



Communiqué

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Prolonged Exposure Therapy

By Kevin Reeder, Ph.D.

Clinical Psychologist, Central Arkansas Veterans Healthcare System

Prolonged exposure therapy is an evidence-based psychotherapy for PTSD. It is the product of over 20 years of well-controlled studies of its use (Foa, Hembree, & Rothbaum, 2007). It has been designated a strongly recommended treatment in the VHA-DoD Practice Guidelines for the Management of Traumatic Stress (2010).

Prolonged exposure is an individual, cognitive behavioral therapy that consists of three primary components; psychoeducation about treatment and common reactions to trauma, exposure to the trauma memory through repeated recounts of the traumatic event (imaginal exposure), and exposure to real-world, trauma-related situations that are objectively safe but avoided due to trauma related distress (in vivo exposure). The protocol typically lasts 8-15 sessions, each from 90-120 minutes in length. Sessions 1 and 2 emphasize the psychoeducational component and presentation of the rationale for the treatment and its components. The second and third sessions establish the in vivo and imaginal exposures. The remaining sessions are designed to use these types of exposures to address two factors that are thought to maintain trauma related difficulties, avoidance and negative beliefs. Avoidance of the traumatic memory and situations in the Veteran's current life prevent emotional processing of the memory. By actively engaging with the trauma memory and facing challenging real-life situations, Veterans learn they can tolerate the emotions associated with the event. They also begin to develop a sense of mastery that allows them to challenge maladaptive beliefs they hold about the traumatic event, the world around them and, most importantly, themselves.

A RAND Corporation study (Tanielian & Jaycox, 2008) estimated that approximately 300,000 OEF/OIF service members suffer from PTSD. In the context of a healthcare system that is also tasked with treating Veterans from prior conflicts, the VA has taken steps to ensure increased access and quality of care for PTSD. In light of strong evidence supporting the efficacy of prolonged exposure therapy, the Office of Mental Health Services in VA Central Office, in collaboration with the National Center for PTSD, and Drs. Edna Foa and Elizabeth Hembree introduced the Prolonged Exposure Mental Health Training Initiative in 2007. Headed by the National Center for PTSD, Dissemination and Training Division, the Prolonged Exposure Mental Health Training Initiative has trained nearly 1300 clinicians. Training to deliver prolonged exposure therapy in the VA involves two essential components; a

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four-day training workshop for clinicians and a period of structured consultation. The training workshop relies on a variety of experiential modalities to train clinicians in both the implementation of prolonged exposure therapy and the theory behind it using lectures, clinical demonstrations, and videotaped reenactments of prolonged exposure therapy sessions. Workshop participants are given several opportunities to learn through role-play exercises that are coupled with observation and feedback from trainers (Karlin et al., 2010).

Immediately following the training, clinicians are assigned a prolonged exposure therapy consultant with whom they meet over the phone twice weekly. This includes an individual consultation call and a one-hour long group consultation call each week. To receive provider status as a prolonged exposure provider in VA, clinicians are required to participate in consultation for a minimum of two cases. More cases may be required if the consultant thinks this would help the clinician develop a better understanding of the protocol. Consultants review audiotapes of all sessions and give feedback to the clinician. The process is designed to ensure that clinicians adhere to the prolonged exposure protocol, while also remaining sensitive to unique aspects of the clinician's environment. Trainers and consultants in the training initiative are VA clinicians who have demonstrated mastery of the prolonged exposure protocol and its implementation. This ensures quality of training and that clinicians receive support from those who are familiar with delivery of care to Veterans and working in the VA system. This quality has been evident in a 20-point mean decrease in PTSD Checklist scores in cases to date under consultation in the initiative (Eftekhari et al., 2011).



The Prolonged Exposure Mental Health Training Initiative has developed a variety of resources for VA clinicians providing prolonged exposure therapy. Among these are an information-sharing website “PE for PTSD” that has a variety of information about prolonged exposure therapy and the training initiative. A video clip is available to educate providers about prolonged exposure therapy and its benefits. Also available is a separate video clip for providers to watch with Veterans that provides information and Veteran testimonials of their experience with prolonged exposure therapy. A clinic guidance manual has been developed to facilitate implementation of prolonged exposure therapy with different Veteran populations and in a variety of clinical environments in the VA system. Drop-in consultation calls are available on an ongoing basis several times a month for clinicians who have completed training and consultation through the initiative.

There are many benefits of prolonged exposure therapy and this training within the VA. Patients report that they are engaging in activities that they have been avoiding for years. Clinicians have the opportunity to learn a state-of-the-art therapy for PTSD. With the prolonged exposure protocol, clinicians have a powerful tool that gives them the opportunity to participate in a diverse, highly skilled community of practice and gives hope to the Veterans they serve.

References

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- Foa, E. B., Hembree, E. A., & Rothbaum, B. O. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences: Therapist guide*. Oxford: Oxford University Press.
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Recognition of Excellence in the SC MIRECC

The South Central MIRECC applauds the substantial contributions of several individuals to our mission to reduce mental health disparities among rural and other underserved Veterans in VISN 16. Please join us in congratulating the following awardees:

SC MIRECC

Major Contributor Award: Kristin Ward, M.S.

