**Scenario #1:** The Prolonged Exposure (PE) provider meets with a patient who is newly diagnosed with PTSD. There are two scripts for this scenario, one for a patient, TSgt Ansley, who completed the intake with the PE provider (Script A) and a second that involves a patient, SGT Nolan, who was referred by the intake provider to the PE provider for treatment (Script B).

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| **Script A** | **Comments/Rationale** |
| *Provider: It’s great to see you again, TSgt Ansley. I’d like to follow-up on our conversation from last week. If you remember, I diagnosed you with PTSD based on you sharing your experience with the IED blast when you were deployed to Afghanistan and the symptoms we spoke about that started after that event. What questions do you have for me about the diagnosis of PTSD or related symptoms?* | The provider had completed a diagnostic assessment for PTSD and briefly spoke about PTSD-focused treatment prior to this meeting. |
| TSgt Ansley: Honestly, I’ve just been trying to not think about all the stuff we talked about last time. | This is a normal avoidance reaction of patients with PTSD. |
| *Provider: It’s common for people diagnosed with PTSD to want to avoid thinking and talking about the traumatic events they’ve been through. In fact, avoidance is one of the symptoms we’ll be working on. The treatment I want to talk with you about today is called Prolonged Exposure, or PE for short. It directly addresses avoidance, as well as other aspects of PTSD. Be sure to let me know if any questions surface as we’re meeting today.*  *Before we talk about that in more detail, I want to review one of the assessments you completed before our session, the PCL-5. This questionnaire helps us understand more specifically, what PTSD symptoms have been bothering you.*  {{Provider shows patient PCL-5 assessment.}}  *We can see that your scores on the PCL are elevated. Your total PCL score of 55 is above the cutoff score, which means it’s in the “clinically significant” range. Also, you can see here that the four symptom cluster scores are also moderate or higher. This means that your scores on the PCL-5 are confirming our diagnosis of PTSD. Do you remember any of the four PTSD symptom clusters I mentioned last week?* | When patients complete outcome measures, they should be reviewed with the patient. Using scores on outcome measures helps support the diagnosis given at intake. Provider is linking patient’s demonstrated symptoms with the PTSD diagnosis and recommended PE treatment. |
| TSgt Ansley: Not really. You said something about my flashbacks being one, but I can’t recall anything else. | Patients with a trauma history benefit from repeating information. |
| *Provider: Yes, you’re right about one of the clusters already. We call it re-experiencing and a couple of examples of this are flashbacks or unhelpful thoughts that are hard to push out of your mind. Another symptom cluster is avoidance, like we talked about a few minutes ago. The last two are negative changes in mood and thinking, for example this one - [point out a specific example expressed by the patient of an elevated symptom in this category] and arousal, which includes things like having trouble sleeping or feeling irritable.*  *Now I want to talk with you about the treatment that helps alleviate these symptoms, PE. Any questions before we move into that?* | Reviewing the PTSD symptom clusters helps to normalize the patient’s symptoms. Asking patients often if they have questions helps to make these interactions more collaborative. |
| TSgt Ansley: Not that I can think of, Doc. Are we going to have time to talk about the fight my wife and I had last night? |  |
| *Provider: I’m glad you let me know that there’s something specific you want to talk about today. In PE treatment, we will most often keep our focus on the agenda for the session. We don’t want to let other issues take us too far off track so that we lose focus on the PTSD symptoms. However, we can take time at the beginning or end of the session to cover anything important to you that may be unrelated to the PE work we’re doing. Would you like to spend about 10 mins now or at the end of session to talk about the fight with your wife?*  *Today, I want to explain PE and answer any questions you might have about the treatment so that we can plan to have Session 1 of PE next week.* | Provider offers brief education on how PE deals with current concerns. He/she empowers the patient to identify his needs (i.e. talking about marital fight), while also maintaining the focus on the PE treatment. |
| TSgt Ansley: It can wait until the end of the session. I just want to get some ideas of what to do when she’s on my back like last night. |  |
