St. Louis CENTER FOR Family Development LLC

Prolonged Exposure Therapy for Posttraumatic Stress Disorder

Presented by:

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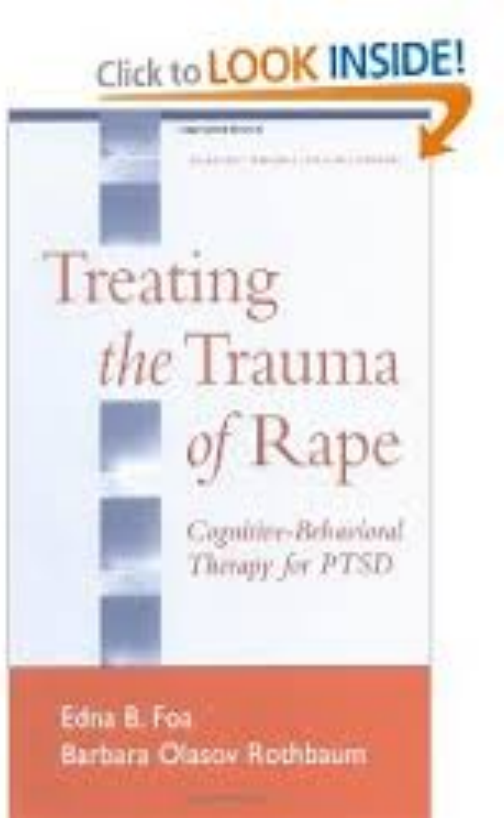
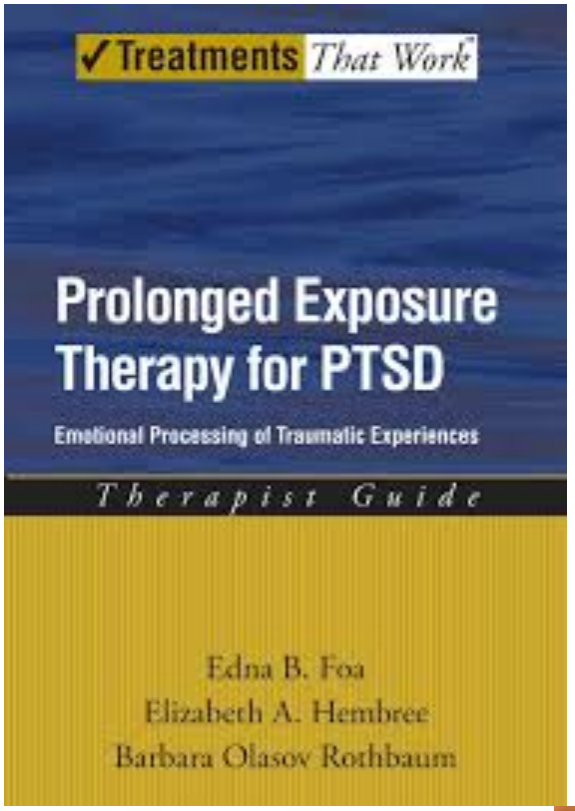
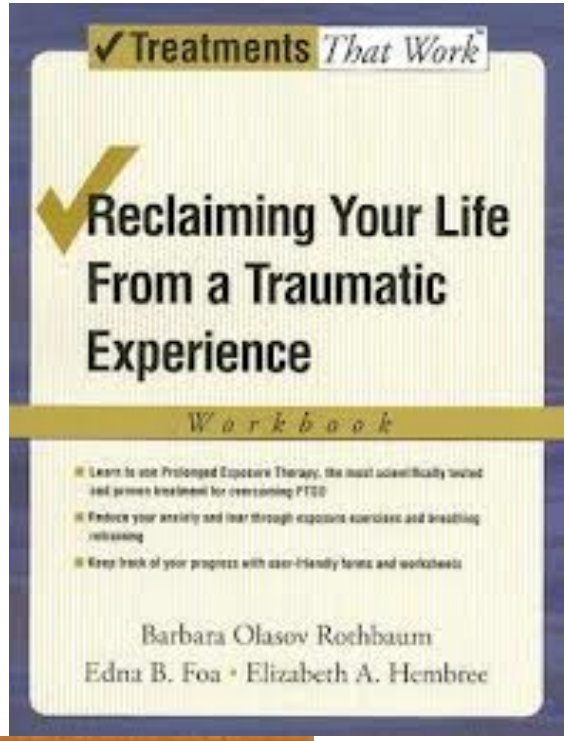
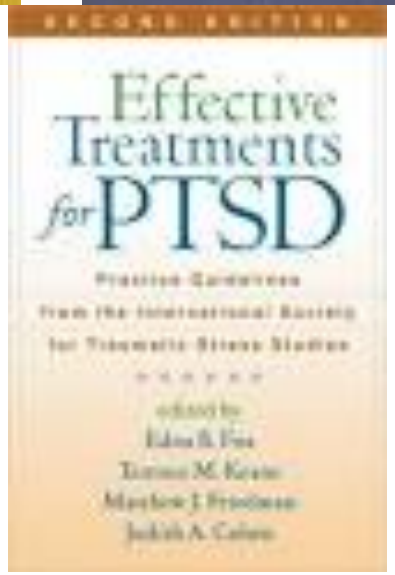
Workshop Overview

