



PE-Web: An online training program for providers in Prolonged Exposure for PTSD

Kenneth J. Ruggiero, Ph.D.

Associate Director and Research Health Scientist
HSR&D Center of Innovation, Ralph H. Johnson VAMC

Professor and Director of Research Coordination
Department of Psychiatry & Behavioral Sciences
Medical University of South Carolina



Presentation Overview



-
- Behavioral health needs of Veterans
 - Providers' readiness to deliver EBTs
 - Benefits of web-based training approaches
 - Evaluation of web-based approaches
 - Process of developing *PE-Web*
 - Description of the *PE-Web* site



Key Collaborators



University of Pennsylvania

- Edna Foa, Ph.D., Director of CTSA, Professor, Developer of PE

Ralph H. Johnson VAMC / Med Univ South Carolina

- Ron Acierno, Ph.D., Director of PTSD Clinical Team
- Mary Mauldin, Ed.D., Professor in Library Sciences, Informatics
- Alyssa Rheingold, Ph.D., Associate Prof, Dir. Clinical Operations
- Jonathan Coultas, B.A., Media Specialist
- Cheryl-Lyn Samuels, M.S., Information Resource Consultant
- Martha Strachan, Ph.D., Research Associate, Project Coordinator
- Kyleen Welsh, B.A., Research Coordinator

Other VA-Affiliated Contributors

- Josef Ruzek, Ph.D., Director, Dissemination branch NC PTSD
- Afsoon Eftekhari, Ph.D., PE Training Initiative Proj Coordinator
- Ken Weingardt, Ph.D., National Director for Web Services
- Jessica Hamblen, Ph.D., National Center for PTSD



Veterans' MH Needs



- Veterans are at risk for behavioral health problems
 - Posttraumatic stress disorder (PTSD) is prevalent
 - Depression and substance use problems often co-occur
- Untreated PTSD, depression may negatively affect overall health and wellness
- Ensuring that Veterans have access to effective treatment for PTSD is a major priority
- Prolonged Exposure is a best-practice intervention



Web-based training



- National dissemination initiative in VA (Karlin, Ruzek, et al., 2010, JTS, vol. 23, pps. 663-673)
- Technology-based provider training resources may support dissemination
- Wide dissemination of ESTs is limited by a lack of easily accessible, cost-effective training resources.
- Web-based training is a promising mechanism for delivering basic training in ESTs.

POLL

- Have you ever completed a web-based training for CE credits?
 - Yes
 - No



Prior Successes



- Our team has developed several online provider-training websites in evidence-based treatment
 - Trauma Focused CBT (www.musc.edu/tfcbt)
 - Cognitive Processing Therapy (<http://cpt.musc.edu>)
 - Helping Heroes (<http://helping-heroes.org>)
 - Child Traumatic Grief (www.musc.edu/ctg)
- In our HSR&D project, we developed *PE-Web* (<http://pe.musc.edu>), a web course for providers working with adults with PTSD
 - Veteran focused, but relevant to range of populations



TF-CBT *Web* Data



- Funded by SAMHSA
- 8-10 hour web-based training course for providers
- Free learning opportunity with CE credits offered
- Asynchronous learning (i.e., learn at your own pace)
- Developed between 2003-2005
- Launched in October, 2005

TF-CBT *Web*

TF-CBT *Web* is a web-based, distance education training course for learning Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT).

Launched on
October 1, 2005

The screenshot shows the homepage of the TF-CBT Web website. At the top, there are logos for MUSC Medical University of South Carolina, Allegheny General Hospital, LIMONI CARES INSTITUTE, and NCTSN (National Child Traumatic Stress Network). Below the logos is a navigation menu with buttons for Register, Login, Introduction, Resources, and Contact Us. The main content area features a large image of a young girl with blonde hair, wearing a dark jacket, looking off to the side. To the right of the image, the text reads "TF-CBT *Web*" and "A web-based learning course for TRAUMA-FOCUSED COGNITIVE-BEHAVIORAL THERAPY". Below this, there is a list of course topics: Psychoeducation, Stress Management, Affect Expression and Modulation, Cognitive Coping, Creating the Trauma Narrative, Cognitive Processing, Behavior Management Training, Parent-Child Sessions, and Evaluation. At the bottom of the page, there is a banner with the text "A Strategy to Help" and "System Requirements | Credits". The footer contains the copyright information: "Copyright 2005 Medical University of South Carolina All Rights Reserved".

MUSC
MEDICAL UNIVERSITY
OF SOUTH CAROLINA
National Crime Victims
Research and Treatment
Center

ALLEGHENY
GENERAL HOSPITAL
Center for Traumatic Stress
in Children and Adolescents

LIMONI
SCM
CARES
INSTITUTE
Child Abuse Research Education & Service

A PARTNER IN
NCTSN
The National Child
Traumatic Stress Network

Register Login Introduction Resources Contact Us

TF-CBT *Web*
A web-based learning course for
TRAUMA-FOCUSED
COGNITIVE-BEHAVIORAL THERAPY

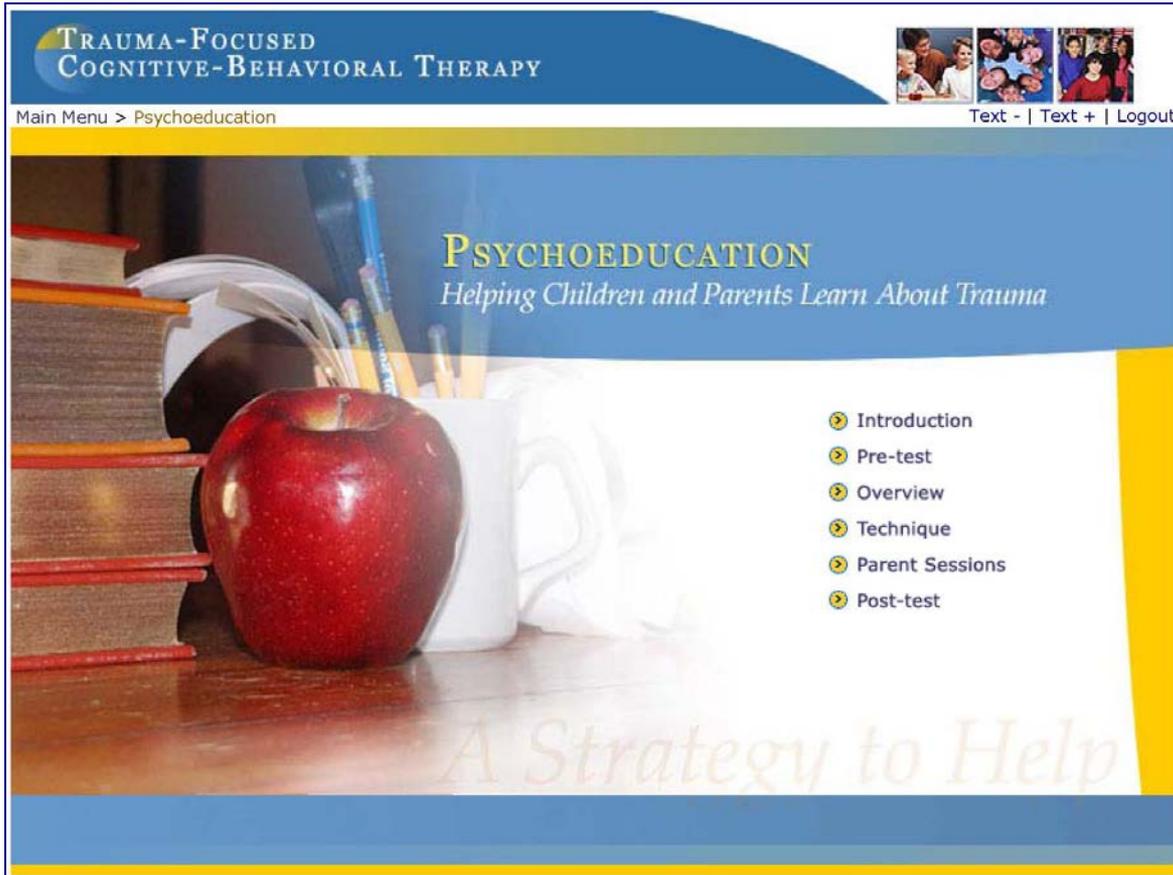
- ▶ Psychoeducation
- ▶ Stress Management
- ▶ Affect Expression and Modulation
- ▶ Cognitive Coping
- ▶ Creating the Trauma Narrative
- ▶ Cognitive Processing
- ▶ Behavior Management Training
- ▶ Parent-Child Sessions
- ▶ Evaluation

