this problem as it comes up in your current life, and try to sort out how much of the anger you are feeling comes from the old experiences, versus what seems to be causing the anger in the present. For example, when your son doesn't listen to you, you blow up. How much of this has to do with your trauma symptoms (for example feeling tense, wired and irritable from sleep deprivation) versus the present incident? Focusing on this question may help you gain some distance from your anger and the events triggering it".

Generating alternatives

"What do you think you can do about that situation? ...Is there anything you can do to change the situation? ...Have you ever tried to think of different things you could do? ...Like what? What might you do to cope with this problem?

3. Reflections / Home diary

The end of the session should involve a reflection on what has been achieved so far and clients are encouraged to continue daily monitoring of mood/emotions using their home diary. The client should be asked to write down their feelings as well as the strategies they used to cope with what happened.

PSYCHOLOGIST'S HANDOUTS

HANDOUT D

CHECKLIST FOR SESSION 2

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

PLEASE TICK

_____ 1. Session audio taped; commence with date, client no, session no

_____ 2. Review home diary

_____ 3. Provide supportive therapy

_____ 4. Reinforce home diary completion

_____ Client completed homework diary

Comments:

CHECKLIST FOR SESSION 3

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

PLEASE TICK

_____ 1. Session audio taped; commence with date, client no, session no

_____ 2. Review home diary

_____ 3. Provide supportive therapy

_____ 4. Reinforce home diary completion

_____ Client completed homework diary

Comments:

CHECKLIST FOR SESSION 4

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

PLEASE TICK

_____ 1. Session audio taped; commence with date, client no, session no

_____ 2. Review home diary

_____ 3. Provide supportive therapy

_____ 4. Reinforce home diary completion

_____ Client completed homework diary

Comments:

CHECKLIST FOR SESSION 5

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

PLEASE TICK

_____ 1. Session audio taped; commence with date, client no, session no

_____ 2. Review home diary

_____ 3. Provide supportive therapy

_____ 4. Reinforce home diary completion

_____ Client completed homework diary

Comments:

CHECKLIST FOR SESSION 6

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

PLEASE TICK

_____ 1. Session audio taped; commence with date, client no, session no

_____ 2. Review home diary

_____ 3. Provide supportive therapy

_____ 4. Reinforce home diary completion

_____ Client completed homework diary

Comments:

CHECKLIST FOR SESSION 7

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

PLEASE TICK

_____ 1. Session audio taped; commence with date, client no, session no

_____ 2. Review home diary

_____ 3. Provide supportive therapy

_____ 4. Reinforce home diary completion

_____ Client completed homework diary

Comments:

CHECKLIST FOR SESSION 8

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

PLEASE TICK

_____ 1. Session audio taped; commence with date, client no, session no

_____ 2. Review home diary

_____ 3. Provide supportive therapy

_____ 4. Reinforce home diary completion

_____ Client completed homework diary

Comments:

SESSION 9 & 10

(60 mins)

Objectives

The objectives of the final two sessions are to prepare the client for termination of therapy with relapse prevention plans and reflect on what the client has been achieved in therapy.

Outline of session

1. Review home diary
2. Supportive therapy
3. Relapse prevention
4. Assign home diary (*session nine only*)
5. Termination and review (*session ten only*)
6. Completion of measures

Handouts for Psychologist

E. Checklist per session
F. Therapist WAI

Handouts for Client

4. Client WAI and CEQ

1. Reviewing the home diary

See previous sessions.

2. Supportive therapy

See previous sessions.

3. Relapse prevention

Relapse prevention is a critical component of treatment because it is common for traumatised clients to experience setbacks in the months following therapy. Identifying potential problems and discussing coping strategies can assist the client's longer term adaptation to the trauma. This component is particularly important because many clients will have ongoing stressors, including legal proceedings, ongoing medical complaints, and social difficulties.

Steps for relapse prevention:

1. Identify high-risk issues or situations
2. Discuss these issues/situations with anticipatory guidance
3. Discuss acquired problem-solving skills in coping with negative mood states and interpersonal conflict
4. Encourage the client to identify relapse signs and discuss with anticipatory guidance, how they might use the coping mechanisms at their disposal to face the relapse

Please note that relapse prevention is not a structured activity as it would be in TF-CBT. No written plan is necessary just a general discussion about how the client may use the problem-solving skills they have developed in future situations.

"Can you envisage anything that might get in the way of your doing X? What would that be? ...Let's take a moment and consider how we can address each one. Being prepared and anticipating each one and having a 'game plan' can help"

"Can we generate a list together of solutions that you have tried and have not worked in your case? Then we can analyse the list together to see what we can learn from what you have tried. We can then list together what solutions, if any, worked on some occasions and why"

"What would you need to do in order to achieve this goal…in order to pull it off?"

4. Assign home diary (session nine only)

See previous sessions

5. Termination and review (session ten only)

In the last session, therapist should include a general review of skills learned and progress made over the ten sessions. Clients can be reassured of progress they have made so far and reassured of the potential gains they can continue to make. This conversation should be interactive and solicit the client's perceptions of their progress, and their sense of readiness to continue the work begun in therapy. Ask the patient what he or she has learned and whether they feel able to handle difficult situations better than prior to treatment. Therapist should encourage clients to continue using the problem-solving strategies that they have learnt.