- Theoretical and empirical work underlying Prolonged Exposure Therapy (PE) and other CBT interventions
- Overview of "standard" 10-session PE
- Treatment components
- Promoting emotional engagement and enhancing outcomes
- Other important considerations: Who is a candidate for PE? Maintaining focus on treatment of PTSD; consultation and supervision







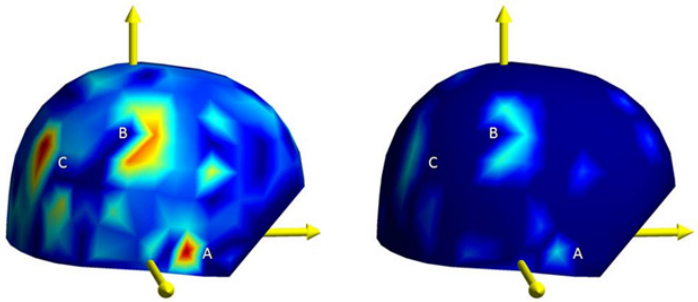


This presentation is taken from the Treatments That Work Therapist Guide, Workbook, and Treating the Trauma of Rape all by Edna Foa et. al.

These slides are an integration of many people's work, people much smarter than I. *Please do not distribute slides without permission*

Diagnosis of PTSD

DSM V PTSD Diagnosis



A. Exposure to a Traumatic Event
   - ✓ Directly, witnessing, learning about, repeated exposure to details

Symptom Clusters

B. Intrusive symptoms

C. Persistent Avoidance

D. Negative Mood and Cognitions

E. Increased Arousal or Reactivity

F. 1 month in duration causes significant distress

How do we define a traumatic event?

Common Psychological Reactions to **Trauma**

- Post-traumatic Stress symptoms
- Traumatic Grief Symptoms
- Depressive symptoms
- Substance Abuse or dependence (e.g., alcohol)

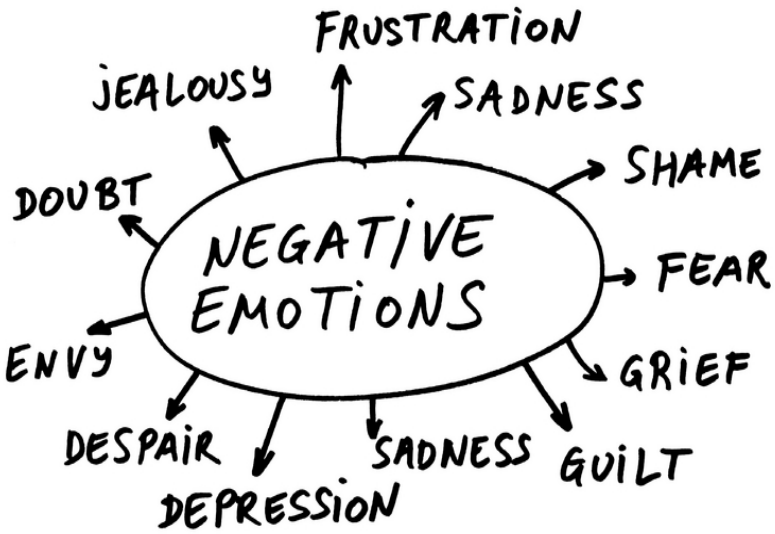
Definition of a Traumatic Event

Exposure to actual or threatened death, serious injury or sexual violation

- Directly experiences the traumatic event
- Witnesses the traumatic event in person
- Learns that a traumatic event occurred to a close family member or friend
- Experiences first-hand repeated or extreme exposure to aversive details of a traumatic event

