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Cognitive Processing Therapy: Training for College Counseling Centers Treating Victims of Sexual Assault

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Cognitive Processing Therapy: Training for College Counseling Centers Treating Victims of Sexual Assault

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By

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Abstract

Sexual assault has been known to lead to subsequent post-traumatic stress disorder (PTSD) in many of its victims, which can be extremely debilitating. One of the populations that is most at risk for experiencing sexual assault is college students. Cognitive processing therapy (CPT) is a known treatment for PTSD and has been shown to be efficacious in its outcomes; however little research has been done on how those outcomes stand the test of time. Due its flexible nature CPT can be delivered via group or individual therapy and the number of sessions can be modified, which makes CPT not only an efficacious treatment for PTSD by also extremely efficient. A review of the literature reveals a gap known efficacy of this treatment and the usage of this treatment in college counseling centers. Because of this gap, I have developed a training for college counseling centers to educate them on why and how to use this treatment in their settings.

Keywords : sexual assault, post-traumatic stress disorder (PTSD), cognitive processing therapy (CPT), outcomes, college

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Introduction

The purpose of this review of the literature is to explore the long-term outcomes of utilizing cognitive processing therapy for the treatment of posttraumatic stress disorder as a result of sexual assault in adult females. As clinicians it is important to determine not only what methods are effective in treating a certain diagnosis, but we must also look to whether or not the efficacy continues past the time of treatment. As reported by the National Intimate Partner and Sexual Violence Survey (NISVS) in 2015, 43.6% of women experience sexual assault in their lifetime. Because of the prevalence of sexual assault in the female population, we must look for how we can most effectively treat the aftermath experienced by victims.

Throughout this research it is determined that cognitive processing therapy is strongly recommended for treating post-traumatic stress disorder and its results are maintained post - treatment (American Psychologist, 2019). The longevity of treatment results is evidenced through studies that determine whether or not those with a PTSD diagnosis pre-treatment who no longer qualify for PTSD post-treatment continue to not qualify for the diagnosis 5-10 years after treatment has been completed (Iverson et al., 2015; Resick et al., 2012).

Through analyzing articles that speak to cognitive processing therapy and its outcomes, it is determined that there is a gap in utilizing this treatment in college counseling centers (Wilkinson-Truong et al., 2020). College students have a particularly high risk of being victims of sexual assault (Conley et al., 2017; Mellins et al., 2017). This high rate of victimization is based on multiple factors including the amount of alcohol and drug use, the hook-up culture associated with college students, and participation in sorority and fraternity organizations (Mellins et al., 2017). Statistics show that on average 20-25% of college students report being victims of sexual assault (Conley et al., 2017). College counseling centers are therefore likely to

encounter a number of victims of sexual assault. But while research has shown that cognitive processing therapy is one of the most efficacious treatments, it was reported that only 1.8% of college counseling centers are utilizing this method when treating victims of sexual assault (Wilkinson-Truong et al., 2020).

Training college counseling center therapists in cognitive processing therapy would be the first step in utilizing this methodology in that setting. The lack of training is not the only roadblock to using cognitive processing therapy as working with the college student population is also limited by the college calendar. Most victims, like other students, live on campus for the semester thereby limiting the time that the campus counselors work with them. The best way to combat this issue would be to use a modified version of cognitive processing therapy, which has been shown to maintain efficacy while reducing the number of treatment sessions and can be done on an individual basis or implemented in a group setting. In order to fill this gap, I have developed a training that includes modifying the number of sessions to allow for the time constrictions that many college counseling centers face.

Cognitive Processing Therapy's Efficacy in Reducing PTSD Symptoms for Long Term Outcomes in Female Sexual Assault Survivors

Sexual assault has long been associated with high levels of post-traumatic stress disorder (PTSD). It is estimated that 35-55% of sexual assault victims meet the criteria for clinical diagnosis 3-4 months from the event (Nixon et al., 2017). PTSD has a negative impact on those with the diagnosis, as it affects nearly every aspect of their lives (Friedman, 2013). However, there are treatments for PTSD following sexual assault with proven efficacy. Cognitive Processing Therapy (CPT) is one of the few treatment modalities that that has earned the American Psychological Association's strongest recommendation for treating (American Psychologist, 2019). Through this review of the literature, it becomes clear that using CPT to treat survivors of sexual assault is extremely beneficial.

Prevalence of Sexual Assault

According to the National Intimate Partner and Sexual Violence Survey (NISVS) in 2015, 43.6% of women reported having sexual contact violence in their lifetime. This population includes 21.3% of women reporting that violence as rape or attempted rape. Sexual assault can include unwanted sexualized touching, attempted penetrative assault, and completed penetrative assault (Mellins et al., 2017). It is estimated that 35-55% of victims of sexual assault meet the criteria for a PTSD diagnosis 3-4 months after the assault (Nixon et al., 2017).

Conley et al. (2017) cites that 20-25% of females are the victim of rape while enrolled in college while Mellins et al. (2017) notes a rate of 28% for women reporting sexual assault, however, they state that the vast majority of these sexual assaults/rapes go unreported. Many factors contribute to the increased prevalence of sexual assault on college campuses including alcohol and drug use and higher rates of casual sexual encounters versus monogamous

relationships (Mellins et al., 2017). Another factor that has been associated with an increased risk of sexual assault in college is membership in a sorority or fraternity (Mellins et al., 2017). Research also has noted that women in college face the highest risk of sexual assault during their freshman year and that women who identify as any sexual orientation other than heterosexual also have a higher incidence of sexual assault (Mellins et al., 2017).

Potter and Laflamme (2011) estimate that the percentage of sexual assaults reported to police range from 3-26%. The findings on the rate of sexual assault have resulted in college campuses implementing prevention programs as among the college-aged population there are negative academic consequences in addition to the impacts on physical and mental health (Wilkinson-Truong et al., 2020). However, it appears that more must be done including adding bystander interventions as well as addressing how colleges handle cases of sexual assault and their aftermath (Mellins et al., 2017).

Post-Traumatic Stress Disorder (PTSD)

PTSD is included in the Trauma and Stress-Related Disorders section of the DSM-5 (Friedman, 2013). The symptoms of PTSD are included under the categories of intrusion, avoidance, negative alterations in cognition and mood and alterations in arousal and reactivity (Friedman, 2013). These symptoms must have an onset or increase following the traumatic exposure (Friedman, 2013). In other words, one of the defining characteristics for PTSD diagnosis is exposure, either directly or indirectly, to a traumatic event which precedes the symptomatology (Friedman, 2013). Additionally, symptoms must exist for a minimum of one month and cause significant negative impact on the individual's life whether social, intrapersonal or work (Friedman, 2013). Unhealthy cognitions including self-blame and negative views of the

world contribute to these negative impacts and add to the maintenance of PTSD symptoms (Schumm et al., 2015).

