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Beyond the Manual: The Insider's Guide to Prolonged Exposure Therapy for PTSD

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Prolonged Exposure therapy (PE; Foa & Rothbaum, 1998) has strong empirical support for its efficacy in reducing trauma-related psychopathology in individuals with chronic PTSD (Rothbaum, Meadows, Resick, & Foy, 2000). In the process of providing PE to many clients and in training therapists in a variety of settings in its use, we at the Center for the Treatment and Study of Anxiety have amassed extensive experience with this therapy. This article extends the treatment guidelines provided in the PE treatment manual by sharing the knowledge and wisdom that years of experience have brought us. We emphasize the importance of forging a strong therapeutic alliance and providing a thorough rationale for treatment, discuss ways to implement in-vivo and imaginal exposure so as to promote effective emotional engagement with traumatic memories, and conclude with some recommendations for how therapists who conduct PE for PTSD can take care of themselves while delivering a therapy that is very rewarding and, at times, emotionally challenging.

Several cognitive-behavioral therapies (CBT) have demonstrated efficacy for the treatment of PTSD—for example, Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), and Stress Inoculation Training (SIT; for reviews see Foa & Rothbaum, 1998; Rothbaum, Meadows, Resick, & Foy, 2000). PE, which involves repeated imaginal exposure to the traumatic memory (trauma reliving) and repeated in-vivo exposure to safe situations that are avoided, has been one of the most investigated treatments for PTSD. Its efficacy has been demonstrated with a wide range of populations, including female sexual assault survivors (Foa, Rothbaum, Riggs, & Murdock, 1991; Foa et al., 1999), male combat veterans (e.g., Keane, Fairbank, Caddell, & Zimerling, 1989), and mixed gender samples exposed to a variety of traumatic experiences (Devilly & Spence, 1999).

Some studies suggest that PE may either be more efficacious or more efficient than alternative treatments for PTSD. Foa et al. (1999) compared PE to SIT (anxiety-management training focused on posttrauma reactions) and their combination (PE/SIT). The SIT treatment used in this study was adapted from Veronen and Kilpatrick's (1983) SIT program. It included training in

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coping skills but omitted in-vivo exposure in order to avoid overlap with the PE treatment condition. While all active treatments resulted in symptom reduction at posttreatment superior to wait-list control, PE consistently produced larger effect sizes on PTSD, depression, and general anxiety than either SIT or PE/SIT. Indeed, 52% of participants in the PE condition achieved good end-state functioning as compared with 31% of participants in the SIT condition, and 27% in the PE/SIT condition. Further, at follow-up, PE resulted in lower posttreatment anxiety and better social adjustment than SIT or the combination treatment (Foa et al.).

Preliminary analyses from a recent study suggest that PE may be a more efficient treatment than PE combined with cognitive restructuring (PE/CR). Both treatments result in substantial and similar reductions in PTSD and related symptoms (Foa, 2001). However, the PE-alone group achieved these reductions more quickly. Fifty-one percent of PE participants achieved responder status after nine sessions versus 30% in the PE/CR group. Furthermore, PE alone reduced dysfunctional, trauma-related cognitions as much as did PE/CR (Foa & Rauch, 2002). Similar studies comparing PE alone to PE plus cognitive interventions have also found no difference in reduction of dysfunctional cognition between the two groups (e.g., Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998).

Despite accumulating evidence that PE is highly efficacious in ameliorating chronic PTSD and the broad availability of published materials on how to implement PE, some clinicians remain reluctant to use this treatment. We at the Center for the Treatment and Study of Anxiety (CTSA) have acquired extensive experience with this therapy program by providing PE to hundreds of clients and by training therapists in a variety of settings to implement the treatment. In addition, our experience as trainers has alerted us to concerns of therapists regarding the effective and safe implementation of PE. In this article, we aim to expand on the information provided in the PE manual to assist clinicians who are using this treatment in their routine clinical practice with PTSD clients. Thus, we will discuss ways to enhance outcome and retention, as well as describe procedural modifications that will help clinicians overcome treatment barriers.

