Prolonged Exposure Therapy for PTSD:
Clinical Issues You Need to Know

Welcome, everyone! This is a Psychotherapy Academy interview with our prolonged exposure therapy for PTSD specialist and author of our course, Dr. Barbara Rothbaum. I am your host, Dr. Jessica Diaz.

As we have already seen, fear and anxiety are a normal response to trauma. But when PTSD occurs, patients need treatment. As we know, PTSD is a disorder of extinction and due to avoidance, fear does not extinguish. In PE, we aim to decrease distress associated with trauma reminders and to change the trauma-related cognitions. As you may recall, some of the interventions used are imaginal and in vivo exposure and breathing retraining.

This is great, but what do you do when out-of-the-manual issues arise?

Today, we will address some common issues clinicians may encounter with patients, for example, is it useful to recommend yoga or meditation? How do you do in vivo exposure if PTSD is due to a plane incident? Should you use a co-therapist? Keep on listening for answers to these issues, and more!

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Breathing Retraining

The first question has to do with the fact that some people feel that their anxiety worsens when they breathe to relax, but breathing retraining is part of PE. So, how do we handle this? Let's listen to Dr. Rothbaum's approach.

> **Dr. Diaz:** Some people say that when they breathe to try to relax they actually feel worse because their anxiety heightens. What can you do about this—besides saying to them not to take deep breaths?

> **Dr. Rothbaum:** Usually, if people have a problem with the breathing and it doesn't feel good right away, I tell them that they are exactly the people who need to practice it because they probably—they might tend to hyperventilate. They probably don't regulate their breathing well. And so we will work with them. There is such a thing as relaxation-induced anxiety. If that's going on with them, then we use the same exposure approach. Letting them notice it, stay with it until it passes. So, I will continue to work with them on the breathing.
> One thing I should mention though, in the revision of the PE manual that we published in 2019, we did de-emphasize the breathing just a little bit. So, it is still a component that we teach people, but sometimes some patients just really don't take to it and then we don't keep hitting them over the head with it. We'll teach them. If it's a useful technique, we'll work with them. If not, we'll let them not bother with it.
> If it makes them more anxious and they have a hard time with it, then I think it's a good exposure for them. If they do it and it doesn't really do much for them, then I wouldn't insist that they keep using it.

> **Dr. Diaz:** Okay, all right. That's good to know. Another question: I have seen that for breathing exercises, some therapists tell the patient not to cross their legs and not to lie down but to sit instead because if they lie down, they may fall asleep. Other therapists turn the lights down. Is all of this really necessary?

Dr. Rothbaum: I don't think that it's necessary because I also want to teach people how to use their breathing in everything they do. So, if they have to have their legs straight in certain conditions, then they might not learn to use it when they really need it: when their anxiety goes up, in a meeting, when they're trying to go to sleep, or in the shower. So, I want them to be able to practice it pretty much everywhere in their day-to-day life.
And we're breathing all the time anyway. So, wherever they're breathing, they can do the exercises. They don't have to get in a certain position or close their eyes or sit down or stand up or lie down or not lie down. They can do it anywhere.

So, take note. Make sure your patients don't hyperventilate. And these exercises can be done anywhere. You don't need a special place or a specific body position to do them.

What About Yoga, Meditation, and Mindfulness?

As we know, there are other approaches that sometimes patients ask about. Listen to how Dr. Rothbaum addresses yoga, mindfulness, and meditation in PTSD patients.

Dr. Diaz: I've seen also that some patients sometimes ask about yoga or meditation to help them learn to breathe. Like they say, "Oh, my sister said that yoga has really helped her breathe better" or "Maybe I should go into meditation." Is this something you recommend?

Dr. Rothbaum: I think there's nothing magic about the breathing that I teach people—that we teach people. And I think as many different clinicians teach breathing there are that many ways to do it. So, if patients already have a breathing that they like, that helps take them down a notch or two—whether it's from yoga or meditation or Lamaze breathing from childbirth—I'm fine with that. If they don't practice it regularly, I'll teach them mine to see which one they like better and I will ask them to practice it regularly. But if it helps bring down their anxiety, calm their bodies down, I'm fine with that.

Dr. Diaz: Okay. And what about mindfulness? Some people may ask about that because some of the mindfulness exercises include breathing. Do you recommend people to take a mindfulness course online maybe or learn some of the techniques that relate to breathing?

Dr. Rothbaum: I think mindfulness is a wonderful technique for everyone. When I first started learning about it to teach patients, I thought everybody should learn about this and there's a reason that it's been around for thousands of years—because it's a wonderful approach to life. I don't think that it's required for PTSD. It's just like good exercise and good dietary habits. I think mindfulness teaches wonderful habits that can help everyone.

So, we can conclude that any of these methods are useful as long as they help decrease anxiety levels.

Imaginal Exposure

As you know, imaginal exposure is an important part of therapy. But it can sometimes present some difficulties and we will try to help you, the therapist, with some of these. Let's listen.

Dr. Diaz: So, we have seen that imaginal exposure is an important part of therapy. But some patients have difficulty imagining things. They can say, for example, "I'm not good at remembering or keeping certain images in my mind." What can you do about this?

Dr. Rothbaum: In exposure therapy, and particularly in imaginal exposure, we find that people remember a lot of details that they hadn't remembered before or they didn't even think they had access to. So, by the concentrated focusing on this event and going through it minute by minute, usually they remember enough. And even if they say they can't imagine it, I'll ask them just to go through it. Try to imagine what it feels like in their bodies. Try to imagine what they were scared about at that time. Describe what's happening in detail. Remember we want really 3 bits of information in exposure. We want information about the stimuli, so if they're describing what's going on, what's happening to them, who's doing it; their responses, so, for example, fear, heart pounding, what they're thinking; and the meaning of it all. And very often, if it's PTSD, the meaning is going to be one of danger. And I think if they can bring up all of these details and stay with that, usually that's sufficient.

Dr. Diaz: Okay. So, basically, what you have to do with the patient is try for the patient to really focus on details. Do you guide the patient while the patient is talking? Like,

focus on exactly where they were or what was the climate like? Do you do those sorts of things?

Dr. Rothbaum: Yes, we will. In the first few sessions of imaginal exposure, if the patient is doing well, then I don't ask a lot of questions. I just stay out of their way. But I do want to set the scene. And so when we're figuring out the start and end points of the imaginal exposure, we'll have a lot of these details specified. And I will ask them—you know, sometimes, for example, if it's a combat veteran, I'll set the stage when I start them off in exposure. I'll say "It's September 9. You're driving back to base. Jones is next to you. Smith is in the turret. Tell me what's happening now." So, I'll kind of get them on the road to describe the imaginal exposure. In subsequent sessions, especially in the hotspots, I will probe for a lot more detail.
In the first few sessions, if they're doing great, let them go. But in the hotspots, I really want to stretch it out and I want to get as much detail as I can—especially about stimuli, responses, and the meaning.

Dr. Diaz: And I don't know if you've ever had patients who tend to fall asleep while they are maybe imagining what happened or these things. Is that something that is common?

Dr. Rothbaum: No. It has actually never happened to me. I've never had a patient fall asleep during exposure.
I have heard—I run a veteran's program, a clinic, and once or twice, we have heard of that. And in general, that can almost be diagnostic. If you've got PTSD and you're going back in your mind's eye to the time of your traumatic event, you're not going to fall asleep. It's going to be distressing. You're going to have a lot of energy focused on it. If you are falling asleep, chances are you don't have PTSD.

