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Refinement and Pilot Testing of a Brief, Early Intervention for PTSD and Alcohol Use Following Sexual Assault

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Experiencing a sexual assault can have long-lasting negative consequences including development of posttraumatic stress disorder (PTSD) and alcohol misuse. Intervention provided in the initial weeks following assault can reduce the development of these chronic problems. This study describes the iterative treatment development process for refining a brief intervention targeting PTSD and alcohol misuse for women with recent sexual assault experiences. Experts, treatment providers, and patients provided feedback on the intervention materials and guided the refinement process. Based on principles of cognitive change, the final intervention consists of one in-person session and four coaching calls targeting beliefs about the assault and about drinking behavior. Initial feasibility and acceptability data are presented for patients enrolled in an open trial (N = 6). The intervention was rated as helpful, not distressing, and interesting by patients and all patients completed the entire treatment protocol. A large decrease in PTSD symptoms pre- to post-intervention was observed. A small effect on decreasing alcohol consequences also emerged, although drinks consumed per week showed a slight increase, not a decrease, over the course of the intervention. Applications of this intervention and next steps for testing efficacy are presented.

In the U.S. an estimated 18.3% of women report experiencing a rape in their lifetime and 44.6% report an experience of sexual violence other than rape (Black et al., 2011). Experiencing sexual assault has been linked to the development of psychopathology including posttraumatic stress disorder (PTSD), depression, suicidality, and alcohol and other substance use (e.g., Dworkin, Menon, Bystrynski, & Allen, 2017). Studies exploring prospective trajectories of symptom development suggest that in the days and weeks immediately following sexual assault almost all individuals report PTSD symptoms, but about half of victims will recover naturally (i.e., without therapeutic intervention) within the first 3 months following exposure (Gutner, Rizvi, Monson, & Resick, 2006; Riggs, Rothbaum, & Foa, 1995; Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992; Steenkamp, Dickstein, Salters-Pedneault, Hofmann, & Litz, 2012). After exposure to traumatic events, greater initial symptoms of PTSD predict chronic PTSD (Rothbaum et al., 1992) and problematic drinking behavior predicts both chronic PTSD and the development of alcohol use disorders (Kaysen et al., 2011; McFarlane et al., 2009), suggesting that these are factors in the acute aftermath of a sexual assault that can indicate the need for early intervention. Of note, the co-occurrence of PTSD and alcohol misuse predicts numerous negative outcomes, including increased health care use, increased functional impairment, and poorer treatment prognosis (Blanco, Xu, & Brady, 2013), suggesting great clinical utility in targeting both PTSD and alcohol use soon after trauma exposure.

Theories on PTSD and alcohol use suggest that the co-occurrence results from self-medication (Chilcoat & Breslau, 1998a; Chilcoat & Breslau, 1998b; Conrod & Stewart, 2003; Simpson, Stappenbeck, Luterek, Lehavot, & Kaysen, 2014), wherein alcohol use relieves symptoms of PTSD, is negatively reinforcing, and thus leads to future alcohol use. It is further theorized that alcohol use maintains PTSD reactions long-term by interfering with adaptive processing necessary for recovery (Kaysen et al., 2011; Zlotnick et al., 2004). Recovery requires individuals to process emotions and cognitions associated with sexual assault, and in the acute trauma phase this processing

Keywords: sexual assault; treatment development; PTSD; alcohol use

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may result in adaptive beliefs and may minimize avoidance that leads to chronic PTSD (Foa, Huppert, & Cahill, 2006). Using alcohol following sexual assault can interfere with adaptive processing, thus explaining why individuals with PTSD reactions and hazardous drinking are at high risk for long-term symptoms and chronic psychopathology.

Numerous efficacious treatments exist to treat PTSD following sexual assault, most of which rely on cognitive behavioral principles to promote processing of the traumatic event and its meaning (e.g., Watts et al., 2013). Of these treatments, cognitive processing therapy (CPT), originally developed to treat female survivors of sexual violence, is considered a front-line treatment for chronic PTSD and has demonstrated large effects for decreasing symptoms in individuals with chronic PTSD (three or more months of persistent PTSD symptoms following trauma exposure; Resick & Schnicke, 1993; Resick, Nishith, Weaver, Astin, & Feuer, 2002; Resick, Monson, & Chard, 2017).

A growing literature has evaluated the use of cognitive-behavioral therapies in the acute aftermath of trauma, including sexual assault (Dworkin & Schumacher, 2016; Roberts, Kitchiner, Kenardy, & Bisson, 2009), to decrease the development of chronic symptoms. However, as reviewed in the International Society for Traumatic Stress Studies practice guidelines (Berliner et al., 2019), at best, existing treatments are seen as having emerging evidence of effectiveness for prevention of PTSD among trauma survivors, and most of the interventions reviewed did not demonstrate robust effects or target comorbidity. For example, although three to four sessions of exposure therapy (Foa, Zoellner, & Feeny, 2006; Rothbaum et al., 2012) delivered acutely following sexual assault led to reductions in anxiety and PTSD symptoms, one study did not find exposure to be superior to supportive counseling or assessment only for PTSD outcomes at 9-month follow-up (Foa, Zoellner, & Feeny, 2006) and neither study evaluated the effects on alcohol.

Little is known about the effects of cognitive therapy when delivered in the acute recovery phase following sexual assault, although up to 12 sessions of cognitive therapy has been shown effective at decreasing anxiety and PTSD acutely following motor vehicle accidents (Ehlers et al., 2003), suggesting utility of the cognitive approach in decreasing acute trauma reactions. Only one small study implemented an abbreviated and modified six-session CPT protocol specifically, and demonstrated large effects (2.55 intent-to-treat pre-post effect size) on assault-related symptoms for individuals exposed to physical or sexual assault within the previous 4 weeks (Nixon, 2012), supporting the potential efficacy of CPT as an acute intervention. It should be noted that treatment retention was only moderate with 15 of the 20 participants randomized to CPT receiving at least three sessions of the protocol, and only nine participants receiving the full six sessions (Nixon, 2012). This highlights challenges with retention for acute survivors and supports the need for briefer, lower-burden cognitive protocols targeting early development of sexual-assault-related PTSD symptoms that might promote engagement in care during those first initial weeks following assault.

In addition, increasing access to care among recent trauma victims is a challenge. Many of the studies of acute interventions following trauma exposure, including sexual assault, rely exclusively or heavily on ER and other emergency or hospital-based services for recruitment (e.g., Foa, Huppert, & Cahill, 2006; Foa, Zoellner, & Feeny, 2006; Resnick et al., 2007; Rothbaum et al., 2012; Zatzick et al., 2004). However, most survivors do not present for emergency services after sexual assault (Resnick et al., 2000). Nor do most survivors present for treatment in specialty mental health settings, even with chronic PTSD (Wang et al., 2005), emphasizing a need for services delivered outside of these settings.

