Prolonged Exposure Therapy

PE- The Basics

Purpose of Presentation

- Introduce the core concepts of PE
- Gain a basic understanding of session structure in PE
- Entice you to consider seeking more in depth training in this area to help our veterans!

Research Findings

- PE has been shown to significantly reduce symptoms and upon follow-up, symptoms stay reduced
  - Foa and Rauch, 2004; Resnick et al, 2002
- PCL scores are significantly reduced in veterans (65 OIF/OEF) who completed treatment
  - Tuerk et al, 2011
- CAPS scores lower in female and active-duty veterans who completed PE, while results maintained both in 3 and 6 month follow-up
  - Schnurr et all, 2007

Research Findings

- 115 Veterans studied in outpatient VA setting
  - 31% had a reduction in depression
  - 42% percent had a reduction in PTSD symptoms
    - Goodson et al, 2013

Research Findings

- Individuals with co-morbid personality disorders did not have any reduction in the efficacy of treatment with PE
  - Hembree et al, 2004
- Individuals with high levels of dissociation benefitted from PE comparably to individuals with low levels of dissociation
  - Hagenaars, Van Minnen, and Hoogduln, 2010
- Co-morbid conditions are not necessarily a rule-out for PE therapy:
  1. Alcohol Dependence/Substance Dependence
  2. Mild Traumatic Brain Injury
  3. PTSD Related Psychotic Disorders (where patient is currently stable)
  4. Personality Disorder
  5. Patient who has a history of suicidal ideation, as long as not actively suicidal presently
  6. Depression Disorders

Research Findings

- PE has not yet been studied in individuals who have PTSD with current:
  1. Non-PTSD related significant psychosis
  2. Serious self-injurious behavior (cutting or self-mutilating)
  3. Imminent threat of suicidal or homicidal behavior
  4. Moderate to severe traumatic brain injury
  5. PTSD related to intentionally harming another person other than in the line of duty

Mechanisms of Therapy for PTSD

- Promotional of emotional engagement with the traumatic memories
- Modification of the erroneous cognitions underlying PTSD

Safety and Acceptability of PE: Exacerbation in Symptoms

- With PE, a minority of clients in treatment show a reliable exacerbation of symptoms:
  - 10.5% in PTSD symptoms
  - 21.1% in Anxiety symptoms
  - 9.2% in Depressive symptoms
- Exacerbation of Symptoms was not associated with:
  - Treatment drop-out
  - Poorer treatment outcome

Foa, Zoeliner, Feeny, Hembree, and Alvarez (2002)

Drop Out Rates

- Meta analysis of 25 treatment studies by Hembree et al, 2003:
  1) Exposure therapy alone
     20.6%
  2) Stress Inoculation/Cognitive therapy
     22.1%
  3) EMDR
     18.9%

Session 1

- Overview treatment for patient
  - Average 10-12 sessions, 90 minutes each
  - Weekly is ideal, not more than 10 days apart
  - Very homework heavy treatment
  - Only get out of it what you put in
  - Session 1 may take 2 sessions
    - Should be interactive and engaging to client

Present Rationale

- Treatment addresses 2 main factors that maintain PTSD:
  - Avoidance
  - Unhelpful thoughts and beliefs
- Explain confrontation of distressing memories or situations:
  - Facilitates emotional processing; decreases numbing
  - Client learns they can tolerate thinking about memories and can feel competent to do so
  - Learns memories are not dangerous

Confronting Distress Memories

- Helps reduce reexperiencing symptoms
  - Overprocessing and overconfrontation
    - Body does not have to "vomit" trauma in fragments
    - Memory is fully integrated and all aspects dealt with
    - Body physically habituates to anxiety
      - The only way to reduce anxiety is to sit with it
    - Still will have memories, but much less distressed
    - Come to acceptance and terms of events that have happened
    - Client will have less fear over trauma and gain a more realistic perspective
      - Client can see trauma in context it occurred by listening to self talk through actual events, alleviates distorted "after perspective"

2 Types of Exposure: Imaginal and In Vivo Exposure

- Imaginal Exposure: revisiting and recounting the trauma memory
  - Recognize trauma has a beginning and an end
  - Deal with aspects client has not dealt with, especially emotional integration
  - Trauma revisiting in present tense with eyes closed, as if happening now

In Vivo Exposure

- Client approaches situations in which they are avoidant
  - Doesn't go at all
  - Gets in and out
  - Engages in safety behaviors while there
  - Identifying environments where client is highly anxious or there are probable triggers

Selecting an Index Trauma

- Obtain full trauma history
  - Must meet criterion A
- Obtaining most distressing trauma
  - Look for highest level of reexperiencing symptoms
  - Look for most sensory loaded
- Select a discrete trauma with a beginning and end point
- Break down lengthier trauma into smaller components

Baseline Measures

- Administer the BDI-II and PCL
  - Not looking for cut-offs, used as a baseline
  - Feedback for client
  - Identifying distressing symptoms
- Have client identify personal goal for treatment
  - What would you like to see different in your life when you have complete this treatment?

