
*National Center for PTSD U.S. Department of Veterans Affairs -
Treatment Interventions: Prolonged Exposure Therapy*



**VA/DoD CLINICAL
PRACTICE GUIDELINES
FOR PTSD (2010)**

Presented by
National Center for PTSD
U.S. Department of Veterans Affairs

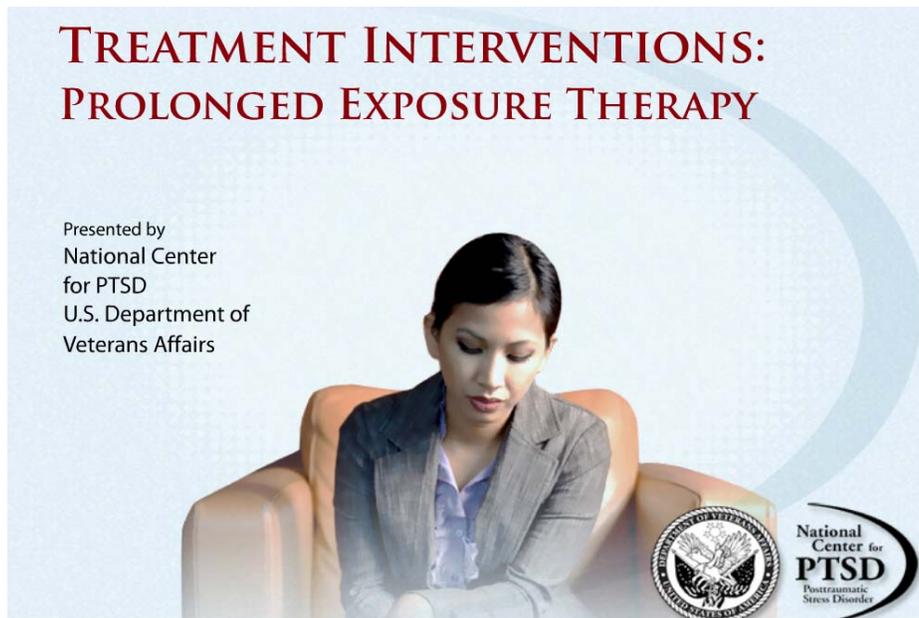
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Treatment Interventions: Prolonged Exposure Therapy



So welcome, I'm going to be talking today about the Veterans Affairs Department of Defense 2010 clinical practice guideline for PTSD focusing on treatment interventions, specifically Prolonged Exposure Therapy.



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My name is Sheila Rauch. I'm a psychologist at the VA Ann Arbor Healthcare system and the University of Michigan Medical School.

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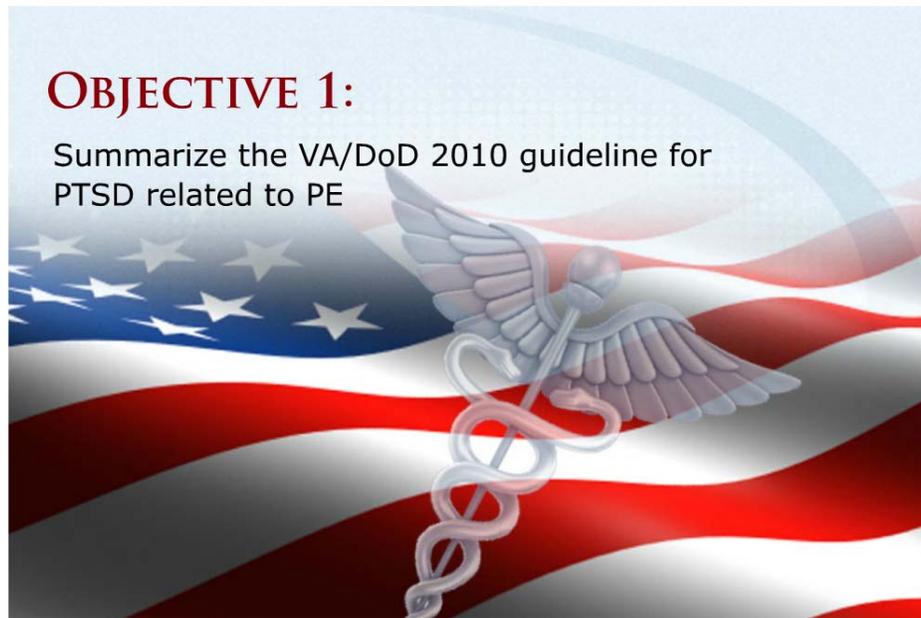


And, I first want to acknowledge the many people that have been involved in research on Prolonged Exposure, as well as the Prolonged Exposure rollouts in the Veterans Health Administration, including many people in the Office of Mental Health Services, lots of people involved at the National Center for PTSD, Dr. Foa, Dr. Hembree and Dr. Riggs, as well as all the PE initiative clinicians, consultants and trainers – and all the other people that have been involved in the development of Prolonged Exposure therapy for PTSD.

PRESENTATION OBJECTIVES

1. Summarize the Veterans Affairs / Department of Defense (DoD) 2010 Clinical Practice Guideline for PTSD related to Prolonged Exposure Therapy (PE)
2. Review the empirical evidence supporting PE
3. Describe and demonstrate the clinical application of PE

The objectives of my talk today include summarizing the Veterans Affairs Department of Defense 2010 Clinical Practice Guideline for PTSD related to Prolonged Exposure Therapy, reviewing the empirical evidence supporting Prolonged Exposure and describing and demonstrating the clinical application of Prolonged Exposure.



So, we will start with objective one, summarizing the Clinical Practice Guideline for PTSD related to Prolonged Exposure.

2010 CLINICAL PRACTICE GUIDELINE

- ▶ First line treatment interventions for PTSD have been identified based on strong evidence:
 - **Psychotherapy:** Trauma-focused psychotherapy that includes a component of exposure (Prolonged Exposure) and/or cognitive restructuring, or Stress Inoculation Training
 - **Pharmacotherapy:** Selective Serotonin Reuptake Inhibitors (SSRIs) and Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)



The 2010 clinical practice guideline for PTSD supports several interventions as first line treatments for PTSD given their strong evidence. This includes psychotherapy, specifically trauma focused psychotherapy that includes a component of exposure, such as Prolonged Exposure, and/or cognitive restructuring, or Stress Inoculation Training.

An alternative first line treatment is pharmacotherapy, specifically selective serotonin reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitors (SNRIs).

GUIDELINE FOR PSYCHOTHERAPY INTERVENTION FOR TREATMENT OF PTSD

BALANCE BENEFIT AND HARM

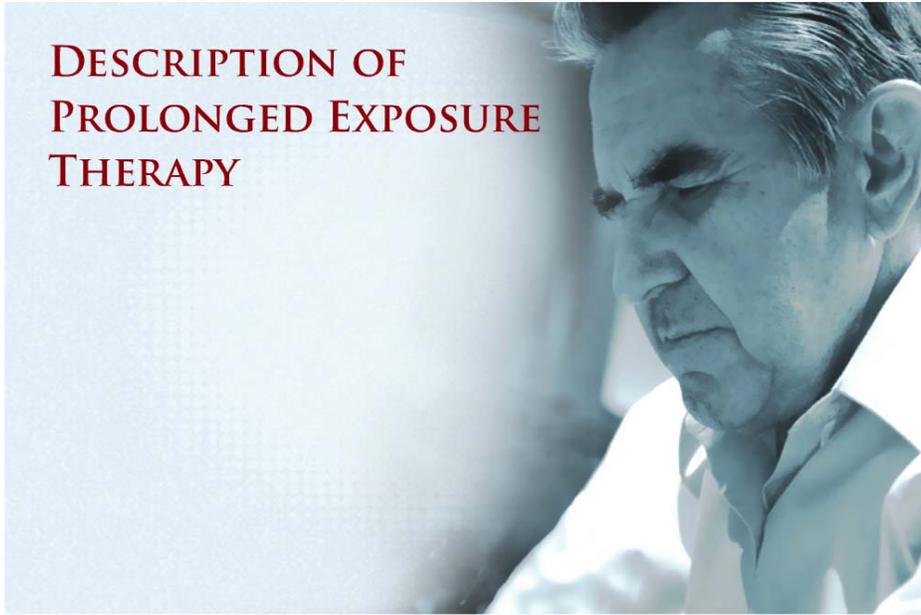
SR	SIGNIFICANT BENEFIT	SOME BENEFIT	UNKNOWN BENEFIT	NONE
A	Trauma-focused psychotherapy that included components of exposure and / or cognitive restructuring; or, Stress inoculation training			
C		<ul style="list-style-type: none"> - Patient Education - Imagery Rehearsal Therapy - Hypnosis - Relaxation Techniques - Group Therapy 		
I		<ul style="list-style-type: none"> - Family Therapy 	<ul style="list-style-type: none"> - WEB-Based CBT - Acceptance and Commitment Therapy - Dialectical Behavioral Therapy 	

SR = Strength of Recommendation

The next slide shows the specifics of the guideline’s support for the psychotherapy interventions. Trauma focused psychotherapy has the strongest level of evidence, and again, this is a repeat of the last slide, but supporting exposure based treatments and/or cognitive restructuring and Stress Inoculation Training.

Your choice of which treatment to start with should generally be based on the level of evidence, the patient’s presentation, or preference, as well as clinician expertise and knowledge about a given intervention.

**DESCRIPTION OF
PROLONGED EXPOSURE
THERAPY**



So, next I'm going to describe the specifics of Prolonged Exposure Therapy.

BASICS OF PE

- ▶ Treatment for PTSD
- ▶ Cognitive-behavioral principles grounded in theory
- ▶ Large body of empirical support
- ▶ 90-minute individual sessions
- ▶ 8-15 Sessions (average of 10)
- ▶ Structured, manualized treatment with flexibility and strong emphasis on collaboration and therapeutic relationship

So, the basics of Prolonged Exposure: it's a treatment for PTSD. It's based on cognitive-behavioral principles that are grounded, strongly, in emotional processing theory. There is a large body of empirical support. Lots of research has been done on Prolonged Exposure with very complex, difficult, patients; all types of patient populations.