Given the large overlap of PTSD symptoms and alcohol use, especially in the acute recovery phase, treatments that address both behaviors concurrently are of great clinical utility. A review of literature on treatments for co-occurring substance use and chronic PTSD showed that trauma-focused interventions are more efficacious for PTSD and substance use symptoms than control interventions (Roberts, Roberts, Jones, & Bisson, 2015; Simpson, Lehavot, & Petrakis, 2017). To date, treatment approaches that address both PTSD symptoms and alcohol misuse in the initial weeks following sexual assault show mixed effects on outcomes and are designed to be delivered in emergency room settings (Acierno, Resnick, Flood, & Holmes, 2003; Resnick, Acierno, Kilpatrick, & Holmes, 2005; Resnick et al., 2007). These studies specifically focus on a video intervention designed to manage negative reactions to a rape kit exam, limiting broader application and reach. A prior study developed an ultra-brief intervention, based on CPT principles, to address alcohol use among individuals with chronic PTSD and alcohol use disorders in a mixed trauma sample, and found that the cognitive restructuring intervention was effective in reducing likelihood to drink. However, the intervention did not change PTSD symptoms, which was likely due to the lack of specific content around PTSD and trauma-related reactions, as the intervention did not include any psychoeducation on trauma-related beliefs and symptoms or any specific restructuring strategies for these beliefs specifically (e.g., strategies to target self-blame; Stappenbeck et al., 2015). In addition, this study recruited participants with chronic PTSD and alcohol

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dependence, which may be less responsive to such a brief intervention compared to those presenting more acutely following trauma exposure.

Thus, brief interventions, which can be applied in a variety of settings (e.g., counseling centers, outpatient clinics) to address both PTSD and alcohol use conjointly are still needed. An intervention that is a simplified version of an existing empirically supported approach is particularly appealing as it can draw on established strategies and can be adapted to be used by those outside of specialty care, such as non–mental health providers embedded in primary care clinics (Feldner, Monson, & Friedman, 2007; Hoeft, Stephens, Vannoy, Unützer, & Kaysen, 2019). In addition, approaches that are low burden for both patient and therapist are particularly appealing to be delivered in the acute aftermath of sexual assault given that high attrition is a considerable problem for treatments that target both PTSD and substance use (Back et al., 2019) and the substantial dropout seen in the one existing early intervention application of CPT (Nixon, 2012).

Qualitative methods can provide valuable information to guide the development or adaptation of empirically based interventions. Indeed, before expending the considerable resources necessary to test a new or substantially revised intervention in the context of a randomized controlled trial (RCT), it is best to receive input from the people who will be using and receiving the intervention. The core of this process is eliciting feedback on intervention materials, as well as on participation in the intervention itself, and using this feedback to guide iterative revisions (de Visser et al., 2015; MacPherson & McKie, 2010). Applying qualitative treatment refinement to an existing established intervention, such as CPT, can result in more precise, streamlined interventions for particular at-risk populations.

This article describes how an empirically based cognitive intervention for trauma was adapted using qualitative methods. Our intervention, Brief Restructuring Intervention after Trauma Exposure (BRITE), refined an existing one-session cognitive restructuring intervention for chronic alcohol dependence and PTSD (Stappenbeck et al., 2015) by adding condensed material from an existing trauma-focused, evidence-based cognitive treatment program (CPT; Resick et al., 2017) to better target both trauma symptoms and problematic alcohol use acutely following sexual assault. It included a counselor manual for a 90-minute in-person session and scripts for four follow-up coaching phone calls, along with supporting materials such as client CPT worksheets. The method for refining the intervention is presented, along with the design and initial data from a small open trial of participants who received the intervention to present feasibility, acceptability, and outcome data for the intervention.

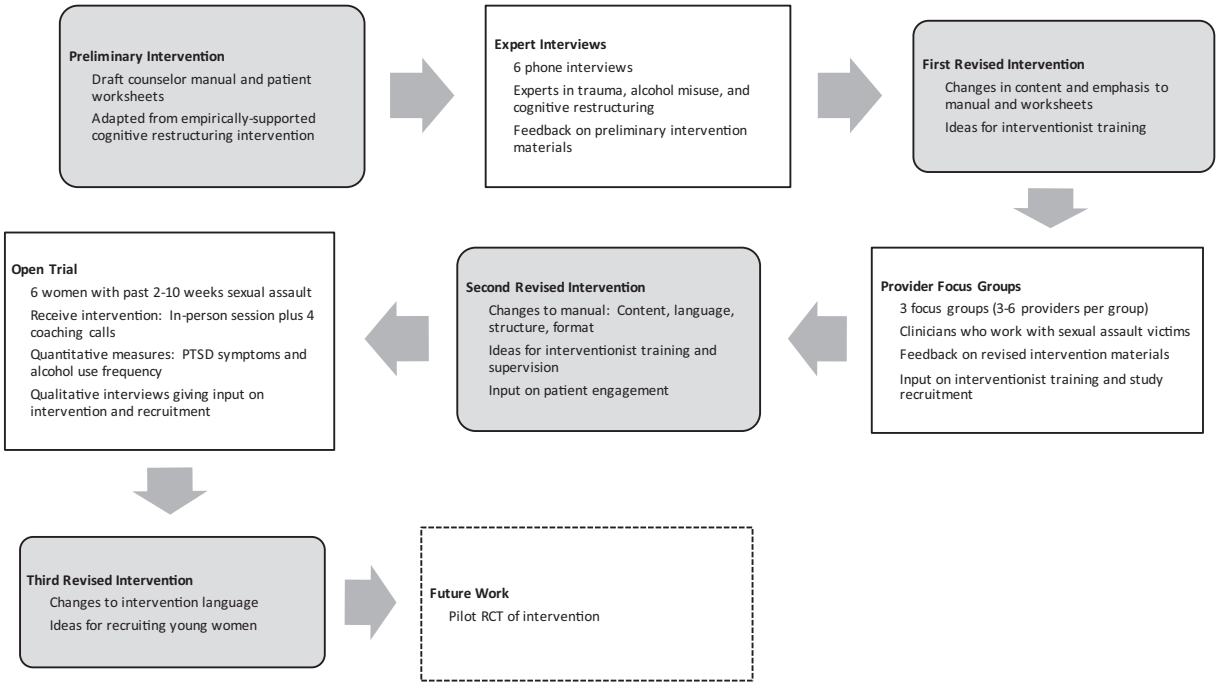

Figure 1. Iterative treatment refinement process for BRITE

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Method

The research design involved an iterative process of qualitative input (Fig. 1) aimed at producing the best possible version of the brief trauma intervention for further testing in a planned pilot RCT (currently ongoing). After analyzing data from each phase, we integrated findings into the intervention-in-development, and then used its next iteration in the subsequent phase. The first phase comprised interviews with six experts in trauma, alcohol use disorders, and cognitive restructuring/CBT. The second involved three focus groups with clinicians with expertise in sexual assault recovery. The third phase used mixed methods and was an open trial of the intervention, including one-on-one exit interviews, with six young women who had recently gone through an unwanted sexual experience and had engaged in recent hazardous drinking.

Participants

Expert Participants/Consultants in Phase 1

Six recognized experts in relevant fields, listed in Table 1, were recruited to read our draft intervention materials and share their feedback and suggestions for improvement. Since participation was limited to professional expertise and consultation, and involved no sharing of personal information, this phase of the project did not require Institutional Review Board (IRB) approval. We paid expert participants (with the exception of one, who declined payment) a $150 honorarium.

