Emory University
Prolonged Exposure Consultant Training Program

Supplemental Materials

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Online Resources

CDP PE Metaphors:

- https://deploymentpsychology.adobeconnect.com/_a1091106028/pemetaphorbank/

CPE PE Videos:

- https://deploymentpsych.org/pe_video-gallery

MUSC PE-Web:

- http://pe.musc.edu/

NBC Dateline Video:

- https://www.youtube.com/watch?v=ViOlBfFu9qk

NC-PTSD "About Face" (Patient stories about PTSD treatment including PE)

- https://www.ptsd.va.gov/apps/aboutface/

NC-PTSD Clinician's Trauma Update Online:

- https://www.ptsd.va.gov/professional/publications/ctu-online.asp

NC-PTSD Continuing Education Courses (including CAPS-5 training):

- https://www.ptsd.va.gov/professional/continuing_ed/index.asp

Dr. Peter Tuerk's PE Training Videos on YouTube:

- https://www.youtube.com/watch?v=YZbJZMmoLwU&list=PL0Phhv0c-pWbkXxpL5aQ604H6IKm30i16

Processing Transcript (Index: Child Combatant Casualty)

Therapist: “Is this a good time to end the imaginal exposure?”

Patient: “Yes. My distress level is now like a 60 out of 100.”

Therapist: “How was it today?”

Patient: “Rough, as usual. Really rough. Easier than the first couple two times, but rough.”

Therapist: “What stood out as important today?”

Patient: “The kid’s demeanor.”

Therapist: “You mentioned today that you saw the boy hold the gun awkwardly. What does that mean?”

Patient: “Yeah, like he never used it before and was afraid of it.”

Therapist: “Show me how he was holding the gun.”

Patient: “Like this – with his arms stretched out and his head turned away – like holding a snake.”

Therapist: “Seems like the image of him is getting quite clear. And you said he was firing it in your direction?”

Patient: “Yeah. But like I said, he wasn’t using a scope. I doubt he hit anywhere near us.”

Therapist: “He didn’t hit anywhere near you guys?”

Patient: “I mean, I really don’t know.”

Therapist: “Well, what do you know for sure?”

Patient: “I’m positive he was firing his weapon. That part is clear as day each time we go through the memory.”

Therapist: “That’s true. With each iteration, you mention his sporadic firing. Tell me again what you were thinking as you saw him awkwardly fire his gun.”

Patient: “I thought we needed to stop him.”

Therapist: “Why?”

Patient: “Because it doesn’t matter who is pulling the trigger. Our rules of engagement are to fire back. It didn’t matter if the kid was untrained or doing that against his will. He could have been awkward or totally confident. It didn’t matter.”

Therapist: “What mattered?”

Patient: “Protecting my guys. We were ambushed and there is no way I was going to let them down. In that moment, I turned into a machine. I had to pretend he was an adult. I had to not see his fear. He was holding the AK-47 like a damn snake and I had to believe he was Rambo.”

Therapist: “Let’s go back to what you said during the imaginal exposure. When you revisit the memory, it seems like you didn’t ignore the boy. It seems like you were fully aware that he wasn’t an adult. You describe his beardless face and short stature.”

Patient: “I was fully aware! It was a damn child in a firefight. I was furious the second I saw him!”

Therapist: “I understand you were upset. But, when you revisited the memory, you also mentioned another emotion.”

Patient: “I was scared obviously!” [Volume of voice increases.]

Therapist: “What does that say about you?”

Patient: “I think parents need to protect kids, not throw them out there to fight your fights. Children have no place in war, at all. This is the purest form of evil.”

Therapist: “Tell me how being furious and scared affected your performance.”

Patient: “It didn’t. They wanted to mess with our heads but I knew exactly what my priority was.”

Therapist: “What was your priority?”

Patient: “To protect my guys.” [Volume of voice decreases.]

Therapist: “Tell me about that.” [Matches quieter voice.]

Patient: “Because we got each other’s back. They were my brothers. I would die for them. I would have literally died for them. Civilians don’t understand that kind of connection. They only thing that mattered was bringing everybody home safe.”

Therapist: “Is that something a machine would say?”

Patient: “No.”

Therapist: “During the imaginal exposure, you said you hesitated before pulling the trigger.”

Patient: “I knew it was my only choice. I didn’t want to do it. I fought against my instinct. But I had to do what I had to do.”

Therapist: “It was your only choice and you did not want to do it.”

Patient: “But I was able to it. And I did it exactly how I was trained to do it. It only took one shot.”

Therapist: “And tell me again what you thought immediately after that shot.”

Patient: “Are my guys still safe?”

Therapist: “What does that say about you?”

Patient: “I always had their safety in mind.” [Sobbing starts.]

Therapist: [Keeps quiet.]

Patient: “I did my job.”

Therapist: “You did your job. Did you expect this would be part of the job?”

Patient: “Not in a million years. I wasn’t prepared for it.”

Therapist: “Tell me about how you would prepare for it?”

Patient: “You can’t. You either rise to the occasion or you don’t.”

Therapist: “Can we say that you rose to the occasion?”

Patient: “Yes. It was my call, my shot. I would do it again.”

Prolonged Exposure Consultation Agreement

Trainee Background

1. Name:
2. Email:
3. Clinic/Setting:
4. Highest Degree:
5. Professional Discipline:
6. Status of License (State):
7. What percent of time you do you currently spend providing psychotherapy (vs. other activities like case management)?
8. What percent of time do you currently spend treating clients with PTSD?
9. Describe the primary theoretical orientation(s) you use in psychotherapy:
10. Have you completed any didactics in PE? If so, describe:
11. Have you ever used PE? If so, describe:
12. What issues or concerns may prevent you from using PE with your clients?

Trainee Expectations

Trainees must:

1. Must see patients at least once per week for 8 to 16 weeks using 90-minute sessions.
2. Must complete two PE cases within six-month window.
3. Must audio- or video-record all PE sessions.
4. Must transfer/mail recordings to consultant-in-training (Emory may be able to assist).
5. Must meet with consultant-in-training at least 30 minutes per week (day/time TBD).
6. Must attend and contribute to weekly trainee conference calls (day/time TBD).

Trainee Agreements

Please acknowledge the following:

1. I am certified or licensed by a state as a mental health provider, or am working as a trainee under a licensed mental health provider. (Initials: _____)
2. I understand that my relationships with my consultant and the consultant trainers at Emory University are consultative in nature and should not be viewed as clinical supervision and therefore my consultant and the consultant trainees are not legally responsible for my conduct or the well-being of my patients. (Initials: _____)
3. I will attend a PE didactic workshop or online training in its entirety and participate in all discussions and role plays. (Initials: _____)
4. I have discussed the consultation group expectations with my supervisor, if applicable, and both he/she and I fully understand the expectations and time requirements. (Initials: _____)
5. I will begin to identify clients appropriate for PE several weeks prior to consultation. I will inform my clinic that I am seeking PE referrals and request staff assistance in identifying clients with whom I could use PE. (Initials: _____)
6. I will attend and actively participate in 75% of the weekly one-hour group consultation calls in the 6-month period and 30 minute weekly individual calls. I am aware that weekly consultation is expected regardless of active cases. (Initials: _____)
7. I will provide audio- or visual-recordings of all sessions for my consultant to review. (Initials: _____)
8. Since consultation calls will take place using password-protected conference calls offered by freeconferencecall.com. I agree to use this platform and will seek technical assistance from my organization as needed. (Initials: _____)
9. I will complete a full course of PE treatment with at least two clients during the 6-month period of this training program. (Initials: _____)
10. If I complete two cases before completing the required number of consultation calls during this training program, I will continue attending the weekly calls until the required number has been completed. (Initials: _____)
11. Before starting to use PE with clients, I will inform them that I am receiving consultation from a PE consultant-in-training on a regular basis for training purposes. (Initials: _____)
12. I understand that I am legally and ethically responsible for all decisions that I make concerning the care of clients I am treating during my participation in this consultation process. Any decisions about beginning or discontinuing the PE will be made by me (and my supervisor if I am a trainee) in collaboration with my clients in order to address their most pressing needs. (Initials: _____)

If selected for consultation, I agree to abide by the terms and guidelines of the PE consultation program and understand that if I don't adhere to them, I can be removed from the consultation group.