The treatment manual to which we refer is Prolonged Exposure for PTSD published by Foa and Rothbaum (1998). Treatment is delivered in an individual format and consists of 9 to 12 sessions that are 90 to 120 minutes in length. The goal of the treatment program is to ameliorate the severity of chronic PTSD symptoms. Core components of therapy include psychoeducation about PTSD symptoms and common reactions to trauma, breathing retraining, approaching safe situations (in-vivo exposure), and recounting the traumatic memories (imaginal exposure or reliving of the trauma memories). Daily homework assignments are designed to encourage exposure practice and calm breathing and are an extremely important aspect of the treatment.

As noted above, this paper aims to extend the treatment guidelines detailed in the PE treatment manual by sharing the knowledge and wisdom that years of experience have brought us. We begin by emphasizing the importance of building a good foundation for treatment. This is followed by a discussion of ways to implement in-vivo and imaginal exposure so as to promote effective emotional engagement and processing of traumatic experiences. We conclude with some recommendations and guidelines for how therapists using this treatment can take care of themselves while delivering a therapy that is very rewarding but at times emotionally challenging.

Laying the Groundwork

A solid foundation for PE should include the following components: (a) conveying to the client that PE has been found highly effective for reducing chronic PTSD and that the therapist is knowledgeable about the use of this treatment; (b) forming a strong therapeutic alliance; (c) providing a clear and thorough rationale for PE; and (d) tailoring the treatment plan to the individual client by consistently aiming to promote trauma processing and overcome avoidance while at the same time retaining flexibility.

Conveying Effectiveness and Competence

Conveying the effectiveness of the treatment and the competence of the therapist in treating posttrauma reactions is an important aspect of building a solid foundation for treatment. In PE, clients are asked to directly confront memories and situations they fear and work hard to avoid. In order to follow this plan, it is helpful to have confidence in the treatment model and in the therapist's knowledge. The presentation of a credible rationale that links the treatment procedures to the client's specific PTSD symptoms can help to instill this confidence. Using examples of success from the therapist's clinical experience can also be a powerful tool to convey the effectiveness of the therapy.

Forming an Effective Therapeutic Alliance

A critical component of any therapy is a strong therapeutic alliance. For trauma survivors, feeling trust in an empathic and supportive therapist is crucial, and may be particularly so with clients who have suffered interpersonal violence such as rape, nonsexual assault, or childhood sexual abuse. A strong therapeutic alliance can give the client the support necessary to disclose the traumatic event, successfully comply with treatment, and conquer PTSD. This alliance offers the powerful combination of

safety and compassion without judgment, allowing the client to overcome the fear, blame, and shame that she may associate with the trauma.[1]

Several factors can help establish an effective therapeutic alliance. First, praising the client for having come to therapy and acknowledging her courage in doing so communicates the therapist's appreciation of the client's desire to recover. Second, when presenting psychoeducation in the early sessions of therapy, inclusion of specific examples from the client's PTSD symptoms and traumatic experience conveys that the therapist has been listening and knows about and understands her unique experience.

Third, a strong and nonjudgmental stance on the part of the therapist, especially while listening to the client's traumatic experience, is important. For some PTSD clients, this is the first time they have related the trauma to anyone and thus the therapist's reaction to their story is particularly critical. Emphasizing the client's courage in sharing the trauma and demonstrating nonjudgmental empathy without excessive emotional display can help the client realize that the story is not unbearable. One of our clients, after describing her trauma to her therapist for the first time, commented, "You have no idea what a relief it is to tell that story and not have you look horrified or sorry for me or tell me that you can't help me with this." Fourth, decision making regarding in-vivo exposure assignments and on which parts of the trauma memory imaginal exposure should be focused must be collaborative. During collaborative decision-making the therapist makes recommendations while taking into consideration the client's judgment regarding the pace and targets of therapy.

"Selling" the Rationale

Presenting a convincing rationale for the therapy is critical to the success of PE because the client must accept the rationale in order to follow the therapy plan both in and out of session. While some clients will easily accept the rationale with high expectation for improvement, others who are engaged in extensive avoidance, suffer extreme anxiety, or are unwilling to tolerate high levels of anxiety may be harder to convince. Being thoroughly acquainted with the exposure model helps the therapist present a convincing rationale.

