

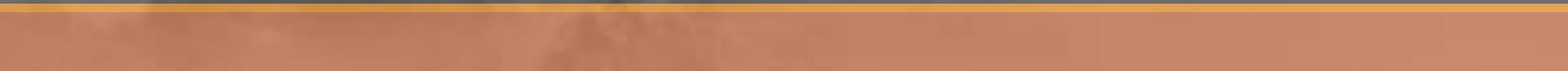


Prolonged Exposure

PRESENTED BY: EMILY DREHER, M.ED., LPC, NCC

LINEHAN BOARD CERTIFIED IN DIALECTICAL BEHAVIOR THERAPY

PLACES FOR PEOPLE



About the presenter: Emily Dreher M.Ed., LPC, NCC, DBT-LC

Training Associate with Illume

Professor for “Counseling Skills for Healthcare Professionals” at Washington University – Applied Behavioral Health Research Program

Practicing clinician for 11 years

Specialize in evidence-based treatments for complex mental health diagnoses, including Borderline Personality Disorder.

Linehan Board Certified in Dialectical Behavior Therapy

Objectives

After this training you should be able to...

- Describe the underlying theories of Prolonged Exposure (PE)
- Determine which clients would be most appropriate for PE
- Explain the exposure procedures of PE
- Identify the structure of PE sessions
- Debunk myths about exposure treatment for PTSD



- ✓ Most people who experience a traumatic event recover naturally
- ✓ PTSD represents a failure of natural recovery
- ✓ If PTSD does not remit within a year, it is unlikely to remit on its own
- ✓ PTSD is highly distressing and debilitating disorder

Post Traumatic-Stress Disorder

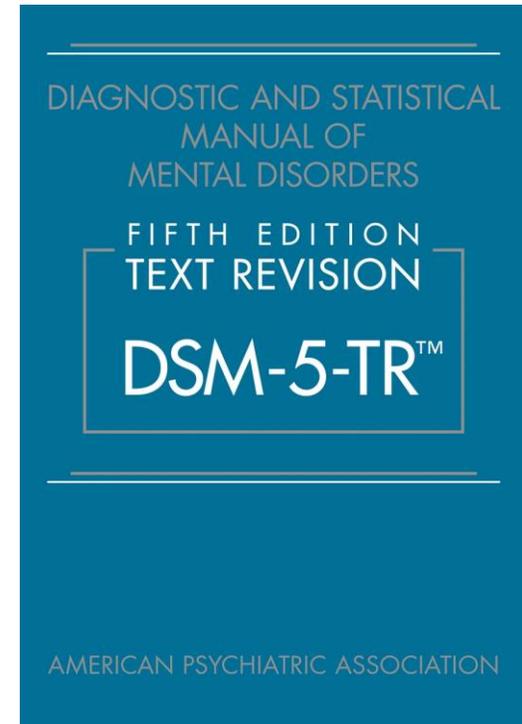
DSM V criteria:

Exposure to a traumatic event

1. Re-experiencing
2. Persistent avoidance
3. Negative mood and cognitions
4. Increased arousal

1 month in duration

Causes significant distress



SYMPTOM CLUSTERS

B. (1) Intrusion Symptoms	C. (1) Avoidance Symptoms	D. (2) Cognition and Mood	E. (2) Arousal and Reactivity
<ol style="list-style-type: none"> 1. Recurrent, Involuntary, & intrusive memories 2. Recurrent dreams with content or affect 3. Dissociative reactions – flashbacks or experiences of reliving 4. Prolonged psychological distress at exposure to internal or external cues 5. Physiological reactions to internal or external cues 	<ol style="list-style-type: none"> 1. Avoidance of or efforts to avoid memories, thoughts, images or feelings about the traumatic event 2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts or feelings 	<ol style="list-style-type: none"> 1. Inability to remember important parts of the traumatic event (not due to head injury, alcohol, or drugs) 2. Persistent negative beliefs or expectations about oneself, others, or the world (I am bad; no one can be trusted; the world is entirely dangerous and unsafe) 3. Distorted cognitions related to the cause or consequences to that lead to self-blame 4. Persistent negative emotional state 5. Markedly diminished interest or participation in activities 6. Feeling detached or estranged from others 7. Inability to experience positive emotions 	<ol style="list-style-type: none"> 1. Irritable behavior or angry outbursts 2. Reckless or self-destructive behavior 3. Hypervigilance 4. Exaggerated startle response 5. Problems in concentration 6. Sleep Disturbance (falling, restless, waking in panic)

