CENTER FOR DEPLOYMENT PSYCHOLOGY

PROLONGED EXPOSURE THERAPY FOR PTSD:

HANDOUTS AND SUPPLEMENTARY MATERIALS FOR THE PE CLINICIAN WORKSHOP

CDP

Uniformed Services University

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Course Description

This intensive 2-day module provides training in Prolonged Exposure (PE) Therapy, an evidence-based treatment for PTSD described in the manual, *Prolonged Exposure Therapy for PTSD – Therapist Guide*, by Foa, et al., 2019. It covers the consistent and credible empirical and theoretical support for PE and reviews the main clinical techniques used in this structured protocol. Step-by-step instructions for conducting PE therapy sessions, including in vivo and imaginal exposure, along with strategies for working with over- and under-engaged patients and other difficult cases, are shared. Videotaped examples of PE cases are used to demonstrate therapist skills. Participants are expected to do role-plays in class to practice PE techniques, and they must attend both days (Acierno et al., 2017; Benuto et al., 2020; Foa et al., 2019; Kline et al., 2020; Schnurr et al., 2022).

Agenda

Day 1

1) **Introduction and course overview**
2) **Body of evidence**
3) **Theoretical assumptions**
4) **Who is appropriate for PE?**
5) **What does a PE therapist do?**
6) **Session 1: Introducing the treatment**
    a) **Overall treatment rationale**
    b) **Index trauma/Trauma interview**
    c) **Relaxed breathing**
7) **Session 2: Common reactions/Introducing in vivo exposure**
    a) **Common reactions discussion**
    b) **Rationale for in vivo exposure**
    c) **Generating in vivo targets**
    d) **Developing the SUDS rating scale**
    e) **Refining the in vivo hierarchy**
    f) **Preparing the client for their first in vivo exposure**

Day 2

1) **Session 3: Introducing imaginal exposure.**
    a) **Rationale for imaginal exposure**
    b) **Implementing imaginal exposure**
    c) **Processing**
2) **Sessions 4-5: Shaping engagement**
    a) **Under-engagement**
    b) **Over-engagement**
    c) **Anger**
3) **Assessing progress to improve outcome**
4) **Session 6-7: Introducing hotspots**
    a) **Rationale for hotspots**
    b) **Identification of hotspots**
    c) **Exposure and processing**
5) **Final Session**
    a) **Discontinuing PE: When is PE "done"?**
    b) **Final session summary**
    c) **Relapse prevention**
6) **Improving the accessibility of PE**

Learning Objectives

Participants will learn how 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 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.

Overview of PE Components by Session

Component	Session	Agenda
Psychoeducation	**Session 1**	● **Overview of treatment program and overall rationale** ● **Collect information relevant to the trauma and establish index trauma with beginning and end of the trauma memory** ● **Introduce breathing retraining** ● **Assign homework**
Psychoeducation	**Session 2a**	● **Review homework** ● **Educate client about common reactions to trauma** ● **Assign homework**
Psychoeducation	**Session 2b**	● **Review homework** ● **Discussion of rationale for in vivo exposure** ● **Introduction of SUDS / anchor points**
Exposure/ Processing	**Session 2b (continued)**	● **Construct in vivo hierarchy** ● **Instructions for in vivo exposure** ● **Select in vivo assignments for homework** ● **Assign homework**
Exposure/ Processing	**Session 3**	● **Review homework** ● **Present rationale for imaginal exposure** ● **Conduct imaginal exposure** ● **Process imaginal exposure** ● **Assign homework**
Exposure/ Processing	**Sessions 4-5**	● **Review homework** ● **Conduct imaginal exposure (shaping engagement as needed)** ● **Process imaginal exposure** ● **Assign homework**
Exposure/ Processing	**Sessions 6-9**	● **Review homework** ● **Review rationale for hotspots** ● **Conduct imaginal exposure focusing on hotspots** ● **Process imaginal exposure** ● **Assign homework**
Termination	**Session 10**	● **Final Session - Review homework** ● **Conduct imaginal exposure on entire trauma** ● **Process imaginal exposure and discuss changes** ● **Review outcomes and discuss functional impact** ● **Evaluate usefulness of procedures and what the client learned in treatment**

**Note session 2b is both psychoeducation and exposure. In practice, psychoeducation may be reviewed as needed.*

Sample In Vivo Items

Combat

- Movie or TV shows with war/combat
- Stadium events
- Burning smells (e.g., smoke, fire, BBQs)
- Construction sites
- Middle Eastern spices/scents
- Military vehicles/Humvees
- Talking to other service members or veterans about combat experiences
- Loud noises (e.g., car backfiring)
- Fireworks
- Seeing wounded/injured people
- Sand/beach/desert
- Hot weather
- Gas stations
- Convenience stores (7/11)
- "Big Box" or other crowded stores
- Hearing a foreign language (e.g., Arabic)
- Seeing people in Middle Eastern clothing
- Children playing in a park
- Stray dogs
- Military gear/memorabilia/insignia
- Being at a military base
- Going to an appointment at a VA hospital
- Driving on crowded roads
- Dead animals
- Roadside trash or debris
- Firearms
- Being "unarmed"
- Traffic/being boxed in on the road
- Violent video game

Avoidance is often related to being put in harm's way or a life-threatening event again; feeling unsafe or unable to protect oneself and others (e.g., military colleagues, family members); bad things happening unpredictably; remembering the combat event and losing emotional control; showing weakness, including PTSD symptoms; letting military colleagues or others down; loss of loved ones; becoming close to and trusting others; people who appear threatening or like the enemy.

Sexual Abuse/Sexual Assault

- Going out at certain times of day or night
- Going out alone
- Being at home alone
- Associated clothing, shoes, makeup
- Associated smells (alcohol, cologne, body odor)
- Sweat, sweaty smell
- Physical characteristics of the perpetrator (incl. voice, appearance, gender)
- Dirty fingernails, hands
- Cigarette smell or breath
- Doctor visits or medical treatments
- Being held in an immobile position (like at the dentist or doctor, massage)
- Putting something in the mouth (dentist)
- General or specific touch
- Associated music
- Associated foods, food textures
- Associated rooms (shower, bathroom, bedroom, door closed or locked)
- Associated places, parts of town
- Parties, bars
- Groups of people
- People who are drinking, intoxicated
- Words/phrases, esp. explicit or "dirty"
- Terms of endearment
- Going to the gym
- Saying "no," refusing to cooperate with someone's wishes
- Talking to someone about the trauma
- Sleeping with bedroom door unlocked
- Sleeping with bedroom door left open
- Walking alone outdoors
- Sitting with one's back to people
- Responding to an intimate partner
- TV shows or movies with evocative scenes (intimacy or sex, sexual assault, violence)
- Small, confined spaces
- Hugging or kissing significant others/loved ones
- A perceived vulnerable position with another person (i.e., alone, someone larger, socially more powerful, louder, expressing anger)

Avoidance is often related to being assaulted or harmed again, being judged as promiscuous, being blamed for the assault, shame, being rejected as damaged or dirty, remembering the assault, and losing emotional control.

Motor Vehicle Accident (MVA)

- Wearing a seatbelt
- Checking a seat belt obsessively
- Sitting in a certain seat of a vehicle
- Driving
- Time of day or night
- Places, certain roads
- Traffic conditions
- Passenger count
- Type of vehicle
- Weather
- Riding as a passenger
- Talking while driving or riding
- Crossing a street
- Pedestrian crossings
- Smell of gasoline
- Driving on a similar highway/road
- Smell of burning plastic or hair
- Pain/injury related to the accident
- Scars or disfigurement (self or other)
- Song that was on the radio
- Sound of car screeching
- Medical or hospital settings
- Police emergency services siren
- Medical procedures
- Checking behaviors related to driving safety (looking behind too many times, tentative about parking, merging, driving the speed limit)
- Getting lost
- Using or not using GPS
- Car insurance company/paperwork

Avoidance is often related to being in another accident or causing an accident with careless behavior, thinking about the accident leading to a loss of emotional control, or being at fault for another accident.