A Strategy to Help

System Requirements | Credits

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TF-CBT *Web*



TRAUMA-FOCUSED
COGNITIVE-BEHAVIORAL THERAPY

Main Menu > Psychoeducation

Text - | Text + | Logout

PSYCHOEDUCATION

Helping Children and Parents Learn About Trauma

- Introduction
- Pre-test
- Overview
- Technique
- Parent Sessions
- Post-test

A Strategy to Help

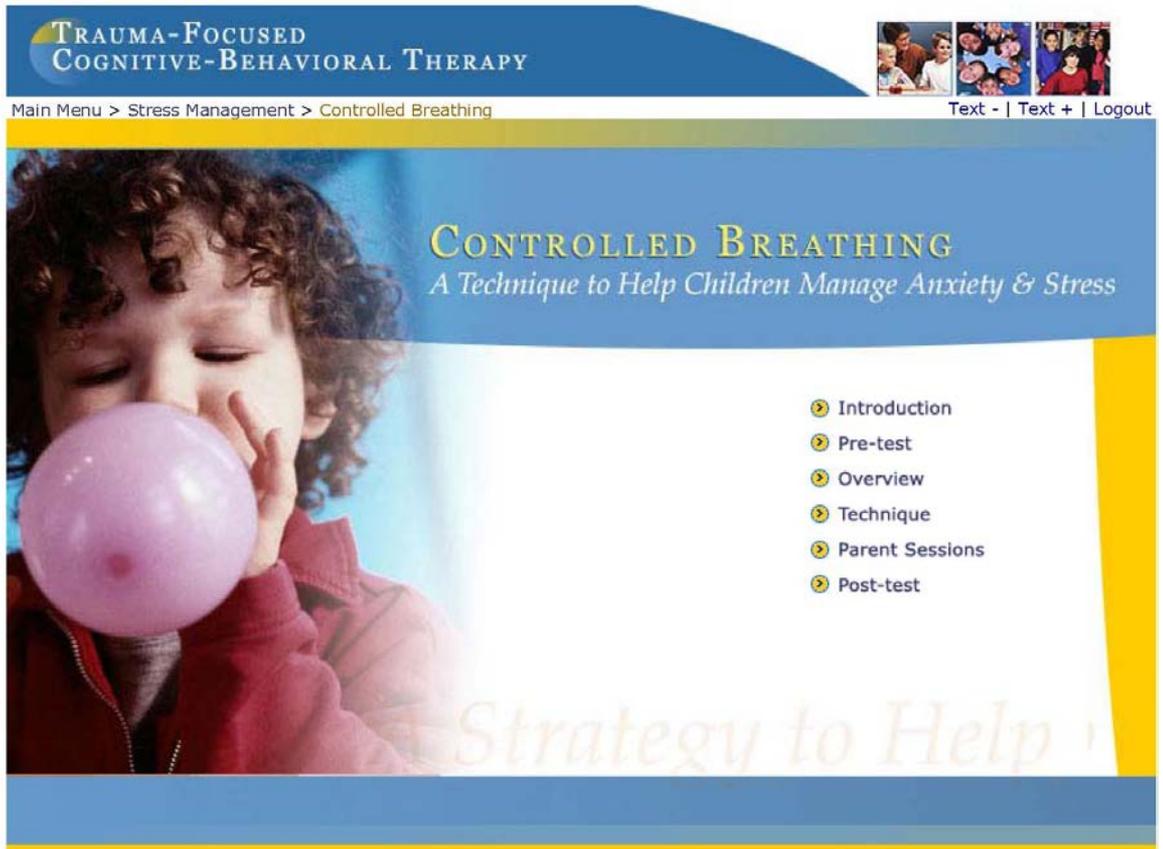
- Web-based learning
- Learn at your own pace
- Learn when you want
- Learn where you want
- Return anytime
- **10 hours of CE**

**TF-CBT *Web* is offered
free of charge.**

TF-CBT Web

Each module has:

- Concise explanations
- Video demonstrations
- Clinical scripts
- Cultural considerations
- Clinical Challenges



The screenshot shows the web interface for the 'Controlled Breathing' module. At the top, the header reads 'TRAUMA-FOCUSED COGNITIVE-BEHAVIORAL THERAPY' with a logo on the left and a group photo of children on the right. Below the header is a navigation bar with the text 'Main Menu > Stress Management > Controlled Breathing' and 'Text - | Text + | Logout'. The main content area features a large image of a child blowing a pink bubble. To the right of the image, the title 'CONTROLLED BREATHING' is displayed in yellow, followed by the subtitle 'A Technique to Help Children Manage Anxiety & Stress'. A list of menu items is shown on the right side of the page, each preceded by a yellow arrow icon: Introduction, Pre-test, Overview, Technique, Parent Sessions, and Post-test. At the bottom of the page, the text 'Strategy to Help' is visible in a light, semi-transparent font.