_____ _____

Trainee Signature Date

I hereby authorize and support the above-named clinician/trainee to participate fully in the PE consultation processes as outlined in the terms above if he/she is accepted to the program. I understand that it is my responsibility to set trainees up for success through various accommodations, including but not limited to allowing 90 minute sessions, allowing sessions once or twice per week, and prioritizing PTSD case assignments to trainees.

_____ _____

Clinic Director Signature Date

_____

Clinic Director Name (Print)

Measures of Effective Attributes of Trainers (Boyd et al., 2017)

Please rate your consultant as accurately as possible along each of the characteristics listed. Choose the number indicating the extend to which that characteristic describes your consultants using the scale below.

1	2	3	4	5
Very slightly / not at all	*A little*	*Moderately*	*Quite a bit*	*Extremely*

Attribute	Score		Attribute	Score
Experienced			Supportive	
Likeable			Approachable	
Sociable			Accessible	
Friendly			Knowledgeable	
Entertaining			Motivational	
Prepared			Expert	
Skillful			Humorous	
Caring			Flexible	
Open to criticism			Considerate	
Warm			Professional	
Passionate			Humble	
Trustworthy			Intelligent	
Respectful			Patient	
Able to Listen			Empathetic	
Enthusiastic			Intellectually stimulating	
Engaging			Communicates effectively	
Organized				

Therapists Beliefs About Exposure Scale (Deacon et al., 2013)					
	Disagree Strongly	**Disagree**	**Unsure**	**Agree**	**Agree Strongly**
1. Most clients have difficulty tolerating the distress exposure therapy evokes.	0	1	2	3	4
2. Exposure therapy addresses the superficial symptoms of an anxiety disorder but does not target their root cause.	0	1	2	3	4
3. Exposure therapy works poorly for complex cases, such as when the client has multiple diagnoses.	0	1	2	3	4
4. Compared to other psychotherapies, exposure therapy leads to higher dropout rates.	0	1	2	3	4
5. Conducting exposure therapy sessions outside the office increases the risk of an unethical dual relationship with the client.	0	1	2	3	4
6. Exposure therapy is difficult to tailor to the needs of individual clients.	0	1	2	3	4
7. Compared to other psychotherapies, exposure therapy is associated with a less strong therapeutic relationship.	0	1	2	3	4
8. Asking the client to discuss traumatic memories in exposure therapy may retraumatize the client.	0	1	2	3	4
9. It is unethical for therapists to purposely evoke distress in their clients.	0	1	2	3	4
10. Clients are at risk of decompensating (i.e., losing mental and/or behavioral control) during highly anxiety-provoking exposure therapy sessions.	0	1	2	3	4

11. Conducting exposure therapy sessions outside the office endangers the client's confidentiality.	0	1	2	3	4
12. Arousal reduction strategies, such as relaxation or controlled breathing, are often necessary for clients to tolerate the distress exposure therapy evokes.	0	1	2	3	4
13. Compared to other psychotherapies, exposure therapy places clients at a greater risk of harm.	0	1	2	3	4
14. Most clients perceive exposure therapy to be unacceptably aversive.	0	1	2	3	4
15. Exposure therapy often causes clients' anxiety symptoms to worsen.	0	1	2	3	4
16. Asking the client to discuss traumatic memories in exposure therapy may vicariously traumatize the therapist.	0	1	2	3	4
17. Clients may experience physical harm caused by their own anxiety (e.g., loss of consciousness) during highly anxiety-provoking exposure therapy sessions.	0	1	2	3	4
18. Having clients conduct exposures in their imagination is sufficient; facing feared stimuli in the real world is rarely necessary.	0	1	2	3	4
19. Exposure therapy is inhumane.	0	1	2	3	4
20. Most clients refuse to participate in exposure therapy.	0	1	2	3	4
21. Compared to other psychotherapies, exposure therapy increases the risk that the therapist will be sued for malpractice.	0	1	2	3	4

Case Presentation Form

Structure of the Presentation
Step 1. Trainee presents the case for 5-10 minutes
Step 2. Consultant consults with trainee for 5-10 minutes
Step 3. Other consultants on the call can weigh in for 5 minutes
Step 4. Emory team weighs in for 5 minutes
Step 5. Repeat with second trainee

Case Description (i.e., demographics and relevant history)

Brief Description of Index Trauma

In Vivo Targets (include information on safety behaviors and SUDs ratings)

Clinical Issue to Discuss

Common Pitfall in PE Delivery and Corresponding Consultation Strategies

Under the heading of each major component of PE is a list of common trainee pitfalls. Listed below each pitfall is one recommended consultation strategy to correct pitfalls. These consultation strategies are not exhaustive and will not apply to every occurrence of a given pitfall. Therefore, consultants-in-training should not view these strategies as a troubleshooting guide but ideas to stimulate the formulation of new strategies individualized for each trainee.

1. Skill #3B: Psychoeducation (PTSD, PE Rationale, SUDs, Common Reactions, Breathing Retraining):
    - Pitfall: Trainee does not seem to remember critical components of psychoeducation.
        - Strategy: Emphasize that memorization is key to skillfully providing psychoeducation. Have trainees make their own checklists outlining the required components of PE psychoeducation and commit this to memory.
    - Pitfall: Trainee rushes through items like a "to-do list" or uses an instructional tone.
        - Strategy: Role-play psychoeducation with and without the manual in the trainee's lap and help them identify what works the best for them in order to facilitate a two-way discussion that helps a) individualize treatment, b) instill hope, and c) build a therapeutic relationship. Identify when psychoeducation becomes a lecture or soliloquy and remind trainee to use basic therapy skills (e.g., active listening) to make it a conversation. Prompt feedback should be provided to trainee after reviewing session recordings. It is common for trainees to sound robotic or instructional when first getting used to providing psychoeducation. Having your trainee listen back to their session can help recognize where improvement is needed.
    - Pitfall: Trainee does not spend enough time with practicing breathing retraining in session.
        - Strategy: Role-play the proper duration with trainee as the patient, taking the patient through 10 to 15 breaths and fading out instructions while patient continues to practice. Explore how trainee experienced the exercise and discuss its clinical utility.
    - Pitfall: Trainee frames breathing retraining as a safety behavior.
        - Strategy: Ask trainee to review emotional processing theory and whether or not breathing retraining facilitates extinction.
    - Pitfall: Trainee does not do breathing retraining, citing that "it is not an active ingredient of PE."
        - Strategy: Ask trainee to describe its potential benefits, even if not an active ingredient. Next, ask trainee if the current patient could have achieved those benefits. At very least, consultants should remember that breathing retraining is useful to see if a) patients are compliant and b)

trainees are compliant. In both cases, noncompliance needs to be addressed immediately.