Natural Disaster

- Weather conditions
- Locations perceived as vulnerable to natural catastrophes
- Items associated with emergency preparedness (flashlight, candles, storm cellar)
- Feeling trapped (small room, elevator, locked door)
- Windows
- Windowless rooms
- Emergency sirens and sounds
- TV shows or movies with content related to natural disasters
- Fire alarms and drills
- Smells associated with the disaster or aftermath (e.g., burned plastic, flesh, decomposition, mold, gasoline)
- Smoke
- Fire
- Traffic jams
- Clothing/shoes worn at the time
- Topography/landscape associated with the disaster (e.g., mountains, ocean)

Avoidance is often related to being caught in/hit by another natural disaster, being surprised by a catastrophe or calamity when doing something relaxing or pleasant, feeling unsafe in one's environment, or thinking about the disaster leading to a loss of control.

Common Safety Behaviors

Distractions

1. Mental/covert distractions during in-vivo exposures (e.g., counting, mantras, poems, songs, memory tasks)
2. Texting
3. Games on the phone
4. Checking email

Protections

5. Carry a weapon (gun, knife, box cutter, walking stick (non-therapeutic))
6. Carry “protective” objects (lucky charms, medication bottle, cell phone)
7. Carry a backpack (to keep hands free)
8. Wear combat boots
9. Wear baggy clothing, or too much clothing for the climate
10. Avoid eye contact, smiling, context-appropriate friendliness around strangers
11. Take spouse (or other trusted companion) when going out shopping, to crowded places, etc.
12. Walk slow to let someone pass who is close behind
13. Scope a place out before entering
14. Locate exits
15. Formulate contingency and escape plans
16. Check others' hands
17. Rush through a store directly to desired items
18. Sit with back against the wall/facing entrance/exit
19. Keep entrances, exits and other people in sight (e.g., in waiting room, in restaurants, when shopping, in church, in movie theaters)

Driving/Roadway Measures

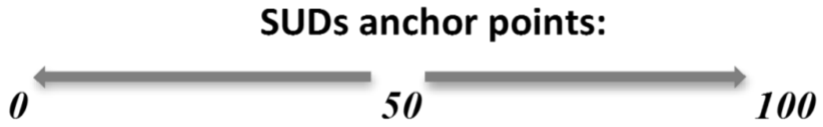
20. Drive toward the middle of the road to avoid driving close to the roadside
21. Check (for unlikely scenarios) while driving
22. Avoid stopping in traffic (some veterans buy motorcycles so that they can keep moving when other traffic stops)
23. Seatbelt unbuckled for quick exit

Precautions at Home

24. Not sleeping until the rest of family is asleep
25. Checking the yard ("Perimeter Checks")
26. Checking and rechecking locks
27. Sleep with lights on
28. Sleep with television on
29. Wear multiple layers of clothing to bed

Subjective Units of Distress Scale (SUDs)

Anchor the SUDs Scale by establishing memorable anchor events for 0, 50, and 100.



Anchors should be:

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

Zero is relatively easy to identify, 100 is often identified as the trauma. The 50-anchor point can be more difficult for some clients. Here are some examples that might be helpful.

REMEMBER: SUDS ARE SUBJECTIVE. EACH CLIENT WILL DETERMINE WHAT FITS FOR THEMSELVES.

- Dancing in public
- Driving in ATL traffic
- Shopping with my mother-in-law
- Public speaking unfamiliar topic
- Giving a speech
- Speaking in front of others
- Walmart on payday/Christmas Eve
- Writing on a board in front of others
- Job interview
- Getting a traffic ticket
- Diving into the deep end
- Swimming in a deep lake/open water
- Phone call with mother-in-law
- School drop-off car line
- Paying a fine
- Waiting in line for a rollercoaster
- See a poisonous snake on a hike
- Giving a presentation
- Oversleeping for work
- Public speaking
- Dentist appointment/Cavity filled
- Standing on a roof
- Flying
- Providing wedding speeches
- Following the wedding speaker
- Taking tests
- Introducing myself to a room of people
- Roaches
- Hiking to the top of a mountain
- Job interview
- Taking young children on a plane
- Medical procedures
- Breakout rooms :)
- Going to party where I don't know anyone

Imaginal Exposure

Instructions to the Patient

During the Imaginal Exposure:

- "Close your eyes."
- "Speak in the first person, present tense ('I am walking toward the door …')."
- "Describe all the details you can remember, such as thoughts, feelings, sights, sounds, and sensations."
- "Allow yourself to experience your emotions and whatever else comes up."
- "Don't worry about what you can't remember; focus on what you can recall."

While you're revisiting your trauma memory:

- "I'll ask you to repeat the narrative to fill 20/45 minutes."
- "This means you may have to recount the trauma several times. For example, if it takes you 10 minutes tell it the first time; you're probably going to need to repeat it three more times. When you finish, I'll prompt you to begin again."
- "I'll ask you for your SUDS before you begin and about every 5 minutes thereafter."
- "Give your SUDS level from 0 to 100 like you've been doing for in vivo homework assignments. Then go right back to telling me your trauma. I don't want you to stop or pull out of the memory."

Additionally:

- "I may occasionally make a comment or ask a question, but you're going to take the lead. Other than asking for your SUDS, I will mostly remain quiet and listen."
- "We'll record the imaginal exposure separately from the session recording so you can listen to it later."
- "After we are finished with the imaginal exposure, we will save about 10-20 minutes of time to talk about the experience."

Therapist Tasks During Imaginal Exposure

- **Listen and Document** – Take notes and record SUDS on the Therapist Recording Form.
- **Manage Time** – Monitor the clock so there is time to process after.
- **Support and Guide** – Use minimal encouraging words and occasional probes to titrate emotional response and create a safe space.

Optimal engagement is one foot in the present and one foot in the memory.
To achieve this, ask yourself:

- Is this experience conducive to the patient taking in corrective information or new learning?
- Is the patient able to learn that the memories are not dangerous even if they are experiencing distress?

Facilitating Optimal Engagement

Use minimal and goal-focused comments/open-ended questions

Offer encouragement.

"You're doing a good job staying with it/visualizing it."
"Stay with the feelings. You're doing great."
"You're doing really well. Hang in there."

Express empathy with patient's distress.

"I know this is hard."
"I can tell this is difficult but stick with it."
"This is tough to get through but keep at it."

Offer reassurance if needed.

"This is hard but remember you're safe here with me."
"This is going to help you get better. Keep going."
"Remember the memories aren't dangerous like the trauma was."

Direct focus to important/missing details.

"What happens next?"
"What does it look like?"
"How are you feeling now?"
"What is your body feeling?"
"Where do you feel that in your body?"
"What are you thinking at this time?"
"What does it smell like?"
"Tell me what you hear/see?"
"Describe what's going on around you/inside of you?"

Processing Strategies

General Strategies

- Be non-directive and reflective.
- Use open-ended questions rather than challenging your patient.
- Offer praise. Remember that all exposures are successful in some aspect.
- Restate and summarize implicit corrective information gained to make it explicit.
- Help your patient evaluate the usefulness of their cognitions and beliefs, rather than focusing on dysfunction.

Specific Comments and Queries

Calm, support, and praise

"Okay, let's stop there, and open your eyes. You did a great job."
"This is tough to do, and you stuck with it. Good for you."
"Although it was difficult, you hung in there really well, and that took a lot of courage."
"You did a great job. I know that was hard to do. That was amazing you got through it."