Excellence in Education Award: Jeffrey A. Cully, Ph.D.

Best Publication by a Senior Investigator: Jeffrey M. Pyne, M.D.

Best Publication by a Junior Investigator: Salah U. Qureshi, M.D.

Special Contribution Award: Steven Sullivan, M.Div., Th.M.

Special Contribution Award: Brenda Schubert

Special Contribution Award: Penny White, B.A.

SC MIRECC/VISN 16 Mental Health Product Line

Clinical Leadership Award: Tina McClain, M.D.

Clinical Care Award: Russell Smith, Ph.D.

Clinical Care Award: Nilam Patel, M.D.

ATTRIBUTION: ACKNOWLEDGEMENT OF MIRECC RESEARCH SUPPORT/EMPLOYMENT

SC MIRECC researchers and educators have a responsibility to ensure that the SC MIRECC receives proper credit for SC MIRECC-supported studies or projects in articles, presentations, interviews, and other professional activities in which the results of those projects are publicized or recognized. All investigators should credit the SC MIRECC if they receive either direct or indirect support from the SC MIRECC. For example, "This work was supported in part by the VA South Central (VISN 16) Mental Illness Research, Education, and Clinical Center." If you receive salary support from the SC MIRECC, you should list the SC MIRECC as an affiliation.

RECENT SC MIRECC PUBLICATIONS

ROUTINE OUTCOMES MONITORING TO SUPPORT IMPROVING CARE FOR SCHIZOPHRENIA: REPORT FROM THE VA MENTAL HEALTH QUERI

Young AS, Niv N, Chinman M, Dixon L, Eisen SV, Fischer EP, Smith J, Valenstein M, Marder SR, Owen RR

Community Mental Health Journal, 2011, 47(2), 123-135

In schizophrenia, treatments that improve outcomes have not been reliably disseminated. A major barrier to improving care has been a lack of routinely collected outcomes data that identify patients who are failing to improve or not receiving effective treatments. To support high quality care, the VA Mental Health QUERI used literature review, expert interviews, and a national panel process to increase consensus regarding outcomes monitoring instruments and strategies that support quality improvement. There was very good consensus in the domains of psychotic symptoms, side effects, drugs and alcohol, depression, caregivers, vocational functioning, and community tenure. There are validated instruments and assessment strategies that are feasible for quality improvement in routine practice.

INCREASED DEMAND FOR MENTAL HEALTH SERVICES ON COLLEGE CAMPUSES: PERSPECTIVES FROM ADMINISTRATORS

Watkins D, Hunt J, & Eisenberg D

Qualitative Social Work, August, 2011, Epub

This study examined changes in the demand and role of student mental health services as reported by administrators from college counseling and mental health centers (CCMHCs). Ten CCMHC administrators from US institutions engaged in semi-structured interviews. Four themes characterized the changes in demand and role of student mental health services: 1) an increase in the severity of mental health concerns and demand for services; 2) overall psychosocial differences in today's college student population; 3) changes in the roles of counseling centers; and 4) institutional challenges and the response to those challenges. Administrators' responses provided an enriched understanding of the current mental

health needs of college students, the potential psychosocial and societal causes of these needs, and the importance of dynamic and flexible responses by counseling centers and institutions more broadly as the mental health profile of students continues to evolve.

EFFECTS OF PRE- AND POST-KATRINA NONVIOLENT AND VIOLENT EXPERIENCES ON MALE VETERANS' PSYCHOLOGICAL FUNCTIONING

Tharp AT, Vasterling JJ, Sullivan G, Han X, Davis T, Deitch EA, Constans J

Disaster Medicine and Public Health Preparedness, 2011, 5(Suppl. 2), S227-S234

Identifying individuals at risk for mental health problems after a disaster often involves assessing potentially traumatic exposures inherent to the disaster. Survivors of disasters also may have been exposed, both before and during the event, to trauma not directly related to the disaster. A substantial literature suggests exposure to interpersonal violence may have more severe negative outcomes than exposure to non-violent events; however, it is unclear whether violent vs. nonviolent exposures before and during a disaster have differential effects on postdisaster psychological functioning. We examined the associations of violent and nonviolent exposures before and during Hurricane Katrina with postdisaster psychological functioning in a sample of male military Veterans. Violent and nonviolent exposures post-Hurricane Katrina as well as pre-Katrina violent exposures were significantly associated with symptoms of posttraumatic stress disorder, panic, and generalized anxiety disorder more than 2 years after the storm. Moreover, Veterans who reported violent exposures pre-Katrina were more than 4 times more likely to have reexperienced interpersonal violence during Katrina than those who did not report such exposures. Results suggest assessing disaster-specific experiences in addition to predisaster interpersonal violence may be important for identifying and triaging individuals at risk for postdisaster mental health problems.