Dr. Diaz: So, that's important to know. In a part of your course, you said that of course this is recorded and the patient has to listen to this recording at home. What do you recommend for patients that say, "Oh well, you know, my home is too noisy," "I don't have any privacy," "The dog is barking all day," etc., etc.?

Dr. Rothbaum: We will problem solve with people to find out if there's a time of day, a place in their house. For example, we've told people to go sit in the car and practice. And so if there's nowhere else, if they have a car that they can just go sit in—not drive anywhere but just sit in the car—then that usually works.

Dr. Diaz: Oh, wow! I hadn't thought of that, but that's a good idea. Go sit in the car. Okay.

As we can see, there are many ways to solve problems that patients encounter with imaginal exposure. Be creative. That brings us to the relevance of measuring the intensity of the patient's distress.

SUDs Levels: Expectations and Engagement

In this part of the interview, Dr. Rothbaum explains how to manage expectations about SUDs levels, emphasizing the fact that it is essential to look for nonverbal signs of anxiety and distress. She also addresses how to solve problems that may arise from patients regarding listening to the exposure recordings in their homes.

Dr. Diaz: And you also talked about the SUDs levels. But how much should they lower? I mean, should I expect them to go down to 0? To 10, 20, 30? What is the realistic expectation for this?

Dr. Rothbaum: SUDs. I don't think in terms of like a formula. I know we do say, I think, in the manual that the SUDs should decrease by half. I find that people have what I think of as response sets. So, a lot of people, their SUDs will be very high. Always. It's 100, 100, 100, 100. Some people, they just have a number and they keep saying that same number. So, I'm like Sherlock Holmes and I'm going to look for all of the clues. So, I'm going to listen to the SUDs level and I'm going to see how it changes with what they're describing. I'm going to look at their body. I'm going to listen to their voice. I'm going to look at, you know, everything they're doing.
The idea about SUDs is that it's just a shorthand for communication between the patient and the therapist, for the patient to be able to relay quickly how distressed they are. If they're not very good at relaying it in the SUDs rating, then the therapist has to look for other signs. The main thing is that we want patients to not leave while they're still distressed. We want their distress to come down while they're still doing the exposure—whether it's imaginal exposure or in vivo. And in some previous research, they found that the within-session SUDs didn't predict outcome, but the between-session SUDs did. So, what that means is not everyone is going to come down to zero within a session and they can still get better as long as session over session, it's getting easier for them. That's what predicts outcome.

Dr. Diaz: Okay. That's interesting that if a patient says, "Oh, my level is 100, 100, 100," you look for these body signs. What are some of the things you look at? I mean, for clinicians who are maybe not used to this, if a patient says, "Oh, my level is 100, 100, 100." Okay. What are some things that you look at or that you look for in the body language?

Dr. Rothbaum: Yeah. We look for nonverbal signs of anxiety and distress, so, for example, clenched fist, holding the body very tight. A lot of times, patients will have maybe even like their arms crossed in front of them or a jacket or a pillow in front of them, kind of a protective posture. We look for signs of distress in their face, so, for example, crying, a lot of tension in their face, how they're describing it, and the tone of their voice. So, sometimes, when people just go into the recording mode and they just describe it very kind of flat, like this, we think that they're not emotionally engaged. So, we want to listen to the tone of their voice. Sometimes, people are acting out a little bit, you know, with their hands and their bodies. We see that a lot in virtual reality. So, we just want signs that they're engaged. And we can also talk to them about it. Ask them how much are they engaged? How much are they feeling it? Do they feel that they're not letting themselves go there and not letting themselves feel it? And then that's something we have to talk about as well.

Dr. Diaz: Great. Now, once you record the imaginal exposure with these patients and you tell them, "Listen to it at home," the question would be, what is the minimum amount of times that the patient needs to listen to this? Because some patients will say maybe, "Oh, I forgot." "I was busy." "Yeah, you told me to listen to it in the car, but my wife took the car." "Oh, Dr. Rothbaum, from your last session to this, it's been a week, but I only listened to that twice." Would you say, "Oh, that's not enough. You need to do it every day"? Or is there a minimum that you recommend?

Dr. Rothbaum: The more they practice every bit of exposure, the better they're going to get and the faster they're going to get better. And that's what I keep telling them. So, we do tell every patient that we want them to practice it every day. To be really blunt and honest, hardly anyone does practice it every day. So, I'm not going to punish someone for not practicing it daily. But I am going to help problem solve with them so that they can practice it more because we really find that the more they practice it, then they come up with the cognitive shifts on their own when they come back. They'll listen to it, listen to it, listen to it, and they'll come back and they'll say, "I don't know what I thought I could've done. There were four of them and one of me." And they're not going to achieve that if they're not practicing the imaginal exposure.

For patients who have trouble reporting SUDs, look at their body signs. In any case, do not let the patient leave your office in high distress. We want their distress to come down. Now let's get into different situations that may arise when doing in vivo exposure.

In Vivo Exposure

At this point, I asked Dr. Rothbaum about different situations that, as a therapist, you may encounter in your practice. We talked about virtual reality and other techniques that can be used to help the patient. But, what do you do if the patient is a war veteran or a victim of an earthquake and you don't have access to virtual reality? Let's listen.

> **Dr. Diaz:** How do you do in vivo exposure with people like, for example, war veterans, people who have been in hurricanes, tornadoes, earthquakes, if they do not have access to virtual reality?

> **Dr. Rothbaum:** We pay attention to what they're avoiding in real life or what causes them a lot of distress. And there are a lot of situations that we know of. So, for example, war veterans often have a hard time driving in traffic. They can have a hard time driving under bridges or overpasses. They can have a hard time with trash on the side of the road. They can have a hard time sitting in a room like a restaurant with their back to the door. They avoid crowds, so sporting events, even movies, sitting in the middle row. So, we know what people avoid and that's what we put on their hierarchy. It doesn't have to be exactly what happened to them, but it's what triggers them here and now. And for example, earthquakes—actually, I did my internship with someone from Greece and she had been through a number of earthquakes. And a movie theater that we went to was over a tube station and so you could feel the rumbling and it was very anxiety provoking for her because she felt like it was an earthquake. So, there are a lot of ways that we can recreate some of the same triggers and sensations that are safe for people.

> **Dr. Diaz:** So, the important thing to remember here is even if you can't recreate another tornado, then you have to see what the person is avoiding. Now, if this patient had access to virtual reality, what would be better for this patient: to do virtual reality with a tornado or war or whatever or do the exposure with the trash on the road or driving in traffic?

Dr. Rothbaum: Both. I would say both. Because even when we do the virtual reality, it doesn't matter if someone gets more comfortable in the virtual reality if they can't do it in reality. So, we really want them to be able to do both. The virtual reality is a good middle step, but we want people to be able to do it in real life as well.

Dr. Diaz: Okay. Suppose you can only do imaginal exposure with these patients, would it be as effective as also doing in vivo exposure or you have to do in vivo exposure necessarily?

