

Cognitive Processing Therapy With a Prelingually Deaf Patient Suffering From Posttraumatic Stress Disorder

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Abstract

This case study describes the treatment of a prelingually deaf patient suffering from posttraumatic stress disorder (PTSD) using cognitive processing therapy (CPT). A 42-year-old woman who had experienced a severe accident several years earlier presented with moderate PTSD symptoms. She was treated with CPT by a therapist experienced in working with PTSD patients but not with deaf patients. A sign language interpreter aided treatment. After 20 sessions, the patient chose to end treatment because she felt she had sufficiently profited from it. The case study shows that, with the help of a professional sign language interpreter, a structured cognitive-behavioral treatment such as CPT can be successfully implemented with a deaf patient.

Keywords

cognitive processing therapy, PTSD, deaf, sign language interpreter

I Theoretical and Research Basis for Treatment

Cognitive processing therapy (CPT) is a cognitive-behavioral treatment (CBT) for posttraumatic stress disorder (PTSD) that builds on a social-cognitive framework. A traumatic event is seen as an experience that does not fit into a person's existing beliefs about the world, the self, and other people. When a person cannot reconcile the event with his or her existing schemas, this may result in dysfunctional cognitions, chronic negative emotions, and dysfunctional behavior such as avoidance.

CPT is a predominantly cognitive therapy but does contain an exposure module. The therapy was first developed for rape victims (Resick & Schnicke, 1993) and later adapted to be used in the military context (Resick, Monson, & Chard, 2007). The efficacy of CPT in civilians has been established in several large studies. Its effect was equal to prolonged exposure (PE; Rauch & Foa, 2006) and better than a waitlist control group in a study involving 171 female rape victims (Resick, Nishith, Weaver, Astin, & Feuer, 2002). Resick et al. (2008) conducted a dismantling study of CPT components and found high effect sizes in all study groups. Their sample consisted of 150 women who had suffered interpersonal trauma. Evidence that CPT works for patients with

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different cultural backgrounds comes from Schulz, Resick, Huber, and Griffin (2006) who found high effect sizes in their predominantly female sample of 53 refugees from Bosnia and Afghanistan. Traumatic experiences in this sample differed but were mostly war related. The only CPT study on civilians with an all-male sample comes from Ahrens and Rexford (2002). They studied the CPT group format with 38 juvenile inmates of a facility for adolescent offenders and reported encouraging results. This suggests that the evidence supporting the efficacy of CPT in civilians is strongest for interpersonal trauma. However, there is also a case report detailing the successful treatment of PTSD following a motor vehicle accident (Galovski & Resick, 2008).

The CPT manual has been translated into German and has been slightly adapted (König, Resick, Karl, & Rosner, 2012). For the German adaptation, only preliminary data from a mixed-gender, mixed-trauma sample are available (König, 2012). In this study, the pre–post effect size for the Posttraumatic Diagnostic Scale (PDS; Foa, Cashman, Jaycox, & Perry, 1997) was Cohen's $d = 1.24$.

Deafness and Deaf Culture

It is difficult to say how large the population of deaf people is exactly. Mitchell (2006) defined functional deafness as being unable to hear a normal conversation, even with the use of a hearing aid. He concludes that in the United States of America, 0.20% of citizens between the ages of 18 and 44 years and 0.33% of citizens between the ages of 45 and 64 years are functionally deaf.

A distinction important to communication is whether a person is prelingually or postlingually deaf; that is, whether the deafness set in before or after spoken language was acquired. Usually, 4 years of age is considered to be the cutoff between the two groups (Leven, 1997).

In recent decades, a cultural view of deafness has developed. The deaf are seen as a cultural minority with sign language as their common language. As 90% of deaf children have hearing parents, most deaf people do not grow up in this culture from the very beginning. The deaf form a rather closely knit group with about 90% choosing deaf or hearing-impaired partners (Leven, 1997). In Germany, their shared language is *Deutsche Gebärdensprache* (DGS), whereas in the United States, it is American Sign Language (ASL). DGS, like other sign languages, is a language in its own right. Its grammar is different from the grammar of spoken German. Indeed, there is such a thing as “signed German,” a system which uses similar signs as DGS but follows the structure of spoken German word for word. This is called *lautsprachbegleitendes Gebärden* (LBG; signing accompanying spoken language) and can be used when a person speaks and signs at the same time. However, prelingually deaf people are generally much more comfortable with DGS (Leven, 1997).

When it comes to language proficiency, the deaf are a very diverse group. Children whose deafness is discovered early and who are sufficiently exposed to language in a modality they can process (such as DGS) will experience a language development much like hearing children. However, there is a substantial subgroup of the deaf who are disfluent in any language (Glickman & Harvey, 2008).

In the United States, when speaking about *deafness* from a cultural viewpoint, the term is frequently spelled with a capital D. In this article, I will use the term *deaf* with a small “d.” In German, there is no such convention, so I could not ask my patient which she would prefer. However, more importantly, I do not pretend to be able to tell apart aspects of deaf culture on one hand and issues specific to my patient on the other.

Psychotherapy With Deaf Patients Conducted by Hearing Therapists

The literature about psychotherapy with deaf patients is rather scarce and not all of it relevant to the therapeutic work in this case. Although the need for working with an interpreter presents

rather frequently in PTSD treatment because of the high prevalence of PTSD in immigrant populations (Frans, Rimmö, Aberg, & Fredrikson, 2005; Schulz, Huber, & Resick, 2006), the focus here will be on the interpretation of sign language.

De Bruin and Brugmans (2006) discussed issues arising during different forms of therapy involving deaf patients: individual, relational, and family therapy. They gave recommendations as to the development of an optimal collaboration between therapist and sign language interpreter based on extensive experience and discussion. However, their environment is a specialized Dutch mental health care institution for deaf patients where there are long-standing relationships between interpreters and therapists.