PTSD is estimated to affect 6.8%-9.2% of the population (Monson et al., 2012). However, Betts et al. (2013) report that females have a higher risk of developing PTSD than males. Analysis of their study shows that females who experienced trauma were three times more likely to develop PTSD than their male counterparts (Betts et al., 2013). One factor that may contribute to this risk imbalance is the reaction a female receives when she discloses her assault to another person. Negative reactions from others upon disclosure can often lead to unhealthy coping strategies or inability to cope, which increases the likelihood of developing PTSD (Ullman & Peter-Hagene, 2014). A negative reaction may include victim blaming and trying to force the victim to report the sexual assault to authorities and have been attributed to survivors of sexual assaults feeling in control of their recovery (Ullman & Peter-Hagene, 2014).

Cognitive Processing Therapy

Cognitive Processing Therapy is a manualized treatment that is traditionally comprised of 12 sessions and can take place in either individual or group sessions (Wilkinson-Truong, 2020). Treatment begins with the client composing a written account of their traumatic event called an impact statement in which they identify why they believe the trauma happened (Wilkinson-Trong et al., 2020). If there are multiple traumatic events the client chooses the one that causes them the most distress (Wilkinson-Trong et al., 2020). The client is asked to identify in this impact statement how the event has affected their beliefs about themselves, other people, and the world (Iverson et al., 2015). Through this exercise the therapist is able to identify stuck points, which are unhelpful thoughts or feelings about the event that fall into the areas of accommodation, assimilation, or overaccommodation (Price et al., 2014). It is important to

identify these stuck points as the unhelpful beliefs actually maintains and exacerbates the symptoms of PTSD (Iverson et al., 2015). These stuck points are then challenged by the therapist through psychoeducation and Socratic questioning to help clients find more helpful beliefs (Wilkinson-Truong, 2020). At the end of treatment clients write a final impact statement using the new, more helpful thoughts and feelings acquired through the process (Wilkinson-Truong, 2020).

According to American Psychologist (2019), the American Psychological Association's recommended treatments for PTSD include cognitive behavioral therapy, cognitive processing therapy, cognitive therapy, and prolonged exposure therapy. To determine which treatments is appropriate it is recommended that clinicians review the empirical evidence, assessing the benefits and outcomes, as well as considering the client's preferences regarding treatment (American Psychologist, 2019).

It is important to note that the clinician's training in the methodology as well as their fidelity to it should be considered important factors in the overall efficacy (American Psychologist, 2019). However, a study by Monson et al. (2018) challenged this belief. The study examined outcomes of clinicians newly-trained in cognitive behavior therapy who had undergone a workshop presented by Patricia Resick, the primary author of cognitive processing therapy (Monson et al., 2018). The therapists were placed into one of two groups: those receiving consultation and feedback and those with no consultation (Monson et al., 2018). Those receiving consultation were evaluated based on their fidelity to CPT (Monson et al., 2018). Fidelity and skill were measured based on different Likert scales and were evaluated by two raters and had good interrater reliability (Monson et al., 2018). Patient outcomes were evaluated based on their completion of the Posttraumatic Stress Disorder Checklist (PCL-IV) pre-treatment

as well as at the beginning of each session (Monson et al., 2018). The Outcomes Questionnaire-45 (OQ-45) was also used prior to treatment, mid-treatment, and post-treatment (Monson et al., 2018). Based on the information derived from the PCL-IV and OQ-45, it was determined that patients had a clinically significant improvement in their PTSD symptoms regardless of the group in which they were placed (Monson et al., 2018). This result shows that therapists who are trained in CPT have the potential for successful patient outcomes even if they stray from fidelity to the treatment or lack consultation from highly skilled CPT therapists (Monson et al., 2018).

The Use of CPT on College Campuses

As mentioned previously, one of the populations at an increased risk of sexual assault and subsequent PTSD diagnosis is college students. However, it has been reported that although empirical research has shown cognitive processing therapy (CPT) or prolonged exposure (PE) to be efficacious in treating PTSD, university counseling centers are using those treatments at the extremely low rate of 5.5% for PE and 1.8% for CPT (Wilkinson-Truong et al., 2020). It is noted that university counseling centers face additional issues such as the number of clients that they are serving, the time constraints of the semester, funding, and issues with administration. What makes CPT an ideal treatment for this setting, however, is that it can be used both individually or in group therapy (Wilkinson-Truong et al., 2020). CPT also has some flexibility with the length of treatment.

Wilkinson-Truong et al. (2020) examined a large university's experience in implementing CPT as part of the therapy methods available at its counseling center. Initially many of the staff were hesitant to implement a manual-based therapy, but a couple of the counselors had previous experience with using CPT and they as well as the students they had successfully treated with CPT spoke to staff, which greatly increased the desire of the other staff

to be trained and implement CPT in their practice (Wilkinson-Truong et al., 2020). One way that they were able to work with issues surrounding the limited number of weeks in the semester and the desire to provide all 12 sessions of CPT was to offer twice weekly sessions for six weeks. Another creative way of working with this population was through the use of a CPT phone app that allowed clients to complete their stuck point logs on the app.

The study determined that when administering CPT in a group it was best to begin those groups near the beginning of the semester and generate their participants through referrals from the counselors in the center, which allowed for the group to develop cohesion and complete all 12 sessions together. Overall, this university found that screening for PTSD and implementing CPT was a success, as the students who utilized the counselors for CPT reported a decrease in their PTSD symptoms. This article really highlights the need and reasons why university counseling centers should implement evidence-based practices in treating their student population that suffers from PTSD (Wilkinson-Truong, 2020).

Treatment Outcomes

Two outcome studies used randomized controlled trials of individuals receiving cognitive processing therapy versus a waitlist (Iverson et al., 2015; Monson et al., 2012). Three studies used randomized controlled trials of individuals receiving cognitive processing versus those receiving an alternative method of therapy (Nixon et al., 2017; Resick et al., 2012; Schumm et al., 2015). One study took information from a prior study and performed a different analysis (Snaider et al., 2014). One study analyzed information from a population that was already receiving CPT as part of their care at the VA (Stayton et al., 2018). This research also includes only one qualitative study examining cognitive processing therapy as there appears to be less purely qualitative studies on this topic (Price et al., 2014).

