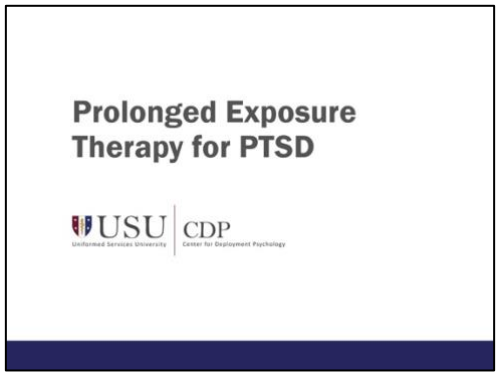
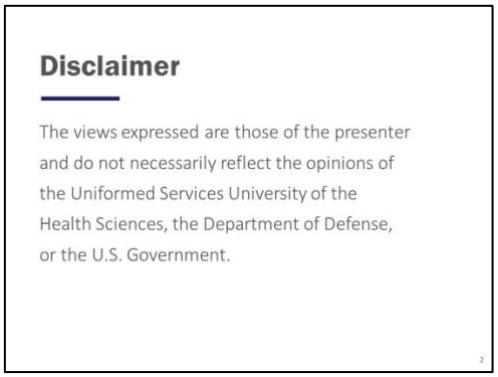
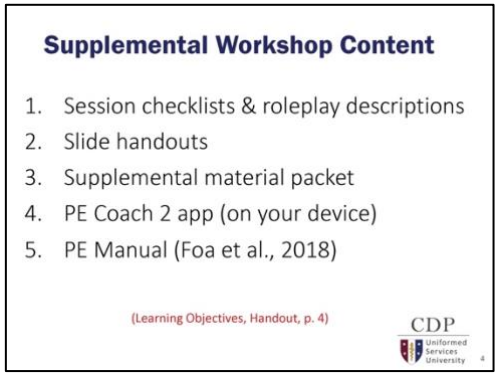
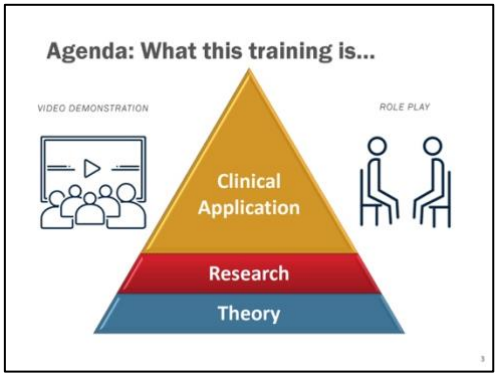
PROLONGED EXPOSURE THERAPY FOR PTSD:
Slide Set and Notes









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.

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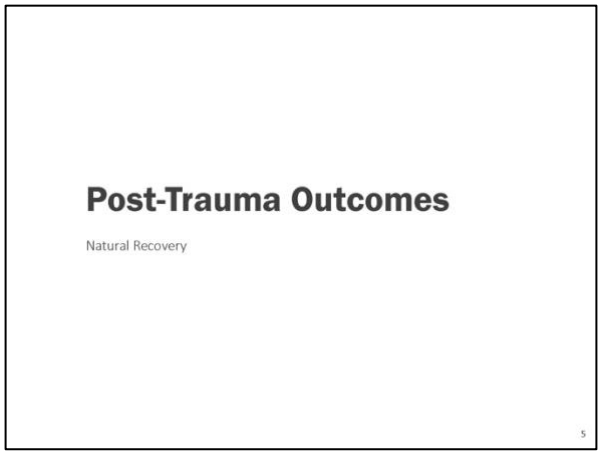

Symptoms are common in the aftermath of a trauma. This is not PTSD but a normal response to trauma.

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

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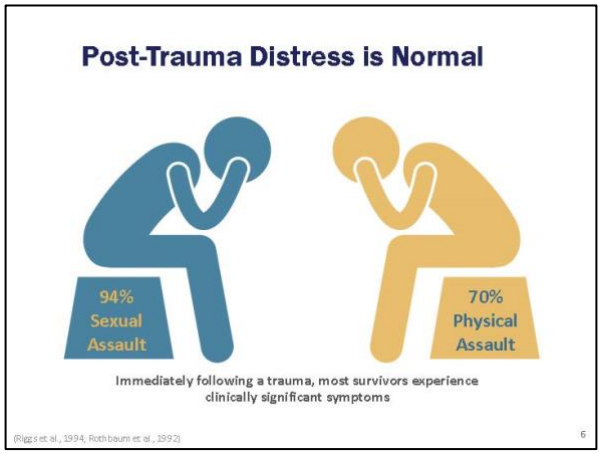

Example: Just after sexual or physical assault is reported, study respondents were highly distressed, and most appeared to meet criteria for PTSD.

- 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.

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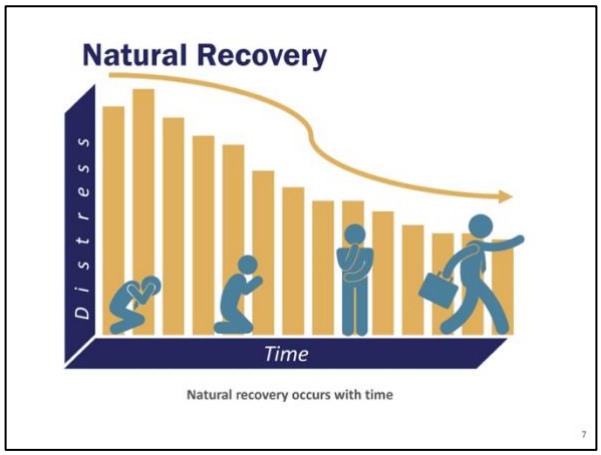

Natural recovery occurs with time.

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.

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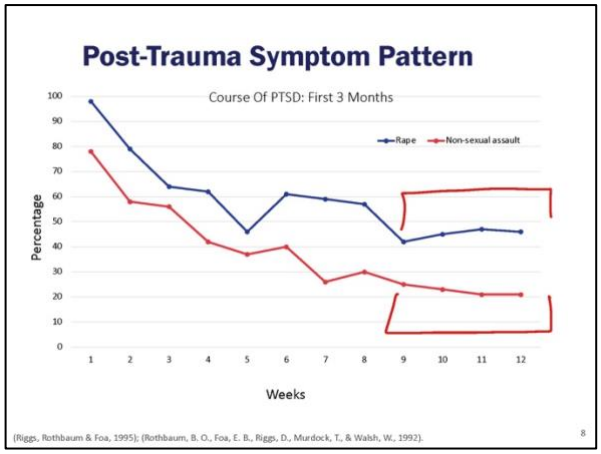

Real life example: PTSD symptoms after rape & nonsexual assault.

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

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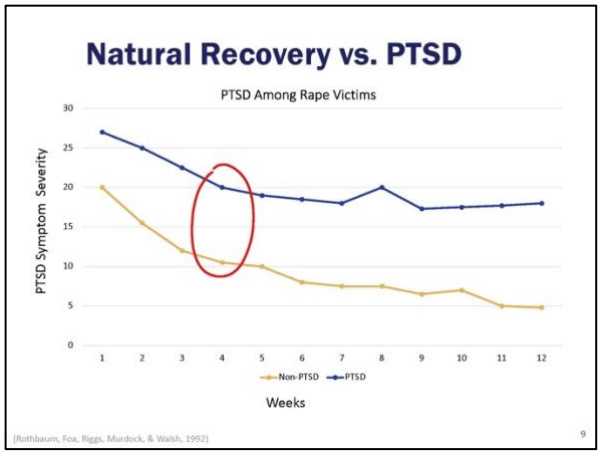

More severe intrusion symptoms may be more predictive of chronic PTSD.

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.

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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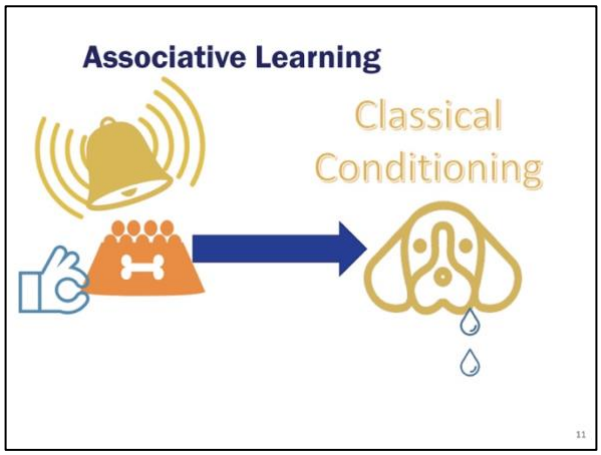

Associative Learning

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

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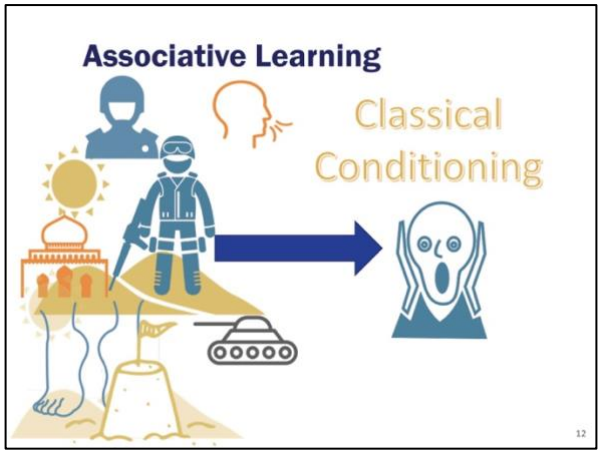

Classical Conditioning

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.

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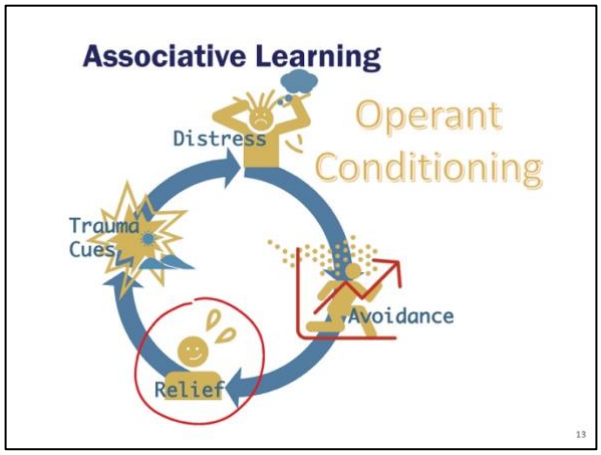

Operant Conditioning

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.

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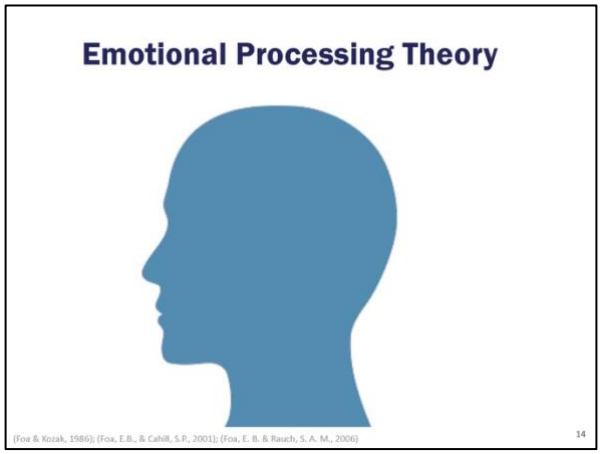

Cognitive-behavioral theories help us understand the complex relationship between thoughts, behaviors, and emotions. For PE, this is best described by Emotional Processing Theory.

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

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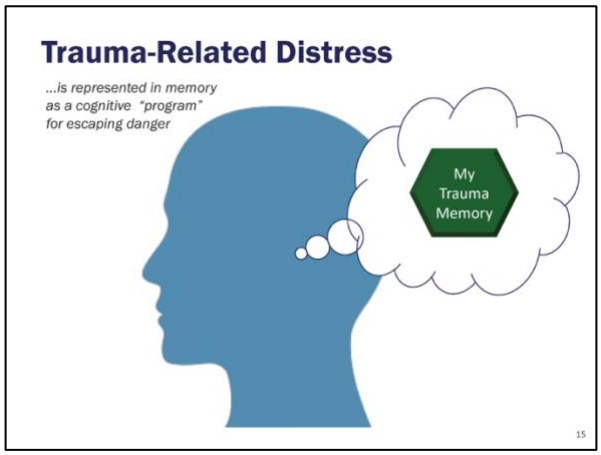

Emotional processing theory conceptualizes PTSD as the result of a pathological fear structure (or emotion structure) that emerges after a trauma.

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

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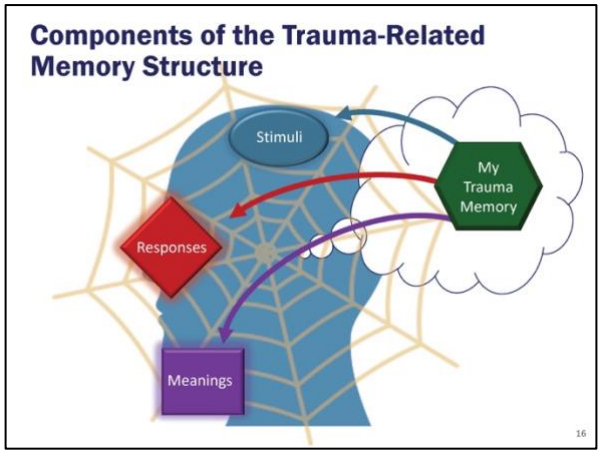

The memory structure includes trauma-related information/memories about:

- 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.

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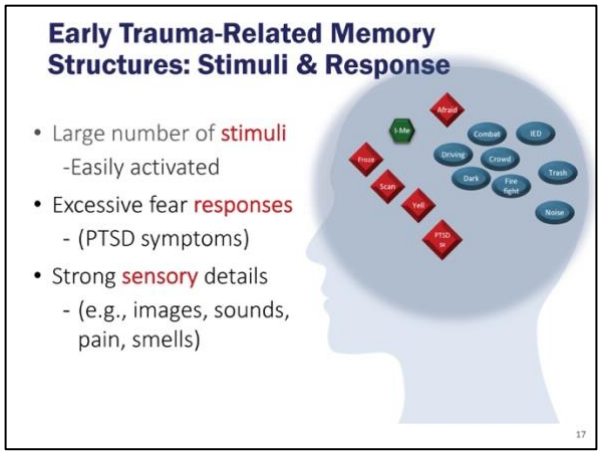

Memory structures are not like narrative memory. They are more like snapshots or momentary images.

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

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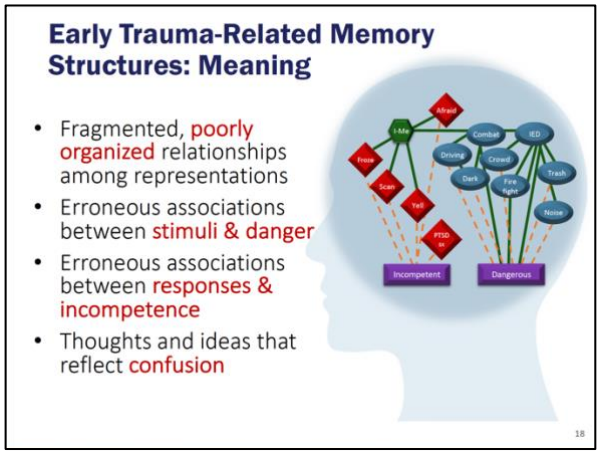

***In the immediate aftermath of the trauma, the memory is poorly organized and confusing. The person associates many things with danger*.**

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.

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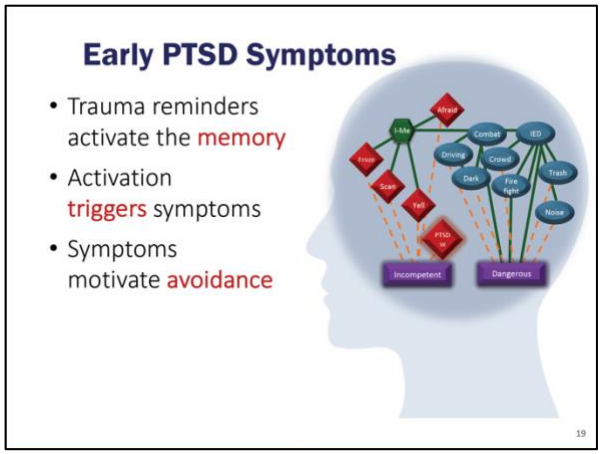

As a person attempts to return to daily life, they encounter trauma reminders that activate the trauma memory and associated perception of "danger" and "self-incompetence".

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

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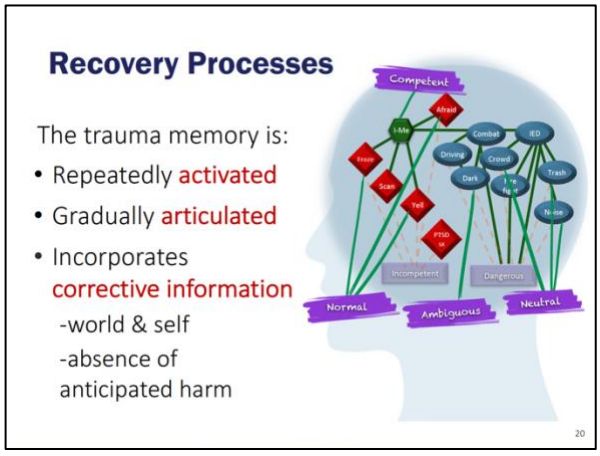

Repeated activation of the trauma memory, in the absence of the expected harm, results in extinction of the distress response.

- 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.

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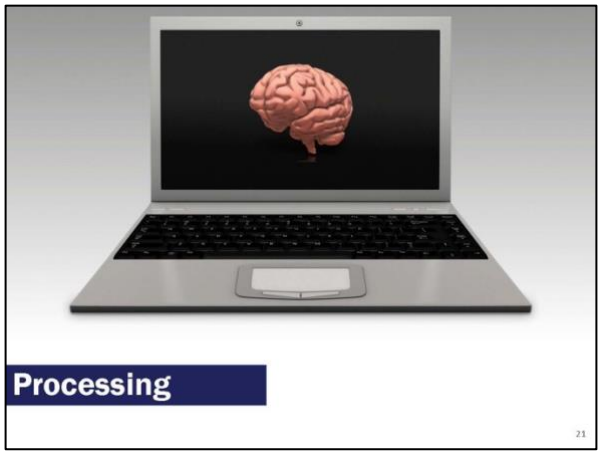

A practical metaphor describing how exposure helps process the traumatic memory.

The trauma memory is like a file in a computer. When the trauma happens, information is saved in a file (memory), but that information is not necessarily complete or accurate. This file needs to be edited.

To edit the file, one must first OPEN the file, review it, and then make appropriate changes (imaginal exposure and processing). If the file is never opened, the memory will remain incomplete, inaccurate, and unhelpful.

