

# The Origins of Cognitive Processing Therapy

**R**ather than writing a review chapter on theories of posttraumatic stress disorder (PTSD)—which have evolved from early learning theory to cognitive and constructivist theories as described elsewhere (Chard, Schuster, & Resick, 2012; Resick, Monson, & Rizvi, 2013; Monson, Friedman, & La Bash, 2014), and which may or may not have influenced the development of cognitive processing therapy (CPT)—I (Patricia A. Resick) have chosen to write this chapter in the first person and make it a little more autobiographical. I have done this so that readers can see how I first developed CPT, what the influences on it were, and how it has evolved into its present form through the engagement of my coauthors and of many others. This chapter also emphasizes the importance of theory: Theory guides therapists in explaining to their clients why they have PTSD, what has maintained it, and how to get over it, as well as in staying within the CPT protocol. It also guides particular ways of thinking about trauma recovery when therapists encounter challenges in treatment delivery. We address the theoretical underpinnings of CPT at several other points in this book as well.

## The Origins of CPT

I started my career in the field of trauma during my internship at the Medical University of South Carolina (MUSC) and the Charleston Veterans Administration (VA; now Veterans Affairs) Medical Center. Specifically, I became one of the first cohort of rape crisis counselors at one of the few rape crisis centers in the United States in the mid-1970s. The very first night I was on call, I went to the hospital in the middle of the night to meet a woman who was nearly speechless in shock at what had happened to her. I was mostly just sitting with her silently, waiting for a nurse or doctor, when her

husband came barreling through the doors of the emergency room yelling, “What have they done to me?” Aside from being flabbergasted at his response, I realized that I was clueless about what this woman was going through and how to help her. As advocates, my fellow counselors and I stayed with women in the emergency room (many times for numerous hours), and accompanied them into the exam rooms if they wished, while some (usually male) physician or resident performed an often rough medical examination and collected evidence, while clearly wanting to get back to the “real patients.”

Some rape crisis advocates focused their efforts on more humane treatment of rape victims in emergency rooms and on the education of the medical community. Being a clinical psychology graduate student, I went to the literature in my field, which back then meant physically going to the library and reading through every index of *Psychological Abstracts*. A fellow student, Joan Jackson, and I did a volume-by-volume search and found only five articles, which were essentially useless. Other, more sociological articles focused on victims’ precipitation of rape, and thus engaged in victim blaming.

However, at about that time, a number of things happened. Susan Brownmiller (1975) wrote *Against Our Will*, which chronicled the history of rape as a political and power weapon. In addition, women who had been raped were conducting “speak-outs” through the National Organization for Women, and it soon became very clear to many how common the problem of rape was and how profound its effects were. Burgess and Holmstrom (1976) published an important article in the *American Journal of Psychiatry*, one of a series of articles on the reactions they observed from conducting interviews with 92 rape victims in an emergency room. Finally, the National Institute of Mental Health (NIMH) set aside \$3 million for studies on rape, and I became involved in writing two grant applications—one with Dean Kilpatrick at MUSC, and one with Karen Calhoun when I went back to the University of Georgia to complete my graduate degree. Both grants were funded.

The first studies at MUSC included a prospective longitudinal study of fear and anxiety among victims, as well as an attempt to develop a brief behavioral intervention and then the use of stress inoculation training, based on Meichenbaum’s work on coping skills training (Meichenbaum & Cameron, 1983, which was an unpublished 1972 manual at the time we used it). The University of Georgia study was conducted in Atlanta at Grady Memorial Hospital, where about 1,000 women a year who had been raped were being seen in the emergency room. The focus of the prospective longitudinal study was on depression. Our goals were simple: to see whether rape produced fear or depressive reactions (a question that had never been studied), and, if so, how long-lasting they might be. We also wanted to see whether we could develop treatments that could be used in rape crisis centers.

While those studies were being reviewed and conducted, I took a faculty position at the University of South Dakota and commuted to either Charleston or Atlanta once a month. After 4 years there and 1 year back in Charleston, I assumed a faculty position at the University of Missouri–St. Louis. Although I had been offered positions at better-known universities, I needed to be in a city that was large enough to allow me to continue my work, and St. Louis fit the bill.