TRAUMA-FOCUSED
COGNITIVE-BEHAVIORAL THERAPY

Main Menu > Stress Management > Controlled Breathing

Text - | Text + | Logout

CONTROLLED BREATHING

A Technique to Help Children Manage Anxiety & Stress

- Introduction
- Pre-test
- Overview
- Technique
- Parent Sessions
- Post-test

Strategy to Help



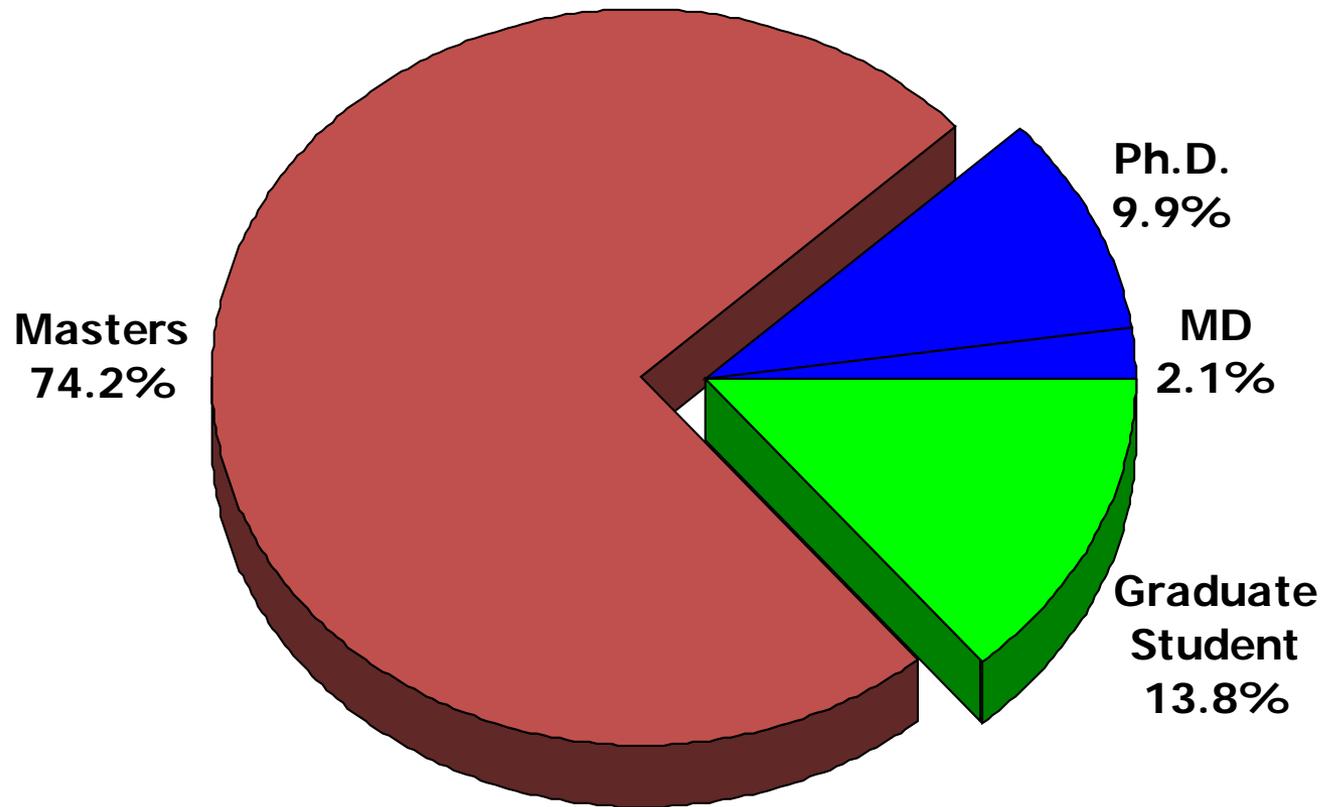
TF-CBT *Web* Learners



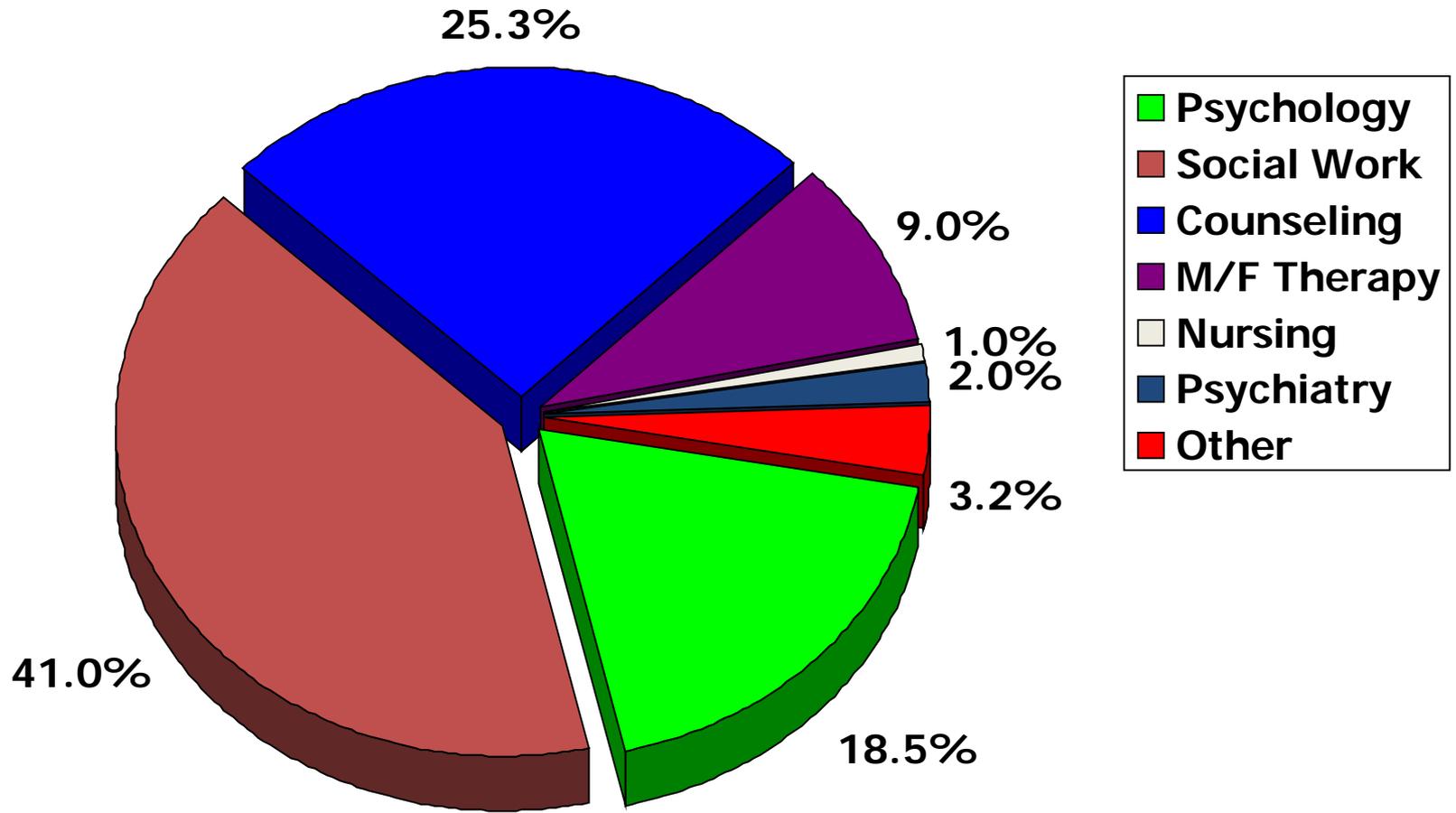
From October 1, 2005 to September 30, 2010:

- TF-CBT *Web* had **73,714** registered learners.
 - On average, **40.4** learners registered for TF-CBT *Web* each day.
- **6,482** (8.8%) learners lived outside the U.S.
 - 111 countries represented, Albania to Zimbabwe.
 - Most learners were from countries where English is prevalent.