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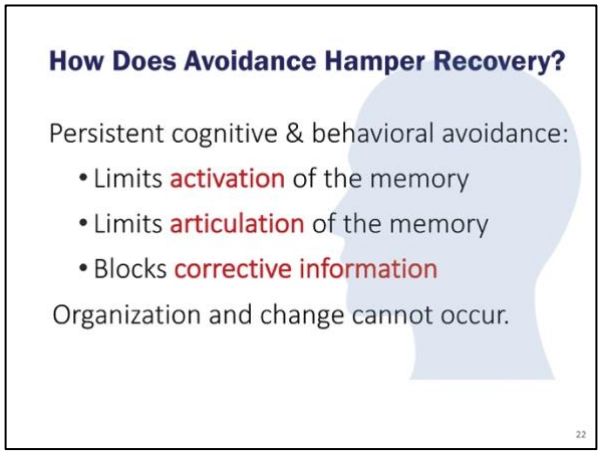

The root of the problem:

- If the urge to avoid is stronger other responses, there is persistent cognitive and behavioral avoidance.
- The person is prevented from activating/engaging with the memory or experiences that trigger the memory.
- The person is unable to sort out, organize, and articulate the memory, so it remains confusing and scary.
- Contact with corrective information is also limited.
- Recovery is derailed.

Normal, transient, post-trauma reactions become chronic symptoms of PTSD**.**

Treatment must reduce _____ to get recovery back on track.

23.

The second factor derailing natural recovery:

- Unhelpful cognitions that support and perpetuate avoidance, promote trauma-related distress.
- The cycle of avoidance and unhelpful cognitions is self-maintaining once it gets started.
- Negatively impacts the person's ability to engage in productive or enjoyable activities/relationships.

People with PTSD have more negative thoughts about themselves and the world when compared to others.

The two main cognitions that interfere with recovery are:

1). _____

2). _____

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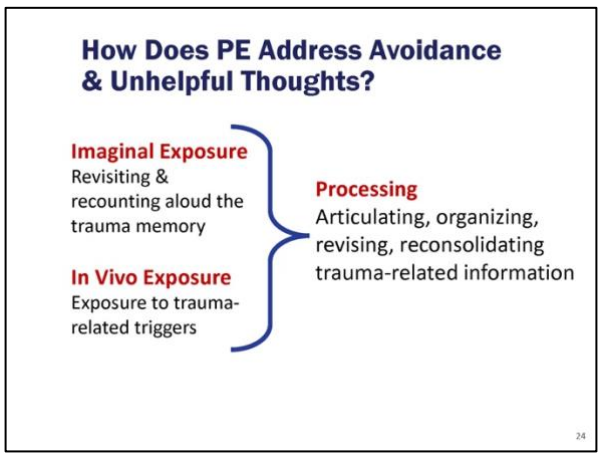

PE addresses avoidance & unhelpful cognitions through Exposure

Exposure – Prolonged, repeated confrontation with relatively safe trauma-related internal or external triggers.

_____**Exposure** includes activities, situations, places, objects, or other cues that provoke the trauma memory.

_____**Exposure** is the narrative account of the trauma.

_____an informal, post-narrative conversation reviewing and incorporating new learning discovered during exposure.

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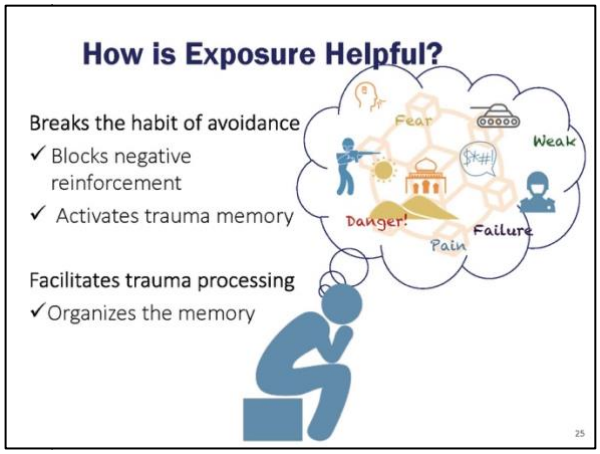

Exposure promotes trauma processing through several helpful mechanisms.

- 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.

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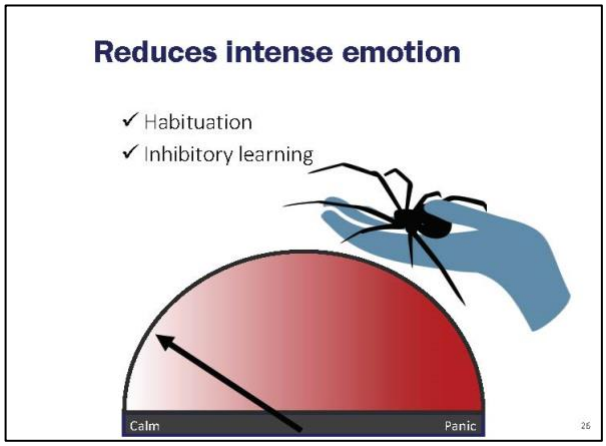

Intense negative emotions associated with the event are reduced as the trauma is processed.
Habituation - Reduction of conditioned responses associated with trauma-related cues (e.g., physiological arousal & excessive fear, anxiety, guilt, & shame).

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.

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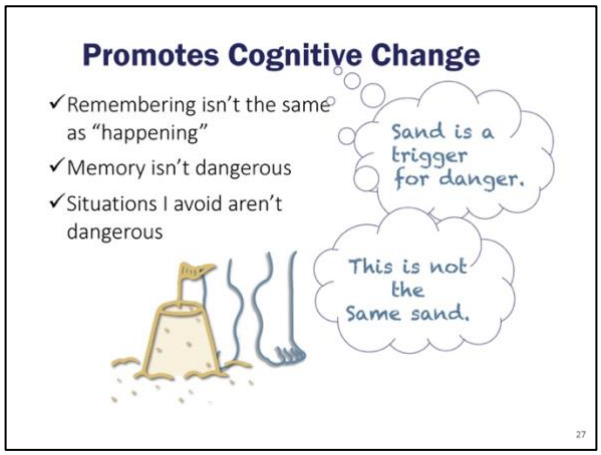

Exposure facilitates cognitive change.

- **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.

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.

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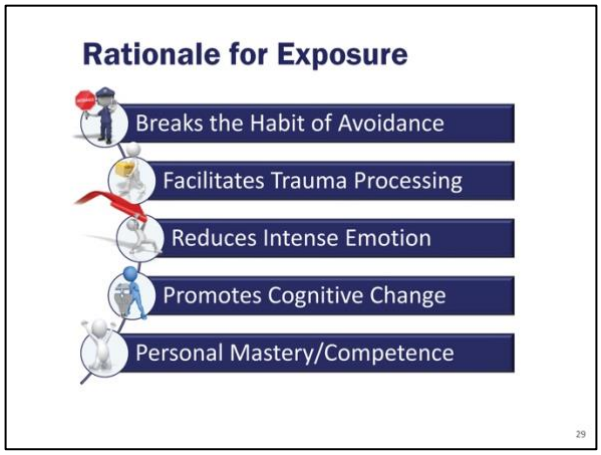

Summary of the Rationale for Treatment.

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.

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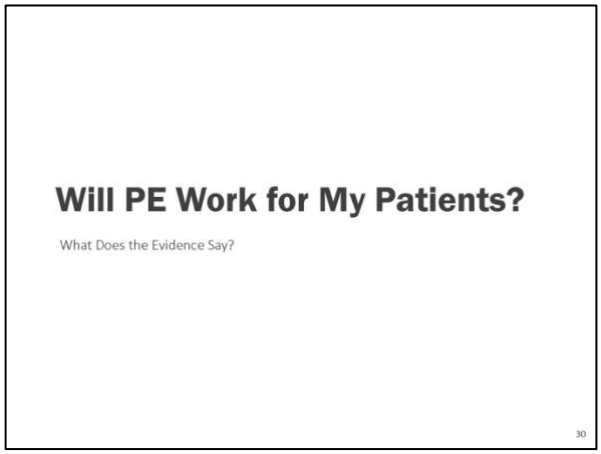

PE is grounded in cognitive and behavioral theory, but it is also evidence-based. PE has been studied for decades.

- 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.

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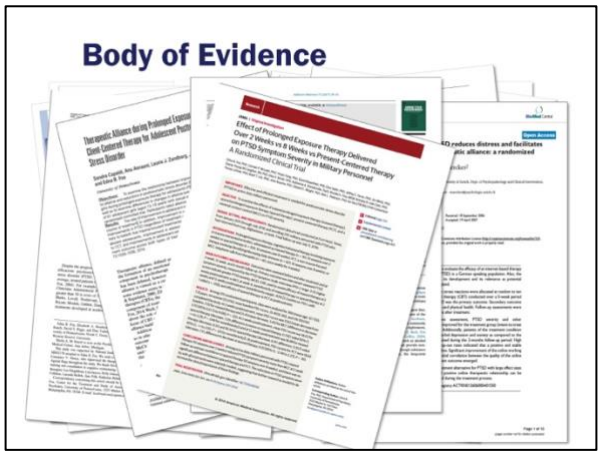

Evidence for PE is solid and impressive.

- 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

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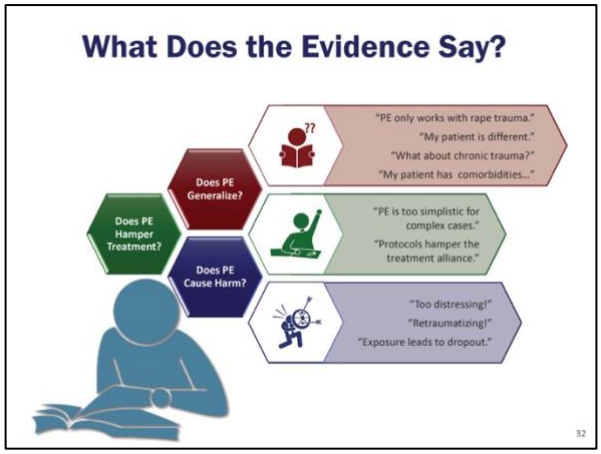

The evidence base for PE is significant and has already addressed many common concerns.

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

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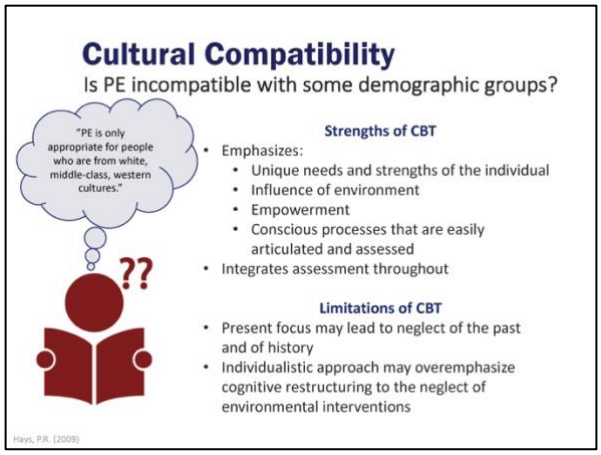

PE is compatible with the cultural practices and beliefs of many different demographic groups and can be individualized to meet a variety of cultural concerns.

PE therapists should be careful assess the unique context, culture and history of every client and approach treatment planning with a collaborative spirit.

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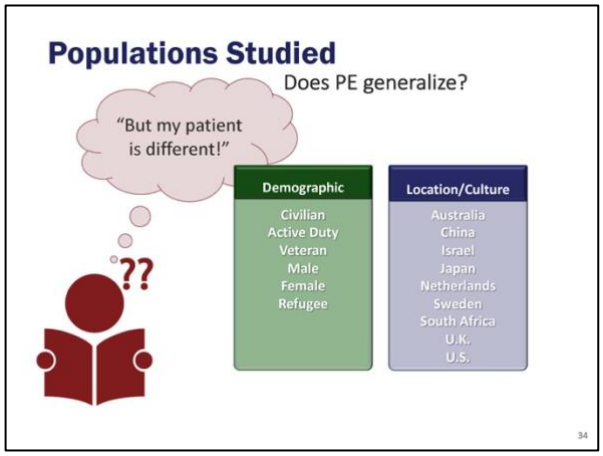

PE has been studied in a wide variety of populations covering most major demographic variables in Western culture and quite a few in other cultures as well. However, some large and important demographic differences have not been studies systematically.

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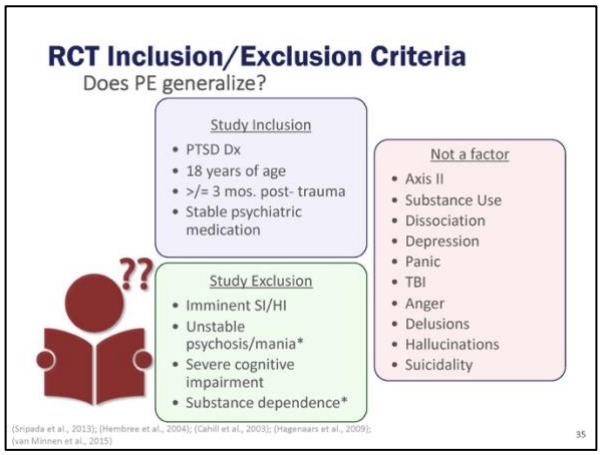

Many historically excluded conditions are included in modern studies, and when studied both directly and indirectly, do not interfere with treatment outcome.

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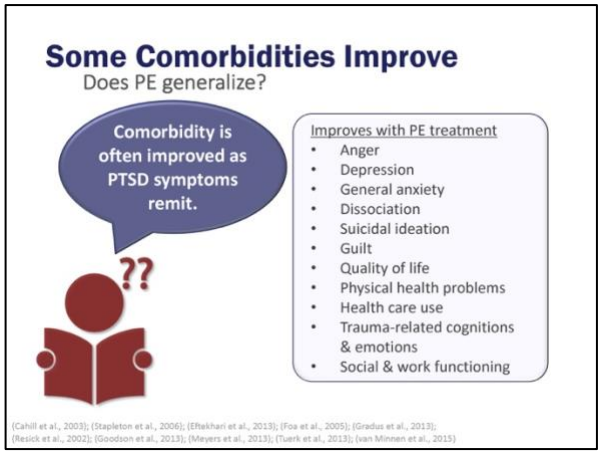

Though not targeted directly during PE, many common comorbidities improve as PTSD symptoms improve.

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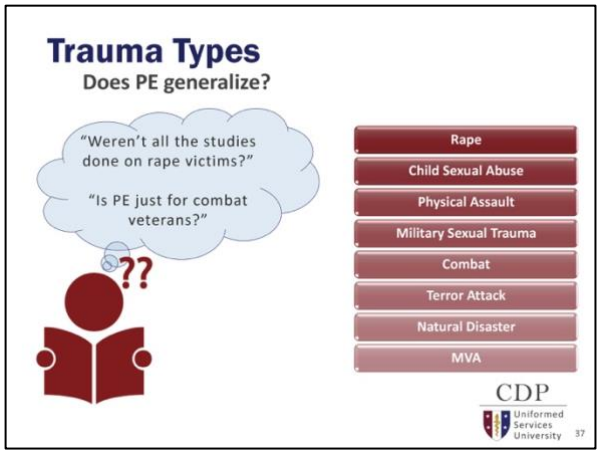

PE has been demonstrated effective across a wide variety of trauma types.

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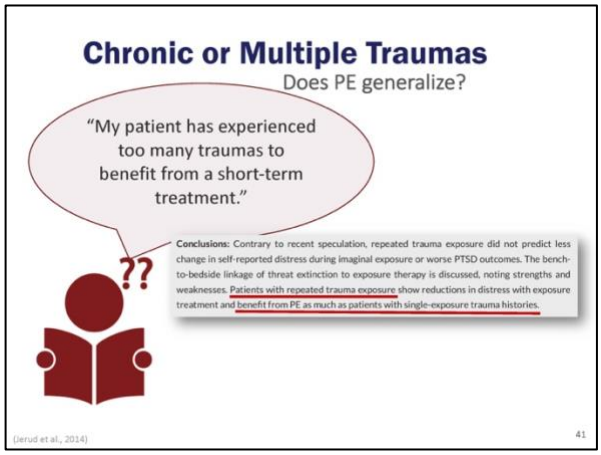

Patients with PTSD from multiple traumas benefit as much as patients with PTSD from a single trauma.

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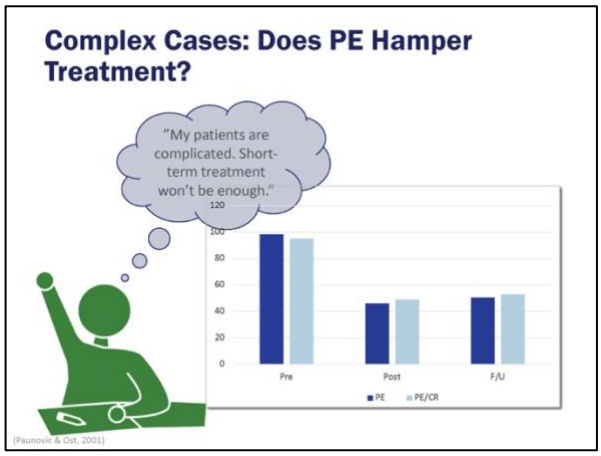

PE is effective in reducing symptoms of PTSD, even in complicated or chronic cases.

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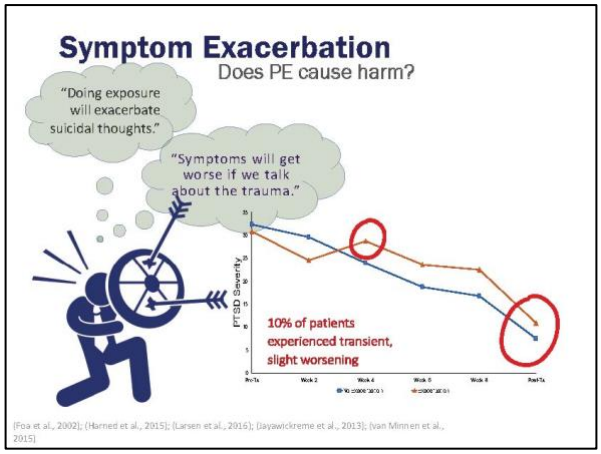

No evidence of exacerbation of suicidality and no completed suicides due to exposure in any known PE study.
Minor symptom exacerbation may occur in a small minority (_____% of the sample) early in PE treatment but does not result in negative outcomes or dropout.

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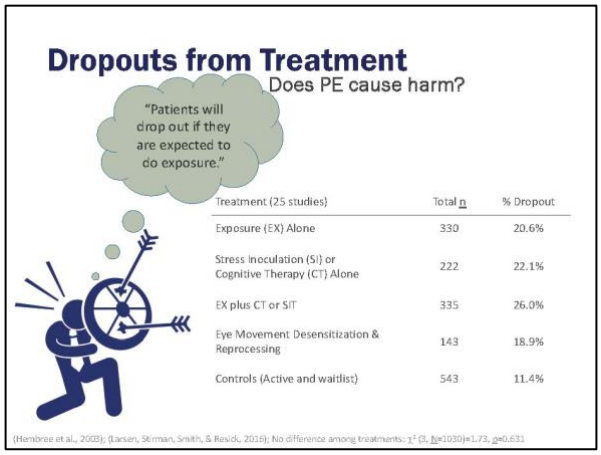
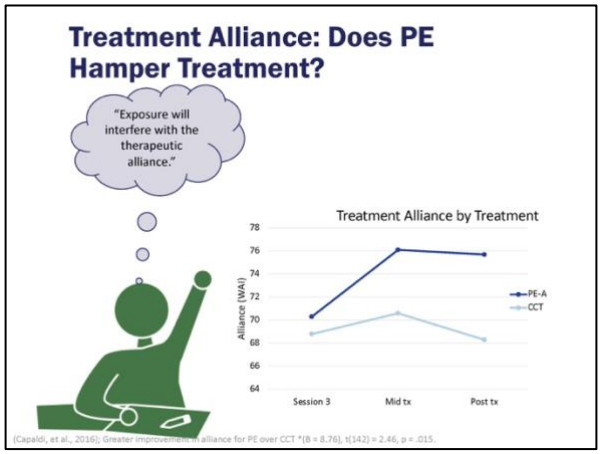


Dropout rates in PE are _____ to other forms of trauma-focused CBT.

