Prolonged Exposure FAQs: Patient Appropriateness

Prolonged Exposure (PE) is a psychotherapy designed specifically to treat patients diagnosed with posttraumatic stress disorder (PTSD). This handout is intended to aid therapists in deciding which patients may be appropriate for PE.

Question 1: How do I determine if a patient is appropriate for PE? Is there a standardized test I should use?

Answer: Before beginning PE, it is important to determine if your patient is likely to benefit from treatment by conducting a thorough diagnostic assessment. Therapists should assess for common co-morbid diagnoses with PTSD such as major depressive disorder, traumatic brain injury, and substance use disorder. Further, therapists should assess for common issues that may complicate treatment including impending training or permanent change of station, and difficulty getting time away from work or being too busy to commit to treatment. Since PE involves working with the memory directly, the patient must be able to recall the trauma that provoked their PTSD symptoms. It is alright if the memory is fragmented or confused, but if they have no memory of the trauma or the events surrounding it, PE isn't the right treatment.

PE is not appropriate if there are other more urgent symptoms or conditions, including:

- Feeling imminently suicidal or homicidal, or engaging in high-risk self-injuring behavior
- Experiencing unmanaged psychotic symptoms
- Being at high risk for re-traumatization in an unsafe environment (e.g., living with perpetrator of sexual violence)

It is highly recommended that therapists use the Clinician Administered PTSD Scale for DSM-5 (CAPS-5) or another structured interview when conducting an initial assessment for PTSD. As part of informed consent, therapists should fully disclose the expectations for participating in PE and help patients evaluate their commitment to participate. This includes determining if the patient has obligations that may interfere with the sessions and homework completion.

Question 2: Is PE appropriate for patients with multiple traumatic events, especially more than one type? What about trauma that happened long ago, such as childhood trauma?

Answer: PE has been used to successfully treat PTSD resulting from many types of trauma ranging from sexual assault to motor vehicle accidents to deployment trauma, including patients who have experienced more than one type of trauma. This also includes both Service members with chronic PTSD stemming from combat experiences that occurred long ago and adults who experienced multiple incidents of abuse as children. Research and clinical practice have shown that there is no relationship between the recency, number, or complexity of traumas and the effectiveness of PE for PTSD.

Question 3: Is PE appropriate for patients with co-morbid conditions?

Answer: Generally, PE is appropriate for patients with co-morbid conditions, including depression, traumatic brain injury, substance use disorder (SUD), PTSD, dissociation, suicidal ideation, and the presence of personality issues. Some therapists assume that clinical research on PE excludes subjects with co-morbid conditions and PTSD, but this is not the case. In fact, many studies have demonstrated that the effectiveness of PE is not impacted by co-morbid conditions. In some cases, conditions such as depression improve during the course of PE, even though they are not directly targeted. For patients with both SUD and PTSD diagnoses, the most effective approach is to concurrently address both problems.

Question 4: Is PE appropriate for patients with suicidal or self-injurious behavior?

Answer: Non-suicidal self-injurious behavior, suicidal ideation, and past suicidal behavior are not uncommon among patients seeking treatment for PTSD. It is important to conduct a comprehensive risk assessment with every patient and to develop a safety plan for clients who are at risk. Treatment for clients who are *imminently* at risk of suicide or non-suicidal self-injury should focus on reducing risk and increasing safety before addressing any other problems areas. However, suicidal thinking or even a history of past suicidal behavior is not a reason to delay the start of PE. In fact, research has shown that suicidal thinking tends to decline significantly during the course of PE.

Question 5: Can patients with dissociative symptoms be treated with PE?

Answer: During PE, dissociative symptoms tend to decrease. In fact, patients with severe dissociation may actually benefit more from PE due to the structure and opportunity it provides to consolidate trauma memories. In some cases, when a patient's dissociative symptoms are interfering with their ability to learn or benefit from the imaginal exposure, the clinician may need to modify the standard techniques to titrate the client's emotions. Simple modifications such as recounting the trauma in past tense and opening their eyes will often be sufficient to manage dissociative experiences.

Question 6: Can PE be done with a patient who has panic attacks when confronting trauma-related cues?

Answer: PE is recommended for patients who worry about or have panic attacks. These are not uncommon in patients diagnosed with PTSD, especially when they are confronted with trauma cues. In PE treatment, panic reactions are non-dangerous anxiety symptoms that will dissipate with repeated, prolonged exposure, much like other less extreme anxiety reactions. In practice, it is often possible to gradually move through the avoidance hierarchy such that the patient is never sufficiently overwhelmed to precipitate a panic attack. For example, by starting at mid-level in vivo assignments (i.e., tasks that are in the 40 to 50 Subjective Units of Distress Scale [SUDS] range), they can learn that they are able to face situations and tolerate distress even if their anxiety goes up and they feel uncomfortable. By the time they get to higher-level in vivo assignments (i.e., tasks that are in the 80 to 100 SUDS range), anticipated panic attacks are unlikely. It's important to inform patients that they may occasionally have a panic reaction to trauma-focused therapy. However, panic reactions should not change the in vivo exposure instructions to remain in the situation until anxiety peaks and starts to decrease.

Question 7: Can I use PE with a patient who is on medications like an antidepressant or a benzodiazepine?

Answer: Due to the nature of PTSD, it is not uncommon for patients to be on medication. The general rule is that it is fine to initiate PE with patients on antidepressants (i.e., SSRIs or SNRIs). Some patients may no longer need medication therapy after they have successfully completed a course of PE and their PTSD symptoms have remitted. Such decisions should be made collaboratively with the prescribing provider. With respect to benzodiazepines, the research is clear that they are ineffective for addressing PTSD and, in fact, are harmful to treatment. If you are working with a patient who is

prescribed a benzodiazepine, it's best to find out why they are using it and consult with the prescribing practitioner. If it is being used to treat PTSD symptoms, provide psychoeducation to both the patient and prescribing provider about how it can have adverse effects and is strongly discouraged. However, if the benzodiazepine is being prescribed as needed for anxiety or to assist with sleep, clarify that it should not be used during exposure assignments and therapy because it will limit the patient's ability to benefit from the experience (i.e., they won't learn that they can tolerate the distress without the aid of the medication). Specifically, recommend that they not take the benzodiazepine before, during, or right after their in vivo exercises, imaginal sessions, and listening of the recordings of their imaginal sessions.

If you have a patient who meets criteria for PTSD, but you are uncertain about whether they are appropriate for PE, we recommend that you consult with one of our PE experts. They can assist you in making a determination about appropriateness for PE and advise you on any necessary treatment modifications.