Dr. Rothbaum: I would recommend doing in vivo exposure because that's going to help get at what they are avoiding or uncomfortable with in daily life and it will help disconfirm the belief that the world is dangerous. In some studies that have taken them apart, people do better when they get both imaginal and in vivo. In some of our studies that we used with D-cycloserine—it's a drug, an NMDA partial agonist that's supposed to facilitate the extinction of fear—we didn't want them doing any exposures outside of our experimental conditions. So, they only got the drug in session and so we only did imaginal exposure in session. So in that, when we didn't ask them to do in vivo exposure, they did still improve. So, I think any exposure is better than no exposure. And if you give people the idea of approaching rather than avoiding, that's going to help turn their life around. But I also believe that more exposure is better than less exposure. So, if you can do both imaginal and in vivo, that's going to hopefully hit all of the patient's targets.

Dr. Diaz: Okay. Thank you. You explained that, for example, for war veterans, they may be avoiding driving in traffic or seeing trash along the road. What if one of these people say, "Oh, Dr. Rothbaum. Yeah, but I don't have a car now"? "Yes, I'm afraid of driving, but I just don't own a car." Do you work with the other things they're avoiding or do you expect them to rent a car or borrow a car for these exercises?

Dr. Rothbaum: It depends on how much not driving is interfering with their functioning. If they plan and really need to be able to drive and plan to get a car if they were more comfortable driving, then I'm going to try to problem solve. So, then I would try to see if there's one that they can borrow or rent a car to practice in. If they, for example, live in New York City and they're never going to drive, even if they could, then it might not be as important. However, I am a dyed-in-the-wool exposure therapist. If somebody says there's something that they're not comfortable doing that's realistically safe and that's related to their trauma, I'm going to want them to do it just to really teach their brain and their bodies that they can do it all and it's a

choice. They're choosing not to drive. It's not because they can't drive because it makes them too anxious.

Dr. Diaz: So, that's important to remember. And what about people who have PTSD due to plane incidents, not necessarily crashes, but whose anxiety is evident only in long intercontinental flights? Obviously, due to cost and other issues, you can't have in vivo exposure with long flights—at least not every day. What can you do? For example, can you use shorter flights? Or what do you do in these cases?

Dr. Rothbaum: So, I have treated people with PTSD from plane crashes, who obviously survived. And you would do the same thing for them. So, if you got the virtual reality—and I do love the virtual airplane, so that's very useful. But we also do imaginal exposure to the memory of the plane crash. In general, people with the fear of flying have 1 of 2 fears. Either they have a fear of crashing—and that's usually, if they've got PTSD, usually it's a fear of crashing and dying—or if they just have the fear of flying, they may have more panic or claustrophobic kinds of fears that they're going to have a fear of having a panic attack. And very often, those are the folks that have more of an issue with the longer flights because then they feel trapped. The people who just have a fear of crashing, generally the length of the flight doesn't matter that much. It's just the idea of flying in a plane.
So, if they are scared of the long intercontinental flights, I'm going to suspect panic disorder. So, I'm going to assess for that and then I'm going to teach them techniques to work with the panic disorder. So, it's going to be a lot of cognitive therapy. I do teach breathing for panic. And then we would start with shorter flights to help them see that they can be anxious and do it anyway and they're not necessarily going to have a panic attack. And even if they have a panic attack, it's going to be fine.

Dr. Diaz: So, that difference is really interesting. What about other techniques? For example, making the patient imagine, I mean, not doing it in real life but imagining they're going to the airport, imagining they are at the counter, imagining they are going through the x-ray machines, and all that. Having all that but in their imagination.

Dr. Rothbaum: That's what we did before. We would do in vivo before we had virtual reality. So, imaginal exposure does work. We would take people to the airports. And so even if we don't go on a flight with them, I would be able to arrange—I'm in

Atlanta, at the Atlanta airport, the busiest airport in the world, to be able to go to the gate or sit on a plane with them, so to get them used to all of the steps prior to flying.

As you can see, you can use in vivo exposure without virtual reality. There are ways to recreate the triggers for anxiety in those patients and do in vivo exposure. Try to always do both imaginal and in vivo exposure in order to hit all of the patient's targets.

Using a Co-Therapist

Sometimes, it's necessary to use a co-therapist to help the patient with in vivo exposure. Is that considered useful in PE for PTSD? Let's listen to what Dr. Rothbaum says about this.

Dr. Diaz: So, that takes us to maybe the next question, which is: if a person is too afraid to do in vivo exposure alone, do you consider using a co-therapist? Like, a person who will go with them to the airport or sit with them on the plane, even if they don't fly with them, or things like that.

Dr. Rothbaum: Yes. This is part of the art and science of creating an in vivo hierarchy list, that you want the right items. And if you tweak one little thing about it, it might make it more or less anxiety provoking. And so very often, the presence of another person—especially if they consider them a safe person or a reasonable person to be with them—that could help. Occasionally, it'll be the therapist, but it doesn't have to be.
In PE, we usually do in vivo exposure homework rather than in the therapy session, although in our veteran's program, we do the in vivo exposure as a group. We have the patients meet together, decide what they're going to do, then they go do their exposure, then they come back as a group. So, they're still doing their exposure by themselves, but I think it's fine if they've got a friend or a family member that knows they're going through therapy, knows they have PTSD, understands exposure therapy, and understands specifically what their role is. So, for example, if it's to drive with someone before they're ready to drive alone or if it's to go to an event where there's going to be a crowd and they didn't want to be alone, I think it's fine to figure out how much anxiety it would cause the person, the patient, to go with this person and then always be working up the hierarchy to get them to be able to do it by themselves. But you want to pick the right increments and usually, that is going to involve another person.

Dr. Diaz: Do you usually need to train this person, if it's a family member? Do you tell this person to come to your office and explain to them what needs to be done? Or do you prefer another psychologist, for example, who is trained in this? What would be better?

Dr. Rothbaum: It depends on who and what we have access to and what we think is going on. So, I have the luxury of working in a large clinic and we use each other for exposure all the time. A lot of times, we'll just bring the patient by and have them talk to us for a few minutes or have them tell someone else about their traumatic event or shake someone's hand or do different things. So, it depends on what we have access to and it depends on how much the patient feels that the person that's going to do this understands. So, if they want us to help explain it, we will.
I actually prefer for the patient to explain it because that means they understand. And they're telling the person, "Okay. Now, don't let me do any safety behaviors. Don't let me do this. I just need you there as a support person."

So, the short answer is yes, you may use a co-therapist. Sometimes the co-therapist can be the same therapist and sometimes a friend or family member can play this important role in the patient's treatment.

Constructing the In Vivo Hierarchy

We have established the importance of in vivo exposure and the hierarchy is an issue many of you may have questions about. Listen in as Dr. Rothbaum answers some of these questions.

Dr. Diaz: All right. What about when we are constructing the in vivo hierarchy? At what level of SUDs do you recommend to start? For example, 20, 30, 40, 50, 0, or, you know—why that level, whichever it is?

Dr. Rothbaum: I usually start with a SUDs of about 50. And I want to make sure that there are items on there in increments of 10. So, I'm going to want to make sure we've got something about 50, 60, 70, 80, 90, and 100. Anything that's below 50, I'll ask them to do for homework once we start—that they shouldn't be avoiding that anymore and they should be doing that exposure in a therapeutic manner.

Dr. Diaz: What about patients, when they construct the hierarchy, they say, “I can’t find something higher than 60 but lower than 80”? And you ask maybe, “What about this activity?” “Oh, no. That’s 60.” “And what about this other one?” “Oh, no. That’s 80.” And you can’t seem to get a 70 or something like that. What do you do?

