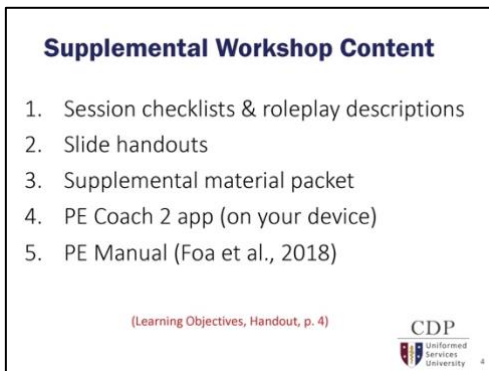
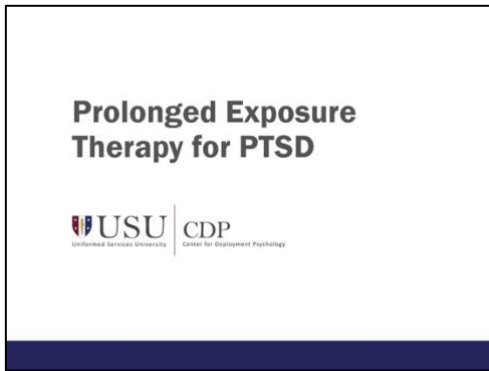


# PROLONGED EXPOSURE THERAPY FOR PTSD:

## Slide Set and Notes



## Learning Objectives

### Participants will be able to:

1. Formulate a rationale for Prolonged Exposure Therapy that builds rapport, improves client motivation, and increases treatment adherence.
2. Demonstrate an effective method of breathing that reduces client arousal and promotes distress tolerance.
3. Design an individualized avoidance hierarchy designed to systematically confront core fears.
4. Use in vivo exposure to block trauma related avoidance.
5. Apply imaginal exposure exercises to reduce the intensity and frequency of PTSD symptoms.
6. Apply specific skills to manage emotional engagement to increase the effectiveness of imaginal exposure.
7. Develop homework assignments that deepen exposure-based learning and further treatment goals.
8. Distinguish “hot spots” in the trauma memory in order to more efficiently reduce the intensity of associated symptoms.
9. Analyze exposure exercises to facilitate new learning and modify client's unhelpful, trauma-based cognitions.
10. Integrate new strategies to revise unhelpful cognitions that promote avoidance and maintain symptoms.
11. Evaluate Prolonged Exposure Therapy outcomes using standardized procedures and use assessment data to refine treatment planning.
12. Modify exposure techniques in a theoretically consistent manner to improve accessibility and clinical outcomes for specific patients.

5.

## Post-Trauma Outcomes

Natural Recovery


5

**Symptoms are common in the aftermath of a trauma. This is not PTSD but a normal response to trauma.**

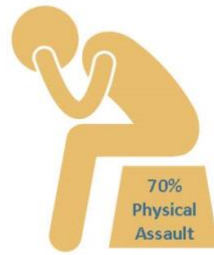
Not everyone who experiences a trauma develops PTSD, though most will experience some symptoms for a while.

6.

## Post-Trauma Distress is Normal



94%  
Sexual  
Assault



70%  
Physical  
Assault

Immediately following a trauma, most survivors experience clinically significant symptoms

(Riggs et al., 1994; Rothbaum et al., 1992)

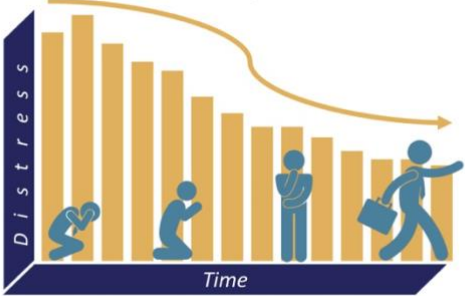
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**Example: Just after sexual or physical assault is reported, study respondents were highly distressed, and most appeared to meet criteria for PTSD.**

- In such cases, shock, distress, and confusion are common.
- Memory is confused, disorganized, distressing.
- Person may withdraw from normal activities while they seek support or recover from injury.

7.

## Natural Recovery



Natural recovery occurs with time

7

**Natural recovery occurs with time.**

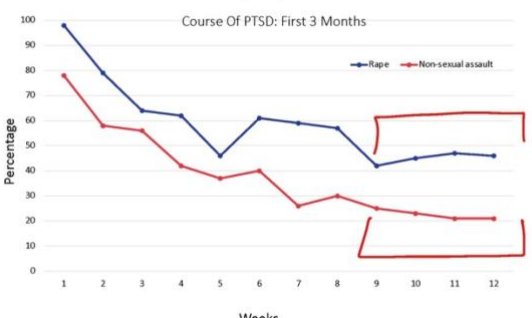
People resume normal activities and/or activities that promote healing.

- Eventually, most will return to business as usual.
- Distress decreases, and confidence increases with time and resumption of normal activity.
- For some, symptoms may continue or worsen, and natural recovery seems to stall.
- PTSD is conceptualized as a disruption of natural recovery.

8.

## Post-Trauma Symptom Pattern

Course Of PTSD: First 3 Months



(Riggs, Rothbaum & Foa, 1995); (Rothbaum, B. O., Foa, E. B., Riggs, D., Murdock, T., & Walsh, W., 1992).

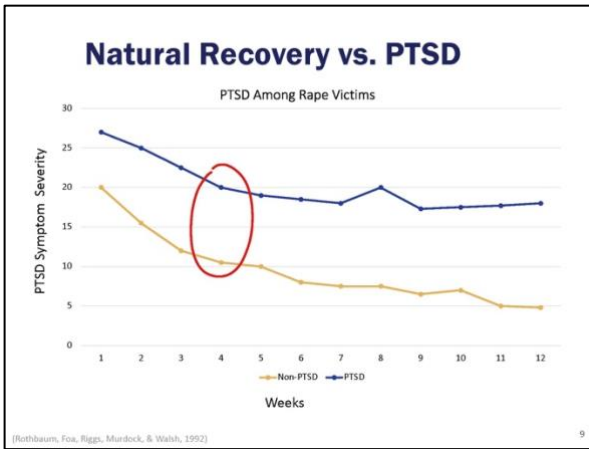
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**Real life example: PTSD symptoms after rape & nonsexual assault.**

Symptoms decline rapidly the first 4 to 8 weeks, slow down after that, and by 1-year post-trauma, recovery appears to plateau.

- If PTSD does not remit within a year, it will become chronic.
- PTSD is a highly distressing and debilitating disorder:
  - High psychiatric and medical comorbidity
  - High unemployment
  - High suicidality

9.



**More severe intrusion symptoms may be more predictive of chronic PTSD.**

Looking at the data another way, this graph separates a group of rape survivors based on their eventual PTSD diagnosis.

- Both the PTSD and the non-PTSD groups experienced decreases in the first few weeks.
- By week 5 or 6, recovery appears to stall for roughly half of participants, while the other half continued to improve.
- Though overall severity does not account for the significant difference, those who continued to meet criteria for PTSD had significantly more severe intrusive reactions.

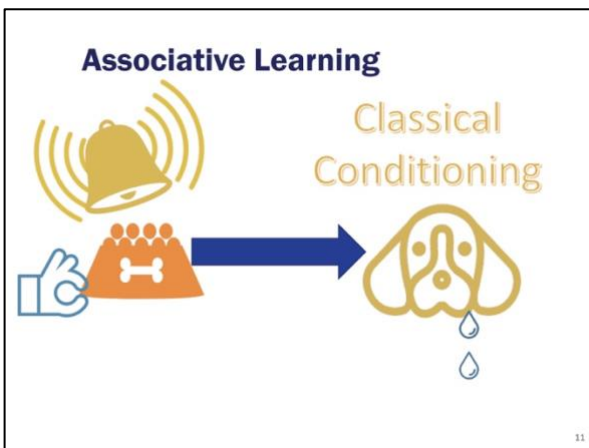
10.

**Theories of PTSD**

Why Do Some People Recover While Others Develop Symptoms?

**Cognitive and behavioral theories help us understand how people recover naturally over time, how PTSD symptoms develop after a trauma, and how recovery can stall out or be derailed. These theories also help us understand how treatment can get recovery on the right track again.**

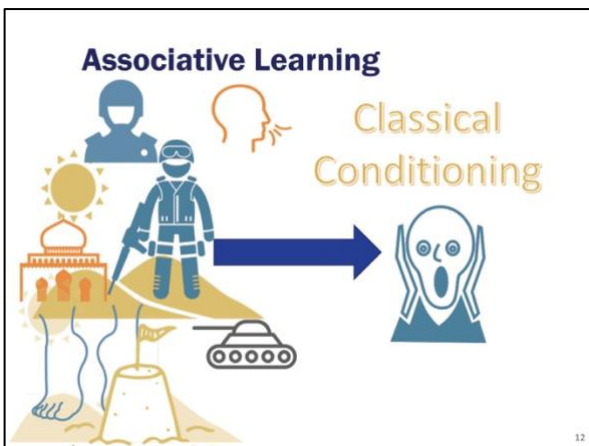
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**Associative Learning**

**In classical conditioning, trauma cues are associated with distress and begin to evoke distress when encountered, regardless of danger.**

12.

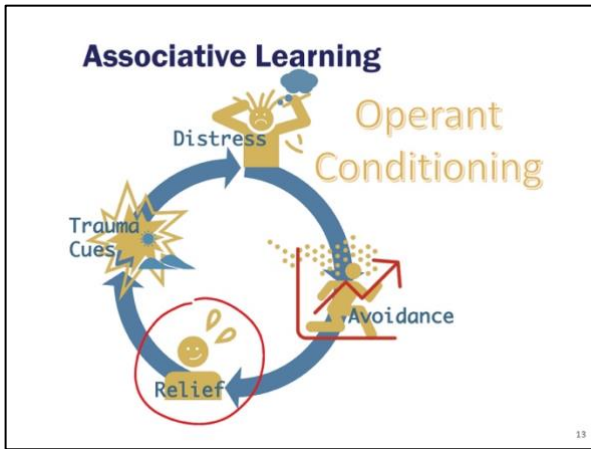


**Classical Conditioning**

**Though some avoidance immediately after a trauma is normal, if it persists to the exclusion of other, more functional ways of coping, it can disrupt natural recovery processes, leading to chronic PTSD.**

- Triggers can be situations, places, people, things, or even thoughts that remind the person of the trauma.
- Can provoke strong feelings of distress/urge to avoid or escape when encountered.

13.



### Operant Conditioning

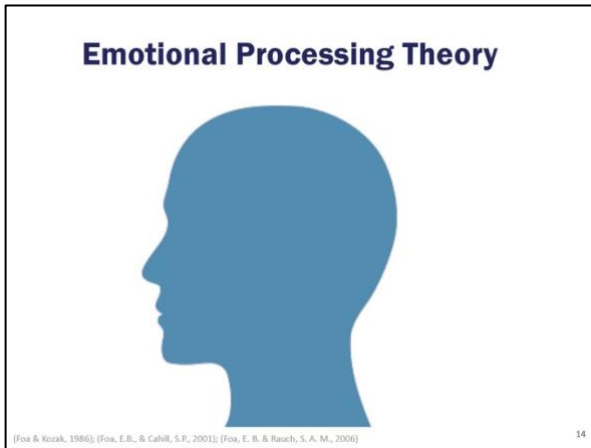
**Operant conditioning principles explain how avoidance can work against recovery and maintain PTSD symptoms.**

- A behavior followed by desirable consequences is “reinforced” and is more likely to be repeated in the future.
- If the consequence is undesirable, repetition is less likely.
- Examples: child rearing, dog training, incentives, gambling (variable intermittent reinforcement)
- Avoidance is reinforced because it quickly reduces or eliminates the conditioned response of uncomfortable physiological arousal or distress.

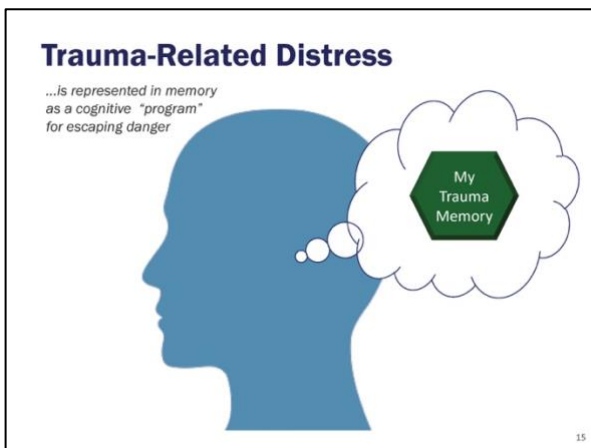
**Cognitive-behavioral theories help us understand the complex relationship between thoughts, behaviors, and emotions. For PE, this is best described by Emotional Processing Theory.**

- EPT, developed by Foa & Kozak (1986), along with others, explains how PTSD develops after a trauma, and how exposure can help with recovery.

14.



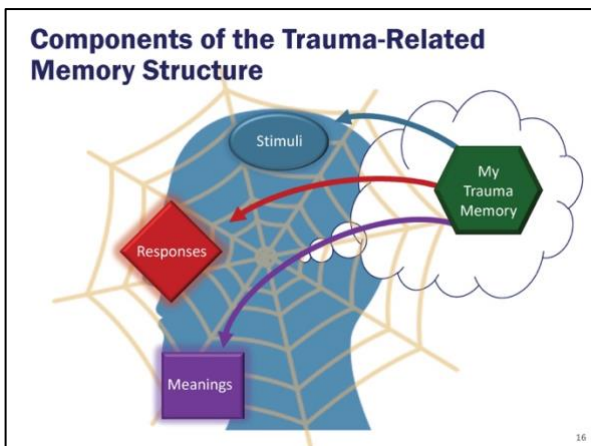
15.



**Emotional processing theory conceptualizes PTSD as the result of a pathological fear structure (or emotion structure) that emerges after a trauma.**

The fear structure is represented in memory as a cognitive program for \_\_\_\_\_.

16.



**The memory structure includes trauma-related information/memories about:**

- the feared \_\_\_\_\_,
- the \_\_\_\_\_ to the trauma,
- and the \_\_\_\_\_ of the stimuli and responses.

Like a spider web, when any part of the fear structure is activated, the whole structure is activated, giving the person access to all the information within it, and helping them escape or avoid danger.

When fear/emotional structures work well, they are refined by experiences and may be a reasonably accurate representation of events.

17. **Early Trauma-Related Memory Structures: Stimuli & Response**

- Large number of **stimuli**
  - Easily activated
- Excessive fear **responses**
  - (PTSD symptoms)
- Strong **sensory** details
  - (e.g., images, sounds, pain, smells)

17

Memory structures are not like narrative memory. They are more like snapshots or momentary images.

Anything there at the time of the trauma can associate with or cue the trauma memory when encountered later.

18. **Early Trauma-Related Memory Structures: Meaning**

- Fragmented, **poorly organized** relationships among representations
- Erroneous associations between **stimuli & danger**
- Erroneous associations between **responses & incompetence**
- Thoughts and ideas that reflect **confusion**

18

*In the immediate aftermath of the trauma, the memory is poorly organized and confusing. The person associates many things with danger.*

The fear structure that arises may be a poor or incomplete representation of what happened.

- Harmless stimuli are erroneously associated with fear such that traumatized pt. sees the world as entirely dangerous.
- The person also feels completely incompetent to make safe choices or to manage their own emotions.
- Distress and confusion interfere with adaptive behavior and promote avoidance.