Porter (1999) described an encounter with a profoundly deaf patient during her psychiatric residency. Because she treated this patient with the aid of an interpreter in a nonspecialized setting, her situation is similar to the one described here. She concludes that working with a sign language interpreter is the second best option after conducting the therapy in sign language. However, in many settings, it is the only possibility and the patient may be more comfortable with this mode of communication than the therapist.

Hoyt, Siegelman, and Schlesinger (1981) interviewed psychotherapists experienced in working with deaf and hearing patients. Therapists reported being more "active and directive" (p. 809) and using less abstract interpretations (these were psychodynamic therapists) when working with deaf patients. The interviewed clinicians also reported that deaf patients frequently came to therapy with less knowledge about psychotherapy and mental health issues "including the ideas that feelings influence actions and that talking about feelings can be helpful" (Hoyt et al., 1981, p. 809). This made more educative work necessary. They explain this situation in terms of the barriers to communication and information: "This situation is quite understandable when one realizes how much is usually learned about the world by overhearing and casual reading and through media resources that are still severely curtailed for the deaf" (Hoyt et al., 1981, p. 809). This article was written more than 30 years ago, so it can be assumed and hoped that the communicative possibilities of the deaf community have improved in many ways, not the least of which is the Internet. However, it remains true that deaf people are shut out from much of the casual communication going on around them.

The recommendations from the literature for the use of sign language interpreters in psychotherapy that had the most relevance to the current situation were those pertaining to the seating arrangement, the question of meetings without the patient, and the perceived role of the interpreter.

Seating arrangement. The ideal arrangement proposed by De Bruin and Brugmans (2006) is "having the interpreter sit immediately next to the therapist, but slightly to the rear, and at the same elevation or even slightly lower" (p. 365). This enables the therapist to address the patient directly, not the interpreter, and it makes it easy for the patient to shift his or her gaze between therapist and interpreter.

Pre- and postsession reviews between therapist and interpreter. Interestingly, opinions here differ greatly, with some authors strongly recommending such meetings and others stating they should be avoided. De Bruin and Brugmans (2006) represent one end of the spectrum in recommending that the therapist and interpreter regularly spend time together before and after each session. Moreover, according to Glickman and Harvey (2008), this "has become recommended practice in order to foster a collaborative relationship between interpreter and therapist" (p. 129). Tresh (1996, cited by Porter, 1999), however, recommends having the interpreter leave before the patient to make it clear that there is no discussion behind the patient's back. Harvey (1989) also cautions that such meetings may contribute to the patient's confusion about the respective roles of the people involved. In settings like the one described in this article, where the interpreter and the therapist are getting paid only for the time spent in session, long and regular meetings are not feasible. It can, however, be helpful to take time for brief discussions.

Role of the interpreter. There is a consensus in the literature that interpreters have to translate everything that is said and refrain from inserting their own opinion. However, different conceptions of the role of an interpreter are still possible, as De Bruin and Brugmans (2006) pointed out. They describe five different possible role conceptions. Two of these seem particularly relevant to the current case, where there was no long-standing collaboration between therapist and interpreter. The first is viewing “the interpreter as a direct line between two parties who do not understand each other’s languages (‘the traditional, language-focused role’)” (De Bruin & Brugmans, 2006, p. 362). The second alternative is a conception of “the interpreter as a ‘bilingual, bicultural mediator,’ who, in addition to translating the conversation, relays information back and forth about the two different cultures” (De Bruin & Brugmans, 2006, p. 362).

For interpretation between two spoken languages, the first, language-focused role conception seems to be preferred (e.g., Schulz, Huber, et al., 2006). However, therapists working with sign language interpreters seem to favor the second, “mediator” conception. Porter (1999) gave an example of the additional information that can be helpful for the therapist:

The interpreter can assist the therapist to adjust to the logistics of the situation, and offer general information about deaf language and culture, as well as about any specific services and communication devices that may be available. He/she can also share information about the quality of the deaf person’s verbal communication, whether the patient appeared to understand the discourse, and whether there were communications the interpreter was unable to interpret. (p. 171)

2 Case Introduction

“Mrs. Smith” is a 42-year-old German woman living with her hard-of-hearing partner. She is prelingually deaf and wears hearing aids to maximize her residual hearing. She is employed full-time in a professional setting, with a 2-hr commute to work (one way). Several years ago, she experienced an accident in which three people died and her own life was jeopardized. She tried to save another person but did not succeed and was a close witness to that person’s death. One of the victims was her best and closest friend since childhood. Therefore, this event more than fulfilled the objective criterion for a traumatic incident according to the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., *DSM-IV*; American Psychiatric Association, 1994).

In this article, more changes to the patient’s history and the traumatic event have been made and more information left out than might be typical for case studies. This was necessary due to the fact that the deaf community is so small and that otherwise, the patient would have been too easily recognized. The patient agreed to the publication of her case as described here.

3 Presenting Complaints

Mrs. Smith was referred by a counseling agency for the hearing impaired to an outpatient clinic that specializes in treating PTSD and other anxiety disorders. The referral was precipitated by a suspected diagnosis of PTSD due to the nature of her accident, and an unwillingness of other counselors to take her case.