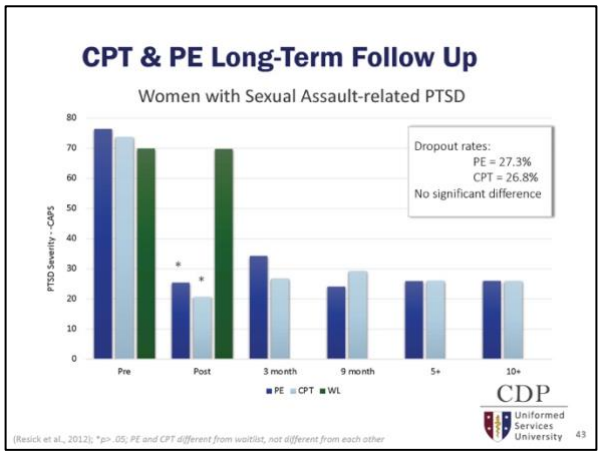
42.



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)

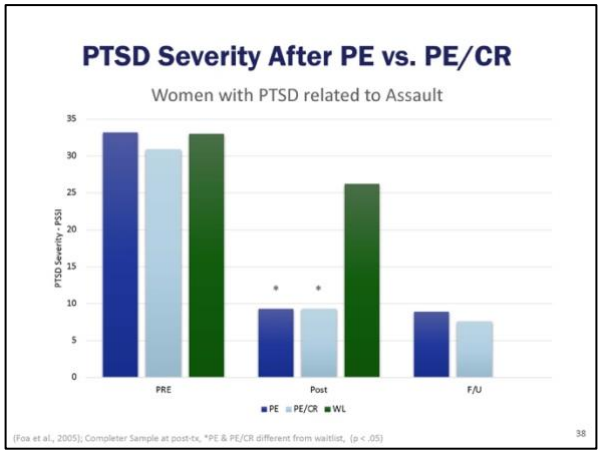
- Gains that were made during treatment were maintained over time (5-10-year span for f/u).

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.

44.



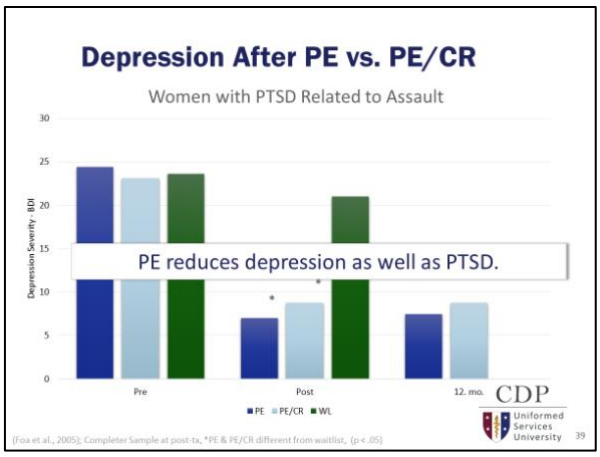
Augmenting PE with formal cognitive restructuring does not improve outcome.

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

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

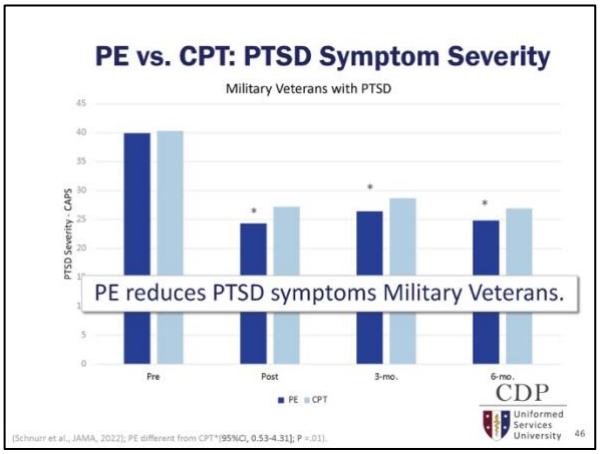
9 weekly sessions w/experienced PhDs & newly trained MA counselors
Extended to 12 for partial responders w/< 70% improvement by session 8.
Both treatment groups did equally well.
Subsequent studies have shown that adding other stuff doesn't improve outcome either.

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.

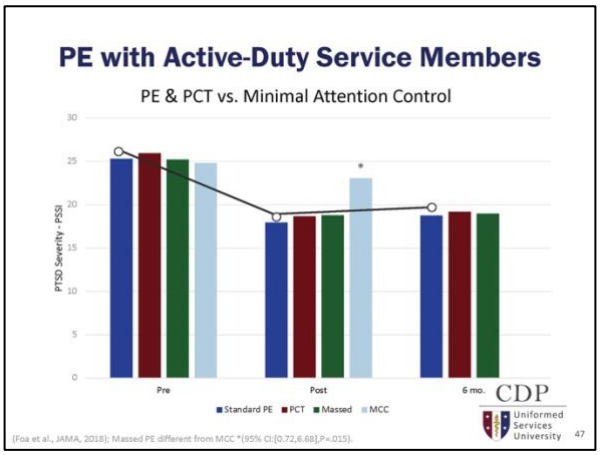
46.



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.

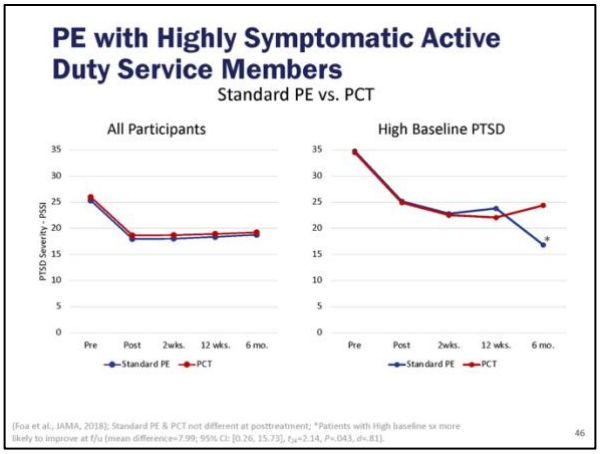
Participants – Active-Duty military Service members with PTSD

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 PSS-I severity or PTSD dx, but all treatment groups were effective in reducing PTSD symptoms.
- Dropout was low for all groups.

48.



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 PSS-I among patients with high baseline PTSD symptoms (21%).

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

Conclusion

50.

Assessment

49

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.

51.

Assessing PTSD in Context

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

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50

Assessing PTSD in Context

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

52.

PTSD starts with Criterion A

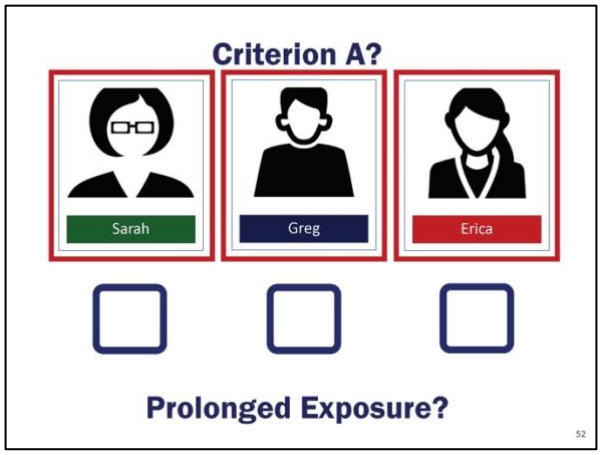
(American Psychiatric Association, 2013)

CDP
Uniformed Services University
52

Treatment follows Assessment

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

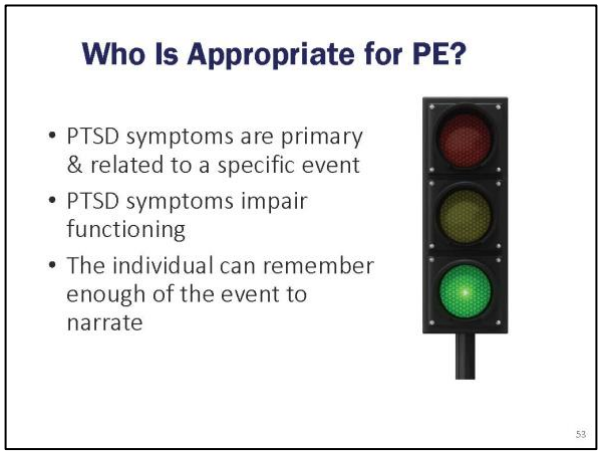
53.



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

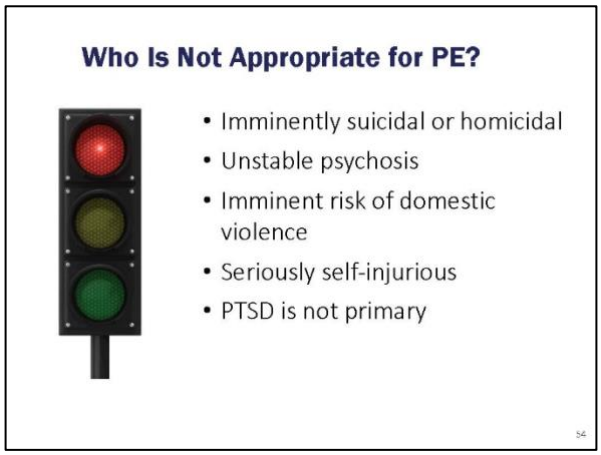
- Sarah?
- Greg?
- Erica?

54.



PE is safe and effective for people with PTSD

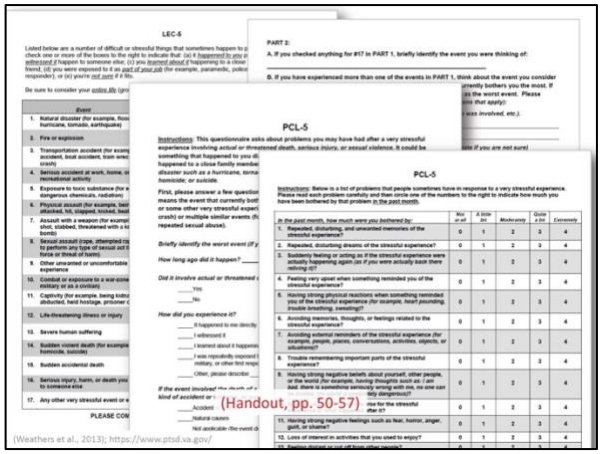
55.



***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.



PCL-5 is a self-report scale completed by the patient.

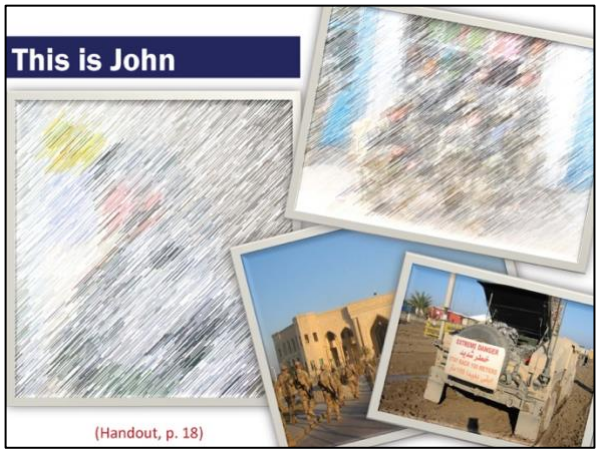
4 formats:

1. With the revised Life Events Checklist for *DSM-5* (LEC-5) and extended Criterion A assessment
2. With brief Criterion A assessment only
3. With symptoms only (past month)
4. With symptoms only (past week)

1 & 2 are best for initial assessment because they include Criterion A & trauma history.

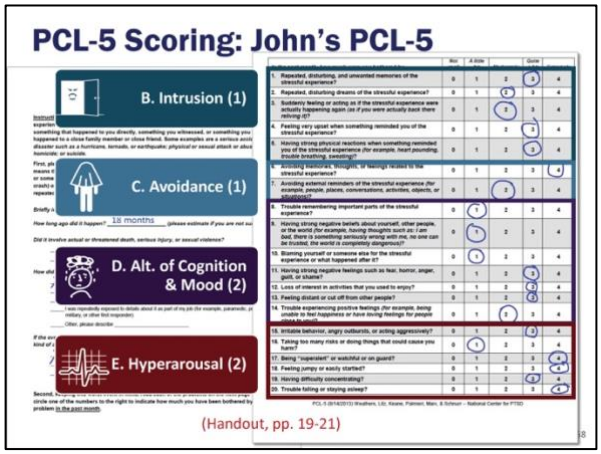
3 & 4 are best for measuring change across sessions at monthly or weekly intervals.

57.



This is John:

58.



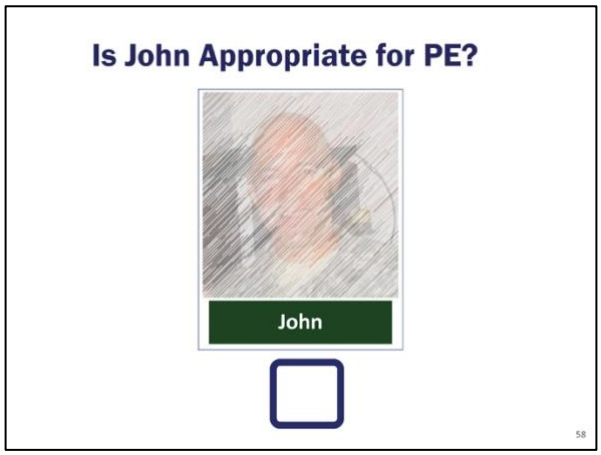
PCL-5 Scoring

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

10-20-point change represents clinically significant change.

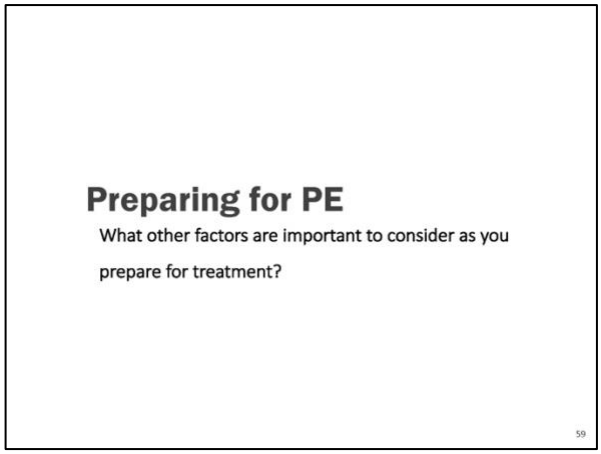
Users should follow the literature and the NCPTSD website (www.ptsd.va.gov) for updates to this information, as it may change as new data is published.

59.



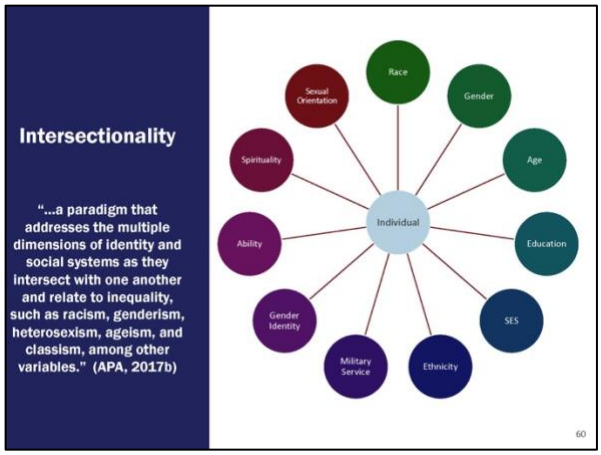
What is important to consider?

60.



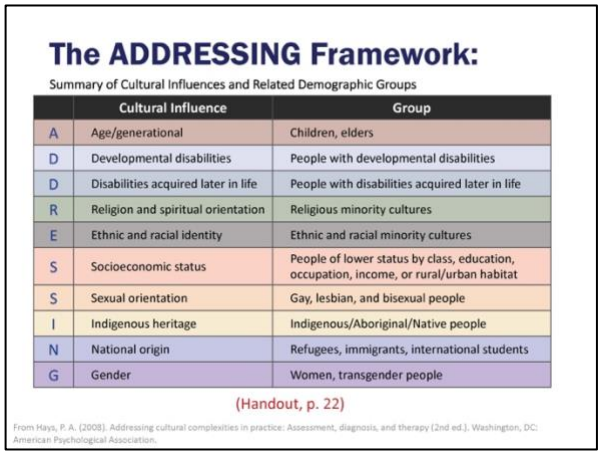
Preparing for PE

61.



Intersectional Assessment

62.



	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

Consider Cultural Influences and Related Demographic Variables

63.

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.

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

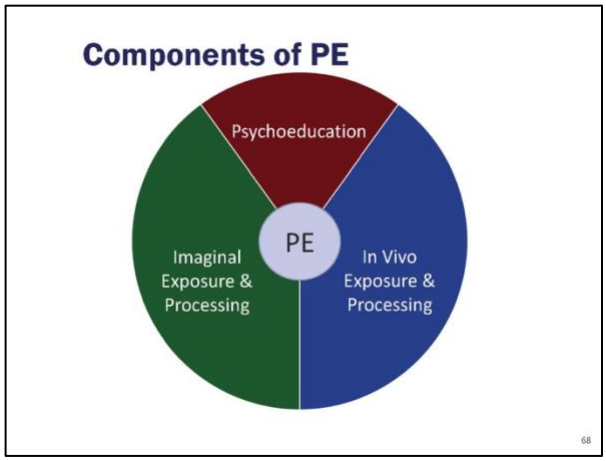
GET IT ON Google Play
http://tinyurl.com/pe2andr

CDP
Uniformed Services University

68

Using the PE Coach App

69.



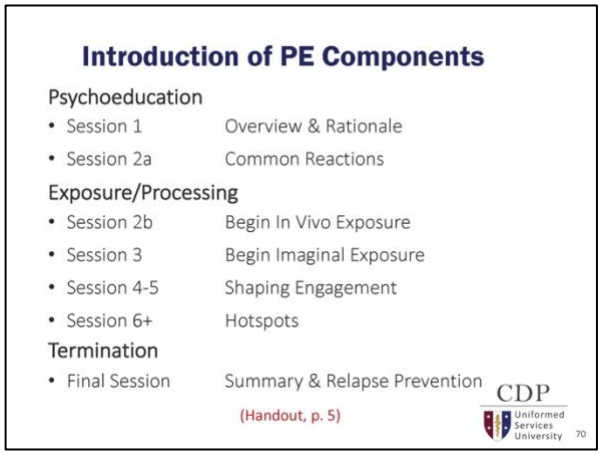
3 main components of treatment:

1. _____

2. _____

3. _____

70.