Often individuals who suffer from PTSD also have co-occurring depression (Schumm et al., 2015). Schumm et al. (2015) conducted a study to determine whether the change to more healthy cognitions improves the symptoms of both PTSD and depression. Assessments used in this study included the PTSD Checklist-Stressor Specific Version (PCL-S), Beck Depression Inventory-Second Edition (BDI-II), and Posttraumatic Cognitions Inventory (PTCI) (Schumm et al., 2015). This study used a combination of individual as well as group CPT. Assessments were completed prior to, during, and post-treatment for analysis. An interesting aspect of this research is that self-blame and negative thoughts of self were reduced prior to the symptom reduction in PTSD and depression symptoms were seen to lessen before a reduction in PTSD symptoms occurred. This study relied on several assessments to determine outcomes which contributes to finding it valid and reliable.

As described previously, one of the main themes that emerges with PTSD is the presence of self-blame. Stayton et al. (2018) conducted research into how the presence of self-blame impacts treatment outcomes in CPT. The study compared two groups half of whom reported low levels of self-blame while the other half reported high levels prior to treatment. Reducing self-blame is targeted early in the process of CPT treatment. It was suggested that perhaps because of early gains in treatment made with those who had high levels of self-blame they would have more successful treatment outcomes, but the study found that there was no clinically significant difference in the outcomes of those with high or low levels of self-blame, and both groups reported success in treatment (Stayton et al., 2018).

Individuals diagnosed with PTSD often suffer negative consequences in relationships with their family, friends and work life (Monson et al., 2012). One of the main assessments used in this study was the Social Adjustment Scale (SAS). Assessments were repeated pre-treatment,

mid-treatment, post-treatment, and again at a one-month follow-up. The social areas that had clinically significant improvement were family and housework although all areas assessed showed some level of improvement, which may indicate that a reduction in PTSD symptoms, specifically avoidance, from CPT improve all areas assessed in the SAS, but the immediate impact on the relationships with family is attributed to the patient having fewer PTSD symptoms (Monson et al., 2012).

Another study that focuses on the psychosocial impacts of CPT was conducted by Snaider et al. (2014). This particular study focused on females only whereas many studies included males and more specifically a military population, so this study is substantial in this review of the literature. The main assessment utilized to analyze the patients was the BASIS-32, which is a Likert scale. The study included three groups of participants that received CPT in its original form, CPT-C, which excludes the written impact statements, and a third group that only worked on written accounts throughout their therapy (Snaider et al., 2014). Assessments for this study were at pre-, post- and a six-month follow-up. The study determined that each group had significant improvement from pre-treatment to post-treatment; however, there were no significant changes from post-treatment to the six-month follow-up, which supports the argument that the gains from treatment were maintained. Clinically significant improvements were found in psychosocial areas with the exception of leisure and nonfamily relationships.

Nixon et al. (2017) conducted a study using cognitive process therapy (CPT) versus treatment as usual (TAU) in a community clinical setting for individuals diagnosed with Acute Stress Disorder (ASD) following a sexual assault. ASD is often a precursor to PTSD as it has the same symptomology; however, these symptoms last for longer than three days but less than one month from the traumatic event (Nixon et al., 2017). The clinicians who used CPT were

trained in it for the purpose of the study and thus would be considered novice users of this therapy method. Additionally, they utilized a condensed version of CPT where therapy is delivered in six sessions rather than the typical 12 session format. Participants were assessed pre-treatment, pos-treatment, and at follow ups at three, six, and 12 months. Assessments included the Clinician-Administered PTSD Scale (CAPS), Posttraumatic Stress Disorder Checklist (PCL-S), Posttraumatic Cognitions Inventory (PTCI), and the Beck Depression Inventory (BDI-II). To screen for comorbidity the MINI International Neuropsychiatric Interview (MINI) was used. The Credibility and Expectancy Questionnaire (CEQ) was used early in treatment to determine client expectations of treatment while the Working Alliance Inventory short form (WAI-S) was used at sessions two, four, and six by both participants and clinicians to assess aspects of the therapeutic alliance. The wide array of assessments used in this study demonstrate how thorough the researchers were in obtaining the information needed to adequately determine outcomes. However, it should be noted that the limitations of this study include a smaller sample size and novice CPT therapists versus experienced TAU therapists.

TAU used a variety of approaches as they were not limited to utilizing one particular treatment method. When exploring the therapeutic alliance both CPT and TAU groups were rated as very good to excellent. Outcomes showed both groups reduced symptomology and unhelpful cognitions. However, the CPT group consistently showed better results. Most notably CPT continued to show better outcomes at the three, six, and 12-month follow-ups. The largest difference in outcomes was shown at the 12-month follow-up. It should also be noted that several of the participants in the TAU group required additional sessions after the planned six for the study to reach favorable outcomes whereas only one individual in the CPT required an

additional session. This study shows not only the efficacy of CPT, but also highlights that it can be delivered efficiently as well (Nixon et al., 2017).

Two studies that involved the longest length of time post-treatment accounted for outcomes five to ten years after the termination of CPT treatment (Iverson et al., 2015; Resick et al., 2012). This randomized controlled study compared the outcomes of CPT, prolonged exposure, and minimal attention (Iverson et al., 2015; Resick et al. 2012). Outcomes were measured by the Clinician-Administered PTSD Scale (CAPS), Beck Depression Inventory (BDI) and the PTSD Symptom Scale (PSS) (Iverson et al. 2015; Resick et al., 2012). The Resick et al. (2012) study also noted the increase in years of education as well as higher income levels reported at the long-term follow up. Each of these was administered pre-treatment, post-treatment and repeated at the long-term follow up.

One of the largest differences in these studies is that the Resick study also had the clients complete their impact statement per the direction of CPT at the first session, the end of treatment, and at the long term follow up (Iverson et al., 2015; Resick et al. 2012). The impact statements were each coded for accommodation, overaccommodation, and assimilation, the three maladaptive cognitions that are treated specifically in the course of CPT, by three coders with high interrater reliability (Iverson et al. 2015). After analyzing the data, it was determined that CPT efficacy was maintained even after a significant period of time (Iverson et al. 2015). This study was both reliable and valid as evidenced by the broad number of assessments utilized and the use of a somewhat mixed methodology by including the impact statements (Iverson et al., 2015).

In the Resick et al. (2012) study they looked at whether the PTSD symptom reduction was maintained by comparing the results of the CAPS, BDI and PSS from pre-treatment, post-

treatment, and the long term follow-up (Resick et al., 2012). It was determined that of those that no longer met the criteria for a PTSD diagnosis at the original post-treatment only two (5.6%) had relapsed and again met the criteria (Resick et al., 2012). Overall there was a significant reduction in the symptoms for the remainder of the participants (Resick et al., 2012). These studies relied on a large amount of data and used multiple sources to corroborate the results showing that the information derived is valid and reliable.