Validate and normalize:

"I can tell it was especially hard when you got to XX part of the trauma. It's normal to want to avoid talking about the memory."
"It makes sense that you cried and wanted to stop when you were recounting your memory. You've never told anybody this before, and it's painful."
"I could see how difficult it was to express your feelings at times. This process is distressing and will evoke painful feelings."

Ask for their reactions:

"How did that feel?"
"You told me the trauma XX times. How was this experience for you?"
"What was that like for you?"

Inquire about changes:

"How do you see things now versus before you walked me through the trauma?"
"Did you notice any changes – from the first to the last telling?"

Introduce your observations:
"The second time you told it, I noticed you gave a lot more detail."
"When you got to the middle, you seemed to jump over it. What do you think that was about?"
"I noticed that you opened your eyes a few times. Were those the most distressing parts?"
"The last time you told the story was different than the other times. You expressed more feelings. Did you notice the changes?"

Point out or inquire about contextual and temporal detail:
"What was happening before, during, and after the event?"
"How is 'then' different from 'now'?"
"Now that you have new information, does it affect how you think about the trauma/your role?"
"How does that event fit with the many other experiences you had during your military career?"

Reinforce the rationale:
"Your SUDS started at 100 and went down to 85. You're already starting to habituate."
"By the last time you told it, you seemed more in control, which is one of our goals."
"What did you notice about your anxiety?"
"You had less anxiety today than last time you did this. The more you face the distressing memory, the less distressed you become."
"You were not sure you could do this but look at how well you did it. You stayed in touch with your feelings and got through it. You're learning you can do it."

Focus on trauma-related beliefs that maintain symptoms:
"What does it say about the world that this happened to you?"
"When did you start viewing it that way?"
"How does that relate to not trusting anybody?"
"How did your thoughts change after the trauma happened?"

Connect to meaning and values:
"What does that mean about you then? Now?"
"How does having that view help you today?"
"What might be a lesson learned from this that could help your life today?"
"Are there other possible explanations about why it happened?"

Challenges in Imaginal Exposure

Under-Engagement

How under-engagers present:

Under-engagers struggle to access the emotional aspects of their trauma memory.

They may:

- Feel detached or numb
- Have difficulty visualizing the memory
- Report low SUDS
- Report high SUDS, but they are inconsistent with their clinical presentation
- Use stilted language

How to help under-engaged patients engage more:

If your patient is under-engaged, check that standard procedures are followed:

- Visualize the trauma with eyes closed.
- Speak in the first person, present tense.
- Describe the trauma as if it were happening now, using all your senses.
- Slow down the narrative to allow for more awareness of thoughts, emotions, details.

If the patient needs more encouragement:

- Increase the use of probes that focus the patient toward important or missing detail, especially sensory and emotional detail, e.g.:

  Describe what's going on around you/inside of you?
  What are you feeling?
  What does that feel like?
  What do you feel in your body?
  Where do you feel it?
  What do you see?
  How are you feeling now?
  What is your body feeling?
  Where do you feel that in your body?
  What are you thinking at this time?
  What does it smell like?
  Tell me what you hear/see.

- Revisit the rationale.
- Use metaphors to increase understanding.
- Share research findings on how emotional engagement facilitates recovery.
- Demonstrate emotional engagement; role-play.

Over-Engagement

How over-engagers present:

Over-engagers experience excessive emotional distress that interferes with new learning as they recount their memory. They may:

- Dissociate
- Exhibit body memories
- Have flashbacks
- Engage in regressive behaviors
- Cry profusely over sessions

How to introduce distance for over-engaged patients:

Begin by offering reassurance, and consider reversing the standard procedures to increase emotional distance:

- Eyes open
- Past tense

If the patient needs more encouragement:

- Use your voice/increase supportive comments.
- Make the experience more conversational.
- Decrease probes.
- Move the memory forward (e.g., "What happened next?").
- Revisit the rationale.
- Start with a part of the memory that the patient can recall aloud.

If the patient is especially agitated:

- Use a grounding object.
- Invite slow breathing.
- Introduce written narrative exposure.

Assessment Summary for John Smith

Demographic Information:

- 35 years old
- Married
- Two children (boy, age 7, and girl, age 5)
- Two combat deployments to Iraq, one to Afghanistan
- Returned two years ago
- Continues active duty

Presenting complaints:

Presents for treatment complaining of "moodiness," irritability, poor sleep, difficulty with aspects of his deployment experience, especially memories and nightmares related to some particularly stressful events which occurred during his deployment. He is concerned that his moodiness and irritability are affecting his relationship with his family and others.

Assessment:

John experiences nightmares about the incident approximately once per week and is reminded of the incident when he encounters memorabilia from the deployment or sees news stories about activity in the area of the world where he was deployed. He reports poor, interrupted sleep, with frequent insomnia. He complains of moodiness. Specifically, he often feels irritable with his children and wife and isolates himself from the family when he is home. He is not comfortable socializing or engaging in activities where there might be crowds or loud noise. He has experienced at least two incidents where he left an activity (his son's baseball game and a concert and picnic in the park) because he became increasingly irritable and reactive to noise and proximity in the crowd. He avoids these types of activities since that time and prefers that his wife do errands and shopping.

Regarding his deployment, John feels positive about his service but feels he failed to meet his own expectations in some instances. Specifically, he blames himself for the deaths of unit members killed while he was unit leader. He also feels some anger toward leadership for what he perceives as a lack of concern for the lives in his unit. Regarding the index trauma, John also feels betrayed by civilians in the village who were the recipients of aid from his unit, but whom he blames for the ambush that killed two of his unit.

Summary of index trauma:

John was team leader in his unit on a routine humanitarian mission when the lead vehicle encountered an IED and exploded, upending the lead vehicle and damaging John's vehicle. John was thrown from the vehicle and received minor injuries. Several members of the unit were severely injured. One young soldier in John's unit was mortally wounded. The unit was subsequently attacked by sniper fire, and it became apparent that the IED was intended to trap them in the narrow street where the attack occurred. John and his unit were rescued, but not before another member of the team was killed by sniper fire.

PCL-5 with LEC-5 and Criterion A

Part 1

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						✓
2. Fire or explosion	✓	✓		✓		
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)	✓	✓		✓		
4. Serious accident at work, home, or during recreational activity						✓
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						✓
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)	✓					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)	✓			✓		
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						✓
9. Other unwanted or uncomfortable sexual experience						✓
10. Combat or exposure to a war-zone (in the military or as a civilian)	✓	✓	✓	✓		
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						✓
12. Life-threatening illness or injury						✓
13. Severe human suffering		✓	✓			
14. Sudden violent death (for example, homicide, suicide)						✓
15. Sudden accidental death						✓
16. Serious injury, harm, or death you caused to someone else	✓					
17. Any other very stressful event or experience						✓

Part 2

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

IED and sniper attack to a convoy

B. If you have experienced more than one of the events in PART 1, think about the event you consider the worst event, which for this questionnaire means the event that currently bothers you the most. If you have experienced only one of the events in PART 1, use that one as the worst event. Please answer the following questions about the worst event (check all options that apply):

Briefly describe the worst event (for example, what happened, who was involved, etc.).

Convoy rolled by IED that exploded and was attacked by snipers who were lying in wait. Many injuries and one death of a close friend.

How long ago did it happen? 2-3 years (please estimate if you are not sure)

How did you experience it?

- [x] It happened to me directly
- [ ] I witnessed it
- [ ] I learned about it happening to a close family member or close friend
- [ ] I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)
- [ ] Other, please describe

Was someone's life in danger?