Introduction of PE Components

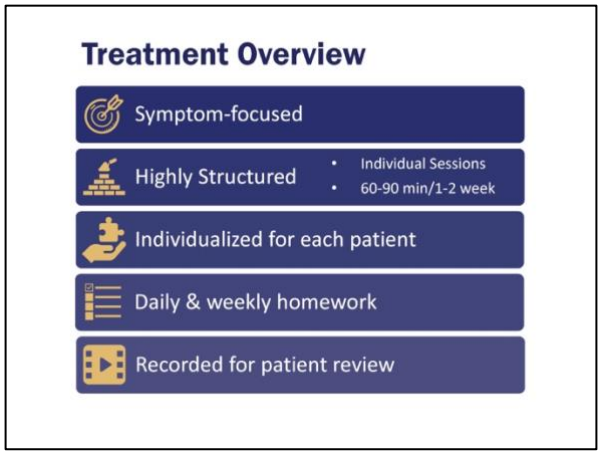
The handout provides a one-page overview of the sequential components of the treatment.

71.

72.

Session 1: Agenda

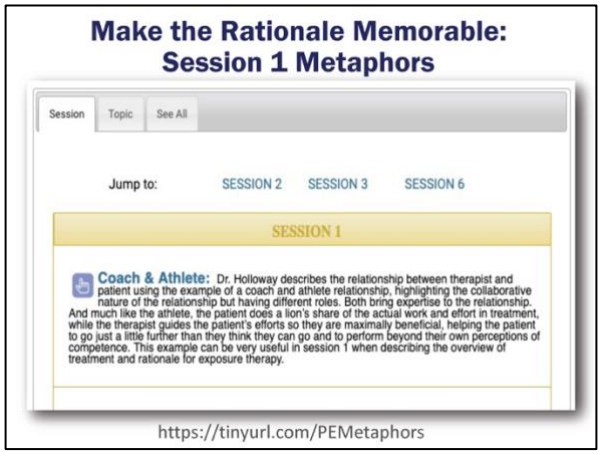
73.



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.

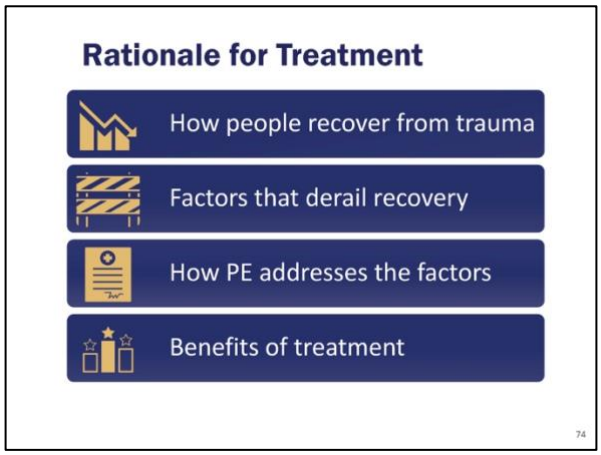
_____ allows the patient to review in-session material between sessions and is an **important** part of the treatment.

74.



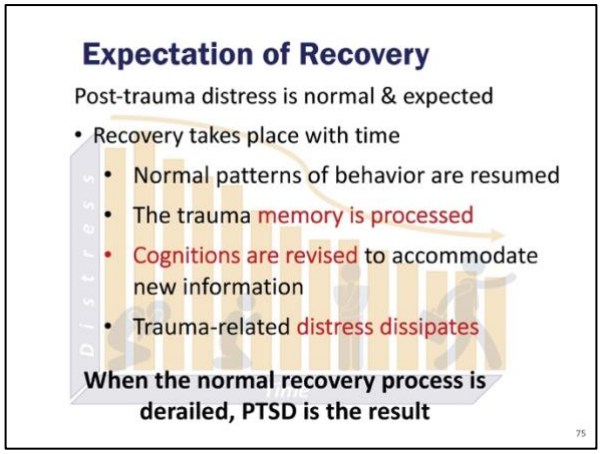
Stories and Metaphors are aids to understanding and memory and should be used liberally throughout treatment when describing the rationale.

75.



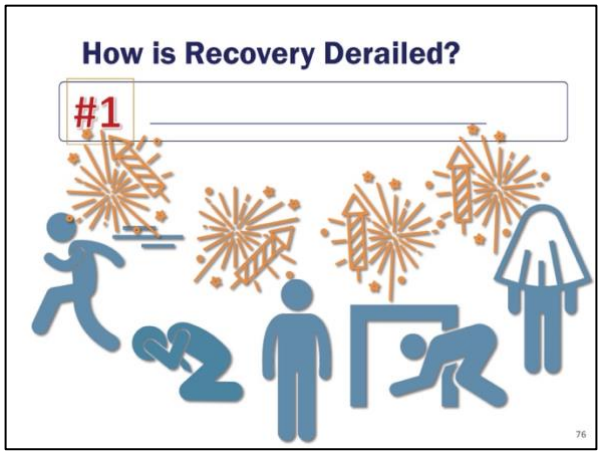
The rationale for treatment is the main focus of session 1.

76.



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

77.



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

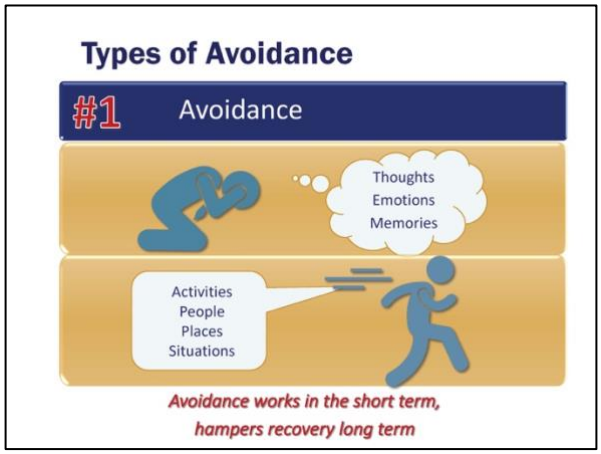
1). _____

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

_____

_____

78.

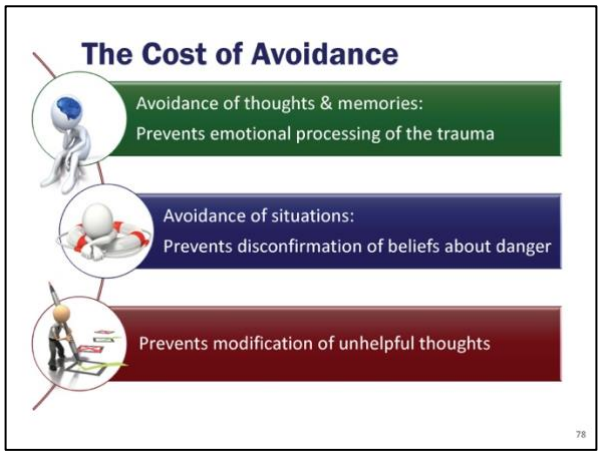


Two types of avoidance are problematic in PTSD:

1). _____

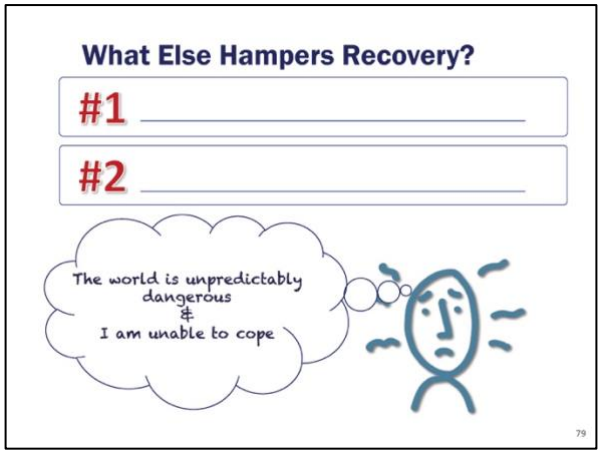
2). _____

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.

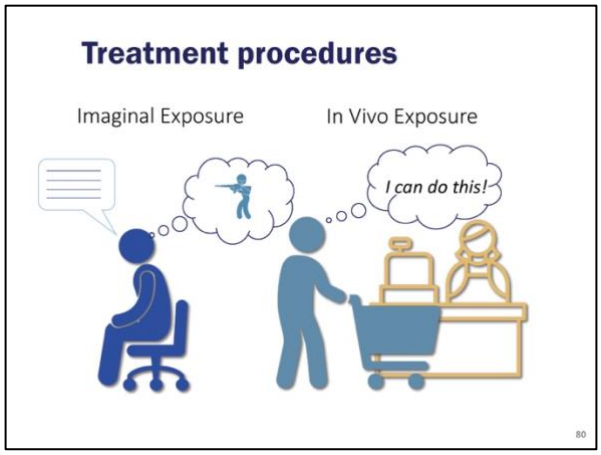
80.



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

1). _____

81.



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

1). _____

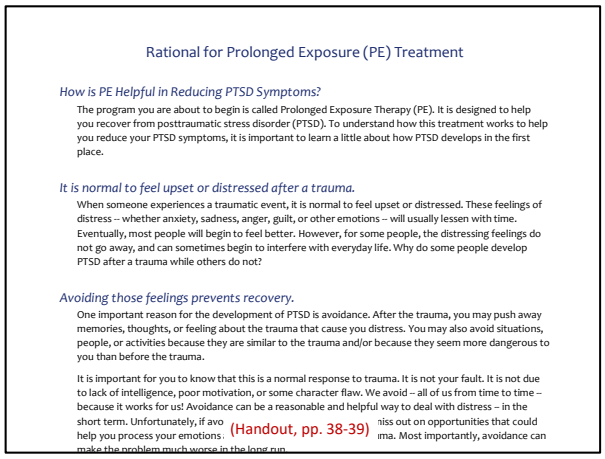
2). _____

82.

O***verall treatment rational 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.

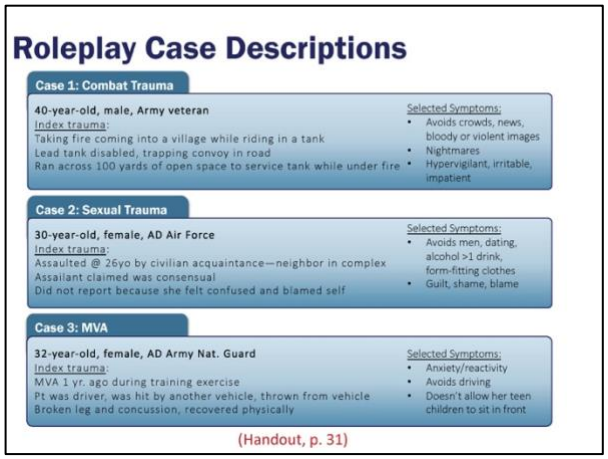


Written materials (handouts) augment teaching and give the patient something to review or share with significant others.

84.

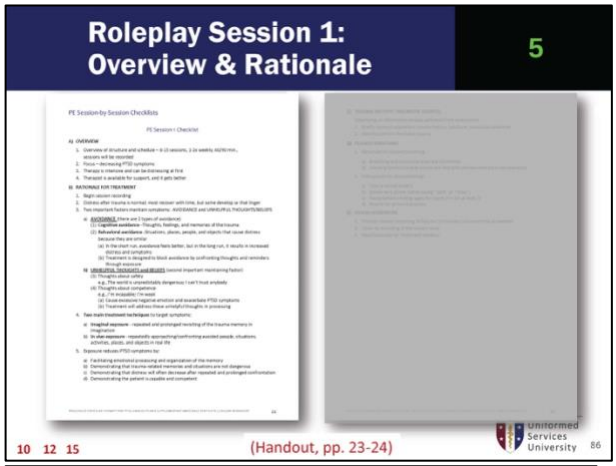
This form is optional and may or may not be used in the workshop.

85.



Demonstration Video: Session 1: Rationale for Treatment

86.



Roleplay Notes:

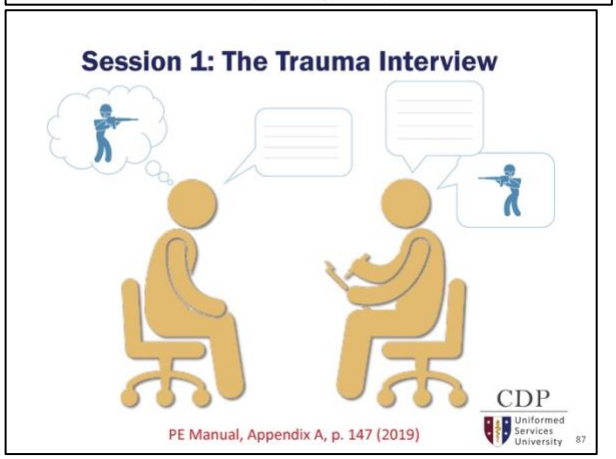
"My name is _____

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.



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.

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

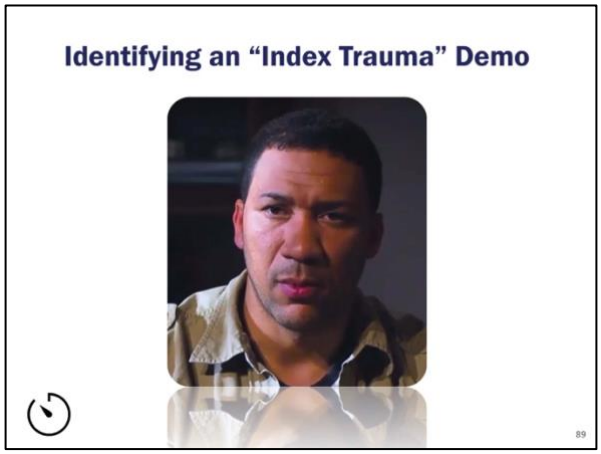
The official "Trauma Interview" is in the appendices of the manual.
If assessment has already covered the material, the full interview may not be needed.

89.

How to identify the index trauma:

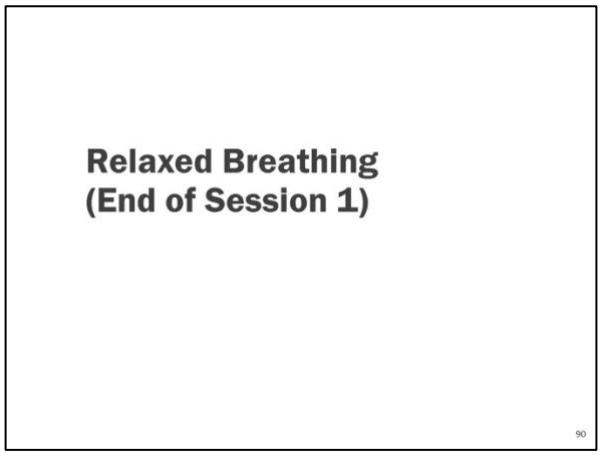
- Which event upsets you the most?
- Which causes the most distress?
- Which comes into your mind the most often?

90.



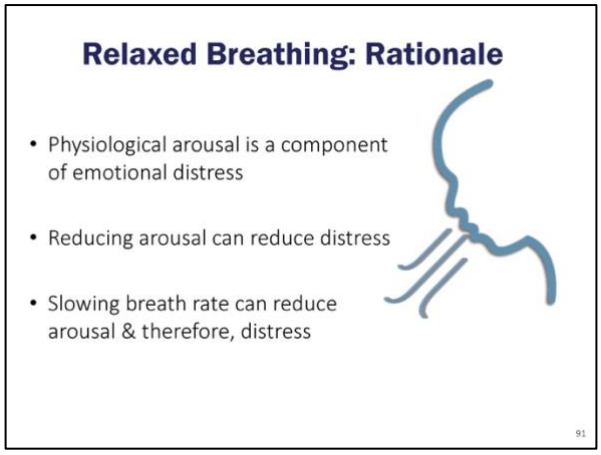
Video Demonstration of Identifying an Index Trauma

91.



Relaxed Breathing

92.



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.

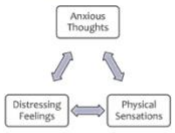
Relaxed Breathing

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:



1) Inhale normally through your nose with mouth closed.
2) Exhale slowly with your mouth closed
3) As you exhale, count slowly to 4.
4) Pause for a count of 4.
5) Take the next inhalation.
6) Practice this exercise several times a day.
7) 10 to 15 cycles of breath at each practice.

(Handout, p. 40)

Helpful Tips:

- 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
❒❒❒	❒❒❒	❒❒❒	❒❒❒	❒❒❒	❒❒❒	❒❒❒

❒ 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

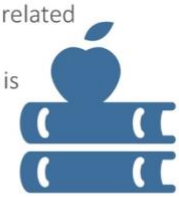
The Importance of Homework

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



(Kazantzis, Deane, & Ronan, 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

CDP
Uniformed Services University

98

Addressing Noncompliance

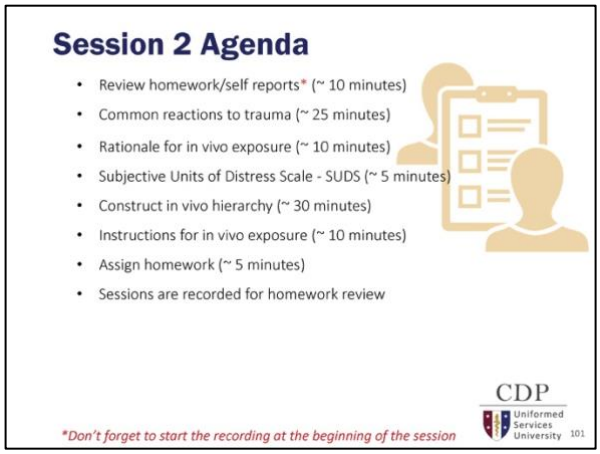
100.

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

99

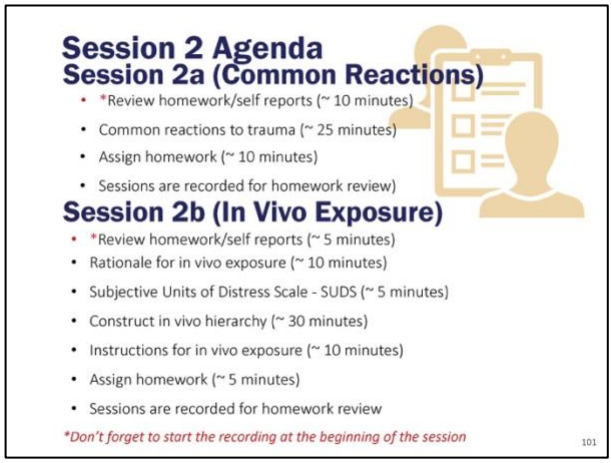
Session 2

101.



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.



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

104.

What Are Common Reactions to Trauma?

106.

Common Reactions to Trauma: Why Review?

Elicit	*patient's unique experience of PTSD*
Validate & normalize	*patient's experiences & symptoms*
Instill hope	*that patient is not broken*
Promote communication	*as a collaborative, therapeutic alliance*

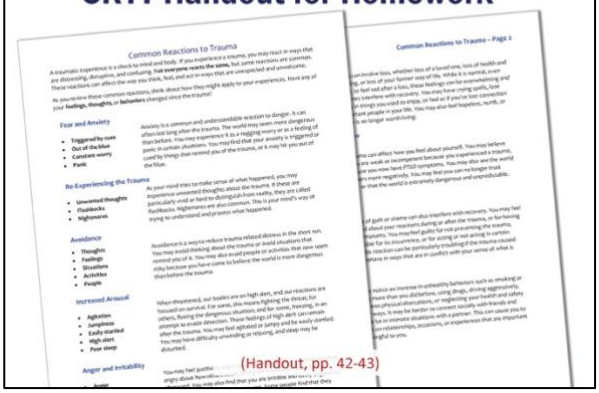
If it's not a conversation, it's not common reactions

105

Why Review Common Reactions to Trauma?

