This PowerPoint file is a supplement to the video presentation. Some of the educational content of this program is not available solely through the PowerPoint file. Participants should use all materials to enhance the value of this continuing education program.

Prolonged Exposure for Post-Traumatic Stress Disorder

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Social Work I 64421

Goals

- Describe the symptoms of post-traumatic stress disorder (PTSD)
- Describe prolonged exposure as a treatment for PTSD
- Describe research supporting the use of prolonged exposure for PTSD

Prolonged Exposure

- Prolonged exposure is the primary empirically supported treatment for post-traumatic stress disorder
- It is also a primary component of other treatments
  - trauma-focused cognitive behavioral therapy (TF-CBT)
  - eye movement desensitization and reprocessing (EMDR)

Prolonged Exposure

What are the symptoms of PTSD?

Prolonged Exposure

- PTSD
  - Criterion A: Stressor
    - the person was exposed: death, nearly being killed, threatened with being killed, actual or threatened serious injury, actual or threatened sexual violence
    - requires 1 of:
      - direct exposure to the above
      - witnessing one of the above
      - indirectly learning that a close person was exposed to the above
        - » if death or threatened death, must be violent or accidental [i.e., prolonged deaths due to illness do not count]

Prolonged Exposure

- PTSD
  - Criterion A: Stressor
    - requires 1 of:
      - repeated or extreme indirect exposure to aversive details of above event(s), including in course of work
        - » does NOT include exposure through TV, internet, movies, unless it is work-related

PTSD

- Example precipitating stimuli
  - military combat
  - sexual assault
  - any serious threat to one's life (mugging)
  - witnessing death or severe injury (EMTs)
  - learning about sudden or violent death of loved one
  - severe auto accidents
  - natural disasters
  - unexpectedly seeing dead/severely injured body or body parts

PTSD

Understanding the Influence of Racial Discrimination on the Associations Between PTSD Symptoms, Physiological Arousal, and Health Among African American Women With Trauma Exposure

Sierra Carter, Abigail Powers and Bekh Bradley

Biological Psychiatry, 2020-05-01, Volume 87, Issue 9, Pages S349-S349, Copyright © 2020

- Repeated, non-life-threatening events have been posited to be capable of causing PTSD, with discrimination being among these kinds of events

PTSD

- This study recruited 75 African American women from a public hospital in a major city
- Participants completed the Experiences of Discrimination Questionnaire, measures of trauma, an electrocardiogram, and heart rate measurement
- Experiences of discrimination were associated with PTSD symptoms (r = .37)
- Events related to police encounters and restaurant settings were especially linked to heightened startle responses
- Even when criterion A is not met and the PTSD diagnosis cannot be made, treatment can be vital
- Discrimination, based on factors such as race, gender identity, or sexual orientation, would be handled differently than typical PTSD, however, as we may fully expect that these incidents will recur for members of marginalized groups

PTSD

- We won't fully cover non-criterion A traumatic stress here, but there are many books and workshops for therapists on developing awareness of and skills around affirming therapy for clients with marginalized identities

Prolonged Exposure

- PTSD
  - Criterion B: Intrusive symptoms
    - re-experiencing one of:
      - recurrent, involuntary, intrusive memories
        - » children older than 6 may express this in repetitive play
      - traumatic nightmares
        - » dreams do not need to be literal reexperiencing
      - dissociative reactions (flashbacks), from brief episodes to complete loss of consciousness
        - » children may reenact the event(s) in play
      - intense or prolonged distress after exposure to traumatic reminders
      - marked physiological reactivity after exposure to trauma-related stimuli

Prolonged Exposure

- PTSD
  - Criterion C: Avoidance
    - persistent effortful avoidance of distressing trauma-related stimuli after the event
    - one of:
      - trauma-related thoughts or feelings
      - trauma-related external reminders (e.g., people, places, conversations, activities, objects, situations)

Prolonged Exposure

- PTSD
  - Criterion D: Negative alterations in cognitions and mood
    - two of:
      - inability to recall key features of the traumatic event (not due to head injury or drug influence)
      - persistent and distorted negative beliefs about oneself and the world
      - persistent distorted blame of self or others for causing the event and/or consequences
      - persistent negative trauma-related emotions
      - markedly diminished interest in formerly significant activities
      - feeling detached from others
      - constricted affect

Prolonged Exposure

- PTSD
  - Criterion E: Alterations in arousal and reactivity
    - two of:
      - irritable or aggressive behavior
      - self-destructive or reckless behavior
      - hypervigilance
      - exaggerated startle response
      - problems in concentration
      - sleep disturbance

Prolonged Exposure

- PTSD
  - Criterion F: Duration
    - persistence of symptoms for more than 1 month
  - Criterion G: Functional significance
    - significant symptom-related distress of functional impairment (social, occupational, etc.)
  - Criterion H: Exclusion
    - not due to medication, substance use, or illness

Prolonged Exposure

- PTSD
  - specifications:
    - dissociative symptoms
      - depersonalization: experience of being an outside observer or being detached from oneself
      - derealization: experience of unreality, distance, or distortion (feeling that the world is “not real”)
    - delayed expression
      - full diagnostic criteria not met until at least 6 months after the trauma(s)