Clinician Participants/Consultants in Phase 2

The first author, a practicing clinical psychologist, recruited professionals from local sites with expertise treating women acutely postassault for focus group participation. We conducted three focus groups of three to six providers, one for each clinical site: a university health and wellness organization (UW Health and Wellness), a university counseling center (UW Counseling Center), and a county-funded community agency (King County Sexual Assault Resource Center). In all recruitment interactions, we emphasized that participation was voluntary and declining would have no effect on employment. Once again, since participation involved exclusively professional expertise, this phase of the project did not require IRB approval. We paid clinician participants a $150 per hour honorarium, and they received release time from work to attend.

Open Trial Participants in Phase 3

Six women age 18 or over who had gone through a sexual assault (defined here as nonconsensual sexual activity ranging from unwanted sexual contact to completed rape) within the past 2 to 10 weeks were recruited to participate in an open trial of the developed BRITE intervention. We selected this number based on qualitative methodological science suggesting that saturation can be reached with very few cases in relatively homogeneous participant groups such as this one (Guest, Bunce, & Johnson, 2006). Other inclusion criteria were (a) meeting criteria for at least three of four DSM-5 PTSD symptom clusters (i.e., reexperiencing, avoidance, cognitions/mood, hyperarousal; APA, 2013), and (b) reporting hazardous drinking over the past month, defined as at least one incident of heavy episodic drinking (four drinks or more on one occasion; NIAAA, 2004), plus at least two negative consequences of drinking. Exclusion criteria were limited to those deemed necessary to reflect appropriate clinical care in the acute aftermath of trauma as well as ensuring feasibility of delivering the intervention and included: (a)

Table 1
Experts Interviewed for First Phase of Intervention Refinement

Name	Title & Institution	Areas of Expertise
Tara Galovski	***Associate Professor, Department of Psychology, Center for Trauma Recovery, University of Missouri-St. Louis***	Trauma, PTSD, and cognitive restructuring
Denise Hien	Professor and Clinical Cluster Head, CUNY Psychology Doctoral Program and Adjunct Senior Research Scientist, Columbia University College of Physicians and Surgeons	Comorbid PTSD and alcohol misuse
Barbara McCrady	Distinguished Professor of Psychology and Director, Center on Alcoholism, Substance Abuse, and Addictions, The University of New Mexico	Alcohol use and misuse
Peter Monti	Distinguished Professor of Alcohol and Addiction Studies, Director, Center for Alcohol and Addiction Studies, Professor, Departments of Behavioral and Social Sciences and Psychiatry	Alcohol use and misuse
Reginald Nixon	***Professor, College of Education, Psychology and Social Work, Flinders University***	Trauma, PTSD, and cognitive restructuring
Patricia Resick	Professor of Psychiatry and Behavioral Sciences, Duke University Medical Center	Trauma, PTSD, and cognitive restructuring

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being acutely suicidal with intent or a plan, (b) exhibiting current psychosis, (c) not speaking English, (d) planned absences that would interfere with 5 weeks of participation, and (e) lacking access to a telephone.

Measures and Procedure

Phase 1: Expert Interviews

Since the national experts were geographically dispersed, we interviewed them over the telephone. Prior to interviews, we sent experts an outline of the planned intervention (one 90-minute in-person session and four follow-up coaching phone calls); the preliminary intervention manual, which drew on core CPT strategies (Resick et al., 2017), existing alcohol misuse interventions, and the brief intervention previously shown to reduce alcohol use in those with chronic PTSD (Stappenbeck et al., 2015); and draft intervention materials such as adapted client ABC worksheets and therapist scripts. Interviews were conducted collaboratively by the first and second authors. Open-ended questions covered topics such as intervention focus, crucial treatment strategies, and specific content for PTSD and drinking. We digitally recorded the interviews. Following completion of the interviews, analysis of the expert interviews was integrated to create a revised set of draft intervention materials.

Phase 2: Clinician Focus Groups

Focus groups occurred at the authors' university offices in a private conference room and were digitally recorded. We served snacks to create a relaxed atmosphere and enhance conversational flow (Krueger & Casey, 2014). Approximately 2 weeks prior to each session, we sent participating providers the revised intervention materials from Phase 1. We asked them to review materials and come prepared to provide detailed feedback. Focus group questions were designed to elicit input on (a) key content to target acutely following sexual assault, based on providers' assessment of victims' needs; (b) additional coping strategies and techniques necessary to include; and (c) adaptations to support novice providers in delivering the intervention effectively. Analyses of the focus groups were integrated to create a second revision of intervention materials for use in the open trial.

Phase 3: Open Trial Overview

Potential participants in the open trial were recruited from the community by flyers, online advertisements, and registrar emails sent to female students enrolled at the university. Interested participants contacted through registrar emails had the choice to either directly contact the study by phone or email or to complete an online screening survey and provide contact information for the research assistant to follow-up. All participants were screened for preliminary eligibility over the phone. All procedures were approved by the IRB at the authors' university.

The first author, a clinical psychologist, carried out consent and baseline assessment interviews. Participants reviewed and signed a consent form detailing study procedures, compensation, and their rights as a research participant and then completed a baseline interview. Eligible participants then received the revised intervention resulting from Phases 1 and 2 delivered by the first author. The intervention included one 90-minute in-person session and 20-minute coaching phone calls weekly for the following 4 weeks. Participants also completed quantitative self-report measures of trauma symptoms and alcohol use each week. They took part in exit interviews (conducted by the second author) eliciting their qualitative feedback on the intervention following the final coaching call and completed self-report measures to assess symptom change. We paid up to $110 for study participation: $20 for the baseline eligibility assessment, $10 for each self-report ($50 total), a $20 bonus for completing all four weekly self-report questionnaires, and $20 for the final self-report questionnaires and exit interview.

Assessment measures. The intake interview to ascertain eligibility criteria used standard, widely established and validated assessment measures. Specifically, the Timeline Followback (Sobell & Sobell, 1992) was administered to confirm alcohol use patterns in the last 30 days including at least one day of heavy episodic drinking (i.e., four+ drinks on one occasion). The Posttraumatic Symptom Scale Interview Version for DSM-5 (PSS-I-5; Foa & Capaldi, 2013) was administered to assess past 2-week symptoms consistent with PTSD or subthreshold PTSD. The mood, psychosis, alcohol and substance use modules of the Mini International Neuropsychiatric Interview for DSM-5 (MINI v7; Sheehan et al., 1998) were administered to rule out exclusion criteria of active psychosis and active suicidality and confirm inclusion criteria of maladaptive alcohol use (i.e., negative consequences of use).

Quantitative measures. After the intake interview, participants completed a demographics questionnaire plus quantitative measures of drinking quantity and frequency (*Daily Drinking Questionnaire*, DDQ; Collins, Parks, & Marlatt, 1985), drinking consequences (*Drinkers Inventory of Consequences*, DrInC; Miller, Tonigan, & Longabaugh, 1995) and PTSD symptoms (*Posttraumatic Stress Checklist*, PCL-5; Weathers et al., 2013) over the past month. They completed these same drinking and PTSD symptom self-report questionnaires assessing for the past week online before the intervention session and each of the four coaching calls, and again assessing for the past month at the exit interview.