107.

CRTT Handout for Homework


Common Reactions to Trauma

A traumatic experience is a shock to mind and body. If you experience a trauma, you may react in ways that are distressing, disruptive, and confusing. **Not everyone reacts the same,** but some reactions are common. These reactions can affect the way you think, feel, and act in ways that are unwanted and unwelcome.

As you review these common reactions, think about how they might apply to your experiences. Have any of your **feelings, thoughts,** or **behaviors** changed since the trauma?

Fear and Anxiety

- Triggered by cues
- Out of the blue
- Constant worry
- Panic

Anxiety is a common and understandable reaction to danger. It can often last long after the trauma. The world may seem more dangerous than before. You may experience it as a nagging worry or as a feeling of panic in certain situations. You may find that your anxiety is triggered or cued by things that remind you of the trauma, or it may hit you out of the blue.

Re-Experiencing the Trauma

- Unwanted thoughts
- Flashbacks
- Nightmares

As your mind tries to make sense of what happened, you may experience unwanted thoughts about the trauma. If these are particularly vivid or hard to distinguish from reality, they are called flashbacks. Nightmares are also common. This is your mind's way of trying to understand and process what happened.

Avoidance

- Thoughts
- Feelings
- Situations
- Activities
- People

Avoidance is a way to reduce trauma-related distress in the short run. You may avoid thinking about the trauma or avoid situations that remind you of it. You may also avoid people or activities that now seem risky because you have come to believe the world is more dangerous than before the trauma.

Increased Arousal

- Agitation
- Jumpiness
- Easily startled
- High alert
- Poor sleep

When threatened, our bodies are on high alert, and our reactions are focused on survival. For some, this means fighting the threat, for others, fleeing the dangerous situation; and for some, freezing, in an attempt to evade detection. Those feelings of high alert can remain after the trauma. You may feel agitated or jumpy and be easily startled. You may have difficulty unwinding or relaxing, and sleep may be disturbed.

Anger and Irritability

You may feel justifie

Common Reactions to Trauma – Page 2

(Handout, pp. 42-43)

CRRT handout for patients

108.

Common Reactions Demo

Video Demonstration - CRTT

109.

Introducing In Vivo Exposure

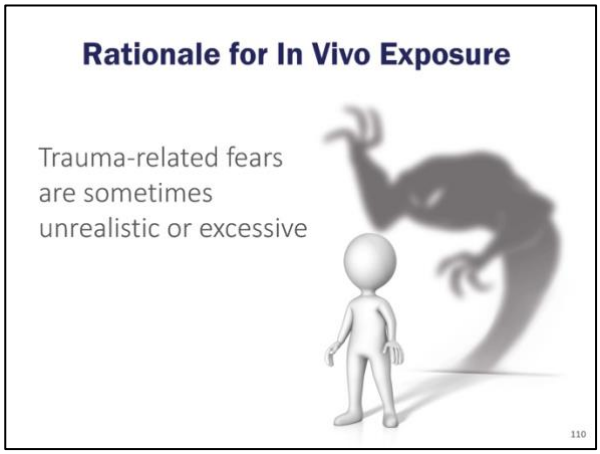
Second Part of Session 2

Introducing In Vivo Exposure

110.

Giving the Rationale for In Vivo Exposure

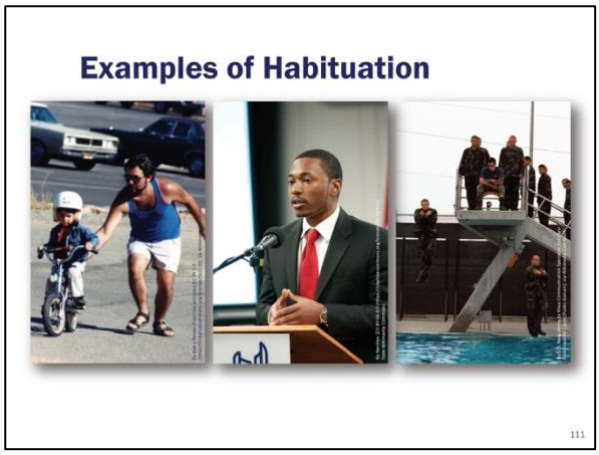
111.



The Rationale for In Vivo Exposure

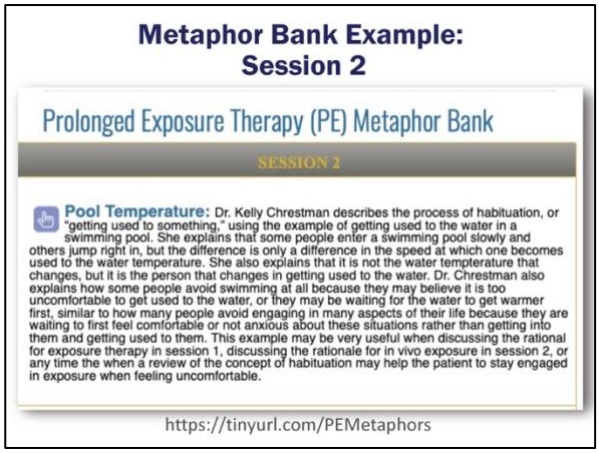
Rationale focuses on in vivo exposure to address excessive distress and/or unhelpful cognitions symptomatic of PTSD.

112.



Examples of Habituation

113.



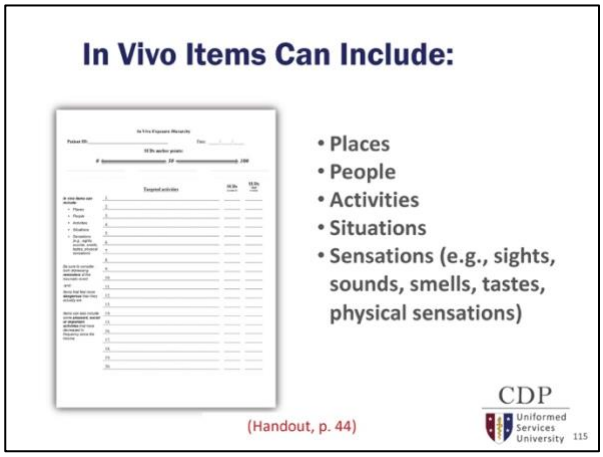
The Metaphor Bank-Pool Temp

114.

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

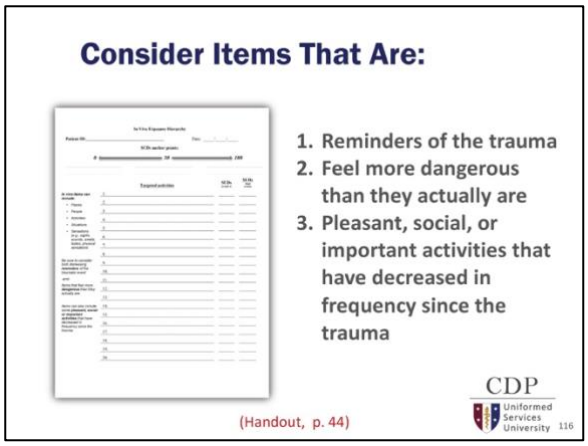
Though other erroneous beliefs are challenged during in vivo, it is especially useful in helping assess _____ more realistically.

115.



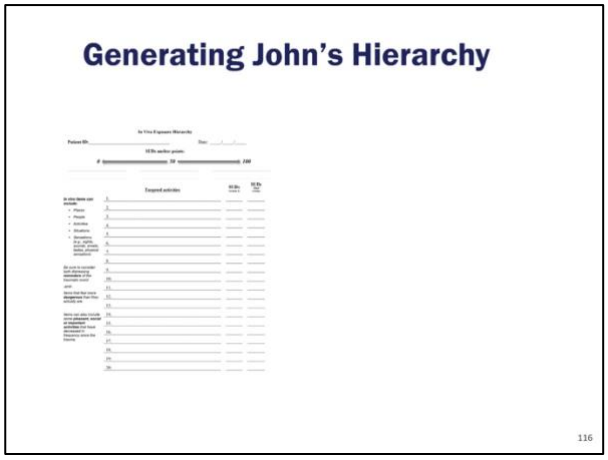
In Vivo Items Can Include:

116.



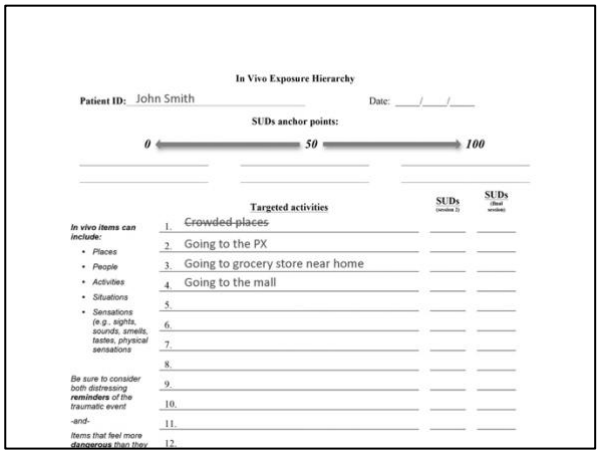
Consider three types of activities.

117.



Suggest items from assessment

118.



In Vivo Exposure Hierarchy

Patient ID: John Smith Date: ____/____/____

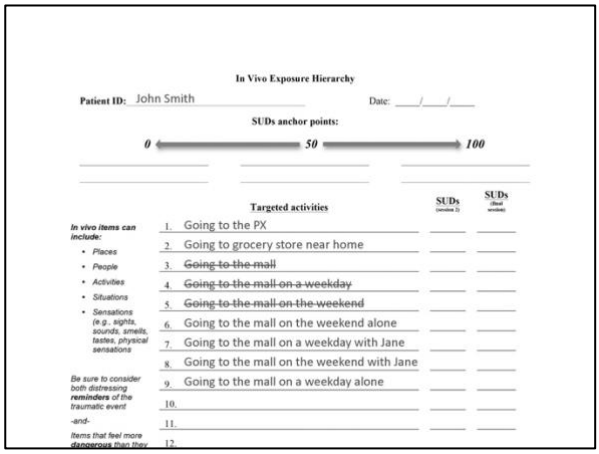
SUDs anchor points:

0 ⟵ 50 ⟶ 100

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

Identify specific situations

119.



In Vivo Exposure Hierarchy

Patient ID: John Smith Date: ____/____/____

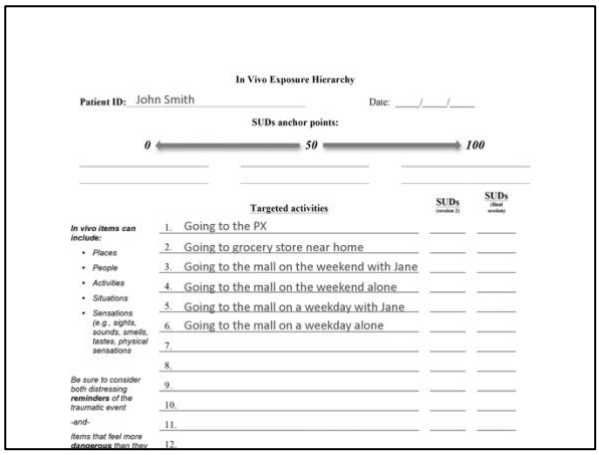
SUDs anchor points:

0 ⟵ 50 ⟶ 100

	Targeted activities	SUDs (current 2)	SUDs (Best worded)
In vivo items can include: • Places • People • Activities • Situations • Sensations (e.g., sights, sounds, smells, tastes, physical sensations	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		
Be sure to consider both distressing **reminders** of the traumatic event -and- Items that feel more **dangerous** than they	9. Going to the mall on a weekday alone		
	10.		
	11.		
	12.		

Elicit variations

120.



In Vivo Exposure Hierarchy

Patient ID: John Smith Date: ____/____/____

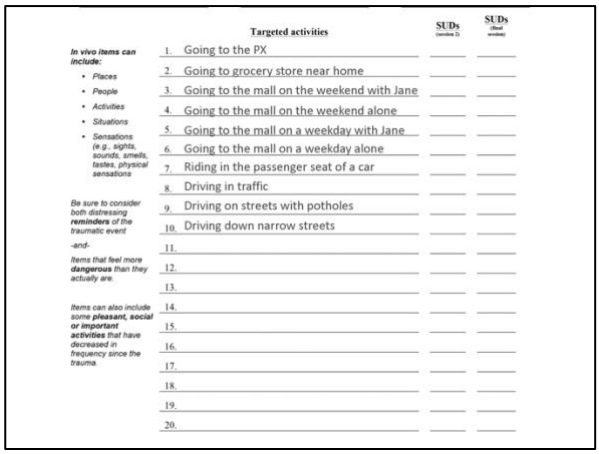
SUDs anchor points:

0 ⟵ 50 ⟶ 100

	Targeted activities	SUDs (current 2)	SUDs (Best worded)
In vivo items can include: • Places • People • Activities • Situations • Sensations (e.g., sights, sounds, smells, tastes, physical sensations	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.		
Be sure to consider both distressing **reminders** of the traumatic event -and- Items that feel more **dangerous** than they	9.		
	10.		
	11.		
	12.		

Understand the anticipated consequence

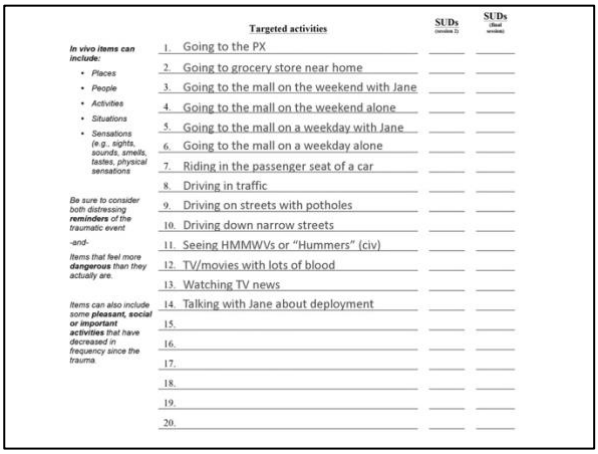
121.



	Targeted activities	SUDs (current 2)	SUDs (Best worded)
In vivo items can include: • Places • People • Activities • Situations • Sensations (e.g., sights, sounds, smells, tastes, physical sensations	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		
Be sure to consider both distressing **reminders** of the traumatic event -and- Items that feel more **dangerous** than they actually are.	9. Driving on streets with potholes		
	10. Driving down narrow streets		
	11.		
	12.		
	13.		
Items can also include some **pleasant, social or important activities** that have decreased in frequency since the trauma.	14.		
	15.		
	16.		
	17.		
	18.		
	19.		
	20.		

Evaluate true danger

122.



Targeted activities	SUDs (current)	SUDs (Goal: weekly)
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)		
12. TV/movies with lots of blood		
13. Watching TV news		
14. Talking with Jane about deployment		
15.		
16.		
17.		
18.		
19.		
20.		

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*

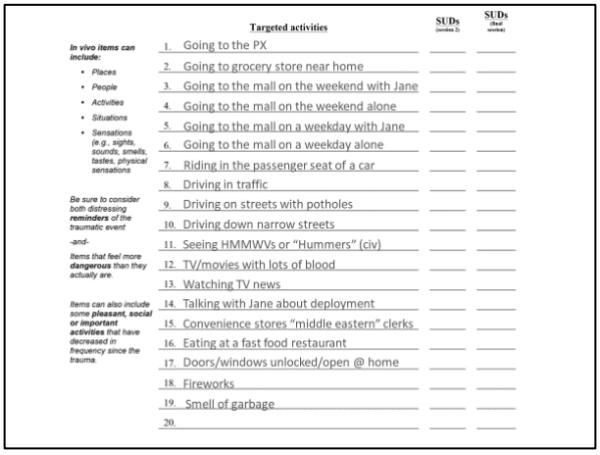
-and-

*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.*

Caution when involving others

123.



Targeted activities	SUDs (current)	SUDs (Goal: weekly)
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)		
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.		

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.*

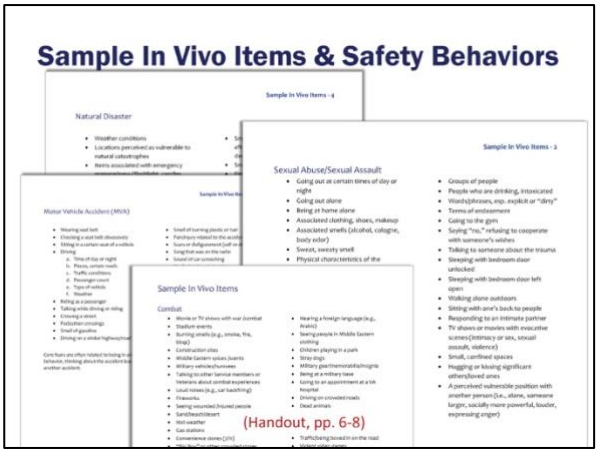
*Items can also include some **pleasant, social or important activities** that have decreased in frequency since the trauma.*

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

124.

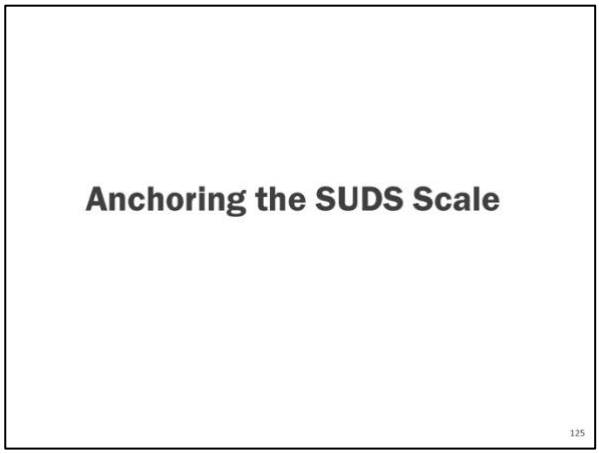
Generating useful items requires creativity and collaboration.

125.



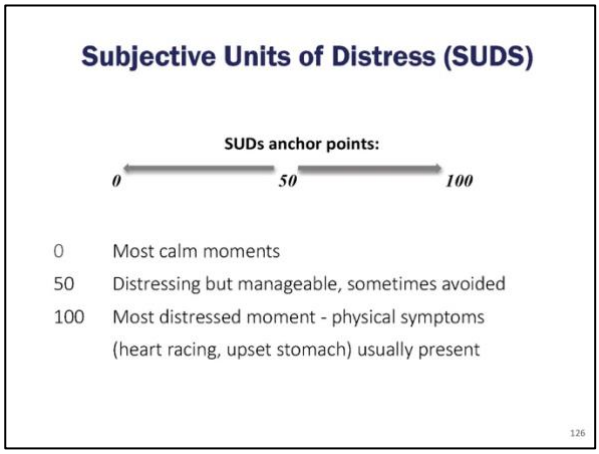
Sample In Vivo Items

126.