My first grant, funded by both NIMH and the National Institute of Justice, was another prospective longitudinal study—this time comparing female rape or robbery victims with male robbery victims. In the meantime, I was trying to conduct treatment outcome research with small university grants. The first study I conducted, still within the anxiety perspective, was a comparison of group stress inoculation, assertiveness training (because assertiveness was thought to counter fear), and supportive psychotherapy. By then the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition* (DSM-III; American Psychiatric Association, 1980) had been published, with a new diagnosis in the anxiety disorders category: PTSD. The DSM-III definition of a traumatic stressor used rape as an example, but there were as yet no measures of PTSD. My colleagues and I used the Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979) and the Derogatis Symptom Checklist-90 (Derogatis, 1977), among other measures. This small study found posttreatment improvements, but there were no differences among the three conditions (Resick, Jordan, Girelli, Hutter, & Marhofer-Dvorak, 1988). Because we did not know how long it would take to fill a group, we could not use random assignment; however, we predetermined the order of groups, so the assignment was unbiased. Later I realized that the lack of differences was probably at least partially due to the small sample size and lack of power, but in the discussion of the study, I focused on the commonalities of the treatments, expectancy theory, psychoeducation, and cognitive change.

The prevailing theory about rape responses at the time was that they consisted of first-order classical conditioning of the fear reaction, along with second-order conditioning that generalized the reaction to other triggers (Kilpatrick, Resick, & Veronen, 1981; Kilpatrick, Veronen, & Resick, 1979). Later, once the PTSD diagnosis was introduced, came awareness of the importance of escape and avoidance learning in maintaining the primary symptoms of PTSD. If someone is experiencing strong conditioned emotional reactions, this person is likely to avoid or escape reminders of the trauma that have spread to nondangerous situations. Mowrer's (1960) two-factor theory of classical conditioning and operant avoidance became more commonly discussed, along with Foa and Kozak's (1986) emotional processing theory of PTSD, which in turn was based on Lang's (1977) theory that people develop fear networks with stimulus, response, and meaning elements. Because there were enough women who said to me, "I knew he wasn't going to kill me, but it was such a huge betrayal, and I feel so much shame and disgust at what he did to me," I began to have doubts that PTSD after rape was just a fear/anxiety disorder. One exception to a theory means that the theory needs to be revised. I began to look toward cognitive theories of PTSD.

## Theoretical Influences

In our earliest conceptualizations of depression among rape victims (Kilpatrick, Veronen, & Resick, 1982), we viewed the development of such depression within several extant theories: lowered levels of positive reinforcement (Lewinsohn, 1974), and

learned helplessness resulting from the unpredictable and uncontrollable nature of the victimization experience (Seligman, 1971). Paykel (1974) proposed that depression occurs following negative interpersonal events, threatening events, or blows to self-esteem. Of course, rape victims experience all of these.

In the 1960s and 1970s, Aaron T. Beck studied the causes of depression and developed his cognitive theory, which focuses on how people absorb negative and erroneous beliefs from society that leave them feeling ashamed and depressed. He and his colleagues produced a treatment manual for cognitive therapy of depression (Beck, Rush, Shaw, & Emery, 1979). Although this was one of the first manualized treatments, I wanted something more specific and progressive that would tell therapists how to proceed session by session. I was hoping that clinicians could pick up the manual and conduct the therapy. I also wanted to help clients to become their own therapists by teaching them new, more balanced ways to cope and think, much as we had done with stress inoculation. I liked the Socratic style of therapy that Beck and colleagues proposed, in which therapists asked clients questions so that they could figure out the answers for themselves. However, Beck et al.'s cognitive therapy for depression focused on current thoughts, and I believed that in treating PTSD, we first needed to go back to revisit the traumatic events to see where clients' thinking developed and whether they had emotionally processed the traumatic events at the time. I started conceptualizing that those who hadn't been able to recover had been "stuck" in their thinking since the time of the traumatic events, and I began to call such clients' thoughts "Stuck Points."