| *Provider: Sounds good. So, let’s dive into what PE is and I’ll make sure we save some time at the end of the session to come back to the fight you had with your wife.*  *As I mentioned, PE is a treatment specifically for PTSD. It is based on the idea that trauma memories can sometimes be so painful that we avoid thinking about them. We also avoid things that remind us of the trauma, activities, situations, and other cues. This feels safer after trauma. Does that sound familiar? Avoidance can make us feel better in the moment, right? Unfortunately, the relief is only temporary, and what is worse, avoidance prevents us from processing the trauma and putting it to rest.*  *Our thoughts play an important role too. Often after a trauma, we have thoughts and ideas that make it very difficult to get back to normal life - thoughts about danger and distrust of others, and even doubts about our own ability to cope, and to manage our emotions. These thoughts support the urge to avoid and lead us to falsely believe that we need to avoid to be safe.*  *As we talk about this, can you think of ways that avoidance and unhelpful thoughts are getting in the way of you doing what you want and need to do?* | Provider describes PTSD symptom clusters and how PE begins to address these. Checking in with patients during the explanation reinforces that this is a collaborative process. |
| TSgt Ansley: Well, I definitely don’t like thinking about what happened, and I have to admit, there are a few things I don’t do anymore just because they make me feel like I am right back there in Afghanistan. | Patient is starting to share about avoidance issues. |
| *Provider: In PE we will spend some time learning exactly how avoidance and unhelpful ways of thinking are contributing to your PTSD symptoms. More importantly, we will work together to develop a systematic plan for blocking avoidance and reconsidering those thoughts and ideas that prevent you from doing the things you want and need to do. The main way we will do that is through a technique called exposure. Exposure is a way of gradually reconnecting with those memories and experiences you have been avoiding. We will talk about that more specifically in a minute.*  *When you participate in exposures, those unhelpful thoughts will pop into your mind and you and I can examine them together to see if they make sense for you, or if there are better ways of looking at things that will help you move forward. This kind of “processing” of your exposures will give you a chance to organize your memory too. It is kind of like cleaning the closet out, getting rid of stuff that doesn’t work for you anymore, and organizing what is left so you can find it and use it more effectively. How does that sound?* | Provider explains about exposure and how it helps to enhance healing following trauma. |
| TSgt Ansley: It sounds good, but I am really not sure what you mean by exposure. | Patient expresses some hope for relief from PTSD but needs more information about exposure. |
| *Provider: As I mentioned before, exposure is the main ingredient of PE and will be done both in-session and in between sessions. The key to exposure is to do the opposite of avoidance. In exposure we approach instead of avoiding. We do this in a couple of ways.*  *The first is imaginal exposure. In imaginal exposure you will repeatedly review the memory of your trauma. You will start that process with me, in session, repeatedly going through the details of the IED blast in a safe, gradual way after which, we will spend some time discussing and processing it together. You will continue imaginal exposure at home because we will make a recording of that part of the session so you can review it at home. After a few weeks, you will find that talking about the IED blast isn’t as overwhelming as it may be now. Of course, we can’t erase the trauma, but imaginal exposure can help you gain control over the memory, so it no longer has the power to sneak up on you or knock you off balance when you encounter a reminder.*  *The second kind of exposure we will do is called in vivo exposure. First, you and I will develop a game plan for recapturing all those things you stay away from since coming home from Afghanistan. Outside of session, working from that game plan, you will start gradually approaching things you’ve stayed away from since the IED blast. For example, you shared that you can’t go to the grocery store since returning from Afghanistan. We will be challenging your “I can’t” rules to prove to yourself that you can do things that are reasonably safe, even if they generate fear or anxiety at first. Remember when you first learned how to ride a bike or swim? It was probably difficult at first but grew easier with practice. Through exposure, you will start reclaiming many of those parts of your life that have been lost to PTSD symptoms. Does that sound worthwhile?* | Imaginal exposure is described in more detail, along with explaining about the at home review of the imaginal exposure recording.  In vivo exposure is described in more detail. Using a metaphor like riding a bike or learning to swim helps patients put this new exposure work into the context of something they have mastered. |