Anchoring the SUDs Scale

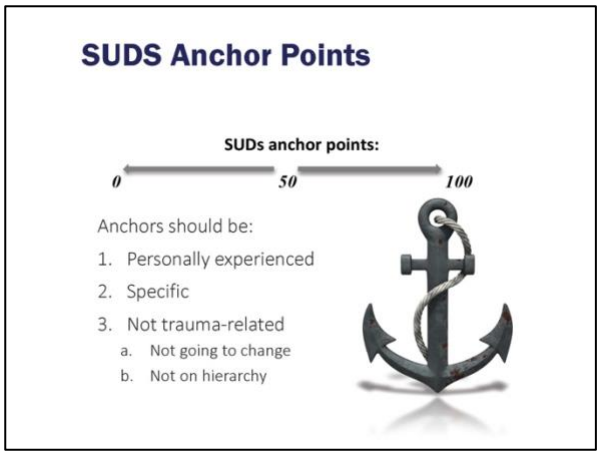
127.



SUDs

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

128.



Generating SUDs Anchors

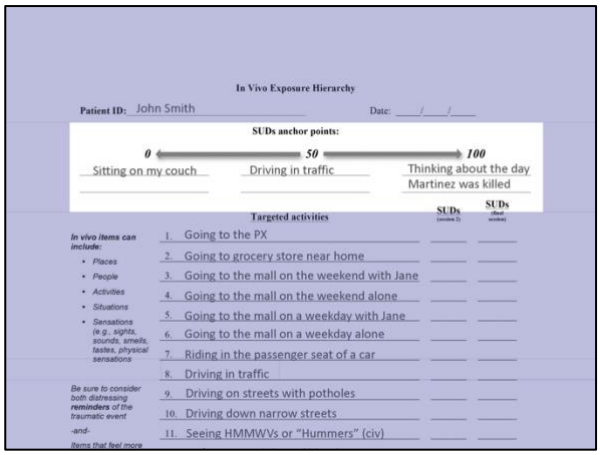
When introducing the SUDS, ask the patient for anchors that reflect a distress level of 0, 50, and 100.

Anchors should be _____ & _____

to make them easier to recall,

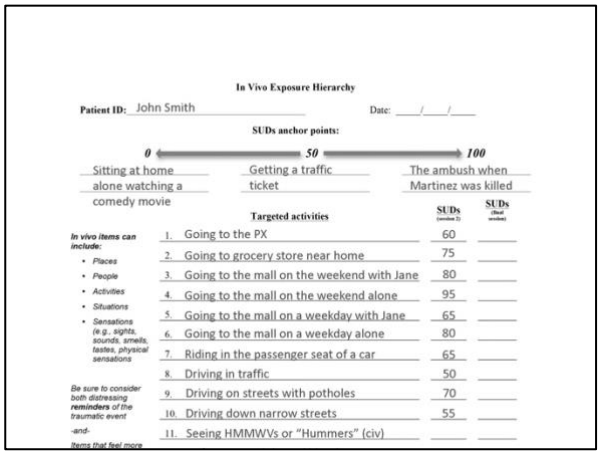
and not _____ so that they remain static over time.

129.



- ***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

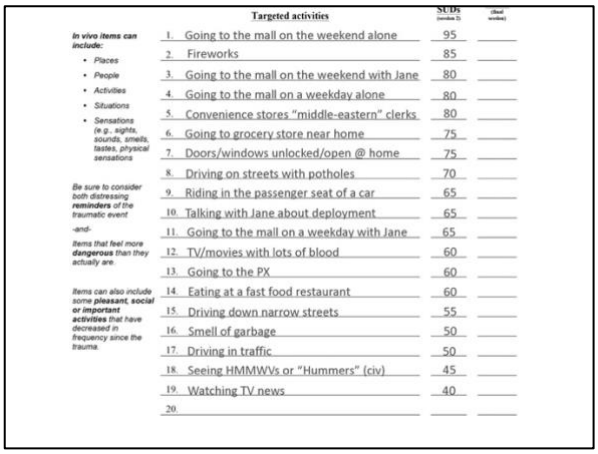
	Targeted activities	SUDs	SUDs (final session)
1.	Going to the PX	60	
2.	Going to grocery store near home	75	
3.	Going to the mall on the weekend with Jane	80	
4.	Going to the mall on the weekend alone	95	
5.	Going to the mall on a weekday with Jane	65	
6.	Going to the mall on a weekday alone	80	
7.	Riding 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

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

133.



	Targeted activities	SUDs	SUDs (final session)
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.			

In vivo items can include:
- *Places*
- *People*
- *Activities*
- *Situations*
- *Sensations (e.g., sights, sounds, smells, tastes, physical sensations*

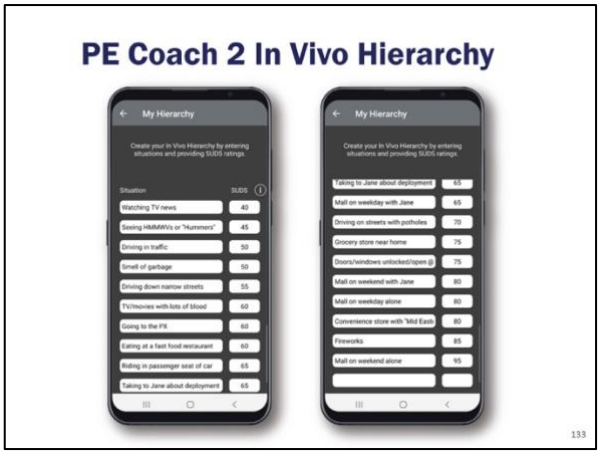
*Be sure to consider both distressing **reminders** of the traumatic event*
-and-
*Items that feel more **dangerous** than they actually are.*

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

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

Specific and detailed instructions will increase the likelihood of success.

136.

Assigning In Vivo Exposure Homework

- **Collaborate** to identify 1-3 situations
  - **-Moderate** distress (SUDS = 40 - 50)
  - -Readily **repeated**
  - **-Success** is likely
- **Remain** in situation 30 - 45 minutes or until distress decreases (~ 50% from peak)*
- **Repeat** daily
- **Track** using homework form

135

Choosing the first item for homework is a collaborative effort.

137.

	Targeted activities	SUDs (awake 2)	SUDs (dead window)
In vivo items can include: • Places • People • Activities • Situations • Sensations (e.g., sights, sounds, smells, tastes, physical sensations	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	
*Be sure to consider both distressing **reminders** of the traumatic event* -and- *Items that feel more **dangerous** than they actually are.*	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	
*Items can also include some **pleasant, social or important activities** that have decreased in frequency since the trauma.*	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.		

Identify potential items in the correct SUDs range.

For the first in vivo assignment choose something in the range of _____.

138.

In Vivo Exposure Recording Form

In Vivo Exposure Homework Recording Form

Patient ID:_____ Date:_____

Instructions: Engage the target situation for 45 minutes or until your SUDS decreases by about half. 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)

1) Target Situation:	Date & Time	Beginning SUDS	Peak SUDS	Final SUDS
Driving in traffic	Monday 1300	60	70	40

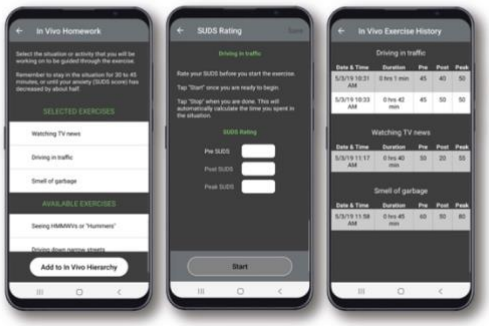
2) Target Situation:	Date & Time	Beginning SUDS	Peak SUDS	Final SUDsS

(Handout, p. 45)

In Vivo Exposure Recording Form

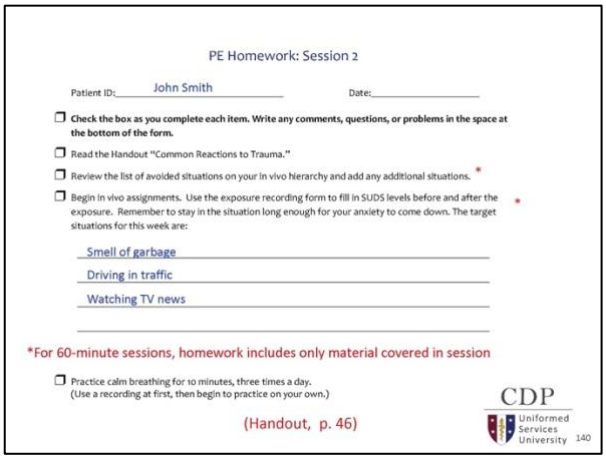
139.

In Vivo Exposure on the App



In Vivo Exposure on the App

140.

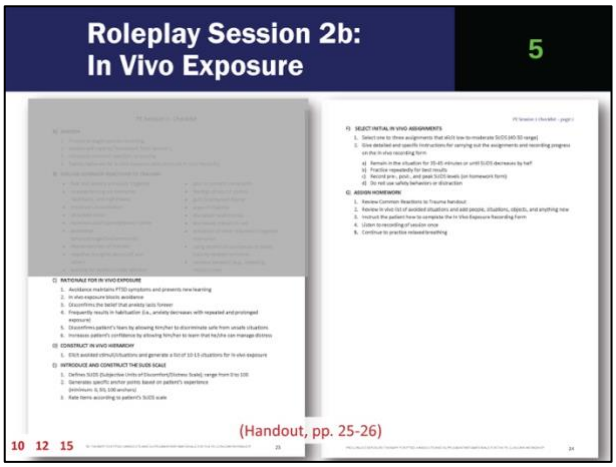


PE Homework Session 2

141.

Video Demonstration of In Vivo Exposure

142.



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

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

CDP Uniformed Services University 144

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 rational 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

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

Aims of Imaginal Exposure

149.

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***.***

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)

CDP Uniformed Services University 150

The instructions for imaginal exposure should be clear and concise.

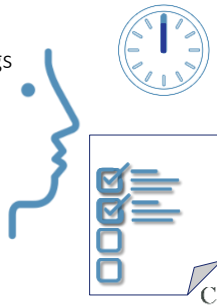
Instructions are intended to promote "one foot in the past, one foot in the present" optimal engagement. It is sometimes helpful for the therapist to demonstrate how it is done; for example, he or she could close their eyes and describe in the first-person, present tense, a minute or two of their daily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

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

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)

CDP Uniformed Services University 151

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

- Listening
- Monitoring

Things to monitor:

_____

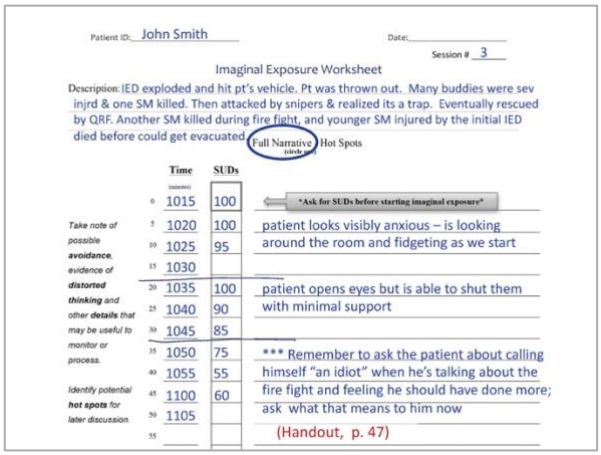
_____

_____

_____

- Prompt only as needed

152.



Patient ID: John Smith Date:

Session # 3

Imaginal Exposure Worksheet

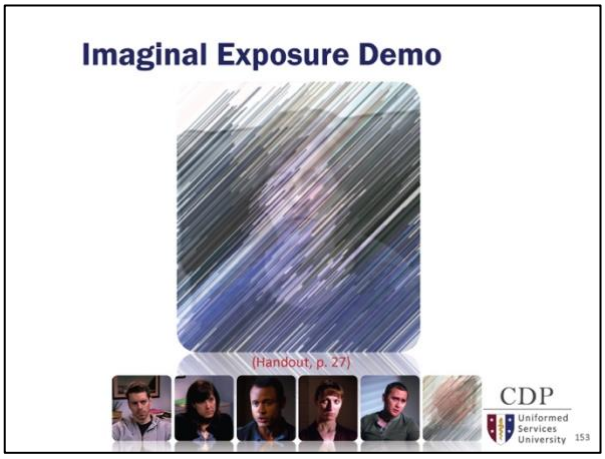
Description: IED exploded and hit pt's vehicle. Pt was thrown out. Many buddies were sev injrd & one SM killed. Then attacked by snipers & realized its a trap. Eventually rescued by QRF. Another SM killed during fire fight, and younger SM injured by the initial IED died before could get evacuated. Full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

	Time	SUDs	
	1015	100	*Ask for SUDs before starting imaginal exposure*
Take note of possible **avoidance**, evidence of **distorted thinking** and other **details** that may be useful to monitor or process.	1020	100	patient looks visibly anxious – is looking around the room and fidgeting as we start
	1025	95	
	1030		
	1035	100	patient opens eyes but is able to shut them with minimal support
	1040	90	
	1045	85	
	1050	75	*** 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
	1055	55	
Identify potential **hot spots** for later discussion.	1100	60	
	1105		
			(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.

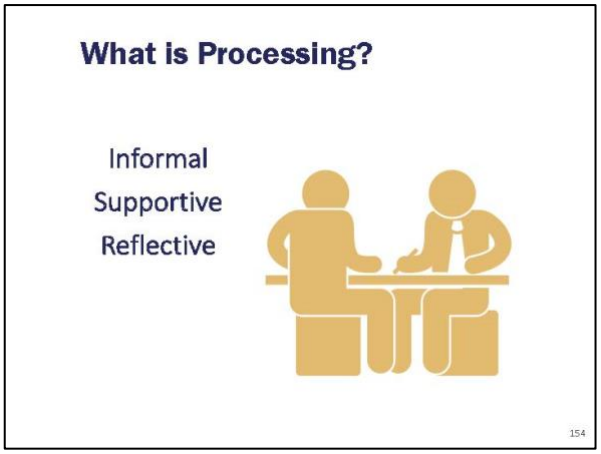


Video Demonstration Imaginal Exposure

154.

Processing Imaginal Exposure

155.



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.

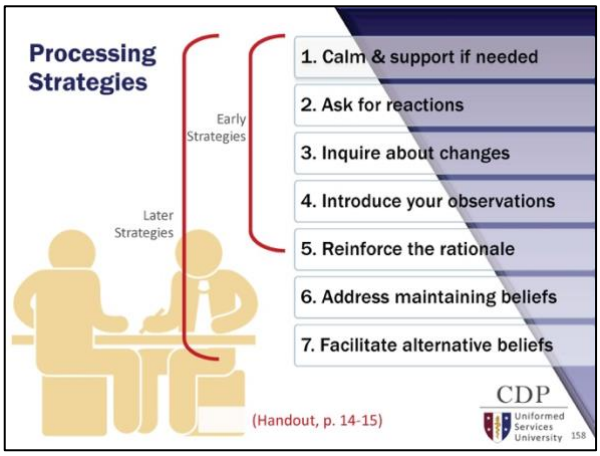
156.

Goals of Processing

157.

Best Practices for Processing

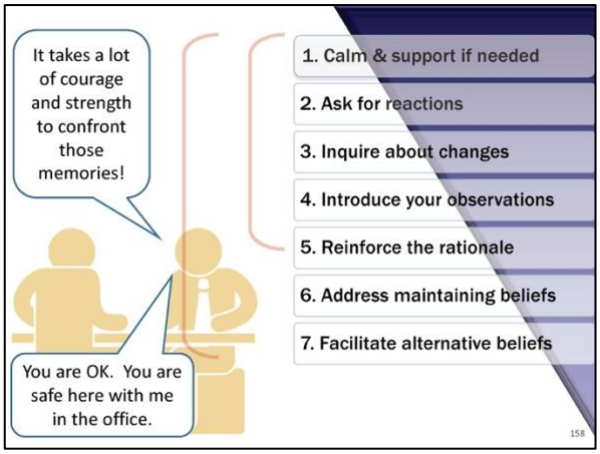
158.



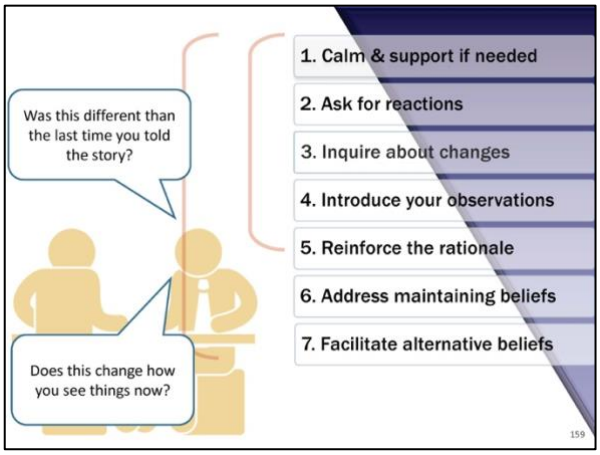
Processing strategies within and across sessions should move from supportive to questioning, working first with the client's observations and comments before introducing your own.

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.

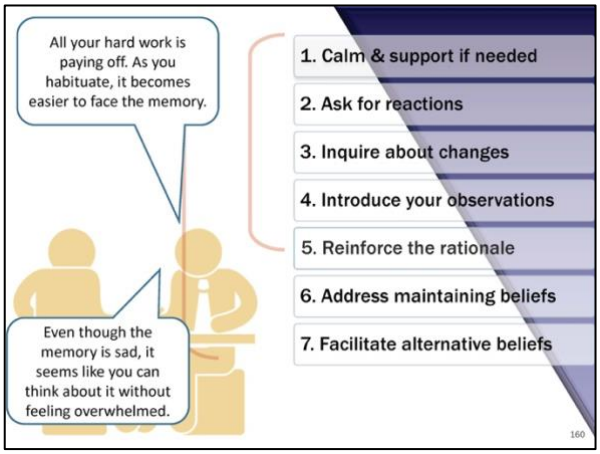
159.



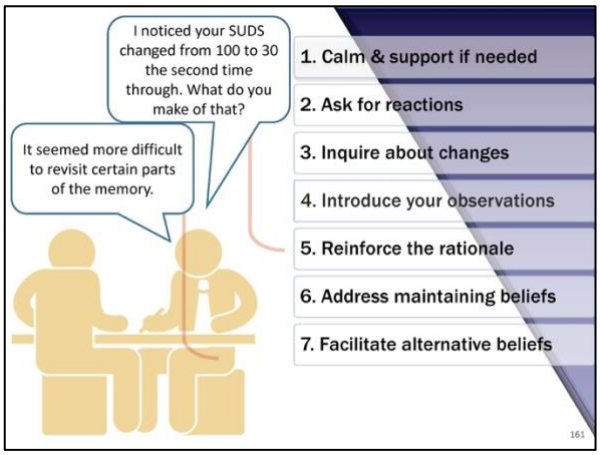
160.



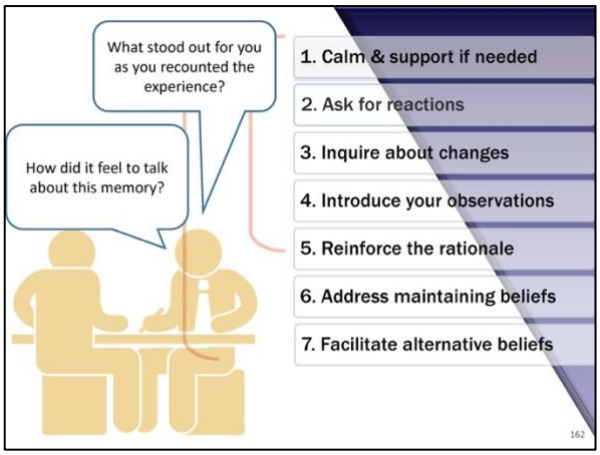
161.