DSM-5 Definition of Traumatic Experience

Criterion A - Exposure to:

- Actual or threatened death
- Serious Injury
- Sexual Violence

In one of the following ways:

1. Direct experience
2. Witnessing, in person, the event as it occurred to others
3. Learning that a traumatic event occurred to a close family member or friend (must be violent or accidental)
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

Types of Trauma



VIGNETTE: Jamie

Jamie is a 25-year-old Caucasian female who referred herself for outpatient treatment due to struggling to manage mental health symptoms. Jamie reported that her symptoms began in college when she was sexually assaulted by a male friend. She reported that following the sexual assault she started to engage in binge drinking behaviors and started to avoid attending classes. She eventually withdrew from school and returned home to St. Louis. Jamie reported that she has been relatively stable, going to work where she waitresses at a restaurant. She also works part-time for a CPA doing filing and other office related tasks. She would like to return to school to become a CPA.

Jamie reported that recently her symptoms have become unmanageable which she believes is due to the abundance of coverage on news and social media about high profile sexual assault cases and the #metoo movement. She reported that she has trouble falling asleep, wakes up throughout the night, and reported having nightmares a few times a week. She reported that her fatigue has made her more irritable, and she has noticed being more sensitive (e.g., cries easily, argues with boyfriend more often). Jamie avoids crowds due to intense anxiety. She used to enjoy shopping at popular retail stores, however lately she has been avoiding them completely. She also is very conscious on what she wears in certain contexts. For example, when she has her oil changed, she wears loose fitted clothing and does not wear makeup because she knows that most employees at her local auto shop are men. She also does not feel safe alone and has requested that a male colleague walk her to her car at night after her evening shifts. Jamie has started to avoid socializing as well, which she previously enjoyed. She prefers to stay home at her apartment with her boyfriend and dog. Jamie attended St. Louis University and she avoids the entire area the school is located. Jamie never told her family about her sexual assault due to intense shame. The assault occurred after a night of drinking and she blames herself for what happened. She reported that she does not remember all of the details of the event. She believes that something may have been put in her drink. However, there are images she remembers that pop into her mind when she does not want them to. Jamie is miserable with her current functioning and would like help addressing her trauma history.

Prolonged Exposure- at a glance

Help trauma survivors emotionally process their traumatic experiences in order to diminish PTSD and other trauma-related symptoms

- ❖ Developed by:
 - **Edna Foa, PhD and colleagues** at the Center for the Treatment and Study of Anxiety at the University of Pennsylvania
- ❖ Emerged from both exposure therapy and Emotional Processing Theory of PTSD
- ❖ Evidenced based treatment – 30 years of research
- ❖ Reduces PTSD as well as other trauma-related problems including depression, general anxiety, anger, and guilt
- ❖ 10-15 sessions
- ❖ Used with adolescents 13-17 years old and adults
- ❖ 90 minute sessions

Exposure

Clients are helped to confront safe but anxiety-provoking situations in order to overcome their excessive fear and anxiety

By confronting trauma memories and reminders, people learn that they can tolerate these situations and that nothing bad happens to them.



Emotional Processing Theory

- Based on the idea that natural recovery from a traumatic event occurs when one effectively “emotionally processes” a traumatic experience
- When processing is interrupted, PTSD symptoms develop
- These symptoms are maintained by avoidance of negative emotional experiences
- Avoidance strengthens negative and problematic associations and thus maintains PTSD



3 Components of a Fear Structure

A fear structure is an automatic and complex response that helps us to spot, avoid, or escape from dangerous situations

- *Activated for the purpose of survival...shortcut to engaging in pro-life behavior!*

Fear Structure is comprised of the following three components:

- The fear *stimuli*
- The fear *responses*
- The *meaning* we attach to stimuli and responses

How can we tell
if our response
is problematic?