Diagnosis Examples

- Jane is a veteran
- During two of her tours overseas in 2003 and 2006, her base was attacked with mortar shelling and in both instances mortars hit the building she was in
- She reports frequent intrusive thoughts about the shellings and extremely elevated startle response to any loud banging sounds, which she tries to avoid being exposed to
- She has also been feeling detached from her family and has trouble expressing herself to them
- She reports that she does not sleep much lately as she has been bothered by nightmares about the attacks
- She reported that she is confused about why these symptoms only started 2 years ago, when the incidents were nearly 2 decades ago

Diagnosis Examples

- Jane appears to meet criteria for PTSD
- She has a history of a Criterion A event, several B, C, D, and E symptoms
- The timeline makes sense for PTSD, delayed onset

Diagnosis Examples

- Mark works in a movie theater
- This past weekend, there was an active shooter in the same company's theater, a few states over
- Mark reported that he feels that he needs to be at work all the time should something happen, and has been getting to work hours before, and leaving hours after, his shifts
- He says he feels as though if he is there, he might be able to do something if there was an attack
- Mark lacks a criterion A event, the constellation of symptoms is not consistent with the PTSD diagnosis, and the timeline is off for a diagnosis of PTSD
- Another diagnosis is likely more apt, such as acute stress disorder

Does Criterion A have to be life and death?

- There is some controversy over whether the "life and death" nature of criterion A is theoretically and empirically justified
- One theoretical example:
  - at Halloween, there are often "spooky houses" set up all around the US
  - these are interactive horror-movie-like events with actors startling the people who pay to walk through the horror house
  - these are scary but safe and monitored; there are rarely accidents, the actors do not actually touch anyone going through the house, etc.
  - nearly every year, there is a poorly researched news story about how one of the houses, somewhere, actually contained real dead bodies
    - these are never actually true

Does Criterion A have to be life and death?

- Let's imagine a scenario, however:
  - Marie walks through a horror house, and the next day sees a news story about how that house had "real dead bodies"
  - Marie hears a description of the exhibit, and realizes that she was looking long and hard at that exhibit
  - she is so distressed by the fact that she (believes she) saw a dead body that she developed PTSD symptoms
  - Marie never hears the news story correct that the story was not accurate
  - so, Marie believes she saw a dead body but did not
  - Should she fit the criterion?

Does Criterion A have to be life and death?

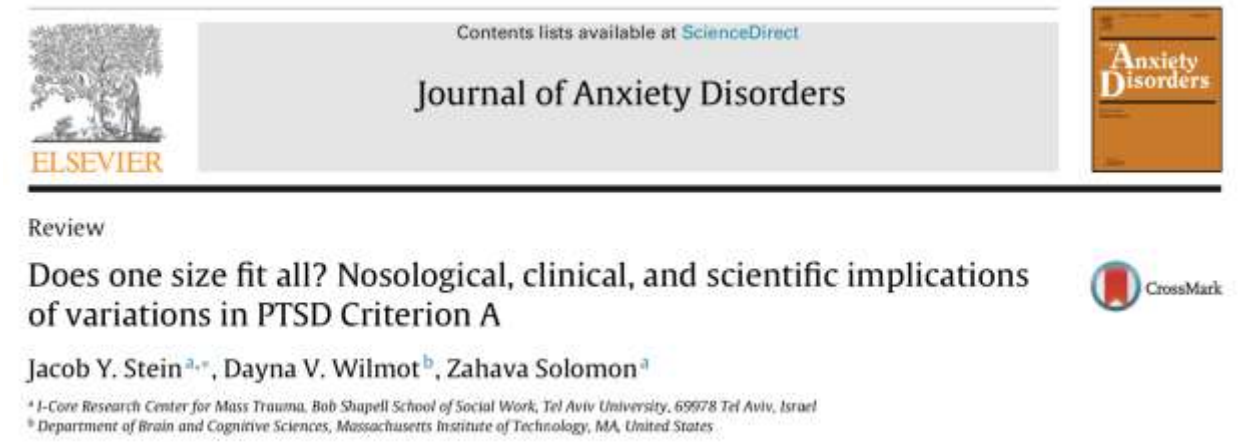
- Let's imagine the scenario a little differently:
  - let's say this ended up being the first instance in which the story was accurate, but Marie never sees the news story
  - Marie, disturbed by the horror house, developed PTSD symptoms
  - when she reports to her therapist, she cannot be diagnosed with PTSD because *as far as Marie and the therapist know*, the exhibit was fake

…but, it wasn't fake, in this example!

Does Criterion A have to be life and death?