- [x] Yes, my life
- [x] Yes, someone else's life
- [ ] No

Was someone seriously injured or killed?

- [ ] Yes, I was seriously injured
- [x] Yes, someone else was seriously injured or killed
- [ ] No

Did it involve sexual violence? ○ Yes ◉ No

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

- ◉ Accident or violence
- ○ Natural causes
- ○ Not applicable (The event did not involve the death of a close family member or close friend)

How many times altogether have you experienced a similar event as stressful or nearly as stressful as the worst event?

- ○ Just once
- ◉ More than once (please specify or estimate the total number of times you have had this experience 3)

Part 3

Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	**3**	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	**2**	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	**2**	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	**3**	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	**3**	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	**4**
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	**2**	3	4
8. Trouble remembering important parts of the stressful experience?	0	**1**	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	**1**	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	**1**	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	**3**	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	**3**	4
13. Feeling distant or cut off from other people?	0	1	2	**3**	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	**2**	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	**3**	4
16. Taking too many risks or doing things that could cause you harm?	0	**1**	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	**4**
18. Feeling jumpy or easily startled?	0	1	2	3	**4**
19. Having difficulty concentrating?	0	1	2	**3**	4
20. Trouble falling or staying asleep?	0	1	2	3	**4**

Integrating Cultural Competence

Hays' (2009) 10 Tips for Culturally Competent Practice

1. Assess the person's and family's needs with an emphasis on culturally respectful behavior.
2. Identify culturally related strengths and supports.
3. Clarify what part of the problem is primarily environmental (i.e., external to the client) and what part is cognitive (internal), with attention to cultural influences.
4. For environmentally based problems, focus on helping the client to make changes that minimize stressors, increase personal strengths and supports, and build skills for interacting more effectively with the social and physical environment.
5. Validate clients' self-reported experiences of oppression.
6. Emphasize collaboration over confrontation, with attention to client–therapist differences.
7. With cognitive restructuring, question the helpfulness (rather than the validity) of the thought or belief.
8. Do not challenge core cultural beliefs.
9. Use the client's list of culturally-related strengths and supports to develop a list of helpful cognitions to replace the unhelpful ones.
10. Develop weekly homework assignments with an emphasis on cultural congruence and client direction.

(Hays, 2009).

The ADDRESSING Framework: Summary of Cultural Influences and Related Minority Groups

	Cultural Influence	Minority 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**

(Hays, 2008)

PE Session-by-Session Checklists

PE Session 1 Checklist

A) **OVERVIEW**

1. Overview of structure and schedule – 8-15 sessions, 1-2x weekly, 60/90 min.; sessions will be recorded
2. Focus – decreasing PTSD symptoms
3. Therapy is intensive and can be distressing at first
4. Therapist is available for support, and it gets better

B) **RATIONALE FOR TREATMENT**

1. Begin session recording
2. Distress after trauma is normal; most recover with time, but some develop sx that linger
3. Two important factors maintain symptoms: AVOIDANCE and UNHELPFUL THOUGHTS/BELIEFS

    a) **<u>AVOIDANCE</u>** (2 types)
        (1) **Cognitive avoidance** -Thoughts, feelings, and memories of the trauma
        (2) **Behavioral avoidance** -Situations, places, people, and objects that cause distress because they are similar
            (a) In the short run, avoidance feels better, but in the long run, it results in increased distress and symptoms
            (b) Treatment is designed to block avoidance by confronting thoughts and reminders through exposure

    b) **<u>UNHELPFUL THOUGHTS and BELIEFS</u>** (second important maintaining factor)
        (3) Thoughts about safety, e.g., "The world is unpredictably dangerous"; "I can't trust anybody"
        (4) Thoughts about competence, e.g., "I'm incapable"; "I'm weak"
            (a) Cause excessive negative emotion and exacerbate PTSD symptoms
            (b) Treatment will address these unhelpful thoughts in processing

4. **Two main treatment techniques** to target symptoms:

    a) **Imaginal exposure** - repeated and prolonged revisiting of the trauma memory in imagination
    b) **In vivo exposure** - repeatedly approaching/confronting avoided people, situations, activities, places, and objects in real life

5. Exposure reduces PTSD symptoms by:

    a) Facilitating emotional processing and organization of the memory
    b) Demonstrating that trauma-related memories and situations are not dangerous
    c) Demonstrating that distress will often decrease after repeated and prolonged confrontation
    d) Demonstrating the patient is capable and competent

C) **TRAUMA HISTORY/TRAUMATIC EVENT(S)**

Depending on information already gathered from assessment:

1. Briefly review/supplement trauma history, reactions, associated problems
2. Identify/confirm the index trauma

D) **RELAXED BREATHING**

1. Rationale for relaxed breathing

    a) Breathing and emotional state are connected
    b) Learning how to breathe slowly will help with distress tolerance and relaxation

2. Instructions for slow breathing:

    a) Take a normal breath
    b) Exhale very slowly (while saying “calm” or “relax”)
    c) Pause before inhaling again for count of 4 (or at least 2)
    d) Record for at-home practice

E) **ASSIGN HOMEWORK**

1. Practice relaxed breathing 3x/day for 10 minutes (use recording as needed)
2. Listen to recording of the session once
3. Read Rationale for Treatment handout

PE Session 2 - Checklist

A) **AGENDA**

1. Prompt to begin session recording
2. Review self-reports/ homework from Session 1
3. Introduce common reactions to trauma
4. Explain rationale for in vivo exposure and construct In vivo hierarchy

B) **DISCUSS COMMON REACTIONS TO TRAUMA**

- fear and anxiety are easily triggered
- re-experiencing via memories, flashbacks, and nightmares
- impaired concentration
- disturbed sleep
- hyperarousal/hypervigilance/ startle
- avoidance (physical/cognitive/emotional)
- depression/loss of interest
- negative thoughts about self and others
- wishing for death/suicidal ideation
- pain or somatic complaints
- feelings of loss of control
- guilt/shame/self-blame
- anger/irritability
- disrupted relationships
- decreased interest in sex
- activation of other traumatic/negative memories
- using alcohol or substances to avoid trauma-related memories
- reckless behavior (e.g., speeding, motorcycles

C) **RATIONALE FOR IN VIVO EXPOSURE**

1. Avoidance maintains PTSD symptoms and prevents new learning
2. In vivo exposure blocks avoidance
3. Disconfirms the belief that anxiety lasts forever
4. Frequently results in habituation (i.e., anxiety decreases with repeated and prolonged exposure)
5. Disconfirms patient's fears by allowing him/her to discriminate safe from unsafe situations
6. Increases patient's confidence by allowing him/her to learn that he/she can manage distress

D) **CONSTRUCT IN VIVO HIERARCHY**

1. Elicit avoided stimuli/situations and generate a list of 10-15 situations for in vivo exposure

E) **INTRODUCE AND CONSTRUCT THE SUDS SCALE**

1. Defines SUDS (Subjective Units of Discomfort/Distress Scale); range from 0 to 100
2. Generates specific anchor points based on patient's experience (minimum: 0, 50, 100 anchors)
3. Rate items according to patient's SUDS scale

F) **SELECT INITIAL IN VIVO ASSIGNMENTS**

1. Select one to three assignments that elicit low to moderate SUDS (40-50 range)
2. Give detailed and specific instructions for carrying out the assignments and recording progress on the in vivo recording form
3. Remain in the situation for 35-45 minutes or until SUDS decreases by half
4. Practice repeatedly for best results
5. Record pre-, post-, and peak SUDS levels (on homework form)
6. Do not use safety behaviors or distraction