The conclusions and associations we make
don't accurately reflect the world we live in

Harmless events evoke problematic and out
of proportion physiological responses and
escape/avoidance responses

Excessive and easily triggered responses
interfere with adaptive behavior

Harmless stimulus and response elements
are erroneously associate with threat
meaning



Trauma Memory

- A fear structure that includes:
 - Stimulus elements (anything occurring around the event)
 - Physiological and behavioral responses
 - Meaning associated with both stimuli and responses (dangerous and incompetent)
- Associations may be **realistic** or **unrealistic**



[This Photo](#) by Unknown Author is licensed under [CC BY-NC-ND](#)

Who is PE for?



Recommended if:

- At least one month since traumatic event
- Client has PTSD and other related problems (depression, anxiety, high levels of anger and shame) following a trauma and it is impacting their functioning
- At least one specific trauma memory

Not recommended if:

- Imminent threat of suicide or self-harm behaviors (DBT protocol)
- Current psychosis and not stabilized on appropriate medications
- Current high risk of being assaulted
- Lack of memory or insufficient memory of trauma

Other considerations...

Medications:

- Avoid the use of benzodiazepines as a way to reduce anxiety during exposure
- Medications should be well established

Substance/Alcohol Use:

- Previously individuals with substance use related disorders were excluded and asked to return when after they sought treatment for SUD
- Now simultaneous SUD and PTSD treatment is recommended
- Substance use can be assessed as avoidance and needs to be monitored
- Clients are asked to not engage in substance use the night before session, or before or after exposure exercises

Advantages of PE



*largest number of studies
supporting efficacy*



*widest range of trauma
populations researched
for efficacy*



*been replicated in multiple
sites with experts and
non-experts*



Ease of learning



Assess, Assess, Assess!

- Use a PTSD self-report measure (PSSI-5, PDS, PHQ-9)
- Use the Trauma Interview form in the manual
- Remember to be validating but do not treat client as fragile

Components of PE

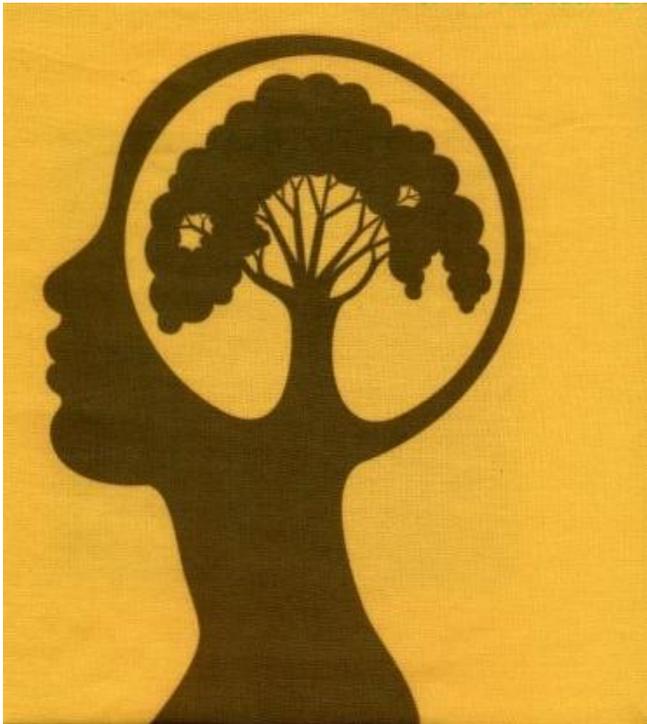
Psychoeducation about common reactions to trauma

Breathing retraining

Repeated in vivo (“in real life”) exposure to situations or activities that remind the client of the trauma