- Imagine if someone was scrolling through the internet and downloaded a file that was mislabeled and contained horrific images—how do we know if they were real or not?
- There is also some controversy over whether repeated exposure to non-life-threatening events can promote the onset of PTSD

Criterion A



Contents lists available at ScienceDirect

Journal of Anxiety Disorders

ELSEVIER

Review

Does one size fit all? Nosological, clinical, and scientific implications of variations in PTSD Criterion A

Jacob Y. Stein[a,*], Dayna V. Wilmot[b], Zahava Solomon[a]

[a] I-Core Research Center for Mass Trauma, Bob Shapell School of Social Work, Tel Aviv University, 69978 Tel Aviv, Israel
[b] Department of Brain and Cognitive Sciences, Massachusetts Institute of Technology, MA, United States

Criterion A

- The experience of a traumatic event is a “gatekeeper” to the PTSD diagnosis
  - only in light of the presence of a criterion A event can the remaining symptoms possibly be interpreted as indicative of PTSD
  - PTSD is the only diagnosis that requires a past experience in this way
    - e.g., depression does not require that something bad have happened to the patient
- The DSM lists more than 35 potential criterion A events
- These include direct experience, witnessing, and indirect exposure
- Regardless of the event though, the other symptoms remain the same
- The symptoms are also considered the same whether the trauma was long past (e.g., childhood sexual abuse) or ongoing (e.g., violent domestic abuse)

Criterion A

- PTSD was introduced in the DSM-III (Diagnostic and Statistical Manual of Mental Disorders), in 1980
- As early as the DSM-I, though, a “gross stress reaction” was listed
  - several other syndromes emerged, all of which were eventually merged into PTSD, unified by criterion A events
- Since then, many other related syndromes have been proposed
  - vicarious and secondary trauma, which do not require direct exposure, might be the most well-known
- We also know that trauma and its aftermath are highly variable among people
- In addition, there may be impacts of cumulative trauma that interact (e.g., childhood abuse, adolescent sexual assault, spousal abuse)
- In summation, we should not consider the current diagnostic set-up for PTSD to be the “end-all” or final word on it

Criterion A

- As well, a “one-size-fits-all” approach is not adequate for clinical treatment
  - understanding the meaning of the specific event and other events, and the context for the patient, is still crucial
  - e.g., if the stressor is ongoing, such as domestic abuse, exposure therapy is not a reasonable strategy

PTSD

- Lifetime prevalence in the US is 8.7%, 12-month prevalence is 3.5%
- Rates are highest among survivors of abuse, those with combat exposure, and individuals from areas that experienced political violence or genocides
- Sub-threshold symptoms that also cause impairment are also very common

Prospective Study of Posttraumatic Stress Disorder and Depression Following Trauma

Arieh Y. Shalev, M.D., Sara Freedman, M.A., Tuvia Peri, Ph.D., Dalia Brandes, M.Sc., Talī Sahar, M.Sc., Scott P. Orr, Ph.D., and Roger K. Pitman, M.D.

TABLE 1. Studies Evaluating the Prevalence and Co-occurrence of PTSD and Depression

Study	Study Group	N	Design and Instruments[a]	Percent With PTSD	Depression	
					Percent	Percent of Subjects With PTSD
Sierles et al. (1), 1983	War veterans with PTSD (inpatients)	25	SADS	100	8[b]; 72[c]	8[b]; 72[c]
Davidson et al. (2), 1990	War veterans with PTSD	44	SADS-L	100	59[c]	59[c]
Shore et al. (3), 1989	Community sample (Mt. St. Helens)	274	DIS	3[c]	—	51[b]
Green et al. (4), 1990	Vietnam veterans	200	Cross-section; SCID; SADS-L	29[b]	15[b]	35[b]
Engdahl et al. (5), 1991	World War II prisoners of war	62	Cross-section	29[b]	26[b]	61[b]
Lima et al. (6), 1991	Earthquake survivors	102	Survey at 8 months; clinical interviews	42[d]	13[d]	—
Carlson and Rosser-Hogan (7), 1991	Cambodian refugees	50	Survey; Dissociation Experiences Scale; SCL-90	86[d]	80[d]	—
Mellman et al. (8), 1992	Veterans (outpatients)	60	Survey; SADS-L	82[c]	68[c]	—
Roca et al. (9), 1992	Patients in burn unit	31	4-month follow-up; SCID	23[b]	—	29[b]
McFarlane and Papay (10), 1992	Firefighters	398	Cross-section at 42 months; DIS	18[d]	10[d]	51[d]
Smith et al. (11), 1990	Survivors of air crash disaster	46	Survey at 4–6 weeks; DIS	22[b]	41[b]	—
Ramsay et al. (12), 1993	Survivors of state violence	100	Retrospective case notes	31[d]	42[d]	65[d]
North et al. (13), 1989	Survivors of mass shooting	136	Cross-section at 1 month; DIS	26[b]	10[b]	30[b]
Blanchard et al. (14), 1996	Help-seeking survivors of motor vehicle accidents	158; 93	Case-control; Clinician-Administered PTSD Scale; SCID	39[b]	23[b]	53[b]
Kessler et al. (15), 1995	Population sample	5,877	Survey; DIS; Composite International Diagnostic Interview	8[c]	18[c]	48[c]
Bleich et al. (16), 1997	War veterans; help seeking	60	Cross-section at 7 years; SADS	87[b]; 100[c]	50[b]; 95[c]	56[b]; 95[c]

[a]SADS=Schedule for Affective Disorders and Schizophrenia, L=Lifetime; DIS=Diagnostic Interview Schedule; SCID=Structured Clinical Interview for DSM-III-R.
[b]Current.
[c]Lifetime.
[d]Since trauma.