Degrees of Learners



Learners' Professions



Clinical Experience





Registration/Completion



Learners	All	U.S. ¹	Outside U.S.
Registered	73,714	67,232	6,482
Completed (by 9/30/10)	34,742 (47.1%)	33,304 (49.5%)	1,438 (22.2%)

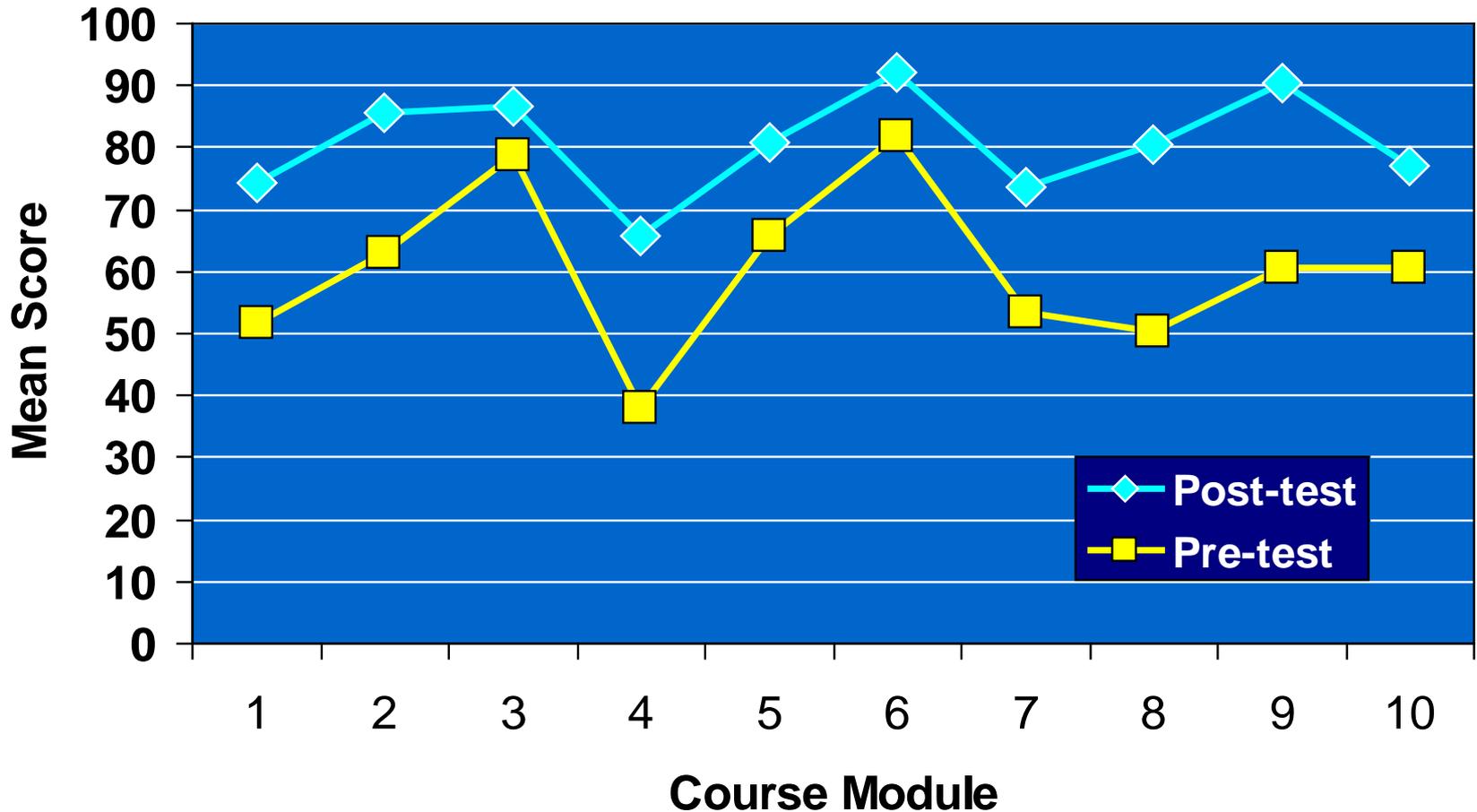
¹Includes learners living in the U.S. and U.S. military and Department of Defense employed personnel living outside the U.S.

Days to Complete

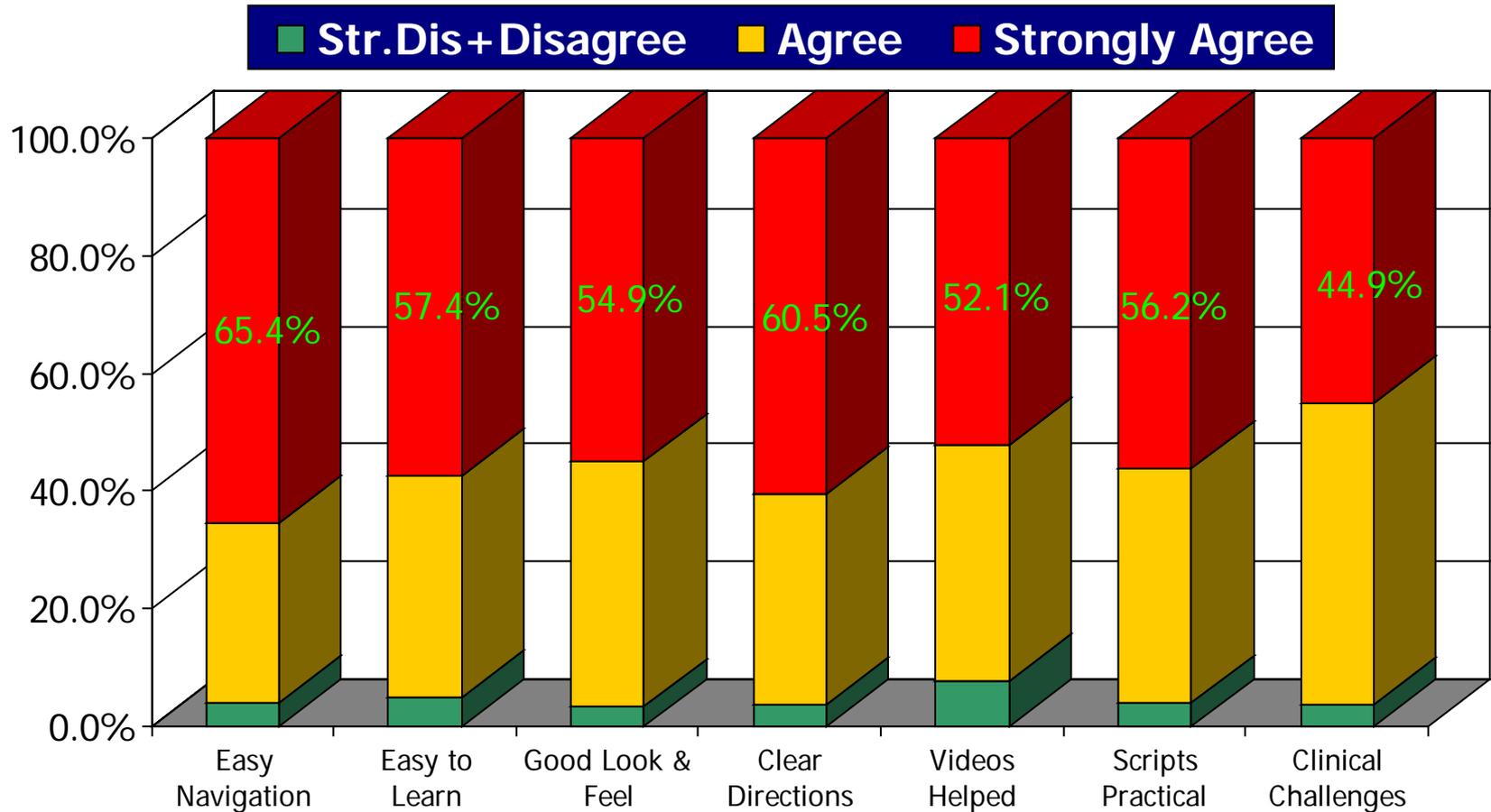


- Mean days to complete course = 67 days
- Longest number of days = 1,778 days
- Shortest number of days = 1
- 50% of completers finish within 13 days
- 75% of completers finish within 49 days