Repeated, prolonged imaginal exposure to the trauma memories

Psychoeducation



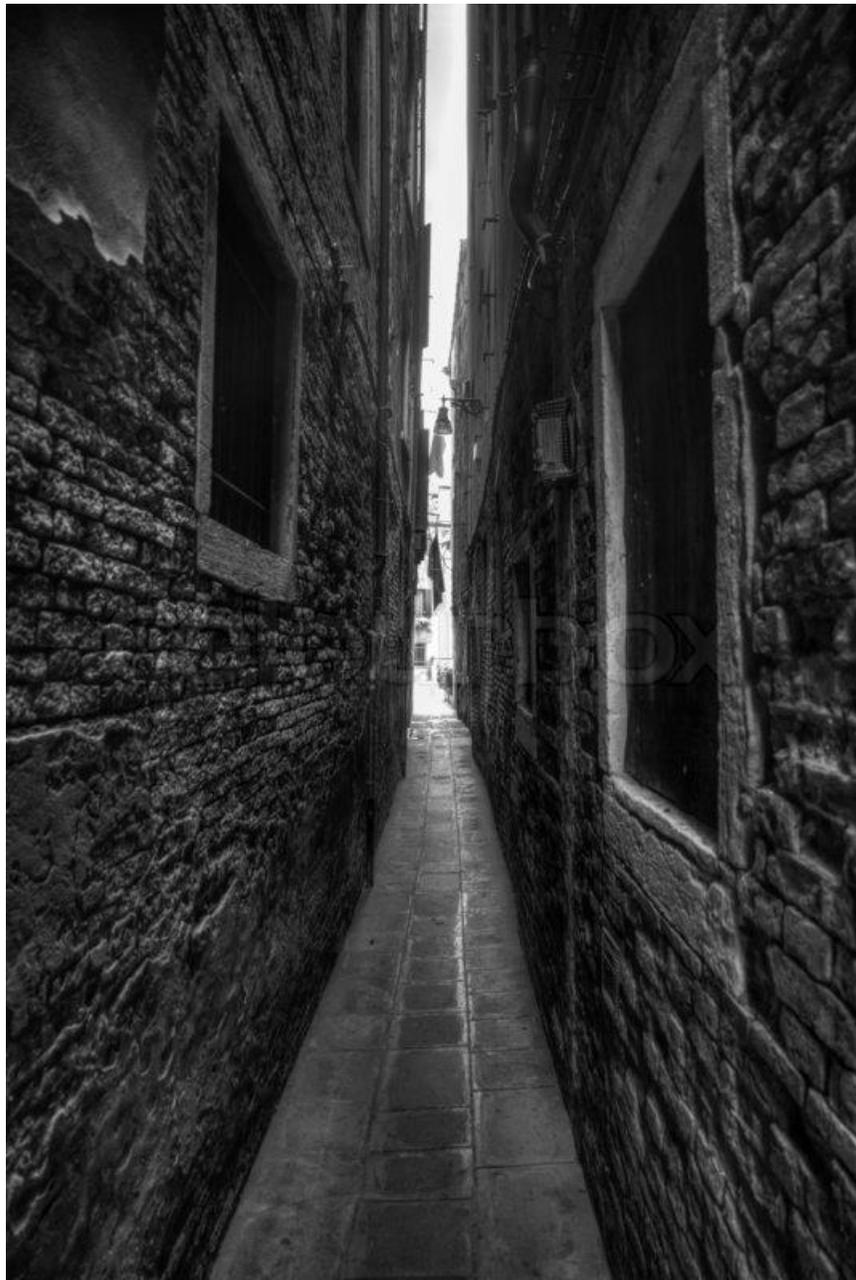
- ❖ Common reactions to trauma and criteria for PTSD
- ❖ Rationale for treatment – analogies!
- ❖ Overview of the treatment

Goals of Psychoeducation

- Elicits from the client their experience of PTSD symptoms and related problems while providing education
- Validates and normalizes client's experience
- Gives a clear orientation on what to expect and increases buy in to treatment
- Starts the process of exposure
- Instills hope