For clients who are uncertain about the treatment rationale, the therapist should describe the treatment procedures as clearly as possible with the goal of helping the client gain a basic understanding of the rationale. It is important that the therapist acknowledge that deliberate exposure to trauma reminders can be frightening while reassuring the client that PE is extremely effective. With skeptical clients we acknowledge the difficulty of accepting the rationale while at the same time emphasizing the following arguments: (a) avoidance interferes with learning; (b) facing, rather than avoiding, painful but safe memories and situations will result in an eventual decrease in anxiety; and (c) successful handling of distressing situations and memories is powerfully reinforcing and promotes a sense of competence. Often, full acceptance of these ideas requires *doing* the first few exposures and seeing the results.

The use of analogies can be helpful in presenting a convincing rationale. Common analogies for imaginal exposure include describing the mind as a file room and the trauma as a collection of loose papers and bits of information that are scattered around in different places because the information does not seem to fit into any of the drawers in the mind. Through PE, a mental drawer is built where the trauma (and the associated stimuli) can be organized and filed away. Second, the trauma may be viewed as a wound that has scabbed over but is not healed and remains sensitive to touch. PE is the process of opening up and cleaning that wound, and healing it thoroughly so that, while it may leave a scar, it will not hurt when something touches it. Such analogies help to illustrate the model and give the client and the therapist something to refer to when therapy is difficult.

After hearing the rationale for confronting rather than avoiding trauma reminders, occasionally a client will say, "But I have tried that and it didn't work . . .," "I have gone to places like the mall but my fear has never decreased." In these cases it is useful for the therapist to clarify the distinction between occasional brief exposures and deliberate, repeated, prolonged exposures to feared situations; only the latter is effective in ameliorating PTSD symptoms.

With clients who report failure to show fear reduction despite systematic exposures, the therapist should closely examine what the client is doing during exposure exercises. Specifically, the therapist should inquire about possible safety cues (e.g., being with safe people, shopping only during daytime, carrying a weapon, etc.) and avoidance (e.g., only going to the west side of the park because the trauma occurred on the east side, leaving a situation shortly after arrival) that take place during exposures. The presence of safety cues and avoidance disrupts fear reduction as they prevent the client from realizing that the situations are not dangerous. Discussion of the client's previous successful natural exposures can also help instill confidence, including previous successes in areas unrelated to the trauma (e.g., learning to ride a bike, giving a talk in front of a large audience, etc.). By pointing to these, the therapist can emphasize that PE is just

[1] For consistency, the pronoun "she" will be used in reference to clients throughout the text. All of the recommendations presented in this article are equally applicable to male clients.

expanding upon techniques the client has used successfully in the past.

Tailoring Treatment: Individualized, Flexible, and Consistent

Tailoring the treatment to the individual client is a key aspect of successful PE. Throughout the initial evaluation, psychoeducation, and exposure sessions, the therapist should listen for and record the client's specific symptoms and avoidances. Since clients are sometimes not aware of avoidance, particularly when it has been longstanding and habitual, the therapist may need to reframe the client's behavior so that she can recognize avoidance patterns.

High rates of comorbidity in chronic PTSD clients (e.g., Davidson, Hughes, Blazer, & George, 1991; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995) and the chaotic and stressful lifestyles that characterize many clients with PTSD call for flexibility in applying the treatment. Therapy sessions are often missed, cancelled, rescheduled, and rescheduled again. Often, it is necessary to problem-solve with the client to increase attendance of therapy sessions. This may include examination of day-care options, transportation difficulties, or discussion of the impact of avoidance on session attendance. For PTSD clients with too little social support, inclusion of activities with a high potential for social contact (e.g., community classes, group meetings, religious fellowship) into the exposure hierarchy may be important. Helping the client develop social contact is likely to improve her quality of life and maintain treatment gains.

Implementing Effective Exposure

Exposure is introduced after the therapist and the client have discussed posttrauma reactions and the rationale for exposure, and after the therapeutic alliance has a solid foundation. How should exposure be conducted? Foa and Kozak (1986) noted that the goal of exposure is to modify pathological fear structures and suggested that two conditions are necessary for treatment to be effective at doing so. First, exposure should activate the fear structure that is targeted by the treatment. Thus, effective exposure therapy should be conducted in a way that promotes emotional engagement with the trauma memory and with objectively safe reminders of the traumatic event. Second, the exposure experience should include corrective information that will be incorporated into the fear structure. For example, a PTSD client who repeatedly recounts her trauma in successive sessions and experiences a progressive decrease in distress learns that thinking and talking about the trauma is not dangerous and that the distress associated with such thoughts will not persist indefinitely.