Breathing Retraining

- Educate regarding benefits
- Not essential to PE
- Not to be used during in vivo or imaginal homework
  - Do not want client to escape emotions or distance from them
- Diaphragmatic breathing coupled with a stress ball

Session 2

- Review homework
  - Check for compliance…did they listen to their tape? Did they practice their breathing?
  - Discuss any further questions client has
  - Check for their understanding of material
    - Avoidance
    - Sitting with their emotions and trauma
    - Homework based
    - Continued commitment

Common Reactions to Trauma

- Review symptoms of PTSD in depth
  - Conversation should be interactive and supportive
  - "What do you understand about PTSD?"
  - "What symptoms to you experience related to your trauma?"
    - Normalize as they verbalize these symptoms as much as possible and expand
    - Overview symptoms of PTSD

Provide Rationale for In Vivo

- Avoidance
  - In vivo blocks avoidance
  - Disconfirms client's belief that exposure to the feared situation will result in the anticipated harm
    - Disconfirms belief anxiety will last forever
    - Results in habituation
    - Increases client's confidence and sense of competence

Subjective Units of Distress Scale- SUDS

- Give definition of SUDS
- Used to help monitor distress throughout the rest of their therapy
- Uses anchor points to help gauge how distressed they are at any given time
  - Anchors 0, 50, 100
- Describe anchors
  - 0 is most relaxed, even if never completely
  - 100 is most distressing moment of life, bar none
  - 50 is a one time event half-way between 0-100
    - This is the one they will have trouble with typically
    - i.e., Fender bender no one hurt, divorce, examination at school, pulled over by police and ticketed

Examples of Habituation

- They may believe environments are intolerable or unsafe
  - Discuss habituation
    - Anxiety will peak and spontaneously reduce if they don't flee or are avoidant
    - Like shaving off a layer of ice (very thin) each time
      - Takes several trials to see a noticeable difference
    - Body gets in the "habit" of tolerating anxiety
      - Only way to reduce it
    - Need to stay minimum of 45 minutes and/or anxiety reduced by 50% spontaneously
- Example
  - Child at the beach

In Vivo List

- Identify around 20 environments, give or take
  - Focus on triggers/stimuli associated with their trauma
    - Crowds, heat, darkness, smells
  - Include social activities with peers
  - Identify environments where they can build peer supports
  - Identify environments they have tried to go to and left because they found intolerable
  - Identify things they used to do prior to deployment
  - Identify environments where they engage in safety behaviors or only go for short periods

In Vivo Exposure Hierarchy

Name: _____

Date: _____

Therapist: _____

SUDS Anchor Points

0— _____

50— _____

100— _____

Item	SUDS (Sess. 2)	SUDS (Final Sess.)
1.		
2.		
3.		
4		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		

Rating Environments

- Review their SUD scores as anchors
- How distressed would they feel if they had to go to the environment and stay a minimum of 45 minutes and:
  - Tried to not engage in safety behaviors
    - No back to the wall, no watching exits, no sizing people up, no carrying a weapon
  - Tried to be in the moment
    - No "what if" statements
    - Watch positive vs. negative focus/self-talk
  - Did not isolate to less populated areas

In Vivo Exposure Homework Recording Form

Name: _____ Date: _____

1) Situation that you practiced _____

Date & Time	SUDS			Date & Time	SUDS		
	Pre	Post	Peak		Pre	Post	Peak
1.				5.			
2.				6.			
3.				7.			
4.				8.			

2) Situation that you practiced _____

Date & Time	SUDS			Date & Time	SUDS		
	Pre	Post	Peak		Pre	Post	Peak
1.				5.			
2.				6.			
3.				7.			
4.				8.			

3) Situation that you practiced _____

Date & Time	SUDS			Date & Time	SUDS		
	Pre	Post	Peak		Pre	Post	Peak
1.				5.			
2.				6.			
3.				7.			
4.				8.			