PTSD

- Diagnosis
  - malingering (faking) is common
    - secondary gain (VA, court)

PTSD Malingering

Psychol. Inj. and Law
DOI 10.1007/s12207-011-9102-7

Do Motivations for Malingering Matter? Symptoms of Malingered PTSD as a Function of Motivation and Trauma Type

Kristine A. Peace · Kimberly A. Masliuk

Received: 18 January 2011 / Accepted: 17 February 2011

PTSD Malingering

- Estimates of malingering PTSD range from 2% to 50%, depending on the context of the claim
- Simple checklists, such as the Life Events Checklist, do not allow for differentiation between trauma survivors and people told to try to malinger a diagnosis
- Other studies indicate that malingered reports of PTSD tend to be more extreme in symptom presentations
- Most studies have also focused on having participants who are simulating trauma reports pretend to have only one specific type of trauma, and then those are compared to people who actually experienced the trauma
- However, we also know differences do tend to emerge by trauma type (e.g., combat trauma tends to be more severe than mugging trauma)

PTSD Malingering

- The context of the claim is also vital—motivations can also affect how symptoms are presented
  - legal cases have to be built on "psychological damage" and disability claims for PTSD may be affected by people wanting to try to be sure they get disability money
- In this study, the researchers examined malingering across event type (assault, man-made disaster, injury), and motivation (compensation, revenge, attention, none)
- Sample
  - 648 undergraduates
    - 71% women, average age 20.7

PTSD Malingering

- Measures
  - fantasy-proneness
  - dissociative experiences
  - instructions on malingering
    - event type (accident, disaster, assault) x motivation (compensation, attention, revenge, none)
  - revised Impact of Events Scale
    - measures reactions to traumatic stress
  - PTSD checklist (PCL)
  - trauma symptom inventory (TSI)

PTSD Malingering

- Results
  - event: mean impact, PCL, and TSI scores were highest for sexual assault
  - motivation: mean impact, PCL, and TSI scores were higher for revenge and compensation motives
  - higher fantasy-proneness and dissociation also resulted in greater faked symptoms
- We may encounter individuals presenting with PTSD who are malingering
- It is important to maintain our standard of ethical practice when completing assessments that may be used in contexts such as trials or disability claims
  - especially, to not align ourselves with whatever side is paying us

PTSD

- Onset
  - most disorders have fairly clear onset times in later childhood or adolescence
    - even if disorder is not florid at that time, signs usually (not always) appeared
      - e.g., many persons don't get diagnosed with ADHD until college, not because they didn't have it but because their school was so easy that the symptoms were never clear
- Not PTSD
  - onset can occur any time with no prior indications of vulnerability
  - symptoms usually onset within 3 months of the event, but not always

PTSD

- Immediate versus delayed expression
  - immediate
    - typically respond well to treatment, even if treatment is delayed
    - better prognosis
    - fewer symptoms
    - symptoms resolved in ~6 months with therapy
  - delayed
    - more symptoms, worse prognosis

PTSD

- Cultural considerations
  - relative risk for PTSD can be higher among many individuals (e.g., refugees, people who have been trafficked, people who were in war zones)
    - be sure to fully explore multiple intersecting traumas—people who lived in war zones often also have experienced sexual trauma
  - specific symptoms may also vary, with some cultural differences in factors such as cognitions (e.g., religious-themed beliefs) or physical symptoms (e.g., somatization symptoms)
- Diagnosing
  - patients often know enough about PTSD to have a guess that they might have it
  - clinical signs are usually specific complaints (sleep disturbance, fear), making diagnosis easier sometimes than other conditions (e.g., depression, which can be vague and manifest oddly)

PTSD

- Differential diagnosis possibilities
  - adjustment disorder: Criterion A met, but not other criteria
  - acute stress disorder: symptoms have been present for between 3 days and 1 month
  - depression: can also be a response to Criterion A events
  - Criterion B (intrusive symptoms) can be common in depression (e.g., thoughts of worthlessness, recall of past failures)
- Some measures can be useful to help diagnose PTSD and do differential diagnosis

PTSD CheckList – Civilian Version (PCL-C)

Client's Name: _____

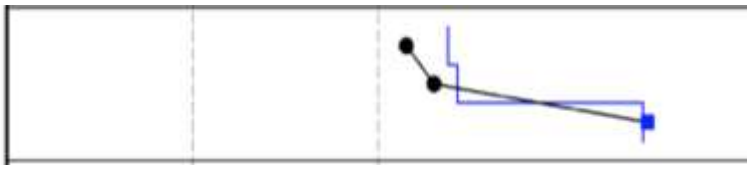
Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					

PTSD

- The Personality Attributes Inventory can also be useful, and has the added advantage of also getting at potential comorbid disorders (such as depression)

ARD-O	Obsessive-Compulsive	18	73
ARD-P	Phobias	16	76
ARD-T	Traumatic Stress	24	99



