FAQs: Using Prolonged Exposure Therapy

Therapists often have questions related to evidence-based psychotherapies (EBP) after attending a training, during the initial implementation, and throughout their ongoing practice with each unique case. Here are some frequently asked questions related to Prolonged Exposure (PE) for the treatment of Posttraumatic Stress Disorder (PTSD).

Question 1: I'm trained in PE and Cognitive Processing Therapy (CPT), or another trauma-focused EBP. How do I know which one to use? Or can I use parts of both?

Answer: Both CPT and PE are equally effective in reducing the symptoms of PTSD. Despite several head-to-head comparisons, neither has emerged as more effective for certain patients, conditions, or circumstances. If a patient has access to both treatments, they should be given a clear and descriptive summary of both to help them decide which they prefer. Remember that a patient's motivation to engage in treatment is influenced by how credible they find the therapist; it's likely you will convey more credibility when you're describing the EBP you prefer. So, let your patient know if you prefer one treatment, while still offering them a choice when possible. Adding other therapeutic elements to PE has not led to improved results, and there is research that shows this contributes to higher dropout. We recommend choosing to implement only one EBP at a time, with fidelity, to save both you and your patient time and confusion.

Question 2: How do you define success in PE?

Answer: There are several sources of data to consider regarding successful PE treatment outcome, and ideally, they should converge toward the end of treatment. The patient should report significantly fewer symptoms on self-report measures like the PTSD Checklist (PCL-5). As habituation occurs, in vivo assignments should also become easier to manage and provoke less distress. If some distress remains, the patient should be able to tolerate it and manage their emotions and behavior in a functional and adaptive manner. During imaginal exposure, the patient should be able to recount their trauma narrative without intense or debilitating fear or anxiety, though they may continue to experience sadness, anger, and other appropriate primary emotional responses to this negative event. Cognitively, the patient should be able to distinguish the memory from the trauma itself and recognize that the memory, though unpleasant, is not dangerous. Consistent with this experience, SUDs ratings collected during imaginal exposure should be low or moderate. Some patients may even describe feeling bored by their narrative rather than distressed near the end of treatment. Maladaptive beliefs about the self (e.g., I'm incompetent; I can't cope; I'm weak) are replaced with compassion for self while maladaptive beliefs about the world (e.g., Nobody can be trusted; The world is unsafe) are revised with more realistic or balanced views. Finally, functioning in areas typically hampered by PTSD symptoms, such as interpersonal relationships, work, and overall quality of life, should be improving.

Question 3: Will manualized treatment interfere with the therapeutic alliance?

Answer: Like other modern manualized therapies, PE is not intended to replace clinical skill or judgment. Rather, PE is a framework that presupposes and depends on the "common factors" essential to all good therapy - active listening, validation, empathy, genuineness, warmth, and unconditional positive regard. In addition, PE is structured to foster alliance-building early in the protocol to improve treatment adherence and outcome. Far from being a "cookie cutter" approach, PE requires the development of an individualized protocol for each patient, addressing symptoms in the specific situations and circumstances that are most affected.

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Question 4: Will repeatedly facing distressing memories, events, and situations worsen my patient's symptoms or cause them to drop out of treatment?

Answer: Some therapists are concerned about using a trauma-focused therapy like PE because they think it will aggravate their patients' symptoms or re-traumatize them. However, research has shown that while minor symptom exacerbation is normal in the course of PE, it is experienced by only about 10% of patients. Additionally, this tends to be brief periods of increased distress rather than shifts in the overall trend of treatment response. The slight worsening does not usually result in negative outcomes, higher dropout, or increased risk for patients receiving PE treatment. In fact, when dropout rates are compared across studies, patients are no more likely to drop out of exposure-based treatment such as PE than from other evidence-based treatments for PTSD.

Question 5: My clinic is set up for a 50-minute hour. Do I have to do 90-minute sessions?