G) **ASSIGN HOMEWORK**

1. Review Common Reactions to Trauma handout
2. Review in vivo list of avoided situations and add people, situations, objects, and anything new
3. Instruct the patient how to complete the In Vivo Exposure Recording Form
4. Listen to recording of session once
5. Continue to practice relaxed breathing

PE Session 3 - Checklist

A) **AGENDA**

1. Prompt to begin session recording
2. Review self-reports/homework from Session 2
3. Describe the rationale for imaginal exposure
4. Conduct imaginal exposure

B) **RATIONALE FOR IMAGINAL EXPOSURE**

1. Trauma is painful and leads to avoidance
2. Avoidance (thought suppression) works in the short run but not in the long run
3. Symptoms signal that the trauma is "unfinished business", that the memory is not processed
4. Use an analogy to illustrate the concept (e.g., bad meal, file cabinet/restaurant)
5. The goal of revisiting the trauma is to:

    a) process and organize the traumatic memories
    b) learn that the traumatic memories are not dangerous
    c) bring about habituation (i.e., with repetition, anxiety decreases)
    d) gain confidence in ability to manage distress
    e) allow the patient to control the memories rather than memories controlling the patient

C) **INSTRUCTIONS FOR ENGAGING IN IMAGINAL EXPOSURE**

1. Close eyes
2. Recall the index trauma as vividly as possible, including the events, thoughts, and feelings
3. Describe aloud, in the present tense, as if it were happening now
4. Give SUDS ratings when asked, without pausing or leaving the image
5. When the narrative is finished, repeat as needed, without stopping for 30-40 minutes

D) **FACILITATE IMAGINAL EXPOSURE**

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

E) **PROCESS IMAGINAL EXPOSURE**

1. Assist patient to regain composure, if necessary
2. Praise patient effort
3. Ask for patient reactions
4. Discuss habituation (or lack of) with patient
5. Share observations after eliciting patient's reactions

F) **ASSIGN HOMEWORK**

1. Listen to recording of entire imaginal exposure daily and record SUDS
2. Continue in vivo exposure homework
3. Listen to session recording once
4. Continue to practice relaxed breathing

PE Sessions 4-5 Checklist

A) REVIEW THE PREVIOUS WEEK

1. Prompt to begin session recording
2. Review self-reports/homework from Session 3
3. Conduct imaginal exposure

B) FACILITATE IMAGINAL EXPOSURE

1. Review instructions again if needed
2. Prompt to separate recording from the session recording
3. Conduct imaginal exposure for 30 to 40 minutes
    a) Prompt patient to stay in the present tense, if necessary
    b) Offer encouragement/support as needed
    c) Prompt patient to focus on thoughts, emotions, and body sensations as needed
    d) Titrate the experience as needed
    e) Collect SUDS approx. every 5 minutes

C) **PROCESS EXPOSURE**

1. Praise patient effort
2. Assist patient to regain composure, if necessary
3. Discuss habituation (or lack of it) with patient as needed
4. Ask the patient what emerged or seemed important during the imaginal exposure
5. Help patient to identify trauma-related thoughts and beliefs as needed
6. Ask questions that help patient to examine the accuracy of unhelpful thoughts
7. Share observations as appropriate
8. Point out recurring themes

D) **ASSIGN HOMEWORK**

1. Continue to practice relaxed breathing
2. Assign in vivo exposure homework
3. Listen to audiotape or digital recording of the session one time
4. Listen to recording of imaginal exposure once a day or as often as possible

PE Sessions 6-9 Checklist

A) **REVIEW THE PREVIOUS WEEK**

1. Prompt to begin session recording
2. Review self-reports
3. Review homework from previous session
4. Conduct imaginal exposure with hotspots.

B) **INTRODUCE HOTSPOT EXPOSURE**

1. As distress dissipates, difficult parts of the trauma narrative emerge
2. Focusing on those difficult parts facilitates recovery more efficiently
3. Use analogy or metaphor to clarify hotspot rationale
4. Collaborate with the patient to identify one to four hotspots
5. Rank order hotspots from least to most distressing

C) **FACILITATE HOTSPOT IMAGINAL EXPOSURE**

1. Begin with the most distressing hotspot
2. Review instructions
3. Prompt to separate recording from the session recording
4. Conduct imaginal exposure for 30 to 45 minutes
    a) Prompt patient to stay in the present tense, if necessary
    b) Offer encouragement/support as needed
    c) Prompt patient to focus on thoughts, emotions, and body sensations as needed
    d) Titrate the experience as needed
    e) Collect SUDS approx. every 5 minutes

D) **PROCESS EXPOSURE**

1. Praise patient effort
2. Assist patient to regain composure, if necessary
3. Discuss habituation (or lack of it) with patient as needed
4. Ask patient what emerged or seemed important during the imaginal exposure
5. Help patient to identify trauma-related thoughts and beliefs as needed
6. Ask questions that help patient to examine the accuracy of unhelpful thoughts
7. Share observations with patient as appropriate
8. Identify recurring themes and cognitions that maintain symptoms

E) **ASSIGN HOMEWORK**

1. Continue to practice relaxed breathing
2. Assign in vivo exposure homework
3. Listen to audiotape or digital recording of session one time
4. Listen to recording of hotspot imaginal exposure once a day or as often as possible

PE Final Session Checklist

A) **REVIEW THE PREVIOUS WEEK**

1. Review self-reports/homework
2. Final imaginal exposure
3. Review progress
4. Termination

B) **CONDUCT IMAGINAL EXPOSURE**

1. Conduct imaginal exposure of the entire memory (one iteration)
2. Prompt patient to stay in the present tense, if necessary
3. Offer encouragement/support as needed
4. Prompt patient to focus on thoughts, emotions, and body sensations as needed
5. Titrate the experience as needed
6. Collect SUDS ratings approx. every 5 minutes

C) **PROCESS EXPOSURE**

D) **REVIEW TREATMENT PROGRAM AND PATIENT'S PROGRESS**

1. Elicit current SUDS ratings for items included on the in vivo hierarchy
2. Discuss patient's progress
3. Review change in SUDS or self-report scores
4. Review skills the patient has learned and make plans for continued exposures, if indicated
5. Discuss possibility of experiencing symptom exacerbation and how to address using skills learned in PE
6. Emphasize that successfully completing PE does not mean they won't face other traumas
7. Elicit the patient's feedback about helpful and not-so-helpful aspects of the treatment
8. Provide patient with positive feedback about their hard work and progress

E) **TERMINATION**

1. Say good-bye
2. Consider having a booster session or f/u check-in in 3 or 6 months

Role Play Case Descriptions

Demographics	Index Trauma	Selected Symptoms
Case 1 **Combat Trauma** 40-year-old male Army veteran	• **Taking fire coming into a village while riding in a tank** • **Lead tank disabled, trapping convoy in the road** • **Ran across 100 yards of open space to service tank while under fire**	• **Avoids crowds, news, bloody or violent images** • **Nightmares** • **Hypervigilant, irritable, impatient**
Case 2 **Sexual Trauma** **30-year-old** **female** **AD Air Force**	• **Assaulted @ age 26 by a civilian acquaintance/neighbor in complex** • **Assailant claimed was consensual** • Did not report because she felt confused and blamed herself	• **Avoids: men, dating, alcohol (>1) drink, form-fitting clothes** • **Guilt, shame, blame**
Case 3 **MVA Trauma** **32-year-old** **female** **AD Army Nat Guard**	• **MVA 1 yr. ago during a training exercise** • **Pt was driver, was hit by another vehicle, thrown from vehicle** • **Broken leg and concussion** • **Recovered physically**	• **Anxiety/reactivity** • **Avoids driving** • **Doesn't allow her teen children sitting in front**