At the exit interview, we also administered a post-study reactions questionnaire to assess feasibility and

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acceptability of the intervention. Participants self-reported distress ratings, interest ratings, and helpfulness ratings for the intervention session, intervention skills, and the coaching calls on a 7-point Likert scale (1 = *not helpful/not distressing/very boring*, 7 = *very helpful/ distressing/ very interesting*). Participants also rated the acceptability of the length of the intervention, coaching calls, online questionnaires, and assessment visits (1 = *about right*, 7 = *too long*), their agreement with the statements "I would be likely to recommend this program to a friend" and "My needs were met by the therapy I received" (1 = *agree strongly*, 7 = *disagree strongly*). Finally, they provided self-report qualitative feedback about the benefits and harms caused by the study and reasons why they would or would not recommend the program to a friend.

Original BRITE manual. The original version of the intervention that was provided to experts and providers for feedback used classic cognitive restructuring techniques specifically around sexual assault and alcohol-related beliefs. The original version of BRITE expanded on prior studies implementing CPT-based principles for PTSD and alcohol use (Stappenbeck et al., 2015) by including specific psychoeducation content on self-blame around sexual assault and addition of specific questions to guide challenging of beliefs. Feedback from experts and providers was incorporated into the intervention manual and is described in detail below.

Open trial intervention. In the open trial, the first author delivered intervention sessions using the edited version of the intervention that incorporated expert/provider feedback. Participants completed cognitive restructuring worksheets (e.g., ABC worksheets) with the interventionist and took others with them as "homework." After the in-person session, participants completed four weekly 15- to 20-minute coaching calls with the interventionist. Coaching calls reinforced participants' use of cognitive restructuring skills around sexual assault and alcohol related beliefs, problem-solved difficulties doing skill-building exercises, allowed time to discuss trauma symptoms and alcohol use, and provided support. Handouts and recordings were supplied to help reinforce learning.

Qualitative exit interviews. At the end of the open trial we carried out interviews with participants to elicit their feedback. Our semi-structured interviews included questions on their overall experiences with the treatment, useful intervention elements, barriers to engagement, and recruitment. The second author conducted the interviews and digitally recorded them.

Analytic Approach. As each expert interview, provider focus group, and participant exit interview was completed, the second author transcribed them using a data extraction tool created for this study. The tool combined verbatim transcription of segments that addressed research aims with note-taking to document other sections and extract key analytic points. Integrated methods like these can enhance analysis while using study resources efficiently (McLellan, MacQueen, & Neidig, 2003). They are appropriate for qualitative analyses that are focused and concrete (e.g., formative research for intervention development and improvement) rather than comprehensive (e.g., phenomenology or grounded theory). To allow insights emerging from analysis to be followed up in subsequent data collection, we carried out interviews/ focus groups, transcription, and data analysis simultaneously within each phase (Hesse-Biber & Leavy, 2011). Analyses used a set of qualitative techniques common across different theoretical frameworks and domains of inquiry, including coding and categorization (Saldaña, 2009), data summarization (Miles & Huberman, 1994), and comparative analysis (Strauss & Corbin, 1998).

Quantitative open trial data were analyzed by computing descriptives for main outcomes and by computing Cohen's *d* effect sizes for change from pre- to post-intervention for each outcome.

Results

Experts and providers both praised the BRITE intervention overall, saying that though it was ambitious to fit so much content into a brief intervention format, the materials were well done. Open trial participants also reacted positively to the intervention in general. All groups offered useful specific feedback, which we detail below.

Phase 1: Input rom Experts

Content

Several experts emphasized that building empathetic rapport between counselor and patient was key to success, even with cognitively focused interventions. They encouraged us to add explicit, written guidance for counselors on forging this therapeutic bond, particularly given that BRITE involved only a single in-person session.

Our alcohol experts stressed the need to show patients the links between drinking, avoidance, and slowed or halted trauma recovery. Patients had "good reasons" (multiple experts) to medicate trauma symptoms with alcohol, so education about the long-term problems this short-term solution often caused would be important, since the blunted affect and reduced cognitive engagement that came with drinking could be a "lost opportunity for new learning and cognitive change" (Nixon).

Treatment Strategies

Consistency and repetition were strategies that trauma expert consultants agreed were critical. They recommended instructing counselors to stick with cognitive

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restructuring basics and avoid introducing other techniques. They emphasized that counselors should not be unkind or dismissive of patient emotion, but should model that consistent use of CR techniques was the way to improve symptoms and distress.

Experts linked consistent return to cognitive restructuring principles to hope and empowerment. The goal was for patients to use cognitive restructuring to "have that experience of changing their mind in the direction of accuracy and feeling better" (Galovski). Experts suggested that when patients used connections between events, thoughts, and feeling to make minor shifts in their thinking early on, they often noticed improvements in their trauma symptoms and took more seriously their own ability to help themselves heal, fueling a positive cycle.

Focus of Treatment

Experts stressed that good identification of stuck points (i.e., negative automatic thoughts) was critical to successful cognitive restructuring. They instructed us to clearly differentiate for counselors, and make sure they could differentiate for patients, between "trauma-related but clearly accurate" feelings and beliefs (Galovski), such as fear of the perpetrator or sadness at thinking that the perpetrator was not the person you had thought they were, and "cognitively mediated problem feelings" (Resick), such as shame or powerlessness. The former should not be construed as feelings arising from stuck points but, rather, emotions that need to be felt to move forward, while the latter are appropriate targets for identifying underlying stuck points appropriate for cognitive restructuring techniques.

Style

Experts encouraged us to simplify the manual's interventionist statements as much as possible to make them accessible to patients experiencing cognitive deficits that sometimes accompany trauma exposure. For example, we substituted "changing your mind" for "cognitive restructuring" throughout. We also broke compound sentences into smaller statements. The goal throughout was to make counselor language easy for patients to understand.

Phase 2: Guidance From Clinical Providers

In many cases, provider focus groups gave us guidance that amplified what we had heard from expert interviews.

Content

Providers suggested providing more psychoeducation on trauma to normalize patients' symptoms and experiences, then framing each element of the intervention in the context of supporting natural trauma recovery. Regarding alcohol consumption, they mentioned alerting patients that they might feel inclined to drink more, but that in fact doing so could block natural recovery, so together "we're going to learn other ways to cope." Regarding cognitive restructuring, providers stressed the importance of laying down the foundational idea that thoughts are changeable, then returning to it throughout the intervention. They also suggested framing cognitive restructuring techniques, and particularly homework with worksheets that connect events, thoughts, and feelings, as something patients could do to support their own natural tendencies to heal from trauma.

Another element that providers encouraged us to include was guidance for patients on what the intervention would involve. In their experience, patients' images of trauma counseling were heavily influenced by popular culture, and these images involved dramatic retellings of assault experiences, not cognitive restructuring work. Stating early on that treatment would not include in-depth descriptions of the sexual assault but would focus on ways to feel better by changing thinking would help keep patient expectations realistic.