2. Skill #3C: In Vivo Exposure
    - Pitfall: Trainee experiences significant pushback from patient on initial in-vivo task and will not assign "easier" tasks.
        - Strategy: Remind trainee that mastery experiences early in treatment help increase engagement and that it is more important to complete imperfect in-vivo exercises than bypass all in-vivo exercises. When there is significant pushback from patients, tell trainee that "the best exposure is the one the patient is willing to do." Take the in-vivo apart or titrate it down to something the patient agrees to practice. Trainee must ask about how it went as soon as the patient sits down in the following session. This helps emphasize its importance.
    - Pitfall: Trainee assigns an in-vivo assignment that is actually dangerous.
        - Strategy: Ask trainee to describe the assignment in terms of conditioned stimuli and unconditioned stimuli and what the patient will learn. After trainee notices his or her error, ask how the assignment might be restructured. If it really is potentially dangerous, it may be necessary to ask trainee to call the patient between sessions and recommend another exposure.
    - Pitfall: Trainee assigns in-vivo task involving trauma reminder and sexual behavior but does not describe what the patient needs to learn. For example, trainee recommends sexual assault victim kiss and embrace a trusted romantic partner who happens to remind the patient of past perpetrator, though does not articulate the exact purpose.
        - Strategy: Tell trainee that all exposures need to have clearly articulated goals and the patient must fully agree with the task and its goals. In-vivos involving sexual behavior can be challenging because they can combine extinction processes with automatic reinforcement processes. In this example, it is unclear to the patient if she needs to learn that she can tolerate discomfort, that discomfort will diminish, or that pleasure will somehow override discomfort. In-vivos involving sexual behavior can often be broken down to specific targets with specific goals. It may be, for example, that the patient needs to learn that discomfort with reminders (e.g., similarly looking men) will diminish and to accomplish this goal kissing and embracing is not needed (e.g., looking at pictures of other similarly looking men). It ALWAYS must be consensual and the patient must always be in charge of their own sexual behavior.
    - Pitfall: Trainee does not detect a safety behavior.
        - Strategy: Validate that the current PE manual does not thoroughly describe safety behaviors, despite its critical importance. Provide education regarding safety behaviors. Encourage trainee to assign the same task without the safety behavior, to note differences, and to make adjustments, noting what the patient will learn from the exposure exercise with and without the safety behavior.

- Pitfall: Trainee does not assign a sufficient number of in-vivo tasks due to worry that they are assigning "too much.
    - Strategy: Remind trainee that all assignments should ultimately relate to patients' getting their lives and freedom back, so what feels like work now will eventually feel like valued living. The best exposure exercises are doing things that the patient wants to be doing regularly.

3. Skill #3D: Imaginal Exposure
    - Pitfall: Trainee does not present as confident when talking about imaginal exposure and communicates that it will be difficult.
        - Strategy: Increase trainee's awareness of sending the message that the patient cannot handle his or her memory. Trainee must believe the patient can actually handle all exposures. If trainee seems fearful of the task, validate the discomfort and help trainee notice if the discomfort is making the rationale delivery unconvincing, and note the parallel process. Role-play rationale delivery until trainee communicates with confidence that the task is not dangerous and the patient can handle the imaginal exposure. If trainee is unable to express confidence after role-playing and considering the empirical literature and consultant anecdotes, ask trainee to "act as if he or she were confident." Trainees are often able to "fake it until they make it" with respect to exhibiting confidence. Acknowledge that trainee does not have the experience to base this on, but they can borrow from our experience. The patient already lived through the trauma; they can talk about it even if it is very distressing.
    - Pitfall: Trainee experiences significant pushback on first imaginal exposure and postpones the task for a future session.
        - Strategy: Ask trainee to report what the patient has learned from the postponement. Instruct trainee to negotiate short-term titration strategies with the patient: writing the narrative, opening eyes, using the past tense, and relying on clinician prompts to continue the narrative. Tell the trainee to avoid using the "second worst event" when the patient is rigidly refusing to work on most distressing memory.
    - Pitfall: Trainee and the patient use jargon, euphemisms, and "sterile" words and phrases that reflect avoidance during exposure.
        - Strategy: Instruct trainee to follow the lead of the patient's vocabulary unless words reflect avoidance. Help trainee notice when clinical terms are used to feed trainee's avoidance or the patient's avoidance. Remind trainee that words are just words and that taking the power away from words in particular contexts is important. The consultant should model saying the words in questions repeatedly.
    - Pitfall: Trainee delays or weakens exposure because the patient reports somatic complaints before or during imaginal (e.g., not closing eyes because it might aggravate headache).
        - Strategy: Remind trainee that it is not uncommon to have somatic experiences in the course of imaginal exposure. These complaints are likely avoidance or a manifestation of the patient's distress or could be

body memories of what was experienced at the time of the trauma. In any case, help trainee use emotional processing therapy to understand that the emergence of somatic complaints is an opportunity for new learning as long as a robust exposure is completed.

- Pitfall: Trainee has difficulty helping the patient get engaged and activated in imaginal exposure.
    - Strategy: Role-play with trainee as clinician giving prompts for sensory details and using reinforcing comments. When playing the role of the patient, consultants should reward appropriate prompts and comments with increased engagement.
- Pitfall: Trainee provides too much reassurance to the patient.
    - Strategy: Ask trainee to describe his or her understanding of safety behaviors and the role of the clinician during imaginal exposure. Validate trainee's impulse to provide support and frame these actions as "providing new safety behaviors." Subsequently monitor and provide feedback.
- Pitfall: Trainee does not limit the patient editorializing and occasionally asks questions that seem to promote editorializing.
    - Strategy: Model and role-play imaginal prompts. When playing the role of the patient, consultants should provide many examples of the leaving the present tense and editorializing. Feedback should be provided on each redirection or omission thereof. As role-playing while simultaneously taking notes is difficult, consultants should either use short role-plays or audio-record role-plays with trainee and subsequently review together.
- Pitfall: Trainee allows or encourages patient to talk too much before the imaginal exposure and between repetitions of the narrative during imaginal exposure.
    - Strategy: Remind trainee that the main goal is to get the exposure going quickly and then get out of the patient's way while they are engaging in it. Instruct trainee to save talking for the processing.
- Pitfall: Trainee does not know when to switch to hot spots.
    - Strategy: Ask trainee to describe the function of hot spots and if the patient will benefit from that function. Instruct the trainee that when in doubt, switch after two sessions focused on the full memory.
- Pitfall: Trainee does not facilitate the same start and end points from session to session.
    - Strategy: Remind trainee why start and stop points of a memory need to be clearly anchored. Inform trainee that it is common during hot spots for trainees to experience "hot spot drift" when they do not feel comfortable holding the patient to the most difficult parts. Ask trainee to describe the function of hot spots and the learning implications for drifting away from the hot spot.
- Pitfall: Trainee seems to suggest elements of memory.
    - Strategy: Remind trainee that they do not know what happened and that patients can be very suggestible. Instruct trainee to almost only use open-ended prompts. When the patient cannot recall an element, instruct trainee to ask them to recall what they can and then take time to elaborate.

Remind trainee that the purpose of imaginal exposure is not to recover memories – though sometimes forgotten details emerge and help the patient make new meaning. Tell trainee that if the memory truly is not there, its absence should be discussed during processing not as a problem but something to better understand and accept.

- Pitfall: Trainee allows patient to gloss over highly aversive details of memory.
    - Strategy: Tell trainee that "whatever is bypassed during exposure will continue to be re-experienced." This framing places responsibility on trainee to be thorough. Instruct trainee to use the prompt "what else?" or "what haven't you told me?" when unclear if all important details were described.
- Pitfall: Trainee is disheartened due to lack of fear extinction.
    - Strategy: Remind trainee that extinction is not the only target and ask trainee to identify other gains being made (e.g., increased distress tolerance, increased confidence, reduced self-blame, progress in in-vivos, etc.). Ask trainee to consider how celebrating current gains could help motivate patient for additional gains.