Dr. Rothbaum: There can often be little items that you can tweak. For example, a different time of day, going to a crowded store when people are getting off work versus very often, they’ll go at 3 in the morning or at times that they don’t think a lot of people are there. So, a lot of times, there can be a little detail that we can tweak. And then also, just comparing it. Is this easier or more difficult than this? Is it easier or more difficult to go to Walmart at 7 o’clock or to go to Walmart at 3 o’clock in the afternoon? And then we can usually tweak it that way. If there really is nothing, then I wouldn’t worry about it too much. But I really do try to get something that is about increments of 10. And also, what I tell them is this hierarchy doesn’t have to be exhaustive. It doesn’t have to have everything on it that they avoid or makes them uncomfortable, but just representative, so they can do these things and then know that their anxiety comes down while they’re doing it, nothing bad happens, and they can tolerate the distress.

Dr. Diaz: Okay. But that seems to be very time consuming if the patient has these difficulties and maybe it could lengthen the time with your therapy or your session—or not?

Dr. Rothbaum: No. I push people through it pretty quickly. And I tell people when they’re doing this therapy—so, this therapy is, in general, about 9 sessions. And most of the people that come to me have been suffering from PTSD for years, sometimes decades. So, I will let them know that in these few weeks, the more work they do—and I really want them to eat, breathe, and sleep exposure therapy—then the faster that they’ll get better and the faster they’ll get through things. And if you’ve got a good patient who’s motivated and they start and they feel the benefits right away, that helps motivate them and give them hope, and they do more.

To recap, start with a SUDs of 50 and try to do increments of 10. If the patient can’t pinpoint a number, try tweaking the activities. In any case, this therapy is time limited and the patient and therapist should try their best not to get derailed from the objective, which is therapeutic exposure.

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Difficulties With Activities and SUDs

What about if there are difficulties with activities and SUDs? Here, Dr. Rothbaum addresses what to do in the event that a patient encounters difficulties. So, let's listen.

Dr. Diaz: Okay. Great. Maybe this is related to the previous question. Patients who have difficulty breaking down an activity, to use your example: SUDs 50, driving to the mall with Judy, eating together at food court; 60, Judy stays at food court in mall while I walk to the other end and back; 70, Judy stays in the car in the mall parking lot while I go in and shop at least 45 minutes; etc. What would you do if this patient says, "Oh, I don't know how much anxiety driving to the mall is" or "Well, you know, that depends on where I park" or "Wait, well, you know, I get lost in that mall, so I don't know what the SUDs would be"? What I mean is when it is not straightforward and it seems to take a lot of time just to get the patient's ideas together.

Dr. Rothbaum: I rate all of these. So, for example, I've treated patients who were carjacked in the parking lot of a mall. So, just being in the parking lot was, for them, probably the top of the hierarchy. Once they got into the mall, they experienced some relief. So, whatever it is that we need to work on, I'll rate that and we'll put that in the right order. Whenever I go to the doctor and they give me one of these rating scales, I hate them, too. Everybody hates committing to a rating. And we just tell people to just throw out a number. It's subjective. We can change it if we find out that it's not right. But it's just a way to organize and to communicate. So, I do push people when they say, "I don't know how much anxiety driving to the mall is." I say, "All right, picture it now. Driving to the mall. If you got into the car right now, about how anxious do you think you'd be, 0 to 100?" And then just train them to throw out a number.

Dr. Diaz: What about if more than one activity is a 60, for example, SUDs level? "Oh," a patient says, "walking to the mall, that's 60. Using the bathroom at the mall, that's 60, too. Buying a cup of coffee at the mall, that's 60, too." So, which activity would you use?

Dr. Rothbaum: And this is pretty common. They tend to cluster around certain SUDs levels. This is where I might try—if we have enough other items, if I have something at 50, 60, 70, 80, 90, 100, I might not worry about it too much. If not, then that's where I'll use the comparison. Is it easier to walk alone in the mall or to use the bathroom when you're alone in the mall? Easier or more difficult to go to the

bathroom alone in the mall or buy a cup of coffee? And if there really is no difference, then they can do them all. I mean, actually, for this example, they'll need to walk in the mall to use the bathroom, to buy a cup of coffee. All of these things would be adaptive things to do. So, we can just cluster those all under going to the mall because they are normal things. Probably when you go to the mall, you do all of these as well.

Dr. Diaz: What about if a patient can't give a specific SUDs number? For example, this patient says, "Well, walking in the mall is between 60 and 80, but I can't pinpoint exactly where it is. It's just between 60 and 80."

Dr. Rothbaum: I will generally try to get them to throw out a number. And I'll tell them, "I would rather you throw out a number than me. So, let's try to get exact." And usually, they can.

Dr. Diaz: A few minutes ago, you said you recommend the SUDs be separated, like say, by 10 points: 20, 30, 40. But some patients may say, "Well, this is a 40 and this is 55 and this is 85." What do you do about that?

Dr. Rothbaum: I tell people when we're constructing the hierarchy that, really, we want things in increments of 10: 50, 60, 70, 80, 90, 100. You're right that a lot of patients will say, "This is 75." Sometimes, people say, "This is 72" and they get very exact. If they're giving me around the right numbers of items and we've got them around 50, 60, 70, 80, 90, 100, I wouldn't worry about it too much. If they're clustering things—that this is 72, this is 73, this is 77—then I will try to get them to spread it out more. Again, it's subjective and it's a kind of rough hierarchy. So, it doesn't bother me too much if that's how they prefer to rate them.

Dr. Diaz: Okay. What about if their hierarchy does not follow logical steps? For example, they report that driving to the mall is a SUDs 60, parking at the mall is 70, but actually going inside of the mall is 40 where you would expect, you know, going inside the mall is higher. What do you do about that?

Dr. Rothbaum: Then that's exactly how we structure the hierarchy. As I said, you know, I've had people like this that were carjacked in the mall. So, being in the mall parking lot was more anxiety provoking than actually going in the mall. Once they got

in the mall, they felt safe again. So, we just work on their hierarchy in the way that it works for them, moving up in anxiety.

Dr. Diaz: What about for patients who have difficulty understanding SUDs? Can you talk about the percentage of anxiety? For example, going to the mall 60% anxiety, walking inside 70% anxiety, and so on. Do you ever use that?

Dr. Rothbaum: I don't. But sometimes, patients fall into that. And I don't really correct them if I think it's still their SUDs and they're just calling it percent. I will try to use examples from the person's life. I'll ask them, "Okay, how much anxiety, distress, are you feeling right here with me?" And most people—if it's their first or second session and they're there for PTSD—they are not relaxed. And I'll ask them about other areas of life. "Okay, what about if the principal of your child's school calls you in for a parent meeting? How much discomfort do you think you'll feel there?" So, I use other levels in other areas of their life to try to help teach them the scale. Most people are able to get it.

Dr. Diaz: Also, do you need to get up to 100 in SUDs? I mean, does the patient need to do in vivo exposure to whatever they say is 100?

Dr. Rothbaum: If you've constructed your exposure hierarchy properly and if your patient is doing a lot of exposure therapy and in a therapeutic manner, they may not ever actually hit 100 because, by the time they get to the top of the hierarchy to whatever they rate as 100, they've already experienced some decrement in their anxiety. So, by doing everything before it, it's no longer 100 when they do it. But I do think that people need to do every single thing on their hierarchy—and more—because they just need to not avoid in their life and they need to learn that they can handle it. So, yes. I do think we need to expose them to the top of the hierarchy, but it probably wouldn't be 100 by the time we get there.