Mrs. Smith did not report a lot of intrusive symptoms at intake, probably because she had learned over the years to avoid triggers. She did not talk to others about the accident and did not look at pictures taken during that time. She also avoided contact with the deceased friend’s family. However, she did report sometimes having unwanted thoughts about the accident, which made her feel upset and which she considered “unnecessary.” Besides avoiding the memory of the event, she no longer traveled abroad. Although trusting others had never been easy for her, this difficulty increased after the accident, and she was quicker to suspect that others did not like her. She reported

several symptoms of hyperarousal. She was feeling irritable and under pressure, was impatient with others and herself, and had trouble concentrating. She also reported crying easily and feeling unhappy with herself in general. Overall, the symptoms justified a diagnosis of PTSD of moderate severity. However, the hyperarousal symptoms in particular were difficult to discriminate from the consequences of leading a stressful life. She worked full-time in a hearing environment and had a long commute, causing her to leave very early in the morning and not return before late in the evening. She did not acknowledge that this situation might be contributing to her current problems.

4 History

Mrs. Smith grew up in a hearing family. Following the discovery of her deafness, she was sent to a boarding school at an early age. She recalls intense feelings of frustration at not being able to communicate effectively with her family, especially her parents, who did not know sign language then. She reports having needed and claimed a lot of attention while at home, identifying herself as a “difficult” child. After school, she completed vocational training and is now the only deaf employee at her workplace. Her social circle is mostly composed of other deaf people with whom she can easily communicate. This involves a lot of traveling. She reports that it is very difficult to find like-minded people to form close relationships with because the deaf community is so small. Moreover, she says that the fact that everybody knows everybody else offers grounds for a lot of gossip. This makes it difficult for her to confide in people because she does not trust them to keep things to themselves. She describes the traumatic event as having caused a disruption in her social life. In the first place, she lost her closest friend. In the second place, after the event she has felt that some of her acquaintances were only interested in the accident and not in her, which made her feel used. Some had even “corrected” her regarding some details of the accident because they had read about it in the newspaper and did not believe her although she was present at the event. She describes that the relationships with her partner and her parents (especially her mother, whom she feels closest to) have improved since the traumatic event.

After the trauma, Mrs. Smith reports having “felt really bad” for about a year, grieving the loss of her friend. But then people told her she should be over it and she tried to avoid thinking about it at all. She has long been reluctant to look for help, even though she has not really felt well since the event. She attributed all her symptoms to the loss of her friend and only at the counseling agency learned that there might be help.

5 Assessment

During Mrs. Smith’s first visit to the clinic, an experienced clinician conducted an intake interview. This interview established a diagnosis of PTSD according to the *DSM-IV* with the *International Diagnostic Checklists for ICD-10 and DSM-IV* (IDCL; Hiller, Zaudig, & Mombour, 1996). In addition, Mrs. Smith completed several self-report scales, the most important of which are reported here. When looking at these data, it should be kept in mind that German grammar does not map onto DGS; therefore, to Mrs. Smith, the instruments were not in the language she was most comfortable with. She completed the instruments reported below before and after therapy, as well as at a 6-month follow-up interview. The only exception was the Impact of Event Scale–Revised (IES-R; Maercker & Schützwohl, 1998), which was given prior to each session.

PDS

The PDS (Foa et al., 1997) is a self-report instrument with very good psychometric properties allowing a diagnosis of PTSD and rating its severity. The psychometric properties of the German version are also very good (Griesel, Wessa, & Flor, 2006). Mrs. Smith only had a total score of 6,

which is well within the healthy range (mild PTSD is indicated by scores between 10 and 20). However, the clinical interview yielded a diagnosis of PTSD, which was also compatible with the IES-R score reported below, so treatment was commenced despite this test result.

IES-R

The IES-R (Weiss & Marmar, 1997) is a 22-item self-report instrument for the assessment of PTSD symptoms. It cannot be used to establish a diagnosis; however, its economy and psychometric properties make it a good instrument for measuring progress of therapy. According to the authors of the German translation (Maercker & Schützwohl, 1998), the three symptom clusters are scored individually. For all clusters, scores below 9 denote mild or no symptoms; scores between 9 and 19, moderate symptoms; and above 19, severe symptoms. At intake, Mrs. Smith had a score of 12 for intrusion, 18 for avoidance, and 10 for hyperarousal, indicating symptoms of moderate severity in each cluster. Her scores, with avoidance as the most prominent symptom cluster, reflect a profile that is typical for patients whose trauma is several years in the past. That is, as patients become practiced in avoiding reminders of the event, intrusive and hyperarousal symptoms decrease somewhat.

Brief Symptom Inventory (BSI)

The BSI (Derogatis & Melisaratos, 1983) is a measure of general psychological distress. It contains nine subscales, but as factor analyses have often found only one factor (Geisheim et al., 2002), only the Global Severity Index (GSI) will be reported here as a comprehensive measure for psychological distress. Mrs. Smith had a GSI score of .62 at intake. This translates into a *T*-score of 63 compared with the German norm sample (Franke, 2000), indicating above-average distress.

Posttraumatic Cognitions Inventory (PTCI)

The PTCI (Foa, Ehlers, Clark, Tolin, & Orsillo, 1999) is an instrument for the measurement of negative cognitions due to traumatic experiences. Mrs. Smith had a total score of 81 points, which is below the range of PTSD patients from a normative German sample ($M = 133$, $SD = 44$; Ehlers & Boos, 2006). This result was unexpected because the PTCI has been shown to discriminate well between participants with and without PTSD.

Inventory of Interpersonal Problems—Circumplex Version (IIP-C)

The IIP-C (Alden, Wiggins, & Pincus, 1990) is a self-report instrument in which respondents are asked to rate interpersonal difficulties. The German version has satisfactory psychometric properties (Horowitz, Strauß, & Kordy, 1994). Mrs. Smith had a total score of 1.25, which is within the range of the healthy German norm ($M = 1.29$, $SD = 0.52$; Brähler, Horowitz, Kordy, Schumacher, & Strauß, 1999).