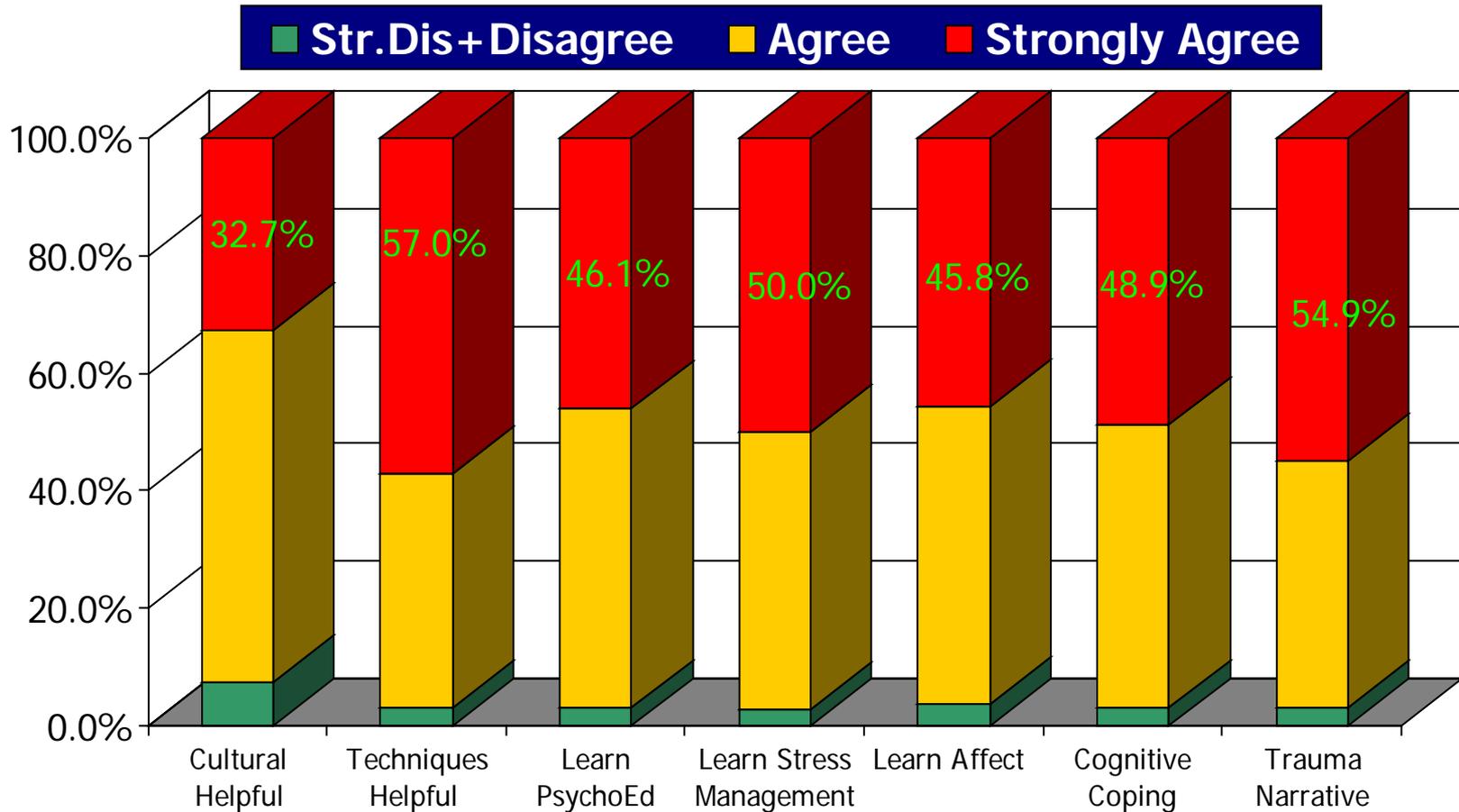
Pre/Post Knowledge



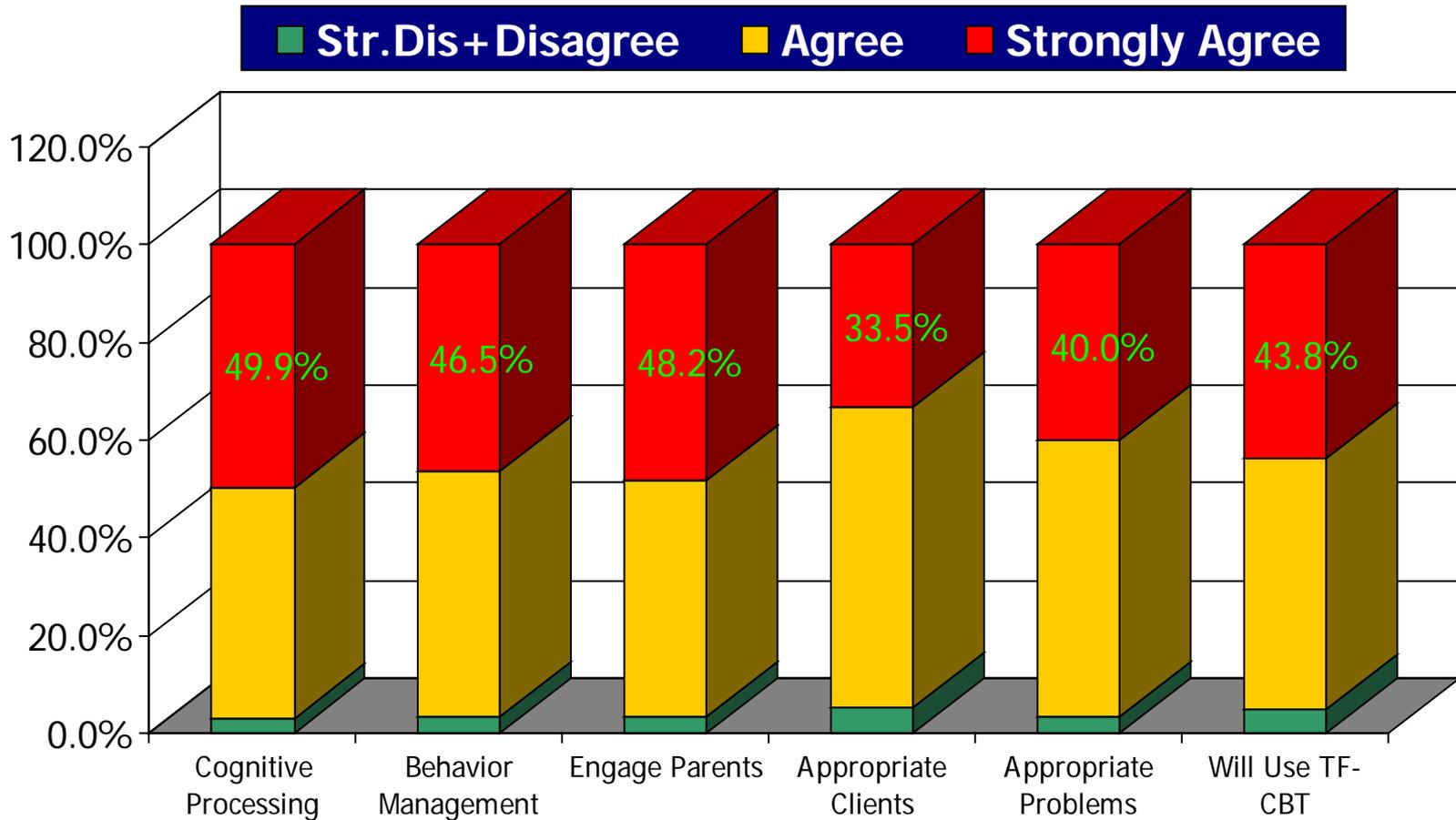
Learner Evaluation



Learner Evaluation



Learner Evaluation





Development of *PE-Web*



- Goal: Develop user friendly, but sophisticated web course for providers serving Veterans and other adults with PTSD
- Designed to be fully sustainable and accessible without cost to the learner
- Divided into 13 learning modules
- Addresses all of the major components of *Prolonged Exposure* treatment for PTSD



Development Process



- Expertise in PE (Drs. Foa, Eftekhari, Ruzek, and Rheingold)
- Video production (MUSC staff, UPenn existing videos)
- Actors (VA/MUSC faculty, staff; existing VA DVD training videos)
- Web design and platform development (MUSC)
- Content development
- Content entry
- Alpha and beta testing (faculty and staff at UPenn, Charleston, and Palo Alto sites)



Learning Modules



- Module 1: Basics
 - Structure of PTSD
 - Theoretical framework
 - Patient profiles
 - Who is a good PE candidate?
 - Case descriptions



Learning Modules



- Module 2: Assessment
 - Overview of Assessment for PE
 - Structured diagnostic interviews
 - Symptom scales
 - Special considerations
 - Within-session assessment (e.g., SUDS)

- Module 3: Treatment Components
 - Overview of major therapeutic components
 - Psychoeducation
 - In-vivo exposure
 - Imaginal exposure
 - Processing
 - Session logistics (e.g., audiotaping, structure/length of sessions, session agendas)



Learning Modules



- Module 4: Rationale & Trauma Interview
 - Program overview
 - PTSD symptoms
 - Information gathering (structured trauma interview)
 - Breathing retraining protocol



Learning Modules



- Module 5: Psychoeducation
 - Common reactions to potentially traumatic events
 - Relations between traumatic events and symptoms
 - Address common clinical challenges
 - Report of suicidality, etc.

- Module 6: In-Vivo Exposure
 - Rationale
 - SUDS
 - Constructu hierarchy
 - Homework
 - Trouble-shooting



Learning Modules



- Module 7: Imaginal Exposure
 - Rationale
 - Implementation
 - How to address multiple traumatic events
 - Trouble-shooting
 - Over-engagers
 - Under-engagers
 - Avoidance / safety-behavior
 - Homework



Learning Modules



-
- Module 8: Processing
 - Implmentation
 - Do's and Don'ts



Learning Modules



-
- Module 9: Hotspots
 - Identification
 - Implementation
 - Trouble-shooting (e.g., multiple hot spots)



Learning Modules



- Module 10: Homework
 - Rationale
 - Review
 - Troubleshooting



Learning Modules



-
- Module 11: Special Issues
 - Over-engagement
 - Under-engagement
 - Anger, Guilt, and Shame



Learning Modules



- Module 12: Special Populations
 - TBI
 - Substance use
 - MDD
 - MST
 - Axis II
 - Active duty service members



Learning Modules



- Module 13: Telehealth
 - Optional module with useful implementation and safety-related logistics

BASICS

A Strategy for Healing

Section 3: Module Overview

In this module you will learn about:

1. The history, course, and prevalence of PTSD
2. DSM-IV diagnostic criteria for PTSD
3. Common symptom trajectories following trauma exposure
4. How emotional processing theory applies to development, course, and treatment of PTSD symptoms
5. Research that challenges common misperceptions about Prolonged Exposure