Observer Notes

Roleplay #1

Activity	✓	Notes
Introduce Program and Treatment Procedures		
● 8-15 sessions/1-2x weekly		
● 60/90-minutes		
● Focus = decreasing PTSD symptoms		
● Addresses two maintaining factors: 1. avoidance of trauma-related reminders 2. unhelpful thoughts and beliefs		
Present Rationale for Exposure		
● Distress/urge to avoid after trauma is normal		
● Avoidance works in short term, not in long run		
● Exposure blocks avoidance, which:		
▪ Facilitates processing and organization of memory		
▪ Demonstrates trauma-related memories and situations are not dangerous		
▪ Results in decreased distress (habituation)		
▪ Demonstrates patient competence		
Review Two Types of Exposure		
1. In Vivo Exposure: Repeated, prolonged confrontation of avoided situations, activities, and places in real life		
2. Imaginal Exposure: Repeated, prolonged reliving of the trauma memory in imagination		
Review Trauma-Related Beliefs		
● The world is very dangerous		
● I'm completely incompetent		
● Such beliefs can cause excessive negative emotions and worsen PTSD symptoms		
● Patient will learn to identify beliefs and question whether they are helpful or reasonable		

Overall strengths:
Areas for improvement:

Roleplay #2

Activity	✓	Notes
Present Rationale for In Vivo Exposure		
Blocks avoidance (avoidance maintains PTSD symptoms and prevents new learning)		
Results in habituation		
Disconfirms belief that anxiety lasts forever		
Disconfirms patient's fear by allowing him/her to discriminate safe from unsafe situations		
Increases patient's confidence by allowing him/her to learn that he/she can manage distress		
Introduce SUDS Scale		
Define SUDS		
Generate anchor points (at 0, 50, and 100)		
Construct In-Vivo Hierarchy		
Use example/analogy to illustrate habituation		
Elicit avoided situations/stimuli		
Generate a ranked list of items for in vivo exposure with a range of SUDS levels		
Collaborate with patient to pick one or two items to do for homework (with SUDS around 40)		

Overall strengths:

Areas for improvement:

Roleplay #3

Activity	✓	Notes
Present Rationale for Imaginal Exposure		
Remembering trauma is painful, leads to avoidance		
Reexperiencing symptoms and other trauma reactions signal memory is not processed		
Present analogy to convey meaning of ***processing*** traumatic memory		
Imaginal Exposure Helps to:		
Process and organize trauma memories		
Differentiates memory from "happening"		
Patient learns that with repetition, anxiety decreases (habituation occurs)		
Remembering isn't dangerous		
Increases mastery and control		
Provide Instructions for Imaginal Exposure		
Close eyes		
Remember traumatic event as vividly as possible		
Present tense, as if it were happening now		
Ask for SUDS ratings		
Tell story for about 45 minutes without stopping; may have to repeat it a few times to fill time		
Will process imaginal exposure at end		

Overall strengths:

Areas for improvement:

BLANK CLINICAL FORMS & CLIENT HANDOUTS

ID: Date:

Initial Assessment Summary

Brief case demographics:

Summary of index trauma:

DX:

Plan:

Concerns/Additional information:

ID: Date:

Psychometric Summary

DSM-5 Diagnosis/codes

Date	Intake Measures				

Ongoing Assessment					
Date	Session #	Self-report Measures			

Notes:

Rationale for Prolonged Exposure (PE) Treatment

How is PE helpful in reducing PTSD symptoms?

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

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

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

Avoiding those feelings prevents recovery.

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

It is important for you to know that this is a normal response to trauma. It is not your fault. It is not due to lack of intelligence, poor motivation, or some character flaw. We avoid -- all of us, from time to time -- because it works for us! Avoidance can be a reasonable and helpful way to deal with distress -- in the short term. Unfortunately, if avoidance is your main strategy, you miss out on opportunities that could help you process your emotions and begin to recover from the trauma. Most importantly, avoidance can make the problem much worse in the long run.

It's kind of like falling off a bicycle when you were a kid. If you get back on, you eventually master the bike, and you feel less afraid of falling. If instead, you refuse to get back on the bike and try again, the bicycle can start to seem very dangerous, and you become more and more afraid and avoidant of it over time. You might also feel more and more ashamed or embarrassed that you haven't learned to ride when your friends have already learned. Just thinking about the bicycle becomes distressing.

Thinking the worst about yourself and others makes recovery more difficult.

A second factor that keeps PTSD going are the unhelpful thoughts that go along with the trauma and your reactions to it. Many people with PTSD believe the world is a pretty dangerous and unpredictable place, and they have very little confidence in their own ability to manage difficult or distressing situations. You can see how beliefs like that encourage more avoidance and keep you from taking on experiences that might help you look at things differently. Those beliefs increase your distress and keep you from processing and getting past the trauma. Eventually, avoidance and unhelpful beliefs can creep into other areas of your life and interfere with things that are not even related to the original trauma.

Treatment will help you face your feelings and thoughts.

In this treatment program, you will begin to approach those trauma-related thoughts, feelings, activities, and situations instead of avoiding them. You will learn two new strategies to help you. The first is called in vivo exposure. In vivo means "in life". When you do in vivo exposure, you gradually begin engaging those relatively safe situations that you have been avoiding in your life since the trauma. The second is imaginal exposure, in which you revisit the trauma repeatedly in your mind while saying what happened aloud.

It gets easier with time and practice.

Imaginal and in vivo exposure both work in similar ways. Basically, these strategies help you confront or approach your distressing emotions, under relatively safe circumstances. As you practice these strategies over and over again, you begin to learn that your distress gradually decreases. In other words, you can become more comfortable in those situations, and you begin see that the distress doesn't last forever. We call this habituation. Habituation is a natural process that occurs when we stay in a distressing experience rather than escaping it or avoiding it.

When you begin approaching instead of avoiding, you begin to organize and process the memory and the emotions that go with it. This will eventually make the memory less likely to pop up all the time and help you to feel more comfortable when you are sometimes reminded of it. This will also allow you to feel more in control because the memories are less likely to pop up at times when you don't want them to. As you repeatedly revisit the trauma in therapy, the flashbacks, nightmares, and unwanted thoughts will be less likely to bother you. With time, you may even come to see the trauma differently.

By approaching instead of avoiding, you also begin to see that the situations you avoid and the memories you try to push away are not dangerous. You don't actually need to avoid them. Doing the things you need to do, in and out of therapy, can become easier over time, as your urge to avoid decreases.

You can begin to feel and think differently.

As you work your way through your avoidance, you get a chance to check those unhelpful thoughts, too. You experience firsthand how you can make effective choices and take care of yourself without falling apart or losing control, even if you are distressed or upset. With the benefit of those experiences, you will be able to challenge unhelpful thoughts and beliefs, bring your thinking more in line with what you are learning, and let go of inaccurate or unhelpful ideas that are holding you back and preventing your recovery.

You can recover and move forward in your life.

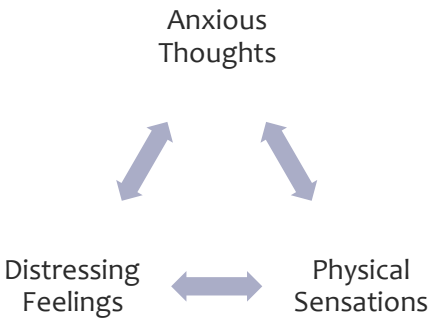
This treatment will be challenging, and some people feel nervous or doubtful in the beginning. The urge to escape and avoid can be very strong. But with time and practice, you will find that in vivo and imaginal exposure help reduce the urge to avoid. This will allow you to organize and process your experiences so that you can recover from the trauma, regain your confidence, and move forward with the things you need and want to do in life.