Session 3 to 4-5

- Administer PCL and BDI-II every other session
- Review Homework
  - Did they go EVERY day
  - Did they go to all environments assigned
  - Did they go to environments more than one time each
  - What caused problems in compliance?
    - "Too busy"
    - Financial issues
    - Avoidance
  - Note trends in SUD scores
    - Anticipatory anxiety
    - High peak scores- what happened?
  - Solicit reactions to listening to their tapes at home
  - Make sure to include lots of praise for effort, no matter what

Session Agenda

- Review rationale for imaginal exposure
- Will review trauma memory for 45 minutes
- Will help client "regroup" before leaving
- Remind client of the following:
  - Avoidance perpetuates their PTSD, even if they fell better temporarily
  - Reexperiencing symptoms indicate the memory has not fully been processed

Trauma Processing

Goal of processing trauma:

1) To learn memories are not dangerous

2) Difference between remembering and being retraumatized

3) Help client differentiate between the trauma and similar events

-decrease generalization from trauma to safe situations

4) Bring habituation and reintegrate emotions, break numbing

5) Enhance a sense of personal competence, confidence regarding client's ability to handle and think about their trauma

Rules to Imaginal Exposure

- Client should:
  - Keep eyes closed throughout processing
  - Visualize the trauma as much as possible, including describing what happened, including their thoughts, feelings and sensory experiences
  - Tell story in present tense as if happening right now

Inquiry

- Give your inquiries short, brief, and not directive in content
  - How do you feel emotionally?
    - Eventually "and emotionally"
  - What are you experiencing physically?
    - "and physically?"
  - What can you see?
  - Do can you smell?
  - What is going on around you?
  - What are you thinking?
- Ask questions in the present tense

Therapist Imaginal Exposure Recording Form

Name of Client: _____ Therapist: _____

Date: _____ Exposure #: _____ Session #: _____

Description of exposure in imagination: _____

_____ Start time	SUDS	*Notes:*
Beginning		
5 minutes		
10 minutes		
15 minutes		
20 minutes		
25 minutes		
30 minutes		
35 minutes		
40 minutes		
45 minutes		
50 minutes		
55 minutes		
60 minutes		

Titrating the Experience

- If the processing is just too overwhelming and they refuse to go on or just stop:
  - Explore why they are stopping and normalize aspects of their distress
  - Gently discuss how stopping is their continued avoidance
  - Discuss how you can adapt processing to make it more tolerable

Titrating Imaginal Processing

- Discuss how you can adapt processing to make it more tolerable
  - Eyes open
  - Allow grounding and/or breathing if completely overwhelmed
  - Allow them to take small breaks:
    - Be very praising to them during breaks
    - Focus on their successes
  - May allow them to write their trauma
  - If they are embarrassed or ashamed:
    - They can turn away from you
- May need to allow them to write the trauma initially between session daily

Imaginal Processing

- Reflect statements client made during processing and get their reaction
- Processing is not confrontational, but more reflective, focusing on areas where client is stuck
  - Self-blame
  - Guilt
  - Woulds, shoulds, musts

Processing

- Imaginal helps clients see what happened and why things happened as they did
  - Timeframes, being in danger themselves, lack of information (hindsight), unrealistic beliefs
- Client may bring up other traumas during this time that are triggered by processing
  - Explore themes or similarities

Assign Homework

- Listen to tape once a day, every day
  - Quiet, uninterrupted place
    - Not outside (breeze, temperature, sounds distracting)
  - Not directly before bed
    - Will have increased nightmares
  - Wear headphones
  - Eyes closed
  - Remind client of slight increase in symptoms
  - Provide tracking log
    - Review SUDs and layout of form

Imaginal Exposure Homework Recording Form

Name: _____ Date: _____

Instructions: Please record your SUDS ratings on a 0–100 scale (where 0 = no discomfort and 100 = maximal discomfort, anxiety, and panic) before and after you listen to the audiotape of the imaginal exposure.

Tape #: _____

DATE & TIME				
SUDS Pre				
SUDS Post				
Peak SUDS				

DATE & TIME				
SUDS Pre				
SUDS Post				
Peak SUDS				

Homework

- Continue to practice breathing retraining
- Listen to rationale of imaginal one time
- Listen to entire imaginal exposure one time each day, every day
- Remind them to complete their in vivo homework
- Make copies of in vivo log for yourself
- Firmly remind them to bring their logs back

Review of Homework Continued

- Look for trends in scores and process
  - High anticipatory anxiety
  - High post scores
  - Scores decrease
  - High peek scores
- Explore client's symptom level and tolerance to exercises and process
- Ensure client goes on with day after engaging in homework
- If several missed days, discuss increased compliance
  - Explore problems with compliance
    - Time, money, childcare, transportation, etc.
  - Will not get full benefits if not fully engaged
  - Continued avoidance?