"We've been working together for about 10 weeks. Today I'd like to review your progress in the program and discuss what you have learned. I'd also like to take a few minutes to say good-bye. We have spent these weeks working together to help you understand your reactions to the trauma and learn new ways to cope with current problems in your life. I'd like to know how you are feeling now, what you found helpful or not helpful during the therapy, what additional skills you need to learn, and your plans for the near future."

6. Complete WAI and CEQ

At the end of the session, the therapist is to complete the therapist Working Alliance Inventory (WAI, **handout E**) and the client is to complete the client WAI and the Credibility/Expectancy Questionnaire (CEQ, **handout 4**). Please get the client to complete before they leave the session. These forms are to be returned to the research team at the completion of therapy.

PSYCHOLOGIST'S HANDOUTS

HANDOUT E

CHECKLIST FOR SESSION 9

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

PLEASE TICK

_____ 1. Session audio taped; commence with date, client no, session no

_____ 2. Review home diary

_____ 3. Provide supportive therapy

_____ 4. Discuss relapse prevention

_____ 5. Reinforce home diary completion

_____ Client completed homework diary

Comments:

CHECKLIST FOR SESSION 10

THERAPIST _____

PARTICIPANT ID _____

RETURN TO RESEARCH TEAM

PLEASE TICK

_____ 1. Session audio taped; commence with date, client no, session no

_____ 2. Review home diary

_____ 3. Provide supportive therapy

_____ 4. Discuss relapse prevention

_____ 5. Termination and review

_____ Client completed homework diary

Comments:

HANDOUT F
WORKING ALLIANCE INVENTORY
Short Form (Therapist)
Return to Research Team

Therapist _____ Participant ID _____ Date _____

Measurement Point (circle one): 1st week Last Week

Instructions:
On the following page there are sentences that describe some of the different ways you might think or feel about your client.

As you read the sentences mentally insert the name of your client in place of _____in the text.

Below each statement there is a seven point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you *always* feel (or think) circle the number 7; if it never applies to you, circle the number 1. Use the numbers in between to describe the variations between these extremes.

Work quickly; your first impressions are the ones we would like to see.

PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.

Thank You!

1. _____ and I agreed about the steps to be taken to improve his/her situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. My client and I both felt confident about the usefulness of our current activity in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. I believe _____ liked me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. I had doubts about what we were trying to accomplish in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. I was confident in my ability to help _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. We worked towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I appreciated _____ as a person.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8 We agreed on what was important for _____ to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. _____ and I built a mutual trust.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. _____ and I had different ideas on what his/her real problems were.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. We established a good understanding between us of the kind of changes that were good for _____.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. _____ believed the way we worked with his/her problem were correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

HANDOUT 4

WORKING ALLIANCE INVENTORY
Short Form (Client)
Return to Research Team

Therapist _____ Participant ID _____ Date _____

Measurement Point (circle one): 1st week Last Week

Instructions:
On the following page there are sentences that describe some of the different ways you might think or feel about your psychologist.

As you read the sentences mentally insert the name of your counsellor in place of _____in the text.

Below each statement there is a seven point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you *always* feel (or think) circle the number 7; if it never applies to you, circle the number 1. Use the numbers in between to describe the variations between these extremes.

Work quickly; your first impressions are the ones we would like to see.

PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.

Thank You!

1. _____ and I agreed about the things I needed to do in therapy to help improve my situation.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

2. What I have done in therapy has given me new ways of looking at my problem.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

3. I believe _____ liked me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. _____ did not understand what I was trying to accomplish in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. I was confident in _____'s ability to help me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. _____ and I worked towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I felt that _____ appreciated me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8. We agreed on what was important for me to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. _____ and I trusted one another.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

10. _____ and I had different ideas on what my problems were.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

11. We established a good understanding of the kind of changes that were be good for me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. I believe the way we worked with my problem was correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

CREDIBILITY / EXPECTANCY QUESTIONNAIRE (CEQ)

Set I

1. At the completion of therapy, how logical did the therapy offered to you seem?

1	2	3	4	5	6	7	8	9
not at all logical				somewhat logical				very logical

2. At the completion of therapy, how successfully do you think this treatment has been in reducing your trauma symptoms?

1	2	3	4	5	6	7	8	9
not at all useful				somewhat useful				very useful

3. How confident would you be in recommending this treatment to a friend who experiences similar problems?

1	2	3	4	5	6	7	8	9
not at all confident				somewhat confident				very confident

4. At the completion of therapy, how much improvement in your trauma symptoms do you think has occurred?

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Set II

For this set, close your eyes for a few moments, and try to identify what you really feel about the therapy and its success. Then answer the following questions.