A rarity in the research on this topic was qualitative studies. Price et al. (2014) completed a qualitative study that reviewed themes presented in the patients' impact statements prior to treatment as well as post-treatment. This study was a randomized controlled waitlist group. The specific themes of safety, trust, power and control, esteem and intimacy that clients were asked to address in the impact statement during CPT were all coded and prevalent. Additional themes that emerged from coding the impact statements were emotions and symptoms, perspective, work, and positive effects of therapy. Each individual statement in the impact statements was coded for theme and had very high interrater reliability. The raters were also blind as to which impact statement they were reading whether initial or final. For each of the nine thematic areas, there was an obvious shift in the cognitions to a healthier perspective. The importance of this study highlights the areas that are of importance to target during therapy. As clinicians this study brings an awareness of not only what we are targeting, but also additional areas that benefit from CPT (Price, 2014).

Conclusions

Throughout the examination of the literature on long term outcomes, it has become apparent that much more research can and should be done to assess outcomes further out from treatment to continue to support the efficacy of CPT post-treatment. As clinicians we must look

for long term recovery and resiliency in our clients which makes the Iverson et al. (2015) and Resick et al. (2012) studies of utmost importance.

The research has also made apparent the high risk of sexual assaults that can lead to PTSD in the college-aged population as evidenced in articles by Conley et al. (2017), Mellins et al. (2017) and Wilkinson-Truong et al. (2020). CPT would thus be especially impactful in the college setting due to the number of sexual assaults that campuses experience and the improvement of PTSD symptoms that the treatment provides.

Cognitive Processing Therapy has shown its efficacy in treating sexual assault victims as evidenced by the strong recommendation given it by the American Psychological Association (American Psychologist, 2019). Therefore, this writer believes that counselors, including those working at college counseling centers, should be implementing this efficacious treatment with their clients who are victims of sexual assault. Therefore, in order to provide information on how to utilize this treatment in a reduced session format to allow for the constraints of the college semester, I have developed a training to combat these issues.

Training Proposal

Based on the information obtained through the previous research, it has become apparent that there is a need to train college counseling centers in Cognitive Processing Therapy. Cognitive Processing Therapy has shown high efficacy in the treatment protocol for victims of sexual assault. This training should be given by an individual trained and/or certified in Cognitive Processing Therapy that has experience in utilizing this treatment. The target audience would be college counseling center counselors, supervisors and administration. The purpose of including those individuals includes getting buy in from all parties that either provide direct support in counseling to the students as well as those that determine funding and support for the counselors. The following training is using information based on the student population at Minnesota State University Moorhead. However, this can be adapted to any college campus by replacing the statistics from Minnesota State University with that of the college for the training.

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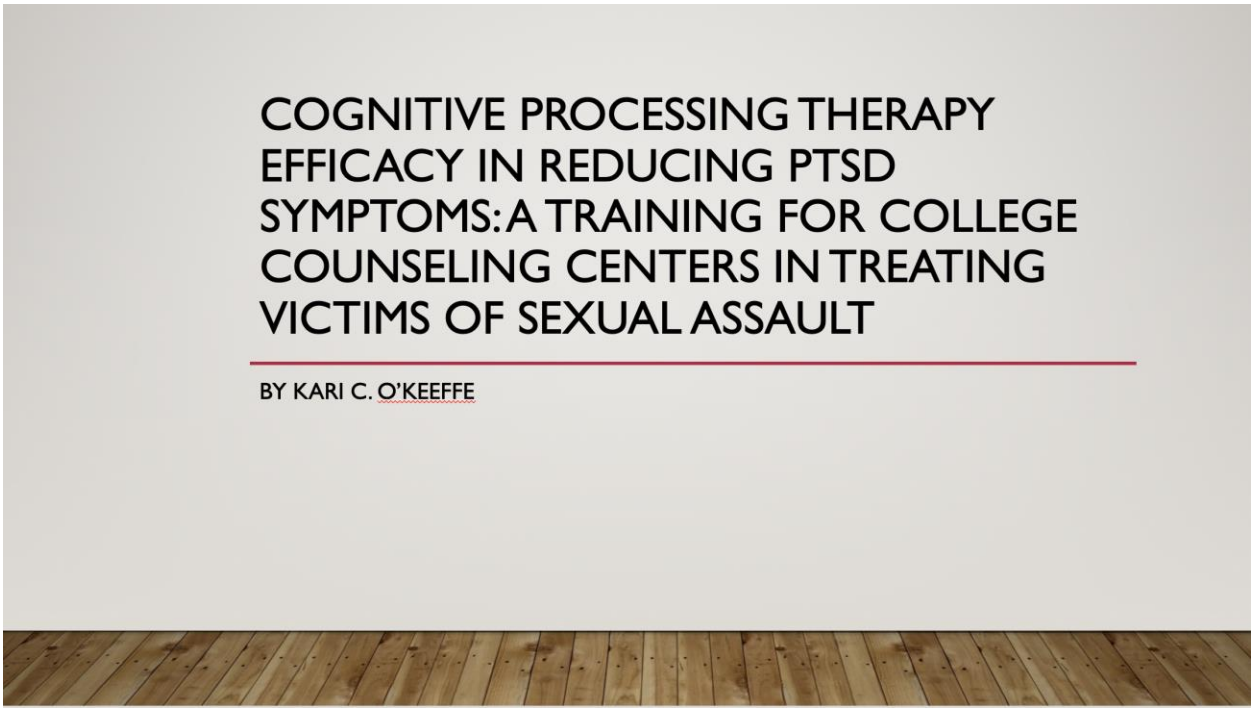
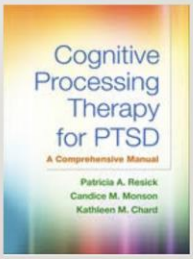


Slide 2:

RECOMMENDED PREWORK TO TRAINING

- Complete CPT Web2.0 – a web-based learning course for Cognitive Processing Therapy – approx. 12 hours of content, earning 13 ceus
- This can be accessed through the following link: cpt2.musc.edu
- Obtain the book Cognitive Processing Therapy for PTSD: A Comprehensive Manual



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Slide 3:

PREVALENCE OF SEXUAL ASSAULT

- What is sexual assault?
  - Unwanted sexualized touching
  - Attempted penetrative assault
  - Completed penetrative assault
- 43.6% of women reported having violent sexual contact in their lifetime
- 20-25% of women are the victim of rape while enrolled in college
- Sexual assault is widely unreported, so these figures could be much higher

Conley et al., 2017; Mellins et al., 2017; NISVS, 2015;