The sessions are 90 minutes and individual. Generally, there's between 8 and 15 sessions with an average of 10 sessions per patient. It's a structured and manualized treatment with flexibility and strong emphasis on collaboration and the therapeutic relationship.

PROLONGED EXPOSURE FOR PTSD: TREATMENT PROCEDURES

- ▶ Psychoeducation: Education about treatment and common reactions to trauma; breathing retraining
- ▶ Repeated in vivo exposure
- ▶ Imaginal exposure
- ▶ Emotional Processing



So, now let's get into the specifics of the treatment procedures for Prolonged Exposure. There are four treatment procedures that make up the full protocol for Prolonged Exposure. The first is Psychoeducation, and that includes education about treatment and common reactions to trauma, as well as breathing retraining.

Then there is repeated in vivo exposure, which is exposure to people, places, situations that the patient avoids for fear of trauma reminders or for fear of having a strong reaction. Imaginal exposure, which is actual exposure to the trauma memory or memories in their imagination. Emotional processing, which involves going back and looking at the context of the memory and putting the memory into the context in which it happened as well as putting it into the patient's life context.

TREATMENT STRUCTURE AND OVERVIEW

- ▶ Session 1 - Psychoeducation, assessment, breathing retraining, homework
- ▶ Session 2 – Homework review, common reactions to trauma, rationale and construction of in vivo, homework
- ▶ Session 3 – Homework review, rationale for imaginal exposure, begin imaginal exposure, “processing” exposure, homework



Treatment structure and overview. In session one the therapist focuses on psychoeducation, assessment; they do a brief little breathing retraining exercise, and they start giving the patient homework exercises to start that pattern of doing homework between sessions.

Then in session two, the first thing you always do in every session is review homework. Then they cover common reactions to trauma, they cover the rationale for the therapy as well as the rationale for in vivo exposure, and they construct the in vivo hierarchy and assign homework.

In session three, again, they start by reviewing the homework and focusing briefly on the rationale for imaginal exposure before starting the critical component of imaginal exposure in session. That occurs for 45 to 60 minutes in that first session, and then they do emotional processing for another 10-15 minutes, and then they assign the homework.

TREATMENT STRUCTURE AND OVERVIEW

- Sessions 4-X – Homework review, imaginal exposure (working towards “hot spots”), processing, homework
- Final session – Homework review, imaginal exposure (entire memory), process exposure for that session, process treatment in general (reviewing usefulness and skills learned), relapse prevention

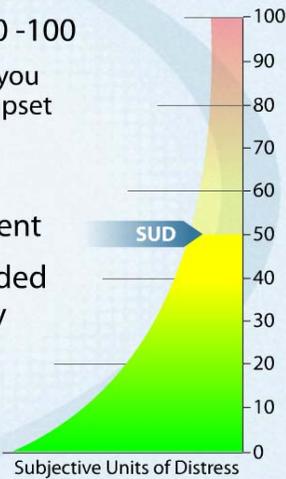


Session four through whatever session you are ending with, whether it is 10, 12 or 15 or even 8 or 6, you start with homework review, you do the imaginal exposure in those additional sessions—it’s typically between 30 and 45 minutes of imaginal exposure—and you work from working on the whole memory, cutting it back, to working on the specific hot spots, or those moments in the memory that hold the most emotion or meaning for the patient. Then you move to the processing again for 10-15 minutes and assign homework.

And, in the final session, you, again, start with homework review. You do imaginal exposure of the entire trauma memory again, just one time through, and you process the exposure for that session, and then you process the whole treatment experience in general, by reviewing what was most useful, what were the skills that were learned, what are the things that did or didn’t help the most, what exercises were most useful, and you also cover relapse prevention: to talk with them about how if they notice the symptoms coming back, how are they going to deal with that, can they use these exposure skills on their own, if they have symptoms that do come back, and also knowing when they might need to come in to get some extra assistance.

IN VIVO EXPOSURE

- ▶ Subjective Units of Distress (SUDs) scale 0 -100
 - 0 = not feeling any distress, 100= most upset you have ever been, 50 = start to notice feeling upset but manageable
 - Decide on anchors for the scale
- ▶ Create *In vivo* hierarchy created with patient
- ▶ Items include people, places, things avoided due to distress or trigger trauma memory
- ▶ Can also include behavioral activation items as needed

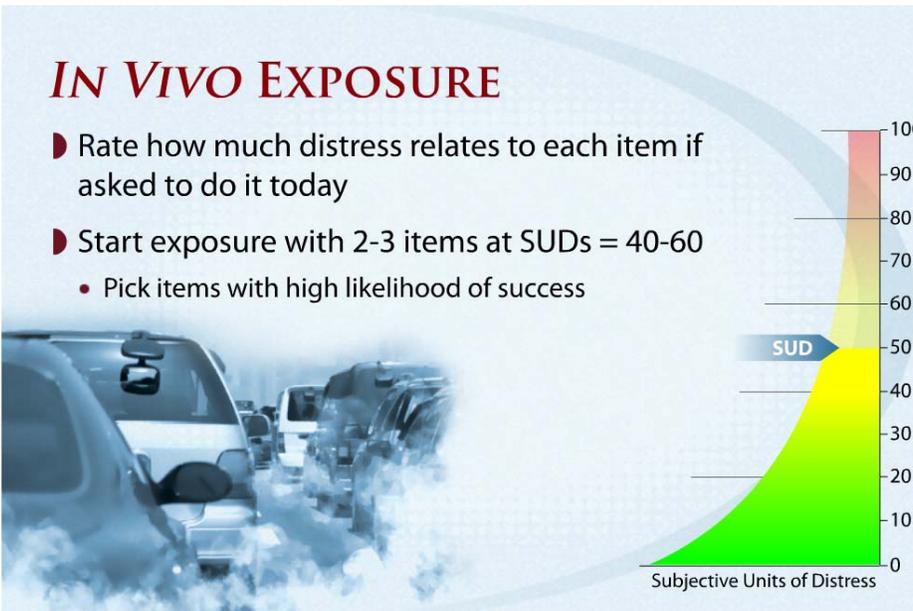


Now I'm going to provide a little bit more detail about each of the different types of exposure in emotional processing. So, we'll start with in vivo exposure since it's the first procedure that actually the patient engages in, in the treatment. In vivo exposure you start by developing subjective units of distress scale which many people might be familiar with but a SUDs scale goes from 0 to 100. Zero is not feeling particularly any emotional distress, feeling relaxed. It is not necessarily feeling happy but just feeling relaxed and no upsetting or distressing emotions. 100 is the most upset you have ever been in your entire life, and then 50 is typically what we call halfway between there, so it's where you start to notice that you are feeling upset but it is manageable in that moment. And, you come up with anchors for that scale for this individual patient from their real life that are specific so that they remain consistent as a tool that can be used throughout the treatment when you are working together.

The next thing you do with in vivo exposure is to go back and talk about the rationale and why you are doing exposures as opposed to avoidance, and then you create a hierarchy with the patient. And, the in vivo hierarchy is a list of situations: people, places, things that they avoid due to distress or they avoid because of triggers of the trauma memory, and you want to typically have between 10 and 20 items on there depending on the patient and how quickly they are going to move through things. You can include a majority of avoidance items, but you can also include behavioral activation items as needed. If you have a patient who is suffering with depression it can be important to put things on there that are helping them take their life back from PTSD and depression and help them feel alive again.

IN VIVO EXPOSURE

- ▶ Rate how much distress relates to each item if asked to do it today
- ▶ Start exposure with 2-3 items at SUDs = 40-60
 - Pick items with high likelihood of success



Subjective Units of Distress

You want to, then, rate how much distress each of those items on the hierarchy would have: how much distress they would have if they were asked to do that today. So, for instance if someone put on their hierarchy, “Driving on the highway – I avoid driving on the highway because there’s lots of trash and junk on the side of the road.” Then, as a therapist, you would say, “Okay, if I asked you to drive down the highway outside of town today, for 30 minutes, and just drive straight down it, don’t switch lanes when there is trash on the side, where would you be on your SUDs scale?” And, they would give you a number, for instance maybe 75, and you would record that for each of the items on the hierarchy.

Then you would pick 2-3 items from that hierarchy for the patient to start working on between sessions, and you want to pick those things that have a high likelihood of success and that are going to be reinforcing for the patient to actually engage in again. So, if there’s something they have avoided but that they really want to be able to do again, and it’s somewhere between a 50 and a 60 on their scale, or a 40 and 60 on their scale, those are good items for including on that first week of in vivo exposure. You want them to have success so then you can build on it when you are asking them to do the memory exposure the next week.

IN VIVO EXPOSURE

- ▶ Patient works on items between sessions
 - unless additional assistance needed (due to avoidance including safety behaviors)
 - May require doing with therapist or specific directions to take safety behaviors away
 - Call between sessions
- ▶ Stay significant amount of time
 - 45 minutes or until SUDs 50% peak
 - then do it repeatedly



So, then the patient goes home and works on those items between sessions. The exception to that would be if they need additional assistance due to avoidance including safety behaviors. So what that means, is if the patient is unable to engage in the exposure without doing things to protect themselves, like scanning the area, or bringing a safe person with them, if they are unable to stop doing those kinds of safety behaviors then the therapist probably is going to need to work with the patient on approaching those in vivos either with the therapist or specifically giving directions to take those safety behaviors away.

That might include things like asking a patient to call between sessions with questions, or having check-in calls after they have done specific in vivo exposures.

Then, you also need to make sure when the patients are working on these in vivos is staying in the situation for a significant amount of time, so typically that's defined as 30-45 minutes or until their peak SUDs for that situation is half of the peak.

So, going back to our guy that's driving on the highway, if he says his peak is a 75 (that's what he thinks it's going to be) and then he going into the situation and his peak is actually an 80 when he's in the situation, we want him to stay there until he's been there either 45 minutes or until his SUDs has dropped to a 40.

And, then, the second important part of it is that he is doing it repeatedly. So, you don't just do that once, you go back and you try and do it every day, or even twice a day, or as much as you can possibly get the repetition in with the patient.