1. At the completion of therapy, how much do you really feel that therapy has helped you to reduce your trauma symptoms?

1	2	3	4	5	6	7	8	9
not at all				somewhat				very much

2. At the completion of therapy, how much improvement in your trauma symptoms do you really feel has occurred?

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

Physiotherapy Exercise Intervention

Physiotherapist Manual

INTRODUCTION

The majority of individuals who sustain a whiplash injury do not recover and are left with persistent pain and disability. Chronic WAD is a heterogeneous and complex condition involving physical impairments such as movement loss, disturbed movement patterns and sensory disturbances [1] as well as pain related psychological responses. In contrast to many common musculoskeletal pain conditions (eg low back pain, non-specific neck pain) whiplash related neck pain usually occurs following a traumatic event, namely a motor vehicle crash. Psychological responses related to the traumatic event itself, posttraumatic stress symptoms, are emerging as an important additional psychological factor in the whiplash condition. The early presence of posttraumatic stress symptoms have been shown to be associated with poor functional recovery from the injury [1,2]. Thus it would seem logical that interventions targeting both the physical and psychological manifestations of the whiplash condition would be of benefit.

We propose that by pre-treating the PTSD with psychological counselling, PTSD symptoms and pain related disability will decrease allowing the usual graded exercise approach to be more effective than has been seen to date [3,4].

1. Project Aim

The primary aim of this project is to investigate the effectiveness of combined trauma-focused CBT and physiotherapy exercise to decrease pain and disability of individuals with chronic whiplash and PTSD.

The secondary aims are to investigate the effectiveness of combined trauma-focused CBT and physiotherapy exercise to decrease posttraumatic stress symptoms, anxiety and depression, and to investigate the effectiveness of trauma-focused CBT alone on posttraumatic stress symptoms and pain/disability.

2. Research Plan

Design: The study will be a randomised controlled multi-centre trial.

Participants: A total of 120 people with chronic whiplash disorder (>3 months, <5 years duration) and PTSD (DSM-V diagnosed with CAPS) will be enrolled in the study across Southeast Queensland and Southern Denmark. The assessors measuring outcomes will be blinded to the assigned treatment group allocation.

Interventions:
The same 6 week physiotherapy exercise intervention will be delivered to all participants. Prior to attending these sessions (detailed below), participants will have either participated in:

(1) Trauma-focused Cognitive-behavioural therapy (CBT) (10 weeks) (Intervention Group); or
(2) Supported counselling (10 weeks) (Control Group).

Outcomes:

Outcomes will be measured 10 weeks (immediately post-psychological intervention), 16 weeks (immediately post-exercise), 6 and 12 months after randomization. The primary outcome is NDI. Secondary outcomes include:

1. Average pain intensity over last week (0-10 scale)
2. Average pain intensity over last 24 hours (0-10 scale)
3. Patient's global impression of recovery (-5 to +5 scale)
4. Clinician administered PTSD scale (CAPS)
5. The PTSD Checklist-5 (PCL-5)*
6. Depression Anxiety Stress Scale-21 (DASS-21)
7. Generic measure of health status (SF-12)
8. Patient-generated measure of disability (Patient-Specific Functional Scale)
9. Physical measures (Cervical range of movement, pressure pain threshold, cold pain threshold)
10. Pain Catastrophizing Scale (PCS)
11. Pain Self Efficacy Questionnaire (PSEQ)
12. Tampa Scale of Kinesiophobia (TSK)

** The Posttraumatic Stress Diagnostic scale (PDS) used in previous studies has been discontinued as it is yet to be updated by its authors to reflect DSM-5 criteria.*

General Procedures

1. **The trial centre** will contact your practice to arrange a suitable time for the patient's first appointment. You will be provided with a patient record proforma and a brief overview of the patient's history and summary of baseline measures taken at the trial centre.

2. **Patient record proforma** (Appendix 6). Please use this proforma to record:
   - dates of attendance
   - initial assessment
   - initial management and exercise program
   - details of progressive assessment and management in the 10 sessions
   - a record of patient compliance with the exercise program

3. **Keep a copy of the home exercise program** that is developed with the patient and its progressions at each management session.
   Please check patients are completing their diaries. We are using diary entries as a measure of compliance so this is important for the study.

4. What if a **patient reports an increase in symptoms**?
   Minor fluctuations in pain could be expected when the patient is embarking on an exercise program.
   - check performance and design of the exercise, modify if necessary
   - provide assurance
   - retain the emphasis on an active and graded approach

- If the subject's condition has markedly deteriorated, and there are ethical concerns with continuing the treatment, please contact the Adverse Effects Committee for the trial (Michele Sterling, Tonny Andersen). In Qld, concerns should be addressed to Michele via phone on (07) 55529771. In Denmark, contact Tonny on xxxxxx. Please do not contact other trial personnel for 'blinding' reasons.

5. **Cancellation Policy.** Each subject should receive 10 physiotherapy exercise sessions. A subject is able to cancel up to 2 sessions without penalty (ie, these 2 sessions may be made up within the 6 week period). If a subject cancels or fails to attend on more than 2 occasions, these sessions will not be made up. Each patient will receive a sheet outlining the procedure to be followed for cancellations.