Effective in-vivo exposure begins with the construction of a hierarchy of trauma-related situations that are safe but that the client avoids because they elicit varying degrees of fear. While the client selects each week's exposure exercises, the therapist should guide her selection in a way that maximizes the chance of success as the client progresses up the hierarchy. For example, we try to make the first in-vivo exposure exercise a situation that the client has a high likelihood of accomplishing with habituation. This may be a situation that she has difficulty confronting but can already do on occasion. Early success increases confidence and motivation to continue by showing the benefits of exposure, and helps the client become convinced of the rationale for PE.

Imaginal exposure in the treatment of PTSD consists of emotional engagement with the trauma memory via repeated recounting of the memory so that the images, thoughts, and feelings represented in the fear structure can be processed and integrated. Emotional processing is facilitated when the client is fully engaged with the memory but at the same time is not overwhelmed with anxiety and is not losing grounding in the present.

During imaginal exposure, the client is instructed to describe and vividly visualize the trauma as though it is happening now. To encourage emotional engagement with the memory, the client is asked to keep her eyes closed, use the present tense, and to include the thoughts, feelings, physical sensations, and behaviors that she experienced during the traumatic event. The therapist prompts for details (i.e., feelings, thoughts, sensory details) that are not spontaneously included (i.e., "What are you feeling?" or "What are you thinking as he says that?") and monitors the client's distress level throughout imaginal exposure. When emotional engagement is effective, the client is close enough to the experience to access all of its important, fear-related elements, but is also grounded in the present. Thus, the client relives the trauma knowing that she is safe and that the memory, although distressing, cannot hurt her. We sometimes describe this optimal level of engagement to the client as follows:

> "While it is necessary to connect to the memory on an emotional level, it is also important to remind yourself that you are safe and that the memory cannot hurt you. I want you to process this memory with one foot in the past and the other in the present—safely grounded here, but reliving the past."

Immediately following imaginal exposure, the client and therapist discuss the client's response to imaginal exposure, insights that may have resulted from it, and patterns of habituation that have occurred both within and between sessions. As described in the therapy manual, repetition of imaginal exposure through listening to session audiotapes for homework and progressively

focusing exposure on memory "hot spots" encourage further processing.

Procedural Modifications for Imaginal Exposure

Despite all of our careful groundwork and our efforts to promote effective emotional engagement, sometimes the desired response is not obtained. This is where the skill of the therapist, thoroughly grounded in the model of treatment, becomes more crucial as he or she works to titrate the client's level of engagement and distress.

Underengagement. The term *underengagement* refers to a client's difficulty in accessing the emotional components of the trauma memory. In such instances, the client may describe her trauma, even in great detail, yet feel disconnected from it emotionally or not be able to visualize what happened. SUDs levels are typically low when the client is underengaged. Alternatively, the underengaged client may report high SUDs levels yet her nonverbal behavior does not reflect high distress. Underengagement can often appear as though the person is giving a police report of the trauma.

Several procedural modifications help to increase engagement in the memory. First, if underengagement has persisted across sessions, the therapist should revisit the rationale for exposure. The client is reminded why she is asked to engage in this highly distressing memory. Then the therapist inquires about what is interfering or preventing her from engaging with the memory, explores the feared consequences of connecting with it (e.g., I'll lose control), and validates her feelings while at the same time helping her realize that being distressed is not dangerous.

Once imaginal exposure is under way, specific therapist behaviors can encourage emotional engagement. It is important to encourage the client to keep her eyes closed and to use present tense. Brief questions that probe for details, sensory information, feelings, and thoughts (e.g., "Describe what you see . . ." "Describe the room . . ." "How does it smell . . . ?" "What are you wearing . . . ?" "What are you feeling . . . ?" "What are you thinking . . . ?") can increase engagement in the memory as they help to activate elements of the fear structure. These questions should always be asked in present tense to facilitate the client's remaining engaged with the memory. Also, to make the use of probe questions minimally intrusive and disruptive, they should be linked to the last thing that the client said (e.g., "What are you feeling as he does that?"). As the therapist's verbal behavior increases in order to facilitate greater engagement, he must remember that imaginal exposure is *not* a conversation with the client. Thus, the therapist should keep probe questions very brief, infrequent, and directed only at what the client is describing at that moment in order to help the client stay in the memory. Conversations with the client during imaginal exposure should be avoided as they reduce emotional engagement with the memory.