Dateline Video on PE

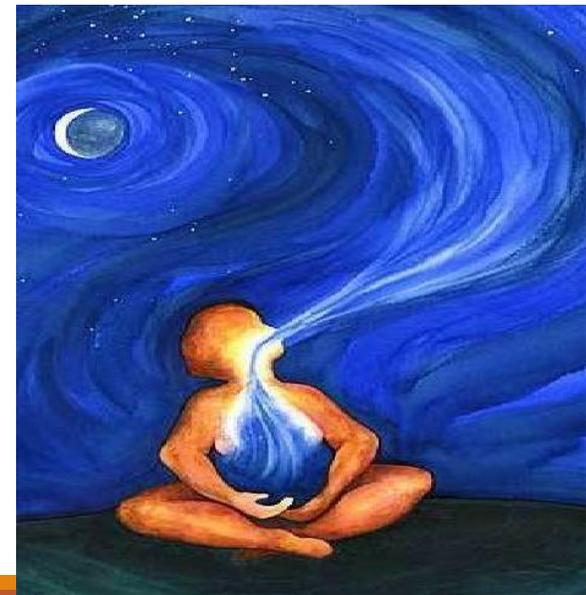
<https://www.youtube.com/watch?v=ViOIBfFu9gk>



Breathing retraining

When we become afraid or upset we feel like we may need more air which leads to breathing fast. Unless we are fighting or fleeing from real danger we don't need that much oxygen. Breathing fast, or hyperventilating does not have a calming effect and instead tricks our bodies.

- ❖ Breathing retraining targets not deep breathing but *slow* breathing
- ❖ Can use a cue word or counting
- ❖ Not to be used during exposure but when distressed other times of day



In Vivo Exposure



- ❖ Rationale:
 - ❖ Avoidance becomes a habit that is only strengthened the more the person avoids
 - ❖ By repeatedly confronting situations that were previously avoided because they were believed to be dangerous, the person learns that these situations are actually safe
 - ❖ Habituation then occurs which is when someone's anxiety diminishes
 - ❖ Getting over fears increases self-esteem and feelings of competency

In Vivo Exposure Process

Systematically confront relatively safe situations that the client is now avoiding, beginning with easier ones and progressing towards more difficult situations

Clients believe if they remain in the situation that makes them anxious, their anxiety will remain indefinitely or get worse. However, staying in the situation long enough will actually diminish anxiety.

Constructing the Hierarchy- SUDS

Create a Subjective Unit of Distress Scale (SUDS) Scale 0-100

100- Feeling like I felt during the trauma

75- Getting a phone call from child's teacher

50- Making a mistake and being asked to meet my boss and explain the mistake

25- Taking a bus across town

0- Laying in bed watching TV

Constructing the Hierarchy

Types of situations that are avoided:

1) Situations that you think are dangerous, not because they are dangerous, but because you now see the world as a dangerous places.

2) Situations that are reminders of the traumatic event – avoided because they trigger memories of the traumatic event and cause you to feel bad

3) Doing things that you used to enjoy (behavioral activation)

Creating an Exposure Hierarchy



What have you been avoiding?

What have you not been doing?

What have you given up doing?

What would you like to do?

What scares you the most?



Let's
practice
together!

In Vivo Exposure Homework Recording Form

Name: _____ Date: _____

1) Situation that you practiced _____

Date & Time	SUDS			Date & Time	SUDS		
	Pre	Post	Peak		Pre	Post	Peak
1.				5.			
2.				6.			
3.				7.			
4.				8.			

2) Situation that you practiced _____

Date & Time	SUDS			Date & Time	SUDS		
	Pre	Post	Peak		Pre	Post	Peak
1.				5.			
2.				6.			
3.				7.			
4.				8.			

Imaginal Exposure

Rationale: Person pushes away memory of trauma and therefore is unable to digest it or process it

- ❖ Imaginal exposure allows the person to process and organize the memory
- ❖ Promotes differentiation between “remembering” the traumatic event and “being retraumatized”
- ❖ Promotes reduction of anxiety and distress connected with the memory
- ❖ Promotes the realization that thinking and talking about the trauma do not cause you to go crazy or fall apart
- ❖ Increases mastery and sense of control

Imaginal Exposure Process

Instruct the client to...