   Please notify the trial centre if a patient has failed to attend on more than two occasions
   QLD Contact:
   Sarah Robins
   Tel: XXXXXXX
   Email: whiplashresearch@uq.edu.au

Background and Approach

This protocol provides an outline of our requirements of you as a trial physiotherapist as well as a comprehensive guide to assessment requirements and exercise prescription. The assessment required throughout the management period underpins the exercise prescription and progression. The physiotherapist can tailor the management program to the individual patient's presentation and functional goals. Nevertheless, the physiotherapist must prescribe exercises as per the overall aims of the exercise intervention (see below). Some patients may need to commence the exercises at a very low load level but others may commence at a higher load level. We are reliant on your skill as a physiotherapist to determine the initial level of exercise and progression based of your assessment. *Manual therapy techniques may also be provided at your discretion but no grade V (high velocity thrust/manipulation) techniques can be provided*. No additional modalities such as acupuncture, dry-needling, electrotherapy can be provided.

The physiotherapy intervention to be utilised in this study will be governed by aims and principals of the exercise without regimented specificity. The exact exercises prescribed will depend upon the individual assessment of the patient by the treating physiotherapist.

The physiotherapy sessions will be conducted over 6 weeks. There will be 2 sessions per week for the first 4 weeks and then one session per week in weeks 5 and 6 of the program. Thus there are a maximum of 10 sessions in total.

Aims of the Exercise Intervention.

1. Restore range of movement of the cervical spine, thoracic spine, upper quadrant as required.
    - Range of movement exercises in lying, sitting or standing
2. Improve control, strength and endurance of cervical flexors, extensors and shoulder girdle muscles
3. Exercises to improve kinaesthesia and balance
4. Advice/supervision of functional activities
    - These will depend upon the patients reported difficulty with specific functional tasks
5. Advice and guidance on general aerobic exercise
    - This will depend upon the patient's prior activity levels with the aim of restoring their activity levels to those prior to the accident
    - In patients who performed no general aerobic exercise prior to their injury, advice should be provided on a walking program or similar.

In addition, patients will be provided with education/advice that adheres with clinical guidelines for the management of acute WAD and as a physiotherapist would normally do.

Initial assessment to direct specific exercise prescription

Analysis of patient's provocative postures, functions or movements

(i) Directed by the patient interview, analyse the patient's main postures, functions or movements that are provocative of pain.
(ii) Analyse the reasons why these manoeuvres might be provocative in terms of postural attitudes, muscle or movement dysfunctions.
(iii) Attempt to alter postures or positions so that the task/position is less painful. This serves as a powerful treatment and educational directives.

Analysis of Posture: perform in sitting

Analysis of spinal posture

(i) Analyse the patient's habitual sitting posture (ie ideal is a neutral lumbo-pelvic (L/P), thoracic (T), cervical and shoulder girdle position; **observe for** too much flexion or too much extension in the L/P and T regions).
(ii) Check range and pain response and range of cervical rotation in each direction in their habitual posture (baseline).
(iii) Analyse their attempt to assume an ideal sitting posture.
(iv) Observe any poor pattern **eg** predominant use of thoraco-lumbar erector spinae with an inability to assume a neutral lumbo-pelvic position; over extension of thoracic region, alternately - too much flexion of thoracic region.
(v) Facilitate the correct L/P postural position and thoracic region if necessary.
(vi) Assess effect of change in posture on: cervical range of movement and pain response (Treatment and education directives).
(vii) Can the patient replicate an ideal sitting posture once taught and if not what is the reason - kinaesthetic ability, poor active control, loss of passive mobility (Treatment directives).

Analysis of scapular posture

(i) Observe and analyse any positional fault of the scapulae in habitual posture.
(ii) Repeat baseline cervical ROM test in each direction.
(iii) Facilitate correct sitting posture and then manually position the scapula in a neutral posture on thorax (do separately and choose most deviated scapula first; analyse components of correction).
(iv) Check cervical rotation ROM and pain response (treatment and education directives).

Scapular muscle assessment (initial)

Analysis of scapulae under light load

(i) Gently resist each of arm, flexion, abduction and external rotation.
(ii) Reveals where specific weaknesses lie.

Analysis of scapular control during arm flexion and abduction

(i) Assess control during concentric and eccentric phases as per an examination of the glenohumeral joint.

Scapular holding test in prone

(i) Modified grade 3 test of the lower trapezius (arm rests by side to eliminate arm load).
(ii) Perform after manual examination of the cervical spine – obtain baseline VAS of most symptomatic segment.
(iii) Passively place scapula in a neutral position on the chest wall and require the patient to hold the position.

(iv) **Outcome** - a) balanced use of scapular synergists or predominant use of one muscle group eg lat dorsi;
- b) observe for fatigue tremor or movement of scapula indicting a loss of holding capacity.

(v) Re-assess manual examination and determine change in quality of joint feel and VAS score (Treatment and education directives).

Cranio-cervical flexion test (CCFT)

Test of pattern of cranio-cervical flexion

- Test for neural tissue mechanosensitivity: supine lying, assess passive CCF range and resistance and retest in sensitising positions of SLR and BPTT.
  (**NB**, the presence of NT mechanosensitivity will modify how CCF is trained).
  Also gauge ROM of CCF.
- Prepare patient, supine, crook lying, ensure cranio-cervical and cervical regions are in a neutral position (support with a folded towel if necessary).
- Teach the CCF action. Use instructions of 'feel the back of your head slide up the bed as you nod your chin'.