So, that's the basic idea of in vivo exposure in that first session.

IMAGINAL EXPOSURE

- ▶ Begins in session 3
- ▶ Full memory
 - Identify memory based on symptoms
- ▶ Collaborate to determine beginning and end point
 - Determine on case by case basis
- ▶ 45-60 minutes in first exposure session



So, now we move to imaginal exposure, and imaginal exposure starts in session 3, and imaginal exposure is what most people think of when they think of Prolonged Exposure, but it is only one of the important components.

Imaginal exposure begins by focusing on the whole memory, the whole trauma memory, and you identify the memory based on the PTSD symptoms that the patient has. So, you don't do exposure to a memory that they are not having trouble re-experiencing symptoms for. You do a good assessment, initially, and you focus the imaginal exposure on the memory that is related to the most symptoms that the patient is reporting.

You want to collaborate with the patient to determine the beginning and the end of the memory, and, basically, you are going to figure out the moment when they started to feel like things were going bad, and that would be where you start the trauma memory exposure, the first session that you are doing it. And, then you end at the point where the person felt they were out of immediate danger.

So, sometimes when you are working with combat Veterans, they are still in a dangerous situation, but the immediate threat was ending. So, it might be the end of a fire fight, but they still had to get picked up by the helicopter, and you determine that on a case by case basis. You want to make sure that you have the full memory that they are having re-experiencing to, but that it's not too long or too big to be cumbersome.

Then you do 45-60 minutes of imaginal exposure, in that first session.

IMAGINAL EXPOSURE

► Directions include:

- Eyes closed
- As though it is happening now (present tense)
- Engage with the feelings it invokes
- Include as many details as possible: include events, thoughts, feelings, and sensory details
- Collect SUDs every 5 minutes

► Then move to hot spots

- 2-3 moments in memory that hold most emotion/intensity



And the specific directions that you give the patient in that session are that you want them to do it with their eyes closed. You want them to go through the memory as though it is happening now which means in the present tense so, “I am walking.” “I am running.” “I am sleeping”, whatever they are doing in that moment.

You want them to engage with the feelings the memory evokes, so you want them to actually feel sad, or feel happy or feel anxious in the session with you. And, then you want them to include as many details as possible, that includes the events that happened, the thoughts that they had, the feelings that they had: feeling sad or happy or numb or terrified, and include as many sensory details as possible. Sensory details can be really important because they can help the patient connect to the emotions that are also often there. So, remembering how the air felt on their skin, or if it was raining or sunny, or nighttime or daytime, those sensory details can really help the patient to connect with the memory.

And, then the therapist is going to be collecting SUDs about every 5 minutes in the session to just monitor how anxious the person is feeling. And, those SUDs are not what they felt at the time of the trauma, but what they’re feeling in your office as they are going through the memory in their imagination.

As you progress through imaginal exposure, you move from doing the full memory to actually working on specific hot spots. And, hot spots are typically the 2-3—couple—minutes of time, in real time, but the 2-3 moments in the memory that hold the most emotion, that hold the most intensity for the patient. They might also be the moments that hold significant meaning. So, it might be the moment the person realizes that they could be dead, or that someone else is dying, or where they felt intensely terrified. So, that’s imaginal exposure.

PROCESSING

- ▶ Begin processing with encouragement (Good job!)
- ▶ Review the imaginal exposure with open ended questions
 - How was that for you today?
 - How did that compare to how you thought it would be?
 - Did anything stand out today compared to other times?
 - What has changed/not changed as you have been working on the memory?
 - What does XXX mean to you?
- ▶ Normalize and reflect
- ▶ Review pattern of habituation

Now I'm going to move on to processing; the emotional processing. Processing begins from the moment that you tell the patient, "It's okay, open your eyes." You want to start right away by giving them encouragement, saying something like, "Good job. Nice work today." Then you want to move into reviewing the imaginal exposure and using open-ended questions.

As a therapist you are following the patient in this whole processing part of the session. You're not directing the session, you're just following what the patient is bringing up with questions like, "How was that for you today? How did that compare to how you thought it would be? Did anything stand out today compared to other times? What has changed or not changed as you have been working on the memory? Or what does 'blank' mean to you?", some important part of the memory or important thing that they said today that stood out to you as meaningful.

You want to normalize and reflect, so, again, you are not interpreting what they are saying or telling them what they should or should not think. You're just playing back its normal to feel sad when your friend is dying in your arms. It's normal to feel terrified when you almost got shot in the head, and then reflecting those feelings and those emotion statements and important meaning statements back to the patient, so that the patient can think through it and figure out what it means to them.

You want to review the pattern of habituation and that includes the pattern within the session so whether they had a reduction in the session or whether they have changes between the sessions. So, is it progressively getting easier? Is their peak SUDs rating getting lower across the sessions?

PROCESSING

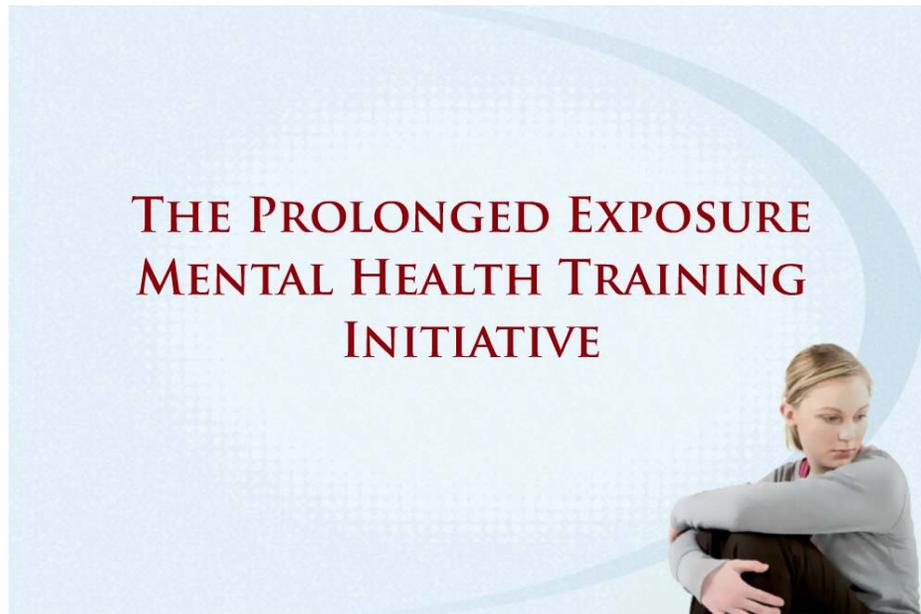
- Refer to rationale
- Place memory in context
- If time, bring up PTSD related themes that may have been apparent in the exposure and discuss
- Over sessions, processing becomes more focused on the areas maintaining PTSD
 - i.e., moving the behavior into the trauma context



You always want to refer back to the rationale in the processing, so pointing out the ways that their progress matches with what you talked about in the first session for how this treatment was going to work. And, an important part of processing is placing that trauma memory in context. So that's both the context that the trauma happened as well as placing that trauma memory in the context of their life and their life story so it's not a disembodied memory, but it's something that happened that's now just in there as one thing that happened in their life. So, you do that by contrasting what happened then with now and how is that then and how is it for you now.

If you have time, at that point, you can bring up PTSD related themes that may have been apparent during the exposure to discuss. So, if they brought up some really interesting way of thinking, so, for instance, "I felt like I should do something to save myself," those are good moments to talk through and have them think through what do they think about that now, now that they are not in the trauma.

And, then you want to, over the sessions, focus the processing more on specific areas that are maintaining PTSD symptoms. So, that might be moving the behavior into the trauma context or it might be focusing in on blame, if blame is a significant issue for this patient, or focusing on forgiveness if that is an issue for this patient.



So, next I am going to talk pretty quickly about the Prolonged Exposure Mental Health Initiative. This is a rollout in the VHA, in the Veterans Health Administration, to train mental health providers in Prolonged Exposure.

GOALS OF INITIATIVE

- ▶ Train critical mass of VA providers in the implementation of PE, balancing adherence and flexibility
 - Intensive training model supported by research and experience
- ▶ Establish on-going capacity within VHA for training and implementation of PE
 - FY2011 - targeted trainings in facilities with greatest need
- ▶ Ensure long-term sustainability of PE services

The goals of the initiative include training people in Prolonged Exposure and balancing adherence with the protocol with flexibility. We wanted to make sure we are intensively training people in the Prolonged Exposure model, in the way that we know that it works, and to establish an ongoing capacity for the VA to provide Prolonged Exposure. And, we also wanted to make sure that this was something that was sustainable; that it's not just going to happen while we have money to train providers but it's going to continue after the fact.

The image shows two identical slides side-by-side. Each slide has a light blue background with a faint grid pattern and a silhouette of a person presenting to a group. A whiteboard in the background displays the word 'Community'. The text on each slide is as follows:

TRAINING MODEL – TRAIN-THE-TRAINER

- ▶ Clinicians
 - 4-day interactive, experiential workshops
 - Weekly small group and individual consultation to provide on-going support
 - Tape review to ensure fidelity
- ▶ Consultants
 - 5-day interactive, experiential workshops
 - Ongoing support from Drs. Edna Foa and Elizabeth Hembree
 - Support and Community

So, the training model that was implemented was a train-the-trainers model, and that focuses on three different types of trainings. The first is training clinicians, and that involved a 4-day interactive, experiential workshop on Prolonged Exposure; weekly small group and individual consultation; as well as tape review of training cases to actually make sure that people are understanding and feeling comfortable with the model doing training cases.

The next step was consultants, so we trained consultants. These were people who completed that first level of training, got advanced training with Drs. Foa and Hembree through a 5-day interactive, experiential workshop and ongoing support from Dr. Foa and Dr. Hembree, as well as support and community between consultants, so that then they became the people who watched the training cases and ran the small groups and individual consultations for the next wave of VA clinicians.