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

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 designed to help you feel better while you are awake!
- If you feel a little lightheaded, slow down.
- Some people find it helpful to have a calming word like PEACE or RELAX to focus on as they breathe. Feel free to try it and see If this works for you.
- Don't worry if you don't notice immediate effects from the exercise; it takes practice to develop the habit.
- Once you become familiar with the exercise, it is easy to practice on the spot while you are waiting in a line or doing some other routine activity. No one will be the wiser, and you can reap the benefits.

PE Homework: Session 1

ID: 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:

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. N**ot everyone reacts the same,** but some reactions are common. These reactions can affect the way you think, feel, and act in ways that are unexpected 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

- **Anger**
- **Irritability**
- **Impatience**
- **Over-reactions**

You may feel justifiably angry because of the trauma. You may also feel angry about how others acted during the trauma or reacted to you afterward. You may also find that you are irritable and easily angered by things that are unrelated to the trauma. Some people find that they have less patience, lash out at those close to them, or overreact to small annoyances.

Sadness and Depression

- **Sadness**
- **Depression**
- **Hopelessness**
- **Loss of interest**
- **Emotional numbness**

Trauma can involve loss, whether loss of a loved one, loss of health and well-being, or loss of your former way of life. While it is normal, even healthy, to feel sad after a loss, these feelings can be overwhelming and sometimes interfere with recovery. You may have crying spells, lose interest in things you used to enjoy, or feel as if you've lost connection to important people in your life. You may also feel hopeless, numb, or that life is no longer worth living.

Shifted Self-Image and World View

Self=
- **Worthless**
- **Incompetent**
- **Weak**

World=
- **Untrustworthy**
- **Dangerous**
- **Unpredictable**

The trauma can affect how you feel about yourself. You may believe that you are weak or incompetent because you experienced a trauma, or because you now have PTSD symptoms. You may also see the world and others more negatively. You may feel you can no longer trust people, or that the world is extremely dangerous and unpredictable.

Guilt and Shame

- **Guilt**
- **Shame**
- **Self-blame**

Feelings of guilt or shame can also interfere with recovery. You may feel ashamed about your reactions during or after the trauma or for having PTSD symptoms. You may feel guilty for not preventing the trauma, being responsible for its occurrence, or for acting or not acting in certain ways. This reaction can be particularly troubling if the trauma caused you to behave in ways that conflict with your sense of what is right.

Behavior Changes

- **Increased substance use**
- **Increased risky or unhealthy behaviors**
- **Avoiding social situations, intimacy, closeness**

You may notice an increase in unhealthy behaviors such as smoking or drinking more than you did before, using drugs, driving aggressively, getting into physical altercations, or neglecting your health and safety in other ways. It may be harder to connect socially with friends and family or be in intimate situations with a partner. This can cause you to miss out on relationships, occasions, or experiences that are important or meaningful to you.

ID: Date:

In Vivo Exposure Hierarchy

SUDS Anchor Points:

	Targeted activities	SUDS (session 2)	SUDS (final session)
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.*			

ID: Date:

In Vivo Exposure Homework Recording Form

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

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

3) Target Situation:	Date & Time	Beginning SUDS	Peak SUDS	Final SUDS

ID: Date:

PE Homework: Session 2

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

☐ Read the handout "Common Reactions to Trauma".

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

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

☐ **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
☼☼☼	☼☼☼	☼☼☼	☼☼☼	☼☼☼	☼☼☼	☼☼☼

☐ **Listen to the recording of the therapy session one time.**

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

☐ **Other:**

ID: Date:

Imaginal Exposure Worksheet

Description:

Full Narrative / Hotspots
(circle one)

	Time (minutes)	**SUDs**	
	0		***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.*	5		
	10		
	15		
	20		
	25		
	30		
	35		
	40		
	45		
*Identify potential **hotspots** for later discussion.*	50		
	55		
	60		

Processing notes:

Imaginal Exposure Homework Recording Form

ID: Date:

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

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

Date & Time	Beginning SUDS	Peak SUDS	Final SUDS

PE Homework: Session___

Patient ID: 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:

☐ **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
☼☼☼	☼☼☼	☼☼☼	☼☼☼	☼☼☼	☼☼☼	☼☼☼

☐ **Listen to the recording of the therapy session one time.**

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

☐ **Other:**

The PTSD Checklist for DSM-5 (PCL -5)

Administration and Scoring

The PCL is a self-report scale completed by the patient.
Administration time: 5-10 minutes
There are four formats:

- With the revised Life Events Checklist for *DSM-5* (LEC-5) and extended Criterion A assessment
- With a brief Criterion A assessment
- Standard administration (brief instructions assessing symptoms only in the past month)
- Weekly administration (brief instructions assessing symptoms only in the past week)

The weekly version is the best one for measuring change across sessions. The other versions are best for initial assessment, as they address Criterion A and trauma history. You will choose which one depending on how you will assess Criterion A.

Scoring:

- Provisional PTSD diagnosis can be made by treating each item rated as 2 = "Moderately" or higher as a symptom endorsed, then following the *DSM-5* diagnostic rule which requires at least: 1 B item (questions 1-5), 1 C item (questions 6-7), 2 D items (questions 8-14), 2 E items (questions 15-20).
- *DSM-5* symptom cluster severity scores can be obtained by summing the scores for the items within a cluster, i.e., cluster B (items 1-5), cluster C (items 6-7), cluster D (items 8-14), and cluster E (items 15-20).
- Total symptom severity score (range 0-80) can be obtained by summing the scores for the 20 items.
- **Current data suggests a PCL-5 cut-point score of 33 for PTSD diagnosis.**

Interpretation

A lower cut-point score maximizes sensitivity, resulting in identification of more possible cases. This is best for screening situations. A higher cut-point score maximizes specificity, resulting in fewer cases overall and fewer false positives. This is best for provisional diagnosis.

Measuring Change

Current evidence-based DSM-IV versions of this scale suggests that a 5-10-point change represents reliable change (i.e., change not due to chance), and a 10-20-point change represents clinically significant change.

Follow the literature and the NCPTSD website (www.ptsd.va.gov**) for updates to this information, as recommendations may change as new data is published.**

Citation

Weathers, F.W., Litz, B.T., Keane, T.M., Palmieri, P.A., Marx, B.P., & Schnurr, P.P. (2013). The PTSD Checklist for *DSM-5* (PCL-5). Scale is available from the National Center for PTSD at www.ptsd.va.gov.

PCL-5 with LEC-5 and Criterion A

Part 1

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)	☐	☐	☐	☐	☐	☐
2. Fire or explosion	☐	☐	☐	☐	☐	☐
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)	☐	☐	☐	☐	☐	☐
4. Serious accident at work, home, or during recreational activity	☐	☐	☐	☐	☐	☐
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)	☐	☐	☐	☐	☐	☐
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)	☐	☐	☐	☐	☐	☐
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)	☐	☐	☐	☐	☐	☐
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)	☐	☐	☐	☐	☐	☐
9. Other unwanted or uncomfortable sexual experience	☐	☐	☐	☐	☐	☐
10. Combat or exposure to a war-zone (in the military or as a civilian)	☐	☐	☐	☐	☐	☐
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)	☐	☐	☐	☐	☐	☐
12. Life-threatening illness or injury	☐	☐	☐	☐	☐	☐
13. Severe human suffering	☐	☐	☐	☐	☐	☐
14. Sudden violent death (for example, homicide, suicide)	☐	☐	☐	☐	☐	☐
15. Sudden accidental death	☐	☐	☐	☐	☐	☐
16. Serious injury, harm, or death you caused to someone else	☐	☐	☐	☐	☐	☐
17. Any other very stressful event or experience	☐	☐	☐	☐	☐	☐

Part 2

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

B. If you have experienced more than one of the events in PART 1, think about the event you consider the worst event, which for this questionnaire means the event that currently bothers you the most. If you have experienced only one of the events in PART 1, use that one as the worst event. Please answer the following questions about the worst event (check all options that apply):

Briefly describe the worst event (for example, what happened, who was involved, etc.).