6 Case Conceptualization

In addition to preparatory reading, I consulted via telephone the person who had referred the patient to get some general advice on working with deaf patients (Mrs. Smith's actual case was not discussed at all). During this very helpful consult, I learned that it was important to use precise and concrete language during therapy to make things easier for the interpreter and to heighten the

chances of being understood by the patient. The counselor also gave a brief “crash course” about some issues that frequently occur among deaf people, such as early separation from the family because of the need for specialized schooling, communication problems within families, and the very closely knit structure of the deaf community with a clear distinction between in-group and out-group. This distinction often goes along with a distrust of hearing people.

CPT seemed suited for Mrs. Smith for several reasons, her PTSD symptoms having already been discussed. CPT relies on a rationale that is comprehensible and is thoroughly discussed with the patients. This makes engaging in the therapy easier for patients who initially experience reluctance.

The exposure component of CPT seemed suited for Mrs. Smith because she was avoiding reminders of the event. She also avoided contact with the dead friend’s family, whom she had been very close to.

After the exposure component, CPT focuses on cognitive strategies. Assimilation is treated first, because one needs to accept that an event occurred before being able to come to terms with it. Mrs. Smith blamed herself for convincing her friend to join her on the vacation and the particular trip where the accident happened. Her reasoning was “if I had never convinced her to go on that trip, she would still be alive.” Cognitive strategies to work with this point out the “hind-sight bias.” Mrs. Smith could not have known that the accident was going to happen. She had considered the trip as being perfectly safe, and had been there herself.

A good example of overaccommodation was Mrs. Smith’s shift in her opinions about traveling. She reported having been “reckless” in traveling abroad and in going on that particular vacation as well. Before the accident, she had enjoyed traveling a lot. This means that the event caused Mrs. Smith to shift from being curious about other countries to viewing such curiosity as recklessness.

The goal of discussing assimilation and overaccommodation is the development of beliefs that will be able to integrate the event but that will not be extreme (accommodation). With respect to the two examples given above, accommodated statements might be “I could not have known that the trip was not safe” and “sometimes accidents happen even if one is careful, but that does not mean that all traveling is dangerous.” The fact that CPT relies on worksheets for this cognitive work also seemed to be advantageous as worksheets can help keep the discussion concrete and focused.

For these reasons, Mrs. Smith seemed a good candidate for CPT, but I did not know what difficulties to expect from working with a sign language interpreter. I decided to go ahead with CPT while staying alert as to whether the patient seemed able to relate to the issues discussed. I also resolved to ask any question about deaf culture that might be helpful in understanding “where the patient came from” in terms of her beliefs and to keep my language as concrete and precise as possible.

7 Course of Treatment and Assessment of Progress

According to custom with patients in compulsory health insurance in Germany, Mrs. Smith was offered 25 sessions of therapy (“short term”) with the option of requesting additional sessions if needed. Sessions were usually conducted twice weekly at one of two clinics. This constant change of place was due to scheduling difficulties and is not indicative of the usual practice at either clinic. The patient was offered the choice of only weekly sessions, but she wanted to complete therapy as quickly as possible and therefore preferred alternating locations.

The German CPT manual contains 15 manualized sessions, so having up to 25 sessions makes it possible to take more time for specific issues if necessary. It was expected that the interpreting process would slow the therapy down somewhat.

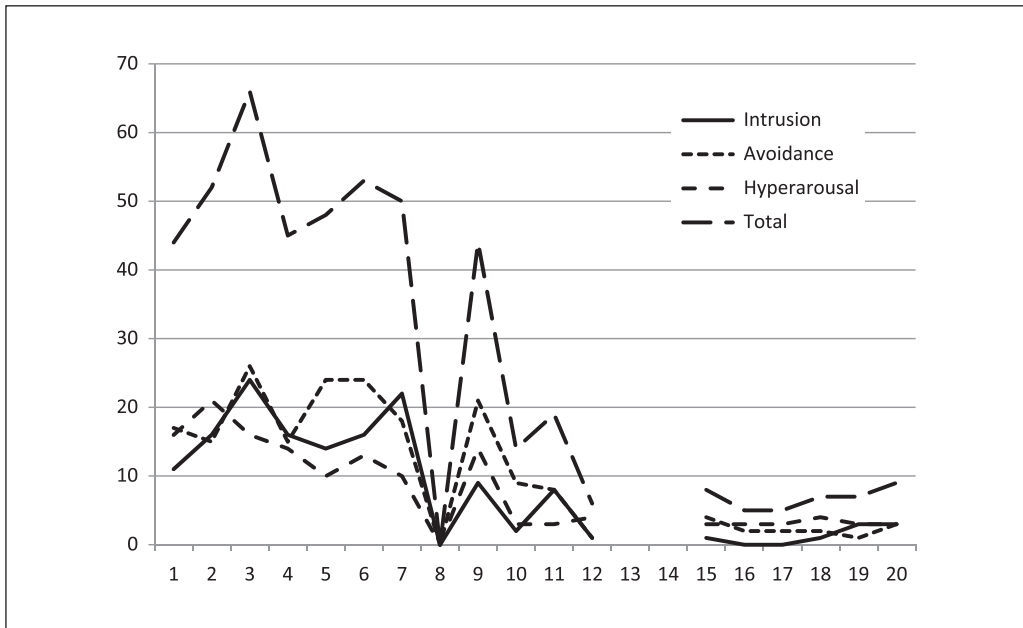


Figure 1. Change of IES-R scores over time

Note: IES-R = Impact of Event Scale–Revised. The patient reported that the 0 points at Session 8 were from her being sick for almost the whole week. No data were collected at Sessions 13 and 14 as reflected in the figure.