All right. So, make it clear to patients we need to do exposure therapy, as much as possible. If patients have trouble with a number for a SUDs rating, try to get the patient to throw out a number. It's important to keep in mind that for many people, it's difficult to commit to a rating, but in PE for PTSD, this is important to convey the information to the therapist. The good news is, if patients practice exposure enough, their anxiety will decrease, so they may never get to 100 SUDs in their hierarchy.

Psychotherapy Academy

Repeating the In Vivo Exposure

Many times the patients are going to feel anxious as to the time it will take them to repeat the in vivo exposure until they are done with it. Others are going to have issues with when to practice it. Here, Dr. Rothbaum elaborates on these topics.

Dr. Diaz: How many times does the patient need to repeat the in vivo exposure before they can go on to the next step? Like, for a typical hierarchy, if a patient asks, "Oh, how much time would it take me to do this step?" is there an approximate amount of time you would say or expect the patient to practice?

Dr. Rothbaum: In general, well, first, it's going to depend on the patient and how long they stay anxious for or how long before they habituate and calm down. In general, I'm going to ask people to stay in the exposure for about 30 to 45 minutes to learn how long it takes for them to calm down. If they learn that they calm down before that—and I'll explain that the whole idea is not to leave when you're still anxious and I want them to feel relief when they leave. And so I'll train them in that. Sometimes, for example, people with borderline personality disorder, they do seem to go from 0 to 100 and then they seem to stay at 100 for a long time. I remember one patient, she was so diligent about doing her homework and every day, she reported it was still 100, still 100, still 100—until the seventh day. And then it would finally come down. So, we knew to predict that for her. That some people, they go up high, they stay high, it takes a long time for them to habituate, but if they stay with it, it usually does.

Dr. Diaz: What about patients who say, "Well, you know, this is great, but I can only practice once a week because I'm busy" or "I need to travel for work" or "You know, I'm going to Italy in the middle of therapy for a month"? So, what is the minimum you would say is feasible before saying, "You know, this is like doing nothing. If you practice only once a week, for example, it's like doing nothing. If you're going to travel in the middle of therapy, when you come back, we will have to start at the beginning again." What do you recommend? Or what do you do about that?

Dr. Rothbaum: Yeah. I'll talk to people about if this is the right time in their life to do this therapy because it really does—it doesn't last long. It lasts a matter of weeks, but

I am going to ask people to devote a lot of time every day to really get the most out of it. And if this isn't the right time, then that's fine. Now that they know what's involved, we can schedule it when it is the right time. I would rather wait and do it completely than do it piecemeal. There's a little bit of data that indicates that incomplete exposures can hurt people, that they can make it harder to habituate in the future. So, when I do it, I'm going to want to do it the right way and do it fully.
As far as people traveling in the middle of the exposure therapy or the therapist traveling—because this happens a lot—I want to at least get to about the middle of therapy. I wouldn't want to have, for example, the first imaginal exposure, even the second imaginal exposure, and then take a week or 2 weeks off. If we can get to about session 5 or 6, then we can let them travel or the therapist travel, take a break, and come back. And that's not usually as critical. If we can't do that, then I might have sessions 1 and 2 to prepare them for it and wait until they return or wait until the therapist returns to start with imaginal exposure therapy. You really want to do the imaginal exposure therapy pretty close together.

So, remember, the patient needs to stay in the exposure for about 30 to 45 minutes, until the anxiety goes down and they learn how much time it takes them for the anxiety to decrease. The patient needs to stay motivated and on track and must know that the idea is to do the whole therapy and not only part of it or take breaks.

What About Sex Issues?

To end this interview, we presented Dr. Rothbaum with a sex issue to help us understand what happens when a patient needs to include a person in their hierarchy and certain difficulties arise.

Dr. Diaz: How do you handle exposure with a woman who has been raped and she has PTSD, for example, and now she has a new boyfriend and she's afraid to have sex? Would you include the boyfriend in the hierarchy? And if you can't include him, what options are there for this woman?

Dr. Rothbaum: Yes. We use partners all the time and we include all of that in the hierarchy. And so it depends what causes her distress, what she has a problem with. And yes, she does need to communicate with him. And usually, we let the patient communicate with them, with their partners, because that's what they need to learn to do. We have had every sex act that you can imagine that's consensual on the

hierarchy. And we'll go with whatever. So, sometimes, people who've been assaulted, they don't even like kissing or hugging because, even though that might feel good, they're scared that their partner is going to get aroused and want sex after that. So, if we have that on the hierarchy—let's say that's a 50—the patient has to explain to their partner that this is all we're going to do. We are not having sex. Sex isn't until further along on the hierarchy and that we also need them to explain to the partner that the patient has to be in control. If at any point the patient says stop, then the partner has to stop. Even if he or she is aroused, it doesn't matter. And so I go through all of the rules, if you will, for including sexual acts on the hierarchy. But we do it with all of them.

Dr. Diaz: What about if she can't include the boyfriend? For example, she says, "Oh, but, you know, I'm just starting out with him. I really don't feel so close to him that I can tell him all of this." Would you tell this woman to wait or what?

Dr. Rothbaum: Yeah. And then it depends where they are in the relationship, how fearful she is. We'll work with the woman in terms of touching herself and whatever we need to put on the hierarchy that can allow her to have a better experience and not an anxiety-provoking experience when she does want to include him.

Then yes, by all means, include specific people in the hierarchy, if it is needed. If it is not possible, there are ways around that.

This concludes Part 1 of the PE for PTSD interview with Dr. Barbara Rothbaum. We'll remind our listeners that the course by Dr. Rothbaum, "Prolonged Exposure Therapy for PTSD" is available for you at psychotherapyacademy.org. I am your host, Dr. Jessica Diaz. Thanks for listening! Stay tuned for Part 2 of this interview!

Prolonged Exposure Therapy for PTSD: Special Populations, Treating Guilt, Family Issues, Ending Therapy, and More

Welcome back! This is Part 2 of the interview with our PE specialist, Dr. Barbara Rothbaum. I am your host, Dr. Jessica Diaz.

As a reminder, in the first part of this interview, we talked about breathing retraining in PE with comments on yoga, meditation, and mindfulness, imaginal and in vivo exposure, SUDS, sex issues, and using a co-therapist.

We know you need to learn more, for example: Do patients need to move to another city or state to get better from PTSD? How do you treat patients with cognitive impairment? Is it possible to help family members who are tired of the patient? How can you, the therapist, tolerate the patient's distress?

The answers to these questions and much more are in this interview!

You can't miss this! Let's start.

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[Where Can I Find More Information?]

PE for PTSD in Special Populations

As a clinician, you may need to treat patients with PTSD who belong to special populations. They could be patients with borderline personality disorder or with cognitive, hearing, or speech impairment. Can you use PE for these patients? The short answer is yes. Let's listen.

Dr. Diaz: Going on to another topic: PE for PTSD in special populations. You talked about patients with PTSD and borderline personality disorder. Can you use this therapy for these patients? Is it effective? Because these patients tend to have frequent crises and phone calls and issues. So, can you really use this therapy with these patients?