Additional inspiration came from an article and book by McCann and colleagues (McCann, Sakheim, & Abrahamson, 1988; McCann & Pearlman, 1990), who developed the constructivist self-development theory of traumatic victimization. This theory was based on Mahoney's (1981) constructivist perspective, in which humans actively create their personal realities, such that new experiences are constrained to fit people's determinations of what "reality" is (Mahoney & Lyddon, 1988). McCann et al. proposed a constructivist theory of trauma in which people construct meaning from events. They theorized that aside from frame of reference (the need for a stable and coherent framework for understanding experiences), the schemas (mental structures and needs) that are likely to be affected by trauma are those regarding safety, trust, power/control, esteem, and intimacy. These constructs can be self- or other-directed. Because these constructs appeared so frequently in our discussions with clients, my colleagues and I also began to think that we could use the work of McCann and colleagues in a briefer cognitive-behavioral therapy.

I was also influenced by a chapter by Hollon and Garber (1988), in which they proposed that when someone is exposed to schema-discrepant information, one of two things happens. The information may be altered so that it can be assimilated into the person's existing beliefs/schemas without changing the prior beliefs (e.g., "It wasn't a rape, it was a misunderstanding; I must have done something for him to think it was OK"). The other alternative is that existing beliefs (e.g., "Only strangers rape") are changed to incorporate the new, discrepant information (e.g., "It is possible to be raped

by someone you know”). This new learning represents accommodation and is the goal for therapy. Hollon and Garber’s proposal, of course, was based on the work of Piaget (1971), but I had not thought about it in the context of therapy or trauma before.

I realized further in working with trauma survivors that sometimes people changed their beliefs too much, even while they were distorting and attempting to assimilate the traumatic events. They overgeneralized their beliefs to whole classes of schemas (e.g., “I always make bad decisions,” “No one can be trusted,” “I must control everyone around me”). We called this “overaccommodation” (Resick & Schnicke, 1992, 1993). As we (my graduate student Monica Schnicke and I) were in the early stages of developing CPT, we realized that it was important to work on assimilation of the trauma first and not move to the overaccommodated beliefs until the index trauma was resolved. For example, once clients stop blaming themselves for the occurrence of the traumatic event, then it is easier to tackle the idea that they can’t make good decisions. Accordingly, we placed the work with overaccommodated themes later in the therapy.

### Early Development of CPT

My first study of CPT was again funded with small grants from the University of Missouri–St. Louis. I conducted CPT in groups for the very practical reason that I could collect more data on clients in groups than on those receiving individual therapy. However, by the time I was funded by NIMH to conduct a randomized controlled trial (RCT), I had conducted 84 pilot cases and the first CPT manual was published, which included the results of the first 35 participants in group treatment and the first 9 clients in individual treatment (Resick & Schnicke, 1993).

In 1994, while she was a graduate student, Kathleen M. Chard (my first postdoctoral fellow) created a version of CPT for individuals with childhood sexual abuse histories that combined group and individual sessions of CPT. While working as a therapist on the study comparing CPT with prolonged exposure and a wait-list control (see Chapter 2 for a discussion of this study), she submitted a grant application for research on her adaptation of CPT (CPT-SA). In addition to combining group and individual treatment, CPT-SA included several sessions to cover these topics: family “rules” (e.g., “If anything goes wrong, it is your fault”); what children are developmentally capable of (e.g., telling a 4-year-old to come home at 5:00 is expecting too much of the child); assertive communication; ways of giving and taking power; and social support.

In the process of developing CPT-SA, Chard noted that not everyone’s beliefs were shattered by trauma (Janoff-Bulman, 1992), and it soon became obvious as we continued to study and treat PTSD that sometimes trauma was schema-congruent. We observed that if clients had been abused as children (emotionally, physically, or sexually), or had other prior traumas, they might already have (and perhaps had always had) negative beliefs about themselves and about their roles in the traumatic events (e.g. “I must deserve bad things to happen to me”). Any new trauma would be assimilated



without alteration because it was not schema-discrepant, but schema-congruent. The question then arose: Why would such people have PTSD, if their beliefs were already matching the new events? It is possible that these individuals did not get *new* PTSD; they might have already had it. However, the new events might have strengthened their distorted beliefs about themselves and others and about their roles in traumatic events. In other words, they might be using the new events as “proof” that their prior beliefs were accurate. Their PTSD would worsen, and their beliefs would become more entrenched (Resick, 2001; Resick, Monson, & Chard, 2007). On the other hand, even with prior negative schemas about themselves or others, people might still ask, “Why me?” or “Why again?” They might still find new traumatic events to be schema-discrepant, because they had done everything they could to change what they perceived to be the cause of prior trauma (“I try to be perfect”), or they could see how members of other families behaved toward one another and couldn’t figure out what they were doing wrong.