(i) **Analyse**: pattern of movement
- Does patient perform sagittal rotation (correct) or a rotation/retraction action/retraction action (incorrect) Note retraction is seen when there is a direct descent of the head, or when they are using almost the same range of CCF to attain each target pressure.
- Is there unwarranted activity in the sternocleidomastoid (SCM), anterior scalene (AS) muscles.
- Is there over-activity of hyoids? – retest with mandible in relaxed position
- Is there breath holding? ensure the patient nods with exhalation

CCF low level endurance or holding capacity

Stage 2 of the test is only performed when the patient has a correct CCF pattern. Often this stage of the test has to be performed on the second treatment as first aim in rehabilitation is to train the patient to achieve the correct movement pattern.

(i) Set up patient as above.

(ii) Ensure movement correct pattern is used at all times.

(iii) The patient nods their head whilst palpating their superficial neck muscle activity. They are requested to keep this to a minimum and hold the CCF position for 10 seconds.

Assessment of craniocervical and cervical extensors

The test exercise is performed either prone on elbows or in four point kneeling. This is not a test with absolute outcomes, but more a pre-exercise assessment/instruction, that will lead into an exercise protocol. In the test position, all extensor muscles will work to hold the head against gravity. However we know from research that the suboccipital muscles and the deep cervical muscles (multifidus and semispinalis cervicus) atrophy or may have fatty infiltrate. Therefore the movement strategies are designed to be biased towards those muscles.

(i) ***Sub-occipital muscles:*** Focus on a neutral neck position
- require the patient to perform cranio-cervical extension (chin, chin down).
- require the patient to perform cranio-cervical rotation (the saying 'no' action).
Assess quality of movement and for smooth co-ordination.

(ii) ***Deep cervical extensors:*** the cranio-cervical region remains in neutral and the axis of motion is now at C7.
- instruct the patient to curl their neck first into flexion and then to curl their neck back to extension. The patient will often require manual facilitation to achieve the correct action.
To assist in maintaining the cranio-cervical neutral position, let the patient imagine they have a book between their hands and they must keep their eyes on the book as they lift their head. Check that muscles such as splenius capitis are not overactive.
    - **Outcome:** many patients cannot extended much beyond neutral to begin with (not a pain protection response). Others will fatigue quite quickly.

Progressive assessment

Scapular function

(i) Assess control of serratus anterior in prone on elbows or 4 point kneeling.

(ii) Assess scapular control in functional tasks pertinent to the patient's work activities. Observe or palpate pattern of use, their maybe underactivity of the trapezius on the dominant side, or there can be overactivity. Observe control of scapular position during the task. Can take task to fatigue.

Pattern of cervical flexor eccentric-concentric control (should have fair to good control of CCF when tested in supine)

(i) examine pattern in available range of cervical extension in sitting.

(ii) examine holding ability in progressively increasing ranges of cervical extension (obtain baseline for progression of endurance exercises).

Cervical somatosensory function

The three elements tested are:

- cervical reposition sense, cervical movement sense
- eye movement control
- balance

Cervical reposition sense

Use prepared target and a laser light.

Position patient in sitting, one meter from target. Attach target to wall once the patient is in the relaxed sitting and 'neutral' position.

Test with eyes closed or use eye mask.

(i) Test relocation from each of rotation (L), (R) and extension.

(ii) The patient should repeat the movement 3-5 times. Between repetition, patient keeps their eyes closed, the therapist repositions the head to neutral between each repetition.

(iii) **Outcome**: mark the average reposition error on target >4.5 mm is abnormal.

Cervical movement sense

Use prepared target and a laser light. Position patient in sitting, one meter from target.

(i) Require patient to trace the laser light within the boundaries of the target. Require to go from left to right and from right to left.

(ii) **Outcome:** abnormal if 4-5mm outside central line. Also assess whether the patient can perform with a reasonable speed.

Eye movement control

Gaze Stability- (Eyes still - head moves)

(i) Fixate Gaze - Rotation of head
- Vertical movement of head

(ii) **Outcome**: - Difficulty maintaining focus
- Symptoms reproduction
- Marked decrease in ROM

Smooth pursuit neck torsion test (Head still eyes move)

Sit patient on a swivel chair.

(i) Patient focuses on target (eg a pen) and therapist moves the target through visual angle of 40 degrees crossing the midline left to right at a speed of 20 degrees per second.

(ii) Perform at least 5 times to make a judgment. Observe for saccades, especially observed around the mid line (not like nystagmus which is observed at the periphery). Make baseline judgment.

(iii) Keep patient's head still and rotate trunk to the left approximately 45 degrees. Repeat test of eye follow.

(iv) Keep patient's head still and rotate trunk to the right approximately 45 degrees. Repeat test of eye follow.

(iii) **Outcome**: There is a difference in saccadic movement between the trunk neutral and trunk torsioned positions.