A typical session started with questions about the patient’s work at home since the previous session. This led to a discussion of the topics the patient had worked on or thought about at home and to any changes that had occurred. After this, I introduced a new topic or worksheet. I kept eye contact with the patient, not the interpreter, while the patient alternated between looking at me and the interpreter. Other than scheduling new sessions, the interpreter only spoke and signed in his capacity as interpreter and never offered thoughts or reactions of his own.

Prior to each session, the patient completed the IES-R to assess progress (except for two sessions when specific reasons prevented me from it). The changes in IES-R over the course of therapy are charted in Figure 1.

Sessions 1 to 3: Beginning of Therapy

The first two sessions were used to collect Mrs. Smith’s history and to discuss her goals for treatment and the rationale for CPT. Before the third session, patients are asked to write an *impact statement* about changes in their thinking about the world, oneself, and others. This is not the story of the traumatic event but an account of changes caused by it and the reasons why it happened. During this time, the concept of “stuck points” is introduced. Stuck points are issues where a patient assimilates or overaccommodates and therefore becomes “stuck” in the recovery process. Mrs. Smith related that in writing the statement, she realized for the first time how much she had changed after the event. The overaccommodation described above became very apparent from her statement, whereas her assimilation themes only surfaced during in-session discussion.

Between the first and third sessions, the intrusive and avoidance symptoms increased. This is not uncommon. Especially in patients who have become expert in avoiding reminders of their trauma, the decision to start therapy and thinking about the consequences of the trauma can trigger intrusive symptoms and increased efforts to avoid them.

Sessions 4 to 6: ABC Sheets

In Session 4, the cognitive work begins with worksheets designed to help patients examine how their beliefs or thoughts about events influence their feelings (ABC sheets). At this point, thoughts about everyday events and thoughts about the trauma are considered. This did not go very well with Mrs. Smith; she did not seem comfortable with the worksheets. Therefore, we took to discussing her issues only loosely based on the written word. The most important reasons for using the ABC sheets are (a) helping patients understand that emotions are usually not caused by events but by our interpretations of them and (b) they are an exercise in making one's inner monologue explicit. I did my best to convey these concepts without relying on the worksheets. Because of Mrs. Smith's difficulties with the worksheets, this phase took longer than in the manual. During this time, her self-blame came to the foreground even more. In thinking about the event and starting the therapy, memories and thoughts of the event surfaced more and more in her daily thoughts. This is also reflected by an increase in intrusive symptoms during this phase. Avoidance scores were the highest of the three clusters during this time. As this also became apparent in homework noncompliance, avoidance and how it hinders recovery were often discussed in session.

Sessions 7 to 10: Trauma Narrative and Negative Emotions

In CPT, patients are asked to write an account of the traumatic event and then read it back to the therapist in the next session. In this case, Mrs. Smith signed her written narrative to the interpreter who told it to me, which means that there was a lot of translation involved. It did seem preferable to my simply reading the account, however, as this would have allowed the patient to avoid the confrontation with the event. Two sessions were spent focusing on the traumatic event in this manner. Like most patients, Mrs. Smith found that writing the narrative was a stressful task. She reported feeling sad and remembered some details that she had forgotten since the event. This is an indicator of emotional involvement with the memory. After the first signing of the trauma narrative, she also looked at pictures taken right before the accident. A few weeks later, she brought the pictures in and could show and explain them calmly.

In the course of writing and discussing the trauma narrative, a lot of memories and emotions stemming from the time before the trauma had surfaced for Mrs. Smith. She reported feeling more irritable and thinking more about her childhood and youth and her relationships with her family members. During two sessions, she described her childhood in more detail. Usually, the focus of CPT is on the present, but preexisting beliefs are also discussed. The rationale for slight deviations from the CPT protocol is given in the "Complicating Factors" section.

Mrs. Smith told the story of a child who often could not make herself understood by her family. She remembered intense feelings of envy toward her siblings because they could return home every day instead of only on weekends like her. It was the story of a girl who had always been different, always had to advocate for herself, and who sometimes had not been believed because she was deaf. I began to understand better why Mrs. Smith viewed herself and her personality so negatively. This stemmed from years of being told or shown that she was difficult ("the most difficult child in the family") and claimed too much attention, while she often felt excluded. During this phase of therapy, a focus was on validating her emotions as well as helping her feel and label them. I developed a lot of respect for her perseverance in the face of adversity.

During this phase, there is a marked decrease in Mrs. Smith's IES-R scores (see Figure 1). This often happens when patients stop avoiding memories of the event and find that they can tolerate the resulting emotion and that remembering becomes less stressful. The "perfect" IES-R score of zero in Session 8 is the result of her being sick with the flu and feverish most of the week and not thinking about the event at all.

Sessions 11 to 20: Cognitive Work

After the processing of the trauma narrative, the worksheets “challenging thoughts,” “faulty thinking patterns,” and “challenging beliefs” are consecutively introduced. As Mrs. Smith still did not seem to profit very much from the written work, more focus was put on in-session discussions. It has been the experience at the clinic that most patients profit greatly from the worksheets and that many of them do so only after some extra encouragement to really engage in this type of work; however, a minority of patients never really warm up to it. These are often patients for whom German is a second language or who are not exposed to a lot of writing in their daily lives. As Mrs. Smith seemed emotionally engaged in therapy, there was no reason to attribute her not working with the worksheets to avoidance.

The worksheet “myths of mourning” was also used during this phase. This is usually done in the second session of CPT if there has been a loss connected with the trauma. However, Mrs. Smith said in the beginning that she had finished mourning the loss of her friend. Only at this point in therapy did it become apparent that other people had often told her that she should be over the loss by now but was in fact still struggling with it.