And, then the final level of training was the trainers. So, these people completed another 3-day, interactive, experiential workshop to establish the ability for the VA to train their own people, because prior to that time, it was only the University of Pennsylvania faculty of Dr. Foa and Dr. Hembree that were training people in Prolonged Exposure, so now we wanted the VA to be able to do that.

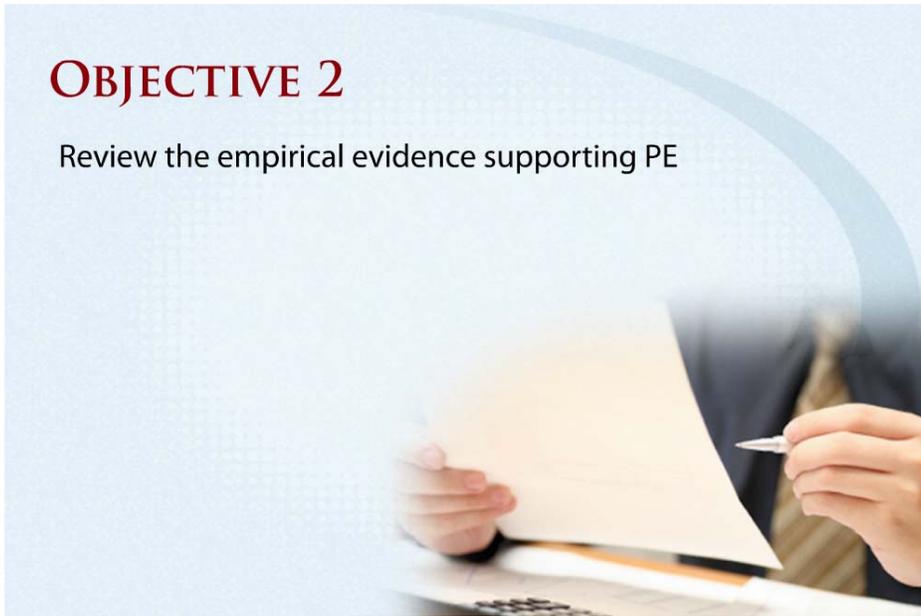
PE INITIATIVE TO DATE (FY11)

- ▶ Trainings –
 - Thirty-seven 4-day clinician trainings
 - Eight 5-day Consultant trainings
 - One 3-day Trainer training
- ▶ Over 1,300 trained in VA

So, the PE initiative to date, fiscal year 11, completed 37 clinician trainings, 8 consultant trainings and 1 trainer training. It's over 1,300 people have been trained in PE in the VA to date. So, it's a lot of work and it's an impressive number.

OBJECTIVE 2

Review the empirical evidence supporting PE



So, now we are moving to objective two, reviewing the empirical evidence supporting PE.

PUBLISHED RANDOMIZED STUDIES

Chronic PTSD:	
EX therapy only	23 studies
EX therapy + SIT and/or CR	26 studies
Acute PTSD or ASD	
EX only	2 studies
Ex therapy + SIT and/or CR	5 studies

EX = Exposure Therapy
SIT = Stress Inoculation Training
CR = Cognitive Restructuring

There's a lot of research that's been done on Prolonged Exposure, so this slide just points that out. Twenty-three studies on Exposure Therapy alone; these are just the randomized trials, so there other studies that have been done with specific populations and clinics and other things. These are just randomized trials.

Twenty-three with exposure alone, twenty-six with combination with cognitive restructuring and other things, and then additional studies that have been done to look at versions of PE for use with Acute PTSD or Acute Stress Disorder.

EFFECT SIZES OF PE VS. CONTROL

Time Point	PTSD Outcome	General Distress Outcome
Post-treatment	$g = 1.08$	$g = 0.77$
Follow-up	$g = 0.68$	$g = 0.41$

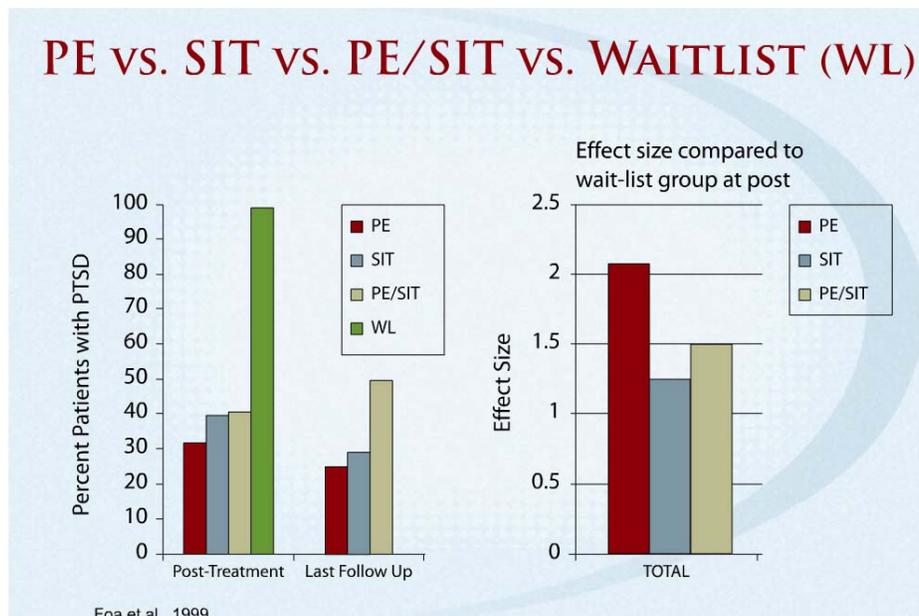
The average PE-treated patient fared better than 86% of patients in control conditions at post-treatment on PTSD measures.

Effect size = strength of the effect
Small effect size = .2, medium = .5, large = .8

Powers et al., 2010

The next slide covers effect sizes for Prolonged Exposure versus control, and this is from a meta analysis conducted by Powers in 2010, or published by Powers in 2010. And, it really shows that Prolonged Exposure has a large effect size on Posttraumatic Stress Disorder symptoms. It also has large effect size on general distress outcomes that include things like depression, or anxiety, or other things.

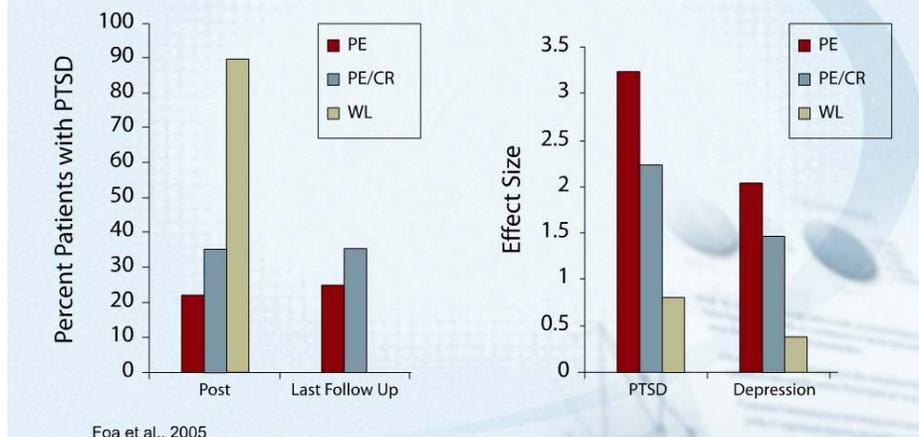
In general, an average PE patient fared better than 86% of patients in control conditions, including supportive therapy or other unstructured talk therapies, so PE is very effective in related to significant life changing differences. So, we are going to get into a little bit more detail about that.



The next slide covers one of the first large randomized trials of Prolonged Exposure run by Dr. Edna Foa. It was in a sample of sexual assault women, presenting for PTSD, who were randomly assigned to Prolonged Exposure, Stress Inoculation Training or their combination. And, this slide actually shows two different things. In the first half of the slide, we're looking at percentage of patients with PTSD at post-treatment. And, the tall bar is the wait list condition, and you can see almost all of the people who came in at pre-treatment still have PTSD at post-treatment if they're in a wait list condition. So, people aren't spontaneously recovering in this group.

In the PE and SIT group, or the combination group, you see very impressive effects. With the PE group having about 32% still meeting criteria for PTSD, that means you've got 68% not meeting PTSD criteria at post-treatment. And, this study was actually done with 10 sessions over 5 weeks, so within 5 weeks they've lost that diagnosis, and that change is maintained up to a year of follow up. The average follow up here is a 10.7 months. And, the effect size for Prolonged Exposure is over 2 in this sample, which is huge. That's the pre-post compared to wait list effect size. The combination condition has a slightly lower effect size, but it's not significantly lower.

PE, PE + COGNITIVE RESTRUCTURING (CR), WAITLIST (WL)

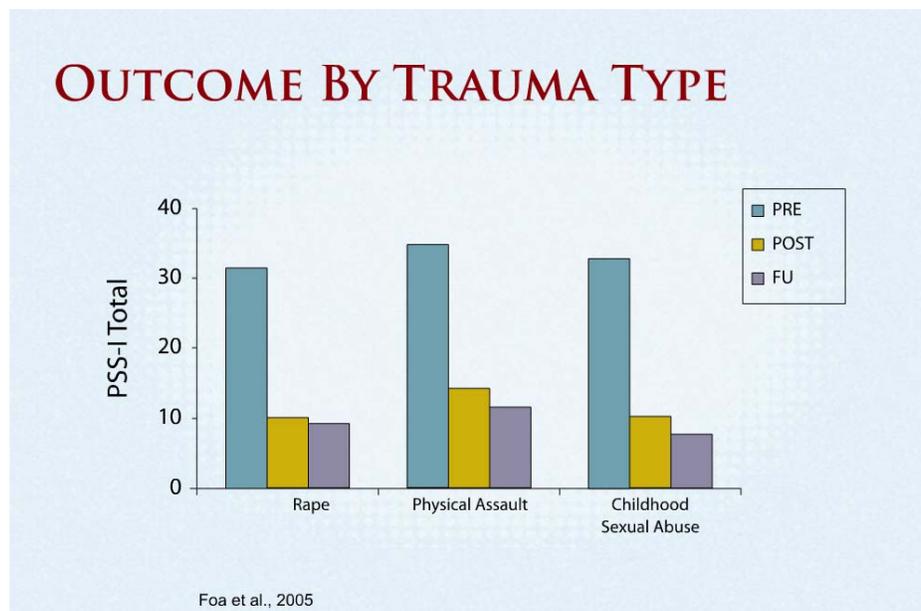


So, this next slide covers another large trial of Prolonged Exposure. Again, it was in female sexual assault survivors, and in this study, patients were randomly assigned to Prolonged Exposure, Prolonged Exposure plus Cognitive Restructuring, or a waitlist. And, again, patients responded well to Prolonged Exposure and Prolonged Exposure with Cognitive Restructuring. There were no differences in those two conditions in symptom outcome, at post-treatment or follow-up, and you can see that they did significantly better than waitlist.