Eye head co-ordination

(i) Eyes move first to 30 degrees and then head to 30 degrees keeping focused- return to neutral.

(ii) Perform to both sides, repeat 3 or 4 times.

(iii) Outcome: - Difficulty controlling co-ordination.
- Ability to move head and eyes independently.
- Symptom reproduction.

Saccadic Movements

Head is kept still

(i) Patient's fix gaze on and follow a target (eg a pen) that the therapist moves quickly and then holds still.

(ii) The target is moved in several different directions – pure planes, diagonals.

(iii) **Outcome:** - Difficulty controlling the task.
- Inability to move eyes independently of head.
- Symptoms reproduction.

Balance

Test balance to determine the level the patient is capable of performing

(i) Foot position
Comfortable
Narrow
Tandem
Single leg

(ii) Eyes open vs closed (shown that conditions with eyes closed have more discrimination for WAD)

(iii) Surface- **firm**; progressing to **soft**, progressing to **unstable**

(iv) **Outcome:**

Ability to maintain the stance position for 30 secs
Check for increased sway, rigidity, dizziness

Reference text

Jull G, Sterling M, Falla D, Treleaven J, O'Leary S (2008) Whiplash, Headache and Neck Pain: research based directions for physical therapies. Churchill Livingstone, Edinburgh, Elsevier UK

This text can be used to obtain more details of the assessment procedures and the management strategies described in the following two appendices.

Guide to the Exercise Program

Introductory notes

The following is a **guide only.** The program must be individualised to the particular patient you are treating.

- The assessment will provide baselines at which the patient can commence the various exercise protocols.
- The rate at which exercises can be introduced will depend on the patient's pain and disability level.
- The **home exercise program** will replicate that performed in the treatment session. The patients can be provided with some equipment to practice with at home (eg laser light).
- Patients are required to practice exercises twice per day (once in the morning and once in the evening).

Technical notes

Facilitation of posture

Pointers

- Some patients have extremely poor kinaesthetic awareness and struggle initially to learn the neutral lumbo-pelvic position. If this is so, delay any teaching of scapular posture to the next session to give them the opportunity to master the first phase.
  Trying too much too soon will lead to loss of one position.
- Ensure that you teach simple self-facilitation strategies. For example:
  Use their own thumb as a proprioceptive cue to regain a neutral L/P position;
  Try simple strategies to improve scapular position – the 5% stretch of the diagonal rubber band on their chest for a downwardly rotated, anteriorly tilted and protracted scapular, the 5% stretch of a rubber band placed horizontally across their upper chest for protracted scapulae.
- Add in correction of head position as a third stage of posture correct. Teach as a gentle manoeuvre to lengthen the back of the neck. This has been shown to strongly facilitate the longus colli.

Facilitation and re-education of the craniocervical flexion action

- Teach the action of head slide, this is the easiest form of feedback for the patient to learn the correct action.
- Utilise eye movement in facilitation.
- Use a spot on the ceiling to ensure patients can return to a neutral posture.
- Encourage relaxed breathing during the action.
- Instruct in the neutral mandibular position if there is a tendency to jaw clench or to substitute with the hyoids.
- Teach patient to self-palpate superficial muscles. They must understand what a contracted and relaxed muscle feels like.

CCF training in the presence of nerve tissue mechanosensitivity

- If patients report increased pain with CCF training, this may be due to nerve tissue mechanosensitivity. Always assess before commencing exercises.
- In these cases, train in supine initially from extension to neutral. The patient can use eye movement facilitation and also use their thumb to provide gentle resistance and an isometric hold. As tolerated, increase the times and repetitions of the holds in the neutral position, so that they too are doing 10x10sec holds.
- If possible, progress into some CCF range, if not possible in the 4 week time frame, stay with the isometrics.
- Determine if there are other ways you can treat the nerve tissue sensitivity, eg sliding exercises.

Training the cervical extensors

- The CCE and C1-2 rotation are familiar movements and usually present no challenge to train. Ensure a good trunk and scapular position.
- The CE is an unfamiliar movement and may require manual guidance when first training. The strategy of ‘keep reading a book’ while curling the neck into extension usually keeps their CC region in neutral.
- Beware that patients will substitute an unwanted retraction action.

- Keep watching the superficial extensors, these should not predominate with the cervical extension exercise.
- Ensure that the physio can perform the correct action in standing, as demonstration is an effective teaching tool.

Training the interaction of the deep and superficial flexors

- (i) This first part of training is re-teaching the action of cervical extension and return from extension in the sitting position. To ensure appropriate balanced work between the muscle groups, the action focuses on initiating neck extension with the chin, ensuring the head is gradually taken posterior to the shoulders and the return is led by cranio-cervical flexion.

- (ii) The training is progressed to holding the extension position with an emphasis on control of the CCF position. These exercises are performed in predetermined positions of extension as tolerated by the patient and the head is just lifted off a wall or the therapist's/patient's hand.

- (iii) The training is further progressed to head lifts from a resting position on two pillows with all concentration on maintaining the CCF position and not allowing it to move into extension, which signals that the superficial flexors have taken over all work.