Dr. Rothbaum: I think PE has been very effective with patients with borderline personality disorder and I think the structure of the sessions is very useful. I had a patient that I remember she was crying in the waiting room. And when I brought her back, found out what was going on, it was basically the crisis du jour. And when I determined we didn't really need to pay attention to that yet, I said, "This is important, but let's come back to it afterward. The best thing I can do for you is to treat your PTSD and just stick to the agenda." And we did it and she did great, had a great session. And I asked her how she felt. She said she felt better. I said, "What did you learn?" And she said, "I learned that I can be upset about something and still do what I need to do." And then I asked her, "And?" And she said, "And it makes me feel better to get something accomplished that I needed to do even when I was upset." So, I've had a lot of success.
But I should add it's when PTSD is primary, not necessarily when the borderline personality disorder is primary. But if they've got PTSD, I urge the therapist to keep the sessions structured because, like you said, the patients can bring in lots of—I call them the crisis du jour—and we really don't want to follow that because then we don't get anything done.

Dr. Diaz: Yeah, that's true. So, that's interesting. Keep the structure. It's important for these patients. After you're done with therapy with these borderline personality

disorder patients, do you refer them to another therapist? Or what do you do about them?

Dr. Rothbaum: It depends. If I think that they could use, for example, DBT skills, then I would refer them to another therapist who can teach them DBT. A lot of times, the exposure therapy—they can transfer those skills because they're learning to sit with it and to stay with the anxiety until it comes down. They're learning how to make decisions that are good for them. So, sometimes, that can transfer to their borderline personality trait. Sometimes, they might need a full course of DBT, though.

Dr. Diaz: What about certain other patients? For example, a patient with maybe low IQ, mild cognitive impairment, speech or hearing impairment. Because if a person is deaf, how can they listen to audios? Or a person with mild cognitive impairment maybe has difficulty understanding instructions. So, can you work with these patients?

Dr. Rothbaum: For most that you mentioned, yes. So, for low IQ, I mean, people can understand the basic concept of exposure. And they can understand. And you can use examples, you know, the kid in the water who gets scared of the water and doesn't go back in the water. What will the mom do? Help him feel more comfortable with the water. So, people understand the concept of exposure. It really is a simple concept—and especially when people have fear and when something happens to them and they see their life change because they've been avoiding it. And so that's been fine. We've worked with folks with mild cognitive impairment. We have a TBI track in our veteran's program, mild traumatic brain injury, and it works very well. I've had, and some of my colleagues, we've also worked with people with even more than mild TBI and exposure works very well. And a colleague of mine, Sheila Rauch, published a case study with a patient, a veteran with cognitive impairment—and it might have even been early Alzheimer's—who did very well with exposure therapy. His family would help him do exposures and structure things, but he did very well. Speech and hearing impairment would be harder for me because I'm not trained to deal with that population. If people are trained to deal with speech and hearing impairments and they're trained in exposure therapy, I don't think that it should present any obstacles. You would just need to change. For example, for a hearing-impaired person, maybe writing it instead.

So, this is great news! Patients with PTSD who belong to special populations can also benefit from PE. It is good to know that even patients with PTSD and borderline personality disorder can transfer some of the skills learned in PE to their personality traits.

Treating Feelings of Guilt and Shame

You surely have had patients who have felt guilt and shame. In the context of PTSD, this may be amplified due to not following certain procedures or rules, or due to the thought they could have done something differently. This is common in war veterans. So, how do you handle this? Here is what Dr. Rothbaum said.

> **Dr. Diaz:** What about people who say they are better? For example, “Oh, yeah. I sleep better. I don’t have any flashbacks. I’m eating better. I have a better mood. But, Dr. Rothbaum, I still have this gut feeling that I am guilty because my friend died and I should’ve done something different. I feel better and your therapy has helped me but I can’t get rid of this gut feeling.” What do you do about that?

> **Dr. Rothbaum:** That’s where we’ll work on it in the processing. So, if they say that “I should’ve done something different,” a lot of times, especially at the right point in therapy, I’ll say, “What? Tell me what you wish you would’ve done.” And then they can tell me and I’ll say, “Why didn’t you do it?” Because there are reasons that they didn’t do it. Maybe it was dangerous to do it. Maybe they didn’t have the presence of mind. Maybe they had to protect themselves. But there are usually reasons.
> And the context matters so much. And that’s what we try to emphasize with people, that what you would do now in the situation, here in a safe place, is different than what happened then. And so we’ll go through that. And it doesn’t mean that it isn’t terrible. For example, if their friend died, that is terrible and they need to grieve that. We’ll use a number of techniques in the processing. For example, what if it was the other way around? What if you had died and your friend survived? Would you want them to carry around this guilt or would you want them to lead a full and happy life? And almost always, they say, “I would want them to lead a full and happy life.” And so then we can apply that to them as well.

> **Dr. Diaz:** That makes sense. Usually, military personnel have a set of rules they have to follow. What if they say, “Yeah, my friend died because I didn’t follow the rules”? “I didn’t do what I was trained to do or what I was supposed to do. And because of that, my friend died. So, I am guilty.” So, yeah. He could’ve done

something different. He could've followed the rules and he didn't. Is that something that happens when you treat patients? What do you do about that?

Dr. Rothbaum: Oh yes. And the first thing I'll do is exactly what I just said. We'll talk about the context. Why didn't they follow the rules? And usually, there's a reason for it. If they just drove through a village and everyone was trying to kill them and then they get to another village and a family walks out and the adults are armed, then they might be acting differently than if they had just arrived at that family. So, the context matters for everything. And very often, we will invoke the rules of engagement for combat veterans. And a lot of times, they have a terrible choice. A lot of times, somebody is going to die and in a split second, they have to decide who. Do I shoot this kid who looks like he's wired with explosives or do I not because I know him and then take the chance that my buddies are going to die? So, we go through it in a lot of detail. And again, there are usually reasons for it.
If the patient made a mistake—which we do, we make a mistake—if the patient had bad judgment, if the patient just didn't follow the rules, then we need to work on that guilt and how they want to approach that. And there can be a number of ways, depending on the patient. For example, if a patient is religious, I will sometimes use that. Do they believe in a forgiving God? Do they think that God can forgive them for this? All right. If God can forgive them for this, why can't they? Do they think their friend would forgive them for it? Or do they need to do some kind of act of reparation? Do they need to talk to the friend's family? Do they need to contribute to a charity? Do they need to make it their mission that this doesn't happen again? How can they use this? What do they need to do? So, we'll explore all of that.

To recap: It's important to examine the context in order to help patients with their guilt. As Dr. Rothbaum said, and I quote, "the context matters so much. And that's what we try to emphasize with people, that what you would do now in the situation, here in a safe place, is different than what happened then." End quote. It is not the same here and now, to what happened back then.

What If the Patient Only Has 2 Weeks to Do PE?

Also, it may happen that the patient wants to do PE, but only has a short period of time to do it. Would it be possible to help? Listen carefully to how Dr. Rothbaum addresses this situation.

Dr. Diaz: What about a patient with PTSD who comes to your office saying, “Well, you know what? I need your help because in 2 weeks I need to go to a government office where I got mugged a few months ago.” What do you do in cases like these?