| TSgt Ansley:Sounds difficult, but I need to try something because what I’m doing isn’t working. |  |
| *Provider: PE has worked very well for many patients who I’ve treated with PTSD, and I think it can help you too. Here’s a brochure on PE for you to take a review before we start with session 1 of PE next week. Do you have any questions?* | Provider offers belief and confidence in the effectiveness of PE. |

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| **Script B** | **Comments/Rationale** |
| *Provider: It’s nice to meet you, SGT Nolan. It’s my understanding that you completed an intake with Dr. Smith, and he thought that you and I might work well together. He mentioned that you spoke about an event that took place during a training exercise that was traumatic and that symptoms of posttraumatic stress disorder have followed this event. In fact, he gave you a diagnosis of PTSD. What questions do you have for me or about the diagnosis before we dive into talking about treatment?* | Provider introduced diagnosis of PTSD and invites questions from the patient. |
| SGT Nolan: I didn’t experience anything as bad as many other people did, but Dr. Smith seemed sure that I have PTSD. | Some people with PTSD may minimize their trauma experience. |
| *Provider: Since this is our first meeting, let’s go through the symptoms that you and Dr. Smith discussed. One of the assessments you completed before our session is the PCL-5. It is a questionnaire about the symptoms of PTSD.*  {{Provider shows patient print out of scores on outcome measure(s.)}}  *We can see that your scores on the PCL-5 are elevated. Your total PCL score of 50 is above the cut-off score, which means it’s in the clinically significant range. Also, you can see here that the four symptom cluster scores are also moderate or higher. This means that your scores on the PCL-5 are confirming a diagnosis of PTSD. Let’s take a moment to go over these four symptom clusters.*  *One of the clusters is called re-experiencing and a couple of examples of this are flashbacks or unhelpful thoughts that are hard to push out of your mind. Another symptom cluster is avoidance, which is when a person avoids talking about, thinking about, or coming into contact with people, places or things that might remind them of the traumatic event. The last two are negative changes in mood and thinking and arousal, such as having trouble sleeping or feeling irritable. What are some of the symptoms that bother you most?* | When patients complete outcome measures, they should be reviewed with the patient. Using scores on outcome measures helps support the diagnosis given at intake. Provider is linking patient’s demonstrated symptoms with the PTSD diagnosis and recommended PE treatment. |
| SGT Nolan: The nightmares are the worst. I just can’t get a good rest and it’s wearing me down. I think about what happened all the time, but I hate to talk about it. My husband keeps asking me if I’m ok and I just want him to stop. I don’t want to talk about the accident and what I saw. I can’t help thinking that I should have done more to save the men and women in the helicopter crash. |  |
| *Provider: It’s common for people to feel a sense of responsibility after a traumatic event like the helicopter crash you witnessed, even if there was nothing more you could have done to save the people who died. During treatment, we’ll be addressing the concerns you’ve indicated. Let’s talk specifically about Prolonged Exposure therapy for PTSD; we call it PE. Any questions before I describe it to you?* | Noting that a heightened sense of responsibility is a common symptom after trauma exposure may be comforting to the patient. |
| SGT Nolan: No, I’m ready. |  |