Style

We responded to expert input in the previous phase by simplifying the manual and client materials. Clinical providers urged us to simplify even further. Using nontechnical language in the manual and other materials, they pointed out, would be helpful to novice clinicians administering the intervention as well as making it more accessible to patients. For example, although the term "just world belief" is a classic element of CPT, the more typical current word choice would be "fair." We made this change and many similar ones. We also changed several instances of language that was unintentionally victim-blaming or subtly rape-myth-supportive. For example, one ABC sheet example included the statement, "I told him no, but he had sex with me anyway"; we changed this statement to "I told him no, but he raped me anyway."

Providers who had worked with manualized interventions also suggested numerous format changes to increase usability. These suggestions included: highlighting the clinician statements in the text, providing a session outline with approximate timing for each section to keep clinicians on track, and printing handouts for use in the coaching calls (such as the ABC sheets) on colored paper so the patient could find them easily.

The majority of participating providers' patients were emerging adults, and they offered many ideas on tailoring intervention materials to appeal to this group. One important example was input on the recording of the BRITE manual, a spoken version of the in-person session that we planned to distribute to participants to listen to on their own. Providers' guidance was that a "podcast" format, one that broke the session up into multiple short recordings,

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would be far more accessible to participants than a single 90-minute recording.

Counselor Training

Clinical providers contributed thoughtful input on how to train and support novice counselors so they could deliver the intervention effectively. One major point from expert input that providers also brought up was emphasizing rapport and connection in counselor training. Though counselors would be trained to deliver a manualized intervention, they needed to demonstrate empathy and respond to patients' emotions while doing so. One provider suggested telling trainees that "you have a script, but the client does not."

Providers also mentioned that intervention counselors should be trained in the difference between painful but natural feelings and problematic, cognitively mediated stuck points. They had noticed less-experienced clinicians believing that the goal of cognitive restructuring was to take away all negative feelings, rather than to hear and legitimize patients' natural emotions while also teaching them to intervene cognitively with erroneous feelings like self-blame.

Revised BRITE Intervention: Synthesis of Phase 1 and 2

The revised version of BRITE included the feedback described above from experts and providers. As in the original version, the focus remained on helping participants learn new ways of thinking about their sexual assault and their reactions to it, including their alcohol use. In the updated version of the manual the intervention is framed around asking participants questions to elicit existing beliefs and teach them self-questioning aimed at developing more helpful perspectives. For example, the rationale for the intervention is stated to participants as, *"One of the most successful ways of treating assault-related symptoms involves teaching people to do two things. First, to notice what they say to themselves, and second, to think about what they are thinking and why. The first step is looking at the way the sexual assault may have affected the way we think."* The manual directly targets beliefs theorized to lead to PTSD symptoms and maladaptive alcohol use using Socratic questioning methods characteristic of CPT (Resick et al., 2017). For example, the intervention protocol incorporates examples of beliefs around self-blame regarding why the assault occurred, beliefs about the world being dangerous, beliefs about the function of alcohol, and beliefs about using alcohol to cope with negative emotions. The client learns skills to identify maladaptive beliefs (termed "stuck points," consistent with CPT). Together, the therapist and client practice gently questioning these beliefs to explore their accuracy and appropriateness after considering the facts and context of the situation and then devise new, more balanced beliefs. The sessions rely heavily on the use of a modified ABC worksheet where participants identify situation, thought, consequence (emotion and behavior) as well as the use of challenging questions to explore the accuracy of the thought, identification of a new, more balanced thought, and observation of the new emotion and behavior that accompanies the revised thought. A blank ABC worksheet is included as Appendix A. The intervention also includes a USB for participants to take home that had all handouts and worksheets in digital form as well as an audio recording of the general script of intervention content. The recording is divided into "chunks" that outline the main teaching concepts (e.g., what is self-blame) as well as generic examples of using the self-questioning. The recordings are included in case the participant wants a reminder on content and skills, although they are not assigned as homework and are instead available as an as-needed resource.

Phase 3: Open Trial

Twelve phone screen assessments were completed to enroll the sample of six participants. Of these phone screens, nine women were scheduled for an intake assessment and two women were excluded (one for experiencing her most recent sexual assault outside the 10-week window needed for eligibility and one for subthreshold drinking below criteria), and one was not able to be contacted to schedule the intake. Of the nine women scheduled for intakes, eight women completed intake assessments (one woman did not show), six women were enrolled, and two women were excluded (one for current psychosis and inability to participate in the assessment and one for a subthreshold PTSD severity score). Demographics for the enrolled participants are presented in Table 2. Of the six women, four

Table 2
Means and Standard Deviations for Participant Demographics

Participant Characteristics	M *(SD)* or N (%)
Age (years)	20.83 (*3.55*)
Sex (% Female)	6 (100%)
Gender (% Female)	6 (100%)
Sexual Orientation	
(% Heterosexual)	5 (83.3%)
(% Lesbian)	1 (16.7%)
Ethnicity (% Caucasian)	4 (66.7%)
Education	
(% Some college)	4 (66.7%)
(% College educated)	2 (33.3%)
PTSD symptoms (PCL-5; pre-intervention)	40.33 (*13.44*)
PTSD symptoms (PCL-5; post-intervention)	29.20 (*19.11*)
Average drinks per week (DDQ; pre-intervention)	7.50 (*6.65*)
Average drinks per week (DDQ; post-intervention)	10.80 (*9.73*)

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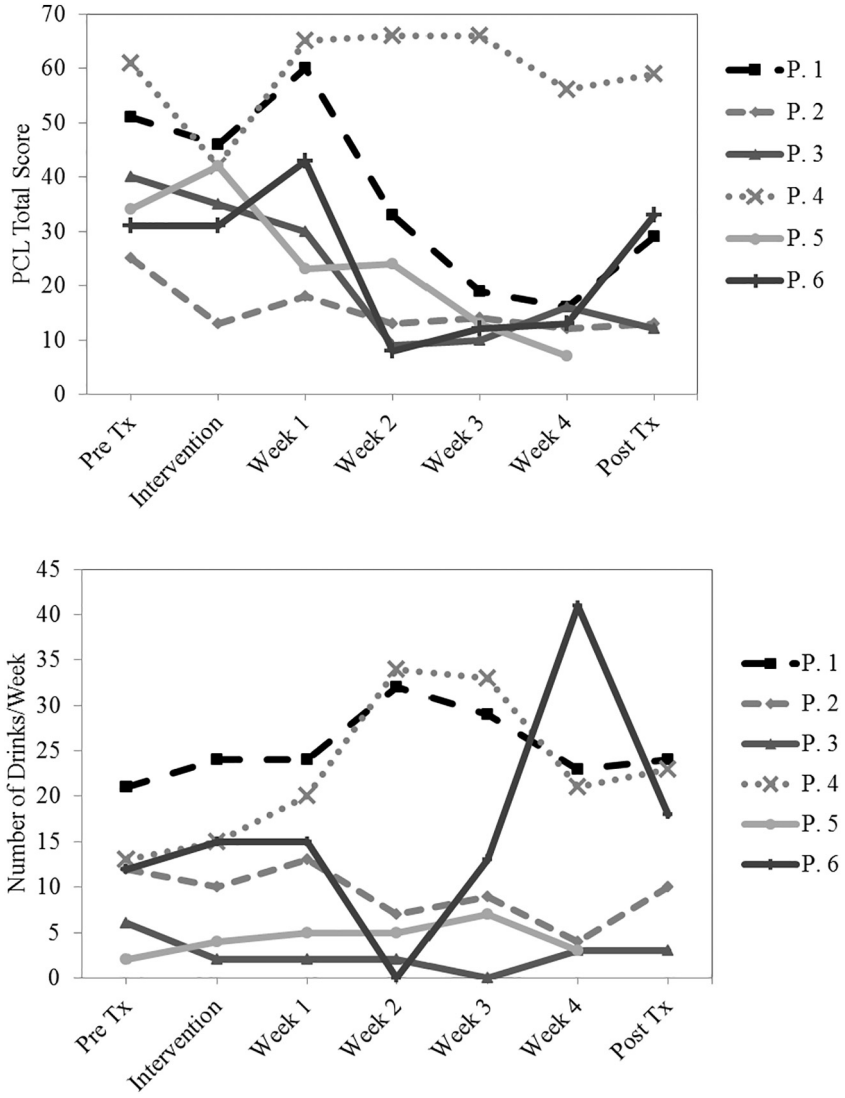