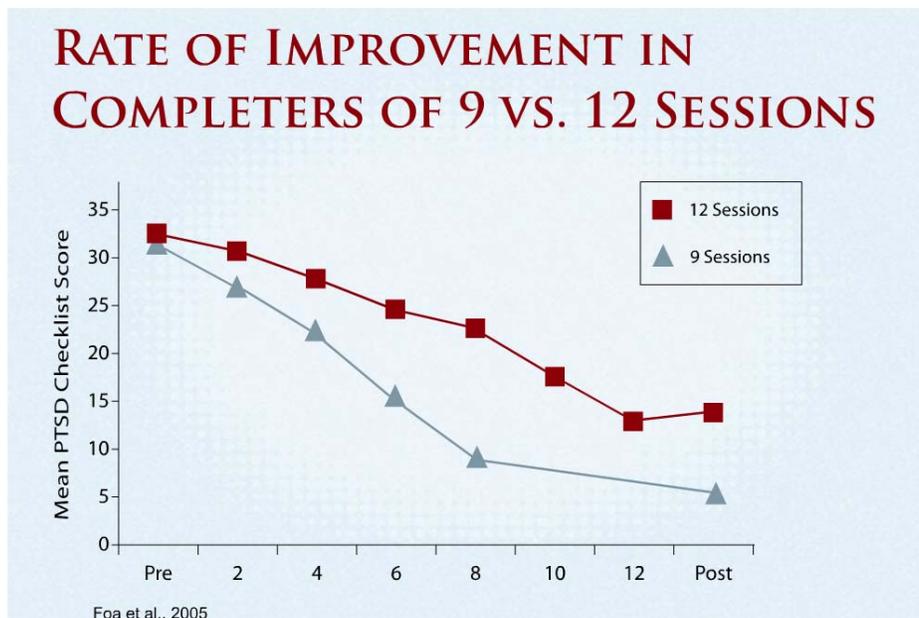
Again, here we don't have very many people who are spontaneously recovering. The waitlist group is still at about 90% at post, and the combined condition is at about 35% maintaining PTSD diagnosis, whereas the Prolonged Exposure alone is at the lower twenties, about 22%.

When you look at effect size in this trial, the effect size is even larger than the first trial: it's over 3. It's about 3.25 for Posttraumatic Stress Disorder symptoms in the PE alone group. It's slightly lower in the PE/CR group, but still, it's a large effect size. It's almost 2.5.

When you look at depression, which is not directly addressed in Prolonged Exposure, you're still getting a large effect size in Prolonged Exposure, where you got an effect size of 2 for that. So, it's very effective and it's also effective in reducing comorbid depression in PTSD patients.



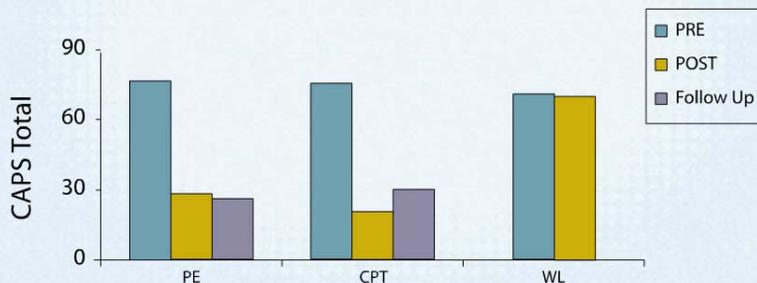
Moving on to the next slide, I'm going to cover this really quickly. There's often concerns from people who are learning about Prolonged Exposure that you can only use this treatment with people who have traumas that are single incident trauma, but actually looking at the data from Foa's study in 2005, we find that there's not a significant difference between single incident and multiple incident trauma. In fact, child sexual abuse survivors fared very well in this trial with significant reductions from pre to post and maintenance of those changes out to follow up.



So, the next slide, again, is really included here to show this study design: people who didn't fully respond by session nine received additional sessions out to session twelve. And, what this slide really shows is that those people who hadn't fully responded at session eight, actually is when they had the assessment, continued to benefit from those additional sessions that they received.

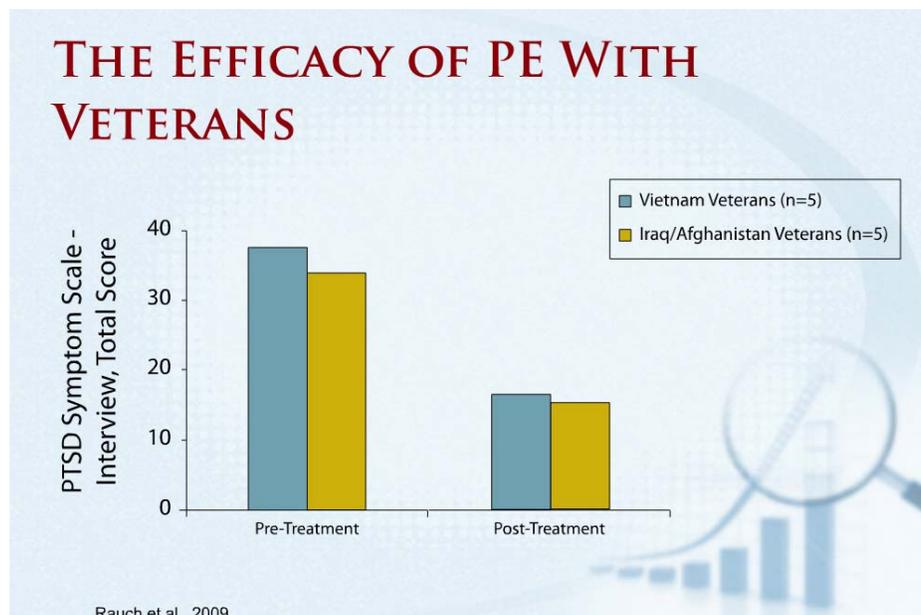
So, there's good reason to believe that if someone isn't all the way better by session eight or session ten, giving them a few additional sessions might actually help them to get to the same place at post-treatment, so both of these groups ended up not significantly different at post.

9 PE SESSIONS, 12 CPT SESSIONS, AND WAITLIST (WL) WITH FEMALE ASSAULT SURVIVORS



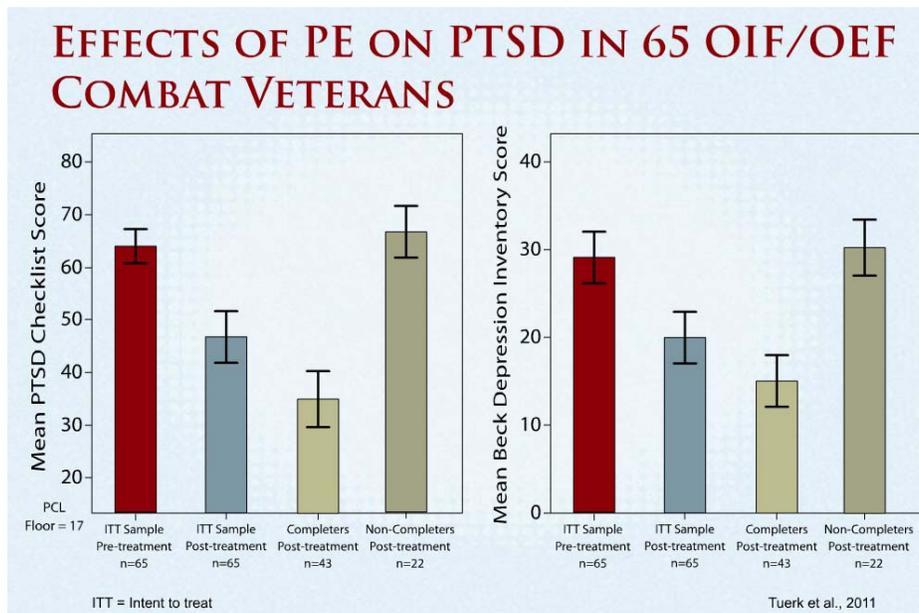
Resick et al., 2002

Now, the next slide covers a trial that included a design where patients were randomly assigned—these were sexual assault survivors, again. They were randomly assigned to either nine PE sessions or twelve sessions of Cognitive Processing Therapy, which is a cognitive therapy for PTSD that's also demonstrated effective to reduce PTSD symptoms, or they were assigned to a waitlist. And, here, we find that there's significant reductions from pre to post that are maintained out to follow up, and there's no difference between those two interventions, but both are better than waitlist.