19. **Early PTSD Symptoms**

- Trauma reminders activate the **memory**
- Activation **triggers** symptoms
- Symptoms motivate **avoidance**

19

*As a person attempts to return to daily life, they encounter trauma reminders that activate the trauma memory and associated perception of "danger" and "self-incompetence".*

- Activation is reflected in re-experiencing and arousal.
- Re-experiencing & arousal motivate avoidance behavior

20. **Recovery Processes**

The trauma memory is:

- Repeatedly **activated**
- Gradually **articulated**
- Incorporates **corrective information**
  - world & self
  - absence of anticipated harm

20

*Repeated activation of the trauma memory, in the absence of the expected harm, results in extinction of the distress response.*

- Activation and disconfirmation occur via confronting reminders (e.g., thinking about, contact with reminders) in everyday life.

A necessary element of the corrective information is the absence of the anticipated harm.



25.

### How is Exposure Helpful?

Breaks the habit of avoidance

- ✓ Blocks negative reinforcement
- ✓ Activates trauma memory

Facilitates trauma processing

- ✓ Organizes the memory

25

**Exposure promotes trauma processing through several helpful mechanisms.**

- PE promotes approach instead of avoidance
- “Activation” occurs when the individual confronts trauma reminders (e.g., thinking about trauma, approaching trauma cues in the environment) and engages with associated information contained in the fear structure.
- Trauma processing is enabled when the outcome is different, less dangerous/distressing than expected, prompting changes in the memory.

26.

### Reduces intense emotion

- ✓ Habituation
- ✓ Inhibitory learning

26

**Intense negative emotions associated with the event are reduced as the trauma is processed.**

**Habituation** - Reduction of conditioned responses associated with trauma-related cues (e.g., physiological arousal & excessive fear, anxiety, guilt, & shame).

**Inhibitory learning** – Adds contextual, temporal, and other useful types of information, **facilitating more adaptive responses & enabling more functional & accurate discrimination** between safe/unsafe.

Because more functional responses are associated with more reinforcing outcomes, they also inhibit the initial conditioned distress/avoidance response.

27.

### Promotes Cognitive Change

- ✓ Remembering isn't the same as “happening”
- ✓ Memory isn't dangerous
- ✓ Situations I avoid aren't dangerous

27

**Exposure facilitates cognitive change.**

- **Differentiate** remembering the event from the trauma itself and begins to understand that the memory isn't dangerous.
- **Realize** the situations they avoid because they trigger distress are not actually dangerous.
- Re-evaluate experiences (**cognitive reappraisal**) in a more balanced way.
- When done repeatedly, the person can incorporate **corrective information** into their view of themselves and the world, changing the way they respond to trauma-related cues.

28.

### Promotes Personal Mastery

- ✓ Anxiety doesn't last forever
- ✓ I can manage my own emotions

28

**As the individual successfully confronts anxiety-producing stimuli, experiences decreasing anxiety, and incorporates corrective information, they begin to feel more competent.**

The person learns that:

- Anxiety dissipates on its own, & they can manage emotions effectively.
- Even when anxiety doesn't entirely disappear, they learn that they can tolerate distress and be effective, even when uncomfortable.

29.

### Rationale for Exposure

- Breaks the Habit of Avoidance
- Facilitates Trauma Processing
- Reduces Intense Emotion
- Promotes Cognitive Change
- Personal Mastery/Competence

29

**Summary of the Rationale for Treatment.**

Notice how this slide is just a summary of the preceding slides about the benefits of exposure. Each time the rationale is given, it focuses on different specific benefits of exposure, but the underlying rationale is the same.

30.

### Will PE Work for My Patients?

What Does the Evidence Say?

30

**PE is grounded in cognitive and behavioral theory, but it is also evidence-based. PE has been studied for decades.**

- The first RCT investigating Prolonged Exposure Therapy as a treatment for PTSD was published in 1991.
- Compared PE to active and inactive control conditions to demonstrate that PE was effective in reducing PTSD symptoms in women who developed chronic PTSD because of rape.

31.

### Body of Evidence

31

**Evidence for PE is solid and impressive.**

- The first RCT investigating Prolonged Exposure Therapy as a treatment for PTSD was published in 1991.

**Published RCTs on Exposure or Exposure/combination**

**Chronic PTSD:**

EX therapy only	>25 studies
Ex therapy + SIT and/or CR	>29 studies

**Acute PTSD or ASD**

EX only	>4 studies
Ex therapy + SIT and/or CR	>6 studies

32.

### What Does the Evidence Say?

- Does PE Generalize?
  - "PE only works with rape trauma."
  - "My patient is different."
  - "What about chronic trauma?"
  - "My patient has comorbidities..."
- Does PE Hamper Treatment?
  - "PE is too simplistic for complex cases."
  - "Protocols hamper the treatment alliance."
- Does PE Cause Harm?
  - "Too distressing!"
  - "Retraumatizing!"
  - "Exposure leads to dropout."

32

**The evidence base for PE is significant and has already addressed many common concerns.**

Most concerns have to do with one of three areas:

- Generalization of findings
- Potential for exposure to hamper treatment
- Potential for exposure to cause harm



33. **Cultural Compatibility**  
Is PE incompatible with some demographic groups?

"PE is only appropriate for people who are from white, middle-class, western cultures."

**Strengths of CBT**

- Emphasizes:
  - Unique needs and strengths of the individual
  - Influence of environment
  - Empowerment
  - Conscious processes that are easily articulated and assessed
- Integrates assessment throughout

**Limitations of CBT**

- Present focus may lead to neglect of the past and of history
- Individualistic approach may overemphasize cognitive restructuring to the neglect of environmental interventions

Hays, P.R. (2009)

**PE is compatible with the cultural practices and beliefs of many different demographic groups and can be individualized to meet a variety of cultural concerns.**  
PE therapists should be careful assess the unique context, culture and history of every client and approach treatment planning with a collaborative spirit.

34. **Populations Studied**  
Does PE generalize?

"But my patient is different!"

Demographic	Location/Culture
Civilian	Australia
Active Duty	China
Veteran	Israel
Male	Japan
Female	Netherlands
Refugee	Sweden
	South Africa
	U.K.
	U.S.

34

**PE has been studied in a wide variety of populations covering most major demographic variables in Western culture and quite a few in other cultures as well. However, some large and important demographic differences have not been studied systematically.**

35. **RCT Inclusion/Exclusion Criteria**  
Does PE generalize?

**Study Inclusion**

- PTSD Dx
- 18 years of age
- >= 3 mos. post- trauma
- Stable psychiatric medication

**Study Exclusion**

- Imminent SI/HI
- Unstable psychosis/mania\*
- Severe cognitive impairment
- Substance dependence\*

**Not a factor**

- Axis II
- Substance Use
- Dissociation
- Depression
- Panic
- TBI
- Anger
- Delusions
- Hallucinations
- Suicidality

(Sijdsma et al., 2013); (Hembree et al., 2004); (Cahill et al., 2003); (Magenhaars et al., 2009); (van Minnen et al., 2015)

35

**Many historically excluded conditions are included in modern studies, and when studied both directly and indirectly, do not interfere with treatment outcome.**

36. **Some Comorbidities Improve**  
Does PE generalize?

Comorbidity is often improved as PTSD symptoms remit.

**Improves with PE treatment**

- Anger
- Depression
- General anxiety
- Dissociation
- Suicidal ideation
- Guilt
- Quality of life
- Physical health problems
- Health care use
- Trauma-related cognitions & emotions
- Social & work functioning

(Cahill et al., 2003); (Stapleton et al., 2006); (Eftekhari et al., 2013); (Foa et al., 2005); (Grabus et al., 2013); (Resick et al., 2002); (Goodson et al., 2013); (Meyers et al., 2013); (Tuerk et al., 2013); (van Minnen et al., 2015)

**Though not targeted directly during PE, many common comorbidities improve as PTSD symptoms improve.**

37.

### Trauma Types

Does PE generalize?

"Weren't all the studies done on rape victims?"

"Is PE just for combat veterans?"

Rape
Child Sexual Abuse
Physical Assault
Military Sexual Trauma
Combat
Terror Attack
Natural Disaster
MVA

CDP  
Uniformed Services University

*PE has been demonstrated effective across a wide variety of trauma types.*

38.

### Chronic or Multiple Traumas

Does PE generalize?

"My patient has experienced too many traumas to benefit from a short-term treatment."

Conclusions: Contrary to recent speculation, repeated trauma exposure did not predict less change in self-reported distress during imaginal exposure or worse PTSD outcomes. The bench-to-bedside linkage of threat extinction to exposure therapy is discussed, noting strengths and weaknesses. Patients with repeated trauma exposure show reductions in distress with exposure treatment and benefit from PE as much as patients with single-exposure trauma histories.

(Ieraci et al., 2014)

*Patients with PTSD from multiple traumas benefit as much as patients with PTSD from a single trauma.*

39.

### Complex Cases: Does PE Hamper Treatment?

"My patients are complicated. Short-term treatment won't be enough."

Time Point	PE	PE/CR
Pre	~100	~100
Post	~45	~50
FAU	~50	~55

(Paunovic & Cah, 2011)

*PE is effective in reducing symptoms of PTSD, even in complicated or chronic cases.*

40.

### Symptom Exacerbation

Does PE cause harm?

"Doing exposure will exacerbate suicidal thoughts."

"Symptoms will get worse if we talk about the trauma."

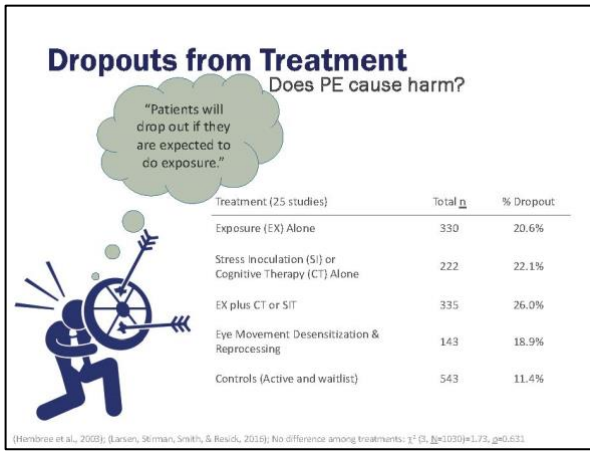
10% of patients experienced transient, slight worsening

Week	PE	PE/CR
Week 1	~10	~10
Week 2	~8	~10
Week 3	~6	~10
Week 4	~5	~10
Week 5	~4	~10
Week 6	~3	~10
Week 7	~2	~10
Week 8	~1	~10

(Foa et al., 2002); (Harned et al., 2015); (Larsen et al., 2016); (Jayawickreme et al., 2013); (van Minnen et al., 2015)

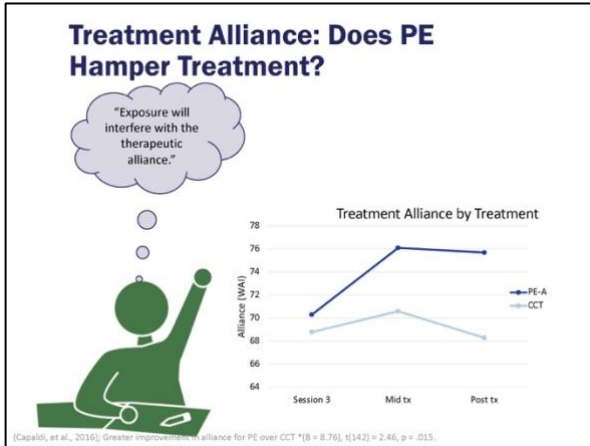
*No evidence of exacerbation of suicidality and no completed suicides due to exposure in any known PE study. Minor symptom exacerbation may occur in a small minority (\_\_\_\_\_ % of the sample) early in PE treatment but does not result in negative outcomes or dropout.*

41.



Dropout rates in PE are \_\_\_\_\_ to other forms of trauma-focused CBT.

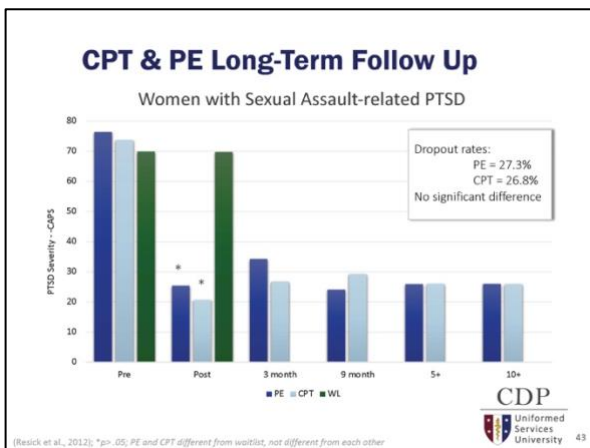
42.



Stronger alliance is associated with greater improvement in PTSD symptoms across both treatments.

Alliance was rated stronger in PE than in Client-Centered Therapy.

43.



PE is effective in reducing PTSD symptoms in female rape survivors in long-term (5-10 year) follow up

Participants -171 female rape survivors (121 completers)

Treatments - Exposure (PE) 9 weeks/sessions (90 min.)

Cognitive Processing (CPT) 12 weeks/sessions (60 min.)

Wait List (WL)

- Gains that were made during treatment were maintained over time (5-10-year span for f/u).

In the interim:

- 47% had received no further psychotherapy.
- 24% received six months or less of treatment.
- 15% had been in therapy for two or more years.
- At pre-treatment, 41% were taking psychotropic meds.

At the long-term follow-up, 23% were taking medication.

Augmenting PE with formal cognitive restructuring does not improve outcome.

Participants -179 non-sexual & sexual assault survivors (incl. CSA)

Treatments - Exposure (PE) alone  
PE + Cognitive Restructuring (PE/CR)  
Wait List (WL)

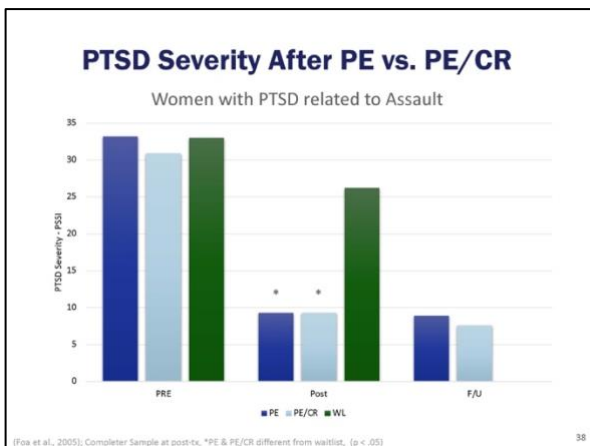
9 weekly sessions w/experienced PhDs & newly trained MA counselors

Extended to 12 for partial responders w/< 70% improvement by session 8.

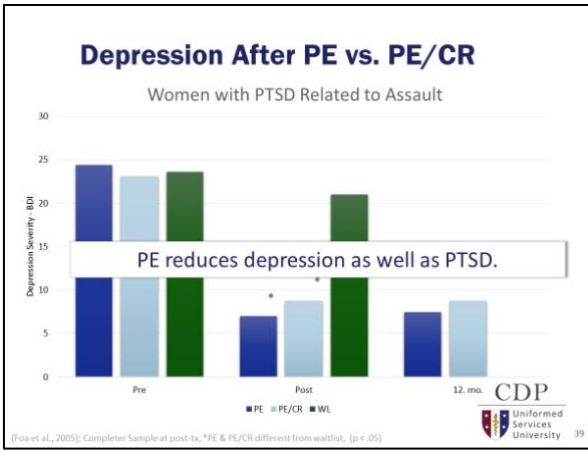
Both treatment groups did equally well.

Subsequent studies have shown that adding other stuff doesn't improve outcome either.

44.



45.