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Section 7: Support for Prolonged Exposure

Empirical support for Prolonged Exposure

Dozens of clinical trials have found that Prolonged Exposure is a robust intervention that can be effectively disseminated to a variety of clinical settings and adapted to meet the needs of diverse patient populations with various comorbid conditions including major depressive disorder and substance use disorders.

Organizational Support for Prolonged Exposure

There is strong federal agency support for Prolonged Exposure. Clinical practice guidelines issued by the Veterans Health Administration (VHA) and Department of Defense (DoD) have identified Prolonged Exposure as one of four frontline psychotherapies for Veterans with PTSD. Further, the 2007 Institute of Medicine and NICE guidelines selected exposure therapy as the only PTSD treatment with sufficient evidence to support its use with Veterans for PTSD. In response to these strong endorsements, in 2007, VA launched a national initiative to disseminate Prolonged Exposure to clinical practice settings. As of May 31, 2010, VA has provided training in Prolonged Exposure to over 1,500 mental health staff.

Patient Support for Prolonged Exposure

Would it surprise you to learn that when presented with rationales for various PTSD treatments, most people say they would choose exposure therapy for a friend or relative with PTSD? In a survey assessing college students' acceptance of, and preference for, 14 different PTSD treatments, participants preferred exposure therapy to psychopharmacological treatments, EMDR, and supportive therapies for patients with PTSD even when told exposure therapy involved reliving upsetting memories and engaging in distressing situations. People seem to intuitively grasp the benefits of "talking about it." This is good news because it implies people understand the rationale for exposure therapy and they are often willing to endure the temporary distress that often comes with it.



ASSESSMENT

A Strategy for Healing

Section 6: Common Questions

Q: I would prefer to establish rapport first with my patients before asking them questions like the ones in a structured trauma history interview? Is this ok?

[Show/Hide Answer](#)

Some clinicians may be concerned that asking about distressing events during their first meeting can damage rapport and potentially reduce the likelihood that the patient will not return for the first session. In our experience, we have found that even very anxious/avoidant patients are relieved at the end of the pre-treatment assessment having had an opportunity to share an experience they have never shared before with anyone. Indeed, rather than serving as a potential deterrent to treatment, the pre-treatment assessment provides an opportunity to build rapport and establish the expectation that you will be discussing the trauma during therapy.

Q: When should I use self-report measures vs. diagnostic interviews?

[Show/Hide Answer](#)

Q: Are there co-morbid conditions where I should not use PE?

[Show/Hide Answer](#)

Q: When and how often should I give the within-in treatment self-report measures?

[Show/Hide Answer](#)

Q: My patient is subthreshold for PTSD diagnosis. Is he appropriate for PE?