Another difference between the theoretical approach that led to CPT and the theories on which other therapies are based lies in the range and type of emotions addressed in CPT. Because PTSD was classified as an anxiety disorder until the publication of DSM-5 (American Psychiatric Association, 2013), most of the extant theories on PTSD focused on fear and anxiety. Because I did not come from an academic background of work in the anxiety disorders, I was impressed by the amount of “erroneous” guilt, shame, disgust, sadness, and so forth that we were finding among the clients. In the longitudinal studies we conducted, nearly everyone said that they were afraid during the event—but most people recovered from their fear, and fear did not always seem to be the driving force behind the flashbacks, intrusive memories, nightmares, and avoidance we observed. Furthermore, if PTSD were only about fear conditioning, then it wouldn’t matter what the trauma was; the rates of PTSD should be equal. The epidemiological studies of PTSD (e.g., Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995) made it clear that all traumas did not have the same effects: Rape and other interpersonal traumas produced greater rates of PTSD than impersonal traumas such as natural disasters and accidents. Something else was going on besides fear conditioning, because the persons who had experienced these traumatic events evaluated it in relation to their beliefs and prior experiences.

In addition, self-blame and/or erroneous other-blame, leading to guilt or shame, were almost universal among those with PTSD. By the time I wrote an unpublished manual for a generic version of CPT (Resick, 2001), after the September 11 attacks, I was differentiating “natural” emotions from “manufactured” emotions. The “natural” emotions are those we humans are hard-wired with and do not need to think about (e.g., fight-flight leads to fear or anger; losses elicit sadness). The emotions referred to as “manufactured” result from faulty cognitions about the traumatic event. While natural emotions may take a while to dissipate, if not avoided, emotions that are generated by thoughts (“It must have been my fault, because things like this don’t happen to good people”) will disappear immediately if the thought is changed with more accurate information.

As discussed in more detail in Chapter 2, the first RCT of CPT compared it with prolonged exposure and a minimal-attention wait list among women who had been raped. The large majority of the participants (85%) had experienced other interpersonal traumas, and 41% had experienced childhood sexual abuse (Resick, Nishith, Weaver, Astin, & Feuer, 2002). The second RCT included women who had experienced any kind of interpersonal violence in adulthood or childhood as their primary (index) trauma to begin treatment (Resick et al., 2008). While we were conducting that study, Candice M. Monson received a grant from the VA to conduct the first study of CPT with veterans. The majority of participants were male veterans of the Vietnam War (Monson et al., 2006). Given that most of them had received treatment for years, and that all had a history of substance abuse, the loss of a PTSD diagnosis in 12 sessions among 40% of these veterans had an immediate impact on the field. Monson also noted that there were more commonalities than differences among trauma survivors, and that the veterans' interpretations of their traumas were very similar to those of the interpersonal violence victims in the earlier studies.

In 2003, I moved from St. Louis and academia to a job with the VA's National Center for PTSD as the director of the Women's Health Sciences Division. The following year, Monson moved to Boston to become my deputy director, and Chard moved from the University of Kentucky to the Cincinnati VA Medical Center to become the director of the PTSD programs there. Over the next few years, Chard not only expanded the outpatient clinic in Cincinnati, but developed three residential programs for PTSD: one for men, one for women, and one for those suffering from the aftermath of traumatic brain injury. She also adapted the individual and group protocols for veterans receiving treatment in residential centers. Monson continued her work on a couple therapy for PTSD that incorporated aspects of CPT.