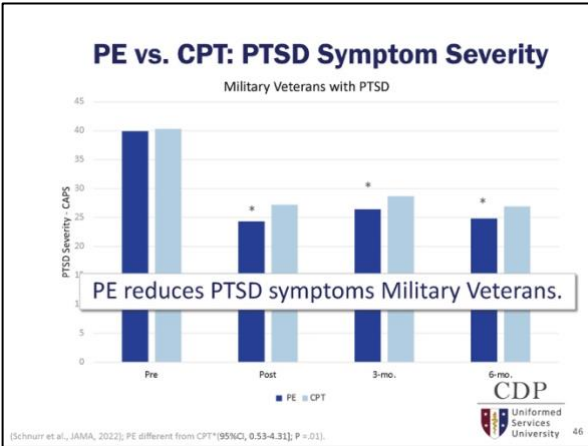


**Even though depression isn't targeted directly, PE is effective in reducing symptoms of depression as well as PTSD.**

(Depression outcomes from previous study)

Both treatment groups improved with regard to depression. In addition, newly trained MA counselors in this study, who were skeptical of the treatment and using more supportive /psychodynamic orientations, performed well. Their patients had positive outcomes like seasoned PhD PE therapists.

46.



**PE and CPT are both demonstrated to be effective in reducing PTSD symptoms in military Veterans**

Randomized clinical trial across VA Med Centers  
916 randomized.

Aged 21—80 (mean=45.2)

79.7% Men

20.3% Women

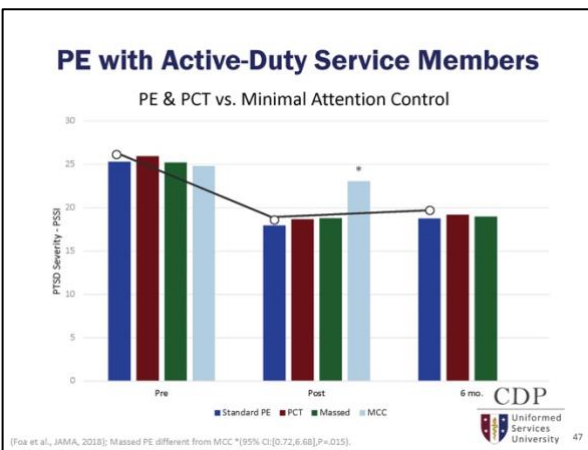
249 Black participants (27.1%)

590 White participants (64.4%)

139 Hispanic participants (15.2%)

70% reported combat exposure and roughly one third reported sexual trauma.

47.



**PE is demonstrated to be effective in reducing PTSD symptoms in military Service members.**

Participants – Active-Duty military Service members with PTSD

Treatments

Standard PE (PE-S) (109)

Present Centered Therapy (PCT) x10 sns/  
8 wks (107)

Massed Sessions (PE-M) x 10 sns/2 wks (110)

Minimal Contact Control (MCC) x 2 wks (40)

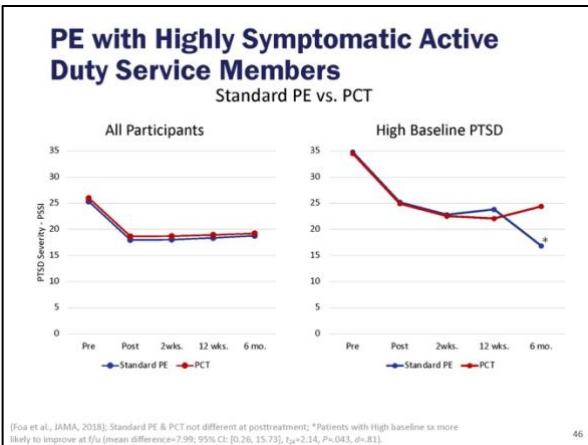
- PE-S was not superior to PCT on PSSI severity or PTSD dx, but all treatment groups were effective in reducing PTSD symptoms.

- Dropout was low for all groups.

**For more severely impaired Service members, PE results in continued improvement at follow-up.**

- In post-hoc analysis, PE-S was superior to PCT at the 6-month follow-up on PSSI among patients with high baseline PTSD symptoms (21%).

48.



49.

## Conclusion

PE is more effective than treatment as usual:

- Across gender, culture, location, & other demographic variables
- With a wide range of trauma types
- In complicated or chronic cases
- With PTSD from multiple traumas as much as a single trauma
- With no increased risk of symptom exacerbation or dropout
- Does not benefit from the addition of CR or SIT
- Does not hamper, and may facilitate therapeutic alliance
- Can be successfully disseminated to non-CBT trained/community therapists

48

50.

## Assessment

49

51.

## Assessing PTSD in Context



- Diagnostic criteria
- Acute risk
- Functional status
- Medical history and status
- Past treatment
- Psychosocial stressors
- Cultural identity
- Strengths and supports

52.

## PTSD starts with Criterion A



## Conclusion

### Assessment

- PE is designed specifically to treat the symptoms of PTSD.
- It isn't for people who do not meet all or most of the criteria for PTSD.
- And because PE involves working with memory directly, the person must recall a trauma that happened to them.

### Assessing PTSD in Context


Assessment is more than diagnostic criteria and should include a comprehensive psychosocial assessment of the individual.


### Treatment follows Assessment


- Trauma doesn't always lead to PTSD.
- Bad experiences are not always "Criterion A" trauma, even though people may experience symptoms

53.

**Criterion A?**

  
Sarah

  
Greg

  
Erica

**Prolonged Exposure?**

52


**Is there a criterion A event? Would treatment with PE be appropriate?**

- Sarah?
  
  
- Greg?
  
  
- Erica?

54.

**Who Is Appropriate for PE?**

- PTSD symptoms are primary & related to a specific event
- PTSD symptoms impair functioning
- The individual can remember enough of the event to narrate




53

**PE is safe and effective for people with PTSD**

55.

**Who Is Not Appropriate for PE?**



- Imminently suicidal or homicidal
- Unstable psychosis
- Imminent risk of domestic violence
- Seriously self-injurious
- PTSD is not primary

54

**Rule outs are due mainly to concerns about 1) safety and 2) poor prognosis.**

Conditions with the greatest threat to life and/or functional impact should be addressed \_\_\_\_\_.

56.

LEC-5

Listed below are a number of difficult or stressful things that sometimes happen to a check one or more of the boxes to the right to indicate that you experienced one or more of the things listed. If you reported about something in a current event, (E) you were exposed to it as part of your job (for example, paramedic, police, firefighter) or in your personal life (for example, E) or F.

In the next 12 months, have you experienced more than one of the events in PART 1, think about the event you consider (check one or more of the boxes to the right) to indicate how much you have been bothered by that problem in the past month.

Please check one box for each event.

1. Natural disaster (for example, fire, hurricane, tornado, earthquake)

2. Fire or explosion

3. Transportation accident (for example, airplane crash, train accident, boat crash)

4. Serious accident or event, home or workplace injury

5. Exposure to toxic substance (for example, chemical, radiation)

6. Physical assault (for example, rape, physical, sexual, verbal, threat)

7. Assault with a weapon (for example, shot, stabbed, threatened with a knife)

8. Sexual assault (rape, attempted rape, sexual harassment, sexual abuse)

9. Death of a loved one

10. Other unrelated or uncontrollable experience

11. Witnessed or exposure to a war-zone incident or an epidemic

12. Captivity or exposure, being held against your will, kidnapping, imprisonment

13. Life-threatening illness or injury

14. Severe human suffering

15. Severe human death (for example, homicide, terrorism)

16. Severe accidental death

17. Serious injury, harm, or death you or someone else

18. Any other very stressful event or event

PLEASE COPY

(Weathers et al., 2013); <https://www.ptsd.va.gov/>

PART 1

A. If you checked anything for #17 in PART 1, briefly identify the event you were thinking of:

B. If you have experienced more than one of the events in PART 1, think about the event you consider (check one or more of the boxes to the right) to indicate how much you have been bothered by that problem in the past month.

PART 2

Instructions: This questionnaire asks about problems you may have had after a very stressful experience involving actual or threatened death, serious injury, or sexual violence. It could be something that happened to you or happened to a close family member, a friend, or someone you know well as a homicide, terror, homicide, or suicide.

First, please answer a few questions to identify the event that currently best or most accurately describes the event you are thinking of.

1. How long ago did it happen?

2. Did it involve actual or threatened?

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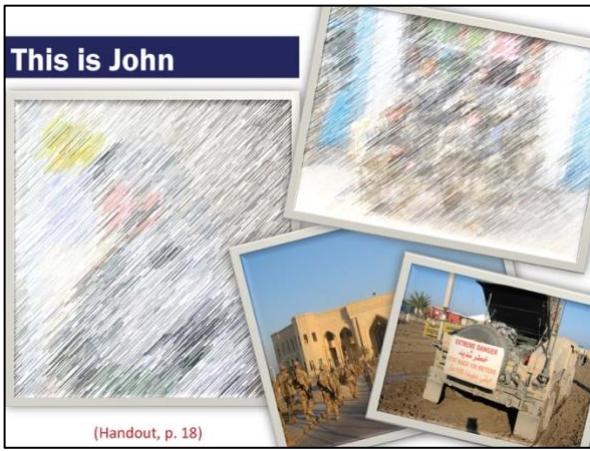
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57.



**This is John:**

58.

### PCL-5 Scoring: John's PCL-5

**B. Intrusion (1)**

**C. Avoidance (1)**

**D. Alt. of Cognition & Mood (2)**

**E. Hyperarousal (2)**

Item	0	1	2	3	4
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Intrusive feelings or acting as if the stressful experience were actually happening again (if you were actually back there thinking of)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding places or situations that remind you of the stressful experience?	0	1	2	3	4
7. Avoiding people, conversations, activities, objects, or situations?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, thinking thoughts such as "I am bad" or "there is something seriously wrong with me, no one can do anything, or the world is completely dangerous")?	0	1	2	3	4
10. Blaming yourself or someone you for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Feeling distant or cut off from other people?	0	1	2	3	4
13. Feeling numb or not feeling things?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or love, loving feelings for people)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "on edge" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

(Handout, pp. 19-21)

**PCL-5 Scoring**

A 5-10-point change represents reliable change (i.e., not due to chance).  
 10-20-point change represents clinically significant change.

Users should follow the literature and the NCPTSD website ([www.ptsd.va.gov](http://www.ptsd.va.gov)) for updates to this information, as it may change as new data is published.

59.

### Is John Appropriate for PE?

**John**

58

**What is important to consider?**

60.

### Preparing for PE

What other factors are important to consider as you prepare for treatment?

59

**Preparing for PE**

61.

**Intersectionality**

“...a paradigm that addresses the multiple dimensions of identity and social systems as they intersect with one another and relate to inequality, such as racism, genderism, heterosexism, ageism, and classism, among other variables.” (APA, 2017b)

60

**Intersectional Assessment**

62.

**The ADDRESSING Framework:**

Summary of Cultural Influences and Related Demographic Groups

	Cultural Influence	Group
A	Age/generational	Children, elders
D	Developmental disabilities	People with developmental disabilities
D	Disabilities acquired later in life	People with disabilities acquired later in life
R	Religion and spiritual orientation	Religious minority cultures
E	Ethnic and racial identity	Ethnic and racial minority cultures
S	Socioeconomic status	People of lower status by class, education, occupation, income, or rural/urban habitat
S	Sexual orientation	Gay, lesbian, and bisexual people
I	Indigenous heritage	Indigenous/Aboriginal/Native people
N	National origin	Refugees, immigrants, international students
G	Gender	Women, transgender people

(Handout, p. 22)

From Hays, P. A. (2008). Addressing cultural complexities in practice: Assessment, diagnosis, and therapy (2nd ed.). Washington, DC: American Psychological Association.

**Consider Cultural Influences and Related Demographic Variables**

63.

**Collaborative Treatment Planning**

*Context, Culture and History*

- Problem definition
- Causes
- Meaning
- Stressors and supports
- Aspects of identity that impact the problem
- Strengths and skills
- Self-coping, help-seeking
- Barriers to care
- Concerns about the provider

CDP  
Uniformed Services University

(American Psychiatric Association, 2013)

62

**It's not just about summing up various characteristics, but how does an individual's context, culture and history influence his or her identity, and how do those factors relate to the problem?**

64.

**Collaborative Treatment Planning**

*Enhancing Motivation*

- What is the cost of PTSD?
- What are the patient's goals?
- What motivates the patient?

63

**Help the patient weigh the pros and cons of treatment.**

**How is life different after the trauma?**

“Tell me about the life you want to reclaim”

“What do you wish you could do at the end of therapy, or six months from now?”

**Are there potential barriers to treatment?**

Consider work schedule, family demands, impending travel or change in duty station, financial or legal issues, housing/socioeconomic hardship

Would treatment, if successful, hamper or help?

**Is this the right time? If not now, when?**

What needs to be addressed to make treatment successful?



65.

### Laying the Groundwork: Facilitating Treatment Alliance

- Collaborative style
- Non-judgmental approach
- Contextualize examples
- Validate the patient's experience
- Acknowledge the patient's courage
- Demonstrate knowledge, expertise, & confidence in the treatment
- Support, encouragement, positive feedback

64

*The alliance in PE is established as part of the protocol, even as you are accomplishing other things.*

66.

### Collaborative Treatment Planning Informed Consent

- Symptoms may increase before decreasing
- Time commitment
- Homework
- Treatment options



*Help the patient understand what to expect from treatment.*

Some people feel worse before they feel better – brief, temporary

**What are the demands of treatment?**

Time, effort, focus, potentially some temporary distress

**What treatment options are available to the patient?**

Rural vs. urban, insurance or benefit limited, self-pay, other EBPs

67.

### How to Record Sessions

- Patient downloads *PE Coach 2* app
- Patient purchases digital recorder
- Patient borrows your recorder
- **You** transfer recordings via CD, flash drive, or email

66

*Recording best practices*

68.

### PE Coach 2 App

- Free on iOS & Android platforms
- Installed on the patient's device
- Adjunct to PE treatment
  - Rationale handouts
  - Homework assignments
  - Homework tracking sheets
  - Record/review session audio
  - Appointment scheduling



Download on the  
App Store  
<http://tinyurl.com/pe2ios>



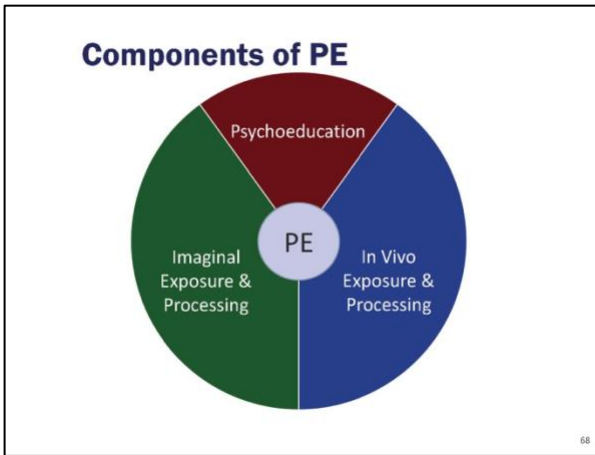
GET IT ON  
Google Play  
<http://tinyurl.com/pe2andr>



68

*Using the PE Coach App*

69.



**3 main components of treatment:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

70.

**Introduction of PE Components**

**Psychoeducation**

- Session 1 Overview & Rationale
- Session 2a Common Reactions

**Exposure/Processing**

- Session 2b Begin In Vivo Exposure
- Session 3 Begin Imaginal Exposure
- Session 4-5 Shaping Engagement
- Session 6+ Hotspots

**Termination**

- Final Session Summary & Relapse Prevention

(Handout, p. 5)

70

**Introduction of PE Components**

The handout provides a one-page overview of the sequential components of the treatment.

71.

**Session 1:  
Overview & Rationale**

70

72.

**Session 1: Agenda**

- Overview & Rationale\* (~ 20-30 minutes)
- Trauma Interview (~ 10-30 minutes)
- Relaxed Breathing (~ 10 minutes)
- Homework (~ 5-10 minutes)

*\*Don't forget to start the recording at the beginning of the session*

72

**Session 1: Agenda**

73.