Figure 2. Changes in self-reported symptoms for participants in the open trial.

were current undergraduate students, one was a current graduate student, and one was a college graduate working full time. Participants ranged in age from 18 to 27 years of age. At baseline, results of the PSS-I suggested participants had moderate PTSD symptoms (M = 34.67, SD = 8.31, Range 27–47). Participants were diverse with regard to alcohol consumption as assessed using the TLFB for number of drinks (M = 28.33, SD = 13.81, Range = 10–52) and number of heavy episodic drinking episodes (M = 4.00, SD = 2.37, Range = 1–8) in the past 30 days.

Participants in the open trial received the version of BRITE that incorporated feedback from experts and providers. All six open trial participants completed the intervention session and all four coaching calls. Five of the six participants completed their scheduled exit interview and quantitative measures post-intervention. Results from these five participants are presented below. For the sixth participant, baseline and weekly measures are reported.

Feedback From Interviews

We explicitly requested both negative and positive feedback, yet participants mainly reported finding the intervention helpful. They stated that the therapeutic relationship established during the in-person session was maintained into the coaching calls and was of great value to them; that the action-oriented and structured (vs. reflection-oriented and free-ranging) qualities of the intervention were positives; and that validation and normalization of posttrauma emotions were key components.

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Reaching women to participate in the trial proved challenging, and it took longer to recruit the six women in the open trial than anticipated. Due to this unanticipated difficulty recruiting our target sample for the open trial, we chose to additionally focus exit interviews on ways to attract participants and remove barriers to involvement in the study. We identified two major themes regarding recruitment: framing to avoid therapy stigma and publicity saturation.

Some participants spoke about the intervention being a study (vs. therapy), and thus "for something," was attractive to them. One said:

> "[It being a study] made it so that everything that I discussed … even if it made me feel ashamed about things … that something good was going to come out of it, or that it could be beneficial to someone else."

Another added that "it was a very relaxed environment, and it didn't feel like 'therapy' therapy." Therapy stigma and stereotypes appeared to be common and to be recruitment barriers, as in this participant's statement: "… you don't want to have to be that person who is going through therapy," which she cited as a factor that made contacting the study difficult. Taken together, this input led us to frame future recruitment materials to emphasize research, helping others as well as yourself, and the concrete, goal oriented, nonintrusive nature of the program.

The other recruitment theme we identified was the importance of having publicity in every possible location (e.g., on campus, local businesses) and medium (e.g., printed flyers, emails from the university registrar) that resources allowed. When recruitment materials saturate the environment, any woman who experiences a sexual assault victimization has a higher likelihood of seeing them at the appropriate time, being able to steer a friend toward them, or having a recent memory of them, as in this participant's account: "The timing of it was good for me because it [the assault] had just happened and then I found out about it [the study]."

Responses to Open-Ended Self-Report Items on Reactions to Intervention

Participants reported positive reactions in response to open-ended items regarding benefits and harms of the intervention. Responses on benefits of the intervention emphasized the usefulness of having someone to listen and talk with about emotions and beliefs. Statements such as, "It's beneficial to seek help and talk to trusted ones about any issue instead of keeping it to oneself" and "I gained a sense of not being so alone in these very dark times" convey the perceived helpfulness of having a supportive person. Participants also identified approaching instead of avoiding the emotions as helpful. One participant stated, "I found a way to not ignore what happened but instead a way to confront it without having strong negative reactions." Finally, participants identified learning skills as beneficial, as in this statement: "A method of having detached assessment of the event and processing emotions related to it." No participants identified harms from the intervention. However, several identified it being difficult to think and talk about the sexual assault, especially at first, but also identified it as ultimately useful (e.g., "It made me think about it more than I would have but in the long run it was probably a good thing").

Results of Quantitative Measures

Descriptive statistics on participants' self-reported alcohol consumption and trauma symptoms across the open trial appear in Table 2. Fig. 2 depicts PTSD and alcohol use symptom change from baseline, across all five sessions (in-person intervention, four coaching calls) for all six participants and post-intervention assessment for the five participants who completed all time points. As depicted, at post-intervention four of the five participants showed clinically meaningful decreases in PTSD symptoms and the average level of PTSD symptoms decreased from pre-post intervention, consistent with a large effect (pre-intervention: $M = 40.33$, $SD = 13.44$; post-intervention $M = 29.20$, $SD = 19.11$; $d = 0.96$). Effects on alcohol were less robust, with average drinks per week increasing (pre-intervention: $M = 7.50$, $SD = 6.65$; post-intervention $M = 10.80$, $SD = 9.73$; $d = -0.80$) from pre-post intervention, but alcohol-related consequences showing a small decrease (pre-intervention: $M = 20.83$, $SD = 15.14$; post-intervention $M = 17.20$, $SD = 20.95$; $d = 0.23$).

Of note, one of the six participants was assaulted during the course of the study. This participant had shown initial decreases in symptoms, but following this experience, which occurred between the intervention session and the Week 1 coaching call, reported increases in PTSD and drinking behavior (P.4 presented in Fig. 2). Analyses of participants' PTSD and drinking behavior pre- and post-intervention excluding this individual results in a larger effect size for decreases in PTSD symptoms ($d = 1.14$), a smaller effect for increased average number of drinks per week ($d = -0.41$), and a larger effect for decreasing alcohol consequences ($d = .78$).