## Dissemination of CPT

In 2006, the three of us received funding from the VA Central Office to begin developing materials for disseminating CPT throughout the VA system. We wrote a treatment manual for active-duty military personnel and veterans; developed training materials (slides with notes, videos, trainers' manual, consultants' manual); and then trained a first group of national trainers. Because there were so few people in the VA system who had conducted CPT, many of the trainers were from St. Louis (former faculty colleagues, postdoctoral fellows, or graduate students of mine). Up until then I had only conducted 1-day workshops, with no follow-through with case consultation. Monson rightly suggested that we emphasize the teaching of the Socratic method as the most difficult part of the therapy, but we had to think through what we were doing naturally at that point to teach it to other therapists, who might have been taught never to ask a question or to let thoughts go rather than changing them. We also had to teach the reasoning behind the approach of asking questions that would help clients examine their Stuck Points, (erroneous thoughts and beliefs dating from the time of the trauma, as

explained earlier), to put them back into the context of what they actually knew at the time, what choices they really had, and (if they had choices) why they made the ones they did. We also had to help clients differentiate among intentionality, responsibility, and the unforeseeable. Finally, Chard noted that we needed to include a Stuck Point Log that would serve as a “living” document throughout the therapy. This log would help to keep both a client and a therapist focused on the unhealthy cognitions and not get derailed into more supportive forms of therapy.

The first 2 years of the dissemination project included 22 workshops each year, and then the project was cut back slowly, as more VA therapists completed training that included workshops and case consultation. Along the way, we received good feedback from the trainers about ways to streamline the handouts and make them more accessible to people with lower education levels or with traumatic brain injuries. We also developed “help sheets” for understanding Stuck Points and for answering challenging questions. Beyond the VA context, CPT is now being disseminated through mental health centers in the United States, as well as in different countries.

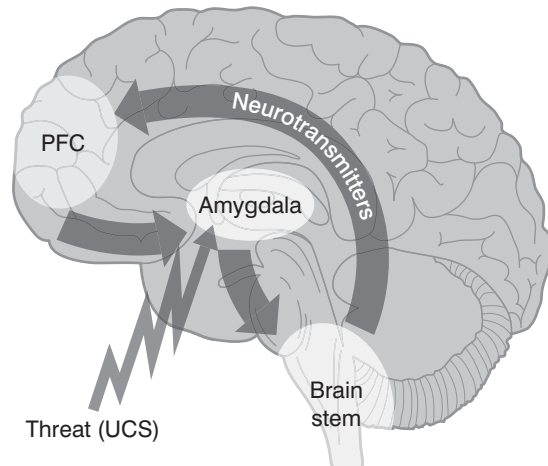
The CPT manuals have been translated into 12 languages thus far, and the therapy appears to work rather well across cultures (see Chapter 14). Because the cognitive impact of a traumatic event is very individualized, clients across cultures can describe why they think their events happened and what the events mean to them. Even though there may be differences in some concepts, many of them translate well—and even in very strict traditional cultures, it can be pointed out that not all people believe identically and that there is some flexibility in beliefs. People can change their minds.

## **A Biological Model of PTSD and CPT**

The most recent additions to our training and conceptualization involve the connections between the biological underpinnings of PTSD and the reasons why CPT works. Most of this new material reflects research on activation of the amygdala, which triggers strong emotions and sends neurotransmitters throughout the brain to activate the emergency response. Additional factors that were not noticed immediately, but are actually found more frequently in research, are the diminished responsivity and smaller size of the prefrontal cortex (Shin, Rauch, & Pitman, 2006) among those with PTSD.

In a normal fight–flight response, activity in the prefrontal cortex (which is the seat of decision making and control over the amygdala) decreases, along with other immune functions and normal physical processes like digesting food, in order to free all available resources for either running or fighting. The natural emotions accompanying flight and fight are fear and anger. During a life-threatening emergency, it is more important to activate the brain stem and neurotransmitters to aid in the fight–flight response than to think about what to have for dinner or whether to change jobs. However, in a well-modulated emergency response (see Figure 1.1), the prefrontal cortex is activated enough to notice when the danger is over, and to send messages out to