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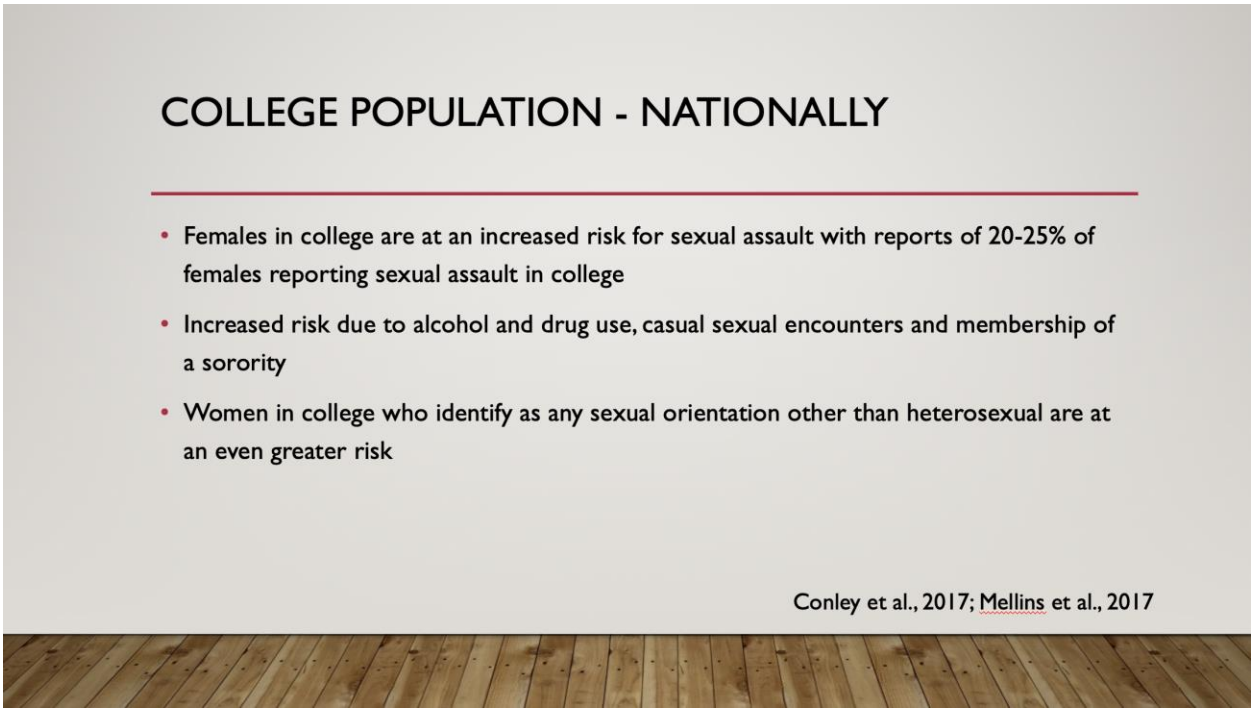

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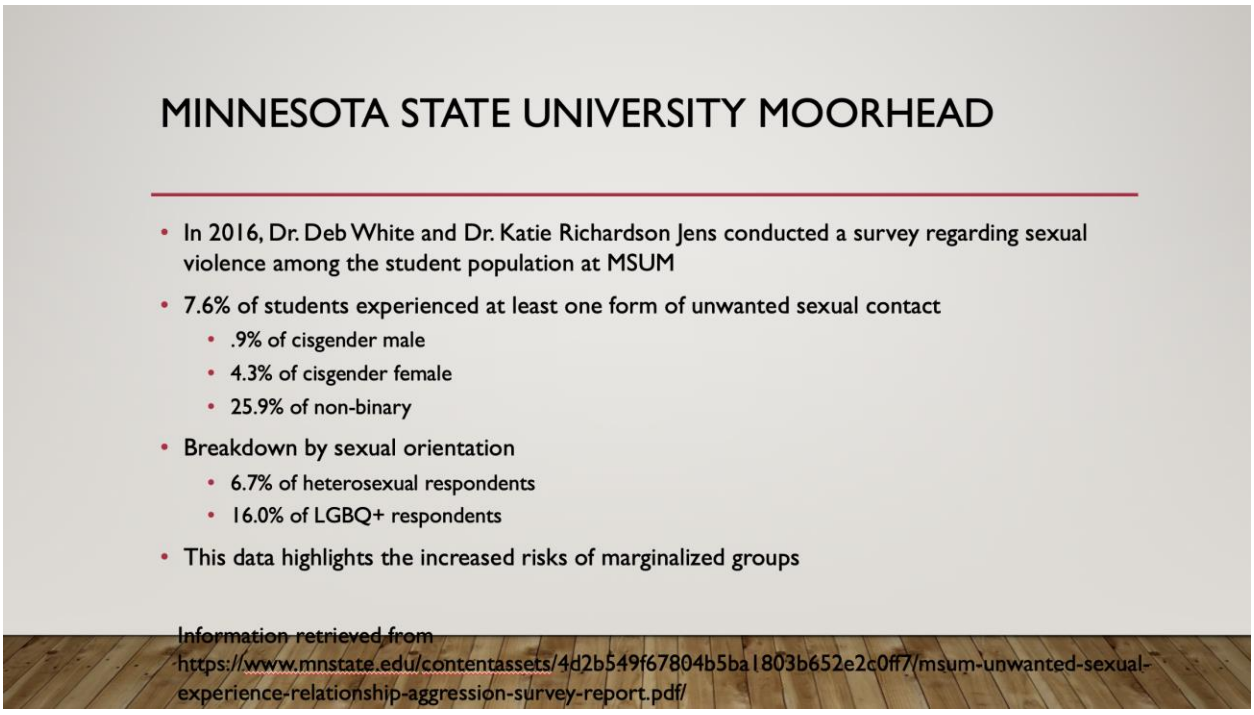