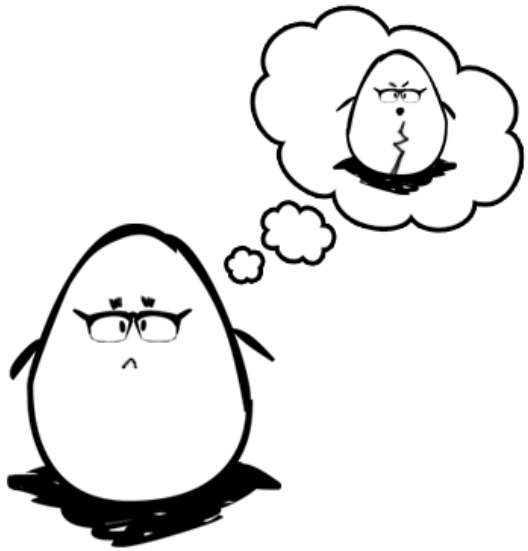
- PTSD does not involve only fear; for some people **shame**, **guilt**, **sadness**, or **anger** are the prominent emotions that drive PTSD

- Some events which do not involve threat of death or injury may also be traumatic



Intrusive Symptoms (at least 1 symptom)

- Distressing recollections of the trauma
- Distressing dreams of the event
- Reliving the experience (flashback)
- Psychological distress at exposure to trauma reminders (internal or external)
- Psychological reactivity to trauma reminders



Persistent Avoidance (at least 3 symptoms)

Avoidance refers to distressing memories, thoughts, feelings, or external reminders of the event

- Efforts to avoid trauma-related thoughts or feelings
- Psychogenic amnesia
- Diminished interest in activities
- Detachment from others
- Restricted Range of affect
- Foreshortened future

Increased Arousal or Reactivity

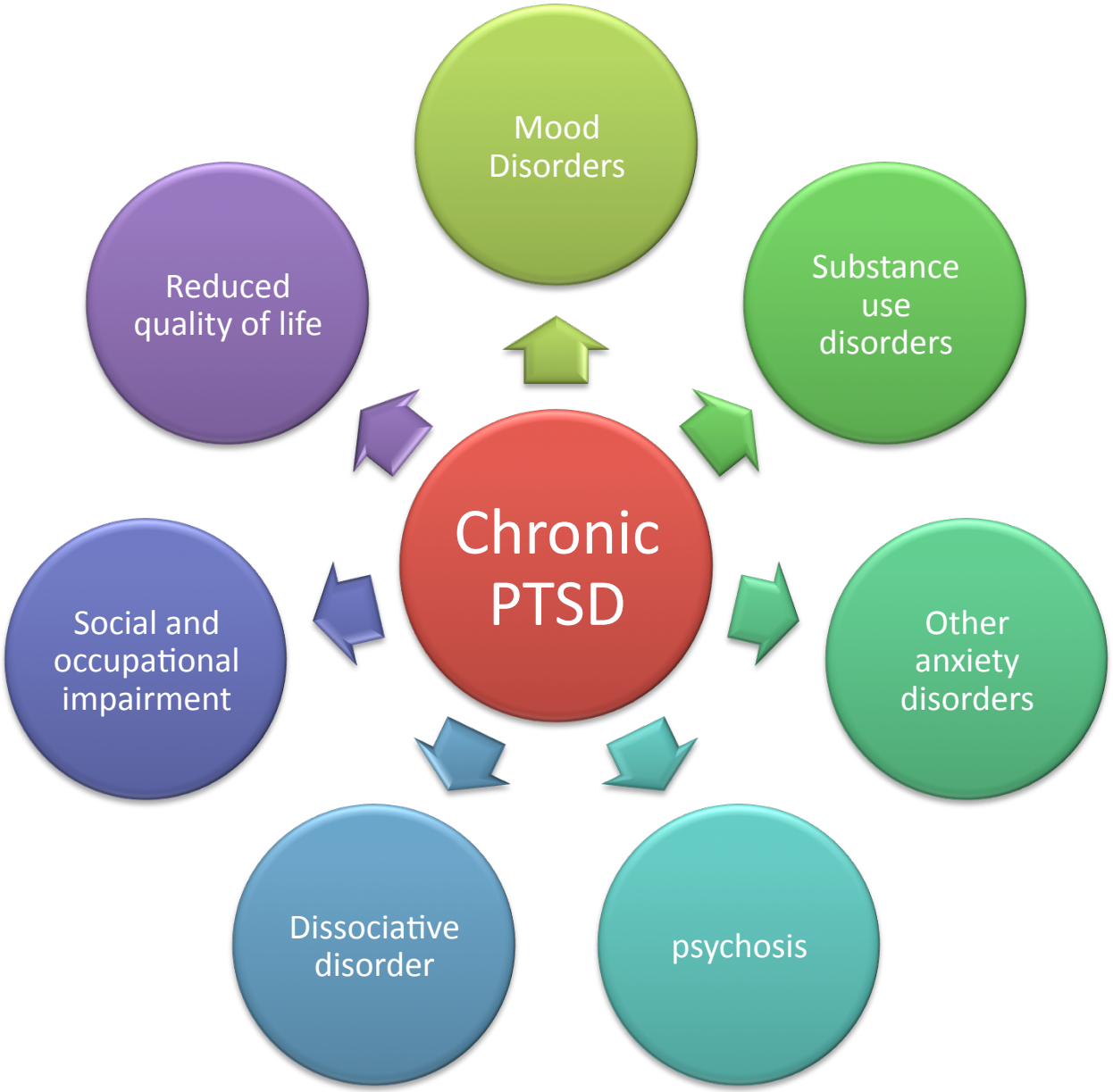
(at least 2 symptoms)