4. Skill #3E: Processing
    - Pitfall: Trainee reports the manual's processing instructions are too vague.
        - Strategy: Validate that processing is often the most difficult component for trainees to learn while underscoring that processing, much like exposure, is guided by emotional processing theory. Many trainees benefit from the modelling of nondirective reflection to help develop new perspectives of the index trauma, what happened as a result of the trauma, and the patient's ability to handle stress. Trainees may also benefit from a close reading of processing transcripts, such as the one provided in Section 3 of this manual. Remind the trainee that processing is intended to make the learning that is occurring in the exposure explicit.
    - Pitfall: Trainee struggles with being nondirective and letting the patient lead processing. Rather, trainee provides feedback or reactions that interfere with the patient's exploration of imaginal exposure and its meaning.
        - Strategy: If processing is not natural for trainee, he or she may need over-correction during role-plays. Encourage trainee to "pull back" during processing and, when he or she wants to reflect, to "pull back" again. Encourage trainee to use silence and inhibit any reassuring gestures. Instruct trainee to think about the function of each reflection before giving each reflection. If trainee can limit reflections to just a handful, each reflection can be examined between the trainee and consultant. Remind trainee it is more important what the patient noticed than what trainee noticed.
    - Pitfall: Trainee provides only close-ended questions.
        - Strategy: Provide trainee with the following universal open-ended responses to practice in each role-play:
            1. Immediately after imaginal exposure:
                a. "How was that?"

b. "What was different or new?"
c. "What stood out as important?"

2. Ask directly about self-concept:
   a. "What does that mean about you then?"
   b. "What does that mean about you now?"

- Pitfall: Trainee is quick to correct or challenge negative self-judgments.
  - Strategy: Ask trainee if the urgency to correct negative self-judgment is a function of trainee's avoidance of discomfort. Remind trainee that processing is a "lite" version of cognitive therapy and that cognitive restructuring is not being taught as a skill. Use of reflection is preferred to more directive challenge. Instruct trainee to reinforce patients' efforts to be candid and unrestrained, especially with regard to negative self-judgments. It is important to first elucidate baseline perspectives before exploring new perspectives. Remind trainee it is important to not do too much work for the patient. The patient will remember better what he or she thought of than what the therapist told him or her.
- Pitfall: Trainee reassures patient immediately after imaginal exposure.
  - Strategy: Ask trainee if the urgency to reassure is a function of the trainee's avoidance of discomfort. Inform trainee that, compared to imaginal exposure, processing can occasionally be more emotionally evocative. Instruct trainee that after patients come out of the memory and open their eyes, the clinician's job is to not provide reassurance but rather keep a window of vulnerability open to make perspectives flexible and open to change. Instruct trainee to not "correct" painful thoughts and emotions but rather draw them out to be examined by the patient. A part of this process may include simply being present with the patient as he or she feels that emotion without necessarily doing anything to reduce or end the emotion. Remind trainee that new learning in PE is built upon the problematic learning that is distressing the patient and interfering with functioning. Part of this problematic learning is that feeling strong emotions will result in bad outcomes (going crazy, never being able to move on, etc.).
- Pitfall: Trainee is disheartened after patient leaves session feeling little or no relief from ex-experiencing.
  - Strategy: Remind trainee that he or she is aiming to help the patient first learn that he or she can handle the distress – the patient may feel very accomplished and proud of taking an important step toward improvement. Any approach toward the trauma memory is a success and the therapist should confidently project this to the patient. Remind trainee that if it worked in "X" number of sessions, then that's what we would have designed the protocol to include. It takes more than that and is a process.
- Pitfall: Trainee is trying to discover the "magical cognition" that will "set the patient free."
  - Strategy: Tell trainee that "no clinician is credentialed to process another person's memory." Remind trainee that arriving at new perspectives is a personal achievement that takes time. Remind trainee that if it were easy

to see the event in a different way, the patient would have done it themselves long ago. Role-playing is particularly helpful to learn how to set up a context for patients to view what happened differently. It does not matter how trainee sees the event – it only matters how the patient views it.

- Pitfall: Trainee seems to aimlessly ask questions and provide reflections with no obvious function.
    - Strategy: Feedback to view processing as "cognitive therapy lite" is often taken to the opposite extreme: a nondirective and unproductive chat. Trainees need to follow the patient to find what is most helpful for them. The guide here is typically whether exploring this thought or experience is going to help the patient feel more able to handle negative affect. If it probably will, then continue exploring with processing. If it does not seem to lead to increased sense of ability to handle negative affect then move to a new processing target. If trainee appears lost with identifying processing targets, ask him or her to develop at least two hypotheses about perspective shifts and new learning that might benefit the patient. Next, ask trainee how he or she may use exposure and processing to examine these hypotheses. It is important that trainee frames hypotheses as tentative and not urgent because actively "testing" hypotheses can interfere with other unanticipated insights. Insights are often impossible for the clinician to predict – remember, trainees need to follow the patient.
- Pitfall: Trainee constructs good hypotheses but does not use the hypotheses to guide reflection choices (e.g., "You mentioned something about rules of engagement…") but rather to form explicit questions that are rebuffed by patients (e.g., "Can you consider the idea that you were just doing your job?").
    - Strategy: While reviewing session recordings, write down verbatim unproductive prompts and questions and ask trainee why they did not work. Next, ask trainee to rephrase prompts and questions that will facilitate new perspectives.
- Pitfall: Trainee uses confrontational reflections.
    - Strategy: Tell trainee that confrontational approaches are not recommended. However, if trainee chooses to take that risk, tell trainee to examine the patient's immediate reaction, as it will let trainee know how the patient received it. It is very helpful to have trainee review his or her own session tapes.
- Pitfall: Trainee is impatient that patient has not reached an important perspective shift.
    - Strategy: Remind trainee to give the patient a chance over the following week while listening to audio-recordings or during the next session. Thankfully, since PE uses the same strategies from session to session (imaginal exposure and processing of the same memory), there are not many missed opportunities. If it is truly important, it will come around again.