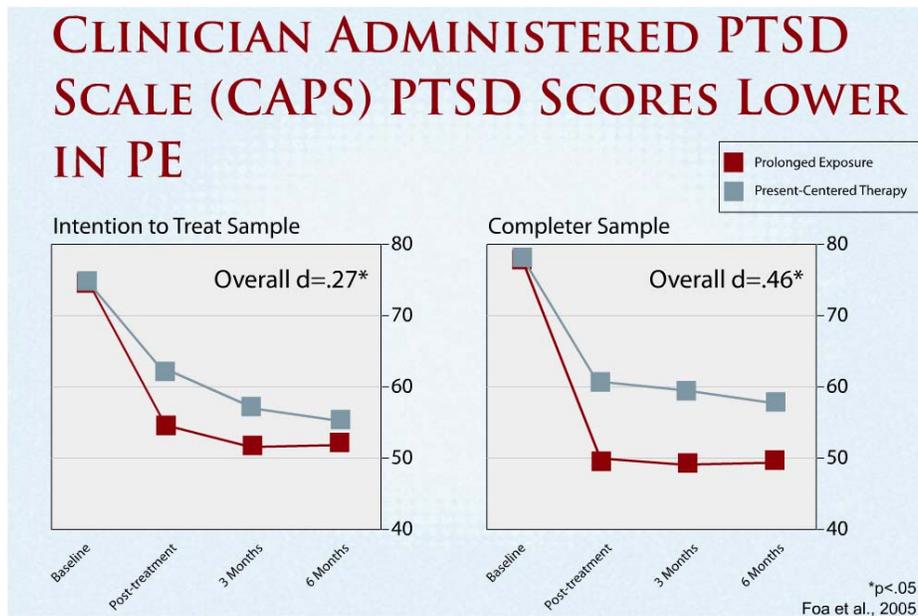
So, the next slide is included in this slide set simply because we're the VA, and most of the data on PE—the early data and the larger studies—have been with sexual assaults survivors or mixed trauma samples and not with U.S. Veterans in the VA System.

So, this study is actually the first ten clinic patients in the clinic that I work in that got PE, and it's really just to demonstrate that PE works in the VA with our real VA patients who are highly comorbid and complex. And, we got an effect size of 2.2, which is really good and it's comparable to what we find in the randomized trials.



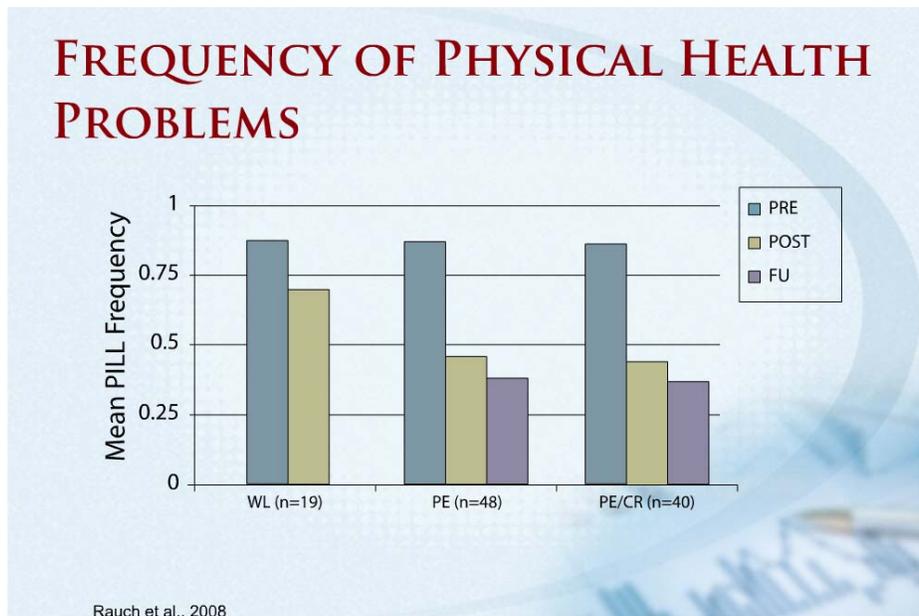
The next slide is a study, again, that was done with VA clinic patients. This was a larger study that came out, just this year, from Peter Turk. And, again, it shows that PE works in the VA. From pre to post treatment, we get significant reductions in PTSD symptoms and in depression symptoms.

And, the one thing is that's interesting here is that, unlike other populations, or randomized trials, the people who don't complete don't tend to be getting much benefit. And, they tend to be dropping out earlier on in treatment. So, the completers are getting the benefit, but the people who aren't completing aren't seeing much change at all.

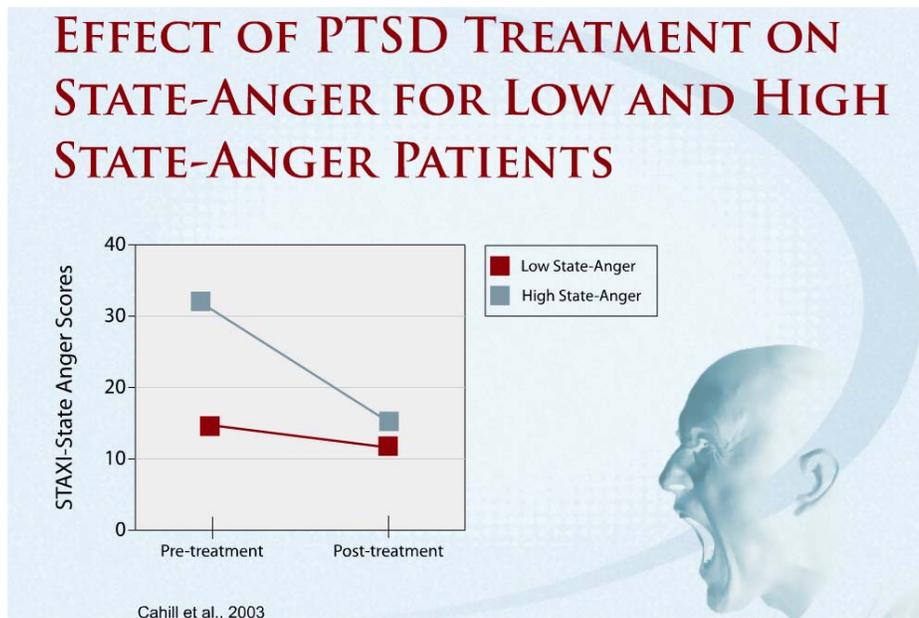


This next slide is a large randomized trial of Prolonged Exposure in the VA system with female Veterans, and it's included here to demonstrate the control condition here was Present-Centered Therapy, which is an active, effective treatment for PTSD, that's really used as a control for what exposure adds to good therapy.

So, here, in the intent to treat sample, we have an effect size of 0.27, which is good. It's not huge, but it's good. When you look at the completer sample, you've got an effect size 0.46, which again, that's significant. And, again, you're using an active control here, so that's actually quite impressive.



So, this next slide was included to look at the frequency of physical health problems in female sexual assault survivors, that were randomly assigned to Prolonged Exposure, Cognitive Restructuring or their combination. And, the point of this slide is really just that even though we don't focus on changing health, we find that self-reported health issues, for most of these patients, it was chronic pain, that they significantly are reduced with Prolonged Exposure, or the PE/CR combination. There is no difference between the two, and it's significantly better than wait list. So, there is actually something going on here that's helping patients feel better about their physical health.



So, the next slide is about the effect of PTSD treatment, state-anger for low and high state-anger patients. So, the one line here is completely flat. That's the low anger people, so they were angry at pre-treatment, and they are not angry at post-treatment.

What's important here is the other line. So, the people who are clinically angry at pre-treatment are reduced to within normal levels at post-treatment. So, just with the 10 sessions of PE, without a specific focus on anger, they had reduction in those symptoms. Again, it's improving lives.

OBJECTIVE 3

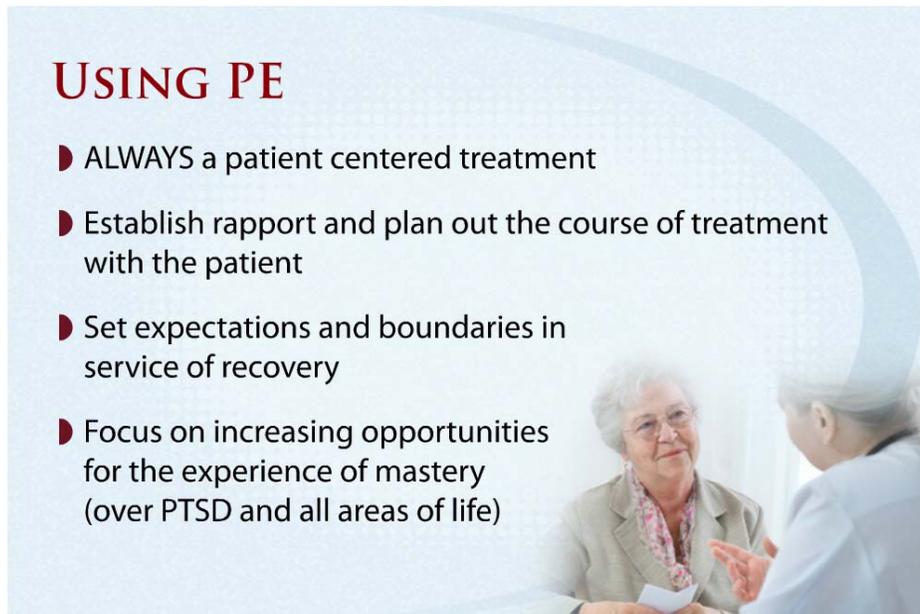
Describe and demonstrate the clinical application of PE



So, now we will move on to the last objective, which is, describe and demonstrate the clinical application of Prolonged Exposure.

USING PE

- ▶ ALWAYS a patient centered treatment
- ▶ Establish rapport and plan out the course of treatment with the patient
- ▶ Set expectations and boundaries in service of recovery
- ▶ Focus on increasing opportunities for the experience of mastery (over PTSD and all areas of life)



So, I've covered a bit of this in the initial slides as well, but I'll get into more detail here. So, using PE; PE has always a patient centered treatment. You establish rapport and plan out the course of treatment with the patient. You set expectations and boundaries in the service of recovery.

So, there's always a focus on, "I want you out living your life at the end of this. I don't want you feeling like you need me or you need to come in here. I want you to do stuff that you want to do." You focus on increasing opportunities for the patient to experience mastery. That includes mastery over PTSD, as well as all areas of their life.