- Sleep disturbances
- Irritability or outburst of anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response

Prevalence of PTSD

- General population in the US:
  - Men: 1.8%; women: 5.2% (Kessler et al., 2005)
- Veteran populations:
  - Vietnam: 9% Gulf War: 3-12% lifetime
  - Afghanistan and Iraq: 15-17%
- In 2007, 14,000 US soldiers were treated for PTSD
- General Population in Germany:
  - 2.3% for men and women (Maercker et a., 2008)
  - 18.2% for professional firefighters (Wagner et al., 1998)
- The number of German soldiers treated for PTSD has been increasing: 83 in 2006; 245 in 2008

Impact of Chronic PTSD



PTSD has highest psychiatric comorbidity rates of any disorder but depression

- ✓Any current anxiety or mood disorder (92%)
- ✓Current Major Depression Disorder (69%)
- ✓Lifetime alcohol abuse or dependence (31%)
- ✓Current panic disorder (23%)
- ✓Current obsessive compulsive disorder (23%)

What we know about responses to trauma exposure

- The majority of trauma victims recover with time
- PTSD represents a failure of natural recovery
- If PTSD does not remit within a year, it will last a lifetime unless treated
- PTSD is highly distressing and debilitating disorder

Emotional Processing Theory

The Theoretical Framework

Emotional Processing Theory

- Theoretical foundation of Prolonged Exposure
- Based in the idea that natural recovery occurs when one effectively "emotionally processes" a traumatic experience
  - "process" translates to: thinking about, talking about, experience emotions related to, all combined with the opportunity to create associations that the event was isolated and allows for individuals to "make sense" of the event

Emotional Processing Theory

- Suggests that when "processing" is interrupted, PTSD symptoms develop
- These symptoms are maintained through avoidance of current negative emotional experiences (negative reinforcement)
- Avoidance strengthens negative and problematic associations and thus maintains PTSD symptoms

Emotional Processing Theory

- To effectively “emotionally process” traumatic experience, the treatment must mimic that of natural recovery
- Through the systematic and repeated confrontation with the traumatic memory and/or situations etc..

Fear (Emotional) Structure

- A fear structure is a program for escaping danger
  - Activated for the purpose of survival…shortcut to engaging in pro-life behavior!

- Fear Structure is made of the following:
  - The feared *stimuli*
  - The fear *responses*
  - The *meaning* of stimuli and responses