[Show/Hide Answer](#)

Subthreshold PTSD is typically defined as meeting Criterion A, B, and either C or D. Recent studies suggest subthreshold PTSD is associated with significant emotional suffering, functional impairment, and even suicidality in Veteran populations. Thus, PE can be an appropriate treatment even when a patient does not meet the full diagnostic criteria for PTSD.

Q: Is it ok to have patients take measures home with them?

[Show/Hide Answer](#)

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PSYCHOEDUCATION

A Strategy for Healing

Section 2: Pre-test

1. The aims of psychoeducation include all of the following EXCEPT:

- Normalizing and validating your patient's experience of PTSD and secondary symptoms.
- Instilling hope that treatment will be effective and fostering your patient's expectancy for improvement.
- Discussing the benefits of medication treatments for PTSD
- Helping your patient make connections between the trauma and his PTSD symptoms.

2. All of the following include common reactions to trauma EXCEPT:

- Difficulty sleeping
- Feeling angry or irritable, lashing out at loved ones
- Excessive overeating
- Experiencing significant distress for about a month after the trauma before symptoms taper off naturally

3. When presenting common reactions to trauma (select ALL that apply):

- Probe for your patient's personal experiences and reactions
- Utilize informational handouts and brochures that talk about PTSD
- Spend one to two full sessions presenting current data on PTSD
- Use examples from your personal experience with trauma to illustrate key points

Continue



PSYCHOEDUCATION

A Strategy for Healing

Section 6: Provider FAQs (Common questions)

Below are common questions that providers have about presenting information about PTSD to patients.

1) ***The discussion of common reactions to traumatic events includes asking whether the patient is having thoughts that life may not be worth living. What should I do if my patient discloses suicidal ideation during this discussion?***

[Show/Hide Answer](#)

At any point over the course of treatment if your patient reports suicidal ideation, shift gears and conduct a suicide assessment. This assessment should be consistent with the standard operating procedures for suicide prevention at your organization. Please see the links in this module for information about suicide prevention in Veteran and active duty populations. Above all, the patient's safety is a priority. Thus, when patients present with a high risk of suicidal behavior, this should take precedence; Prolonged Exposure can be resumed after these symptoms have been assessed and treated.

2) ***My patient is endorsing symptoms that are not on the list of common reactions, and is attributing them to the trauma. How should I address this?***

[Show/Hide Answer](#)

First, don't contradict/disagree with the patient. It may be part of a comorbid set of symptoms or it may relate to one of the common reactions in unique ways. If it seems like something that is medically meaningful (e.g. significant headaches), consider referring to a medical doctor for evaluation. If this symptom is directly causing impairment, consider addressing it separately with a functional assessment—that is, by assessing antecedents, behaviors, and consequences that can possibly be addressed in treatment. If it is related to the traumatic event, it is likely that successful treatment will reduce this symptom.

3) ***My patient asked if he could bring his wife to session 2 so that she could learn more about common reactions to trauma and the PTSD diagnosis. Is this a good idea? In what other ways can I involve family members to facilitate my patient's treatment?***

[Show/Hide Answer](#)

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IN VIVO EXPOSURE

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Section 5: Introducing SUDs

Your patient will use subjective units of distress (SUDs) to rate his/her anxiety level during in vivo and imaginal exposure exercises. SUDs are numerical rankings used to indicate level of distress experienced at a particular moment during exposure. SUDs ratings range from 0 (no distress whatsoever, very relaxed) to 100 (highest possible distress). We advise having patients select SUDs ratings at intervals of 5 (e.g., 25, 65, 90).

SUDs are subjective—a rating of 100 for one person may equate to a 75 for someone else. Despite this limitation, SUDs ratings are helpful because they allow you to track changes in your patient's distress over time. SUDs ratings should be introduced as follows:

- First, select anchor points to help your patient figure out how to use the scale. Prompt your patient to generate example situations that elicit anxiety at 0, 25, 50, 75, and 100. Do NOT to generate anchor points that are directly related to the trauma. Your patient's distress associated with trauma cues should change over the course of treatment which could throw off the SUDs scale if anchors refer to these cues.
- Check your patient's understanding of SUDs asking questions such as, "How much discomfort do you feel right now as we are talking?"
- [Click here to view and print a script, "Introducing SUDs to your patient."](#)



Therapist Introduces SUDs (Military Sexual Trauma Case)

Continue



IN VIVO EXPOSURE

A Strategy for Healing

Section 6: Creating the Fear Hierarchy

After presenting the rationale for in vivo exposure and introducing SUDs, help your patient generate a list of activities he/she has avoided since the trauma because they trigger trauma-related fear or distress. An in vivo hierarchy is a graded list of situations and activities that your patient avoids because they trigger trauma-related fear. Your patient should rank activities based on the level of distress they generate—ranging from least distressing (0) to most distressing (100). Use the list of activities and fear hierarchy to guide selection of exposures for homework. Note that the hierarchy is always a work in progress. New activities and situations can be added to the list, and changes can be made throughout treatment.

Creating the fear hierarchy involves the following steps:

- 1. Have your patient generate a list of 15 to 20 feared and avoided situations and activities.**
- 2. Assign SUDs ratings.**
- 3. Ensure that activities selected for homework are feasible and accessible.**
- 4. Ensure that activities selected for homework are objectively quite safe.**
- 5. Instill confidence by identifying your patient's successful experiences with natural exposure.**

Continue to the next page for an in depth explanation of each step.

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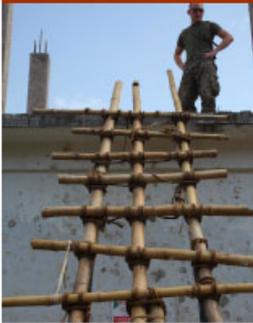
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IN VIVO EXPOSURE

A Strategy for Healing

Section 8: Common Questions

"My patient is having difficulty generating a list of 15 to 20 items for the fear hierarchy. How can I help him come up with ideas?"

[Show/Hide Answer](#)

"What do I do if my patient seems to avoid doing his in vivo homework?"

[Show/Hide Answer](#)

"How do I know my patient is actually completing the homework?"

[Show/Hide Answer](#)

"My patient regularly comes to session without his homework completed. How do I increase his adherence?"

[Show/Hide Answer](#)

"Last week my patient came to session and was very happy that he had completed his in vivo assignment. His assignment was to drive alone at night. Later during the session he confided that he had called his wife prior to getting in the car and that she remained on the line throughout the duration of the drive. Is this okay?"

[Show/Hide Answer](#)

"My patient says he is doing the in vivo exercises, but his SUDs levels are remaining the same. What should I do?"

[Show/Hide Answer](#)

"My patient refuses to do his in vivo assignments. Can I do it with him?"

[Show/Hide Answer](#)

"My patient describes almost everything as a SUDs of 100. How can I get him to use the full SUDs range?"

[Show/Hide Answer](#)

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IMAGINAL EXPOSURE

A Strategy for Healing

Section 5: Implementation of Imaginal Exposure

Approach to Imaginal Exposure

Imaginal exposure is designed to promote your patient's emotional engagement with the trauma memory by inviting her to talk about the trauma in her own words. Your role is to provide a safe, supportive, and empathetic presence as she revisits the painful memory. While you should probe for thoughts and feelings as necessary, in general, keep comments to a minimum.