At their exit interviews, participants reported overall high ratings of satisfaction with the intervention (possible range for each item 1–7, with higher ratings indicating more positive perceptions). Participants reported that the intervention session ($M = 6.0$, $SD = 0$; range: 0), coaching calls ($M = 5.60$, $SD = 0.89$, range: 5–7), and intervention skills ($M = 5.80$, $SD = 0.55$, range 5–7) were all *helpful* to *very helpful*. Distress ratings for each portion, intervention session ($M = 5.00$, $SD = 1.87$; range: 3–7), coaching calls ($M = 6.20$, $SD = 0.84$, range: 5–7), and intervention skills ($M = 5.00$, $SD = 1.58$, range 3–7), indicated *low* to *moderate* distress during the intervention and

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when using the skills. Finally, interest ratings (intervention session [$M = 6.20$, $SD = 0.84$; range: 5–7]; coaching calls [$M = 5.80$, $SD = 1.30$, range: 4–7]; intervention skills [$M = 5.60$, $SD = 1.14$, range 4–7]) suggested *high* interest in all aspects of the intervention program. In addition, most participants agreed with the statement that the program overall met their needs ($M = 2.80$, $SD = 1.92$, Range 1–6 with 1 "*agree strongly*" and 7 "*disagree strongly*")[1] and reported being overall very likely to recommend this program to a friend with similar problems (rating of agreeableness to this item, $M = 1.60$, $SD = 0.55$, Range 1–2).

Discussion

Overall results of this iterative intervention refinement and open trial study suggest that the developed intervention is feasible and effective for decreasing PTSD, and to a lesser extent alcohol consequences, in the acute recovery phase following sexual assault. The goal of the refinement procedures was to elicit expert and provider feedback to ensure an intervention protocol that was acceptable and helpful to recent survivors of sexual assault. By including these perspectives, the final intervention includes both gold-standard evidence-based strategies and aspects of delivery that make it feasible and accessible. Given that it is difficult to reach and engage individuals in interventions in the initial weeks following sexual assault, especially for individuals who do not present for medical services or follow-up, an approach that is acceptable and liked by consumers while also being effective in alleviating distress and maladaptive behaviors is crucial. Moreover, this intervention can be used outside of hospital/ER settings, which is an advantage over previous approaches (e.g., Resnick et al., 2007; Rothbaum et al., 2012), given that most women do not seek treatment in an ER or other health care setting immediately following an assault (Resnick et al., 2000). Open trial findings presented here are encouraging that BRITE may be a feasible and disseminable approach for women suffering negative effects of a recent sexual assault.

Details of the final BRITE intervention protocol, which include suggestions from experts, clinicians, and participants, are presented in Table 3. Feedback from all three groups (experts, providers, and women enrolled in the open trial of the intervention) had several common themes. The intervention itself focused on cognitive change strategies, based on the large existing literature that cognitive-behavioral approaches are effective for both PTSD symptoms and drinking behavior (Simpson et al., 2017). Given that the intervention had so few points of contact, the feedback process truly highlighted the importance of being on the right treatment target as providers would have few chances of correcting a mistake. This issue also was highlighted by the participant who was assaulted during the trial. This does happen during longer trauma-focused therapies; however, with more points of contact, the therapist is typically able to support the client in addressing the new beliefs and symptoms to return to healing. With this ultra-brief intervention, the disruption by the new assault was not able to be adequately addressed. This would be an important point to address in future intervention refinement.

There was an additional emphasis in the feedback on reducing stigma around seeking care in the aftermath of sexual assault, with various suggestions on how to do so both in the intervention and with recruitment. This ranged from packaging the intervention as something other than therapy to reduce stigma, to emphasizing the normative nature of these symptoms and coping strategies in the immediate weeks following sexual assault (e.g., common reactions, psychoeducation). With regard to effects of stigma on recruitment, the suggestions from users around participating precisely because it was research highlight some of the challenges around outreach for this population. Other marketing strategies, such as framing it as a "check-up" or a "conversation" and explicitly not using terms around counseling or therapy, may be useful in approaching this issue. This strategy has worked with outreach for other heavy-drinking, non-treatment-seeking, trauma-exposed populations as a way of getting them in the door for further intervention (Walton et al., 2013).

In general, we were able to add suggestions of experts and providers to the existing intervention. However, a few suggestions were not integrated for either empirical or practical reasons. In particular, motivational interviewing (MI) was suggested as potentially important to include. Given our observed weaker effects on alcohol use and the known therapeutic effects of MI on substance use and treatment engagement (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010), this might be an important strategy to consider incorporating in the future. However, based on the demonstrated efficacy of cognitive interventions for decreasing PTSD symptoms (e.g., Resick et al., 2002; Resick et al., 2017), we were committed to employing these strategies and to not overburdening the brief intervention with other active therapy techniques. Other factors that were suggested but were not included were varying the intervention based on trauma history (i.e., providing women with more extensive trauma histories more sessions/skills), adding more in-

[1] Of note, one participant endorsed a "6" on this scale, indicating disagreement with the statement that the program met their needs. This same participant provided self-report qualitative feedback that was inconsistent with this rating, reporting, "*It was a huge help to have weekly calls and have someone routinely check in on how I am doing.*" She also reported that "*No harm came to me as far as I can tell*" and "*Although this program is short and did not heal me fully, it was a great temporary support and was certainly helpful.*" Thus, it is difficult to reconcile the numeric rating with the open-ended feedback.

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Table 3
Components of Final BRITE Intervention

In person Intervention	Components	Time	Worksheets	Example Text
Part 1. Introduction and Orientation	Introductions, confidentiality, and establishing rapport	5 min	None	*"I want to help you cope as effectively as possible with your recent traumatic experience"*
				"There are some specific exceptions to confidentiality…."
	Explaining session structure and goals	5 min	None	"*One of the most successful ways of treating assault-related symptoms involves teaching people to do two things. First, to notice what they say to themselves, and second, to think about what they are thinking and why."*
				"We will talk about how you can apply these ideas to your life"
	Psychoeducation on PTSD, alcohol use, and cognitive restructuring	15 min	Common Reactions to Trauma Handout	*"Negative reactions are normal and expected- when something like an unwanted sexual experience happens we ALL struggle to make sense of it"*
				"Drinking can interfere with recovery and with finding healthier coping strategies"
				"We can change what we are thinking, and changing our thoughts can help us feel better and be more effective"
				"Many people have the belief that the world is supposed to be fair and predictable. The problem with this belief is it isn't always accurate"(Fair world belief)
				"Another way people sometimes try to make sense of an unwanted sexual experience is by making sense of what happened based on what they know now" (Hindsight bias)
Part 2. ABC sheet and Examples	Introduce ABC sheet with a non-trauma example	10 min	ABC Worksheet	*"Let's look at an example where someone could easily think in an unhelpful way"*
				"I'm walking down the street and see someone I know. I smile and say hi, but she doesn't respond and keeps walking. What might I feel? What might I think?"
				Challenging questions of: Evidence for/ against belief, All or none thinking, Confusing feelings with facts, and

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Table 3 (*continued*)