The last sessions of CPT focus on five topics that are important to most trauma survivors. These are safety, trust, power and control, esteem, and intimacy. These topics are considered with respect to the patient and with respect to other people (e.g., trusting oneself and trusting others). In addition, the patient is asked to write another impact statement to be able to compare it with the first one. As is frequently the case with CPT, during these sessions, some issues emerged again that had been important before. Mrs. Smith was interested in these worksheets and completed most of them but still did not use the “challenging beliefs” worksheets. Even though more sessions were available to her, and even though she still reported some difficulties, she wanted to end therapy after Session 20. She did not write the second impact statement, stating she had not found the time, but said that the therapy had changed a lot for her and that she could think about the event without intense emotions. Her own opinion of having profited from therapy is underscored by her IES-R scores during this phase: Symptom cluster scores stayed stable at a low level (below 5, clinically significant scores would be more than 9) over the last few sessions.

Assessment of Progress

Mrs. Smith’s symptom scores at the three assessment points are given in Table 1. At the post-treatment assessment, her IES-R scores were 0 for intrusion and avoidance and 6 for hyperarousal. This is within the healthy range in each cluster. The PDS (which, as mentioned before, had been within the healthy range before therapy as well) had a score of 4. The BSI GSI had decreased to 0.46, translating into a *T*-score of 53, which is close to the mean of the German norm population. The PTCI total score had increased by 25 points to 106 points. This is surprising because usually, the PTCI is highly correlated with PTSD symptom measures such as the PDS and the IES-R, and values decrease with successful therapy (Ehlers, Clark, Hackmann, McManus, & Fennell, 2005; Foa et al., 1999). Mrs. Smith’s posttreatment score is still below the average for PTSD patients, but within the range of this group. This development is difficult to interpret. It is possible that Mrs. Smith became more aware of her thoughts throughout the course of therapy. It could, however, be an indication that the self-report instruments are not highly valid in this case because of the differences between DGS and written German. Interestingly, Mrs. Smith’s interpersonal distress also improved: Her posttreatment overall IIP score was at 0.89 points, which is within the range but below the average of the German healthy norm sample.

Table 1. Scores at Three Assessments

Instrument	Pretreatment	Posttreatment	Follow-up (6 months)
PDS Total	6	4	6
IES-R Total	40	6	4
IES-R Intrusion	12	0	0
IES-R Avoidance	18	0	0
IES-R Hyperarousal	10	6	4
PTCI Total	80	106	111
BSI GSI	0.62	0.46	0.17
IIP-C Total	1.25	0.89	0.70

Note: PDS = Posttraumatic Diagnostic Scale; IES-R = Impact of Event Scale–Revised; PTCI = Posttraumatic Cognitions Inventory; BSI = Brief Symptom Inventory; GSI = Global Severity Index; IIP-C = Inventory of Interpersonal Problems–Circumplex Version.

8 Complicating Factors

As was to be expected, the patient's deafness was the most significant complicating factor. The discussion on this will be organized into two broad issues: complications influencing the "content" of therapy and complications arising in the therapeutic situation and how I experienced them.

Complications Influencing the Content of Therapy

Because the deaf community is so small, it is difficult to get in touch with diverse opinions and ideas. Mrs. Smith had been told multiple times by friends that it was not normal to still be grieving her friend's death and no one could relate to her posttraumatic symptoms. In this situation, a hearing patient could be encouraged to expand her social circle, to meet new people. For Mrs. Smith, this was not an option.

The therapists interviewed by Hoyt et al. (1981) reported that deaf patients often had less knowledge of mental health issues. This issue had some influence as well. Although CPT is mostly present-focused, past experiences will often be discussed to examine how preexisting beliefs have been influenced (shattered or confirmed) by the trauma. Therefore, these preexisting beliefs and how they were acquired will often be discussed in CPT sessions. CPT makes a distinction between "natural" emotions that stem from the traumatic event itself (such as sadness after a loss) and "secondary" emotions that stem from thoughts about the event, such as fear related to the new belief that "the world is a dangerous place." In Mrs. Smith's personal theory of emotion, there seemed to be no room for natural negative emotions. She probably associated feeling sad or frustrated with "being difficult" because that was the feedback she had received as a child. When the discussion in therapy turned to emotions, it seemed a novel concept to Mrs. Smith that sometimes it is "right," "adequate," or "natural" to have negative feelings. This led her to reappraise some of her childhood memories. As she reported having nobody with whom she could talk about these issues, I decided to take the time (about two sessions) to discuss these past issues because I felt that if Mrs. Smith persisted in considering herself a bad person for experiencing negative emotions, this would hinder her processing the trauma.

Another fact that I had not given much thought to before working with Mrs. Smith was how stressful the communication difficulties can render daily life. This stress was one of the reasons

why Mrs. Smith's homework compliance was sometimes not optimal. In retrospect, it might have been better to do only one session per week.

Complications During the Sessions

It was strange to have a patient make eye contact with a different person so much of the time during the sessions of therapy. The *timing* of eye contact was especially difficult to get used to. I watched the patient's face for nonverbal cues as she was signing and then waited for the matching words that came while the patient was often observing my reaction to her words with an expression of interest. This reversal of the "normal" timing of eye contact (watching while listening and being watched while speaking) never quite lost its unfamiliarity. This caused me to experience the whole therapeutic relationship as somewhat distant, even though I clearly felt that we connected emotionally. Reading the facial expressions of someone who signs is also difficult at first because such expressions are a part of DGS and can seem strange and exaggerated in the beginning. Especially during the first one or two sessions, in my fascination with DGS and my curiosity about what my words looked like in sign language, I probably looked at the interpreter too often instead of focusing on my patient. Sitting next to the interpreter and not having him in my line of sight in later sessions helped.