Task specific training

The low level endurance of the scapular stabilizers is often poor, and they need to be trained out of function (side lying), in function (re-education of postural position), under light load (arm movements without and with light weights) and importantly scapular posture and control must be trained in the tasks in which the patient reports pain. This is after sitting and computer work, though it can be any function. It is necessary to train the patient in their nominated adverse work condition so that they can perform it painlessly.

Training somatosensory function

- Base selection of exercises on findings of physical examination and relate exercises to level of dysfunction.
- if JPE, balance, oculomotor function are all impaired there is a need to address each individual impairment.
- Exercise 2-3 times per day, there is a need to take exercises to a point where they might provoke dizziness but they should never exacerbate neck pain or headache.
- In progression consider combinations of eye and balance exercises.

Kinaesthetic sense

- repositioning to neutral with laser feedback (add to home program).
- repositioning to points in range with laser feedback.
- Movement position sense: follow patterns with laser, progress complexity of patterns.
- DNF retraining eyes open-closed.

Eye movement control:

Gaze stability

- Perform with neck rotation, flexion and extension.
- Progressions: Body position, Supine, sitting, standing, walking
  Speed
  Focus point; pen, spot, complex background
  Imaginary - perform with eyes closed - open to check accuracy

Eye follow

- Directions: rotation, flexion/extension/diagonals; Neck torsion
    - Progress Positions – lying, sitting, standing (increase difficulty of stance position)
    - Progress speed

Saccades

- Directions: rotation, flexion/extension/diagonals

Balance

Progressions

- Hard surface to foam to unstable
- Vision to no vision
- Wide to narrow base of support
- Two legs to one leg
- Functional- stairs, stepping

-

Exercise Progression

(i) Cervical flexor strength and endurance assessment

Determine the head flexion load that the patient can perform 12 times.

Protocol

- Patient supine in crook lying position with the head on two pillows.
- Hands resting on their abdomen.
- In performing head and neck flexion, the subject should be instructed to flex the cranio-cervical region to a comfortable range and maintain the chin position while they lift their head attempting 12 repetitions.
    - *Loss of cranio-cervical position is failure in the test.*
    - If the patient cannot perform 12 head lifts on two pillows, position them in reclined lying position, such that they can achieve 12 repetitions.
    - If the patient can achieve 12 repetitions on 2 pillows, progress test to one pillow and then to no pillow (do tests of other muscles in between repeated tests to gain baseline for cervical flexor exercise)

(ii) Cervical extensor strength and endurance assessment

Determine the head extension load that the patient can perform 12 times.

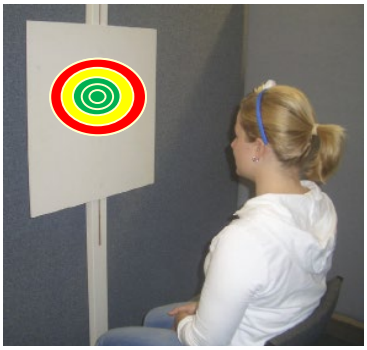
Protocol

- Subject lies prone on the therapy table with their head and cervical spine unsupported. Arms are by the participant's side with their hands by their hips.
- Test range is from 20º flexion to maximum achievable extension. Cranio-cervical region is maintained in a neutral position and the action is a curl into flexion and a curl into extension. The position of the cranio-cervical region can be maintained in neutral by instructing the patient to keep their eyes focussed on an imaginary book on the floor.
- Perform test with no added load in the first instance.
- For added load suspend weights on a helmet and progress in increments of 0.5Kg to determine baseline.

(iii) Higher level sensorimotor exercises

Progress to higher level of exercise eg increased complexity of task, combinations.

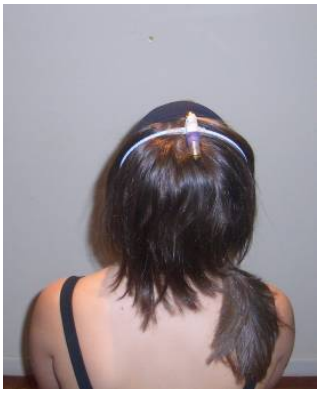
Sensori motor exercises
1. Head repositioning to neutralexercise: Rotation



Place the headband with laser attached on your head. Place the target pattern on the wall one metre away in line with the laser. Sit and focus on the bullseye point on the wall straight in front of you. Close your eyes and rotate your head as far as you can to the *left/right.* Try and return to the starting position as accurately as you can, open your eyes to see how accurate you have been.

Repeat ____ times up to 5

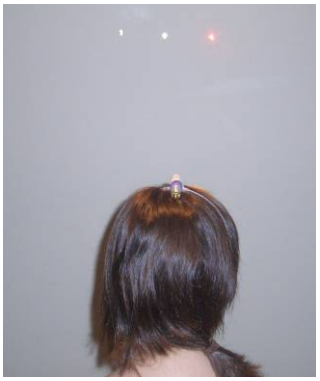
2. Head repositioning to neutral Exercise: flexion and extension



Sit and focus on the bullseye point on the wall straight in front of you. Close your eyes and take you head as far as you can *forwards /backwards*. Try and return to the starting position as accurately as you can, open your eyes to see how accurate you have been.