Feared Stimuli

Fear Responses

Fear Meaning

Meaning Responses

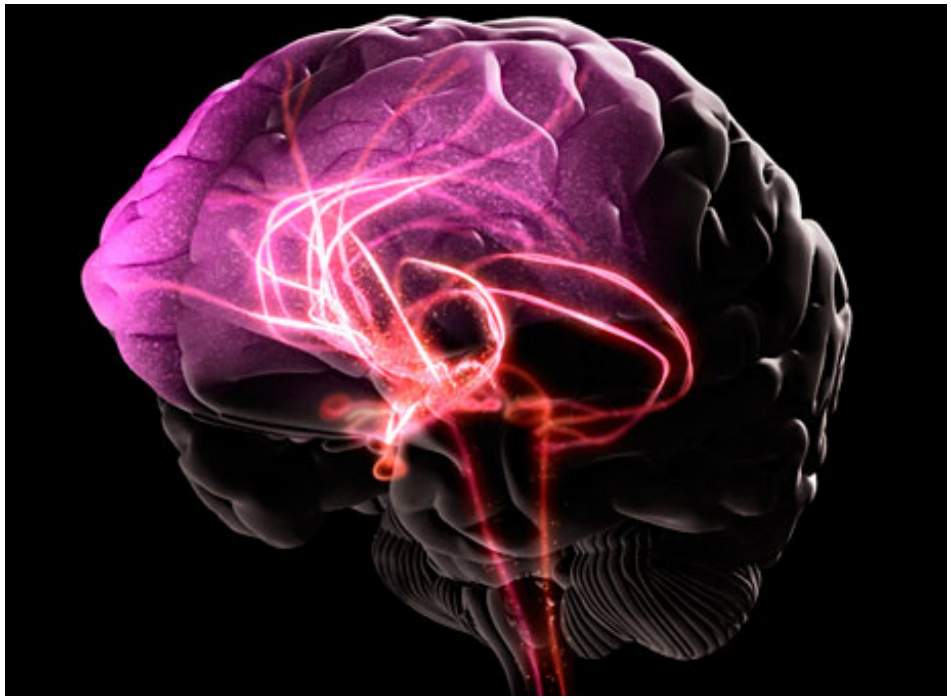
- Fast heartbeat means I'm afraid
- Sick to my stomach means something bad is about to happen
- Sweaty palms and increase body temperature means I need to leave
- When these things happen I should run

Becoming Pathological

1. Associations don't accurately represent the world
2. Harmless stimuli evoke physiological and escape/ avoidance responses
3. Excessive and easily triggered responses interfere with adaptive behavior
4. Harmless stimulus and response elements are erroneously associate with threat meaning

Treatment Intervenes by…

- Modifying problematic parts of the fear structure
- Particularly the meaning….



Fear Structure

Fear (Emotional) Structure

- A fear structure is a "program for escaping danger"
- It includes information about:
  - The feared *stimuli*
  - The fear *response*
  - The *meaning* of stimuli and responses

Trauma Memory

- A specific fear structure that includes representations of:
  - Stimuli present **during** and **after** the trauma
  - Physiological and behavioral responses that occurred during the trauma
  - Meaning associated with these stimuli and responses
- Associations among stimulus, response, and meaning representations may be **realistic** or **unrealistic**

Emotional Processing involves…

1. Repeated activation of the trauma memory (emotional engagement)
2. Incorporation of corrective information about "world" and "self"
3. Activation and disconfirmation occur via confronting trauma reminders (e.g., thinking about, and contact with trauma reminders)
4. Corrective information consists of the absence of the anticipated harm

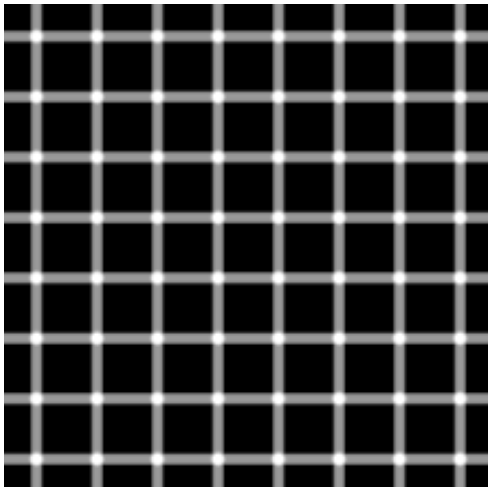
Chronic PTSD

Persistent cognitive and behavioral avoidance prevents change in the trauma memory by:

- Limiting activation of the trauma memory
- Limiting exposure to corrective information
- Limiting articulation of the trauma memory and thus preventing organization of the memory

Problematic Beliefs Present in PTSD

- *"The world is extremely dangerous"*
  - People are untrustworthy
  - No place is safe



- *"I am extremely incompetent"*
  - PTSD symptoms are a sign of weakness
  - Other people would have prevented the trauma

The world is entirely Dangerous

=

I'm completely incompetent to cope with it

Overall Rational for Treatment

PE aims to reduce PTSD symptoms associated with traumatic experiences

<u>What keeps symptoms around?</u>

- Avoidance of trauma related situations
- Avoidance of trauma related thoughts and images
- Problematic cognitions

Treatment Rationale

- Avoidance of thoughts, images, or memories prevents emotional processing of the trauma
- Avoidance of situations prevents new learning about the realities of danger
- Both types of avoidance prevents new learning to aid in modifying problematic cognitions

Treatment Rationale

- **Imaginal exposure**, the repeated revisiting of the event, allows for confrontation with traumatic experiences/ memories and helps to process the experience.
- Through processing, we are able to make better sense of the situation and modify problematic cognitions

Treatment Rationale

- *In-vivo* exposure consists of repeated approaching situations, places, etc..that have been avoided b/c they trigger memories of the event or b/c simply stopped doing b/c they feel dangerous
- By approaching these situations, fear about them decrease, and belief about danger is also modified

Who is Appropriate for PE?