| *Provider: Good. Let’s start by going over the basics of PE. Trauma memories can sometimes be so painful that we avoid thinking about them. We also avoid things that remind us of the trauma, activities, situations, and other cues. This feels safer after trauma. Does that sound familiar? Avoidance can make us feel better, temporarily, right? Unfortunately, the relief is only temporary, and what is worse, avoidance prevents us from processing the traumatic and putting it to rest.*  *Our thoughts play an important role too. Often after a trauma, we have thoughts and ideas that make it very difficult to get back to normal life - thoughts about danger and distrust of others, and even doubts about our own ability to cope, and to manage our emotions. These thoughts support the urge to avoid and lead us to falsely believe that we need to avoid to be safe.*  *As we talk about this, can you think of ways that avoidance and unhelpful thoughts are getting in the way of you doing what you want and need to do?* | Provider describes PE interventions to aid in understanding the treatment. Checking in with patients during the explanation reinforces that this is a collaborative process. |
| SGT Nolan: Yeah, I can definitely see how I avoid anything that might remind me of the crash. I hate watching certain movies now, especially if there are graphic scenes of injured people. I even have trouble cooking sometimes. I don’t like smelling or handling meat. |  |
| *Provider: Those are great examples. I bet life would be a lot more satisfying if you could just make a meal without having to push away memories or see a movie without worrying about whether you will get triggered.*  *I know this is a lot of information. I’ll be repeating it and giving you things to read during treatment that will help it make sense over time. I want to talk a little more about exposure because that is the main ingredient of PE and will be done both in session and in between sessions. There are two main ways we will do exposure in PE.*  *The first is called imaginal exposure. In this kind of exposure, you will repeatedly walk through the details of the helicopter crash in a safe, gradual way. I will help you do this during your sessions and then we will review and discuss it together to help you make sense of it and put the memory to rest. We will also record the session and you will listen to it at home to help you further process the experience. After a few times of doing this, you will find that talking about the crash isn’t as overwhelming as it may be now. We won’t erase the memory, but imaginal exposure can help you put it in the past where it belongs. This will prevent the memory from sneaking up on you unexpectedly and stopping you from doing the important things you want and need to do in life.*  *The second kind of exposure we will do is called in vivo exposure. First, you and I will develop a game plan for recapturing all those things you stay away from since the trauma. Outside of session, in a gradual way, you will begin to approach those things you have been avoiding since the crash. For example, you shared that you need to go to the hospital for some appointments but have been avoiding it because you don’t want to hear or see people in any medical distress. We will be challenging your “I can’t” rules to prove to yourself that you can do things that are reasonably safe, even if they generate fear or anxiety at first. Think for a second about when you first learned how to ride a bike or swim. It was probably difficult at first but grew easier with practice. In vivo exposure is like that, it will help you get back those important activities, places and things that have gotten lost since the crash. How does that sound?* | It’s useful and motivating to highlight specific examples of how recovery will make life better. |
| SGT Nolan: That sounds great, Doc. I don’t know if I can do the things you mentioned, but I will try. | A patient with an open attitude at this point is a good sign. |
| *Provider: Some people are a bit uncertain about how PE can help them at first, but if you are open to the therapy and do the work, you should find it helpful. You may be surprised that your symptoms improve rather quickly. I’ve seen it work for so many Service members. With your dedication and willingness to do the work, it will most likely help you too.* |  |
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**Scenario #2:** The provider determines the current course of treatment is no longer producing the desired results and decides to introduce the patient to PE. The provider has greeted the patient and taken a short period of time at the onset of the therapy hour to establish that there are no crises or significant changes in the patient’s clinical situation. We cover one script with two different patient responses and subsequent provider interventions. In Response #1, the patient, Major Tanner, agrees to the shift in therapy and begins preparing for PE. Response #2 involves the patient not being interested in the shift in care, preferring to maintain supportive therapy. The provider navigates this challenge.