Answer: The original PE protocol required 90 minutes for each session, and we recommend this if possible, especially if you are new to the treatment. This allows plenty of time to cover all the content and answer any questions. However, subsequent research has demonstrated that PE can be successfully implemented in shorter sessions by splitting some of the psychoeducational content and shortening the length of imaginal exposures. When doing PE in shorter sessions, you will need to manage your time very carefully to ensure you meet all the session goals. We recommend no less than 60-minute sessions if shorter sessions are required.

Question 6: My patient doesn't want to record sessions. Is it really necessary?

Answer: In PE, sessions are recorded to provide the patient with additional opportunities to review psychoeducational material covered in the session, as well as further opportunities for therapeutic exposure to the traumatic memory outside the session. Though research has not compared PE with and without recording directly, studies have addressed the role of "homework" as it relates to treatment outcome. It is well-established that greater homework completion by patients is directly related to positive outcomes at the end of treatment. Homework in PE includes listening to recordings of the session. Therefore, eliminating session recordings essentially would decrease the "dose" of exposure and opportunities for processing the trauma. Rather than eliminating recording, we recommend discussing patient objections to determine if the nature of the concern (e.g., privacy or technology concerns) can be addressed. Having an open discussion about any concerns and the importance of session recordings prior to starting PE can go a long way in building trust and understanding, especially because this aspect of the treatment may seem different or unusual to patients.

Question 7: What should I do if my PE patient doesn't do their homework?

Answer: Non-compliance of practice assignments is an important concern since homework completion is linked to successful treatment outcome. Therefore, when non-compliance arises, it should be addressed directly and immediately as a threat to treatment outcome. However, because noncompliance is highly related to avoidance, especially in PTSD, homework noncompliance should be anticipated as a normal part of treatment. It is an opportunity to learn more about the patient, and opportunity to refine the treatment plan as necessary. Homework review should never be experienced by the patient as a time of judgment or blame, but rather should be dealt with collaboratively and with understanding. Accomplishing the session agenda should not be postponed. Address homework issues at the beginning of the session with additional focus on problem-solving and adjustments at the end of session as needed.

Compliance barriers can be highly idiosyncratic but may be grouped into a few problem-solving targets: a) logistical barriers, such as an active duty patient who is given an unexpected duty assignment that prevents him or her from doing homework; b) incomplete or inaccurate understanding of the rationale for treatment or instructions for homework assignments; and c) symptomatic avoidance. As you discuss the barriers to homework, you may need to address all three targets. When logistical barriers are at the root of non-compliance, problem-solving can help eliminate or work around life circumstances that stand in the way of completion.

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Work with patients to develop solutions that facilitate homework completion while respecting that sometimes life gets in the way. When the issue is incomplete or inaccurate understanding, it is useful to repeat the rationale and instructions. Make sure you supplement your explanation with analogies and metaphors that resonate with the patient. Confirm that the patient fully appreciates the explanation by asking him or her to explain it to you in their own words. When PTSD-related avoidance is the culprit, explore the anxiety level anticipated by the PE assignment and make sure it is not too high. Sometimes a patient will rate an in vivo item lower only to discover it is much more difficult than anticipated when attempting to do it. It may be necessary to start with a lower-rated assignment. Also, check to see if an in vivo assignment involves more than one trigger. For example, an assignment to go to a crowded shopping area may also involve triggers due to the time of day or night, the area of town, the means of transportation used to get there, or other unanticipated cues. It may be necessary to separate the triggers into multiple assignments if this is the case.

Question 8: What should I do if my patient is having a hard time identifying their index trauma or wants to change to another trauma during treatment?

Answer: Selecting the most distressing traumatic event as the focus of treatment is recommended because it is most associated with trauma-related avoidance and cognitive distortions. When patients focus on and process their most distressing traumatic memory first there is often a ripple effect. As a result, they do not need to target other traumatic events which expedites the course of treatment. When a patient has suffered multiple incidents of trauma that are difficult to distinguish due to the passage of time and/or the similarity of content among the events (e.g., chronic childhood abuse, multiple combat traumas), it can be difficult to select a discrete event. If possible, the index event chosen should be salient in memory and should also be associated with the patient's distress and avoidance so that it can serve as a vehicle for processing.