Not meant for every trauma survivor

- Assessment does not occur until 3 months beyond traumatic event

PE considered for use with:

- Individuals with PTSD and related symptoms (e.g., depression, chronic anxiety, high levels of anger or shame, axis II disorders) following all types of trauma
- Individuals with a sufficient memory of the traumatic event that they have a narrative

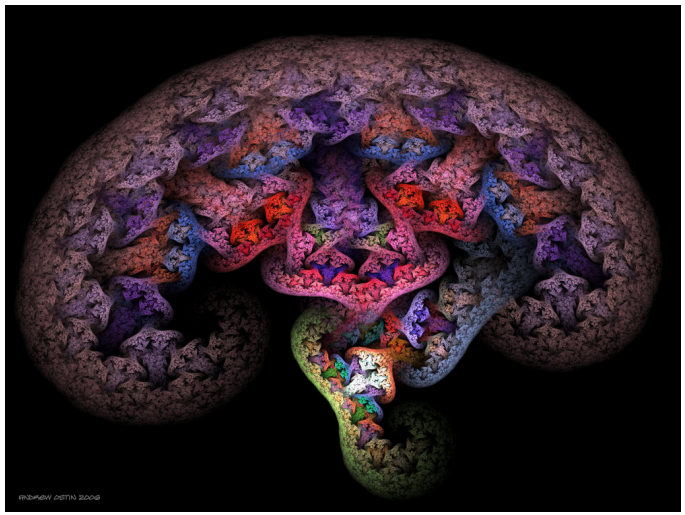
Co-morbid Difficulties

Caution should be taken with presence of any of the following co-morbid difficulties:

- Imminent threat of suicidal or homicidal behavior
- **Serious** self-injurious behavior
- Current psychosis
- Current high risk of being assaulted (living with domestic violence)
- Lack of clear memory or insufficient memory of traumatic event

Issues to Consider

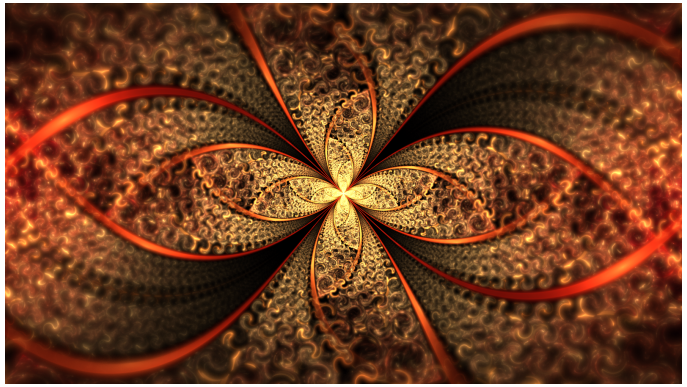
Drug and Alcohol



PE can be implemented successfully for clients with co-morbid alcohol and substance dependence if motivated to stop alcohol and drug use

- Concurrent alcohol/substance abuse treatment
- SUD as avoidance
- Ask them to stop

Living or Working in a High-Risk Environment



Can PE be effective for individuals who are likely to be exposed again in the future?

Fear may be fueled by present-day risk of harm

- PTSD still amplifying fear and expectations of harm in day-to-day life

Work on emotionally processing past trauma so PTSD symptoms diminish

Severe Dissociative Symptoms

Consider the following:

- The severity of the dissociative symptoms relative to the PTSD
- Whether symptoms will prevent client from benefiting from treatment

**The more severe or life-threatening disorder should take precedence*

Presence of Axis II Disorders

Not an exclusion criteria

Studies comparing outcome of clients *with* and *without* personality disorders show **no significant differences in improvement** in PTSD among clients

Clients may be excluded for safety reasons

Guilt or Shame

- Exposure therapy
- Recommend that ample time be devoted to addressing guilt
- Help client view trauma in context and put events in realistic perspective

PE is Effective With Complex PTSD Sufferers

Comorbid Disorders:

- Depression
  - Depressive symptoms are also treated by PE
- Alcohol and Drug Dependent
  - Both Alcohol and Drug use went down
- Borderline Personality Disorder
  - Rarely causes an increase in urges to self-injury
  - Does not increase suicidal and NSSI
  - May even decrease suicidal and NSSI
- High Dissociation
  - Strategies to keep the client grounded, in the session, leads to decreased dissociation over time

Associated symptoms:

- Guilt
- Anger/Aggression
- Suicide gestures
- Poor health

Summary

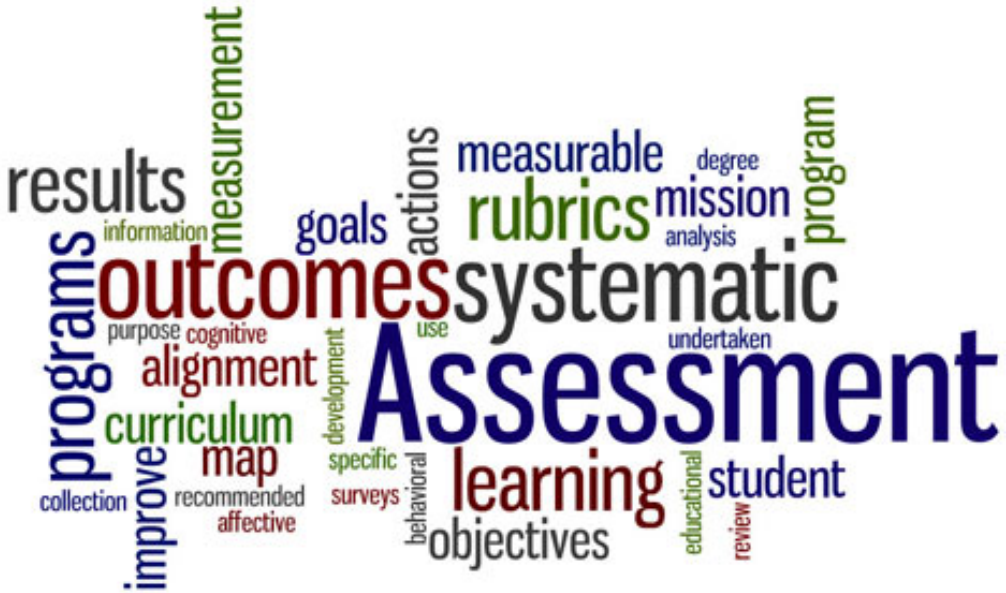
- Most individuals with PTSD following all types of trauma, who have clear memory of traumatic experience, are potentially good candidates for PE
- Co-morbidity of Axis I and II disorders are common in clients with chronic PTSD
- PE is warranted in clients with complex trauma histories and complicated clinical presentation

How does PE Work?

Emotional Processing Requires 2 things

- Accessing of the emotional/fear structure (fear activation)

- Availability of corrective information



Mechanisms of Therapy in PE

- Promotion of emotional engagement with the traumatic memories
- Modification of the problematic cognitions underlying PTSD

We do this by…

Two primary procedures:

- Imaginal exposure: repeated revising, recounting, and processing of the traumatic event.

- *In-vivo* exposure: repeated confrontation with situations, activities, places that are avoided because they are trauma reminders.

Treatment Overview in PE

- Prolonged, *imaginal exposure* to the trauma memory (revisiting, recounting, and processing)
- Repeated *in vivo* exposure to safe situations that are avoided because of trauma-related rear
- Psychoeducation: Education about common reactions to trauma

Treatment consists of an average of 8-15, 90-minute sessions

Typical Session Structure

Review Homework (In-vivo and Imaginal homework sheets)

Present Agenda

Conduct Imaginal Exposure (30-45 minutes)