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| **Script** | **Comments/Rationale** |
| *Provider*: *Major Tanner, I’m glad to hear that things are going much better with your work situation and your relationship with your husband. I know that work and your relationships are really important to you, and you’ve put your energy into getting things back on the right track. What an accomplishment.* |  |
| Major Tanner: Thanks, I know we aren’t in the clear yet, but I at least feel like I have my husband on my side again, and I am not about to lose my job. |  |
| *Provider: I am glad. I know you are still struggling in some areas, but it is important to recognize how your work has already started to pay off. What about your PTSD symptoms? I noticed, on one of the outcome measures you complete each week that those symptoms are still bothering you even though other areas seem to be improving.*  {{Provider shows patient print out of scores on PCL-5 outcome measure.}}  *As we’ve talked about before, our hope with the PCL-5 measure was that your total score would drop below 38 and that we would see a significant reduction in the four cluster ratings as well. Today, your total score is 50 and all four clusters remain elevated, which is the same as when we first met.*  *This makes sense if we think about it. We have been very focused in other areas, but we haven’t directly targeted the PTSD symptoms that you expressed when we started working together a month ago. I realize that at the time, you were more interested in improving your relationship and were not ready to tackle the PTSD symptoms, but I’m wondering if now might be the right time to make a transition to focused PTSD treatment? I’m afraid we aren’t likely to see much progress in your PTSD symptoms until we begin this work. Does that make sense?* | Provider affirms that progress is made but notes lack of change on a PTSD outcome measure.  Reviewing the outcome measure to show the lack of progress will reinforce the upcoming point that PTSD- focused treatment is needed. |
| Major Tanner: Yes, I was hoping my sleep problems and irritability would have improved now that my husband and I aren’t fighting so much. Actually, he just asked me the other day if you and I have been talking about my childhood and everything I went through. He still thinks that stuff is affecting me and our relationship. | Due to the avoidance associated with PTSD, many patients are reluctant to begin PTSD focused treatment. |
| *Provider: What do you think? Do you think the abuse you experienced as a child is causing difficulties in your life and relationship?* | By asking for the patient’s perspective, the provider gains an understanding of whether the patient believes there is a connection between her concerns and past abuse. |
| Major Tanner: I do think it’s a problem, but I’m not sure I want to go there. | Again, patient reluctance is often based in avoidance reactions. |
| *Provider: That’s understandable. For a long time, you’ve tried to keep the abuse out of your mind. What I’ve found in my work though is that at some point for many people it becomes impossible to really put it out of your mind and for it to not negatively impact your life. For those reasons, I recommend that we shift our work toward addressing the abuse and begin Prolonged Exposure therapy for PTSD; we call it PE. How about I tell you about PE and why I think it will be a good fit for your concerns?* | Validating the patient’s discomfort about engaging in PTSD work can reduce their fears. Also, the provider shares that when PTSD reactions are unresolved, over time, they are exacerbated and create significant disturbance in patients’ lives. |
| **At this point, the provider will proceed forward if the patient is agreeable to the change of focus in treatment as in Response #1. Alternatively, in Response #2, we will see how the therapist deals with some resistance to changing the focus of treatment.** | |
| **Response #1** |  |
| Major Tanner: Ok, I’m ready hear about it. |  |
| *Provider: Good. Let’s start by going over the basics of PE. Trauma memories can sometimes be so painful that we avoid thinking about them. We also avoid things that remind us of the trauma, activities, situations, and other cues. This feels safer after trauma. Does that sound familiar? Avoidance can make us feel better, temporarily, right? Unfortunately, the relief is only temporary, and what is worse, avoidance prevents us from processing the trauma and putting it to rest.*  *Our thoughts play an important role too. Often after a trauma, we have thoughts and ideas that make it very difficult to get back to normal life - thoughts about danger and distrust of others, and even doubts about our own ability to cope, and to manage our emotions. These thoughts support the urge to avoid and lead us to falsely believe that we need to avoid to be safe.*  *As we talk about this, can you think of ways that avoidance and unhelpful thoughts are getting in the way of you doing what you want and need to do?* | The provider describes how trauma memories are linked with avoidance. Checking in with patients during the explanation reinforces that this is a collaborative process. |
| Major Tanner: I guess, like I won’t usually go places by myself unless they are really familiar to me and sometimes have a difficult time being vulnerable in my close relationships. |  |