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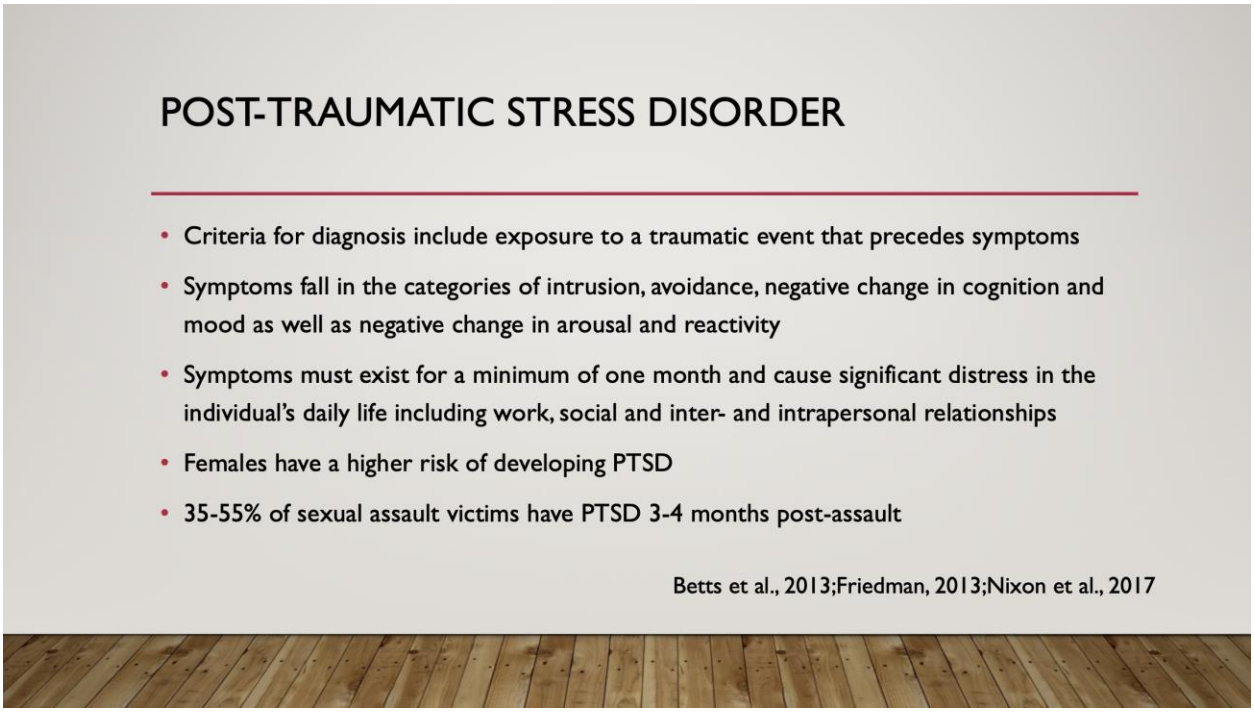

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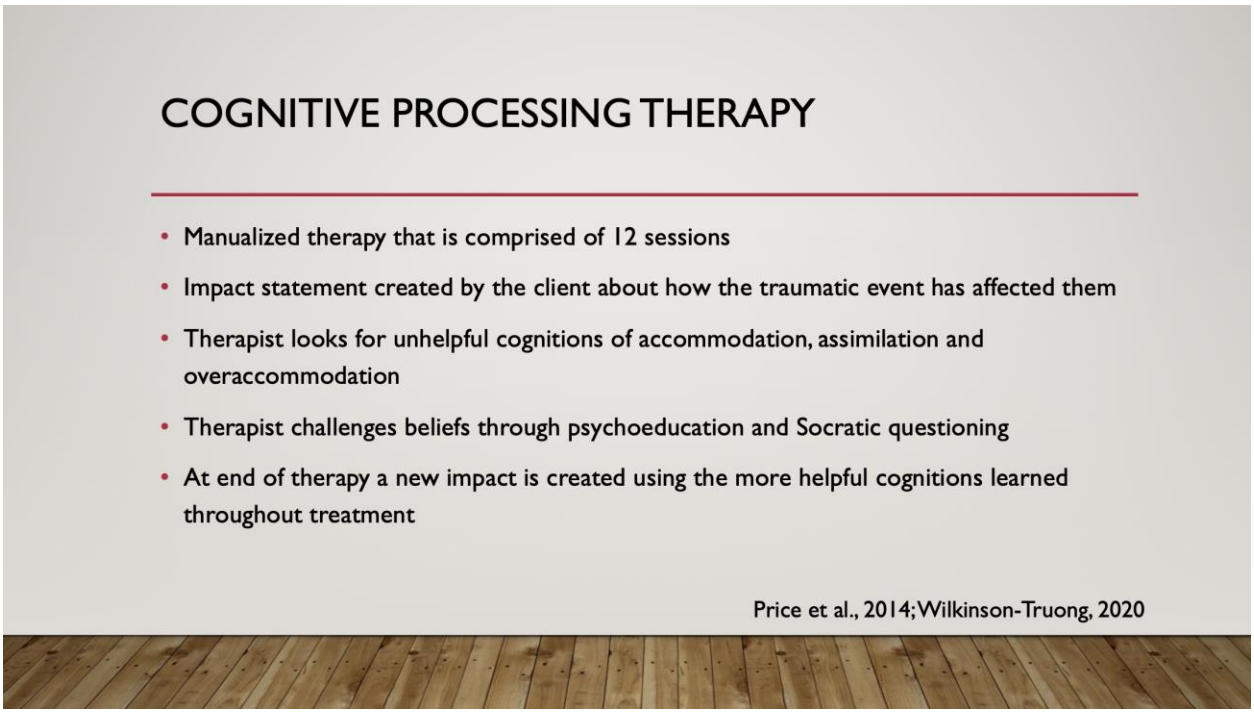

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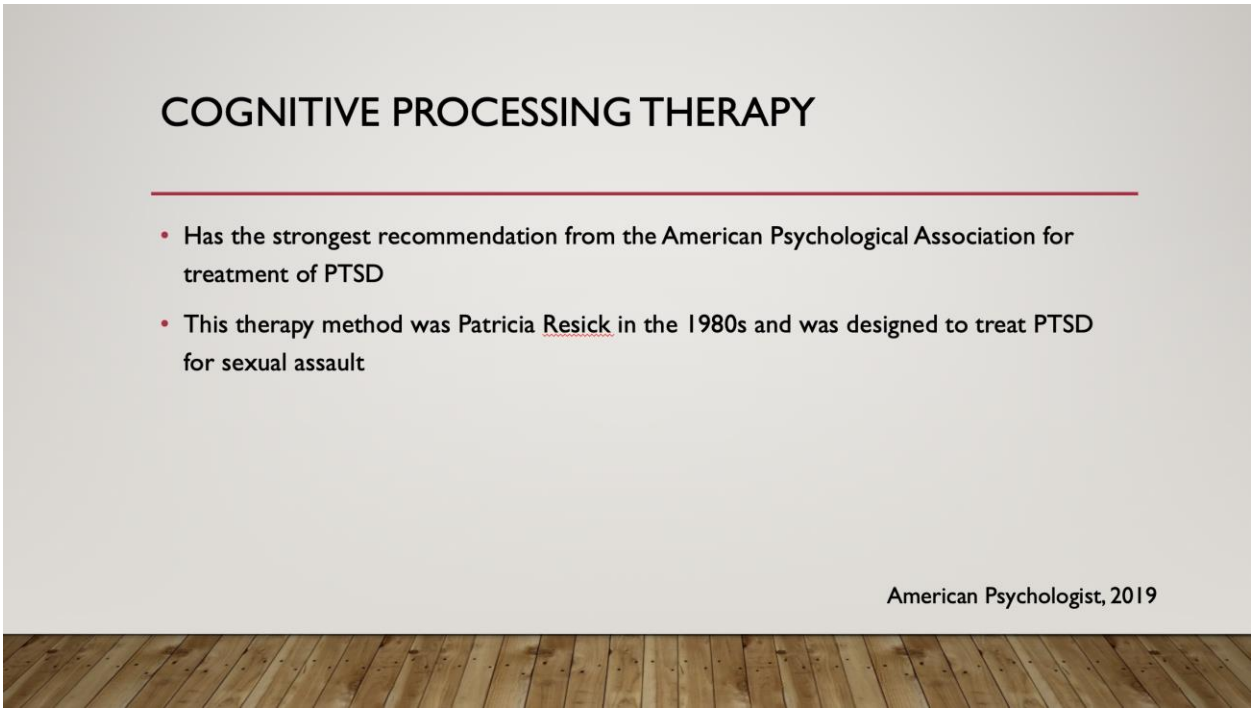