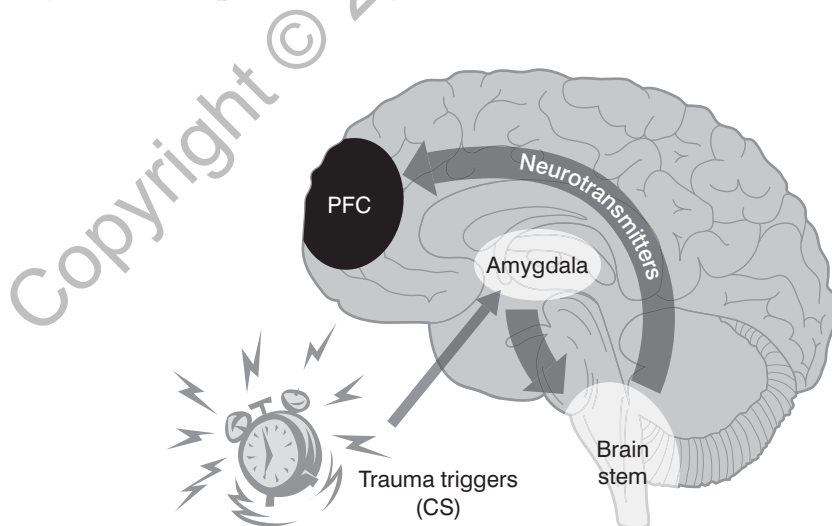




**FIGURE 1.1.** Well-modulated emergency response. UCS, unconditioned stimulus; PFC, prefrontal cortex.

the amygdala to stop the fight–flight response and return to normal parasympathetic functioning. In other words, there is a reciprocal relationship between the prefrontal cortex and the amygdala.

In studies of people with PTSD, by contrast, researchers have found that the amygdala shows heightened responsivity while the prefrontal cortex shows greatly decreased activity, and that there is a functional relationship between the two (Shin et al., 2004). Because the amygdala is too highly activated and the activity in the prefrontal cortex is diminished (see Figure 1.2), it takes a person with PTSD much longer to recognize that the perceived danger has ended and to calm down.

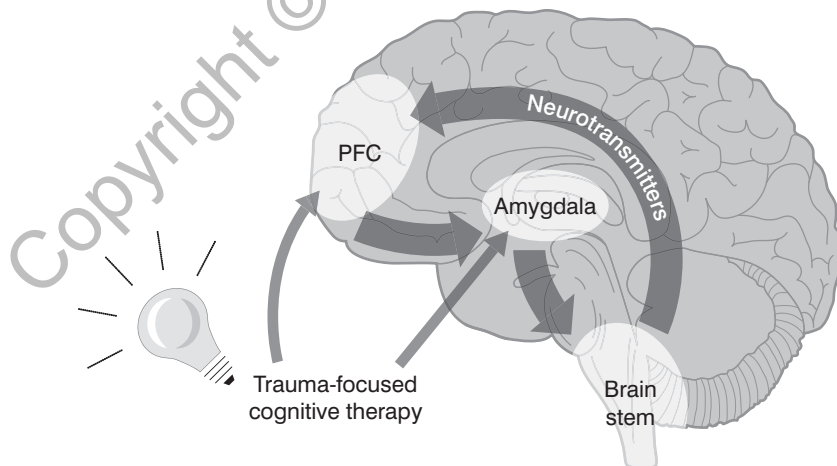


**FIGURE 1.2.** Emergency response in PTSD. CS, conditioned stimulus. Data from Liberzon and Sri-pada (2008), Milad et al. (2009), Rauch et al. (2000), and Shin et al. (2001).

In imaging studies, Hariri and colleagues (Hariri, Bookheimer, & Mazziotta, 2000; Hariri, Mattay, Tessitore, Fera, & Weinberger, 2003) found that when participants were shown pictures of emotional faces or dangerous objects, and were asked either (1) to pick pictures that matched the original pictures, or (2) to label the emotions or objects, in the first case there was no change in the activation of the amygdala. However, when participants were asked to label the objects or to describe whether each picture was of a natural or an artificially created danger, the instruction to use words resulted in the activation of the prefrontal cortex (including Broca's area, which is the speech area), while the amygdala quieted.