If the client continues to have difficulty with underengagement or does not understand the procedure, the therapist can role-play the client and demonstrate the way trauma reliving should be done. The therapist closes her eyes, uses present tense, and recounts the trauma while including all of the relevant elements of the memory.

Overengagement. The term *overengagement* refers to the client's difficulty during imaginal exposure maintaining a sense of safety and grounding in the present moment. In the client's mind, reliving becomes reexperiencing of the traumatic event. In its most extreme form, the client may dissociate (i.e., have flashbacks). During overengagement, SUDs levels are typically extremely high and habituation does not occur. The overengaged client is also visibly quite distressed, but this should not be taken as the sole indicator of overengagement since during imaginal exposure many clients cry and become quite emotionally distressed. Certain procedural modifications may help to decrease engagement in exposure.

As in underengagement, first reiterate the rationale for exposure. It is critical that the client understand why you are asking her to engage in this distressing memory. Emphasize the necessity of staying grounded in the present while reliving the past in order to maintain a sense of safety. As previously mentioned, the metaphor of keeping one foot in the present and one in the past—remembering that "memories can't hurt you"—can be helpful.

The first modification that we introduce is asking the client to keep her eyes open during the imaginal exposure, or, if closed, to open them periodically to promote grounding. We also ask her to use past rather than present tense in describing the trauma. When using these modifications, the therapist should take care that the client does not slip into a conversational mode and out of imaginal exposure. Such a conversational mode is discouraged unless necessary (see discussion below) since this may distract from the client's accessing and processing the traumatic memory. If the client begins relating the trauma in a conversational manner, we may ask her to look at something other than the therapist (e.g., the wall, floor) in order to stay engaged with the memory.

Another standard therapist response to the overengaged client is greater use of voice to connect with and focus the client and to communicate empathy. These comments should be brief supportive statements that acknowledge the client's effort and encourage her to remain with the memory (e.g., "I know this is really difficult, you are doing a great job"; "I know this is distressing, but you are safe here, the memory can't hurt you").

When an overengaged client appears stuck in a particular part of the memory (usually an especially upsetting

or horrifying part), the therapist may direct the client to move forward in time. Asking a directive question (e.g., "What happened next?") can move the memory forward and foster the realization that this difficult moment ended. For instance, if the client is stuck in a rape, saying "... and then he moved away. What did you feel when the rape stopped?" may move the memory forward.

The therapist may also inquire if there are other things that can be done to facilitate the client feeling grounded and supported. Physical touch may be helpful but should always be discussed either prior to imaginal exposure or first offered verbally during exposure (e.g., "May I touch your hand?" or "I am going to hand you some tissues"). Some clients do not want to be touched at all while others may find it helpful. Infrequently, we have had clients who cope with distress during exposure by continuously holding the therapist's hand. Actively directing the client to engage in slow, paced breathing as taught in the first session may also be helpful. When clients are especially agitated or physically restless during imaginal exposure, we may offer her something to manipulate such as a stress ball or a towel. One former client found that she was able to maintain engagement and also remain grounded in the present by describing her trauma while walking outside with the therapist.

As mentioned earlier, conversation between client and therapist should typically be avoided during imaginal exposure. However, when a client is extremely distressed and overwhelmed by engaging with the traumatic memory, the best starting point may be recounting the traumatic memory in the context of a discussion about it. In such cases, exposure is conducted with the client and the therapist maintaining eye contact during a conversation about the trauma. The goal is to increase the client's sense of mastery by successful disclosure of the memory while feeling safe and supported by the therapist. As the client experiences success with the modified procedure, the therapist can progressively reduce conversation and return to more conventional imaginal exposure. Finally, an alternative procedure for overengaged clients is writing rather than verbalizing the trauma narrative. As with imaginal exposure, clients are encouraged to include thoughts, feelings, actions, and sensations in the written narrative. After writing it, the therapist may ask the client to read the narrative aloud while continuing to titrate engagement as needed.