PTSD in Children

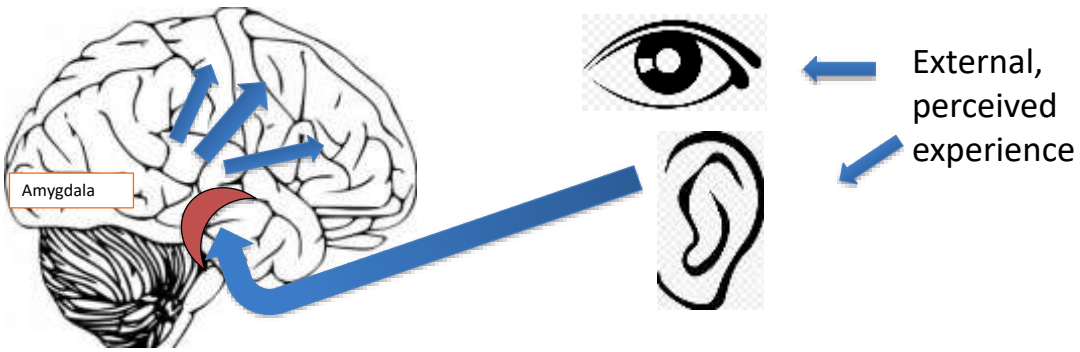
- Manifests differently, but becomes closer to adult diagnostic criteria as child ages
- Special experience working with children necessary to treat responsibly
- Children might not be verbal about problems
  - acting out, nightmares, developmental regression, clinging to parent, trauma-related play, poor emotional regulation (fights at school, bad school performance, etc.), somatization (headaches, etc.)

PTSD

- Medication treatments
  - SSRIs
  - tricyclic antidepressants
  - noradrenergic agents and beta blockers (blood pressure medications)
- But, therapy is very effective

(Very simplified) Neurobiology of PTSD

- Normal emotional processing



The amygdala is responsible for memory, decision-making, and **emotional responses**

Neurobiology of PTSD

- In PTSD patients, hyperactivation of the amygdala during exposure to PTSD reminders is observed
- Activation of the memory trace thus activates adjacent nets of emotional-responding neurons, especially fear
  - lesions to the amygdala terminate fear responses in patients
- Because the memory trace activates adjacent emotional neurons, especially fear, it is not that the experience is merely remembered—the patient relives *the same emotional response* along with the memory, often as intensely as when the event actually happened
- This naturally produces powerful conditioning effects e.g., powerfully conditions avoidance of reminders of the trauma

Neurobiology of PE

- Prolonged exposure works to fix the neurobiological substrate of PTSD
- First, the conditioned fear response is weakened by exposure to the feared stimulus (the trauma narrative)
- Existing abilities to handle the fear response can be retrained
- Event is remembered, but not reexperienced

Research

Ann. N.Y. Acad. Sci. ISSN 0077-8923

ANNALS OF THE NEW YORK ACADEMY OF SCIENCES
Issue: *Psychiatric and Neurologic Aspects of War*

Improvement in cerebral function with treatment of posttraumatic stress disorder[a]

Michael J. Roy,[1] Jennifer Francis,[1] Joshua Friedlander,[1] Lisa Banks-Williams,[1] Raymond G. Lande,[1] Patricia Taylor,[1] James Blair,[2] Jennifer McLellan,[2] Wendy Law,[1] Vanita Tarpley,[1] Ivy Patt,[1] Henry Yu,[2] Alan Mallinger,[2] Joann Difede,[3] Albert Rizzo,[4] and Barbara Rothbaum[5]

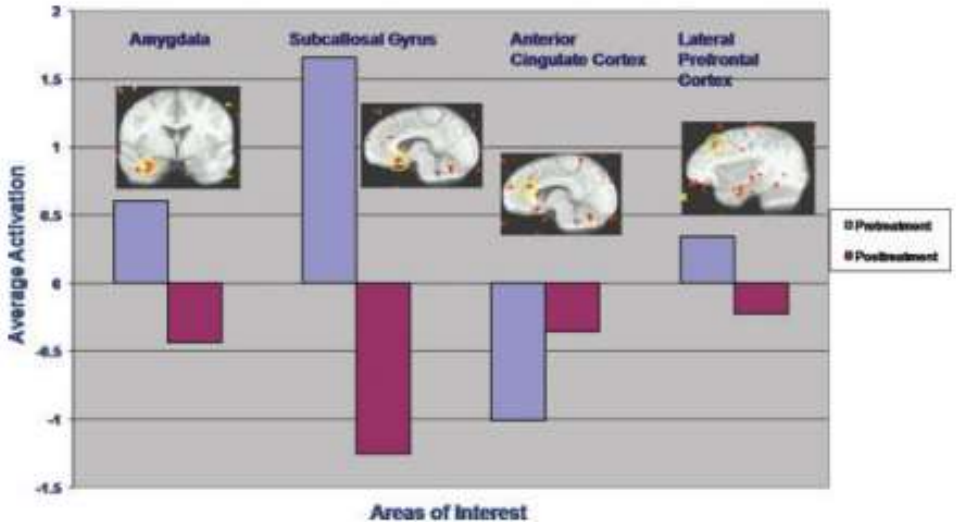
Research

- 22 military service people who were deployed in Iraq or Afghanistan in each condition, both exposed and with and without PTSD
- Exclusions:
  - no prior treatment for PTSD
  - no elevated scores on other symptom indexes
- Functional magnetic resonance imaging (fMRIs) on all subjects
- Patients received virtual reality (VR) exposure or PE
  - VR: e.g., walking through market, market is hit by rocket
    - similar to actual trauma patients experienced, VR machine administered vibrations and odors (spices, burning material), subject could control movement