If the patient becomes aware that another trauma is associated with their distress during or after imaginal exposure on the "index" event, they may process the new event as well after the originally selected trauma has been fully processed. Rarely, a patient may need to move to a second or third trauma after doing a good round of imaginal exposure on the first trauma to gain the most benefit from treatment. Some patients might worry that choosing one trauma over another minimizes or invalidates those events not chosen or even dishonors the military members who were part of those events. This is an opportunity to discuss the patient's beliefs and clarify the purpose of choosing one event while recognizing that other events may be equally egregious, unjust, and/or deserving of attention.

Question 9: Why can't patients use the breathing technique during exposures? Won't they be more willing to try the assignments if they can use it?

Answer: While relaxed breathing can reduce distress in the moment, it is important for the patient to experience the natural course of arousal as it peaks and habituates. Patients may misattribute decreased distress to the breathing rather than to habituation during in vivo or imaginal exposure and consequently begin to use the breathing as a safety behavior. It is preferable that the patient learn to tolerate distress without using special techniques or performing certain behaviors; to learn that distress will decrease on its own with time and exposure.

In addition to the relaxed breathing technique, look out for other safety behaviors patients may use during exposure, such as carrying a weapon, relying on their smartphone, engaging in rituals or superstitious behavior, constantly scanning, or only going out if they are with a family member. Although seemingly benign and helpful, these kinds of safety behaviors are actually avoidance strategies that can reduce a patient's distress in the short run but will likely maintain their PTSD symptoms in the long run.

Question 10: My patient is struggling to come up with enough items for the in vivo exposure hierarchy. How can I help them come up with more?

Answer: There are several strategies you can use when you and your patient are struggling to identify in vivo items. Start by reviewing the patient's current symptoms. Anyone who has PTSD, by definition, is avoiding trauma-related cues of some kind, but they may be unaware of this because their avoidance behaviors have become a habit. Ask the patient how their life and activities have changed since the trauma. What things did they previously enjoy that they no longer do? What would family members or friends say they avoid or have stopped doing since the trauma? If there are only a few avoided situations, look for ways to make those situations easier or harder by changing some characteristics of the activity. For example, if they avoid going to the grocery store, ask if it would be easier to go with their partner or at a time when it is less crowded. Additionally, help your patient pinpoint the core fear associated with identified items, then look for other contexts or activities where they may encounter the feared stimulus. You can also suggest commonly avoided situations or activities reported by other trauma survivors to see if they resonate with your patient such as crowds, open spaces, or social events. If your patient can identify with any of them, ask for examples from their life. Finally, remember that your patient's in vivo hierarchy is a work in progress. Encourage them to take the list home and add items that come to mind as they move through their daily activities.

Question 11: Why should I ask my patient for their Subjective Unit of Distress score (SUDs) throughout imaginal exposure? I worry about distracting them if I ask for these ratings.

Answer: Collecting the SUDs rating helps you track changes in distress over time and helps you identify hot spots when it's time to focus on specific parts of the memory. It may be the case that your subjective evaluation will correspond with the patient's SUDs ratings and therefore seem superfluous; however, it is important to have convergent data. On occasion, the subjective appearance of the patient is different from the SUDs rating given. At those times, the SUDs rating is most useful, as it can indicate if the patient is more or less engaged than perceived, or it can highlight some important piece of information that might be untold but contributory, thus giving you clues about what to prompt or ask about.

To be as unobtrusive as possible, prepare the patient for the brief but regular interruptions and instruct them to answer quickly and continue with the narrative, while keeping their eyes closed. It can feel odd if you are not accustomed to interrupting in this way, but if you prepare the patient in advance and prompt them to stay engaged, most patients do not find it to be distracting or disengaging, even if it is a little awkward for the therapist. Finally, consider explaining how the SUDs ratings gathered during the imaginal exposure and on in vivo assignments are important data to track their progress during treatment along with their self-report scores.

Question 12: What is a "Hot Spot" and does everyone have one?