Prolonged or multiple-incident traumas. For both imaginal and in-vivo exposure, determining a manageable starting point and proceeding at an effective pace enhance successful emotional processing. For clients with a prolonged trauma or multiple-incident traumas (e.g., repeated assaults or childhood sexual abuse), constructing a hierarchy of traumatic memories based upon the intrusiveness and distress associated with each trauma memory should precede imaginal exposure. In a 10- to 12-session treatment, there is usually only enough time to target two or, at most, three memories in imaginal exposure. Therefore, rather than starting at the bottom of the hierarchy, we typically start either at the top of the hierarchy or as close as possible to the top. The starting point is selected by a consensus between the client and the therapist. Often after processing the most upsetting trauma, generalization occurs such that the distress associated with the remaining memories also decreases. However, if other memories continue to prompt distress, treatment may be extended to focus on these memories.

Obstacles to Exposure Therapy

Avoidance. In the first treatment session, avoidance is described as an important factor in the maintenance of posttrauma disturbances and therefore to be counteracted by exposure. This idea often makes great sense to clients. Nonetheless, avoidance is probably the most commonly encountered impediment to compliance with exposure both in and out of session. When avoidance hinders exposure, the therapist should validate the client's fear and urges to avoid, but at the same time remind the client that while avoidance reduces anxiety in the short term, it prevents the client from learning that the avoided situations and memories are not dangerous. In other words, the therapist should review the rationale for treatment.

After the introduction of in-vivo and imaginal exposure, it is not unusual for a client's struggle with avoidance to intensify several sessions into treatment. This middle phase of treatment is difficult for some clients. They have experienced some of the benefits of PE but symptoms remain present. They are sometimes in the "feel worse before you feel better" phase of therapy. In these cases, reiterating the rationale, while important, may not be enough. The therapist may need to take a close look with the client at progress in in-vivo exposures and may need to break them down into a more gradual progression. It also may help to encourage the client to use the calm breathing that was taught in the first session to help manage anxiety during exposure exercises and to remind herself that the memory or situation she is confronting is not dangerous, even though it may *feel* frightening.

Analogies can be a useful tool in helping the client to overcome avoidance. For example, we sometimes describe the struggle between approach and avoidance as sitting on a fence between the land of exposure and the land of avoidance. We acknowledge the difficulty of getting off the fence, but stress that sitting on the fence prolongs the fear and slows progress. Alternatively, avoidance can be described as a cave where the client retreated to heal from the trauma. While this safe cave has allowed

her to function on some level, it has also significantly restricted the client's life. Exposure involves increasingly longer and more extensive journeys outside of the cave, and that feels risky and dangerous. However, in order to completely heal from the trauma, the client must learn to live with the risks outside the cave.

Finally, it is helpful to review the reasons that the client sought treatment for PTSD in the first place (i.e., the ways in which PTSD interferes with life satisfaction) and to review the progress that she has already made. Simply revisiting these important issues, while also validating the client's fear and concerns that exposure can be difficult, may help the client to renew her struggle against avoidance. As noted earlier, problem solving specific solutions to concrete obstacles to exposure therapy (e.g., no place with privacy to listen to tapes, no child care to get to sessions, etc.) can also decrease avoidance.

Anger. Emotional processing theory (Foa & Kozak, 1986) leads us to focus the content of imaginal exposure on the fear-related elements of a trauma memory. Furthermore, it has been our clinical impression that the experience and expression of intense anger during imaginal exposure may interfere with the emotional processing of fear by dominating the client's affect. Thus, while acknowledging the validity and appropriateness of the trauma survivor's anger, our approach has been to direct the client to focus her attention and her narrative on the fear she experienced and on the events that triggered that fear response. Interestingly, using a subset of the participants in the Foa et al. (1999) PTSD treatment outcome study, Cahill, Rauch, Hembree, and Foa (2001) recently examined changes in self-reported anger over the course of treatment and found that the PE, SIT, and PE/SIT treatments resulted in significant decreases in anger even though treatment was focused on reduction of fear.