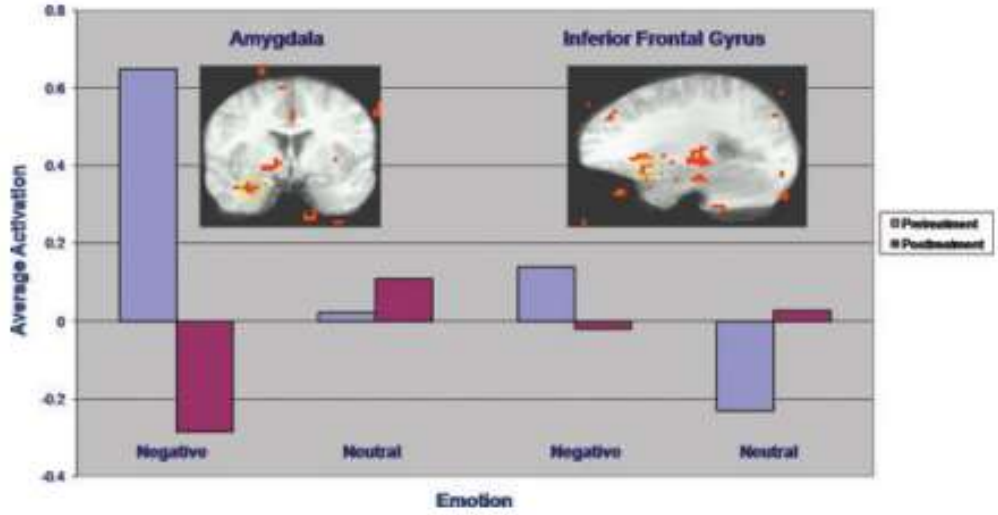
Research

- Functional magnetic resonance imaging (fMRIs) on all subjects
- Patients received virtual reality (VR) exposure or PE
  - results were pooled across the first 8 participants to complete treatment and scans

Research



Research



Treatment of PTSD: Prolonged Exposure

- General PE process:
  - development of rapport
  - identification of acceptable levels of coping
  - beginning trauma narrative

Prolonged Exposure

- Rapport
  - rapport is essential; patients will not disclose, or disclosures will not feel safe, if there is no rapport
  - however, this phase is generally not extended
    - extension of this phase can indicate reluctance or avoidance by either the therapist, client, or both
    - avoidance positively reinforces not talking about the trauma, propagates problem
  - plan is developed early that the trauma narrative will be covered

Prolonged Exposure

- Plan
  - 50-minute and 90-minute sessions are common
  - weekly sessions are normal
    - homework is typical, so skills can be learned and practiced outside of therapy
  - 10-20 sessions are a reasonable expectation for treatment duration
- Coping
  - patient must be able to cope with the material discussed in sessions
  - suicidal tendencies, illicit drug use, or self-harm are not acceptable before beginning PE
  - healthy coping and sufficient support network needed

Prolonged Exposure

- Identifying coping
  - assess how the patient copes now
  - many may already have adaptive coping strategies, which you can encourage and capitalize on
  - many may also have poor strategies
    - suicidal tendencies, self-harm, heavy substance use, aggression (physical or interpersonal), etc.
- Enhancing coping
  - identify and practice new strategies for coping
  - relaxation exercises
    - diaphragmatic breathing or progressive muscle relaxation
    - some patients find this kind of interoceptive awareness training aversive or even detrimental or harmful

Prolonged Exposure

- Enhancing coping
  - identify and practice new strategies for coping
  - relaxation exercises
    - there are other strategies to use if this is not helpful to patients
    - learning to do this well is not the goal of PE, so better to find something that works better than spend time trying to make relaxation exercises work
  - guided imagery
    - soothing and relaxing guided imaginary relaxation
    - talk through a walk in the woods, a calm day at the beach, etc.
      - imagery would be chosen by the client

Prolonged Exposure

- Enhancing coping
  - guided imagery
    - given how easy access is to mobile devices that can play audio, a therapist can easily record one of these and email it to the client to store on their phone and listen to
    - or, the client can create their own, or have a loved one create one (e.g., a client's child describing a nice day they spent with the client)

Prolonged Exposure

- Enhancing coping
  - active disputing
    - some clients may prefer a more active coping response, such as actively disputing irrational beliefs about their trauma
  - behavioral activation
    - doing enjoyable things
    - may vary from simple things such as spending quality time with a pet or a loved one, to activities such as cooking or exercise (weightlifting, yoga, running)
    - may have many secondary benefits (e.g., spending time with a child might be useful for reminding the patient about others who care for them, exercise may help patient to develop more personal interests)

Prolonged Exposure

- Enhancing coping
  - coping does not have to be perfect; patient just needs to be able to generally manage stress in a not-unhealthy way
  - many times, trainees can over-focus on building up coping because they are afraid of starting the trauma narrative
  - once coping is acceptable, the trauma narrative can begin