Answer: Hot spots are segments of the imaginal exposure narrative that are most disturbing to the patient after other parts have ceased to provoke significant distress. They are often the portion(s) of the trauma memory that are directly relevant to the cognitions that maintain symptoms and which are, therefore, addressed intensively later in treatment. In PE, you should be looking for hot spots sometime between sessions 5 and 7. By focusing on the identified hot spots one at a time rather than retelling the full trauma narrative over and over again, the patient can more efficiently work through those parts of the memory that still carry intense emotions.

It is possible that a patient may not have a hot spot, but this is likely an exception rather than a common occurrence. If your patient is struggling to identify hot spots, you can help by pointing out what parts of the memory still have high SUDs ratings associated with them or where you have noticed they have trouble getting through a section (e.g., they skim through or jump over that portion or are not able to provide sensory details). It can also help to share a metaphor to explain what a hot spot is. Examples can be found on the Center for Deployment Psychology website in the PE Metaphor Bank.

Question 13: What do you mean by "processing" the trauma memory after my patient finishes telling their trauma? What do we talk about?

Answer: Processing in PE is functionally similar to cognitive restructuring, though it is generally less structured than formal cognitive therapy. The main goal is to help the patient gain a more balanced perspective about, and an improved sense of mastery over their trauma memory so it has less power or pull over them. This means helping them to develop more realistic or accurate beliefs and new insights regarding themselves, the world, and others, which often occurs during the reflection period that immediately follows the imaginal exposure. This discussion should provide support for the patient's courage and effort, validate their reactions during the trauma and in the present. It should help them identify and evaluate cognitions that maintain symptoms to develop more adaptive views moving forward.

Processing in early sessions is likely to be more heavily weighted toward support and validation than identification of the patient's beliefs related to the trauma. It relies more heavily on open-ended questions to draw out the patient's views and emotions so that they are available for examination, rather than directly challenging the patient's beliefs. As treatment progresses and the patient's views are more fully elaborated, the discussion should shift to focus more on unhelpful thoughts and beliefs. In later sessions, the therapist may offer alternative views or other insights to help the patient evaluate and revise cognitions that hamper functioning.

Question 14: I am working with a patient who is quite irritable. I know this is part of PTSD, but is there a way of working on this along with the PE protocol?

Answer: Irritability is part of the arousal cluster of PTSD symptoms and should dissipate over the course of PE treatment. It is important to note that this cluster of symptoms often dissipates last, after the others have decreased. While you do not need to target irritability, it can help to highlight and work through any cognitions associated with irritability. In some instances, irritability and anger may mask underlying emotions that are more difficult or vulnerable for patients to identify or express, such as sadness, fear, or guilt. Be on the lookout for these more hidden emotions. Assist patients in addressing them and the associated thoughts that may be keeping them stuck. Also, keep in mind that Service members may be more willing to express their anger than other emotions.

Question 15: My patient reports a trauma that occurred during a secret mission, so he/she cannot share details. Can I still do PE? Doesn't HIPAA cover this?

Answer: It is true that if your patient was involved in a mission requiring an elevated security clearance, then she/he will not be able to legally discuss details of it with you, even though your records are protected by HIPAA. It is also possible that your patient, like most people with PTSD, would prefer to avoid discussing their trauma because it is distressing to do so. Your patient may use the secrecy of the mission as an avoidance strategy to prevent facing it at all. What happens in a traumatic event can often have little to do with the strategic or tactical detail of a particular place, date, time, or mission. So, find out if these details of the mission are important to the trauma itself. Is it possible for your patient to discuss the trauma without including those details, but also without sacrificing the organization and articulation of the memory that needs to occur in imaginal exposure? It may be possible to engage in the imaginal exposure by describing the trauma itself rather than the specific details of the mission.

However, if the mission details are key, or if lingering concerns about possible security violations distract from treatment, choose another method of treatment such as CPT or Eye Movement Desensitization and Reprocessing, which do not require patients to share their trauma in as much detail. Also consider discussing with your patient the idea of seeking treatment within his or her organization. Special Operations organizations often have psychologists with training in evidence-based PTSD treatments and a security clearance high enough to discuss any details needed for effective treatment.