

Prolonged Exposure Therapy for Posttraumatic Stress Disorder

Q. What is prolonged exposure therapy?

A. Prolonged exposure (PE) is a short-term, trauma-focused cognitive behavioral therapy (CBT). PE typically consists of 12–15 sessions that last approximately 90 minutes each, and patients are encouraged to attend weekly appointments. PE allows patients to process traumatic events by repeatedly recounting the traumatic memories (*imaginal exposure*) until the memory loses the ability to intensely upset them. PE also focuses on the negative meanings patients may attribute to traumatic events about themselves, the world and other people. In PE, patients are also asked to approach reminders of the trauma in the environment in a systematic and graded manner (*in vivo exposure*). PE was rolled out nationally across the Department of Veterans Affairs (VA) beginning in 2008. The Center for Deployment Psychology offers training in PE.

Q. What is the treatment model underlying PE?

A. PE is rooted in both learning theory (Mowrer, 1960; Eysenck, 1976) and bioinformational conceptualizations of fear (Lang, 1977, 1979). Foa and Kozac (1986) proposed emotional processing theory (EPT) to describe how post-traumatic symptoms develop after a traumatic event and are maintained. During and after the traumatic event the individual associates a range of internal and external cues with the traumatic event and subsequently develops a fear “network” surrounding these associated stimuli. When any of these stimuli are experienced after the event, the survivor experiences increased distress and attempts to avoid the internal or external cues. This avoidance perpetuates the distress and underlies the PTSD symptoms. According to EPT, exposure treatment involves two mechanisms: (a) optimal activation of the fear network (typically through some form of exposure), and (b) engaging the patient with the avoided stimuli (including the traumatic memory) in a safe environment to disconfirm pathological elements of the fear network.

Q. Is PE recommended in the Military Health System (MHS)?

A. **Yes.** The 2010 VA/DoD *Clinical Practice Guideline for the Management of Post-traumatic Stress* gives the highest strength of recommendation (A) for PE. PE has met the burden of evidence required by the most recent VA/DoD publications and is recommended as a first-line treatment.

The MHS relies on VA/DoD clinical practice guidelines (CPGs) to inform best clinical practices. The CPGs are developed under the purview of clinical experts and are derived through a transparent and systematic approach that includes, but is not limited to, systematic reviews of the literature on a given topic and development of recommendations using a graded system that takes into account the overall quality of the evidence and the magnitude of the net benefit of the recommendation. A further description of this process and CPGs on specific topics can be found on the VA clinical practice guidelines website.

Q. Do other authoritative reviews recommend PE for PTSD?

A. **Yes.** Other authoritative reviews recommend the use of PE for PTSD.

Several recognized organizations conduct systematic reviews and evidence syntheses on psychological health topics using similar grading systems as the VA/DoD CPGs. These include the Agency for Healthcare Research and Quality (AHRQ) Systematic Review Repository and the Cochrane Database of Systematic Reviews.

- AHRQ: A 2013 AHRQ comparative effectiveness review found PE to be the only psychological treatment with a high strength of evidence for improving PTSD symptoms.
- Cochrane: A 2013 systematic review (Bisson et al.) supports the efficacy of individual and group trauma-focused CBT. The review does not differentiate between different types of trauma-focused CBT.

Q. What conclusions can be drawn about the use of PE as a treatment for PTSD in the MHS?

A. PE is recommended as a front-line treatment for PTSD. Clinicians should consider several factors when choosing an evidence-based treatment for their patient. Treatment decisions should incorporate clinical judgment and expertise, patient characteristics and treatment history, and patient preferences that might influence treatment engagement and retention.

**Find the full series of Psych Health Evidence Briefs and subscribe to receive future briefs at <http://www.pdhealth.mil/research/evidence-synthesis/evidence-briefs>.*

References

Bisson, J., Roberts, N. P., Andrew, M., Cooper, R., & Lewis, C. (2013). Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. *Cochrane Database Syst Rev*, 12.

Department of Veterans Affairs/Department of Defense. (2010). VA/DoD clinical practice guideline for management of post-traumatic stress. Version 2.0. Washington (DC): Department of Veterans Affairs/Department of Defense.

Eysenck, H. J. (1976). The learning theory model of neurosis: A new approach. *Behaviour Research and Therapy*, 14, 251–267.

Foa, E. B. & Kozak, M. J. (1986). Emotional processing of fear: exposure to corrective information. *Psychological bulletin*, 99(1), 20.

Jonas, D. E., Cusack, K., Forneris, C. A., Wilkins, T. M., Sonis, J., Middleton, J. C., Gaynes, B. N. (2013). Psychological and Pharmacological Treatments for Adults With Posttraumatic Stress Disorder (PTSD). Comparative Effectiveness Review No. 92 (AHRQ Publication No. 13-EHC011-EF). Rockville, MD: Agency for Healthcare Research and Quality.

Lang, P. J. (1977). Imagery in therapy: An information processing analysis of fear. *Behavior Therapy*, 8, 862–886.

Lang, P. J. (1979). A bio-informational theory of emotional imagery. *Psychophysiology*, 16, 495–512.

Mowrer, O. H. (1960). *Learning theory and behavior*. New York: Wiley.