Dr. Rothbaum: So, actually, we can do this therapy in 2 weeks when we do it every day. That’s what we do in our veteran’s program. We bring people from around the country for 2 weeks. They stay at the hotel across the street from our clinic and we do this therapy every day. And even if they’re not coming from out of town, if you’ve got the time or someone else can help work with them, you can get her to do the therapy every day, to do the in vivo exposure every day. You also want to make sure that it’s safe. If she’s going back into that same neighborhood where she got mugged, was that an unusual event? Or is this a dangerous neighborhood? Because you always want to remember that people with PTSD have been in a dangerous situation. And so we want to make sure that what we’re asking them to do is safe.

Dr. Diaz: So, that’s interesting, doing this therapy in 2 weeks. So, a person like this, you would tell the person, “Okay. If you can come in every day, we can work.” And supposing the neighborhood is generally safe, then that’s the way you would be able to help this person.

Dr. Rothbaum: Yeah. And even if you can’t see her every day, say you can see her 2 or 3 times a week, you can tell her she needs to be doing the homework every day and work on a hierarchy with her that she can be doing that every day. So, in 2 weeks, she would be able to go to this office.

So, yes! Even if the patient has 2 weeks to do this therapy, it can be done. The patient would have to work hard and practice exposure every day, but it can be done!

Do I Need to Move to Another State?

Do patients need to move to another city, state, or country to get better from PTSD? Not usually. Listen in as Dr. Rothbaum comments on different case scenarios.

Dr. Diaz: Are there any situations where, besides the therapy, the patient would need to move to another city or state in order to be 100% better? For example, a patient with PTSD due to tornadoes and they live in Oklahoma or PTSD due to hurricanes

and they live in Miami or, I don't know, due to accident driving in snow when they live in Michigan.

Dr. Rothbaum: Again, I'm an exposure therapist. I always want people to act out of their preferences, out of their choice, and not act out of fear. So, even if they decide, "I'm sick of tornadoes. I don't want to be here anymore," I would want them to do the therapy to make sure that they know it's a choice, that they could stay there, and it's a choice that they leave. So, I always want people to know that they can handle it before they leave. If they decide as a lifestyle choice that they don't want to do this anymore, that's up to them. Now, occasionally, when people have been victims of domestic abuse, they have felt that it was safer to move to another city. And I would not necessarily argue with them if they think that that's true.

Dr. Diaz: Okay. Is this the same for professions like emergency medical personnel, firefighters, policemen? For example, firefighters who had PTSD after 9/11, would they have to change their profession? Or would you do the same thing? We'll do the therapy and then it is your choice, you know, to leave your profession or not.

Dr. Rothbaum: Exactly. I would want them to do the therapy to know that they could handle it and then it's their choice if this is what they want to keep doing in life or not. My big thing is choice. And I want them to have an equal scale in the choice based on whatever anyone else would use to decide. If they're fearful or avoidant, then those scales are tipped. So, I want those scales to be equal, that they can make the choice based on whatever anyone else would make the choice on.

Keep this in mind: It is not the idea that the patient acts out of fear. We want them to choose freely if they want to change the place where they live or their profession. The only exception to this may be victims of domestic abuse, where moving may be for the best.

Family Issues: Support and Legal Consequences

Patients are usually not alone. They have families and friends. They are spouses, children, parents, and close friends who may be tired of dealing with someone with PTSD, who do not believe in therapy, or just want a quick fix. How do you handle this? Dr. Rothbaum gave some excellent advice.

Dr. Diaz: So, moving on to family issues. How do you deal with unsupportive family members? Suppose if you explain to them that, you know, “I need your support” or “This person is going through therapy” or “They don’t agree with you,” what do you do about that?

Dr. Rothbaum: As hard as it is to live with PTSD, it’s also hard to live with someone with PTSD. And so, very often, by the time patients get to us, a lot of times—especially with our veterans—it’s because their spouse has said “You got to get treatment or I’m out of here.” So, a lot of times, the spouse is really fed up. A lot of times, the kids are fed up. So, one thing that we’ll do is try to educate them. And that’s where we suggest the common reactions to trauma handout, that the patient should share it with their family members, with their significant others, with children—if they’re old enough to understand that the parent has PTSD and understand this treatment—and a lot of times, that helps family members not take it so personally. When they can see that one of the symptoms is emotional numbing, is detachment from emotions, all of these, then it can help them see, “Okay, this is a symptom of PTSD. This isn’t just because he’s a jerk or he doesn’t love me anymore.” So, we’ll try to educate family members.
In our veteran’s program, we have 4 sessions that include the family members to try to help them understand PTSD and how they can be supportive. And we also give them a way to talk about it because very often family members have been walking on eggshells around the patient. So, we give them a way that they can talk about it together.

Dr. Diaz: What about adverse legal consequences that maybe you have had to face or that you have known of? For example, you’re treating a patient and the patient commits suicide and then the family wants to sue. Is that common? Or if it happens, how do you handle that?

Dr. Rothbaum: Knock on wood. It’s not common. And what we suggest is what they always suggest. So, consultation and careful note taking, informed consent. So, you inform the patient about the risks and benefits to be expected from therapy. If they are suicidal, so, you would need to assess for it or whatever problem that they’re having and work on a safety plan. Consult with other colleagues. Basically, do everything you can to protect yourself and make sure the patient is giving you full informed consent.

So, PTSD is difficult for the patients and their families and close friends. The best way to go is the education of family members on PTSD and what certain reactions mean and how to be supportive. Also, be sure to obtain informed consent from the patient and consult with colleagues when in doubt.

Time to End Therapy: What About Booster Sessions?

So, your patient is better! Great! But now, therapy comes to an end. This may be difficult for some patients. How do you handle that? This is what Dr. Rothbaum said.

> **Dr. Diaz:** Okay. Well, this therapy has to end sometime. And what do you do if a patient does not want to leave therapy, although he is better? Maybe because he has a comorbid dependent personality disorder or maybe panic disorder. What do you do about this, so they don't feel kicked out?

> **Dr. Rothbaum:** In some ways, we start termination at the very first session. So, I let people know at the first session that this treatment takes probably 9 to 12 sessions and that that's what we'll do. And even if they're seeing another therapist or they have other problems, I'll describe that I have just a slice of the pie that I'm dealing with. I'm dealing with their PTSD and so I'm going to stay very focused on their PTSD. If it's clear at the end of therapy that they have other issues that they're dealing with, then it's my decision to decide. Do I have room in my practice? Do I want to keep working with them on this? And is this my expertise? Or should I refer them to another therapist? Usually, what I find is that both the therapist and the patient are ready to end therapy when it's time to end therapy. If it's more of a dependent personality disorder, that's probably not somebody I'm going to treat. And so I'm going to make sure to say at every session, "Okay, this is session 2. We've got 9 more scheduled," and really keep the end of therapy in mind. And then I'll help them problem solve and help them get hooked up with whatever they need after that.

> **Dr. Diaz:** What about booster sessions? Is that something that you do? Do you have patients that keep coming into your office year after year for booster sessions?

> **Dr. Rothbaum:** It totally depends. Probably the majority of our patients don't come back for booster sessions. But we've certainly had a handful of patients that something else happens and they know that they don't want to slip back into this

avoidant lifestyle. And so they'll come back in for a booster session and kind of to get my kick in the butt to get back on track. So, it's not typical, but it does happen.

Always be clear with your patient on how long this therapy will last and stay focused on your slice of the pie, as Dr. Rothbaum said. Regarding booster sessions, they are not usually needed. However, if you, the therapist, believe this will help the patient, then you can schedule a session.