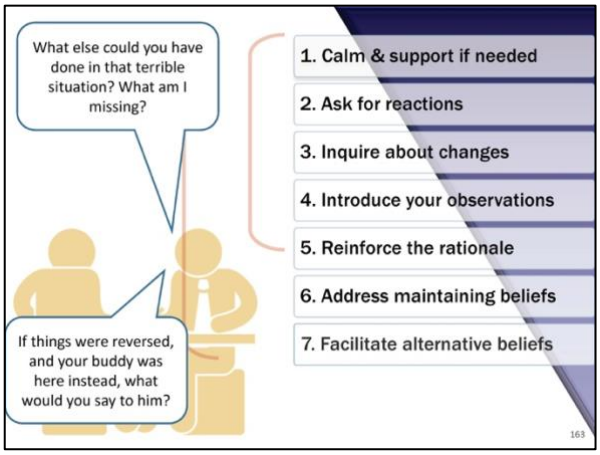
162.



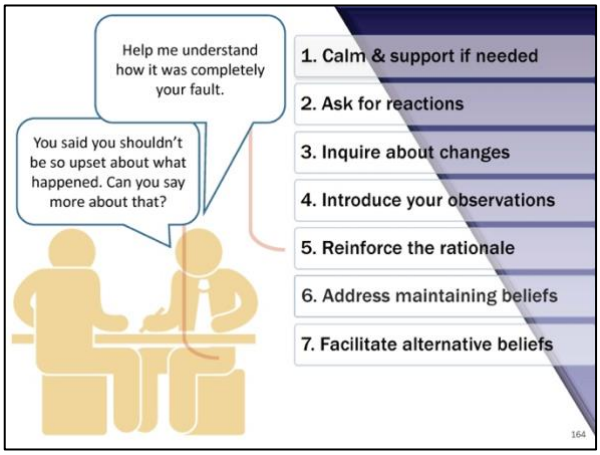
163.



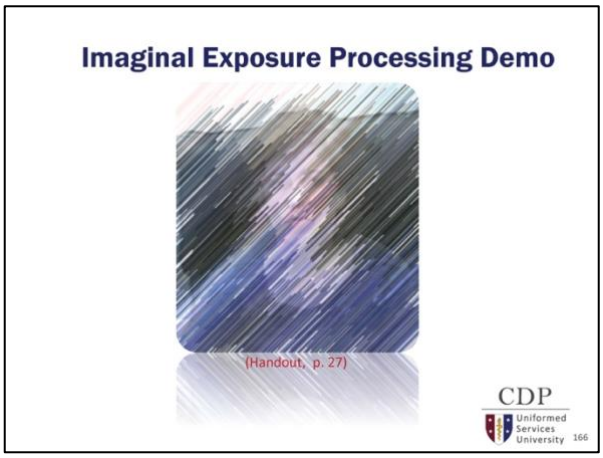
164.



165.

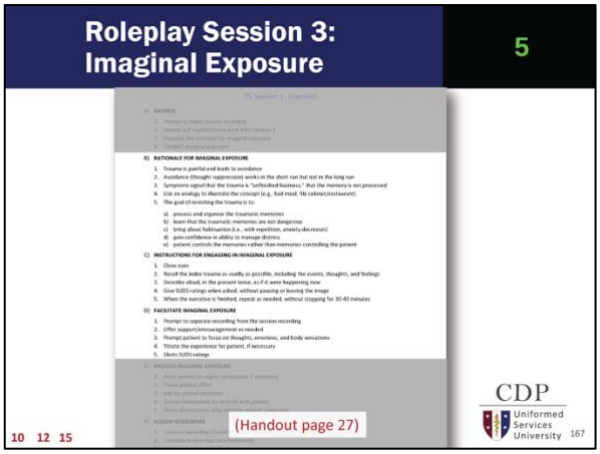


166.



Video Demonstration - Imaginal Exposure Processing

167.



Roleplay Notes:

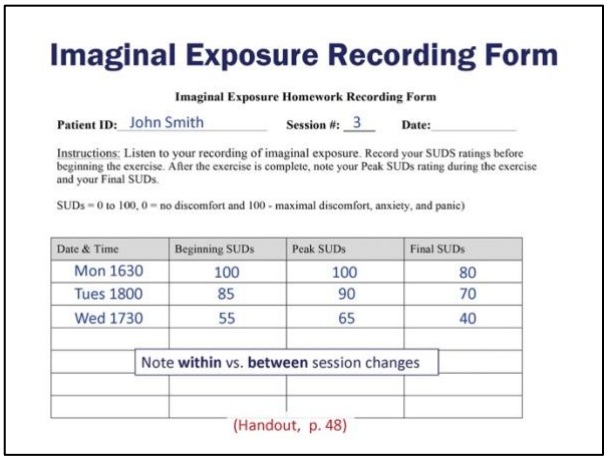
In addition to previously described information, be prepared to describe some details of your traumatic event for the first imaginal exposure. Keep in mind unhelpful cognitions that might color your narrative when telling it for the first time.

Notes:_____

_____

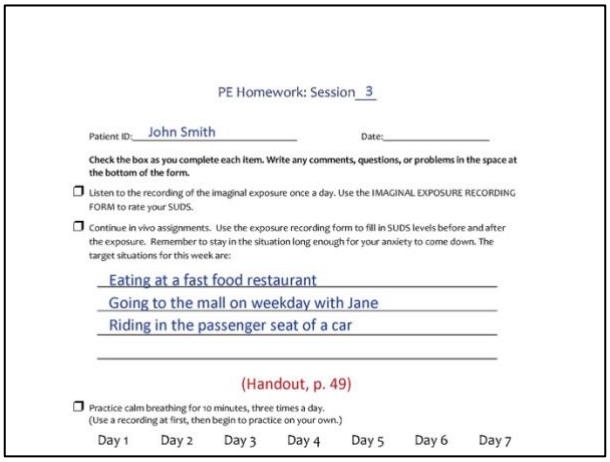
_____

168.



Imaginal Exposure Homework Recording Form

169.



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

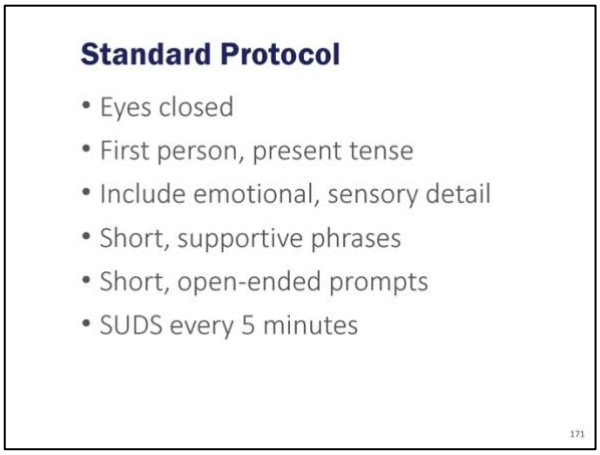
170.

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.

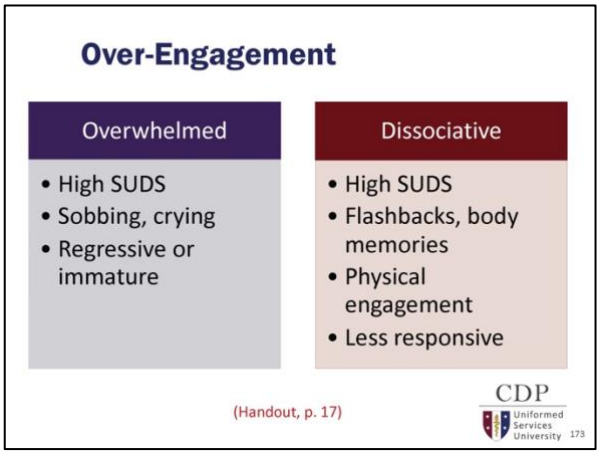
This agenda, similar to session 3 but without the rationale (unless needed) will structure most of the sessions until the end of treatment.

172.



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

173.



Recognizing Over-engagement

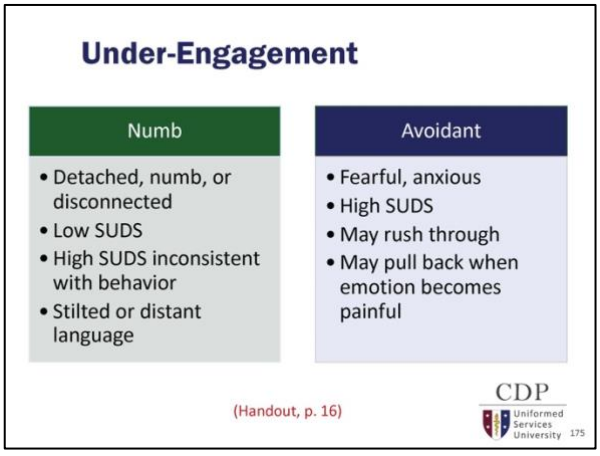
174.

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.

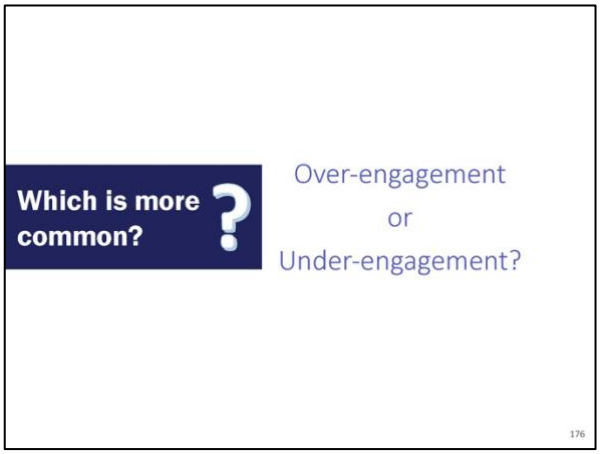


Recognizing Under-engagement

176.

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

177.



What do you expect?

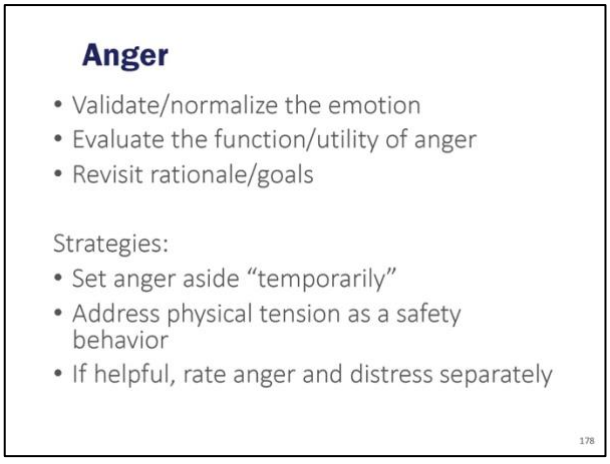
178.

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.



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.

180.

Reducing Distractions

Overall aim - provide emotional support while keeping the focus on PTSD

- Connect PTSD symptoms to other issues
- Conceptualize PTSD as a resource hog
  - prioritizing PTSD symptoms will free up energy and resources in the long run
- Predict other issues will improve as PTSD does

179

If PTSD is primary, continue to remind the patient that adhering to treatment and decreasing PTSD and related symptoms is the best strategy.

- Also, PE can have broad effects on negative emotions beyond those targeted, including depression, anxiety, anger, and guilt

181.

Shaping Engagement Demos

Under-engaged | Over-engaged | Angry

180

Video Demonstration – Shaping Engagement

182.

PE Homework: Session 4

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:

Driving on streets with potholes (Oak Street, Pacific Way)
Driving down narrow streets (3rd Street downtown)
TV/movies with lots of blood (Zombies, Emergency)

(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.)

Homework for Session 4-5

183.

Assessing Progress

- Self Reports
  - PCL/PSS
  - BDI II/PHQ-9
- Functional Indicators
- SUDS

Patient ID: John Smith

Psychometric Summary

DSM-5 Diagnosis/Codes	Date	Intake Measures			
PTSD		PCL-5	PHQ	CAPS	
		52	17	49	

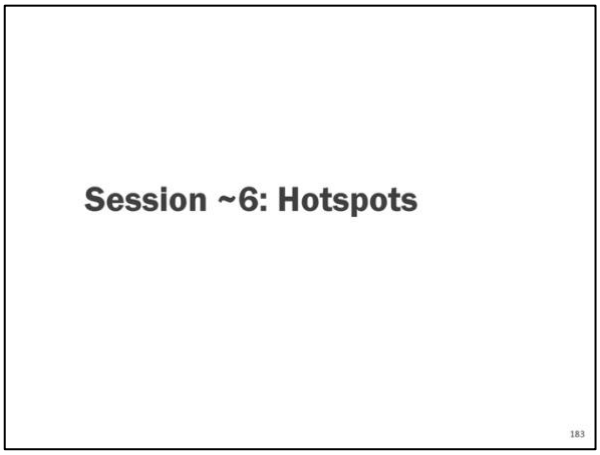
Ongoing Assessment

Notes:	Date	Session #	Self-report Measures	
			PCL-5	PHQ
	2/6	2	52	16
	2/20	4	54	17
	3/6	6	44	11

(Handout, p. 37)

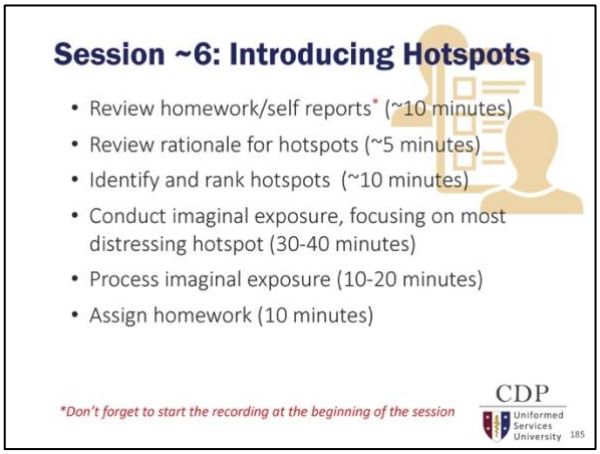
Progress is monitored at least every other week to make sure the patient is progressing.

184.



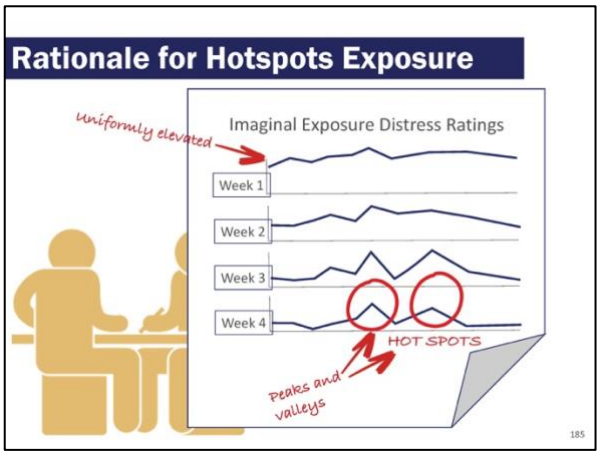
Session ~6: Hotspots

185.



Agenda for Hotspot Introduction

186.

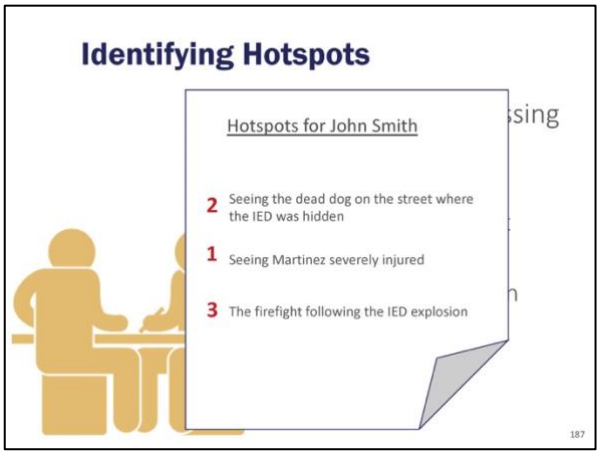


Hotspots are sections of the narrative memory that remain distressing even as distress in most other sections begins to dissipate.

187.

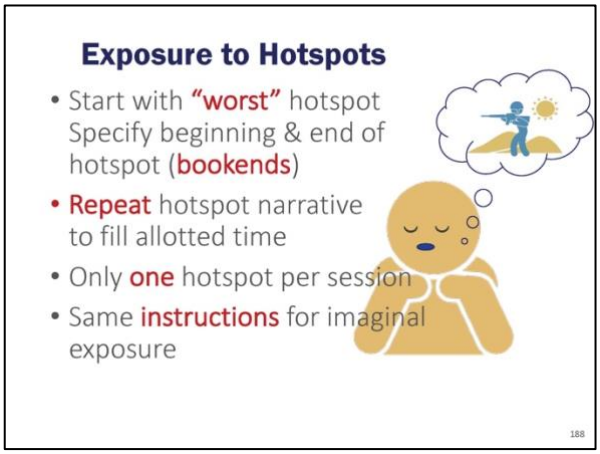
Metaphor Bank – Learning to Play a Song

188.



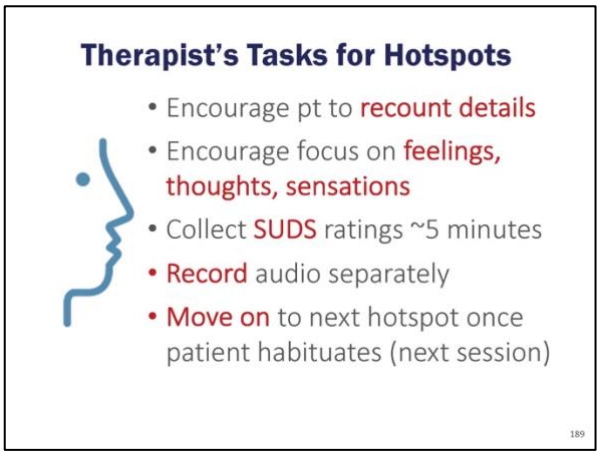
John's Hotspots

189.



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

190.



Therapist tasks are similar to regular imaginal exposure.

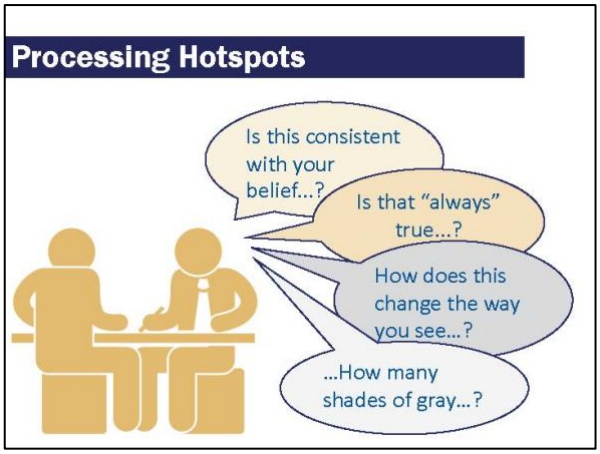
You may want to collect SUDS more frequently since the hotspot is likely quite short compared to the narrative.