| *Provider: I know this is a lot of information. I’ll be repeating it and giving you things to read during treatment that will help it make sense over time. I want to talk a little more about exposure because that is the main ingredient of PE and will be done both in session and in between sessions. The key to exposure is to repeatedly confront feared, but safe memories, situations, and triggers for a prolonged period of approximately 30-45 mins. In session, we will identify an index trauma, which is the worst event from the childhood abuse. We will repeatedly talk through the details of the abuse in a safe, gradual way and then we will process it together. You will also record the session so you can listen to it at home to further help you process the experience. After a few months, you will find that talking about the abuse isn’t as overwhelming as it may be at first. Outside of session, you will approach things you’ve stayed away from since the abuse. For example, you shared that you need to go to your hometown because your high school wants to honor you during homecoming, but you can’t go because being there makes you think too much about the physical abuse by your father. We will be challenging your “I can’t rules” to prove to yourself that you can do things that are reasonably safe, even if they initially generate fear or anxiety. Remember when you first learned how to ride a bike or swim? It was probably difficult at first but grew easier with practice. Approaching things that are safe, but that you’ve been avoiding is similar to this. Also, it’s important that you know that PE doesn’t erase the trauma, but it can help keep the traumatic experience from preventing you from living your life. How does that sound?* | In vivo and imaginal exposures are explained in more depth, with brief examples that apply directly to the patient. |
| Major Tanner: It sounds hard, but I need to do something. | Patient acknowledges she cannot keep doing what she’s been doing. |
| *Provider: Many people do find PE challenging at first; however, it gets much easier as you do the work. In fact, I’ve seen patients gain significant ground in managing their PTSD in just a few short weeks of committing to the work of PE.* | Recognizing the difficulty of PTSD work and sharing the successes can help the patient build hope in getting better. |
| **Now, let’s run through what happens when the patient is more reluctant to accept the recommendation to change the course of therapy and begin PE.** | |
| **Response #2** |  |
| Major Tanner: I think about the abuse a lot already. I don’t believe I’m avoiding it at all. |  |
| *Provider: You’re probably right that you’re spending a lot of time thinking about the abuse. What research has found though is that thinking and talking about the abuse therapeutically using the procedures of PE is very different than simply replaying the events on your own, or even talking about it with a friend. As I described, in PE, we have some specific techniques to help you think and talk about it in a more organized and systematic way. We have found that this kind of supported, focused attention to the memory and to the other PTSD symptoms is much more likely to relieve the symptoms.* | By differentiating ruminative thoughts about abuse from therapeutic processes in PE, it starts to build a rationale for beginning PTSD-focused treatment. |
| Major Tanner: But I don’t want to think about it. So why would I intentionally do that over and over again? |  |
| *Provider*: *When a traumatic event is taking place, the brain can’t fully compute what is happening, so all the thoughts, images, and emotions get stored away in a jumbled mess. Following the trauma, reminders of the event can feel too overwhelming to manage, so understandably, many patients try to avoid them. In PE, we will look at those memories in a safe and systematic way. We will do the same with situations and activities that you avoid, gradually taking those things on one by one. When we do it this way, you will be able to access and express emotions, deal with unhelpful ways of thinking, and activate your natural ability to heal from the abuse.* | The therapist further explains how PE can assist patients in resolving past traumas. |
| Major Tanner: Ok, that makes sense. When I think about the abuse, I do get overwhelmed with all the memories and feelings. |  |
| *Provider: That’s completely normal after a traumatic event. Many people get better on their own. However, some people need a boost to their healing through a treatment like PE.* | The provider introduces natural recovery from PTSD and that PE can aid in this healing process for those who do not naturally recover. |
| Major Tanner: Why do you think I haven’t gotten better on my own? What am I doing wrong? |  |
| *Provider: There are many reasons why people remain stuck in their trauma reactions. It can be related to lack of support in the environment. For instance, you shared that you had nobody to turn to when your father was physically violent toward you. Additionally, people who have trouble identifying and expressing emotions in general may not heal as easily following trauma. Also, experiencing repeated abuse, such as the childhood physical abuse you’ve noted, can make it harder to naturally heal because it may seem as if the abuse will never end. It really is no reflection on your ability to heal now and with the right tools, I believe you can.* | The therapist shares some possible reasons that the patient did not naturally recover from her past abuse and reassures the patient that developing PTSD is not her fault. |
| Major Tanner: Ok, I’m willing to give it a try. |  |
| *Provider: All I ask is that you make a commitment to being open-minded about PE and do the work. If you have other questions or concerns about PE or our work together, don’t hesitate to let me know.* | It’s helpful to request that patients stay open-minded and to judge for themselves if it will be helpful for them in time. |
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