ASSESSMENT

- ▶ Assessment is key, especially with complicated patients
- ▶ Establish what is primary and what the patient is motivated to focus on in treatment
- ▶ Not specific to PE, CAPS or non self-report measure
- ▶ Directly relevant to treatment planning
- ▶ Examine common comorbidities as well
- ▶ Ensure patient understands that remission of PTSD is the goal of PE



So, all good treatment starts with assessment. That includes Prolonged Exposure, but that really includes any kind of treatment that you're providing to a patient. Assessment is key, especially with complicated patients, which we get a lot of them in PTSD clinics. You want to establish what issue is primary for the patient and what the patient is motivated to focus on in treatment.

So, even if you, as a provider, think that substance abuse is primary, if that patient is not agreeing with you, then you have to find a way to get on the same page and come up with a treatment plan together. Assessment, again, like I said, it's not specific to PE. You want make sure you have a CAPS, a Clinician Administered PTSD Scale, or other interview scale; something that's non self-report, something that can be directly relevant to treatment planning.

So, by completing that interview, you're not just getting a score on that. You're actually using that information to plan out in vivo hierarchies, what memories you're going to be working on, what are some things you can do to improve this person's life. What's important to them. You want to exam common comorbidities as well, including substance abuse, depression. You want to ensure that the patient understands that remission of PTSD is the goal of Prolonged Exposure. You're not just doing this to try and make them feel good for a few weeks. You're doing this to get rid of PSTD.

ADDRESSING DEPRESSION

- ▶ Remember the standard protocol has demonstrated reductions in depression
- ▶ Focus *in vivo* exercises on situations that are avoided due to trauma but also those that will result in:
 - Reduction of isolation
 - Increased activity
 - Previously pleasurable
- ▶ Ensure that processing includes those areas that are related to depressive context (i.e., guilt, sadness, self-blame)



So, addressing depression, now, Prolonged Exposure, as I mentioned, isn't a treatment for depression, but there are things that you can do to help address depression, because that's a highly significant comorbidity in PTSD populations in the VA. It's usually somewhere around 60%. You want to remember that the standard protocol has demonstrated reductions in depression.

It's good to focus *in vivo* exercises on situations that are avoided due to trauma, but also those that will result in reduction of isolations; so getting people out and doing things socially, increased activity, getting them to exercise again in ways that are safe, that aren't going to harm their bodies, and getting them involved in previously pleasurable activities, doing things that you like. There's nothing more reinforcing than being able to do the things that you want to be able to do. Ensure that processing includes those areas that are related to depressive content, so that includes guilt, sadness, self-blame, forgiveness, anything that is related to depression.

SUICIDAL RISK

- ▶ Know VA policy and requirements
- ▶ Direct and open discussion of ideation and history to determine triggers
- ▶ Plan for coping with triggers
- ▶ Discussion of exposures and how engaging with strong emotions may increase distress in short term but reduce in long term
- ▶ Specific plan for those patients who are at high risk (planned or as needed check in calls, planned activity, etc.)



So, risk of self-harm, or suicide risk; we have a lot of patients in PTSD clinics that report some level of suicidal ideation or risk. So, it's important to be thinking about that as a provider. If you're in the VA, you need to know the VA policies and requirements and how they are implemented in your facility. You always want to have direct and open discussion of suicidal ideation and their history to determine if there are triggers for increased risk.

If there are triggers, you want to make sure that you're planning for those triggers. If one of their triggers is, "When I go to restaurants and I lose control, I feel like I just want to kill myself, nothing is worth it anymore." Then you want to make sure that when you send that Veteran to the restaurant, that you have some kind of backup plan in place, or some plan to help them know what to do if that trigger comes up.

You want a discussion of exposures and how engaging with strong emotions may increase distress in the short term, but reduce it in the long term. So, you really want make sure that they understand that, and that they know that they can call you if they need to, if they are having a particularly hard time, that you'd rather they called in between sessions than they just stopped doing their exposures. For patients who are at particularly high risks in the judgment of the therapist, you want to make sure you have a specific plan, that might include check-in calls, either when they're doing in vivos or when they are listening to their tape, either planned or as needed, depending on the level of the risk of the patient.

For some patients you might plan an activity either with a support person or some reinforcing activity that they like to do for after they've engaged in difficult exposures. So, that might involve, you know, listening to music that they love after they've completed an hour of being in the grocery store or something like that so that they are reinforcing themselves for the hard work that they're doing. And, you as a therapist want to make sure you are reinforcing them as well.

ADDRESSING ALCOHOL ABUSE

- ▶ Patients often resistant to substance use treatment
- ▶ Willing to commit to specific limits on alcohol use (such as no more than 2 drinks in one occasion/night) for the duration of treatment
- ▶ Committed to letting the provider know if desire to drink or actual consumption increases above these limits
- ▶ Weekly check-in on use



Addressing alcohol abuse; so, patients often are resistant to substance use treatment. I think all therapists know that is often the case. In my clinic, typically, when I'm working with patients who have alcohol abuse issues or substance abuse issues, if they are willing to commit to specific limits on their alcohol use, such as no more than two drinks on one occasion, or in one evening, for the duration of the treatment, so I'm specifically telling them, "We are going to do ten sessions of PE. Can you stick to no more than two drinks for ten weeks?"

If they can commit to that, and they can commit to letting me know if their desire to drink changes, or if their actual consumption increases above those limits, and I feel reasonably confident that they're going to do that, then I am willing to work with a patient in PE, and will, of course, have weekly check-ins on use, and continue discussing alcohol or substance abuse, but Prolonged Exposure can be helpful in those cases.

ADDRESSING MILD TRAUMATIC BRAIN INJURY (mTBI)

- ▶ Diagnosis of history
- ▶ Discussion of concussion and expectation for most people to resume previous function with time
- ▶ Headaches primary symptom attributed to mTBI
- ▶ Given the individualized protocol, no change needed to implement PE as you always tailor

Finally, addressing mTBI, one thing to remember when we're talking about TBI is that the diagnosis of history is actually a diagnosis of an event. The person may or may not be experiencing symptoms currently based on their head injury. So, you want to talk to the patient about that. You want to discuss concussion and, the expectation that most people resume previous level of function given time following concussion. The one exception to that may be that headaches sometimes can continue longer term for some people.

But, with Prolonged Exposure, the protocol itself is individualized to where the patient is and to how the patient is functioning. So, if the patient is having attentional difficulties or is not understanding new concepts, it's already built into the protocol that you're going to be slowing down, or providing a simplified format or, somehow getting them to understand those important, critical pieces that they need to understand to be able to do the intervention. So, there's no change that's needed to implement PE because you're always tailoring PE to the patient's presentation.

ADDRESSING PTSD

- ▶ Psychoeducation
- ▶ *In vivo* exposures
 - Non-military social situations
 - Children
 - Sand and Heat
 - Driving
 - Crowds
- ▶ Imaginal exposure
 - Natural reduction of emotional response to the memory
 - Probe for key elements (stimuli, response, meaning)
 - Focus on engaging with the emotion



ADDRESSING PTSD

- ▶ Processing
 - Putting the memory into trauma context
 - Reviewing habituation and impact of the trauma
 - Refer to rationale



So, finally, addressing PTSD and Prolonged Exposure, and you do this through psychoeducation about Posttraumatic Stress Disorder, as well as the rationale for exposure. You do this through in vivos. I've talked a bit before about what in vivos are, but those might be including exposures to non-military social situations, exposures to children, to sand or heat, to driving or crowds, anything that is avoided because it reminds them of the trauma.

Imaginal exposure, that includes natural reduction of emotional response to the memory or habituation. You are going to be probing for key elements during that imaginal exposure, including stimuli response and meaning elements, and you'll focus on engaging with the emotion. So during that imaginal exposure, again, you're working on emotional processing, so you want to get that patient connected to the emotions that are driving their PTSD. Finally, you address PTSD through the processing, by putting the memory into the trauma context so that the patient can contrast what happened then and who they are as a person now.

You do that through non-directive discussion and presenting different points that the patients find are important or meaningful for them. You review habituation and the impact of the trauma, and, again, in processing you are always referring to the rationale.



I presented all the didactic information about Prolonged Exposure, now I'm going to share with you some video. These videos are based on actual patient transcripts. There have been some details changed to protect identity, and the patient is actually an actor. The therapist is a psychologist named Dr. David Riggs, who works at the Uniformed Health Sciences University at the Center for Deployment Psychology. We thank him for allowing us to use this tape as well. And, we thank the VA rollout as well.

So, the patient that's depicted here is Tom. He's a 27 year old Veteran of the Iraq War. During his second tour of duty in 2006, he had extensive combat exposure. His index trauma was actually a surprise attack on his unit, during which his childhood friend, named Joey, was killed. So, you'll hear him talk a little bit about that. He presented for treatment two years later. So, some things to notice about this video, first of all, the first clip is in two parts, and it's the first imaginal exposure session. And, we're going to be jumping in after Dr. Riggs has already presented. They've had a long discussion about rationale. And, the sessions 1 and 2, where the patient really have a strong grounding in the rationale, and we're going to jump in right after that. And, you'll see a little bit of just the logistics for how to get started in imaginal exposure, then you'll see him get started, and then there will be a little bit of break, and we'll move to a few minutes later in the session, just so you can see him once he's emotionally engaged, and then, that'll end.



Therapist: So if you don't have any questions at this point, we are going to go ahead and get started.

Client: (Shakes head) okay.

Therapist: Okay, so I just want to tell you a little bit about how I want you to do this, okay? It's a little bit different than just us having conversations about what happened or the interview like we did a couple sessions ago.

I am going to ask you to close your eyes and bring up the images of what happened that day. Okay? And I want you to describe it to me in as much detail as you can, not just what you see but what you are thinking, what you are feeling, what your experiences are.

I'd like you to do that in the present tense so it's happening right now, so you can really get into that memory, really revisit it close cuz that is what's going to help you get better. Okay? Does it make sense?

Client: (nods)

Therapist: I am going to kind of leave you on your own at this point to kind of figure out how far to go into it but I want you to begin at the beginning of the story, kind of when you and your troop were mounting up that morning.