Prolonged Exposure

- Trauma narrative
  - the duration of time spent on the narrative is collaboratively decided upon
  - cooldown time at the end of the session is negotiated; does client expect to need 10 minutes? 15? 20?
    - can be adjusted as therapy progresses
  - the narrative is not delayed; every session begins with the narrative unless something major happens (e.g., death in family)
    - delaying the narrative is reinforcing avoidance
  - the patient discusses the event or chooses one specific event to discuss
    - this might be the most distressing event, or it might be a different event

Prolonged Exposure

- Trauma narrative
  - the patient begins before the beginning and tells the story
    - the part of the narrative covered should have a beginning and end; if trauma was repeated or prolonged, it can be broken up
  - the therapist provides support and encouragement, bolsters client to continue, and encourages exploration of deeper emotional reactions
    - often, the therapist's job is to slow the client down
  - narratives can be broken up into several sessions if they are longer
  - narratives are repeated if the events are fewer in number
  - if there are more events, the patient can go through them in any order and also can revisit events that were already discussed

Prolonged Exposure

- Trauma narrative
  - the narrative should always be being approached
  - often, workbooks are used to have the client work on their own, if they are able to
  - sometimes, alternative methods of approaching the trauma can be explored
    - e.g., writing it out

Prolonged Exposure

- The client should retain control over the therapy after agreeing to the premises (e.g., not avoiding the narrative)
  - part of PE is returning a sense of ownership to the event
  - client chooses what aspects of the trauma to discuss, therapist does not question client's perceptions or memories
- Therapist and client can take "breaks" if narrative becomes overwhelming
  - e.g., spend one week focusing on some other concern or aspect of the client's past
  - this is decided upon mutually and recognized as a move back from the narrative if it has become too intense, with complete intention to return to the trauma narrative

Prolonged Exposure

- Cooldown
  - here, we can shift to discussing more everyday challenges to help the patient to calm down
  - or, we can address things such as successes in the past week
  - overall, we'd want to give the client time to come down from the extreme emotional arousal most patients will feel during PE
- Monitoring progress
  - continued use of either inventories (such as the PCL-C) or rating scales (such as a subjective units of distress scale) can be useful to monitor treatment outcomes
  - coping should continue to be monitored to make sure the patient does not decompensate during therapy
  - DSM criteria can be re-reviewed to see if the patient is in remission

Prolonged Exposure

- When is PE over
  - first, check to see if the patient no longer meets criteria (e.g., if intrusive thoughts or negative cognitions have ended)
  - for remaining symptoms, assess whether another method of treatment might be more useful
- Addressing specific symptoms
  - intrusive thoughts and anger might be addressed with acceptance-based therapies, mindfulness, and thought-stopping to end rumination
  - disturbing dreams can be addressed using nightmare rescripting therapy
  - avoidance symptoms, extreme reactions, or exaggerated startle response can be addressed using exposure therapy
  - negative cognitions or anger can be addressed using cognitive restructuring or active disputing
  - feelings of detachment can be addressed with intentionally building social support

Research

Journal of Consulting and Clinical Psychology
2003, Vol. 71, No. 2, 330–338

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Comparative Efficacy, Speed, and Adverse Effects of Three PTSD Treatments: Exposure Therapy, EMDR, and Relaxation Training

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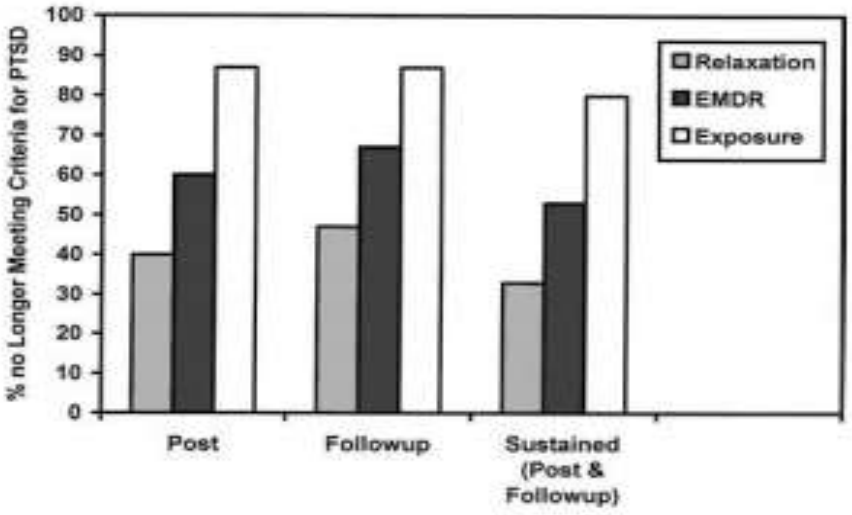
Research

- 60 participants
  - mean age of 37
  - 75% women, 77% White
  - mean duration of PTSD was 8.7 years
  - 65% had more than one trauma event
  - 45% sexual assault, 43% car accidents, 43% physical assault, 22% exposed to death

Research

- Exposure:
  - 4 sessions of imagined exposure to trauma
    - narrative
  - 4 sessions of in vivo exposure
    - getting in car for participant who was in auto accident, going to nearby gym for participant who was sexually assaulted in locker room
  - 60-minute exposures, 30-minute cooldowns
  - accompanied by relaxation training
- Eye movement desensitization and reprocessing (EMDR)
  - 1 session coping training
  - narrative and eye movements
- Two therapists delivered all sessions (both therapists trained in EMDR)