When a client primarily expresses anger, we first validate that feeling as an appropriate response to the trauma and as a symptom of PTSD. We then discuss with the client our impression that focusing on this anger during exposure may prevent one from engaging with the fear and anxiety associated with the trauma memory. The treatment rationale is reviewed as needed to encourage the client to focus on the fear and anxiety she experienced during the trauma. In doing so, we encourage the client to direct her anger toward getting better and/or to "move it aside" in order to focus on other equally important elements of her experience. The Cahill et al. (2001) study described above suggests that this approach has been effective with our clients. However, it may require repeated conversations during the course of treatment when engagement with the memory and other trauma reminders trigger anger.

Maintaining the focus of treatment on PTSD. As mentioned previously, comorbidity of other psychiatric disorders with chronic PTSD is quite high (e.g., Davidson et al., 1991; Kessler et al., 1995). In addition, clients with chronic PTSD will often face multiple life stressors, leading to chaotic lifestyles. Therefore, crises during treatment are not unusual, especially if early or multiple traumatic experiences have interfered with development of healthy coping skills. Poorly modulated affect, self-destructive impulse-control problems (e.g., alcohol binges, substance abuse, risky behaviors), numerous conflicts with family members or others, and severe depression with suicidal ideation are common with chronic PTSD. These problems require attention but can potentially disrupt the focus on treatment of PTSD. If careful pretreatment assessment has determined that chronic PTSD is the client's primary problem, as opposed to other psychiatric disorders, our approach is to maintain the focus on PTSD with periodic reassessment of other problem areas as needed.

If the client's mood or behavior causes imminent concern about her personal safety or the safety of others, the need to focus on this may require cessation of PE in order to work on the prominent risk. However, if a crisis arises without imminent risk, we often tell the client that adhering to the treatment plan, and thereby decreasing PTSD symptoms and associated problems, is the best help we can give. In maintaining this focus, the therapist must clearly state support for the client's desire to recover from PTSD. Communicate a strong belief that the client wants to get better, and applaud every step in the direction of healthy coping and adherence to the treatment program. If appropriate, the therapist may label and externalize crises as related to the PTSD and predict that these situations will improve as the client's skills improve and PTSD symptoms decline. The aim is to provide emotional support through the crisis yet keep PTSD as the major treatment focus.

In their review of cognitive behavioral interventions for PTSD, Rothbaum et al. (2000) noted that some findings suggest that not everyone may be a candidate for exposure therapy. This group may include trauma survivors who are unwilling to confront trauma reminders or memories or to tolerate temporarily increased levels of anxiety and PTSD symptoms, individuals who are perpetrators of harm, especially where guilt is the predominant emotion (cf. Pitman et al., 1991), and perhaps those whose primary emotional response to trauma is anger (cf. Foa, Riggs, Massie, & Yarczower, 1995). The very recent findings of Cahill et al. (2001) do not support the exclusion of the latter group from PE, however. Rothbaum et al. also concluded that even with these limitations, exposure therapy has received the strongest evidence in support of its efficacy in reducing PTSD, and should be considered a first-line intervention unless ruled out for some reason.

Tips for the Trauma Therapist: How Do We Handle It?

Our experience as trainers has suggested that even experienced therapists are sometimes concerned about using PE procedures with highly distressed PTSD clients. As any therapist who has listened to a painful and horrifying experience can attest, helping a client to emotionally process traumatic events can be challenging and emotionally draining. In order to conduct PE, therapists sometimes need to develop or increase their tolerance for client distress. These procedures trigger an intense emotional response; indeed, this is the purpose of the work. How can therapists cope with this reaction?

First, the therapist needs to review the rationale for treatment and let the model guide her. At the same time that we are helping clients to learn that intense anxiety and emotional engagement with painful memories can not hurt them, and that anxiety does not last indefinitely, we also trust this again ourselves. Developing tolerance for client distress requires that the *therapist* accept the rationale for treatment, and especially the idea that memories can't hurt either the client or him or her. Indeed, typically the therapist will habituate to the trauma memory along with the client.

Nonetheless, conducting PE is at times emotionally challenging and replete with difficult choices for the therapist. The internal dialogue of a trauma therapist is full of questions: Do I stop the imaginal exposure now because of how upset she is? What if this makes her more depressed? What if she keeps feeling this way when she's not in my office? Is this a realistically safe situation she is avoiding? Allowing the treatment model to guide these decisions both assists in making the decisions and leads to decisions well grounded in the available research. Keep in mind that even though emotional processing is painful work, it is often quite beneficial. Remind *yourself* of this as often as you do the client.