- Close eyes
- Visualize the trauma as vividly as possible, and describe what happened, including the events, thoughts, and feelings experienced
- Tell story in the present tense as if it were happening now

Explain...

- Patient will be asked to provide SUDS ratings every 5 min
- Patient will continue the revisiting for 45 minutes



[This Photo](#) by Unknown Author is licensed under [CC BY](#)



Metaphor Demonstration

“Let me demonstrate to you how trying hard to push a thought out of your mind actually can make this thought stronger. For the next 10 seconds, I want you to think about anything that comes into your mind, EXCEPT one thing. Whatever you do, DO NOT think about a pink elephant floating about my head [Wait several seconds.] What are you thinking about now? I bet you are thinking about a pink elephant.”

Processing the Imaginal Exposure

Therapist follows the client as she considers how this event impacts her thoughts about herself and the world, at the time of the trauma and now

- ❖ Starts by acknowledging courage to recount painful memory
- ❖ Ask client to discuss thoughts and feelings during the imaginal. Compare this experiencing of recounting the memory to other experiences.
- ❖ Normalize and help the client understand her reactions and behaviors in the trauma and aftermath

Processing the Imaginal Exposure contd.

- ❖ Comment on the reduction in distress that you observe within or across sessions
- ❖ Share your own observations with the client, highlight areas that felt meaningful or important
- ❖ Focus on thoughts and beliefs that are maintaining PTSD
- ❖ Use open-ended questions and reflective listening

Hot Spots Procedure



Focusing exclusively on most currently distressing parts of the trauma

“Hot spots”



Introduced after 2 or 3 imaginal exposure sessions



Identify based on client’s self-report



Focus on hot spots until each has been sufficiently processed based on SUDS levels

Session Outline

Session 1

- Overview of the treatment and procedures
- Rationale of treatment
- Information gathering using the Trauma Interview
- Introduce breathing retraining
- Assign homework
(listen to session 1x)

Session 2

- Review self-report scales
- Discuss common reactions to trauma
- Rationale for in vivo exposure
- Construct in vivo hierarchy
- Assign in vivo exposure homework
(listen to session 1x)

Session Outline

Session 3

- Review homework
- First imaginal exposure
- Process imaginal exposure
- Assign homework:
 - Listen to imaginal exposure everyday and the whole session 1X
 - In vivo exposure

Sessions 4-14

- Imaginal Exposure
- Process imaginal exposure
- Plan/implement in vivo exposure

Final session

- Review self-reports
- Brief imaginal exposure
- Discuss treatment progress and plans for continuing to use exposure skills (relapse prevention)



Why Aren't Therapists Using Exposure Based Treatments for PTSD?

Lack of training

Belief that manualized treatment is too rigid

Concern that clients will get worse and/or drop out of treatment

Becker, C.B., Zayfert, C., & Anderson, E. (2004). A survey of psychologists' attitudes towards and utilization of exposure therapy for PTSD. *Behaviour Research and Therapy*, 42(3), 277-292.

Myths about Exposure Therapy for PTSD

Myth 1: Exposure therapy is rigid and insensitive to clients' needs

Myth 2: Bigger is better: Adding additional interventions enhances outcome

Myth 3: Exposure therapy doesn't generalize to the "real world"

Myth 4: Exposure therapy will lead to exacerbation of symptoms and high drop out rates

Norah C. Feeny, Elizabeth A. Hembree, Lori A. Zoellner, (2003) "Myths regarding exposure therapy for PTSD," *Cognitive and Behavioral* 10, 1;85-90

Things to remember....

- Want to continue assessing PTSD symptoms throughout treatment. PTSD symptoms may not go away completely.
- When SUDS for both In vivo exposures and Imaginal exposures reduce to a 30 or below then exposure has been effective
- Ensure clients are prepared with a way to record sessions.

CLINICIANS WHO ARE TREATING CLIENTS WITH SEVERE TRAUMATIC EXPERIENCES NEED SUPPORT!