### Treatment Overview

- Symptom-focused
- Highly Structured
  - Individual Sessions
  - 60-90 min/1-2 week
- Individualized for each patient
- Daily & weekly homework
- Recorded for patient review

*There are no surprises in PE. Convey basic structure, importance of staying with the structure for learning, the focus and intensity of the treatment before treatment begins.*

\_\_\_\_\_ allows the patient to review in-session material between sessions and is an **important** part of the treatment.

74.

### Make the Rationale Memorable: Session 1 Metaphors

Session Topic See All

Jump to: SESSION 2 SESSION 3 SESSION 6

**SESSION 1**

**Coach & Athlete:** Dr. Holloway describes the relationship between therapist and patient using the example of a coach and athlete relationship, highlighting the collaborative nature of the relationship but having different roles. Both bring expertise to the relationship. And much like the athlete, the patient does a lion's share of the actual work and effort in treatment, while the therapist guides the patient's efforts so they are maximally beneficial, helping the patient to go just a little further than they think they can go and to perform beyond their own perceptions of competence. This example can be very useful in session 1 when describing the overview of treatment and rationale for exposure therapy.

<https://tinyurl.com/PEMetaphors>

*Stories and Metaphors are aids to understanding and memory and should be used liberally throughout treatment when describing the rationale.*

75.

### Rationale for Treatment

- How people recover from trauma
- Factors that derail recovery
- How PE addresses the factors
- Benefits of treatment

74

*The rationale for treatment is the main focus of session 1.*

76.

### Expectation of Recovery

Post-trauma distress is normal & expected

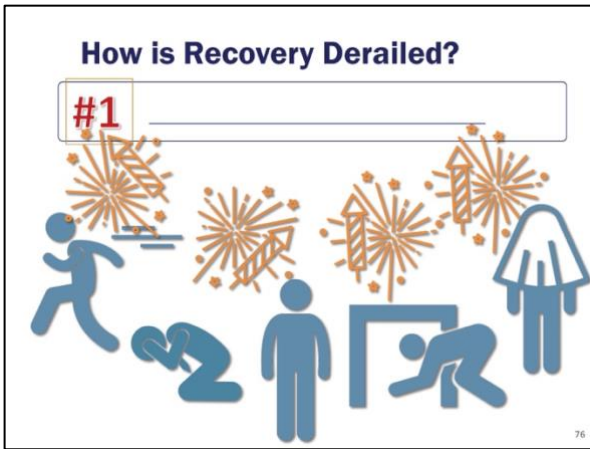
- Recovery takes place with time
  - Normal patterns of behavior are resumed
  - The trauma **memory is processed**
  - Cognitions are revised** to accommodate new information
  - Trauma-related **distress dissipates**

**When the normal recovery process is derailed, PTSD is the result**

75

*Natural recovery is the norm. For some, the natural process is derailed.*

77.



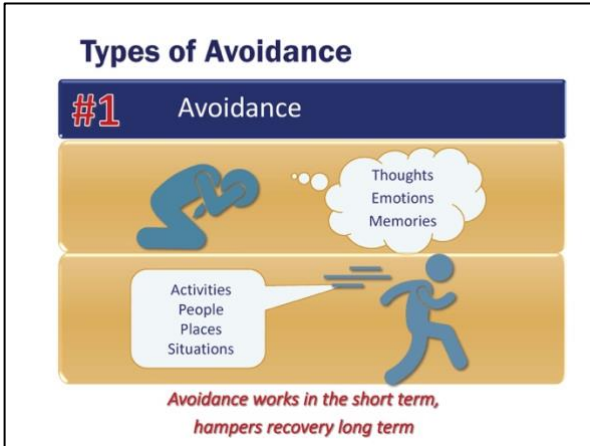
*The most important factor hampering recovery & maintaining PTSD symptoms is:*

1). \_\_\_\_\_

*What is the short term vs. long term consequence(s) of avoidance?*

\_\_\_\_\_  
\_\_\_\_\_

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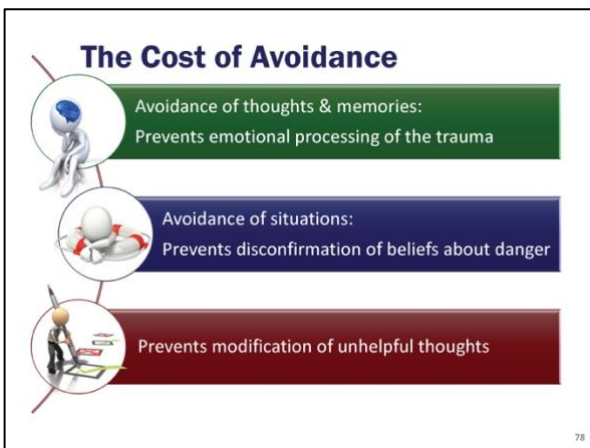


*Two types of avoidance are problematic in PTSD:*

1). \_\_\_\_\_

2). \_\_\_\_\_

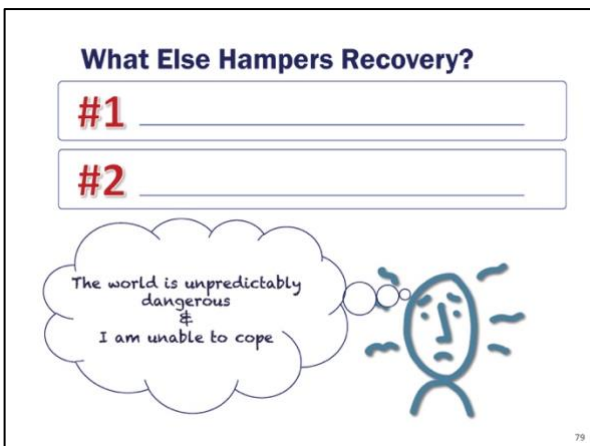
79.



*The cost of avoidance is the derailment of recovery processes leading to chronic symptoms.*

These three points should be clearly made in session1 and throughout treatment.

80.



*After avoidance, the second major factor maintaining PTSD symptoms after a trauma:*

1). \_\_\_\_\_

81.

### Treatment procedures

Imaginal Exposure      In Vivo Exposure

80

**PE relies on exposure to block avoidance. The two types of exposure used in PE are:**

1). \_\_\_\_\_

2). \_\_\_\_\_

82.

### Benefits of Exposure Therapy

- Breaks the Habit of Avoidance
- Process/Organize the Memory
- Anxiety Doesn't Last Forever
- Realize You Can Cope
- Reduction in PTSD Symptoms

81

**Overall treatment rationale presents the theoretical benefits of PE treatment. Later rationales (sessions 2 & 3, and afterward as needed) will focus more specifically on the types of exposure.**

Notice how the language is different from the BIG 5 detailed above, but the message is the same.

83.

### Rational for Prolonged Exposure (PE) Treatment

*How is PE Helpful in Reducing PTSD Symptoms?*

The program you are about to begin is called Prolonged Exposure Therapy (PE). It is designed to help you recover from posttraumatic stress disorder (PTSD). To understand how this treatment works to help you reduce your PTSD symptoms, it is important to learn a little about how PTSD develops in the first place.

*It is normal to feel upset or distressed after a trauma.*

When someone experiences a traumatic event, it is normal to feel upset or distressed. These feelings of distress – whether anxiety, sadness, anger, guilt, or other emotions – will usually lessen with time. Eventually, most people will begin to feel better. However, for some people, the distressing feelings do not go away, and can sometimes begin to interfere with everyday life. Why do some people develop PTSD after a trauma while others do not?

*Avoiding those feelings prevents recovery.*

One important reason for the development of PTSD is avoidance. After the trauma, you may push away memories, thoughts, or feeling about the trauma that cause you distress. You may also avoid situations, people, or activities because they are similar to the trauma and/or because they seem more dangerous to you than before the trauma.

It is important for you to know that this is a normal response to trauma. It is not your fault. It is not due to lack of intelligence, poor motivation, or some character flaw. We avoid – all of us from time to time – because it works for us! Avoidance can be a reasonable and helpful way to deal with distress – in the short term. Unfortunately, if avoidance prevents you from processing your emotions, it can miss out on opportunities that could help you process your emotions. (Handout, pp. 38-39)

84

**Written materials (handouts) augment teaching and give the patient something to review or share with significant others.**

84.

### Rationale for Treatment Demo

(Handouts, pp. 23-24)

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84

**This form is optional and may or may not be used in the workshop.**

85.

## Roleplay Case Descriptions

**Case 1: Combat Trauma**

**40-year-old, male, Army veteran**  
**Index trauma:**  
 Taking fire coming into a village while riding in a tank  
 Lead tank disabled, trapping convoy in road  
 Ran across 100 yards of open space to service tank while under fire

**Selected Symptoms:**

- Avoids crowds, news, bloody or violent images
- Nightmares
- Hypervigilant, irritable, impatient

**Case 2: Sexual Trauma**

**30-year-old, female, AD Air Force**  
**Index trauma:**  
 Assaulted @ 26yo by civilian acquaintance—neighbor in complex  
 Assailant claimed was consensual  
 Did not report because she felt confused and blamed self

**Selected Symptoms:**

- Avoids men, dating, alcohol >1 drink, form-fitting clothes
- Guilt, shame, blame

**Case 3: MVA**

**32-year-old, female, AD Army Nat. Guard**  
**Index trauma:**  
 MVA 1 yr. ago during training exercise  
 Pt was driver, was hit by another vehicle, thrown from vehicle  
 Broken leg and concussion, recovered physically

**Selected Symptoms:**

- Anxiety/reactivity
- Avoids driving
- Doesn't allow her teen children to sit in front

(Handout, p. 31)

**Demonstration Video: Session 1: Rationale for Treatment**

86.

## Roleplay Session 1: Overview & Rationale

5

**PE Session by Session Checklist**

**PE Session Checklist**

**OVERVIEW**

1. Overview of evidence and evidence - in questions, in weekly activities, address of the client
2. Review of the PE checklist
3. The steps in evidence and use of the checklist at the
4. The steps in evidence for support, with questions

**KEYWORDS FOR TREATMENT**

1. Self-compassion
2. Distress after trauma is normal, not a sign of weakness, but a sign of strength
3. Trauma is not a sign of weakness
4. Trauma is not a sign of weakness
5. Trauma is not a sign of weakness
6. Trauma is not a sign of weakness
7. Trauma is not a sign of weakness
8. Trauma is not a sign of weakness
9. Trauma is not a sign of weakness
10. Trauma is not a sign of weakness

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**10 12 15**

**PE Session by Session Checklist**

**PE Session Checklist**

**OVERVIEW**

1. Overview of evidence and evidence - in questions, in weekly activities, address of the client
2. Review of the PE checklist
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8. Trauma is not a sign of weakness
9. Trauma is not a sign of weakness
10. Trauma is not a sign of weakness

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**10 12 15**

(Handout, pp. 23-24)

**Roleplay Notes:**

“My name is \_\_\_\_\_”

I experienced \_\_\_\_\_ and I have PTSD.”  
 (Trauma history)

My symptoms interfere with \_\_\_\_\_

Make any other notes about your roleplay client to help you portray your character:

87.

## Session 1: The Trauma Interview

PE Manual, Appendix A, p. 147 (2019)

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**DISCUSSION** about the trauma that will be the focus of treatment, sometimes referred to as the index trauma.

TALKING about the trauma in session 1 communicates that the treatment is trauma-focused and will engage with the trauma directly.

88.

## Goals of the Trauma Interview

Three main goals:

1. Identify/confirm the index trauma
2. Establish bookends for the imaginal exposure narrative
3. Supplement intake information:
  - trauma history
  - current functioning
  - physical and mental health since the trauma
  - social support
  - use of drugs or alcohol

**The trauma interview should be used to gather information needed to proceed with treatment.**

The official “Trauma Interview” is in the appendices of the manual.

If assessment has already covered the material, the full interview may not be needed.

89.

**How to identify the index trauma?** ?

- Most Distressing Now
- Most Salient
  - Frequently Reexperienced
- Most Representative


88

**How to identify the index trauma:**

- Which event upsets you the most?
- Which causes the most distress?
- Which comes into your mind the most often?

90.

**Identifying an "Index Trauma" Demo**



89

**Video Demonstration of Identifying an Index Trauma**

91.

**Relaxed Breathing (End of Session 1)**


90

**Relaxed Breathing**

92.

**Relaxed Breathing: Rationale**

- Physiological arousal is a component of emotional distress
- Reducing arousal can reduce distress
- Slowing breath rate can reduce arousal & therefore, distress



91

***Breathing retraining provides a means of calming the patient after the trauma interview, if needed. It also gives a concrete skill that can be practiced right away to bring relief in advance of the more significant changes that are possible with exposure.***

Relaxed breathing should not be used during exposure, except in rare occasions, as it may become an avoidance strategy.

93.

### Relaxed Breathing: Caveats

- Evidence is unclear
  - Patients like it
  - It is part of the standard protocol
- RB **should not** be used as a **safety behavior** during exposures
- RB **may** be used after exposure as a **distress tolerance skill**

92

**Relaxed breathing is not believed to be a critical treatment element.**

94.

### Relaxed Breathing

*How is Relaxed Breathing Helpful?*  
Your emotions affect your breathing and heart rate, and your heart rate and breathing affect your emotions. Stressful feelings signal your body to be on the alert and speed up your breathing and heart rate. Increases in heart rate and breathing can further activate anxious thoughts and feelings, which can make you feel more stressed or on edge. Once these feelings arise, it can sometimes be difficult to get out of the cycle.

Calm or controlled breathing helps to slow down your heart rate and breathing, interrupting the stress response cycle, and ratcheting down your stress reaction. With practice, this will help you feel less anxious and/or better able to tolerate stressful situations.

The steps:

- Inhale normally through your nose with mouth closed.
- Exhale slowly with your mouth closed.
- As you exhale, count slowly to 4.
- Pause for a count of 4.
- Take the next inhalation.
- Practice this exercise several times a day.
- 10 to 15 cycles of breath at each practice.

Helpful Tips: **(Handout, p. 40)**

- Space your practice throughout the day rather than saving it all for evening or bedtime. Though the exercise may help you fall asleep, it is really designed to help you feel better while you are awake!

**Relaxed Breathing handout for patients**

95.

### PE Homework: Session 1

Patient ID: John Smith Date: \_\_\_\_\_

Check the box as you complete each item. Write any comments, questions, or problems in the space at the bottom of the form.

Practice calm breathing for 10 minutes, three times a day. (Use a recording at first, then begin to practice on your own.)

Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Read "A Rationale for Treatment" and note any questions that come up.

Listen to the recording of the therapy session one time.

Come early to the next session to complete self-report forms.

Other: \_\_\_\_\_

(Handout, p. 41)

95

**Homework form for session 1**

Homework starts in the \_\_\_\_\_ session.

96.

## The Importance of Homework

Managing homework to maximize outcome

95

**The Importance of Homework**



97.

### Homework Compliance & Outcome

Meta-analysis of homework in CBT  
(27 studies, n = 1702)

- Homework assignments are related to better outcome
- High homework compliance is related to better outcome



(Kazdin, Deane, & Roman, 2000)

96

### Homework Compliance and Outcome

98.

### Facilitating Homework Compliance



- Provide a convincing rationale
- Give clear & specific instructions
- Gradually increase difficulty
- Anticipate barriers
  - Organization (e.g., lost sheet, forgot)
  - Practical issues (e.g., no time, no privacy)
  - Avoidance

97

### Facilitating Homework Compliance

Best to anticipate and prevent noncompliance before it starts.

99.

### Addressing Noncompliance

- Provide support, encouragement
- **Validate** the urge to avoid
- Review the **rationale**
  - Short-term/long-term
  - Memories are not dangerous
- Use **analogies** to support the rationale
  - Physical therapy
  - Infected wound
- Review **costs/benefits**
- **Problem-solve** barriers/obstacles



98

### Addressing Noncompliance

100.