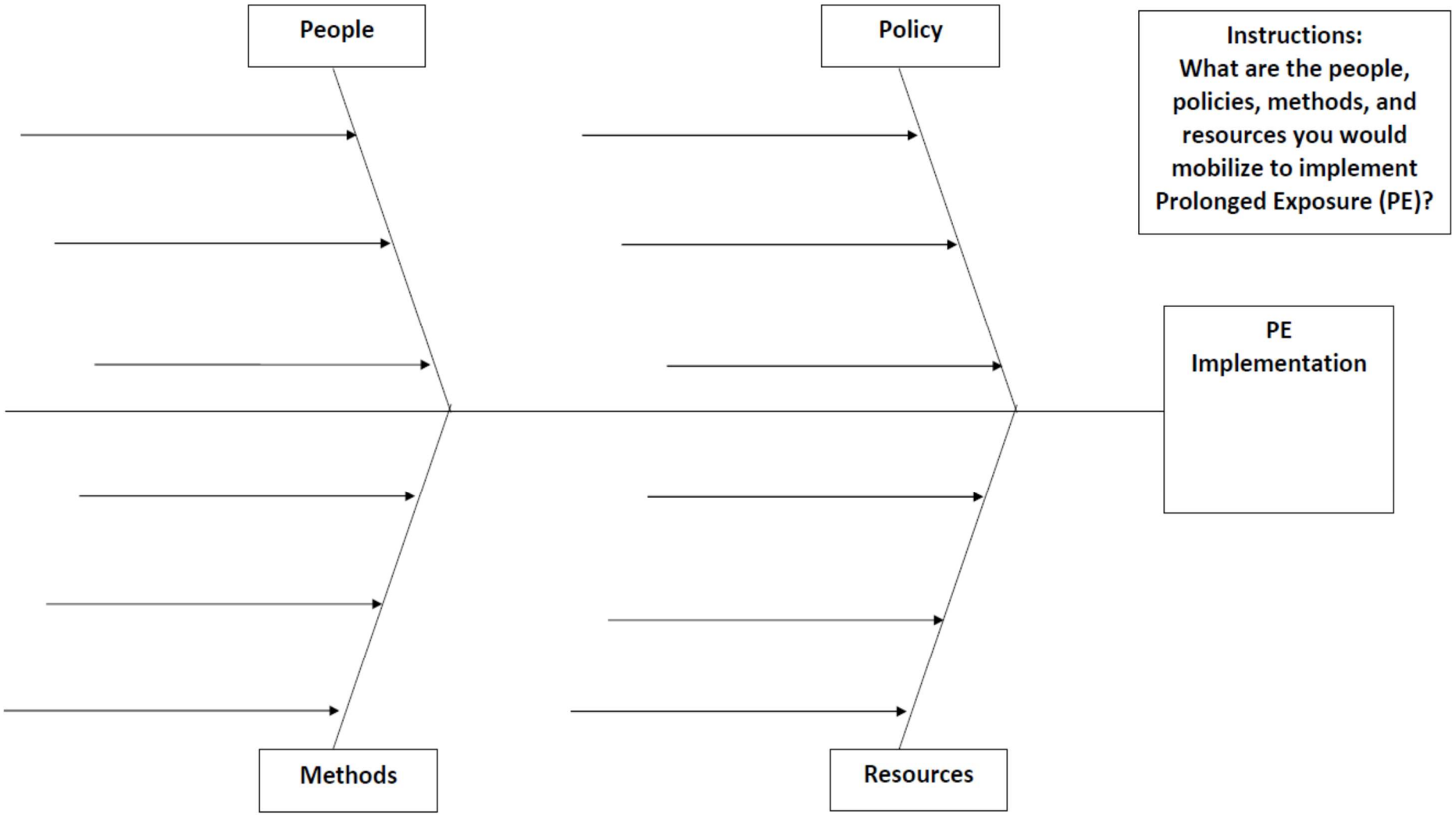
Implementation Stakeholder Map

Instructions: Consider the following to identify convergence/divergence among needs of stakeholders on three dimensions:

1) What are patients', providers' and managers' needs related to Prolonged Exposure (PE) implementation?
2) How would each stakeholder define high-quality PE implementation in this clinic/setting?
3) What are the risks for each stakeholder if PE is not implemented well in this setting?

Stakeholder	Needs related to implementing PE	Quality of PE implementation defined	Risk associated with PE implementation problems
Patient			
Provider			
Manager			

Implementation Strategy Chart



PE Treatment Checklist (Session 1)
(Derived from Foa et al., 2019)

1) Give PCL-5 and PHQ-9

2) Overview of Program and Treatment Procedures

- Present session agenda (go over treatment, explain why it works, conduct interview, answer your questions, assign homework)
- Present overview of treatment (8-12 sessions; each 90 minutes; focus is on decreasing PTSD symptoms; invite to call between sessions for support if needed)

3) Present Rationale for Exposure

Main points:

- Trauma survivors often see the world as very dangerous and themselves as incompetent
- Avoidance and unhelpful thoughts are the two primary factors that maintain symptoms
- Two types of exposure: imaginal and in vivo
- In vivo exposure: approach avoided situations in real life
- Imaginal exposure: revisiting the memory on purpose in a safe environment
- Exposure good because client will learn that trauma-related memories and situations are not dangerous (USE METAPHOR)
- Exposure good because client will learn that anxiety/distress decreases after repeated and prolonged confrontation; distress doesn't last forever.
- Exposure good because confrontation with distressing memories or situations helps to process traumatic events (USE METAPHOR)

4) Conduct Trauma Interview

5) Show and discuss Daniel's Story PTSD Video

6) Breathing Retraining

- Breathing and emotional state are connected
- Many people think deep breathing is good for relaxing HOWEVER taking in more air is good for fight-or-flight and distress, not for relaxing
- Learning how to breathe slowly will help you to relax
- Provide correct instructions for slow breathing:
  → take a normal breath
  → exhale slowly (while saying calm or relax)
  → hold your breath and count until 4 (or at least 2)
- Have client practice breathing sequence for 1 to 3 minutes
- Make a tape or instruct how to use PE Coach's breathing tool for HW

7) Assign Homework

- Listen to audiotape of Session 1 one time
- Read "Rationale for Treatment" handout
- Practice breathing

PE Treatment Checklist (Session 2)
(Derived from Foa et al., 2019)

1) Give PCL-5 and PHQ-9 and Review Scores

2) Review Homework

- Offer positive feedback about homework
- Discuss experiences and answer any questions

3) Present Session Agenda

- We are going to discuss common reactions to trauma
- We are going to discuss rationale for in vivo exposure
- Then I'm going to teach you a method for assessing your distress and we are going to come up with an in vivo list.
- Construct in vivo hierarchy

4) Discuss Common Reactions to Trauma

- Fear and anxiety are easily triggered
- Re-experiencing of the trauma via memories, flashbacks, and nightmares
- Impaired concentration
- Hyperarousal/hypervigilance/excessive startle response
- Avoidance (physical/cognitive/emotional)
- Depression/loss of interest
- Assess patient suicidality if indicated
- Feeling loss of control
- Guilt/shame
- Anger/irritability
- Negative thoughts about self (i.e., poor self-image) and other people
- Disrupted relationships
- Decreased interest in sex
- Activation of other traumatic memories

5) Present Rationale for In Vivo Exposure Treatment

Avoidance works in the short run (reduces anxiety) but in the long run maintains PTSD symptoms and prevents new learning

Exposure:

- Blocks and breaks habit of avoiding (prevents negative reinforcement)
- Allows processing of trauma
- Results in habituation (i.e., anxiety decreases with repeated exposure)
- Disconfirms the belief that anxiety lasts forever
- Disconfirms fears by allowing her to discriminate safe from unsafe situations
- Increases client's confidence by allowing her to learn that she can manage distress

6) Introduce SUD Scale

- Define SUDS (Subjective Units of Discomfort/Distress Scale); range from 0 to 100
- Generate anchor points based on client's experience (minimum: 0, 50, 75, 100)

7) Construct In-Vivo Hierarchy

- **Use examples** (e.g., child at beach) to illustrate habituation
- Elicit avoided stimuli/situations and generate a list of 10-15 situations for in vivos
- Assign SUD level to each exposure situation/item; should have hierarchy with good range of SUD level

8) Assign In-Vivo Homework

- Select situations that elicit moderate SUDS ratings (generally between 40 and 60)
- Explain in vivo procedure:
  → Client needs to remain in the situation until the anxiety decreases by 50% of the initial level or 45 minutes to 1 hour
  → Exposure most successful when practiced repeatedly
- Provide handout and demonstrate how to record SUDS levels (pre, post, peak)

9) Assign Homework

- If they liked the breathing, continue to practice breathing re-training
- Practice situations selected for in vivo exposure
- Listen to audiotape of Session 2 one time
- Review in vivo list of avoided situations and add situations/objects
- Review "Common Reactions to Trauma" handout several times

PE Treatment Checklist (Session 3)
(Derived from Foa et al., 2019)

1) **Give PCL-5 and PHQ-9 and Review Scores**

2) **Review Homework**
   - Discuss homework, offer ample positive feedback and praise
   - Provide patient with constructive feedback about homework
   - Review in vivo exposure homework records and provide feedback

3) **Present Session Agenda**
   - Review rationale for imaginal exposure
   - Imaginal exposure of the trauma for 45 minutes
   - Homework

4) **Present Rationale for Imaginal Exposure**
   - Remembering the trauma is distressing and leads to avoidance
   - Avoidance (thought suppression) works in the short run but not the long run
   - Re-experiencing, avoidance, and hypervigilance signal that the trauma is "unfinished business", that the memory is not processed
   - Present analogy (e.g., bad meal, file cabinet/restaurant)
   - The goal of revisiting the trauma is:
     → to process and organize the traumatic memories
     → to learn that the traumatic memories are not dangerous
     → to gain confidence in ability to manage distress
     → to bring about extinction/habituation
     → to control the memories (rather than memories controlling you)

5) **Instructions for Imaginal Exposure**
   Instruct the client to….
   - Close eyes
   - Visualize the trauma as vividly as possible, and describe what happened, including the events, thoughts, and feelings
   - Tell the story in the present tense as if it were happening now

   Explain…
   - That patient will be asked to provide SUDS ratings; patients should try to quickly give rating without leaving the image
   - That patient will continue the exposure for 45 minutes; if the narrative takes less than that to recount, will ask him to go back to beginning and repeat the narrative.