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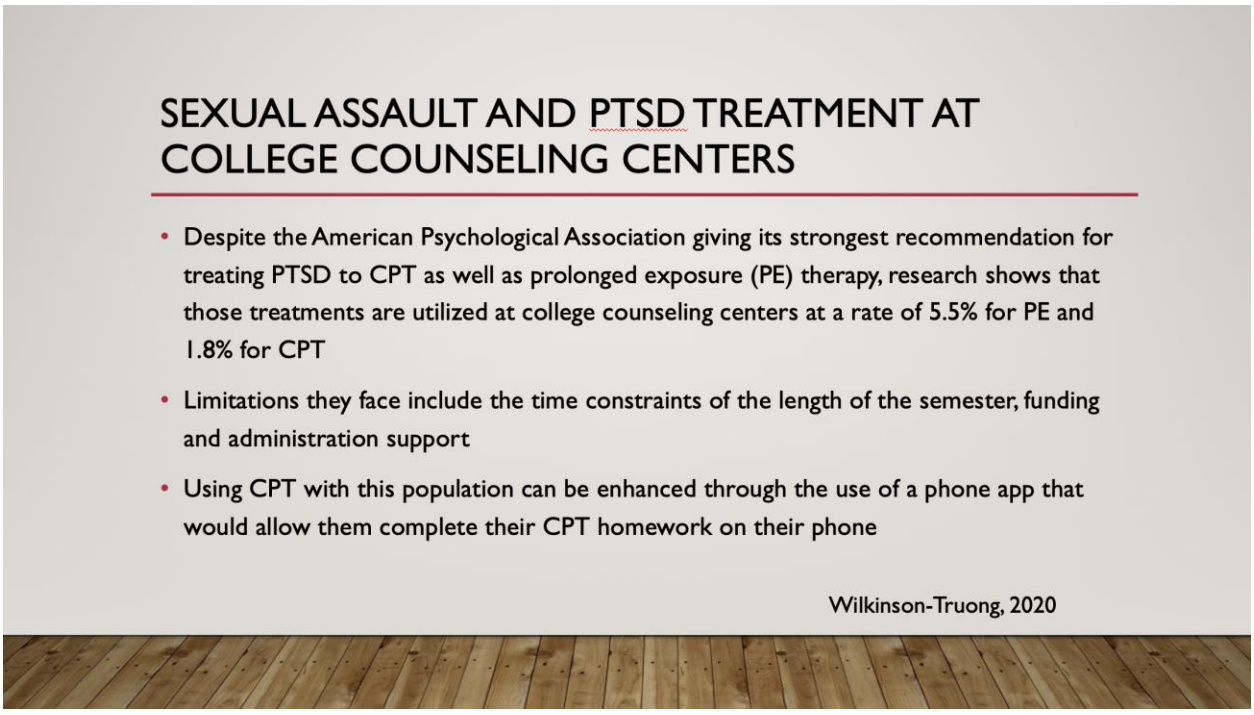

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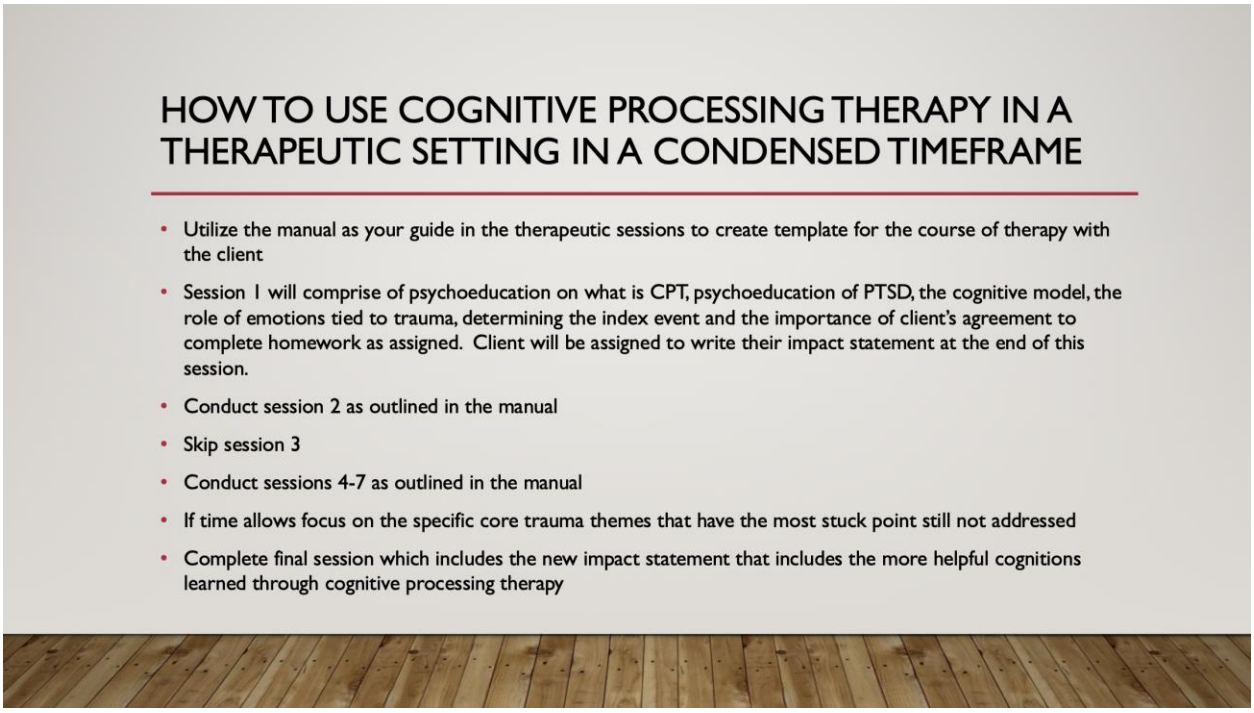