## Session 2: Common Reactions to Trauma & Introducing In Vivo Exposure

99

### Session 2

101.

## Session 2 Agenda

- Review homework/self reports\* (~ 10 minutes)
- Common reactions to trauma (~ 25 minutes)
- Rationale for in vivo exposure (~ 10 minutes)
- Subjective Units of Distress Scale - SUDS (~ 5 minutes)
- Construct in vivo hierarchy (~ 30 minutes)
- Instructions for in vivo exposure (~ 10 minutes)
- Assign homework (~ 5 minutes)
- Sessions are recorded for homework review



*\*Don't forget to start the recording at the beginning of the session*

**Session 2 is a VERY dense session.**

Be sure you have a full 90 minutes to commit to this session. An alternative is to split session 2 into two parts, 2a and 2b.

102.

## Session 2 Agenda Session 2a (Common Reactions)

- \*Review homework/self reports (~ 10 minutes)
- Common reactions to trauma (~ 25 minutes)
- Assign homework (~ 10 minutes)
- Sessions are recorded for homework review

## Session 2b (In Vivo Exposure)

- \*Review homework/self reports (~ 5 minutes)
- Rationale for in vivo exposure (~ 10 minutes)
- Subjective Units of Distress Scale - SUDS (~ 5 minutes)
- Construct in vivo hierarchy (~ 30 minutes)
- Instructions for in vivo exposure (~ 10 minutes)
- Assign homework (~ 5 minutes)
- Sessions are recorded for homework review



*\*Don't forget to start the recording at the beginning of the session*

101

**If sessions must be short, content is split, and corresponding homework is split accordingly.**

Sessions shorter than 60 minutes are not recommended.

103.

## Common Reactions to Trauma

First Part of Session 2

102

**Common Reactions to Trauma**

104.

## What are Common Reactions to Trauma?

- Fear and Anxiety
- Re-Experiencing
- Trouble Concentrating
- Hypervigilance
- Irritability/Anger
- Avoidance
- Reckless Behavior
- Sex/Intimacy
- Emotional Numbing
- Loss of Interest
- Depression
- Feelings of "Going Crazy"
- Shame and Guilt
- Self-Blame
- Poor Self-Image
- Substance Use/Abuse

**What Are Common Reactions to Trauma?**

106.

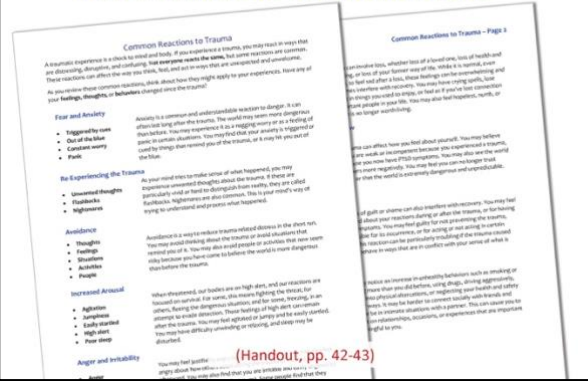
### Common Reactions to Trauma: Why Review?

Elicit	<i>patient's unique experience of PTSD</i>
Validate & normalize	<i>patient's experiences &amp; symptoms</i>
Instill hope	<i>that patient is not broken</i>
Promote communication	<i>as a collaborative, therapeutic alliance</i>
<i>If it's not a conversation, it's not common reactions</i>	

### Why Review Common Reactions to Trauma?

107.

### CRTT Handout for Homework



### CRTT handout for patients

108.

### Common Reactions Demo



### Video Demonstration - CRTT

109.

### Introducing In Vivo Exposure

Second Part of Session 2

### Introducing In Vivo Exposure

110.

### Introducing In Vivo Exposure

- Present **rationale** including:
  - **Naturalistic examples** of in vivo exposure
  - **Examples of habituation** from patient's experience
- Develop a **list** of avoided situations
- Anchor the **SUDS** scale
- **Rate** each in vivo item on SUDS
- **Arrange** hierarchy based on SUDS level

109

### *Giving the Rationale for In Vivo Exposure*

111.

### Rationale for In Vivo Exposure

Trauma-related fears are sometimes unrealistic or excessive



110

### *The Rationale for In Vivo Exposure*

Rationale focuses on in vivo exposure to address excessive distress and/or unhelpful cognitions symptomatic of PTSD.

112.

### Examples of Habituation



111

### *Examples of Habituation*

113.

### Metaphor Bank Example: Session 2

#### Prolonged Exposure Therapy (PE) Metaphor Bank

##### SESSION 2

**Pool Temperature:** Dr. Kelly Chrestman describes the process of habituation, or "getting used to something," using the example of getting used to the water in a swimming pool. She explains that some people enter a swimming pool slowly and others jump right in, but the difference is only a difference in the speed at which one becomes used to the water temperature. She also explains that it is not the water temperature that changes, but it is the person that changes in getting used to the water. Dr. Chrestman also explains how some people avoid swimming at all because they may believe it is too uncomfortable to get used to the water, or they may be waiting for the water to get warmer first, similar to how many people avoid engaging in many aspects of their life because they are waiting to first feel comfortable or not anxious about these situations rather than getting into them and getting used to them. This example may be very useful when discussing the rationale for exposure therapy in session 1, discussing the rationale for in vivo exposure in session 2, or any time the when a review of the concept of habituation may help the patient to stay engaged in exposure when feeling uncomfortable.

<https://tinyurl.com/PEMetaphors>

### *The Metaphor Bank-Pool Temp*

114.

### Benefits of In Vivo Exposure

- Breaks the Habit of Avoidance
- Results in Habituation
- Recognize Situation Is Low Risk
- Anxiety Doesn't Last Forever
- Personal Competence/Mastery

113

*In vivo exposure helps reduce symptoms by breaking the habit of avoidance, thereby facilitating processing, enabling new learning to take place.*

*Though other erroneous beliefs are challenged during in vivo, it is especially useful in helping assess \_\_\_\_\_ more realistically.*

115.

### In Vivo Items Can Include:

- Places
- People
- Activities
- Situations
- Sensations (e.g., sights, sounds, smells, tastes, physical sensations)

(Handout, p. 44)

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*In Vivo Items Can Include:*

116.

### Consider Items That Are:

1. Reminders of the trauma
2. Feel more dangerous than they actually are
3. Pleasant, social, or important activities that have decreased in frequency since the trauma

(Handout, p. 44)

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*Consider three types of activities.*

117.

### Generating John's Hierarchy

116

*Suggest items from assessment*

118.

**In Vivo Exposure Hierarchy**

Patient ID: John Smith      Date: \_\_\_/\_\_\_/\_\_\_

SUDs anchor points:

0 ←———— 50 —————→ 100

Targeted activities		SUDs (week 1)	SUDs (last session)
<i>In vivo items can include:</i> • Places • People • Activities • Situations • Sensations (e.g., sights, sounds, smells, tastes, physical sensations)  <i>Be sure to consider both distressing reminders of the traumatic event -and- items that feel more dangerous than they</i>	1. Crowded places		
	2. Going to the PX		
	3. Going to grocery store near home		
	4. Going to the mall		
	5.		
	6.		
	7.		
	8.		
	9.		
	10.		
	11.		
	12.		

*Identify specific situations*

119.

**In Vivo Exposure Hierarchy**

Patient ID: John Smith      Date: \_\_\_/\_\_\_/\_\_\_

SUDs anchor points:

0 ←———— 50 —————→ 100

Targeted activities		SUDs (week 1)	SUDs (last session)
<i>In vivo items can include:</i> • Places • People • Activities • Situations • Sensations (e.g., sights, sounds, smells, tastes, physical sensations)  <i>Be sure to consider both distressing reminders of the traumatic event -and- items that feel more dangerous than they</i>	1. Going to the PX		
	2. Going to grocery store near home		
	3. Going to the mall		
	4. Going to the mall on a weekday		
	5. Going to the mall on the weekend		
	6. Going to the mall on the weekend alone		
	7. Going to the mall on a weekday with Jane		
	8. Going to the mall on the weekend with Jane		
	9. Going to the mall on a weekday alone		
	10.		
	11.		
	12.		

*Elicit variations*

120.

**In Vivo Exposure Hierarchy**

Patient ID: John Smith      Date: \_\_\_/\_\_\_/\_\_\_

SUDs anchor points:

0 ←———— 50 —————→ 100

Targeted activities		SUDs (week 1)	SUDs (last session)
<i>In vivo items can include:</i> • Places • People • Activities • Situations • Sensations (e.g., sights, sounds, smells, tastes, physical sensations)  <i>Be sure to consider both distressing reminders of the traumatic event -and- items that feel more dangerous than they</i>	1. Going to the PX		
	2. Going to grocery store near home		
	3. Going to the mall on the weekend with Jane		
	4. Going to the mall on the weekend alone		
	5. Going to the mall on a weekday with Jane		
	6. Going to the mall on a weekday alone		
	7.		
	8.		
	9.		
	10.		
	11.		
	12.		

*Understand the anticipated consequence*

121.

Targeted activities		SUDs (week 1)	SUDs (last session)
<i>In vivo items can include:</i> • Places • People • Activities • Situations • Sensations (e.g., sights, sounds, smells, tastes, physical sensations)  <i>Be sure to consider both distressing reminders of the traumatic event -and- items that feel more dangerous than they actually are.</i>  <i>Items can also include some pleasant, social or important activities that have decreased in frequency since the trauma.</i>	1. Going to the PX		
	2. Going to grocery store near home		
	3. Going to the mall on the weekend with Jane		
	4. Going to the mall on the weekend alone		
	5. Going to the mall on a weekday with Jane		
	6. Going to the mall on a weekday alone		
	7. Riding in the passenger seat of a car		
	8. Driving in traffic		
	9. Driving on streets with potholes		
	10. Driving down narrow streets		
	11.		
	12.		
	13.		
	14.		
	15.		
	16.		
	17.		
	18.		
	19.		
	20.		

*Evaluate true danger*

122.

	Targeted activities	SUDs (circle 1)	SUDs (check)
<p><b>In vivo items can include:</b></p> <ul style="list-style-type: none"> <li>• Places</li> <li>• People</li> <li>• Activities</li> <li>• Situations</li> <li>• Sensations (e.g., sights, sounds, smells, tastes, physical sensations)</li> </ul> <p><i>Be sure to consider both distressing reminders of the traumatic event -and- items that feel more dangerous than they actually are.</i></p> <p>Items can also include some pleasant, social or important activities that have decreased in frequency since the trauma.</p>	1. Going to the PX		
	2. Going to grocery store near home		
	3. Going to the mall on the weekend with Jane		
	4. Going to the mall on the weekend alone		
	5. Going to the mall on a weekday with Jane		
	6. Going to the mall on a weekday alone		
	7. Riding in the passenger seat of a car		
	8. Driving in traffic		
	9. Driving on streets with potholes		
	10. Driving down narrow streets		
	11. Seeing HUMWVs or "Hummers" (civ)		
	12. TV/movies with lots of blood		
	13. Watching TV news		
	14. Talking with Jane about deployment		
	15.		
	16.		
	17.		
	18.		
	19.		
	20.		

Caution when involving others

123.

	Targeted activities	SUDs (circle 1)	SUDs (check)
<p><b>In vivo items can include:</b></p> <ul style="list-style-type: none"> <li>• Places</li> <li>• People</li> <li>• Activities</li> <li>• Situations</li> <li>• Sensations (e.g., sights, sounds, smells, tastes, physical sensations)</li> </ul> <p><i>Be sure to consider both distressing reminders of the traumatic event -and- items that feel more dangerous than they actually are.</i></p> <p>Items can also include some pleasant, social or important activities that have decreased in frequency since the trauma.</p>	1. Going to the PX		
	2. Going to grocery store near home		
	3. Going to the mall on the weekend with Jane		
	4. Going to the mall on the weekend alone		
	5. Going to the mall on a weekday with Jane		
	6. Going to the mall on a weekday alone		
	7. Riding in the passenger seat of a car		
	8. Driving in traffic		
	9. Driving on streets with potholes		
	10. Driving down narrow streets		
	11. Seeing HUMWVs or "Hummers" (civ)		
	12. TV/movies with lots of blood		
	13. Watching TV news		
	14. Talking with Jane about deployment		
	15. Convenience stores "middle eastern" clerks		
	16. Eating at a fast food restaurant		
	17. Doors/windows unlocked/open @ home		
	18. Fireworks		
	19. Smell of garbage		
	20.		

Aim for 15-20 items with a broad range of difficulty.

124.

### More Tips for Generating In Vivo Items

- Be **creative**
- List items first, **refine** later
- Take advantage of technology for hard-to-find items



123

Generating useful items requires creativity and collaboration.

125.

### Sample In Vivo Items & Safety Behaviors

**Natural Disaster**

- Weather conditions
- Loud alarms (permitted as vulnerable to)
- Natural calamities
- Alerts associated with emergency

**Sample In Vivo Items - 1**

**Motor Vehicle Accidents (MVA)**

- Hearing road toll
- Hearing horn blower
- Being in a car on a road
- Being in a car at night
- Being in a car with a driver
- Being in a car with a passenger
- Being in a car with a driver and a passenger
- Being in a car with a driver and a passenger and a driver
- Being in a car with a driver and a passenger and a driver and a passenger

**Sample In Vivo Items - 2**

**Sexual Abuse/Sexual Assault**

- Going out on certain times of day or night
- Going out alone
- Being in home alone
- Associated clothing, items, makeup
- Associated smells (alcohol, cologne, body odor)
- Smells, overly small
- Physical characteristics of the

(Handout, pp. 6-8)

Sample In Vivo Items

126.

## Anchoring the SUDS Scale

125

### Anchoring the SUDS Scale

127.

### Subjective Units of Distress (SUDS)

SUDS anchor points:

0 ————— 50 ————— 100

0 Most calm moments  
 50 Distressing but manageable, sometimes avoided  
 100 Most distressed moment - physical symptoms (heart racing, upset stomach) usually present

126

### SUDs

The SUDs scale provides a shared language or metric for understanding the patient's level of \_\_\_\_\_ during treatment.

128.


### SUDS Anchor Points

SUDS anchor points:

0 ————— 50 ————— 100

0 Anchors should be:

1. Personally experienced
2. Specific
3. Not trauma-related
  - a. Not going to change
  - b. Not on hierarchy



127

### Generating SUDs Anchors

When introducing the SUDS, ask the patient for anchors that reflect a distress level of 0, 50, and 100.

Anchors should be \_\_\_\_\_ & \_\_\_\_\_

to make them easier to recall,

and not \_\_\_\_\_ so that they remain static over time.

129.

In Vivo Exposure Hierarchy

Patient ID: John Smith Date: / /

SUDS anchor points:

0 ————— 50 ————— 100

Sitting on my couch    Driving in traffic    Thinking about the day Martinez was killed

	Targeted activities	SUDS (0-100)	SUDs (0-100)
<i>In vivo items can include:</i> • Places • People • Activities • Situations • Sensations (e.g., sights, sounds, smells, tastes, physical sensations)  <i>Be sure to consider both distressing reminders of the traumatic event and items that feel more</i>	1. Going to the PX		
	2. Going to grocery store near home		
	3. Going to the mall on the weekend with Jane		
	4. Going to the mall on the weekend alone		
	5. Going to the mall on a weekday with Jane		
	6. Going to the mall on a weekday alone		
	7. Riding in the passenger seat of a car		
	8. Driving in traffic		
	9. Driving on streets with potholes		
	10. Driving down narrow streets		
	11. Seeing HMMWVs or "Hummers" (civ)		

128

- **Specific**
- **Stable**
- **Not trauma-related (except for the 100 anchor)**



130.