In person Intervention	Components	Time	Worksheets	Example Text
	Identify sexual assault and alcohol related stuck points	10 min	"What is a stuck point?" Handout	Focusing on just one piece of the story *"Let's focus on a thought or belief that is leading to strong unpleasant feelings"* *"Stuck points aren't facts, feelings, or behaviors"* *"Let's pick thoughts that you have had a lot since the unwanted sexual experience, 3 focused on the experience itself and 3 focused on alcohol use"*
	Complete a sexual assault related ABC worksheet	15 min	ABC Worksheet	Challenging questions of: Evidence for/ against belief, All or none thinking, Confusing feelings with facts, and Focusing on just one piece of the story
	Complete an alcohol related ABC worksheet	15 min	ABC Worksheet	Challenging questions of: Evidence for/ against belief, All or none thinking, Confusing feelings with facts, and Focusing on just one piece of the story
Part 3. Summary and homework assignment	Summarize cognitive restructuring	5 min	None	*"Most of us just take our thoughts for granted and it doesn't occur to us maybe we're missing something or adding something in that doesn't belong"* *"Another important thing to remember is that the more helpful thought you get to should be true, not just a feel good sort of thing."*
	Explain daily ABC practice and coaching calls	10 min	ABC Worksheet, How to Use ABC Worksheet Handout, Challenging Questions, USB recording	*"I'd like you to practice with these ABC sheets every day"* *"It will be most helpful if at least 2 or 3 days a week you pick something to work on related to your assault or your drinking"*
	Address questions and close session	5 min	None	Building and reinforcing hope, addressing questions
Coaching Calls (4)	Components	Time	Worksheets	Example Text
	Check in and review symptoms	< 5 min	None	*"I first wanted to check in with you about how your reactions have been this past week"*
	Explore homework practice	1 0 - 1 5 min	ABC Worksheet	*"How has completing worksheets been for you?"* *"Do you have any example worksheets that you really struggled with?"* *"Or any thoughts that have come up for you that you haven't done a worksheet on, but think it would be helpful to try it?"*
	Problem solve for next week	5 min	None	*"It is really important that you continue to use these skills"* Scheduling and problem solving barriers

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person sessions to the intervention overall, and including victim advocacy techniques in addition to counseling. With these suggestions, the tension between being brief and being thorough is illustrated. Adding in another therapeutic approach, like MI, increases the training demands on counselors and decreases the ease of scaling up the intervention. Adding in more sessions increases the time demands on sexual assault survivors. Many of the existing protocols for co-occurring PTSD and substance use involve strategies for targeting PTSD and substance use, and while they show good effects on reducing symptoms, they also show high rates of dropout (e.g., Foa et al., 2013; Mills et al., 2012), arguing that brevity is important in this population. Overall, we prioritized keeping the intervention brief and simple given its intended goal of prevention of long term chronic conditions and of creating a brief, light-touch intervention. In addition, a brief intervention such as this one could have potential as the first step in a stepped-care model for acute recovery following assault. Building in a component where patients who have not improved to a clinically significant degree then receive a referral for more intensive treatment could be a valuable addition and could improve engagement in care for those most in need.

Although there was a small positive shift in alcohol-related consequences such that they decreased slightly from pretreatment to posttreatment, overall drinking amount increased modestly. There are a number of potential explanations for the latter finding. It is important to note that women coming into the study did not need to have a change-goal with regard to their drinking and so may not have been motivated to reduce their consumption. In the prior study evaluating a similar brief intervention, study participants all met criteria for alcohol dependence and had goals to reduce or quit drinking (Stappenbeck et al., 2015). There is also the possibility that as the women's PTSD symptoms declined, they may have begun reengaging in social activities involving alcohol. This is consistent with findings that social motives are a major driver, especially of weekend drinking, even among young women with sexual assault histories and PTSD. Of note, although all participants met criteria for heavy episodic drinking and alcohol-related consequences at baseline, a few of the women in this study reported relatively low drinking at baseline and throughout the course of the study. These women in particular may represent socially normative drinking and, especially given the small sample size, may be exerting a relatively strong influence on the findings presented here showing that drinking is not being impacted by the intervention. In the present study we did not ascertain the women's drinking motives and it is possible that rather than drinking primarily to alleviate negative affect and psychological symptoms, as is often the case among those with chronic co-occurring PTSD and alcohol use, their drinking might have been driven more by desires for sociability (Huh, Kaysen, & Atkins, 2015). Prior research involving individuals with co-occurring PTSD and alcohol use disorders found that these drinking motives strongly moderate the degree to which PTSD symptomatology is associated with drinking (Simpson et al., 2014), suggesting that perhaps a more nuanced approach to cognitions related to drinking behavior may be needed to improve BRITE's impact on alcohol use. It is also possible that drinking was influenced by external contexts. The absence of a control group and the small sample in this study precludes us from making conclusions on this possibility.

This intervention refinement and feasibility study has several limitations to consider. First, the sample was difficult to recruit and was not selected specifically for being interested in changing drinking specifically. The focus on participation for "research" makes it challenging to understand how findings apply to pure treatment-seeking samples, although it should be noted that the ability to reach women who would likely not have engaged in services otherwise is a strength of the study. Due to difficulties with recruitment, the majority of the sample in the open trial (four out of six enrolled women) was college undergraduates, and one more was a graduate student. This makes it difficult to generalize findings to women of different ages, race/ethnicities, and socioeconomic backgrounds. Future studies should seek to better understand how to make treatment services following sexual assault appealing to a more diverse sample of women needing coping skills. In regards to drinking, the fact that women were not necessarily coming in to address drinking specifically might account for our limited effects on changing alcohol use behavior. That being said, many women are likely not seeking services for drinking in the acute aftermath of a sexual assault and reducing PTSD might have longer term effects on reducing drinking. Studies with longer term follow-up can help tease apart these relationships. In addition, this was an initial development and feasibility study. Larger studies with randomized designs, additional information on drinking and victimization history, and interview rated change in symptoms are needed to more fully understand for whom and when this type of intervention can be most effective in promoting recovery following sexual assault. Sequencing data collection such that answers to survey questions (e.g., regarding ratings of the intervention's helpfulness and changes in alcohol-related symptoms) could be followed up in qualitative interviews would also be an improvement, allowing participants to contribute perspectives on topics like whether and how the intervention improved their symptoms. The initial promising findings around this intervention support the completion of an RCT to explore effects of the intervention compared to natural recovery and this study is currently under way.

This study is the first to our knowledge to use an iterative process to distill an evidence-based treatment for

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PTSD and alcohol use down into a brief, and potentially easily disseminable intervention that might evoke change acutely following sexual assault. The initial findings are promising that this process is feasible in designing an intervention that is acceptable for women and that cognitive skills positively impact recovery. Studies that explore this type of brief approach to promoting recovery are needed to more fully understand the extent to which this approach is promising for reducing development of chronic PTSD and alcohol misuse.

Appendix A

A-B-C Worksheet: Practice **Patient: _____** **Date: _____**

A **Activating Event** Something happens	**D** **Challenging Questions** Evidence for the stuck point?	**E** **New, More Helpful Belief** What can I tell myself in the future?
B **Belief/Stuck point** I tell myself something **Underline the stuck point you will work on.**	Evidence against the stuck point? All or none thinking?	
C **Consequence** How does the stuck point make me feel? What do I do?	Confusing feelings with facts? Focusing on only one piece of the story?	**F** **New Consequence** How does the new, more helpful belief make me feel?

Figure 3

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