Working with a sign language interpreter is more stressful than regular therapy because there are additional considerations. I tried to be attuned to the signing going on next to me. I was often able to hear when the signing became more hectic or stopped and could react by pausing or starting to speak again, respectively. Apparently, some things can be said more quickly in DGS than in spoken German, whereas others take more time. I also did my best to use concrete and precise language. The feeling of self-consciousness caused by having a "witness" for any blunders I made subsided after a few sessions and was replaced by the feeling of working as part of a team. At this point, I was no longer as exhausted after the sessions as I had been in the beginning.

Two issues make working with a sign language interpreter easier than when two different spoken languages are involved: (a) Neither the patient nor I had to filter out our own language between two languages being spoken at the same time because DGS and speech use different modalities and (b) with the use of LBG, it was possible for the interpreter to communicate the same thing to both of us at the same time, which made scheduling much quicker.

One particularly complicated session occurred when the interpreter ended up at the wrong clinic (something bound to happen when organizing three people and two locations), leaving the patient and me to our own communicative devices. We decided to hold the session anyway. Mrs. Smith used what seemed to be a combination of hearing (as said before, she wore hearing aids to maximize her residual hearing) and lip-reading to understand me, and she also tried hard to speak as well as she could. I did my best to listen closely, enunciate clearly, and to move my mouth more than usual when speaking. The topic under discussion was the patient's relationship with her dead friend's mother. Possibly not very much "came across" during this session, but the 50 min of diligent effort to understand and to make oneself understood did prove to both of us that there was genuine interest and dedication on the part of the other person. For me, it also made it very clear how stressful my patient's daily life really was. I had gotten used to the interpreter at this point and really felt my patient and I could communicate well, but this session showed me how strenuous being in a hearing environment must be for my patient without the presence of an interpreter.

Maybe the "complication" I had been least prepared for was the one described by Porter (1999), who was told that deaf people "tend to consider all deaf people as their extended family, and feel most comfortable where there are 'the most deaf'" (p. 168). When Mrs. Smith talked

about the traumatic event, she did not say “the man” or “she,” but referred to people as “the hearing person” or “the deaf person.” Interestingly, in an email to me, the interpreter referred to the patient (the only one we had ever worked with together) as “the deaf patient” rather than just “the patient.” Apparently, from the view of deaf culture, being deaf or hearing is the most important distinction between people and Mrs. Smith and I did not belong to the same group. De Bruin and Brugmans (2006) warned that this phenomenon can be damaging to therapy because there may be an alliance against the therapist or the therapist may not be taken seriously. I never felt that this was the case. Maybe it is best compared with an encounter between two people from different cultural backgrounds, a situation in which both partners know that they do not share the same background and are not only communicating “as themselves” but are also perceived as representatives of their respective cultures.

In retrospect, and this may of course be connected, I also never had so little “small talk” with a patient as with Mrs. Smith. With most of my patients, before “really starting,” there will be a few words exchanged on general topics unconnected to the therapy during the unlocking of the room and hanging-up of the coat. Here, this was impossible because during that interval, we had our hands full and/or our backs turned. In addition, when everybody was seated, three people ready to go, it seemed like throwing away valuable therapy time to be making small talk.

The Contribution of the Sign Language Interpreter: An “Uncomplicating” Factor

“Our” sign language interpreter had extensive experience in interpreting therapy sessions and he was an enabler of communication in more than one respect. During the preparation of this article, I was surprised to read about some of the potential problems discussed in the literature because they never appeared in my work with Mrs. Smith. For example, I never had any doubts as to whether the interpretation was correct and complete, and I always felt in charge of the therapy. He explained to me what was going on the one or two times there was a dialogue between him and my patient (“we had to agree on which sign to use for . . .”). He also asked me for clarification when I had not expressed myself clearly.

The issue of meetings between only the interpreter and therapist was never explicitly discussed, as there was no specific time allotted for such meetings. However, the patient usually hurried away after the sessions to catch her train. She knew the interpreter beforehand and trusted him fully and therefore leaving the two of us together was not a problem for her. Sometimes, the short interval after the patient left was used as a kind of debriefing after emotionally intense sessions. However, the interpreter also gave me some general information such as that working with this particular patient was easy because she was fully competent in DGS and that she was something of an exception in that her skills in written German were so good. The sign language interpreter also supported me by volunteering observations about the therapeutic communication. For example, after one session in the middle of the therapy, he commented that he thought the relationship between Mrs. Smith and me had developed well. He observed that, “she looks at you until she sees your mouth begin to move, and only then looks at me to see what you are saying.” This subtle development would have been lost to me because there was still much less eye contact than I was used to with my other patients.

At the same time, the interpreter left me to my own devices to find out for myself what Mrs. Smith’s experiences and issues were, sometimes encouraging me by sharing afterwards that particular themes came up frequently in therapies with deaf patients. However, he never provided information beforehand in a way that might have influenced the direction of the therapeutic conversation.

9 Access and Barriers to Care

In Germany, deaf patients have a right to a sign language interpreter during medical visits, including psychotherapy. The interpreter is paid for by the patient's mandatory health insurance. Theoretically, the deaf have the same access to care as anyone else. Practically, however, the availability of interpreters and of therapists willing to work with a deaf person may vary and it is especially difficult to obtain care for the subgroup that is disfluent in any language. In the United States, the health care provider has to pay for the sign language interpreter.

The interpreter informed me that he had heard of many bad experiences with therapy from members of the deaf community. Glickman and Harvey (2008) also stated that "stereotypical images of mental hospitals and mistrust of hearing mental health providers are not just the product of ignorance and irrationality. They reflect historical experiences so common for deaf people as to have become institutionalized in Deaf folklore," (p. 143). Therefore, there may be more reluctance to seek help in some deaf people.