Repeat ____ times up to 5

3. HEAD REPOSITIONING TO POINTS IN RANGE EXERCISE: ROTATION

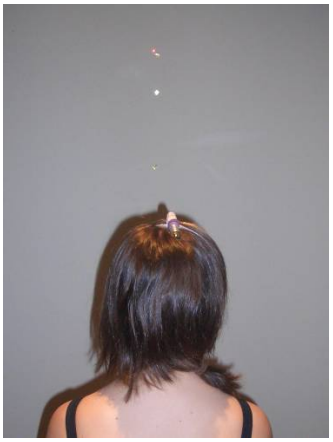


Place dots 20 centimetres apart across the wall. Place the headband with laser attached on your head. Sit, close your eyes and rotate your head to find each dot as accurately as you can, open your eyes to see how accurate you have been.

Repeat ____ times up to 5

4. Head repositioning to points in range: <u>flexion and extension</u>

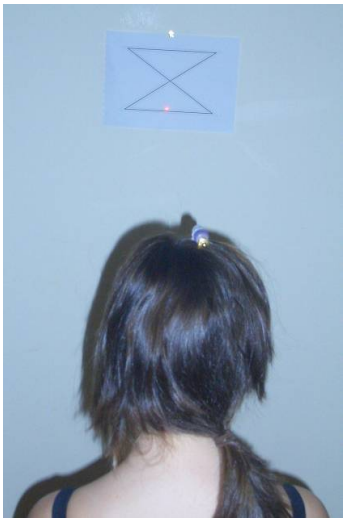
Place dots 20 centimetres apart vertically on a wall. Place the headband with laser attached on your head. Sit, close your eyes and move your head *forward or backwards* to find each dot as accurately as you can, open your eyes to see how accurate you have been.



Repeat ____ times up to 5

5. HEAD TRACKING ACTIVITY

Sit and place the headband with laser attached on your head. Place the figure of eight pattern on the wall in line with the laser. With your eyes open, move your head to trace the pattern with the light. Try to be as accurate as possible.



Repeat ____ times up to 5

You can make these more difficult by

- Increasing the speed of movements
- Performing the activities while sitting on an unstable surface such as a therapy ball
- Performing the activities while standing with feet in an unstable base of support e.g. heel toe

6. GAZE FIXATION WITH HEAD MOVEMENT

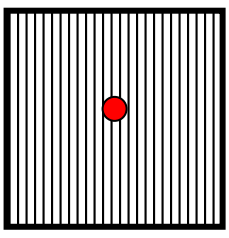
Sit on a chair and fixate your gaze on a dot straight in front of you. Keep the target in focus, while you move your head to the *left, right, back and forwards*.

Repeat each movement ____ times, twice a day

You can make this more difficult by

- Increasing the speed and range of movements
- Adding a busy pattern (e.g. stripes or checks) to the background of the visual target or making the target a word/business card to keep in focus rather than just a spot.
- Performing the activities while sitting on an unstable surface such as a therapy ball

Performing the activities while standing with feet in an unstable base of support e.g. heel toe, or while walking.



7. EYE/HEAD CO-ORDINATION

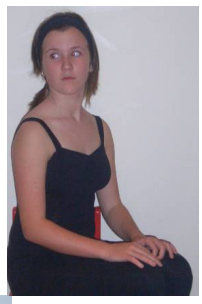
Sit and rotate the eyes and head to the same side, left and right.

Sit and move your eyes first to 30 degrees to the left or right keeping your head still, keep focused and then move your head to that point. Bring eyes back to centre (head still) and then move head back.

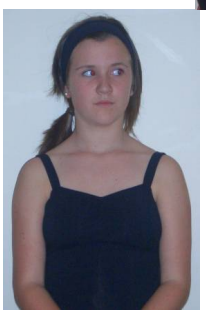
Sit and rotate your eyes and head to the opposite side, left and right. ***Repeat each exercise 5 times, twice a day.***

Move hand, arm, head and trunk following with the eyes

8. EYE FOLLOW WITH THE HEAD STILL



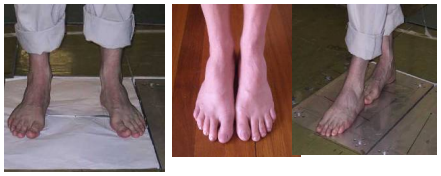
Keep your head still and follow a moving target with your eyes, side to side and up and down. Keep your head still and then rotate your trunk to the left/ right. Keep the head still and repeat following the moving target with the eyes, side to side/ up and down



Repeat each exercise 5 times, twice a day.

To make a moving target, you can shine a laser light onto the wall in front of you and move the laser with your hand.

9. BALANCE



Standing with your feet in *comfortable, narrow, tandem, single leg stance*

Maintain your balance for 30 seconds with your eyes open/closed

firm/ soft surface

You can progress the exercises by

- Changing your foot position
- Eyes closed
- Soft surface
- Walking with head movements (rotation, flexion and extension) while maintaining direction and speed of walking
- Performing your eye and head exercises whilst balance training
-