After presenting the rationale, remind the patient that the trauma(s) identified during session 1 will be the focus of the imaginal exposure(s). Because patients are often anxious about revisiting the trauma, begin the exercise as quickly as possible after presenting the rationale, and the instructions. You should plan on having the patient remain engaged in the exposure for 45 minutes, leaving sufficient time at the end of session to process the experience (Processing is addressed in Module 8). If time allows, the patient may repeat the exposure several times over the course of the 45 minutes. The time required to complete the first imaginal exposure will vary depending on the patient's level of engagement, willingness to comply with the exercise, and length and complexity of the trauma. For example, avoidant patients or patients with relatively short trauma memories (i.e., as would be the case for a patient who lost consciousness shortly after an IED explosion) may complete the first imaginal exposure well-before the allotted time period and should be asked to repeat the same trauma memory as many times as the time allows. In contrast, patients with lengthy/complex trauma memories may require the entire time period to move through memory once. However, the goal of first exposure is simply for your patient to recount as much of the memory as possible, in as much detail as possible.

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Dr. Foa talks about the procedures for Imaginal Exposure.



PROCESSING

A Strategy for Healing

Section 4: Why We Do Processing

Processing involves a 15 to 20 minute interactive dialogue between you and your patient about her experience of doing imaginal exposure. You will process your patient's experience after every imaginal exposure exercise. During processing, help your patient "digest" the trauma by encouraging her to discuss reactions to revisiting the trauma, her thoughts, feelings, and beliefs related to the trauma memory and the trauma itself, and the role of the trauma in shaping her current beliefs and everyday behaviors.

You may be tempted to use formal cognitive restructuring when patients disclose unrealistic beliefs about their role in the trauma (e.g., "*I should have known that he was going to rape me*") or how dangerous they think the world is (e.g., "*It's completely unsafe to drive at night*"). But rather than using cognitive techniques, we want you to apply a broad, open-ended, interactive, and non-directive approach to elicit your patient's views and thoughts *in her own words*. In this way, processing provides a powerful opportunity for your patient to identify and modify unrealistic beliefs and expectations, develop new insights about herself and the world, and expand these new insights to everyday life.

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HOTSPOTS

A Strategy for Healing

Section 5: How to Conduct Hotspot Exposures

In this section, we review the procedures for imaginal exposure to hot spots. Continue to the next page to see a detailed description of each step.

1. ***Shift the focus of imaginal exposure to hotspots after your patient begins to experience symptom improvement and/or reductions in SUDs when recounting the entire trauma memory.***
2. ***Highlight your patient's progress.***
3. ***Summarize the procedure.***
4. ***Present a basic rationale.***
5. ***Apply the same approach.***
6. ***Start with the most distressing hot spot.***
7. ***Revisit the hot spot multiple times without pause during each session.***
8. ***Engage in repeated exposure to each hot spot until habituation occurs.***
9. ***After wearing out one hot spot, move to the next.***
10. ***Withhold processing until the end of session.***
11. ***Offer praise and encouragement.***
12. ***During final sessions, put the entire trauma memory back together.***
13. ***Assign listening to the hot spots audiorecording for homework.***

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SPECIAL ISSUES

A Strategy for Healing

Section 4: Addressing Over-engagement

Defining Over-engagement

It's normal for patients to show strong emotions during imaginal exposure-especially during the initial sessions. Generally speaking, these reactions will subside over time as your patient begins to habituate to the distressing feelings that occur when they are engaged with the trauma memory. However, sometimes patients have such a strong emotional reaction to imaginal exposure that they are unable to benefit from the exercise. Over-engagement refers to excessive, prolonged distress or dissociation triggered by imaginal exposure to the trauma memory.

Identifying Over-engagement

Over-engagement is fairly rare. Although most patients will become visibly distressed during imaginal exposure (e.g., crying, cracked voice), the vast majority do not over-engage. As a general rule of thumb, a patient is over-engaged with the trauma memory when they cannot regulate their emotions during the exercise; thus, their emotional state actually interferes with-rather than promotes-new learning. When trying to determine whether your patient is over-engaged, ask yourself these questions:

- Is your patient's emotional state conducive to learning or is it counterproductive? Can she learn that memories are not dangerous? Is she moving through the pain to the other side? Or is she stuck?
- Will your patient learn anything useful from repeatedly listening to an audiotape?



Dr. Foa defines under and over engagement

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Section 5: Co-morbid Substance Abuse

Prevalence

PTSD appears to increase risk of substance use disorders (SUDs). One-third to one half of people with PTSD will also develop an alcohol use disorder (AUD) and roughly one quarter of people with PTSD will develop a drug use problem. Prevalence of PTSD-SUD comorbidity in military samples varies depending on the demographic characteristics of the sample (e.g., theater) and on the specific SUD being assessed (e.g., alcohol or opioid use disorders). In 2008, 22% of VA users diagnosed with PTSD also received a current SUD diagnosis.

Approach

1. Select a treatment framework.
2. Screen for substance abuse/dependence at the pre-treatment assessment.
3. Explore possible relationship between PTSD symptoms and substance use.
4. Assess motivation for change.
5. Consult with an expert.

For a more detailed description of each step, continue to the next page.

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Section 7: Military Sexual Trauma

Prevalence

Men and women of the armed services report high rates of military sexual trauma (MST; threatening sexual harassment and/or sexual assault that occurs during active duty), a known risk factor for PTSD. The prevalence of MST varies considerably depending on how sexual trauma is defined and on the demographic characteristics of the population being surveyed. In a large-scale epidemiologic survey of VA healthcare users, about 20% of women and 1.1% of men reported they had experienced MST (either sexual harassment or sexual assault) at some point during military service; veterans with MST histories were over 5 times more likely to be diagnosed with PTSD than those without MST histories.

Approach

1. **Why not PE?** Veterans with MST-related PTSD are likely to be good candidates for Prolonged Exposure--an intervention that was initially developed for and evaluated with victims of sexual assault. In fact, the largest clinical trial of Prolonged Exposure to date evaluated the intervention with women Veterans with PTSD related to a variety of traumatic experiences including MST suggesting that Prolonged Exposure for MST-related PTSD is safe and effective.
2. **Facilitate referrals to Prolonged Exposure.** Educate clinicians at your facility the effectiveness of Prolonged Exposure for sexual trauma populations. At VA, all patients are screened routinely for MST and PTSD in primary care. Stop by the primary care clinic and introduce yourself. Ask for an opportunity to provide a brief, informal, in-service about Prolonged Exposure. Tell providers how they can refer patients to you. Attach your business card to copies of "Evidence-based Therapy for PTSD," a free brochure published by VA that describes PE and leave these in prominent areas throughout the primary care clinic.

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Poll

Where do you think this type of training approach would be most valuable in the training process?

1. Pre workshop
2. Post workshop
3. As a “refresher” course
4. As an ongoing resource that providers can refer to as needed

Next Steps



- DoD funded project on mobile Web applications for supervisors and providers
 - Web-based
 - iOS compatible
 - Android compatible
- Expected to be completed within about a year

Conclusions



-
- Engaging Web training courses can be developed for ESTs
 - Web training can effectively build knowledge of EST techniques
 - Free, modular training approaches are popular with mental health professionals.
 - Offering CE credit is critical.
 - Online training is a cost-effective
 - Online training is one way to improve the quality of mental health services