10 Follow-Up

There were two follow-up sessions held 2 and 6 months after the end of therapy. During the first follow-up session, Mrs. Smith reported she had a lot going on in her life and rarely thought about the event. She reported being in touch with the dead friend's family and was better able to distance herself from others' opinions about how she should feel. Six months after therapy, it was much the same. Mrs. Smith reported that her relationship with her partner was at first more harmonious but became more difficult after several months. She did not take up the offer of a conjoint session. She completed the same assessment battery as before and after therapy. The PTSD instruments had remained more or less unchanged as compared with posttreatment assessment (PDS 6, IES-R total 4, PTCI 111). This placed Mrs. Smith's scores in the healthy range in both PTSD scales, but as in previous assessments, her PTCI score was within the range of PTSD patients. The BSI GSI had dropped even more, to 0.17 points. This places Mrs. Smith's general psychological distress on the low end of the normal range with a *T*-score of 43. Similarly, the IIP score had decreased to 0.70 points, which is below the range of the healthy German norm, indicating that Mrs. Smith experienced very few problems in interpersonal relationships. The two latter scores indicate that she had not only profited from therapy with respect to her PTSD but also improved in general psychological and interpersonal functioning. It has to be kept in mind, however, that it is not clear how reliable written measures are in this case. Follow-up scores are included in Table 1.

At 6 months, in addition to the follow-up session with the therapist, Mrs. Smith completed a semistructured interview about her therapy experience conducted by a different clinic staff member. This is done to encourage patients to give feedback they might be reluctant to discuss with their therapist. Mrs. Smith reported that she had "markedly improved" with respect to her mood, coming to terms with her friend's death, and her grief, and she rated the overall success of the therapy as "good." She described the therapeutic relationship as "very good," stating that the therapist had listened to her and given her a lot of advice. She felt that the therapist was very competent, but spoke in an abstract way. This highlights the importance of using concrete language and shows that I was not always successful in my endeavor to do so.

11 Treatment Implications of the Case

This case shows that a structured CBT such as CPT can be successfully implemented with a language-proficient deaf patient with PTSD in a clinic not specializing in serving this clientele.

The deviations made from the CPT protocol were minor, and treatment can therefore be viewed as typical for a clinical setting. Although some therapists may worry that using a manualized treatment in an unfamiliar therapeutic situation such as the one described might cause additional stress, my experience has been very different. I found that doing CPT and deviating from the protocol only as needed helped me to conduct the therapy in a structured manner. CPT may be especially suited for this because the underlying theory is very clear, the worksheets can be used for all kinds of thoughts, and it can be combined with other CBT methods when other problems or symptoms in addition to PTSD arise (Messman-Moore & Resick, 2002; Schulz, Resick, et al., 2006).

It is important to remember that the group of the deaf is diverse and there may be more, less, or different difficulties with other deaf patients. In this case, the patient was high functioning and the therapy had a circumscribed goal that was agreed upon by all parties involved: the PTSD stemming from the accident.

12 Recommendations to Clinicians and Students

It has to be stressed that there are some prerequisites to successful therapy with a sign language interpreter. The first and most important one is the skill of the interpreter. Therefore, it is necessary to have a trained, professional interpreter who will maintain confidentiality and translate impartially (Porter, 1999). In the United States, there is a certification issued by the Registry of Interpreters for the Deaf (RID). In countries where such certification does not (yet) exist, it will be helpful to rely on the patient's judgment as well as one's own. Most deaf individuals will know an interpreter with whom they feel comfortable. During sessions, unexplained and extended dialogues between interpreter and patient in sign language would be a clear indication that something is going wrong and the respective roles need to be discussed. Some authors recommend that interpreter and patient should not have met prior to therapy, but this will be hard to achieve outside specialized settings (Porter, 1999).

"Our" interpreter stated that a lot of experience working in the therapeutic setting was necessary. However, it is not possible to be experienced right from the beginning. Therefore, as a middle ground, I would recommend that at least one person, the interpreter or the therapist, should have experience with sign-language interpretation in psychotherapy. Emotional stability and a good general knowledge are definitely needed. Our interpreter also told me that he worked in very different settings and that for him, there was a limit on how many therapies he could interpret in a day. It seems that this kind of balance will prevent too much stress from translating emotionally intense sessions.

With respect to meetings that exclude the patient, in my experience, spending a few minutes alone with the interpreter from time to time was very helpful. In our case, these brief discussions occurred naturally, but if this is not feasible, I would recommend taking a few minutes out of the therapy time every three or four sessions to get feedback from the interpreter. This does not mean feedback on therapy content but on communication. The interpreter will be able to say whether the patient understands what is being discussed, whether the therapist should adapt his or her speech to improve communication, and whether the therapeutic relationship is developing. Although it is necessary that the interpreters are able to "deal with their own feelings about what they learn in the session" (Porter, 1999, p. 170), it can still be helpful to briefly discuss these feelings after intense sessions.

On the side of the therapist, a willingness and ability to be open, empathic, and genuinely interested in the patient's experience are necessary. This is of course true for every therapy, but may be more so when dealing with members of a marginalized group that have often had very different experiences from one's own. Although stressing the importance of specialized training in the field of deafness, Glickman and Harvey (2008) stated, "When there is no local specialist

or specialty program, it is ethically justifiable to serve a client from a minority group with whom one has no experience provided one seeks out guidance” (p. 172). I have indeed found it very helpful to talk to the counselor from the agency for the hearing impaired and to do some preparatory reading in addition to the usual supervision of the case. As Mrs. Smith’s statement in the follow-up interview proves, it is very important to speak in a very concrete manner. More effort is involved working with a sign language interpreter in therapy than otherwise because more people have to be coordinated, the setting is unfamiliar, and there is one more person present. That being said, some of our patients will always require more effort than others, and the increased effort is more than evened out by the increased learning opportunities.

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Bio

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