It occurred to us that if merely labeling objects or pictures was sufficient to activate the prefrontal cortex and quiet the amygdala, we could accomplish much more with regard to affect regulation through cognitive therapy—specifically, having clients talk *about* and answer question about the trauma—than through having clients reexperience the images of the traumatic events. In other words, these findings reinforced the idea that cognitive therapy could be a more direct route to change than having clients imagine the traumatic events repeatedly (see Figure 1.3). It also reminded me that day care teachers know this intuitively: When dealing with small children who are upset, they remind them, “Use your words.” They may not know about the reciprocal relationship between the prefrontal cortex and the amygdala, but they know that if children are talking about what is upsetting them, they can calm down.

Neurobiology also helps us to understand why younger people are more likely to develop PTSD, aside from the fact that physical and sexual abuse, rapes, assaults, car accidents, and combat are all more likely to occur to those who have not reached full adulthood. The prefrontal cortex is not fully developed until humans are well into their 20s, so not only are young people likely to be traumatized, but they have fewer



**FIGURE 1.3.** How cognitive therapy may work: It may force the frontal lobe online, which inhibits the amygdala and prevents extreme emotional responses, even while the trauma circuit is simultaneously and sufficiently activated.

resources to deal with trauma once it occurs (Johnson, Blum, & Giedd, 2009). According to the Johnson et al. (2009) review article,

The prefrontal cortex coordinates higher-order cognitive processes and executive functioning. Executive functions are a set of supervisory cognitive skills needed for goal-directed behavior, including planning, response inhibition, working memory, and attention. These skills allow an individual to pause long enough to take stock of a situation, assess his or her options, plan a course of action, and execute it. Poor executive functioning leads to difficulty with planning, attention, using feedback, and mental inflexibility, all of which could undermine judgment and decision making. (p. 218)

By the time child and adolescent trauma victims receive therapy as adults, they may have settled on cognitions that were constructed at a time when their executive functions were not fully developed. This is probably the reason why so many clients with PTSD have extreme beliefs and have been traumatized repeatedly. CPT may well assist such clients in developing affect regulation, increasing their cognitive flexibility, and changing many assumptions and beliefs that were developed at a period of cognitive immaturity and that were never reexamined because of avoidance symptoms. One of the goals of CPT is to teach these clients greater flexibility in thinking—specifically, to teach them how to think critically about what they have been saying to themselves regarding the reasons why the traumatic events happened and the events' implications about themselves and others.

### **A Change in Name and a Note on Terminology**

Since 1988, CPT has been referred to as a 12-session therapy that included cognitive therapy and, at first, “written exposures.” However, because the initial “written exposures” did not meet the standards of exposure interventions at the time (i.e., repetitions of the trauma for 45–60 minutes to encourage strong emotions, with ratings of distress to monitor habituation within and between sessions), this term was changed to the more precise description of the technique as “written accounts.” This part of the protocol is described in Chapter 11.

When the CPT dismantling study was conducted (Resick et al., 2008; see Chapter 2), the version of CPT without written accounts was referred to as CPT-C, meaning CPT with cognitive therapy only. The dismantling study found that CPT-C was as effective as CPT and that the written accounts did not add to the outcomes; in fact, CPT-C had a faster trajectory of improvements and had a 22% dropout rate compared with a 34% dropout rate for CPT. Also, Walter, Dickstein, Barnes, and Chard (2014) examined program evaluation data in a U.S. VA hospital and found that the outcomes for CPT and CPT-C were not statistically different from each other. Although the label CPT-C was perhaps appropriate for a single study, we realized that it was rather redundant. Because of these findings and factors, and the positive results of other CPT-C

studies, we have decided to give the cognitive version of CPT primacy. In this book, therefore, we call the cognitive-therapy-only version CPT, and the version with written accounts CPT+A. The main description of the therapy in Part III (Chapters 5–10) is a description of CPT. Chapter 11 covers CPT+A. The written-account-only protocol that was implemented in the Resick et al. (2008) dismantling study is not described in this book, but I can provide a manual of this protocol for interested readers.

A note on the use of two terms in this book is also in order here. We have used both the terms “victims” and “survivors” to refer to CPT clients, with “victims” used more often. On the one hand, many people with PTSD who seek or are referred for CPT are still “victims” and have not yet become “survivors”; also, the term “survivor” may connote that a person could have died as a result of a traumatic event, and this is not always the case (though it often is). On the other hand, the term “survivors” may be more empowering in some contexts.

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