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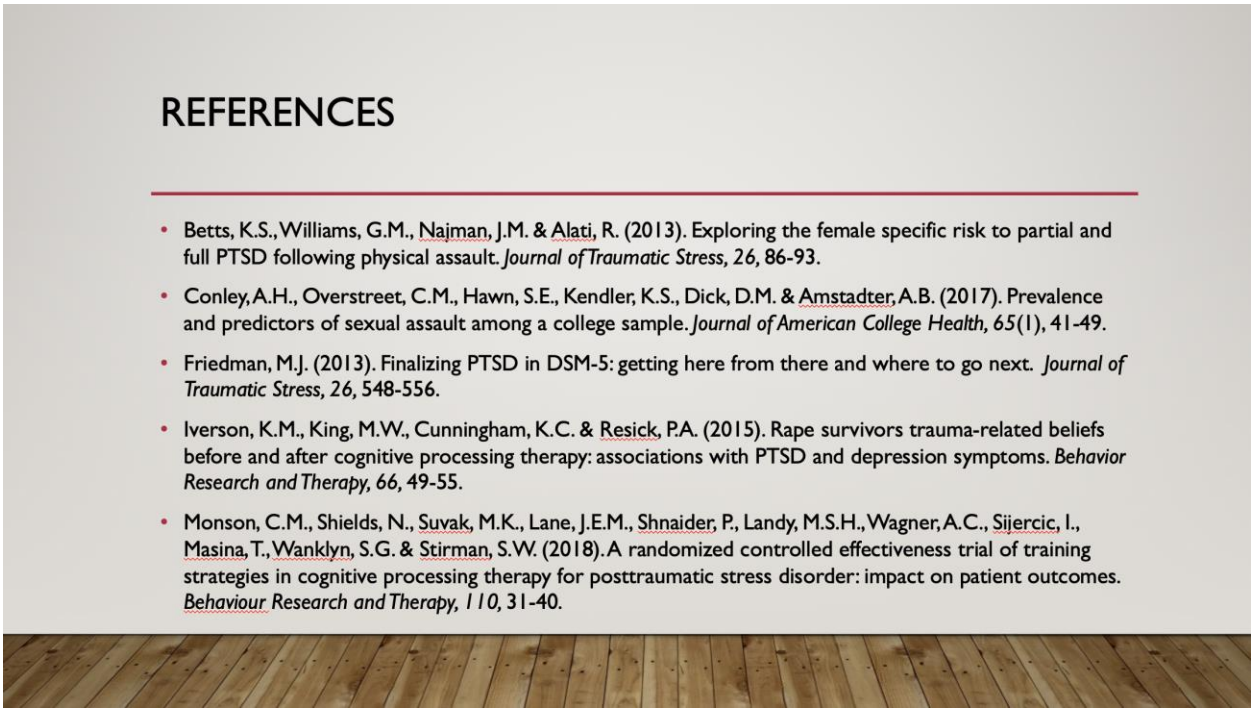

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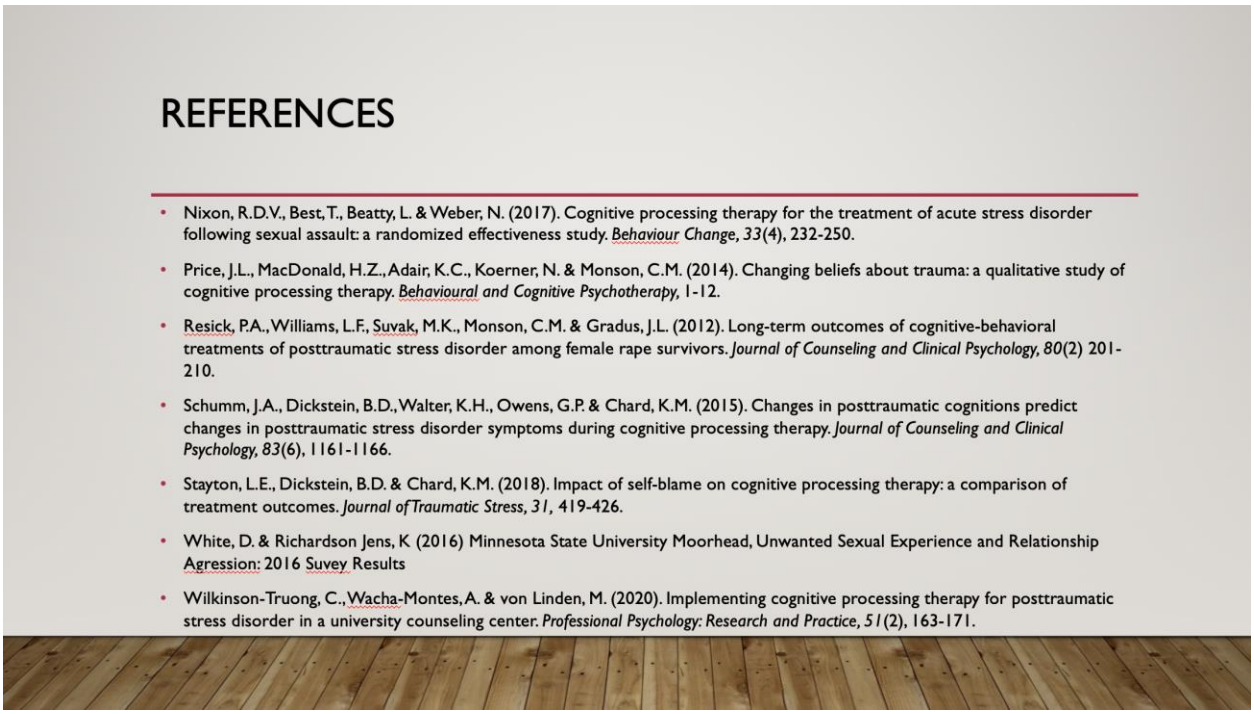
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CPT Training Evaluation

Name: _____ Date: _____

Directions: please mark the box that best describes your level of agreement with each statement.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1.) I know what sexual assault is.					
2.) Sexual assault is underreported.					
3.) College students have an increased risk of sexual assault.					
4.) Those who identify as LGBTQ+ have an increased risk of sexual assault.					
5.) CPT is a recommended treatment for victims of sexual assault.					
6.) I understand how to modify CPT into a shorter # of sessions.					
7.) I understand more about CPT now than before this training.					
8.) I will use CPT in the future.					
9.) This presenter was able to answer my questions throughout the training.					
10.) Overall, this presentation was worth my time.					

Comments:_____

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