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

_____

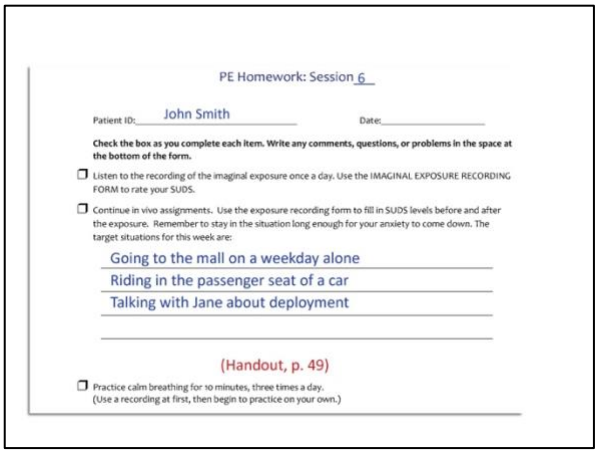
_____

191.



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.

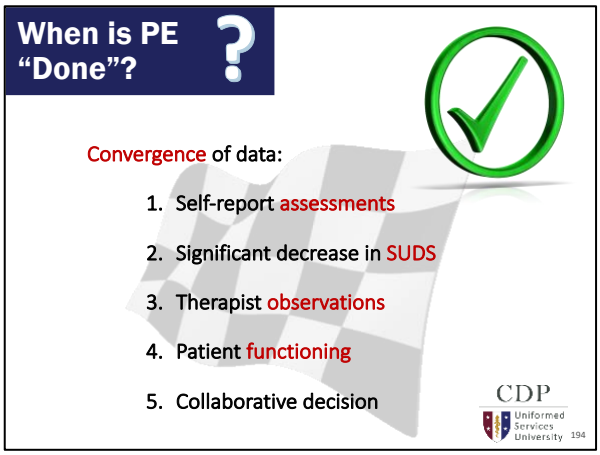


PE Homework Session 6 and after

193.

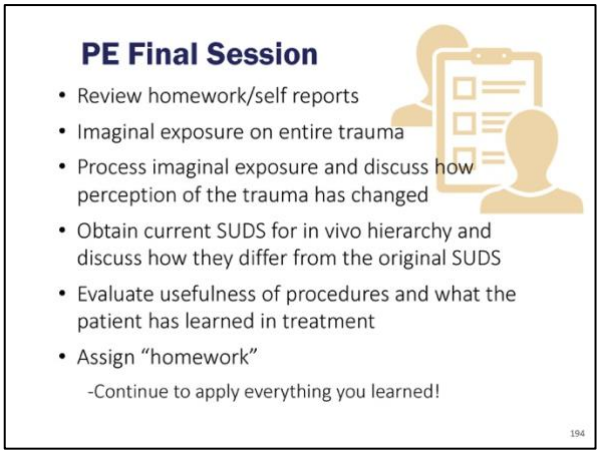
Final Session

194.



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

195.



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

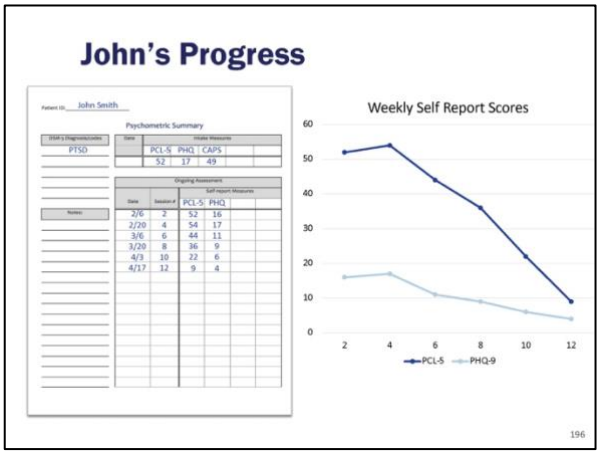
As part of this review, the imaginal exposure discontinues

hotspots and returns to the _____.

196.

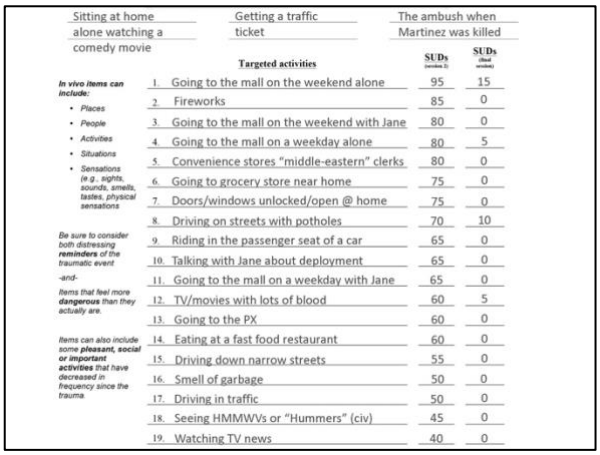
The final session is an opportunity to consolidate learning one last time before the patient discontinues treatment.

197.



John's final psychometrics

198.



John's final in vivo ratings

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.

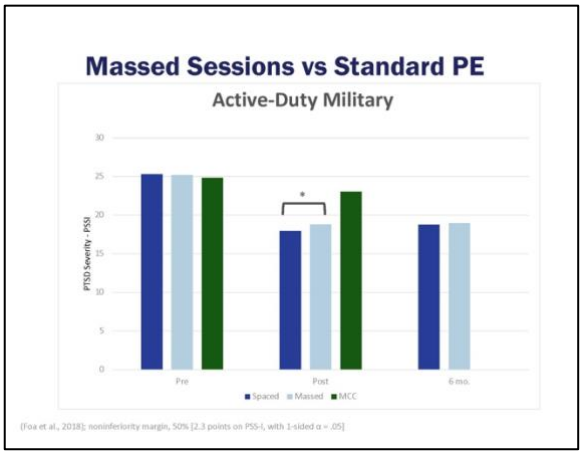
Accessibility

- 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.



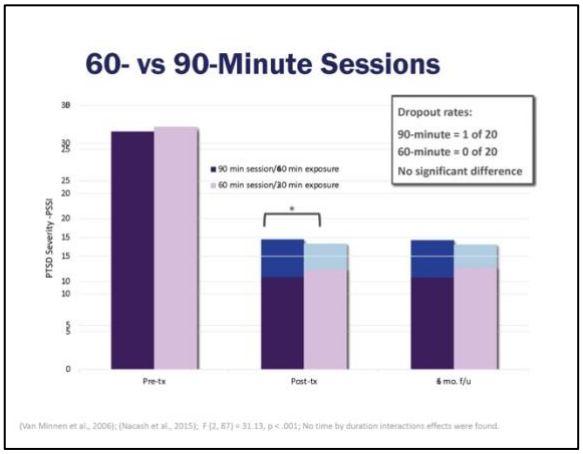
Massed PE is noninferior to spaced PE.

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.

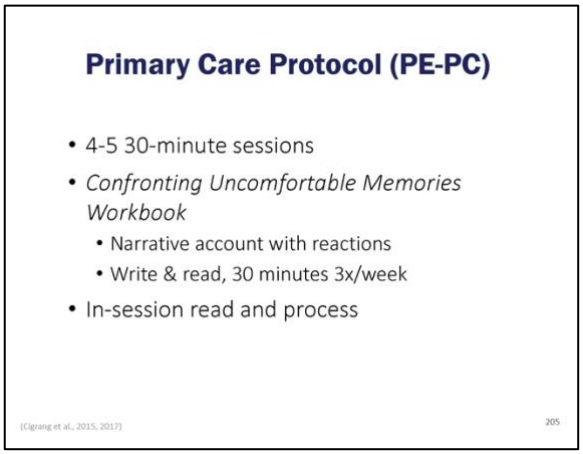
205.



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

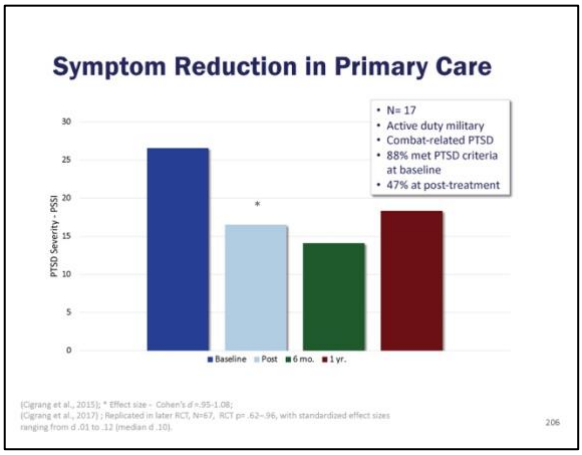
- Both groups improved significantly from pre- to post-treatment
- No significant differences in improvement between treatment groups on:
    - PTSD symptoms (PSSI),
    - depression (SCL-90 depression),
    - anxiety (STAI) or
    - end state functioning (composite)
- ***Dropout rates:***
- 90-minute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

206.



Primary Care Protocol

207.



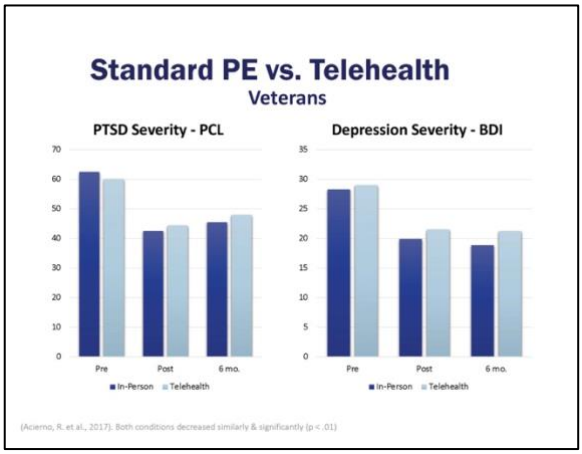
Abbreviated PE reduces symptoms in primary care.

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.

208.

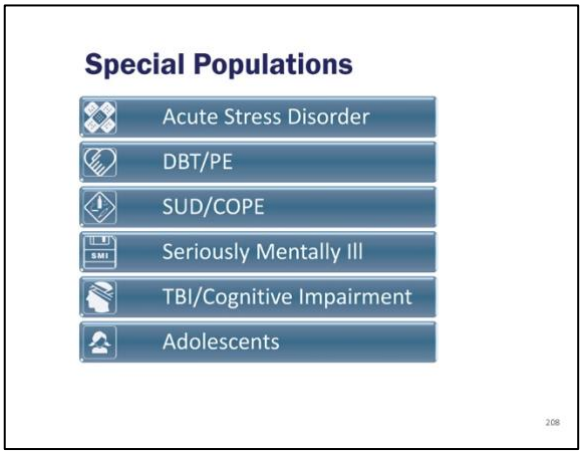


Telehealth noninferior to face-to-face treatment.
Same study discussed in evidence base section but repeated here to highlight findings regarding telehealth.

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

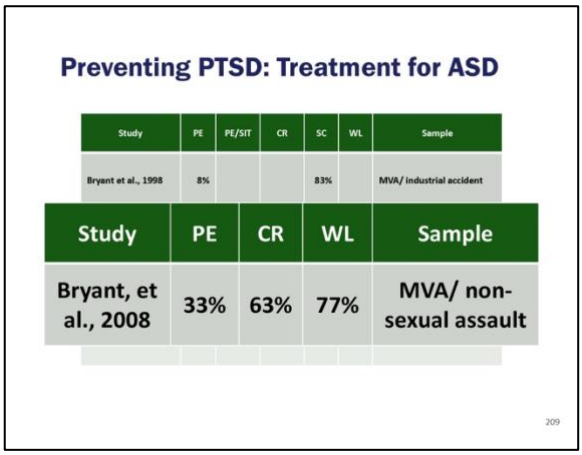
Telehealth and standard PE are _____effective.
Both groups were highly satisfied with tx.

209.



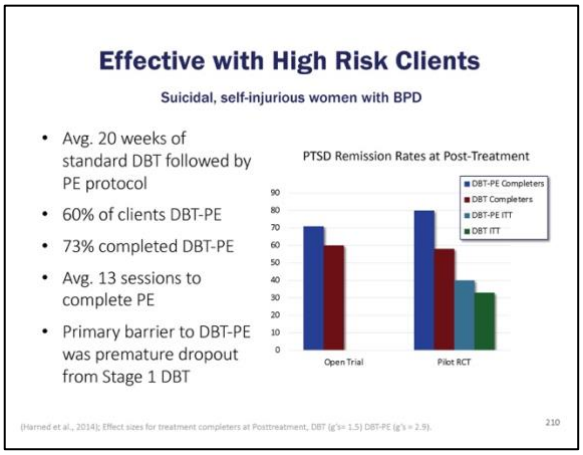
Several researchers have conducted RCTs and other studies applying PE to more complicated patient groups, enabling more people to benefit from treatment.

210.



Early treatment may prevent the development of PTSD

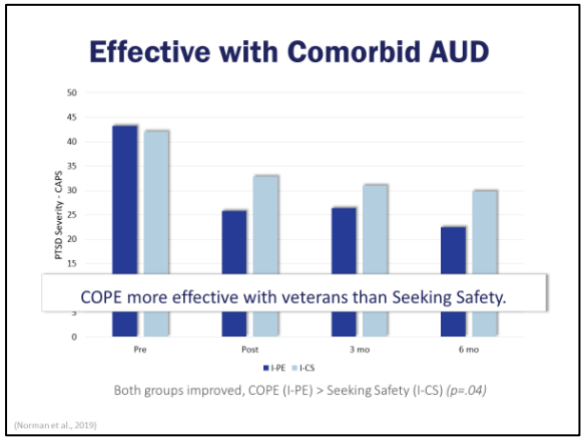
211.



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

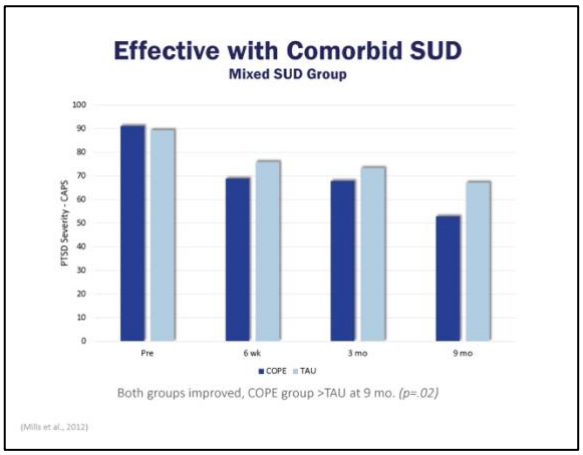
Results from open trial (N=13) and pilot RCT (N=26)

212.



Integrated PE (COPE) is more effective than Seeking Safety

213.



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

Women, mixed trauma history, with PTSD and substance dependence

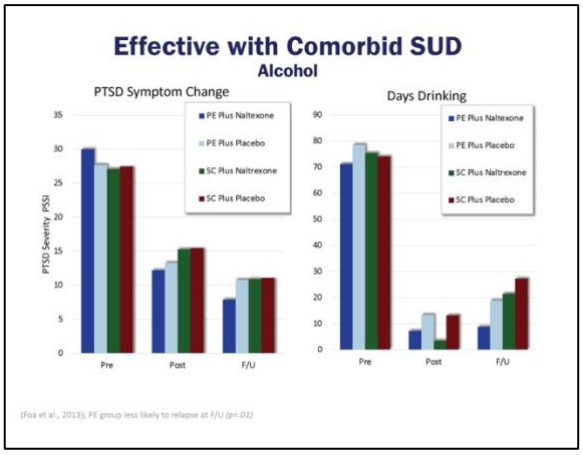
55 received PE-COPE protocol

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

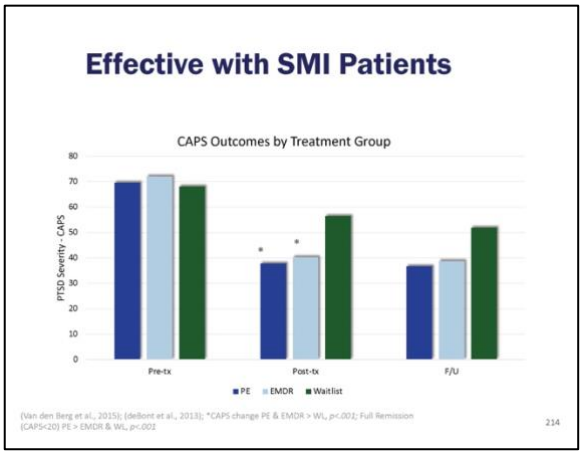
214.



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.



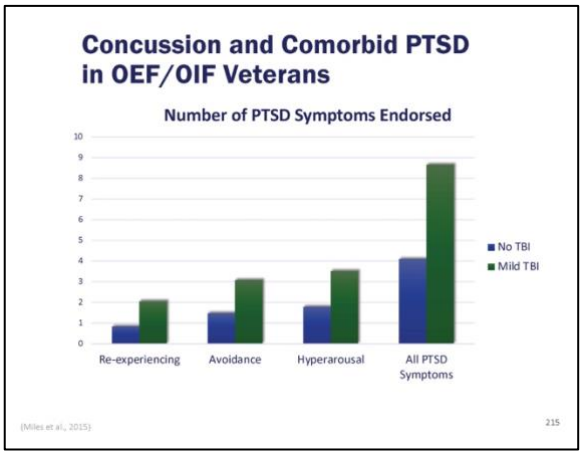
PE safe and effective for SMI patients.

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

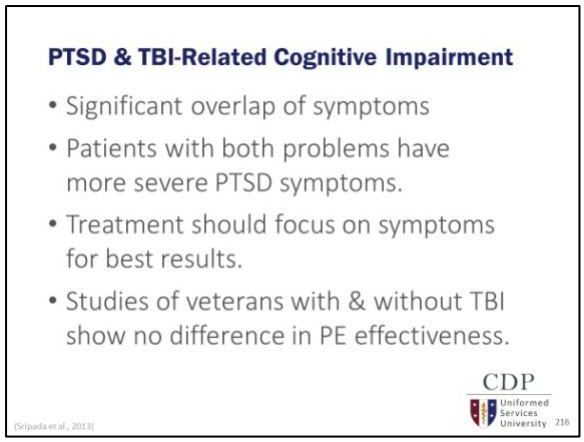
Standard protocols, no additional stabilizing interventions; TAU for psychosis included medication and/or supportive counseling

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

216.

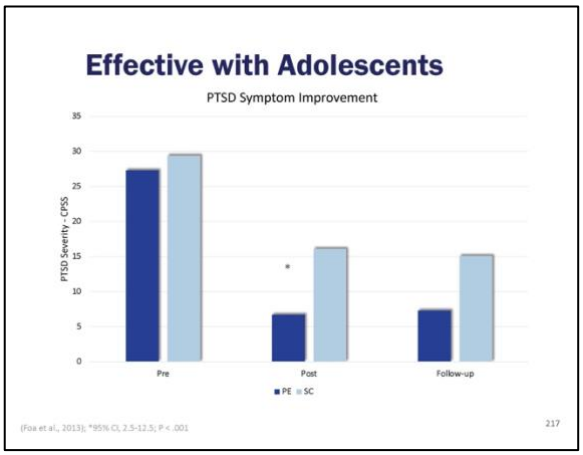


217.



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*)

219.

Next Steps...

- Resources
- Practice Opportunities
- Continued Learning & Consultation

218

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

CDP Uniformed Services University

220

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220

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

221

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!

222

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.

223

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Twitter: @DeploymentPsych

224