**In Vivo Exposure Hierarchy**

Patient ID: John Smith      Date: \_\_\_/\_\_\_/\_\_\_

SUDs anchor points:

0 ←----- 50 -----→ 100

← Sitting at home alone watching a comedy movie      Getting a traffic ticket      The ambush when Martinez was killed →

Targeted activities	SUDs (0-100)	SUDs (0-100)
1. Going to the PX	60	
2. Going to grocery store near home	75	
3. Going to the mall on the weekend with Jane	80	
4. Going to the mall on the weekend alone	95	
5. Going to the mall on a weekday with Jane	65	
6. Going to the mall on a weekday alone	80	
7. Riding in the passenger seat of a car	65	
8. Driving in traffic	50	
9. Driving on streets with potholes	70	
10. Driving down narrow streets	55	
11. Seeing HMMWVs or "Hummers" (civ)		

*In vivo items can include:*

- Places
- People
- Activities
- Situations
- Sensations (e.g., sights, sounds, smells, tastes, physical sensations)

*Be sure to consider both distressing reminders of the traumatic event -and- items that feel more dangerous than they actually are.*

*Items can also include some pleasant, social or important activities that have decreased in frequency since the trauma.*

- **Rate all items.**  
Get specific SUDs ratings for each item.

133.

Targeted activities	SUDs (0-100)	SUDs (0-100)
1. Going to the mall on the weekend alone	95	
2. Fireworks	85	
3. Going to the mall on the weekend with Jane	80	
4. Going to the mall on a weekday alone	80	
5. Convenience stores "middle-eastern" clerks	80	
6. Going to grocery store near home	75	
7. Doors/windows unlocked/open @ home	75	
8. Driving on streets with potholes	70	
9. Riding in the passenger seat of a car	65	
10. Talking with Jane about deployment	65	
11. Going to the mall on a weekday with Jane	65	
12. TV/movies with lots of blood	60	
13. Going to the PX	60	
14. Eating at a fast food restaurant	60	
15. Driving down narrow streets	55	
16. Smell of garbage	50	
17. Driving in traffic	50	
18. Seeing HMMWVs or "Hummers" (civ)	45	
19. Watching TV news	40	
20.		

*Be sure to consider both distressing reminders of the traumatic event -and- items that feel more dangerous than they actually are.*

*Items can also include some pleasant, social or important activities that have decreased in frequency since the trauma.*

- **Fill in any gaps that are apparent with regard to range or core fear.**  
(Slide depicts hierarchy rearranged in order, but this isn't necessary.)

134.



**PE Coach 2**

135.

**Maximizing In Vivo Success**

The goal is disconfirmation of the **feared consequence** (not elimination of distress)

- Emphasize **remaining & staying present**
- Encourage **distress tolerance**
- Link items to **functioning**
- Look for and eliminate covert **safety behaviors**

- **Maximizing In Vivo Success**  
Specific and detailed instructions will increase the likelihood of success.



140.

PE Homework: Session 2

Patient ID: John Smith Date: \_\_\_\_\_

Check the box as you complete each item. Write any comments, questions, or problems in the space at the bottom of the form.

Read the Handout "Common Reactions to Trauma."

Review the list of avoided situations on your in vivo hierarchy and add any additional situations. \*

Begin in vivo assignments. Use the exposure recording form to fill in SUDS levels before and after the exposure. Remember to stay in the situation long enough for your anxiety to come down. The target situations for this week are:

Smell of garbage \_\_\_\_\_

Driving in traffic \_\_\_\_\_

Watching TV news \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*For 60-minute sessions, homework includes only material covered in session**

Practice calm breathing for 10 minutes, three times a day.  
(Use a recording at first, then begin to practice on your own.)

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(Handout, p. 46)

### PE Homework Session 2

141.

## In Vivo Exposure Demo



(Handout, page 25-26)



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### Video Demonstration of In Vivo Exposure

142.

## Roleplay Session 2b: In Vivo Exposure

5

**10 12 15**

**10. PATIENT INFORMATION**

**11. PATIENT HISTORY**

**12. PATIENT HISTORY**

**13. PATIENT HISTORY**

**14. PATIENT HISTORY**

**15. PATIENT HISTORY**

**16. INITIAL IN VIVO ASSIGNMENTS**

1. Select one to three assignments that will use the moderate SUDS (40-50) target.
2. The therapist and patient will discuss for sampling and the assignment and recording progress on the in vivo recording form.
3. Review the situation for the in vivo exposure or until SUDS decreases by half.
4. Practice recording for two weeks.
5. Record pre-, post-, and post-SUDS levels for homework forms.
6. Do not use safety behaviors or avoidance.

**17. ASSIGNMENT NOTES**

1. Review Common Reactions to Trauma handout.
2. Review the list of avoided situations and safe people, situations, objects, and anything else.
3. Instruct the patient how to complete the in vivo exposure recording form.
4. Listen to recording of session once.
5. Continue to practice record-keeping.

(Handout, pp. 25-26)

### Roleplay Notes:

Using the basic information from the case used for the previous roleplay, be prepared to discuss several examples of cognitive and behavioral avoidance that interfere with your functioning – but wait until you are asked.

Things I avoid: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

143.

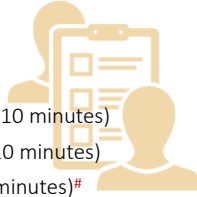
## Session 3: Imaginal Exposure

142

### Session 3: Imaginal Exposure

144.

### Session 3: Agenda



- Review homework/ self reports\* (~ 10 minutes)
- Rationale for imaginal exposure (~ 10 minutes)
- Conduct imaginal exposure (20-40 minutes)#
- Process imaginal exposure (10-20 minutes)#
- Assign homework (~ 5 minutes)
- Session and imaginal exposure are recorded separately for homework review

\*Don't forget to start the recording at the beginning of the session  
 # Time is adjusted for 60- or 90-minute sessions



### Session 3 Agenda

145.

### Rationale for Imaginal Exposure



Because thought suppression doesn't work.

144

*It can be helpful to remind the client of this by asking what happens when they try to stop thinking about the trauma.*

146.

### Metaphor Bank Example: Session 3

#### Prolonged Exposure Therapy (PE) Metaphor Bank

##### SESSION 3

**Cleaning the Closet:** Dr. Jenna Ermold describes parts of the rationale for imaginal exposure using the example of a staple of Saturday morning cartoons—the stuffed closet that bursts open at the wrong times. She describes how imaginal exposure allows for processing and organizing trauma memories by carefully going through details much like going through the items shoved into a closet, and thereby allowing the patient more control over the memory and when they confront it instead of memory details intruding into the person's functioning at the most inopportune times. This example may be useful when discussing the rationale for imaginal exposure in session three, or any time the patient questions how thinking about or talking about their trauma in treatment can be helpful, especially when they consider how much energy they have already expended trying NOT to think about trauma memories.

<https://tinyurl.com/PEMetaphors>

### Metaphor Bank – Cleaning the Closet

147.

### Benefits of Imaginal Exposure

- Emotionally Process/Organize
- Remembering ≠ Experiencing
- Reduce Intense Emotion
- Don't Lose Control or "Go Crazy"
- Personal Competence/Mastery

146

### Benefits of Imaginal Exposure

148.

### Aims of Imaginal Exposure

- Promote **access** to all salient aspects of the memory.
- Foster emotional **engagement** with the memory.
- Develop a **narrative** of the trauma in the patient’s own words.
- Incorporate **corrective information** into the narrative.

147

149.



150.

### Patient Tasks in Imaginal Exposure

- Eyes closed
- Revisit in imagination
- Recount aloud
- First person, present tense
- Include emotional & sensory detail
- Repeat until time is called



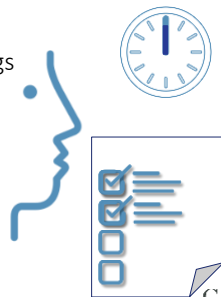
(Handout, p. 11)



151.

### Therapist Tasks in Imaginal Exposure

- Listen quietly
- Request distress ratings
- Offer support as needed
- Monitor engagement
- Prompt as needed
- Manage time



(Handout, p. 12)



### Aims of Imaginal Exposure

**Imaginal exposure offers a more useful alternative to thought suppression One foot in the present, one in the past...**

Somewhere between detachment and dissociation, optimal “engagement” with the memory requires the patient to feel “as if” it is happening yet maintain awareness that they are safe in the present.

**The instructions for imaginal exposure should be clear and concise.**

Instructions are intended to promote “one foot in the past, one foot in the present” optimal engagement. It is sometimes helpful for the therapist to demonstrate how it is done; for example, he or she could close their eyes and describe in the first-person, present tense, a minute or two of their daily routine.

It isn’t typical to talk in this way, so be prepared to prompt the client to increase their engagement.

**The therapist may appear quiet at times during imaginal exposure but is actually quite busy with many tasks.**

- Listening
- Monitoring

Things to monitor:

---



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---

- Prompt only as needed

152. Patient ID: John Smith Date: \_\_\_\_\_ Session # 3

Imaginal Exposure Worksheet

Description: IED exploded and hit pt's vehicle. Pt was thrown out. Many buddies were sev injrd & one SM killed. Then attacked by snipers & realized its a trap. Eventually rescued by QRF. Another SM killed during fire fight, and younger SM injured by the initial IED died before could get evacuated

Full Narrative Hot Spots

Time	SUDs	
0	1015	100
5	1020	100
10	1025	95
15	1030	
20	1035	100
25	1040	90
30	1045	85
35	1050	75
40	1055	55
45	1100	60
50	1105	
55		

Take note of possible avoidance, evidence of distorted thinking and other details that may be useful to monitor or process.

Identify potential hot spots for later discussion.

\*Ask for SUDs before starting imaginal exposure\*

patient looks visibly anxious – is looking around the room and fidgeting as we start

patient opens eyes but is able to shut them with minimal support

\*\*\* Remember to ask the patient about calling himself "an idiot" when he's talking about the fire fight and feeling he should have done more; ask what that means to him now

(Handout, p. 47)

**The imaginal exposure therapist form is used to track SUDs and therapist observations as the client tells the memory.**

The lines indicate separate repetitions of the memory.

153. **Imaginal Exposure Demo**



(Handout, p. 27)



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**Video Demonstration Imaginal Exposure**

154. **Processing Imaginal Exposure**


Session 3 and thereafter

153

**Processing Imaginal Exposure**

155. **What is Processing?**

Informal  
Supportive  
Reflective



154

**Unlike some other forms of CBT, PE processing is intentionally informal.**

Though the addition of more formal techniques did not appear to harm treatment in some early studies, it did prove quite labor intensive for both therapist and patient with no additional gain, leading some to consider it an increased risk for dropout.

156.

### Goals of Processing

- Validate & support
- Explore recurrent themes (e.g., guilt, shame, anger, fear)
- Facilitate empowerment & control
- Promote a more balanced perspective
- Develop more functional beliefs



155

**Goals of Processing**

157.

### Best Practices for Processing

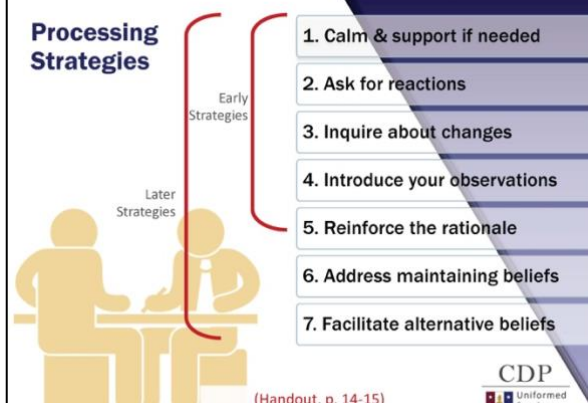
- Leave **adequate time** for processing
- Be **non-directive & reflective**
- Use **open-ended** questions rather than challenges
- Find a **success** in every exposure
- Make the implicit **explicit**
- Evaluate the **usefulness** of cognitions rather than **dysfunction**

156

**Best Practices for Processing**

158.

### Processing Strategies



1. Calm & support if needed
2. Ask for reactions
3. Inquire about changes
4. Introduce your observations
5. Reinforce the rationale
6. Address maintaining beliefs
7. Facilitate alternative beliefs

(Handout, p. 14-15)

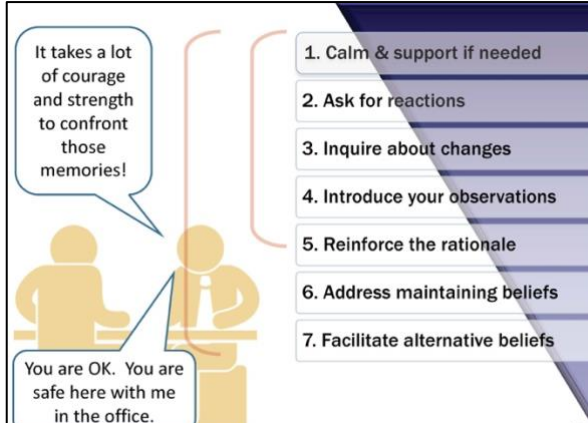
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158

**Processing strategies within and across sessions should move from supportive to questioning, working first with the client's observations and comments before introducing your own.**

Do not lecture the client about how they should be thinking or feeling. It is more powerful for the client to discover their own truths even though you will give guidance from time to time.

159.



1. Calm & support if needed
2. Ask for reactions
3. Inquire about changes
4. Introduce your observations
5. Reinforce the rationale
6. Address maintaining beliefs
7. Facilitate alternative beliefs

It takes a lot of courage and strength to confront those memories!

You are OK. You are safe here with me in the office.

158

160.

Was this different than the last time you told the story?

Does this change how you see things now?

1. Calm & support if needed
2. Ask for reactions
3. Inquire about changes
4. Introduce your observations
5. Reinforce the rationale
6. Address maintaining beliefs
7. Facilitate alternative beliefs

159

161.

All your hard work is paying off. As you habituate, it becomes easier to face the memory.

Even though the memory is sad, it seems like you can think about it without feeling overwhelmed.

1. Calm & support if needed
2. Ask for reactions
3. Inquire about changes
4. Introduce your observations
5. Reinforce the rationale
6. Address maintaining beliefs
7. Facilitate alternative beliefs

160

162.

I noticed your SUDS changed from 100 to 30 the second time through. What do you make of that?

It seemed more difficult to revisit certain parts of the memory.

1. Calm & support if needed
2. Ask for reactions
3. Inquire about changes
4. Introduce your observations
5. Reinforce the rationale
6. Address maintaining beliefs
7. Facilitate alternative beliefs

161

163.

What stood out for you as you recounted the experience?

How did it feel to talk about this memory?

1. Calm & support if needed
2. Ask for reactions
3. Inquire about changes
4. Introduce your observations
5. Reinforce the rationale
6. Address maintaining beliefs
7. Facilitate alternative beliefs

162



164.

What else could you have done in that terrible situation? What am I missing?

If things were reversed, and your buddy was here instead, what would you say to him?

1. Calm & support if needed
2. Ask for reactions
3. Inquire about changes
4. Introduce your observations
5. Reinforce the rationale
6. Address maintaining beliefs
7. Facilitate alternative beliefs

163

165.

Help me understand how it was completely your fault.


You said you shouldn't be so upset about what happened. Can you say more about that?

1. Calm & support if needed
2. Ask for reactions
3. Inquire about changes
4. Introduce your observations
5. Reinforce the rationale
6. Address maintaining beliefs
7. Facilitate alternative beliefs


164

166.

### Imaginal Exposure Processing Demo



(Handout, p. 27)



166

**Video Demonstration - Imaginal Exposure Processing**

167.