Client: (sighs and nods)

Therapist: Go through the ambush and Joey's death til maybe you know, you are back on the convoy and the next time you feel safe. Okay? I'm going to be right here, paying attention and listening to what you are sharing with me. Once in a while I am going to ask you about your SUDS level. I just want you to tell me kind of how you are feeling right now in the chair, in our office right here. What's your distress level, okay? Other than that, I'm going to keep fairly quiet and let you kind of guide us this time through, alright? Offer you some encouragement, remind you that you know, I am here and I am here to help you but you are going to kind of guide us this time.

Client: Okay

Therapist: Alright. So if we are ready, I will just ask you to close your eyes and

Client: I have to close my eyes?

Therapist: You don't have to, but it tends to work better if you can. So I would like you to try if you are willing to.

Client: Okay.

Therapist: Okay. So I am just going to ask you to close your eyes, and starting there you know when you guys are you now meeting up, tell me what happened that day.

Client: (Sighs) ummm

Therapist: Actually, before you get started, what's your SUDS rating right now?

Client: (sighs) 40 yeah 50.

Therapist: Okay, go right ahead.

Client: We were umm getting ready to leave the FOB uhh, loading up the vics, uuuhh there were six in the convoy that day and uhh I was just uuh hanging out uhh talking with my buddy, Joey uhh we were umm

Therapist: Present tense, you are hanging out with your buddy Joey ...

Client: oh, um so umm, we are hanging out, loading up the trucks, and umm I was feeling alright that day.

Therapist: you are doing great Tom, good job.

Client: and uhh, you know I get there and umm looking for him uhh, I'm looking for him and ummm then I see then I see him on uh, I see him on the side of the road and uhh, he's dead.

Therapist: Good job. Just keep going. You are doing fine.

Client: (sighs and sobs) I know he is dead and we are all, everybody is trying to help him at that point and somebody uhh I don't, somebody remem brought a white sheet over and we uhh put it over his body.



So, the next bit of video that I'm going to show you is a section of processing. So, this is from the next session, I believe, with Tom. And, it'll start right when he's at the end of that imaginal exposure, so he's been through another 45 minute exposure at that point, and he is opening his eyes and doing processing with Dr. Riggs.

So, watch for the way that Dr. Riggs is being non-directive and following the patient, discussing the things that the patient is bringing up as important.



Client: My friend is dead. He was killed and uhh I have to deal with it.

Therapist: Okay, let's stop there. What's your level now Tom?

Client: uhhh 40-45

Therapist: Okay. Let's go ahead and open your eyes. You did a great job. You got through it four times today.

Client: Yeah, feels like it was getting a little easier, uhh umm especially compared to the first and second session when we did it.

Therapist: It seemed a little easier as I was watching you too and I know last session was pretty difficult for you but this seemed like it was a little less distressing for you.

Client: Yeah, I mean there is still something inside me that would rather not be doing this right now. It's still difficult but uhh

Therapist: Well, and this is tough stuff you know and processing those painful memories and those emotions is difficult. It takes a lot of courage to do what you are doing. But you know when we look at the SUDS rating from today, you know, it is lower than they were the last couple of times we have revisited this memory. And, you keep you know, coming in and plugging away at it and doing the exposures the way you are and listening to the tapes in between sessions.

Client: Well I mean, I am just working hard to try and be able to put this behind me. Umm, you know not necessarily you know forget about it or anything like that you know but just being able to deal with it. I guess you know like what you were saying in the book.

Therapist: Sure and I think that's a reason for doing this kind of therapy. It is you know, it's never easy to deal with a traumatic event and particularly not one you know where you have had a loss like this, where you have lost somebody you are really close to and you cared about. Umm, but you know, keep in mind when you try to push away or not think about the last couple years, you know, did that help you get better?

Client: (shakes head) No. No it didn't. I mean we have memories like that and there is no way you are forget them and when you have a friend like Joey, you just, I was just so close with him and you know to be 10,000 miles away from home and to have somebody like that, it's just you know, it was really great.

Therapist: Sure and it had to feel good to be you know to have him there, you know, somebody you have known since childhood and you know to have him there

Client: Yeah and especially there of all places and just to have him ripped away from me like that, it was just, it was really difficult.

Therapist: Yeah, it had to be painful. You know, I mean there is no two ways about it, it had to hurt. I am kind of wondering you know, when the mission ended, you know what did you do at that point to try and deal with this?

Client: Uhh, in the aftermath, I was like a zombie. Umm, I was just numb and hollow and you know, did not want to let anything in and remember there was a brief period of time where I did not think you know I could get into a Humvee again. Umm, I guess you never know how you are going to react to something like that until it happens.

Therapist: And, what about now? How does it feel now?

Client: Like right now?

Therapist: Yeah, like as we are talking about this stuff, now, how does it feel?

Client: Umm, these feelings, I think I just want to disarm them you know. I just want to start to feel better. Just feel more normal and I think I am starting to feel a little bit like that. I feel that we are making a little bit of progress and I think that's what keeps me coming back.

Therapist: You are doing a great job, you know working to try and make sense out of this and I know for the last couple of years you have been trying to push it away and now you are going ahead and you know taking the opportunity to explore and I am wondering if anything stood out this time around as you told it?

Client: Yeah, the sounds actually. Umm, the sounds were much more uhh lucid. That the sound of that terrible explosion, that mortar, hitting Joey's vehicle. Uhh. Generally the sounds of all the gunfire, the battle and uhh, the screams and the moans from those guys that got wounded. Something I hope that you would never have to experience or anybody.

Therapist: So yeah (sigh) you know it had to be awful, and those sounds, you know, it had to be bad but I think it is great that you are building those sensory pieces into the memory because the more you put in, you know, what you heard, what you saw, what you smelled, the more you happen to do that, the more engaged you are with the memory. And you have also been able to kind of allow yourself to feel some of those real powerful bad emotions, some of the terror that you felt for example.



So, now I'm going to show you a bit from the final session. So, you'll see most of the final section is really focused on review of progress, review of what it meant to you, what worked, what didn't work. So, we're going to see just a little bit with this patient of how Prolonged Exposure worked for him.



Client: We get back to the FOB and you know, laid down in my bunk and I can't sleep, thinking about my buddy and thinking about my family, and when I am going to see them next, and I am awake for hours. That's about it I guess.

Therapist: Great job. I'd like to stop there. What are your SUDS are right now?

Client: uhh 10.

Therapist: Okay. Why don't you go ahead and open your eyes. It did seem like you were quite a bit calmer that time

Client: Yeah.

Therapist: Than in you know the last several sessions have been a little bit easier for you.

Client: Yeah.

Therapist: What umm, how did it feel for you?

Client: Well, it feels so much easier than the first time we did it and uhh, I guess I am just used to it now.

Therapist: Okay and are you noticing that you are doing anything to kinda push parts of the memory away or to kind of shut down those emotions at all?

Client: No, no no no. I mean I think, I think I am looking at it more objectively umm and I think you know, I am just kind of viewing it from the sidelines and uhh, it's a memory. It's not a good one but, it's just a memory so...

Therapist: Yes, and you know, it is a sad memory. Anytime there is that kind of loss

Client: uh huh

Therapist: We are going to you know, we are going to feel it and it is going to continue to be sad for you

Client: uh huh

Therapist: But you know, I think it seems to have settled quite a bit.

Client: Yeah, um and you know I remember at first when we were doing the tapes, you know, I had a lot of different emotions inside of me. And you know, I was numb, and angry and frustrated and now it's different. It's, like today, I felt sad umm, you know I am still feeling it but I am just sad for my buddy, for his family, for me. I mean it's such a waste.

Therapist: And that's to be expected you know that some of those feelings will still be there.

Client: Yeah and you know I think it always will be sad. I means it's but that's okay with me because I don't want to forget about it, I couldn't ever forget about it, I couldn't forget about him. You know I was just thinking umm, the past couple of weeks I think I am ready to go and visit his parents.

Therapist: Um Humm

Client: I I, you remember at the beginning I said I didn't think I could ever do that.

Therapist: Yeah in fact that's why we did not put it in your in vivo list remember that you didn't think you could handle it.

Client: Yeah, well I was going through a lot then obviously and it was really difficult that time I did go and they were so torn up and they were crying and that got me really worked up and umm it was really tough but I think I can handle it now and uhh, they always call me and invite me over for dinner and I think I will actually take them up on it.

Therapist: That's great. I mean that's absolutely fantastic you know and it will be hard. It will be an emotional visit umm but I think they'll appreciate it. I don't know his family but I suspect they would like to see you again.

Client: I've known them for a long time and Joey would have wanted me to do it. No, I know he would have.

Therapist: Well, and one of the things that I think that says to me is that you are feeling a little bit more ore confident. That you do not know how exactly it will play out, but you feel that you can handle what comes up. Yeah I think that's part of the whole picture of you are getting better. I mean you tell me you are getting better

Client: uh huh

Therapist: and I certainly got to go with that but I also look at your scores, I look at your SUDS rating you have given me, I look at what you tell me about your PTSD symptoms, your depression, are all coming down. This is really what we were after.

Client: yeah. I'm just amazed at how much calmer I feel all the time. Umm, you know just not getting angry anymore. It's nice.

SUMMARY

- ▶ PE is an effective treatment for all types of trauma populations
- ▶ PE is a time limited and focused treatment with an expectation for reduction and even remission of PTSD
- ▶ PE is appropriate for comorbid and complicated patients with primary PTSD
- ▶ Reductions in PTSD and comorbid psychopathology are expected

Alright, so just to summarize, Prolonged Exposure is an effective treatment for all types of trauma populations. PE is a time limited and focused treatment with an expectation for reduction, and even remission, of PTSD. We expect this to be life changing treatment for patients who've suffered from PTSD for years. PE is appropriate for comorbid and complicated patients with primary PTSD.

So, they might have a lot of other stuff going on in their life, a lot of chaos, significant depression, or substance abuse, but if Posttraumatic Stress Disorder is their primary condition, the condition that they want to work on, PE is appropriate. Reductions in PTSD and comorbid psychopathology are expected with this treatment. So, there's lots of reasons to believe that Prolonged Exposure is going to work, and it's going to work for you patients if they have PTSD. Thank you.