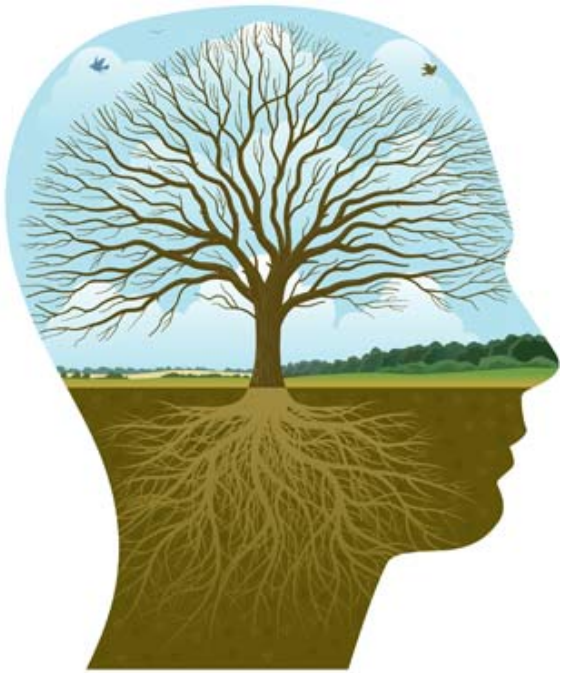
Process Exposure

Discuss or Implement In-vivo Exposure

Assign Homework

Other Fun Stuff for you to review

Effective Psychotherapy For PTSD



Healing Interventions

- Individual counseling
- Support groups
- Psychodynamic psychotherapy (e.g. psychoanalysis)
- Hypnotherapy

- Short-term cognitive behavioral therapy (CBT)
  - The only type of psychotherapy that was systematically studied and therefore is evidence-based
  - Very effective in 8 to 15 sessions

CBT Treatments for Chronic PTSD

- Promote safe confrontations (via exposure, discussions) with trauma reminders (memories, situations)

- Aim at modifying the dysfunctional cognitions underlying PTSD

Cognitive-Behavioral Treatment Can Be Divided Into:

- Exposure Procedures
- Anxiety Management Procedures
- Cognitive therapy

Exposure Therapy

- A set of techniques that are designed to reduce pathological, dysfunctional anxiety and dysfunctional cognitions by encouraging patients to repeatedly confront safe, trauma-related feared objects, situations, memories, and images

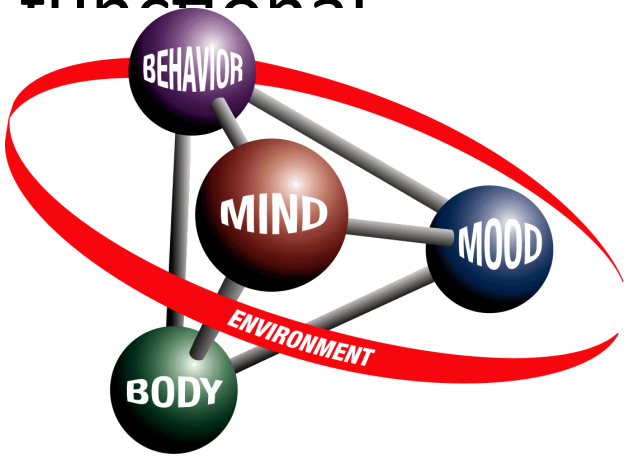
- Exposure helps patients realize that their feared consequences do not occur and therefore are unrealistic

Anxiety Management Treatment

- Relaxation Training
- Controlled Breathing
- Positive Self-talk and Imagery
- Social Skills Training
- Distraction Techniques
  - e.g., thought stopping

Cognitive Therapy

- Identifying dysfunctional, erroneous thoughts and beliefs (cognitions)
- Challenging these cognitions
- Replacing these cognitions with functional realistic cognitions



What is an Evidence-Based Treatment

The rules of well controlled studies contain at least the following conditions

- The treatment was compared to a no-treatment control group or to other treatments
- Patients were randomly assigned to treatment groups
- The results of the treatment were assessed by a valid and reliable measure and an independent evaluator
- The integrity of the treatment is checked

Evidence-Based Treatment for PTSD

- Cognitive Behavioral Therapy
  - Prolonged exposure (PE)
  - Stress inoculation training (SIT)
  - Cognitive therapy (CPT)
- EMDR

The Advantage of Prolonged Exposure

- PE has the *largest number of studies* supporting its efficacy and effectiveness
- PE has been found effective with the *widest range of trauma populations*
- PE has *been studied in many independent centers* in the US and around the world
- It's *effectiveness in the hands of non-experts* has been documented in several studies

Is Consultation Important

- Workshops are relatively low investment in a training program
- Follow-up consultations, on the other hand, carry are very costly

But…

- In the absence of follow-up consultation (supervision), clinicians are less likely to use the treatment they had learned

Conclusion of PE with Adults

- Several CBT programs are quite effective for PTSD
- PE has received the most empirical evidence with a wide range of traumas
- PE is more effective than treatment as usual for combat veterans
- Treatment that include both in vivo and imaginal exposure produce excellent outcomes and do not benefit from the addition of CR or SIT
- PE can be successfully disseminated to community clinics with non-CBT experts as therapists
- PE can be disseminated effectively over long distances and across cultures