Hot Spot Processing: 5-9

- Starting in session 5 or 6, will start Hot Spot processing
  - will continue through session 8 or 9
- Start after at least mild habituation to the entire trauma
- Identifying hot spots
  - Look for peers in SUD scores during imaginal processing
  - Look for emotional or sensory loaded parts of trauma
  - Look for segments that client identifies as highly distressing (i.e., debriefing)

Inquiry

- Process is the same during imaginal hot spot processing, but processing is only 20-30 minutes
- Try to get through hot spot more than once
- 5 minute SUD scores
- Present tense, be in the moment
- Eyes closed

Processing

- Concept same as with full imaginal processing
- Choosing hot spots by identifying peaks in full imaginal processing
- Helps client habituate more rapidly to the most intense pieces of trauma
- Helps client experience emotions more
  - Helps break numbing
  - Helps reduce peak SUDs more rapidly

Homework

- Homework remains the same as full imaginal processing
  - Listen to review of homework and initial processing of reactions to homework 1X
  - Listen to in-session recording of trauma one time daily between this session and next
  - Practice 2-3 environments; one daily
  - Complete both tracking logs
  - Utilize breathing if needed for intense anxiety outside of times engaging in exposure

Final Session (from 10-12)

- Prior to final session may have a session where entire trauma is revisited
  - Check for habituation across the entire trauma, not just hot spots
- Start session with homework review
  - Review logs
  - Review reaction to homework
- Review session structure

Final Session

- Review entire trauma through imaginal processing
  - Do this for only 20 minutes approximately
  - Still inquire regarding SUD scores every 5 minutes
- Process experience of imaginal processing
  - Now vs. first session
  - Focus on progress client has made

Last Session

- Review skills client has learn and how can handle similar situations in the future
  - Move towards things that make them anxious
  - Need to sit with feelings, not be avoidant
  - Need to continue to go out and push selves to do things that make them anxious
- Go through In Vivo list and have client re-rank environments
  - Compare numbers
  - Have them comment on meaning they assign to reduced numbers

Last Session

- Review rationale of overall treatment
- Review what they need to do to maintain gains
- Discuss second round of PE if another focal trauma is highly distressing
- Consider alternatives to verbal recordings
  - Now they know they can process events and it will get better
  - Less fear of challenging memories independently
- Writing trauma out daily in full detail
  - Sensory, emotions, thoughts
  - Still process reaction in between sessions

Internet Access to Forms

- All the forms needed for PE therapy can be found at:
  - **www.oup.com/us/ttw**
    - Found under the title “downloadable tools”

Troubleshooting

- Coming in with off-topic stressors
  - Process true emergencies only
  - Can take 5-10 minutes at beginning of session, but not more than 10 minutes
  - Avoidance?
  - Anticipatory Anxiety?
- Only completed ½ the homework
  - The more they put in, the more they get out
  - Return to rationale of habituation
  - Really something prevented
    - Physically ill, death of family member, fired from job, etc.

Troubleshooting

- Client wants to stop
  - Often asking permission
  - Validate how intense and difficult PE therapy can be
  - Discuss how symptoms have not lessened with what they have tried
  - Remind them they have to get over the "hump" and it will get better
  - Remind them this is their emotions and memories, cannot hurt them
  - Offer supportive phone contact between sessions
  - Client has the ultimate say-so
    - Reviewing the above statements often keeps them going
  - Assure them you will support them and they can come back no matter what their decision

Troubleshooting

- Client's experience during imaginal is too intense
  - Allow very brief scenario and have more detail added each round
  - Eyes open
  - Past tense
  - Minimal inquiry
  - Breaks during processing
  - Writing initially and then moving to verbal processing
    - Greater sense of control
    - Move towards and away from emotional states
  - Normalize physical experiences
    - Body sensations similar to when in trauma situations

Troubleshooting

- Client drops out
  - 20% of individuals who start PE will not complete it
- Give support and work on basic coping skills, with idea can return to PE later
- Better to stop PE than client leaves therapy altogether; disillusioned
- Be flexible and possibly just start with in vivo exercises

Troubleshooting

- Client's anger increases
  - Explore and assess for risk factors
  - Identify activities client can engage in to help reduce anger
    - Sensory loaded: shower warm and cool, finger painting, music, exercise, etc.
  - Work on time-out technique
  - Work on identifying "layers" to client's anger
    - Anxiousness, grief, helplessness, fear, etc.

Troubleshooting

- Client seems distance during processing and remains numb
  - Push for details to help client be more in the moment
    - Emotional, sensory
    - Use your gut reaction to know when to push
  - Review rationale and inquire about "pulling back"
    - Often know they are doing it
    - Channel emotions into anger to have a sense of control
      - Uncomfortable feeling vulnerable
  - Are they doing something to distant when processing
    - In session: rubbing face, hands together, rushing
    - At home: doing other activities during homework, distractions