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THE DEVELOPMENT OF A COUPLE-BASED TREATMENT FOR PTSD IN RETURNING VETERANS

Sautter, FJ, Armelie, AP, Glynn, SM, Wielt, DB

Professional Psychology: Research and Practice, 2011, 42(1), 63-69

Military personnel deployed in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) show high levels of emotional distress and posttraumatic stress disorder (PTSD), and these deployment-related problems may be expected to have a devastating impact on their relationships. It is urgent that researchers develop couple-based treatments to reduce PTSD in OEF/OIF Veterans and to reduce PTSD-related relationship problems. This article describes the development of a novel couple-based treatment for PTSD, called Structured Approach Therapy (SAT), that uses empathic communication training and stress inoculation procedures to help couples improve their ability to cope with trauma-related anxiety and a multicomponent emotion activation program to help couples reduce emotional numbing. The theoretical basis of the SAT Treatment Model is described, and the various treatment components are presented. The authors recommend that couple-based interventions be used to provide OEF/OIF Veterans and their partners with empathic communication skills to discuss their thoughts and feelings about deployment and with dyadic coping skills to confront trauma-related aversive emotions and emotional numbing and return intimacy to their lives.

TREATMENT RESPONSE FOR LATE-LIFE GENERALIZED ANXIETY DISORDER: MOVING BEYOND SYMPTOM-BASED MEASURES

Roseman AS, Cully JA, Kunik ME, Novy DM, Rhoades HM, Wilson NL, Bush AL, Stanley MA

Journal of Nervous and Mental Disease, 2011, 199(10), 811-814

Response to treatment of late-life generalized anxiety disorder has been defined by a variety of methods, all based on statistically significant reductions in symptom severity. However, it is unknown whether these improvements in symptom severity are associated with meaningful differences in everyday functioning. The current study used four methods to define response to treatment for 115

primary-care patients 60 years and older, with a principal or coprincipal diagnosis of generalized anxiety disorder. The methods examined included percentage of improvement, reliable change index, and minimal clinically significant differences. Agreement among classification methods and their associations with general and mental health-related quality of life were assessed. Results indicated moderate agreement among symptom-based classification methods and significant associations with measures of quality of life.

AN EVALUATION OF THE BRIEF MULTIDIMENSIONAL MEASURE OF RELIGIOUSNESS/SPIRITUALITY IN OLDER PATIENTS WITH PRIOR DEPRESSION OR ANXIETY

Bush, AL, Jameson, JP, Barrera, T, Phillips, LL, Lachner, N, Evans, G, Jackson, AD, Stanley, MA

Mental Health, Religion and Culture, 2011, Epub

The primary objective of the study was to examine the psychometric properties of the Brief Multidimensional Measure of Religiousness and Spirituality (BMMRS) in older adults. Older adults (N=66) completed a survey in-person or over the phone. Measures included the BMMRS, Religious Problem Solving Scale, Brief Religious Coping Scale, Functional Assessment of Chronic Illness Therapy – Spiritual Well-being, Satisfaction with Life Scale, Geriatric Anxiety Inventory, and Geriatric Depression Scale. Cronbach's alphas evaluated internal consistency, zero-order correlations tested construct validity, and multiple regressions assessed the association of BMMRS domains with well-being. Most BMMRS domains were reliable and valid. Collectively, they explained 26% to 68% of the variance in well-being and psychological symptoms. Daily spiritual experiences uniquely predicted spiritual well-being, satisfaction with life, and depressive symptoms. The BMMRS is useful in older populations and may help identify those who could benefit from religious or spiritually integrated therapy. ♦



CBOC MENTAL HEALTH ROUNDS: SPONSORED BY THE SC MIRECC

UPCOMING SESSIONS

March 14, 2012

Mind-Body-Spiritual Approach to Symptom Management: Mantram Repetition Program
Jill Bormann, PhD, RN

April 11, 2012

Ethics
*Beth Jeffries, Ph.D.,
Vania Revell, M.D., &
John McBride, L.C.S.W.*

May 9, 2012

Traumatic Brain Injury
Nicholas Pastorek, M.D.

Psychosocial Rehabilitation and Recovery Centers (PRRCs) and CBOCs: Partners in Providing Recovery Oriented Care

Presenters: Amy Cuellar, Ph.D., John Dietrich, L.C.S.W. & Delores Hendrix-Giles, L.C.S.W.

VISN 16 clinicians are invited to attend the next SC MIRECC CBOC Mental Health Rounds on Wednesday, **February 8, 2012 from 8:00-9:00 a.m. (CST)**.

VISN 16 clinicians should visit
https://www.tms.va.gov/plateau/user/deeplink_redirect.jsp?linkId=REGISTRATION&scheduleID=1670381
to register.

VANTS: 1-800-767-1750; Access code: 26461#

Use your computer workstation with telephone capability or local site for viewing. You will need to access Live Meeting and dial into the VANTS call for this presentation. The presentation is limited to 250 participants on a first come, first served basis

For more information, contact Geri Adler, Ph.D. at (713) 794-8660 or Geri.Adler@va.gov

The CBOC Mental Health Rounds: Sponsored by the SC MIRECC is held the second Wednesday of each month from 8:00-9:00 AM (CST). Only VISN 16 clinicians can register for CE credit.

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