Decision making should also be guided by the goal of promoting the client's sense of control. While our job is to make recommendations, the therapist should never force unwilling clients to do exposures. A difficult decision we sometimes have to face is whether to encourage the client to continue therapy or to help her terminate therapy if she is not ready to confront trauma-related fears and avoidance. We would rather help the client stop treatment now, if she is not ready, than have her fail to get better and leave treatment believing that PE did not and can not decrease her symptoms or that she somehow failed the treatment. We will often tell the client that PE is quite effective for many people, so we would rather stop now and invite her to come back when she is ready.

Importantly, supervision with an expert or consultation with peers can be beneficial and can provide technical and emotional support. Ideally, have a team or supervision group that meets regularly to discuss trauma treatment cases. Regular consultation provides opportunities for input from colleagues regarding difficult decisions about how to proceed with these often complex and challenging cases.

Conclusion

Working with chronic PTSD clients can be extremely rewarding for therapists. The availability of effective treatments for PTSD, including PE, allows mental health professionals to positively affect the disrupted lives of chronic PTSD sufferers in a short period of time. However, PTSD symptoms themselves and related comorbidity may hinder some clients' ability to engage in and benefit from the therapy. It is not uncommon for PTSD sufferers to fail to attend therapy regularly, to drop out prematurely, or to take long, unofficial breaks from treatment. Many struggle with avoidance and are reluctant to do exposure homework. Other clients may have difficulty tolerating anxiety or engaging in the trauma memory. Flexibility in the use of PE procedures guided by the treatment rationale and by the manual is often a necessity.

A strong, collaborative, therapeutic relationship is essential to help clients overcome these hurdles. Conducting PE requires joint decision-making by the therapist and client about treatment focus, pace, and homework assignments. At tough decision points, the therapist can offer guidance but must trust the client's judgment and not force her. In our experience, PTSD is often characterized by a sense of feeling out of control of one's thoughts, feelings, and behavior; therefore, helping the client to be and feel in control is imperative. The therapist should express confidence in the client's ability to recover and should actively praise the client's effort, courage, and coping resources. Finally, therapists of PTSD clients must be particularly good at listening. The experience of sharing the pain and horror of the trauma memory with a compassionate, understanding, nonjudgmental person is a powerful healing experience that may by itself begin to reduce the client's fear and shame.

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Some Lessons From Group Supervision of Cognitive Therapy for Depression

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While much has been written on cognitive therapy of depression, we have found that our trainees have the same questions and difficulties year after year. This article reflects the questions and topics that have been asked most frequently during several years of group supervision led by the third author. We cover topics such as the specifics of the agenda, special uses of language, the pacing of therapy, and therapeutic alliance. We aim to address issues, such as guilt, self-blame, and vegetative symptoms, that arise with depressed patients. In addition, attributions of symptom change for patients concurrently taking antidepressant medications, as well as the special problems related to chronic depression, are covered in detail.

There has been a proliferation of manuals—or manual-like books—on cognitive therapy (CT) for the treatment of depression (e.g., A. T. Beck, Rush, Shaw, & Emery, 1979; J. S. Beck, 1995; Leahy, 1996; Padesky & Greenberger, 1995; Persons, 1989). Nonetheless, manuals, for the novice therapist, need to be supplemented with clinical experience. Information contained in manuals must also be interpreted cautiously, as a slavish adherence to a manualized approach to therapy can quickly become an unpleasant experience for therapists and patients alike. In preparing the following, we have accumulated, during several years of group supervision of CT for depression led by the third author, strategies or maxims that supervisees in the group did not recall from their reading of the manuals. In some cases, the material below is an elaboration of what others have said, and some of it is simply a restatement, with emphasis, of principles that appear to be particularly difficult for CT-therapists-in-training to keep in mind, or to follow through on, as they learn to treat depressed patients with CT.

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Agenda

Setting, Finishing, Deviating From the Agenda

Setting an agenda collaboratively with the patient, identifying topics and taking care to apportion appropriate allotments of time to each, is a cornerstone of the