

PROLONGED EXPOSURE AS A TREATMENT FOR PTSD/SUD

The Fear 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 contains representations of:
 - Stimuli present during and after the trauma
 - Physiological and behavioral responses that occurred during the trauma
 - Meanings associated with these stimuli and responses
 - Associations may be realistic or unrealistic

Characteristics of early trauma structure

- Large number of stimuli
- Excessive responses [PTSD symptoms]
- Erroneous associations between stimuli and “danger”
- Erroneous associations between responses and “incompetence”
- Fragmented and poorly organized relationships between representations

Early PTSD symptoms

- Trauma reminders in daily life activate trauma memory and the associated perception of “danger” and “self incompetence”
- Activation of the trauma memory is reflected in re-experiencing symptoms and arousal
- Re-experiencing and arousal lead to avoidance behavior

Recovery Process

- **Recovery is the norm!!!**
- Repeated activation of trauma memory and emotional engagement
- Incorporation of corrective information about “world” and “self”
- Activation and disconfirmation occur via confronting trauma reminders [thinking about, and contact with, trauma reminders]
- Corrective information consists of absence of anticipated harm

Chronic PTSD

- While avoidance may be helpful short term, over long term it is harmful
- Persistent cognitive and behavioral avoidance prevents change in trauma memory by:
 - Limiting activation of trauma memory
 - Limiting exposure to corrective information
 - Limiting articulation of trauma memory and thus preventing organization of the memory

Erroneous cognitions underlying 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

Prolonged Exposure Therapy for PTSD

- **Imaginal exposure:** revisiting the trauma memory (30-45 minutes during sessions 3-12) and processing it (15 minutes)
- **In vivo exposure:** to trauma reminders in life between sessions
- **Education:** about common reactions to trauma (25 minutes in session 2)
- **Breathing retraining:** 10 minutes in session 1
- 9-12 weekly or twice-weekly 90 minute sessions
- Allow patients to process memory, better differentiate past from present, and gain an improved sense of control and mastery over the memory

Endorsements

- More than 20 years of research supports its use
- In 2001, Prolonged Exposure for PTSD received an Exemplary Substance Abuse Prevention Program Award from the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA).
- Prolonged exposure was selected by SAMHSA and the Center for Substance Abuse Prevention as a Model Program for national dissemination.
- the VA Office of Mental Health Services has funded a national rollout to disseminate PE into VA hospitals as a treatment of choice for veterans suffering from PTSD
- 2008 IoM report: upheld the efficacy of PE in treatment of PTSD
- International Consensus Group on Depression and Anxiety: identified exposure as the first-line psychosocial intervention and the single most important treatment for reducing PTSD symptoms

Some data

- produce clinically significant improvement in about 80% of patients with chronic PTSD (Eftekhari, Stines, & Zoellner, 2006)
- A more recent meta-analytic review of prolonged exposure showed that the average PE-treated patient fared better than 86% of patients in control conditions at post-treatment on PTSD measures (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010).

PE data

- Consistent improvements in depression, anxiety, and global functioning
- Clinically significant and lasting improvements in negative cognitions about one's self, the world, and self-blame (Foa, & Rauch, 2004)
- Reductions in anger, particularly in those with high baseline anger (Cahill et al., 2003)
- Reductions in dissociation (Taylor et al., 2003)
- Even those with co morbid axis I and axis II benefit from PE (depression, anxiety, substance use, and personality disorders NOT significant predictors of treatment response) (Van Minnen et al., 2002)
- Demonstrated efficacy around a variety of trauma and variety of ethnic and cultural groups
- Adding PE to sertraline partial responders: improved response rates and end of treatment and follow-up (Cahill et al., 2004)
- PE can be successfully disseminated by community therapists