### Roleplay Session 3: Imaginal Exposure

PT Session 3 - Overview

1. Welcome to the session
2. Review of the previous session
3. Introduce the concept of imaginal exposure

**II. ESTABLISH THE IMAGINAL EXPOSURE**

1. Trauma is painful and leads to avoidance
2. Avoidance (through repression) works on the short run but not in the long run
3. Symptoms signal that the trauma is "unfaded/unfinished". And the memory is not processed
4. Use an analogy to illustrate the concept (e.g., Bad meat, the cabinet/restaurant)
5. The goal of working the trauma is to:
  - process and organize the traumatic memories
  - learn about the traumatic memories and what happened
  - bring about habituation (i.e., with repetition, events lose power)
  - gain confidence in ability to manage distress
  - patient controls the memories rather than memories controlling the patient

**III. INSTRUCTIONS FOR ENGAGING IN IMAGINAL EXPOSURE**

1. Close eyes
2. Recall the index trauma as vividly as possible, including the events, thoughts, and feelings
3. Describe aloud in the present tense, out of your happening time
4. Give SUDS ratings when asked without pausing or leaving the image
5. When the recording is finished, report as needed, without stopping for 30-40 minutes

**IV. FACILITATE IMAGINAL EXPOSURE**


1. Attempt to support recording from the session recording
2. Offer support/management as needed
3. Prompt patient to focus on thoughts, emotions, and body sensations
4. Track the experience for patient, if necessary
5. Offer SUDS ratings

**V. PROCESSING/DEBRIEFING**

1. Review the session recording
2. Discuss patient's experience
3. Address any questions
4. Provide support/management as needed
5. Offer SUDS ratings
6. Review the session recording
7. Offer SUDS ratings

(Handout page 27)

5



167

**Roleplay Notes:**

In addition to previously described information, be prepared to describe some details of your traumatic event for the first imaginal exposure. Keep in mind unhelpful cognitions that might color your narrative when telling it for the first time.

Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

168.

## Imaginal Exposure Recording Form

Imaginal Exposure Homework Recording Form

Patient ID: John Smith      Session #: 3      Date: \_\_\_\_\_

**Instructions:** Listen to your recording of imaginal exposure. Record your SUDS ratings before beginning the exercise. After the exercise is complete, note your Peak SUDs rating during the exercise and your Final SUDs.

SUDs = 0 to 100, 0 = no discomfort and 100 = maximal discomfort, anxiety, and panic)

Date & Time	Beginning SUDs	Peak SUDs	Final SUDs
Mon 1630	100	100	80
Tues 1800	85	90	70
Wed 1730	55	65	40
Note within vs. between session changes			

(Handout, p. 48)

***Imaginal Exposure Homework Recording Form***

169.

PE Homework: Session 3

Patient ID: John Smith      Date: \_\_\_\_\_

Check the box as you complete each item. Write any comments, questions, or problems in the space at the bottom of the form.

Listen to the recording of the imaginal exposure once a day. Use the IMAGINAL EXPOSURE RECORDING FORM to rate your SUDS.

Continue in vivo assignments. Use the exposure recording form to fill in SUDS levels before and after the exposure. Remember to stay in the situation long enough for your anxiety to come down. The target situations for this week are:

Eating at a fast food restaurant

Going to the mall on weekday with Jane

Riding in the passenger seat of a car

\_\_\_\_\_

\_\_\_\_\_

(Handout, p. 49)

Practice calm breathing for 10 minutes, three times a day.  
(Use a recording at first, then begin to practice on your own.)

Day 1   Day 2   Day 3   Day 4   Day 5   Day 6   Day 7

***Homework includes listening to the recording of imaginal exposure for the first time, as well as continuing in vivo exposure.***

170.

## Sessions 4-5: Shaping Engagement

169

***In the next couple of sessions, the patient begins to engage with the memory. Some will do so with little guidance, but others will need prompts or suggestions to help them engage more productively.***

171.

## Session 1: Overview & Rationale

70

***This agenda, similar to session 3 but without the rationale (unless needed) will structure most of the sessions until the end of treatment.***

172.

### Standard Protocol

- Eyes closed
- First person, present tense
- Include emotional, sensory detail
- Short, supportive phrases
- Short, open-ended prompts
- SUDS every 5 minutes

171

***When engagement is not optimal, the first thing to do is make sure standard protocol is being followed.***

173.

### Over-Engagement

Overwhelmed	Dissociative
<ul style="list-style-type: none"> <li>• High SUDS</li> <li>• Sobbing, crying</li> <li>• Regressive or immature</li> </ul>	<ul style="list-style-type: none"> <li>• High SUDS</li> <li>• Flashbacks, body memories</li> <li>• Physical engagement</li> <li>• Less responsive</li> </ul>

(Handout, p. 17)

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***Recognizing Over-engagement***

174.

### Over-Engagement Strategies

- Reverse the standard procedures
- Revisit the rationale, emphasizing discrimination
- Increase support
- Decrease probes
- Move the memory forward
- Start with a smaller part of the memory
- Use a grounding object or procedure
- Slow breathing
- Writing the narrative

173

***Strategies are designed to reduce engagement before it becomes problematic.***

The first over-engagement strategy is to reverse standard protocol procedures to decrease engagement. For example:

- Eyes \_\_\_\_\_
- Tense can be \_\_\_\_\_
- \_\_\_\_\_ emotional & sensory detail

175.

### Under-Engagement

Numb	Avoidant
<ul style="list-style-type: none"> <li>• Detached, numb, or disconnected</li> <li>• Low SUDS</li> <li>• High SUDS inconsistent with behavior</li> <li>• Stilted or distant language</li> </ul>	<ul style="list-style-type: none"> <li>• Fearful, anxious</li> <li>• High SUDS</li> <li>• May rush through</li> <li>• May pull back when emotion becomes painful</li> </ul>

(Handout, p. 16)

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***Recognizing Under-engagement***

176.

**Under-Engagement Strategies**

- Slow down the narrative
- Revisit the rationale
- Increase probes
- Explore feared consequences
- Identify/Address safety behaviors
- Repetition
- Direct instruction/demonstration

175

**Strategies aim to increase confidence in the rationale and decrease avoidance.**

177.

**Which is more common?** ?

Over-engagement  
or  
Under-engagement?

176

**What do you expect?**

178.

**Other Challenges to Engagement**

Anger	Distractions
<ul style="list-style-type: none"> <li>• Difficulty accessing emotion other than anger</li> <li>• May express anger indiscriminately</li> <li>• Responds angrily to probes or questions</li> </ul>	<ul style="list-style-type: none"> <li>• Crises arise but no imminent risk</li> <li>• Focus may change week to week</li> <li>• Life circumstances interfere with homework</li> </ul>

177

**Other Challenges to Engagement**

Anger can reduce engagement with emotions like anxiety, guilt, or shame.

Distractions can also take time away from treatment in a way that is frustrating and unproductive for both patient and therapist.

179.

**Anger**

- Validate/normalize the emotion
- Evaluate the function/utility of anger
- Revisit rationale/goals

Strategies:

- Set anger aside “temporarily”
- Address physical tension as a safety behavior
- If helpful, rate anger and distress separately

178

**Working with anger**

- Utility of anger
  - Empowers, protects, energizes
  - Can hinder, keep the patient stuck
  - Can keep person from accessing fear, vulnerability

For patients afraid of harming others in anger:

- Assess realistic risk, remote and recent behavior; if yes, needs anger management
- If no, discuss instances when the patient was angry but controlled his behavior
- Encourage exposure to feelings of anger as exercise to promote disconfirmation of feared outcome, increase in competency belief.



184.

**Session ~6: Hotspots**

183

**Session ~6: Hotspots**

185.

**Session ~6: Introducing Hotspots**

- Review homework/self reports\* (~10 minutes)
- Review rationale for hotspots (~5 minutes)
- Identify and rank hotspots (~10 minutes)
- Conduct imaginal exposure, focusing on most distressing hotspot (30-40 minutes)
- Process imaginal exposure (10-20 minutes)
- Assign homework (10 minutes)

\*Don't forget to start the recording at the beginning of the session

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**Agenda for Hotspot Introduction**

186.

**Rationale for Hotspots Exposure**

185

**Hotspots are sections of the narrative memory that remain distressing even as distress in most other sections begins to dissipate.**

187.

**Metaphor Bank Example Hotspot**

**Prolonged Exposure Therapy (PE) Metaphor Bank**

---

**SESSION 6/HOT SPOTS**

**Learning to Play a Song:** The procedures and rationale for focusing on "hotspots" is described using the example of learning to play a song on a musical instrument, beginning first on developing general skill on the entire song, then focusing on specific parts of the song that still give the musician trouble. This example can be effective with clients with a music background, connecting with a process with which they are already familiar. It may be best suited for the first hotspots session (around session 6) while discussing the rationale and procedures for hotspots, or anytime when revisiting the rationale for hotspots may be required.

<https://tinyurl.com/PEMetaphors>

**Metaphor Bank – Learning to Play a Song**

188.

### Identifying Hotspots

Hotspots for John Smith

- 2 Seeing the dead dog on the street where the IED was hidden
- 1 Seeing Martinez severely injured
- 3 The firefight following the IED explosion

187

**John's Hotspots**

189.

### Exposure to Hotspots

- Start with **"worst"** hotspot  
Specify beginning & end of hotspot (**bookends**)
- **Repeat** hotspot narrative to fill allotted time
- Only **one** hotspot per session
- Same **instructions** for imaginal exposure

188

**Hotspot exposure proceeds as with imaginal exposure, doing one 3- 5-minute hotspot repeatedly in the session.**

190.

### Therapist's Tasks for Hotspots

- Encourage pt to **recount details**
- Encourage focus on **feelings, thoughts, sensations**
- Collect **SUDS** ratings ~5 minutes
- **Record** audio separately
- **Move on** to next hotspot once patient habituates (next session)

189

**Therapist tasks are similar to regular imaginal exposure.**

You may want to collect SUDS more frequently since the hotspot is likely quite short compared to the narrative.

When is it time to move to the next hot spot?

---



---

191.

### Processing Hotspots

Is this consistent with your belief...?

Is that "always" true...?

How does this change the way you see...?

...How many shades of gray...?

**After your patient does imaginal exposure with a hotspot, you will continue to process the exposure in session just as you did in previous sessions with the full narrative.**

192.

PE Homework: Session 6

Patient ID: John Smith Date: \_\_\_\_\_

Check the box as you complete each item. Write any comments, questions, or problems in the space at the bottom of the form.

Listen to the recording of the imaginal exposure once a day. Use the IMAGINAL EXPOSURE RECORDING FORM to rate your SUDS.

Continue in vivo assignments. Use the exposure recording form to fill in SUDS levels before and after the exposure. Remember to stay in the situation long enough for your anxiety to come down. The target situations for this week are:

Going to the mall on a weekday alone

Riding in the passenger seat of a car

Talking with Jane about deployment

\_\_\_\_\_

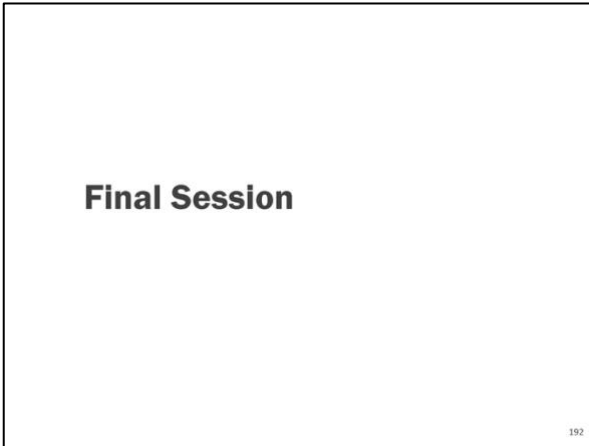
\_\_\_\_\_

(Handout, p. 49)

Practice calm breathing for 10 minutes, three times a day. (Use a recording at first, then begin to practice on your own.)

**PE Homework Session 6 and after**


193.



**Final Session**


194.

**When is PE "Done"?** ?



**Convergence of data:**


1. Self-report **assessments**
2. Significant decrease in **SUDS**
3. Therapist **observations**
4. Patient **functioning**
5. Collaborative decision



**Ideally, PE is considered done when data converge to indicate patient has received maximum benefit.**

195.

**PE Final Session**



- Review homework/self reports
- Imaginal exposure on entire trauma
- Process imaginal exposure and discuss how perception of the trauma has changed
- Obtain current SUDS for in vivo hierarchy and discuss how they differ from the original SUDS
- Evaluate usefulness of procedures and what the patient has learned in treatment
- Assign "homework"
  - Continue to apply everything you learned!

194

**Final session returns to earlier parts of the treatment and reviews progress.**

As part of this review, the imaginal exposure discontinues hotspots and returns to the \_\_\_\_\_.



196. **Final Session: Completing Treatment**

**My Discharge Summary:**

- Goals met
- Skills & accomplishments achieved
- Cognitive changes
- Relapse prevention strategies
- Future treatment goals (if any)
- Discharge plan

195

*The final session is an opportunity to consolidate learning one last time before the patient discontinues treatment.*

197. **John's Progress**

Report for: John Smith

**Psychometric Summary**

Scale	PCL-5	PHQ-9	GAFS
PCL-5	52	17	49

**Weekly Self Report Scores**

Week	PCL-5	PHQ-9
2	52	17
4	54	17
6	44	13
8	36	9
10	22	6
12	17	9

196

*John's final psychometrics*

198. **John's final in vivo ratings**

Sitting at home alone watching a comedy movie

Getting a traffic ticket

The ambush when Martinez was killed

**Targeted activities**

Item	SUDs (before)	SUDs (now)
1. Going to the mall on the weekend alone	95	15
2. Fireworks	85	0
3. Going to the mall on the weekend with Jane	80	0
4. Going to the mall on a weekday alone	80	5
5. Convenience stores "middle-eastern" clerks	80	0
6. Going to grocery store near home	75	0
7. Doors/windows unlocked/open @ home	75	0
8. Driving on streets with potholes	70	10
9. Riding in the passenger seat of a car	65	0
10. Talking with Jane about deployment	65	0
11. Going to the mall on a weekday with Jane	65	0
12. TV/movies with lots of blood	60	5
13. Going to the PX	60	0
14. Eating at a fast food restaurant	60	0
15. Driving down narrow streets	55	0
16. Smell of garbage	50	0
17. Driving in traffic	50	0
18. Seeing HMMWVs or "Hummers" (civ)	45	0
19. Watching TV news	40	0

199

*John's final in vivo ratings*

199. **Final Session Demo**

(Handout, p. 30)

CDP  
Uniformed Services University 199

*Video Demonstration – Final Session*

200.

### Relapse Prevention

- Continue to approach vs. avoid
- Continue to apply everything learned in treatment
- Anticipate future challenges
  - Anniversaries
  - Stressful events or circumstances
- “Setbacks” ≠ starting over

199

*Topics to consider for relapse prevention:*

201.

### Patients Who Aren't “Done”

- More sessions?
  - Extra PE session
  - Focus on other/comorbid problems
- Consider another PTSD EBP
- Refer back to referral source
- Refer to specialty care
- **Continuity of care**

200

*Many patients will not need to consider these issues, but some will require attention to continuity of care.*

202.





### Extending the Reach of PE

Modifications and Extensions

201

203.

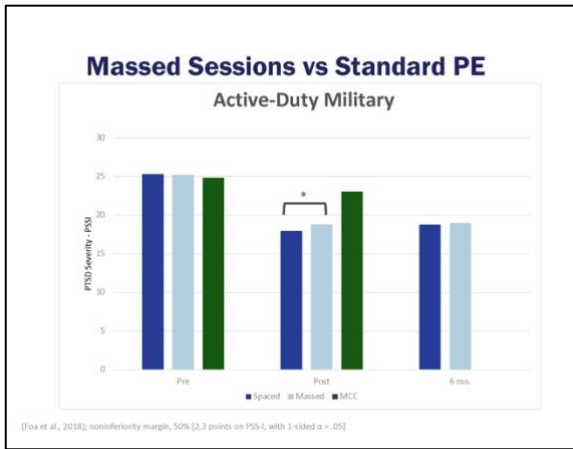
### Accessibility

-  Massed Sessions/IOP
-  Shorter Sessions
-  Primary Care Protocol
-  Telehealth

202

*Several researchers have conducted RCTs and other studies applying PE in a modified format, making it more accessible to patients.*

204.