Therapist Issues: Suggestions

What if you are one of the few therapists in town who sees patients with PTSD, but you are not an expert on PE? What about intersession contact? Should you allow it or not? Listen in as Dr. Rothbaum talks about these topics.

Dr. Diaz: So, Dr. Rothbaum, moving on to therapist issues. You're an expert, but many of the clinicians who are listening to this are not. Are there any suggestions you can give a therapist who is not an expert in PE for PTSD but gets lots of patients with this diagnosis, maybe because there are a few therapists where they live? What are some things that you can say that they can apply in therapy that would help?

Dr. Rothbaum: I would suggest consultation. So, there are a number of consultation programs around the country. You don't even have to be in the same city with the consultant. And we recommend that they videotape their sessions and show them to the consultants, almost in real time, so as soon as you've had the session, so the consultant can give you feedback before your next session. And we usually recommend that for 2 cases. I also recommend that therapists new to PE follow the protocol pretty much exactly. A lot of people want to take bits and pieces from different therapies. And the research that's been done on this shows that PE doesn't really profit from adding other bits of kinds of therapies into it. So, I really recommend that they trust the therapy and administer the therapy according to the protocol before they attempt to make any changes in it.

Dr. Diaz: Another issue that therapists may face is intersession contact. Is it best to allow frequent contact, no contact, or something in between? How do you handle that?

Dr. Rothbaum: This is going to depend on the therapist and their practice. We like to recommend that, if patients have problems in between sessions, that they can contact their therapist because we want them to be doing the exposures properly and therapeutically so that they get better. However, don't tell your patients to contact you if you really can't handle that contact or respond to it. I am not a fan of patients emailing me between sessions for contact because there are so many ways to misunderstand an email. However, I will do it sometimes, just for accountability, I'll tell them to email me. Especially if they've had a hard time getting something done, I'll tell them to email me when they have gotten it done. Occasionally, I will email a patient—especially after the first exposure session—and just check in on them, tell them they did a great job. How are they doing? And they appreciate that very much, when you check in on them. You can do it with a phone call as well. So, it's not required, but we suggest it.

Dr. Diaz: What about maybe a therapist who wants to learn PE for PTSD? They may ask, "Oh, do I need to be in personal psychotherapy first? Because for other therapies, they are telling me that I need to be in personal psychotherapy first. So, do I have to do this for PE for PTSD if I want to get trained?"

Dr. Rothbaum: Not for PE. And PE is considered a form of cognitive behavior therapy, CBT. And in general, not for CBT either, that doesn't require the therapist to be in therapy.

To recap, it's easy as 1, 2, 3. 1. Follow the PE protocol and look for a consultation program to help you with using PE with your PTSD patients. 2. Intersession contact is up to the therapist. Allow it if you can respond to your patients. 3. You don't need to be in personal psychotherapy to become a PE therapist.

How to Develop Tolerance to the Patient's Distress

For PE therapists, it is important to learn to develop tolerance to the patient's distress without becoming immune to it. But how can you do this? Here is Dr. Rothbaum's take on this issue.

Dr. Diaz: You also talked about being tolerant or developing tolerance to patients' distress. A therapist may ask you, "Okay, how do I do that?"

Dr. Rothbaum: One is just by trusting the therapy. And even though it might be uncomfortable to ask the patient these questions, it'll feel like you're making the patient say these uncomfortable things, trust the therapy, do what we recommend in the protocol, and then the therapist should see that the patient gets better and that the therapist gets better when the patient gets better. So, very often, we'll hear their stories and I'll have tears in my eyes. I just think, "Could I have survived that?" And then as the patient tells it several times per session and then over and over again in sessions, I get more comfortable with it and the patient does as well. As they get better, we get better.

Dr. Diaz: Okay. So, this is something that basically develops over time while you are seeing your patients.

Dr. Rothbaum: Yes. And it's a fine balance because you want to be able to tolerate their distress, but you don't want to become immune to it. You don't want to become a cold-hearted rock. You still want to be a person who can respond to them, but you want to have it at arm's length. It is their distress that you're helping them to tolerate. You don't want it to become your distress.

Dr. Diaz: Okay. Because of this, is there a limit on the number of patients any PE therapist can have? Suppose that's all you do or that's 90% of your patients. Would you say, "Hey, no more than X amount of patients" per day or per week?

Dr. Rothbaum: Yeah. Again, this is going to depend on the therapist. For example, when we were doing a study and I had an assessor who was assessing PTSD patients all day long and finally, she said, "This is too much. I'm hearing terrible stories." And unlike when she's the therapist, she's not hearing them over and over again and seeing them get better. So, we had to limit. I think we limited her to 2 assessments of PTSD patients a day.
For the therapist, it is going to depend on the toll it takes on you. It's also going to depend on where the patients are in therapy. Generally, the first few sessions of exposure therapy are a little bit more taxing because you're hearing the story for the first time. The patient can often be distressed. Whereas, towards the end of therapy, hopefully, the patient is doing much better. Hopefully, you know how the patient is responding. It doesn't take as much of a toll. So, even having a mix of patients early in therapy and later in therapy and probably having a mix of other patients in there as

> well and making sure that the therapist is doing good self-care. So, exercising, sleeping, eating right, talking to other therapists for consultation, if they need to.

Well, so the short answer is, it takes time to develop this tolerance to the patient's distress. Also, it is important to observe your own limits. If you are feeling overwhelmed with so many PTSD patients, it is okay to cut down or talk to colleagues. Don't forget the usual: exercise, eat right, get a good night's sleep, and so on.

Where Can I Find More Information?

This seems so interesting! There are ways to learn more. Dr. Rothbaum gave us some tips.

> **Dr. Diaz:** Well, Dr. Rothbaum, thank you very much for all this information. It has been a great interview. Are there any resources out there for therapists who want to get trained in PE for PTSD or any place where they could get further information if they're interested?

> **Dr. Rothbaum:** Yes. There are websites. We have the manual. If they are associated with the VA hospital, very often, they do trainings through the VA. They could probably Google it because a number of my colleagues do trainings throughout the year. Sometimes, we'll do trainings. So, it's not necessarily a regular thing, but they are available.

> **Dr. Diaz:** Well, thank you very much. I really appreciate your time with us. And well, for these therapists who may be interested, then it's Google VA. Is that what you're saying? And then through their websites.

> **Dr. Rothbaum:** They can Google PE trainings. The Center for the Treatment and Study of Anxiety, Edna Foa's place, they conduct PE trainings. Sometimes, through the VA, they are conducting PE trainings for therapists not in the VA. So, there are a number of places where they're available.

Dr. Diaz: Okay. Well, thank you very much.

Dr. Rothbaum: And thank you for giving me this opportunity. I love doing PE. It changes people's lives. And I love training new therapists in PE because it's a wonderful tool to have. So, thank you for giving me this opportunity.

Dr. Diaz: Thank you. This is your host, Dr. Jessica Diaz. And see you later.

Thank you so much, Dr. Rothbaum!

Basically, if you look for "PE trainings at VA" on Google, you can get information on trainings. Remember, our course by Dr. Rothbaum, "Prolonged Exposure Therapy for PTSD" is available for you at psychotherapyacademy.org.

I am your host, Dr. Jessica Diaz. Thanks for listening!