6) During Imaginal Exposure

- **Track SUDS every 5 minutes (fidelity = within 30 sec of 5 min mark)**
- Prompt the patient to stay in the present tense if needed
- Offer support/encouragement as needed
- Prompt patient to focus on thoughts, emotions, and sensations as needed
- After first telling, ramp up the experience for patient if needed
- Keep track of details you want to process
- Make a separate audio recording for the exposure, i.e., using PE Coach

7) Process Exposure

- First question is "How was that for you?"
- Discuss experience with patient; give a lot of praise for accomplishing this difficult task
- Discuss habituation if it happened, i.e. that's good
- Discuss non habituation if it happened, i.e., that's good, you are really connecting with the memory, you'll do great in this treatment.
- Ask patient what emerged or was deemed important during the imaginal exposure
- Therapist may share own observations of patient's imaginal exposure
- Therapist may help patient to identify trauma-related thoughts and beliefs (this is often not initiated until second or third session of imaginal exposure)

8) Assign Homework

- Listen to audiotape of Session 3 one time
- Listen to audiotape of entire imaginal exposure once a day without stopping, focusing on image, eyes closed, <u>but not prior to going to bed at night, not while driving.</u>
- Instruct client how to complete the imaginal exposure record forms
- Assign in vivo exposure homework

PE Treatment Checklist (Session 4)
(Derived from Foa et al., 2019)

1) **Give PCL-5 and PHQ-9 and Review Scores**

2) **Review Homework**
   - Discuss homework, offer ample positive feedback and praise
   - Provide patient with constructive feedback about homework
   - Review in vivo exposure homework records and provide feedback

3) **Present Session Agenda**
   - Review rationale for imaginal exposure
   - Imaginal exposure of the trauma for 45 minutes
   - Homework

4) **Review Rationale for Imaginal Exposure**
   - Remembering the trauma is distressing and leads to avoidance
   - Avoidance (thought suppression) works in the short run but not the long run
   - Re-experiencing, avoidance, and hypervigilance signal that the trauma is "unfinished business", that the memory is not processed
   - Present analogy (e.g., bad meal, file cabinet/restaurant)
   - The goal of revisiting the trauma is:
     → to process and organize the traumatic memories
     → to learn that the traumatic memories are not dangerous
     → to gain confidence in ability to manage distress
     → to bring about extinction/habituation
     → to control the memories (rather than memories controlling you)

5) **Review Instructions for Imaginal Exposure**

   Instruct the client to….
   - Close eyes
   - Visualize the trauma as vividly as possible, and describe what happened, including the events, thoughts, and feelings
   - Tell the story in the present tense as if it were happening now

   Explain…
   - That patient will be asked to provide SUDS ratings; patients should try to quickly give rating without leaving the image
   - That patient will continue the exposure for 45 minutes; if the narrative takes less than that to recount, will ask him to go back to beginning and repeat the narrative.

6) During Imaginal Exposure

- **Track SUDS every 5 minutes (fidelity = within 30 sec of 5 min mark)**
- Prompt the patient to stay in the present tense if needed
- Offer support/encouragement as needed
- Prompt patient to focus on thoughts, emotions, and sensations as needed
- After first telling, ramp up the experience for patient if needed
- Keep track of details you want to process
- Make a separate audio recording for the exposure, i.e., using PE Coach

7) Process Exposure

- First question is "How was that for you?"
- Discuss experience with patient; give a lot of praise for accomplishing this difficult task
- Discuss habituation if it happened, i.e. that's good
- Discuss non habituation if it happened, i.e., that's good, you are really connecting with the memory, you'll do great in this treatment.
- Ask patient what emerged or was deemed important during the imaginal exposure
- Therapist may share own observations of patient's imaginal exposure
- Therapist may help patient to identify trauma-related thoughts and beliefs (this is often not initiated until second or third session of imaginal exposure)

8) Assign Homework

- Listen to audiotape of Session 4 one time
- Listen to audiotape of entire imaginal exposure once a day without stopping, focusing on image, eyes closed, <u>but not prior to going to bed at night, not while driving.</u>
- Instruct client how to complete the imaginal exposure record forms
- Assign in vivo exposure homework

PE Treatment Checklist (Sessions 5 thru Next-to-Final)
(Derived from Foa et al., 2019)

1) Give PCL and PHQ-9 and Review Scores

2) Review Homework

- Review imaginal and in-vivo exposure homework records and provide constructive feedback, express praise and confidence in good prognosis for completed homework. For uncompleted homework, make a big deal, not OK.

3) Present Session Agenda

- Imaginal exposure
- Plan/implement in vivo exposure
- Discuss homework assignment

4) Conduct Imaginal Exposure

- Review instructions and identify 'hot spots' (typically starting Session 5)
- Conduct imaginal exposure for **30 to 45 minutes**
- Prompt client to stay in the present tense if needed
- Offer encouragement/support as needed
- Prompt client to focus on thoughts, emotions, and body sensations as needed
- Titrate the experience as needed
- Elicit SUDS and vividness ratings

Process Exposure

- Discuss experience with patient; give a lot of praise for accomplishing this difficult task; use slow breathing if needed
- Discuss habituation (or lack of) with patient as needed
- Process experience with patient; ask patient what emerged or seemed important during the imaginal exposure; therapist may share his/her observation with patient

  As therapy progresses:
  - Help patient to identify trauma-related thoughts and beliefs as needed
  - Ask questions that help patient to develop realistic perspective on trauma and meaning it has in his or her life as needed

5) Discuss or Implement In Vivo Exposure

- Discuss in vivo homework in depth and assist in problem-solving if needed **and/or**
- Conduct therapist-assisted in vivo exposure (less commonly done)

6) Assign Homework

- Listen to audiotape of session at least one time
- Listen to audiotape of imaginal exposure once a day
- Assign in vivo exposure homework

PE Treatment Checklist (Final Session)
(Derived from Foa et al., 2019)

1) Give PCL-5 and PHQ-9 and Review Scores

2) Review Homework
- Review imaginal and in-vivo exposure homework records and provide constructive feedback

3) Present Session Agenda
- Imaginal exposure
- Discuss treatment progress and plans for continuing to use exposure skills

4) Conduct Imaginal Exposure
- Conduct imaginal exposure for **about 20 minutes**, working on entire memory
- Prompt client to stay in the present tense if needed
- Offer encouragement/support as needed
- Prompt client to focus on thoughts, emotions, and body sensations as needed
- Titrate the experience as needed
- Elicit SUDS

Process Exposure(as needed)
- Process, discuss experience with client as needed
- Focus discussion on how the imaginal exposure experience has changed over course of therapy
- Focus discussion on what is different about how patient thinks about trauma now.