**Massed PE is noninferior to spaced PE.**

Same study discussed in evidence base section but repeated here to highlight findings regarding spacing of sessions.

**Participants** – Active-Duty Service Members with PTSD

**Treatments** – Standard PE (PE-S) (109)

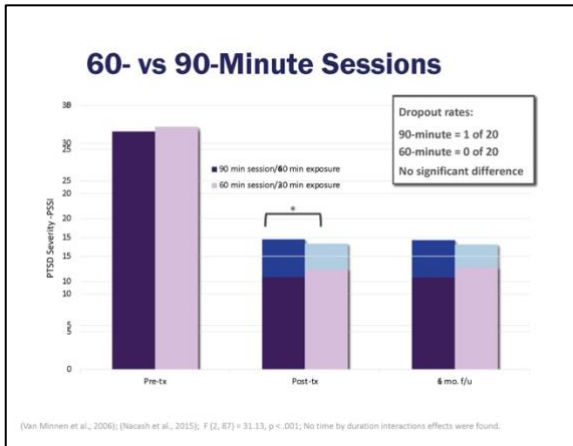
Present Centered Therapy (PCT) x10 sns/8 wks (107)

Massed Sessions (PE-M) x 10 sns/2 wks (110)

Minimal Contact Control (MCC) x 2 wks (40)

- Dropout was low for all groups.

205.



**Shorter PE sessions are as effective as longer sessions.**

Quasi-experimental design (not randomly assigned)

First cohort (N=60)/60-minute imaginal exposure

Second cohort (N=32)/30-minute imaginal exposure

- Both groups improved significantly from pre- to post-treatment
- No significant differences in improvement between treatment groups on:
  - PTSD symptoms (PSSI),
  - depression (SCL-90 depression),
  - anxiety (STAI) or
  - end state functioning (composite)
- **Dropout rates:**
- 90-minute = 23.3%
- 60-minute = 15.6%
- No significant difference
- 

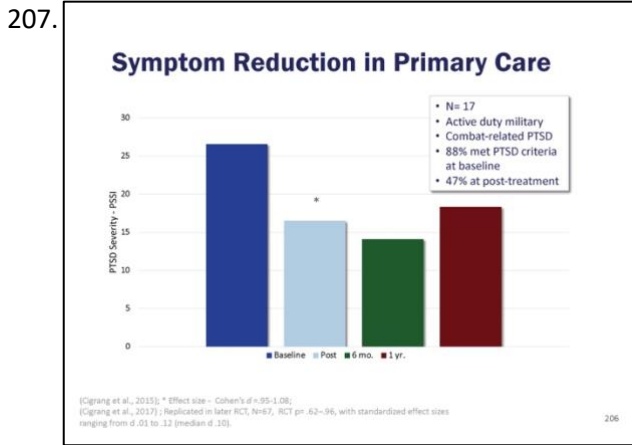
206.

**Primary Care Protocol (PE-PC)**

- 4-5 30-minute sessions
- *Confronting Uncomfortable Memories Workbook*
  - Narrative account with reactions
  - Write & read, 30 minutes 3x/week
- In-session read and process

(Cigrang et al., 2015, 2017)

**Primary Care Protocol**

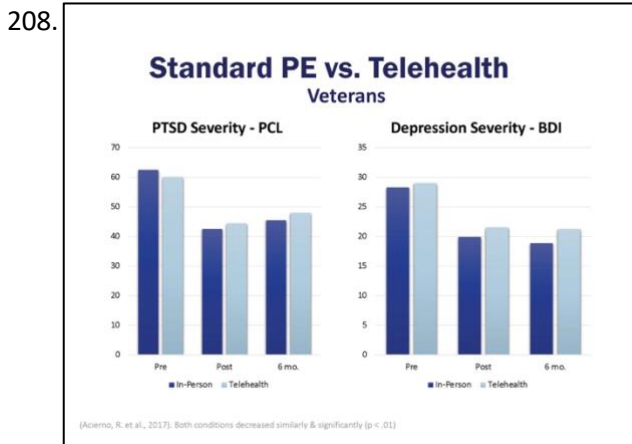


**Abbreviated PE reduces symptoms in primary care.**

N= 17 Active-Duty military / combat-related PTSD

88% met PTSD criteria at baseline 47% at f/u

Decreases pre- to post and f/u were significant ( $p < .0001$ ), and maintained over time.



**Telehealth noninferior to face-to-face treatment.**

Same study discussed in evidence base section but repeated here to highlight findings regarding telehealth.

Participants - Veteran sample, All eras since Vietnam, N=53

Age 20-75

98% male

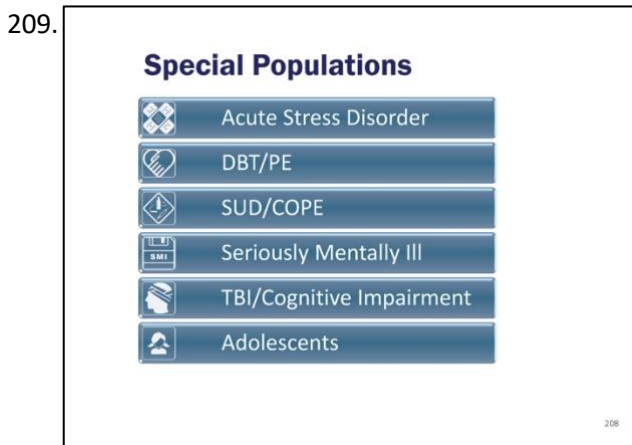
42% comorbid depression

15% co morbid panic dx

Treatments – Standard, office-based, face-to-face PE  
PE via telehealth in the patient's home

Telehealth and standard PE are \_\_\_\_\_ effective.

Both groups were highly satisfied with tx.



**Several researchers have conducted RCTs and other studies applying PE to more complicated patient groups, enabling more people to benefit from treatment.**

210.

### Preventing PTSD: Treatment for ASD

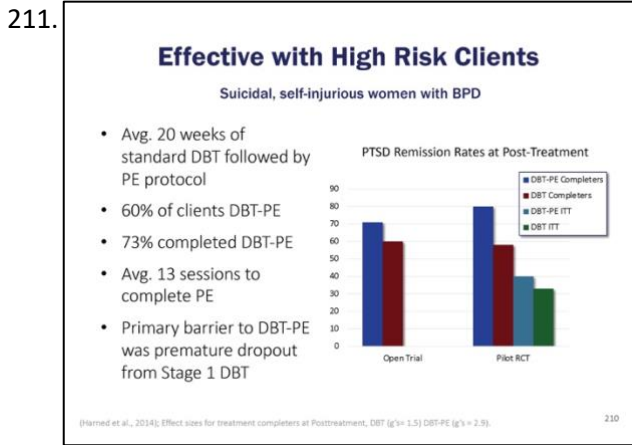
Study	PE	PE/SIT	CR	SC	WL	Sample
Bryant et al., 1998	8%			83%		MVA/ industrial accident

Study	PE	CR	WL	Sample
Bryant, et al., 2008	33%	63%	77%	MVA/ non-sexual assault

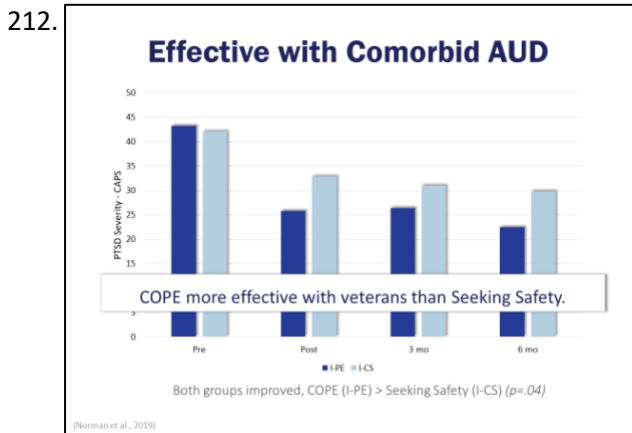
209

**Early treatment may prevent the development of PTSD**

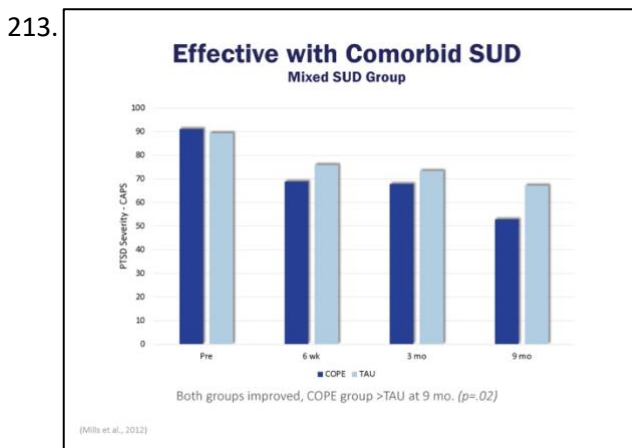


**DBT-PE safe and effective in reducing PTSD symptoms for high-risk patients.**

Results from open trial (N=13) and pilot RCT (N=26)



**Integrated PE (COPE) is more effective than Seeking Safety**



**PE safe and effective for patients with substance dependence, more effective than TAU.**

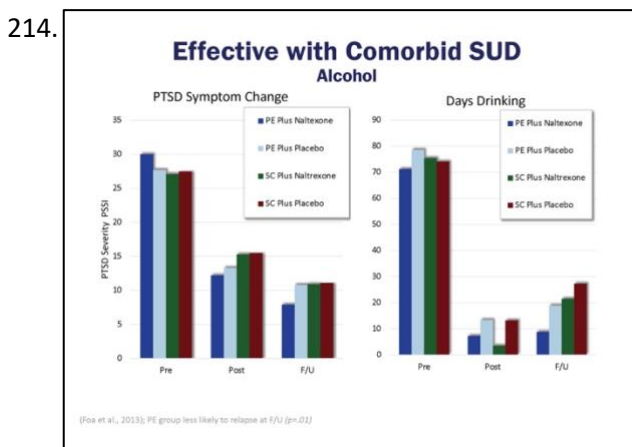
Women, mixed trauma history, with PTSD and substance dependence

55 received PE-COPE protocol

48 received treatment as usual (TAU)

Both groups improved at 9-mo f/u, but PE group showed greater improvement in PTSD symptoms

Substance dependence severity improved equally in both groups



**PE safe and effective for patients with substance dependence; PE group less likely to relapse.**

Mixed gender, mixed trauma, alcohol dependent with PTSD

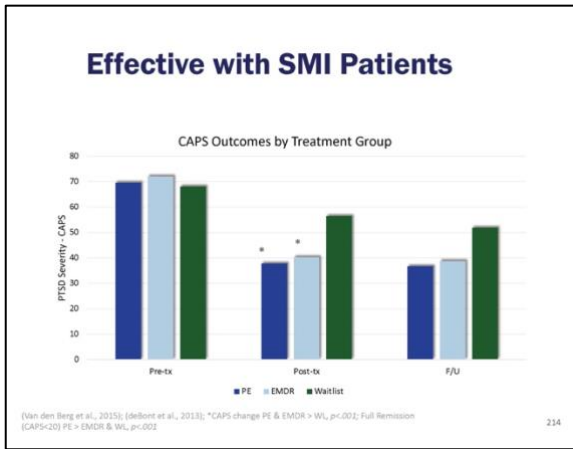
PE/naltrexone (n=40)

PE/placebo (n=40)

SC/naltrexone (n=42)

SC/placebo (n=43)

215.



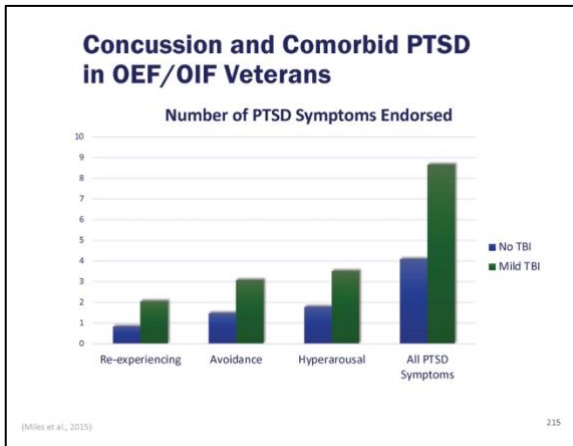
**PE safe and effective for SMI patients.**

PE (n=53)  
EMDR (n=55)  
WL (n=47)

Standard protocols, no additional stabilizing interventions;  
TAU for psychosis included medication and/or supportive counseling

8 early completers in PE  
2 early completers in EMDR  
No statistically significant changes in other kinds of treatment or medication

216.



217.

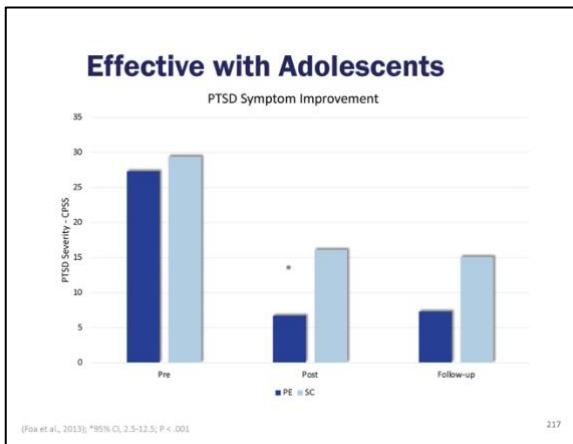
### PTSD & TBI-Related Cognitive Impairment

- Significant overlap of symptoms
- Patients with both problems have more severe PTSD symptoms.
- Treatment should focus on symptoms for best results.
- Studies of veterans with & without TBI show no difference in PE effectiveness.

(Sripada et al., 2013)

***PE is safe and effective for patients with TBI.***

218.



***PE is safe and effective for adolescents.***

Adolescent girls with sexual abuse and assault-related PTSD

PE-A (n=31)  
SC (n=30)

Both groups improved significantly; PE-A more effective than SC ( $p < .001$ )

### Next Steps...

- Resources
- Practice Opportunities
- Continued Learning & Consultation

### Resources and Links

- handout
- Zoom room/phone for consultation group, Thursdays, 1pm Eastern time
- PE Coach 2 (QR codes)
- Video demos
- Metaphor Bank
- Session Notes
- Online learning opportunities
- SL PTSD Learning Center
- Operation AVATAR
- YouTube videos re: SL stuff
- NC-PTSD Assessment webpage
- Blog list
- Relevant links

Handout, pp. 58-60



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### deploymentpsych.org

- Descriptions and schedules of upcoming training events
- Blog updated daily with a range of relevant content
- Articles by subject matter experts related to deployment psychology, including PTSD, suicide prevention, depression, and insomnia
- Other resources and information for behavioral health providers
- Links to CDP's Facebook page and Twitter feed



### Other Learning Opportunities

- CDP Presents - Monthly Webinar Series
  - Live and archived
  - CEs free for live, small fee for on-demand CEs
  - View archived webinars free for no CEs
- On-demand Courses
  - Military Culture
  - Deployment Cycle
  - Intro to PE and CPT
  - ...and more!



### Provider Support

CDP's "Provider Portal" is exclusively for individuals trained by CDP in evidence-based psychotherapies (e.g., CPT, PE, and CBT-I)

- Consultation resources
- Printable fact sheets, manuals, handouts, and other materials
- FAQs and 1:1 interaction with answers from SMEs
- Videos, webinars, and other multimedia training aids



Participants in CDP's evidence-based training will automatically receive an email instructing them how to activate their username and access the "Provider Portal" section at Deploymentpsych.org.

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