How long ago did it happen? _____ (please estimate if you are not sure)

How did you experience it?

_____ It happened to me directly

_____ I witnessed it

_____ I learned about it happening to a close family member or close friend

_____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)

_____ Other, please describe

Was someone's life in danger?

_____ Yes, my life

_____ Yes, someone else's life

_____ No

Was someone seriously injured or killed?

_____ Yes, I was seriously injured

_____ Yes, someone else was seriously injured or killed

_____ No

Did it involve sexual violence? _____ Yes _____ No

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

_____ Accident or violence

_____ Natural causes

_____ Not applicable (The event did not involve the death of a close family member or close friend)

How many times altogether have you experienced a similar event as stressful or nearly as stressful as the worst event?

_____ Just once

_____ More than once (please specify or estimate the total number of times you have had this experience _____)

Part 3

Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 with Criterion A

Instructions: This questionnaire asks about problems you may have had after a very stressful experience involving actual or threatened death, serious injury, or sexual violence. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.

First, please answer a few questions about your worst event, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

Briefly identify the worst event (if you feel comfortable doing so):

How long ago did it happen? _____ (please estimate if you are not sure)

Did it involve actual or threatened death, serious injury, or sexual violence?

_____ Yes

_____ No

How did you experience it?

_____ It happened to me directly

_____ I witnessed it

_____ I learned about it happening to a close family member or close friend

_____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)

_____ Other, please describe

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

_____ Accident or violence

_____ Natural causes

_____ Not applicable (the event did not involve the death of a close family member or close friend)

Second, below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem and then select one of the options to indicate how much you have been bothered by that problem in the past week. The options include not at all, a little bit, moderately, quite a bit, and extremely.

In the past week, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Additional PE Resources and Links

Download PE Workshop Supplementary Materials

(https://tinyurl.com/PESupp)

All workshop supplementary materials are available online (including this page, with live links). Get fresh copies of treatment forms, handouts, and learning materials, or use the live links to check out any of the web resources listed here.

Join us for PE Continued Learning and Consultation

Join us in Zoom or by phone, Thursday**s**, 1 p.m. Eastern time. Let us know you're coming (emails are below), and we will send you a calendar invite and let you know about schedule changes.

Kelly Chrestman	kelly.chrestman.ctr@usuhs.edu
Paula Domenici	paula.domenici.ctr@usuhs.edu
Jenna Ermold	jenna.ermold.ctr@usuhs.edu
Kevin Holloway	kevin.holloway.ctr@usuhs.edu

PE Specific Telehealth Resources

(https://tinyurl.com/CDPteleheath)

Fillable PDF forms and Tips for transferring PE to telehealth

PE Metaphor Bank

(https://tinyurl.com/PEMetaphors)

Review short videos of metaphors or analogies useful in PE.

PE Video Demonstrations

(https://tinyurl.com/CDPPEVids)

PE Session Notes

(https://tinyurl.com/CDPPENotes)

Before your next PE session, watch a quick review of session content to help you prepare.

NC-PTSD Assessment landing page

(https://tinyurl.com/ptsdassess)

Get information, support, and training about PTSD assessment; copies of the Clinician Administered PTSD Scale for DSM-5 (CAPS-5) the PTSD Checklist for DSM-5 (PCL-5) and more.

VA Whiteboard video landing page

(https://tinyurl.com/VAPTSDvids)

VA PE Information page with video description

Complementary Treatments

Dialectical Behavior Therapy-PE (DBT-PE)

Motivational Interviewing

STAIR plus PE

Adaptive Disclosure

Books and manuals

(COPE) Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure

(PE-A) Prolonged Exposure Therapy for Adolescents with PTSD Emotional Processing of Traumatic Experiences, Therapist Guide

(PE-A) Prolonged Exposure Therapy for PTSD Teen Workbook

(PE-IOP) Prolonged Exposure for PTSD in Intensive Outpatient Programs

(WET) Written Exposure Therapy

Second Life PTSD Learning Center

(https://tinyurl.com/vPTSD)

Extend your learning about PTSD diagnosis, assessment, and treatment at CDP's PTSD Learning Center in Second Life.

Operation AVATAR

(https://tinyurl.com/OpAVATAR)

Experience PTSD like never before in this serious role play game in Second Life.

Virtual Provider Training in Second Life

(https://tinyurl.com/SLprovtrain)

Learn more about attending a CDP training workshop in Second Life, or visit CDP's asynchronous, on-demand, experiential learning environments.

Not familiar with Second Life?

(https://tinyurl.com/CDPSLvids)

Watch these YouTube videos to learn how to get a Second Life account, navigate the Second Life platform, and access our Second Life resources. Then you can take advantage of our workshops and the CDP Education Center.

Download PE Coach 2 for Apple devices

https://tinyurl.com/pe2ios

Download on the App Store

Download PE Coach 2 for Android devices

https://tinyurl.com/pe2andr

Get it on Google play

CDP Blogs related to PTSD (https://tinyurl.com/ptsdblogs)

Want to improve your CPT or PE skills? Start with the fundamentals!
Jeffrey Mann, Psy.D., CDP

Prolonged Exposure Therapy (PE) in a VA Hospital Setting - Findings and Observations
Jason Goodson, Ph.D., Philadelphia VA Medical Center

Three-part series on In Vivo Exposure:

- Developing an Effective In Vivo Hierarchy
- Five Strategies to Fortify Your In Vivo Work
- Productive Processing of In Vivo Exposure

Kelly R. Chrestman, Ph.D., CDP

"Complacency Kills"- The Link Between Combat Experiences and Safety Behaviors in War-Related PTSD
Jeffrey Cook, Ph.D., CDP

What Makes a Good Metaphor in Prolonged Exposure Therapy?
Kevin Holloway, Ph.D., CDP

Advances in the Treatment of Combined Borderline Personality Disorder and Post-Traumatic Stress Disorder
Jeffrey Mann, Psy.D., CDP

Symptom Exacerbation When Using Evidence-Based Psychotherapies
Andrew Santanello, Psy.D., CDP

Modifying Evidence-Based Treatment Protocols - Foolhardy Decisions or Strokes of Genius?
Timothy Rogers, Ph.D., CDP

Assessing Patient Readiness for Evidence-Based Psychotherapy
Carin Lefkowitz, Psy.D., CDP

Back in the PE Therapist Seat
Paula Domenici, Ph.D., CDP

To PE or CPT…that is the question
Holly O'Reilly, Psy.D., CDP

Management of PTSD Symptoms: New Recommendations from the DVA/DoD
Andrew Santanello, Psy.D., CDP

Does What Happens in Vegas Have to Stay in Vegas? - Assisting Clients with Decisions About Disclosure
Andrew Santanello, Psy.D., CDP

From the Horse's Mouth - What You Should Know about Consultation
Diana Dolan, Ph.D., CDP

When There's "No Time" for PTSD Treatment
Diana Dolan, Ph.D., CDP

Review of Exposure Therapy for Anxiety: Principles and Practice
Kelly R. Chrestman, PhD., CDP

Moving Prolonged Exposure Therapy (PE) to Telehealth
Kelly R. Chrestman, PhD., CDP

Just how difficult is it to do in vivo exposure while sheltering in place?
Kelly R. Chrestman, PhD., CDP

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