5) Review Treatment Program and Client's Progress, Termination
- Elicit current SUDS ratings for items included on the *old* in vivo hierarchy
- Discuss client's progress
- Review skills the client learned, and make plan for continued exposures if indicated (e.g., if in-vivo exposure items with significant SUDS remain)
- Discuss possibility of experiencing symptom exacerbation in the future and how to prevent/address relapse
- Elicit client's feedback about helpful and not-so-helpful aspects of the treatment
- Provide client with positive feedback about her work and progress
- Say good-bye

SESSION 1 Rating Form
(Derived from Foa et al., 2019)

Patient ID: _____ **Date:** _____

Therapist: _____ **Evaluator:** _____

Part I: Essential Elements

1. Therapist presented an overview of the treatment program? Yes No
2. Therapist discussed factors that maintain post-trauma reactions: avoidance and negative, trauma-related thoughts and beliefs? Yes No
3. Therapist described imaginal exposure? Yes No
4. Therapist described in vivo exposure? Yes No
5. Therapist explained that confrontation with distressing memories or situations:
   - Helps reduce excessive fear and gain realistic perspective on trauma Yes No
   - Helps patient learn that trauma-related memories and situations are not dangerous and that patient can handle them Yes No
   - Helps patient to learn to better discriminate trauma reminders from the trauma itself Yes No
   - Reduces PTSD symptoms Yes No
6. Therapist explains that therapy is intensive and can be distressing; patient may call between sessions for support (therapist provides contact information) Yes No
7. Therapist presented rationale for breathing retraining? Yes No
8. Therapist instructed client on breathing and coached through breathing in session? Yes No
9. Rate the adequacy of the therapist's work regarding these Essential Elements:

   1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

10. Rate the degree to which the patient's responses indicated understanding of the rationale:
    1 = Poor Understanding 2 = Fair 3 = Satisfactory 4 = Good 5 = Excellent Understanding

Part II: Essential but not Unique Elements

1. Therapist established good rapport with the patient? Yes No
2. Therapist engaged with client in a professional manner? Yes No
3. Therapist structured therapy time efficiently? Yes No
4. Therapist administered the Trauma Interview? Yes No
5. Therapist assigned homework? Yes No
6. Rate the adequacy of the therapist regarding Essential but not Unique Elements:

   1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

Part III: Adherence Questions

1. Therapist implemented interventions that are not included in this manual or model of treatment, except as clearly dictated by client safety needs? Yes No
2. Therapist and client engaged in more than 15 minutes of off-task discussion? Yes No

Part IV: Overall Session Elements

1. How difficult do you think this patient was to work with in this session?

   1 = Not Difficult 2 = Somewhat 3 = Moderately 4 = Very 5 = Extremely Difficult

2. Did any significant problems arise during the session that led to a departure from the treatment plan? (If yes answer a & b below) Yes No

   a. Should the therapist have deviated from the planned session? Yes No

   b. Rate the adequacy with which the therapist dealt with the problems that led to a departure from the treatment plan:

      1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

3. Rate the therapist's overall skill as demonstrated for this reason:

   1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

4. Additional comments regarding the conduct of this session:

SESSION 2 Rating Form
(Derived from Foa et al., 2019)

Patient ID: _____ **Date:** _____

Therapist: _____ **Evaluator:** _____

Part I: Essential Elements

1. Therapist reviewed homework and gave feedback? Yes No
2. Therapist discussed common reactions to trauma with client? Yes No
3. Therapist elicited and normalized client's reactions to trauma during discussion? Yes No
4. Therapist discussed the rationale for treatment, with emphasis on in vivo exposure? Yes No
5. Therapist explained that avoidance works in the short term to reduce anxiety, but in the long run, maintains PTSD symptoms and prevents new learning. Yes No
6. Therapist explained that exposure:
   - Blocks avoidance and prevents negative reinforcement Yes No
   - Disconfirms patient's belief that exposure to the feared situation will result in the anticipated harm Yes No
   - Disconfirms the belief that anxiety lasts forever Yes No
   - Results in habituation Yes No
   - Increases patient's confidence and sense of competence Yes No
7. Therapist introduced the Subjective Units of Distress Scale (SUDS) and established anchor points? Yes No
8. Therapist and client developed in vivo exposure hierarchy, aiming for at least 10 avoided situations? Yes No
9. Therapist assigned Session 2 homework? Yes No
10. Rate the adequacy of the therapist regarding Essential Elements:

    1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

11. Rate the degree to which patient's responses indicated understanding of the rationale:
    1 = Poor Understanding 2 = Fair 3 = Satisfactory 4 = Good 5 = Excellent Understanding

Part II: Essential but not Unique Elements:

1. Therapist established good rapport with patient? Yes No
2. Therapist engaged with patient in a professional manner? Yes No
3. Therapist structured therapy time efficiently? Yes No
4. Rate the adequacy of the therapist regarding Essential but not Unique Elements:

    1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

Part III: Adherence Questions

1. Therapist implemented interventions that are not included in this manual or model of treatment, except ad clearly dictated by client safety? Yes No
2. Therapist and client engaged in more than 15 minutes of off-task discussion? Yes No

Part IV: Overall Session Elements

1. How difficult do you think this patient was to work with in this session?

1 = Not Difficult 2 = Somewhat 3 = Moderately 4 = Very 5 = Extremely Difficult

2. Did any significant problems arise during the session that led to a departure from the treatment plan? (if yes answer a & b below) Yes No

    a. Should the therapist have deviated from planned session? Yes No

    b. Rate the adequacy with which the therapist dealt with the problems that led to a departure from the treatment plan:

        1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

3. Rate the therapist's overall skill as demonstrated for this session:

1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

4. Additional comments regarding the conduct of this session:

SESSION 3 Rating Form
(Derived from Foa et al., 2019)

Patient ID: _____ **Date:** _____

Therapist: _____ **Evaluator:** _____

Part I: Essential Elements

1. Therapist reviewed homework and gave feedback? Yes No
2. Therapist explained rationale for imaginal exposure? Yes No
3. Therapist explained that avoidance works in the short run, but in the long run, maintains PTSD symptoms; symptoms represent "unfinished business" Yes No
4. Therapist explained the goal of revisiting and recounting the trauma memory:
   - Process, organize the traumatic memories Yes No
   - Increase differentiation between "remembering" the trauma and being "re-traumatized" again; learn that memories of the trauma are not dangerous Yes No
   - Bring out habituation Yes No
5. Therapist presented analogy (e.g., bad meal, file cabinet, book with scary parts) Yes No
6. Therapist gave client instructions to carry out the imaginal exposure in the session? Yes No
7. Therapist monitored SUDS ratings about every 5 minutes? Yes No
8. Therapist used appropriate reinforcing comments during imaginal exposure? Yes No
9. Imaginal exposure lasted between 30-45 minutes? Yes No
10. Therapist processed the imaginal exposure experience with client? Yes No
11. Therapist explained how to listen to imaginal exposure recordings at home? Yes No
12. Therapist assigned homework? Yes No
13. Rate the adequacy of the therapist regarding <u>Essential Elements</u>:

    1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

13. Rate the degree to which the patient's responses indicated understanding of the rationale:
1 = Poor Understanding 2 = Fair 3 = Satisfactory 4 = Good 5 = Excellent Understanding

Part III: Essential but not Unique Elements:

1. Therapist maintained good rapport with patient? Yes No
2. Therapist engaged with client in a professional manner? Yes No
3. Therapist structured therapy time efficiently? Yes No
4. Rate the adequacy of the therapist regarding <u>Essential but not Unique Elements</u>:

    1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

Part III: Adherence Questions

1. Therapist implemented interventions that are not included in this manual or model of treatment, except as clearly dictated by client safety? Yes No
2. Therapist and client engaged in more than 15 minutes of off-task discussion? Yes No