Research



Research

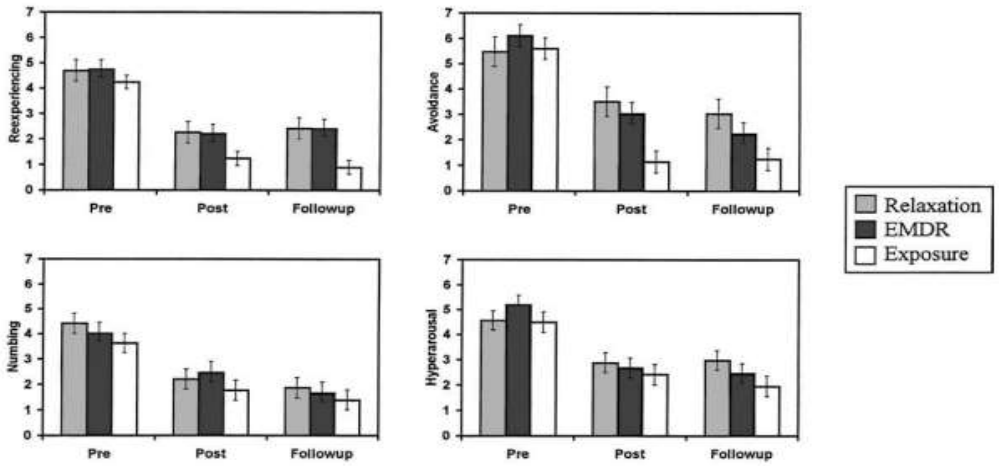


Figure 2. Means and standard errors for the four posttraumatic stress disorder (PTSD) dimensions, as assessed by the Clinician Administered PTSD Scale. Pre = pretreatment; Post = posttreatment; EMDR = eye movement desensitization and reprocessing.

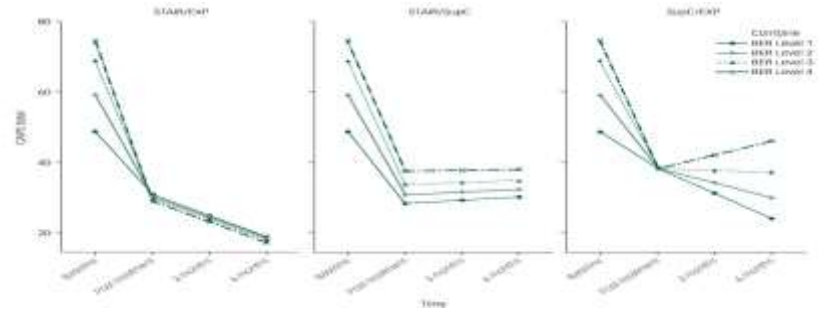
Research

- Patients were 104 women diagnosed with PTSD, all related to childhood sexual and/or physical abuse occurring before age 18
- Exclusion criteria were current psychosis, untreated bipolar disorder, current substance dependence, and current suicidality
- Participants were 22-61 years old (M = 36.5, SD = 9.4), relatively well-educated (87% college degree), diverse racial/ethnic composition

Research

- At baseline, assessed for:
  - PTSD symptoms
  - depressive symptoms
  - dissociation
  - interpersonal problems
  - anger expression
  - negative mood regulation
- Treatment involved:
  - skills training and prolonged exposure
  - skills training and supportive therapy
  - supportive therapy and exposure
- All conditions improved and maintained gains at 6 months follow-up, with skills training and prolonged exposure faring the best

Research



- People who had worse symptoms at baseline did least well with exposure, better in skills training, and best in a combination of exposure and skills training

Research

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Clinical Psychology Review

Psychological treatments for adults with posttraumatic stress disorder: A systematic review and meta-analysis☆,☆☆

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Research

- Many approaches to treatment claim to be useful to treating PTSD
- Most guidelines for the treatment of PTSD list counseling as the front-line intervention, so we need to be confident that our approaches work
- The researchers explored effectiveness for treatment of PTSD using various interventions
- Studies were used if they:
  - were randomized controlled trials of at least 4 weeks
  - enrolled adults that met criteria for PTSD
  - evaluated a psychological intervention
  - used a control group
  - had at least a 4-week follow up

Research

- Eligible interventions:
  - brief eclectic therapy
  - cognitive behavioral therapy (CBT)
  - exposure
  - coping training
  - EMDR
  - hypnotherapy
  - interpersonal therapy
  - psychodynamic therapy
  - narrative exposure therapy
  - etc.

Research

- The strength of evidence was supported most for exposure therapy
- Lower effectiveness was found for brief eclectic therapy, narrative exposure, and EMDR
- Exposure appears to have the most and the strongest support
- Brief eclectic therapy, a manualized treatment that merges CBT and psychodynamic therapy, had the lowest support
- Other forms of therapy may be effective, but less so (or less efficiently) than prolonged exposure

Prolonged Exposure for Post-Traumatic Stress Disorder

If you have any questions about the program you have just watched, you may call us at: (800) 424-4888 or fax (806) 743-2233. Direct your inquiries to Customer Service. Be sure to include the program number, title and speaker.

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