Part IV: Overall Session Elements

1. How difficult do you think this patient was to work with in this session?

   1 = Not Difficult 2 = Somewhat 3 = Moderately 4 = Very 5 = Extremely Difficult

2. Did any significant problems arise during the session that led to a departure from the treatment plan? (if yes answer a & b below) Yes No

   a. Should the therapist have deviated from the planned session? Yes No

   b. Rate the adequacy with which the therapist dealt with the problems that led to a departure from the treatment plan:

      1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

3. Rate the therapist's overall skill as demonstrated for this session:

   1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

4. Additional comments regarding the conduct of this session:

SESSION 4 Rating Form
(Derived from Foa et al., 2019)

Patient ID: _____ **Date:** _____

Therapist: _____ **Evaluator:** _____

Part I: Essential Elements

1. Therapist reviewed homework and gave feedback? Yes No
2. Therapist oriented the client to the exposure planned for that particular session? Yes No
3. Therapist conducted imaginal exposure for 30-45 mins and monitored SUDS? Yes No
4. Therapist used reinforcing comments and elicited thoughts and feelings as appropriate? Yes No
5. Therapist prompted for present tense, closed eyes if necessary? Yes No
6. Therapist reiterated the rationale if necessary? Yes No
7. Therapist discussed and processed client's reactions to the imaginal exposure? Yes No
8. Therapist assigned in vivo and imaginal exposure homework? Yes No
9. Rate the adequacy of the therapist regarding Essential Elements:

1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

11. Rate the degree to which patient's responses indicated understanding of the rationale:

1 = Poor Understanding 2 = Fair 3 = Satisfactory 4 = Good 5 = Excellent Understanding

Part II: Essential but not Unique Elements:

1. Therapist maintained good rapport with patient? Yes No
2. Therapist engaged with client in a professional manner? Yes No
3. Therapist structured therapy time efficiently? Yes No
4. Rate the adequacy of the therapist regarding Essential but not Unique Elements:

1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

Part III: Adherence Questions

1. Therapist implemented interventions that are not included in this manual or model of treatment, except as clearly dictated by client safety? Yes No
2. Therapist and client engaged in more than 15 minutes of off-task discussion? Yes No

Part IV: Overall Session Elements

1. How difficult do you think this patient was to work with in this session?

   1 = Not Difficult 2 = Somewhat 3 = Moderately 4 = Very 5 = Extremely Difficult

2. Did any significant problems arise during the session that led to a departure from the treatment plan? (if yes then answer a & b below) Yes No

   a. Should the therapist have deviated from the planned session?

   b. Rate the adequacy with which the therapist dealt with the problems that led to a departure from the treatment plan:

      1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

3. Rate the therapist's overall skill as demonstrated for this session:

   1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

4. Additional comments regarding the conduct of this session:

SESSIONS 5 to NEXT-TO-FINAL Rating Form
(Derived from Foa et al., 2019)

Patient ID: _____ **Date:** _____

Therapist: _____ **Evaluator:** _____

Part I: Essential Elements

1. Therapist reviewed homework and gave feedback? Yes No
2. Therapist oriented the client to the exposure planned for that particular session? Yes No
3. If "hotspots" procedure introduced for first time, therapist explained the rationale for focusing the revisiting on the hotspots? Yes No
4. Therapist helped patient to identify hotspots as needed? Yes No
5. Therapist conducted imaginal exposure for 30-45 mins and monitored SUDS? Yes No
6. Therapist used reinforcing comments and elicited thoughts and feelings as appropriate? Yes No
7. Therapist prompted for present tense, closed eyes if necessary? Yes No
8. Therapist reiterated the rationale if necessary? Yes No
9. Therapist discussed and processed client's reactions to the imaginal exposure? Yes No
10. Therapist assigned in vivo and imaginal exposure homework? Yes No
11. Therapist explained how to listen to imaginal exposure recordings at home? Yes No
12. Rate the adequacy of the therapist regarding <u>Essential Elements</u>:

    1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

14. Rate the degree to which patient's responses indicate understanding of the rationale:

    1 = Poor Understanding 2 = Fair 3 = Satisfactory 4 = Good 5 = Excellent Understanding

Part II: Essential but not Unique Elements:

1. Therapist maintained good rapport with the patient? Yes No
2. Therapist engaged with client in a professional manner? Yes No
3. Therapist structured therapy time efficiently? Yes No
4. Rate the adequacy of the therapist regarding <u>Essential but not Unique Elements:</u>

    1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

Part III: Adherence Questions

1. Therapist implemented interventions that are not included in this manual or model of treatment, except as clearly dictated by client safety? Yes No
2. Therapist and client engaged in more than 15 minutes of off-task discussion? Yes No

Part IV: Overall Session Elements

1. How difficult do you think this patient was to work with in this session?

1 = Not Difficult 2 = Somewhat 3 = Moderately 4 = Very 5 = Extremely Difficult

2. Did any significant problems arise during the session that led to a departure from the treatment plan? (if yes answer a & b below) Yes No

   a. Should the therapist have deviated from the planned session? Yes No

   b. Rate the adequacy with which the therapist dealt with the problems that led to a departure from the treatment plan:

   1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

3. Rate the therapist's overall skill as demonstrated for this session:
   1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

4. Additional comments regarding the conduct of this session:

FINAL SESSION Rating Form
(Derived from Foa et al., 2019)

Patient ID: _____ **Date:** _____

Therapist: _____ **Evaluator:** _____

Part I: Essential Elements

1. Therapist reviewed homework? Yes No
2. Therapist oriented the client to working on entire memory? Yes No
3. Therapist conducted imaginal exposure about 15-20 and monitored SUDS? Yes No
4. Therapist used reinforcing comments and elicited thoughts and feelings as Appropriate? Yes No
5. Therapist prompted for present tense, closed eyes if necessary? Yes No
6. Therapist reiterated the rationale if necessary? Yes No
7. Therapist discussed and processed client's reactions to the imaginal exposure? Yes No
8. Therapist reviewed treatment progress with client? Yes No
9. Therapist discussed future goals in targeting areas that still need to be confronted? Yes No
10. Therapist normalized and discussed how to deal with symptoms increases (e.g., discussed relapse prevention) Yes No
11. Rate the adequacy of the therapist regarding Essential Elements:

    1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

12. Rate the degree to which the patient's responses indicate that he or she understands the importance of continuing to apply what was learned in treatment:

    1 = Poor Understanding 2 = Fair 3 = Satisfactory 4 = Good 5 = Excellent Understanding

Part II: Essential but not Unique Elements:

1. Therapist encouraged client to use skills learned during treatment? Yes No
2. Therapist maintained good rapport with patient? Yes No
3. Therapist engaged with client in a professional manner? Yes No
4. Therapist structured therapy time efficiently? Yes No
5. Rate the adequacy of the therapist regarding Essential but not Unique Elements:

    1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

Part III: Adherence Questions

1. Therapist implements interventions that are not included in this manual or model of treatment, except as clearly dictated by client safety? Yes No
2. Therapist and client engaged in more than 15 minutes of off-task discussion? Yes No

Part IV: Overall Session Elements

1. How difficult do you think this patient was to work with in this session?

1 = Not Difficult 2 = Somewhat 3 = Moderately 4 = Very 5 = Extremely Difficult

2. Did any significant problems arise during the session that led to a departure from the treatment plan? (if yes answer a & b below) Yes No

    a. Should the therapist have deviated from the planned session? Yes No

    b. Rate the adequacy with which the therapist dealt with the problems that Led to a departure from the treatment plan:

    1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

3. Rate the therapist's overall skill as demonstrated for this session:

    1 = Poor 2 = Mediocre 3 = Satisfactory 4 = Good 5 = Excellent

4. Additional comments regarding the conduct of this session: