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Commentary on Individualizing Exposure Therapy For PTSD: The Case Of Caroline

Manualized Psychotherapies in the "Real World" [a,b]

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ABSTRACT

Manualized psychotherapies, especially those that are cognitive-behavioral in nature, are becoming an increasingly important part of everyday clinical practice. While this development is exciting, it also poses certain challenges. In this context, Kramer (2009) describes a modified application of Foa and Rothbaum's Prolonged Exposure (PE; Foa & Rothbaum, 1998) with Caroline, a 26-year-old woman with a history of depression and posttraumatic stress disorder (PTSD). Kramer pairs this manualized cognitive-behavioral psychotherapy with an enhanced case conceptualization and treatment plan utilizing Caspar's Plan Analysis approach (Caspar, 2007). This commentary reviews the case, evaluates the application of PE, and offers suggestions for future use of manualized treatments in "real world" clinical settings.

Keywords: posttraumatic stress disorder (PTSD); prolonged exposure (PE); Plan Analysis; manualized psychotherapy

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I reviewed with enthusiasm Ueli Kramer's case study on "Individualizing Exposure Therapy for PTSD: The Case of Caroline" (2009). As a clinician who trained with Edna Foa and her colleagues for two years, I am very familiar with PE for PTSD and its application in both research and clinical settings. As a clinician working today in a community mental health setting, I especially appreciate Kramer's intention of utilizing an empirically-supported, manualized cognitive-behavioral therapy (CBT) on the frontline of clinical practice.

When a therapy like PE is found to be efficacious in randomized controlled trials (e.g., Foa, Rothbaum, Riggs, & Murdock, 1991; Foa et al., 1999), a next logical step is to determine if the treatment is effective in real world clinical settings. To this end, Foa and colleagues (Foa et al., 2005) have provided effectiveness data on the use of PE in community settings. Their findings suggest that this treatment can be transported to a community setting with outcomes that rival those seen in academic randomized controlled trials. Kramer's case can be viewed as an example of the third step in the "life" of a manualized psychotherapy: use of the treatment in the natural course of clinical work, with patients who present with comorbidity and in contexts that may involve such factors such as health insurance and open-ended treatment plans (see also Kushner, Muller, & Maher, 2006).

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The present commentary speaks to the case of Caroline presented by Kramer, but also to the larger issue of providing manualized treatments in "real world" clinical settings. I contend that manualized treatments are misunderstood at times and this may lead to incomplete implementation and, at worst, poor clinical outcomes. Many of the ideas proffered in my commentary are supported by the current empirical literature (citations are provided where appropriate), but some are my unpublished, clinical perspectives on flexible, yet adherent, use of manualized interventions like PE.

CAROLINE'S TREATMENT

Use of Caspar's Plan Analysis

Kramer suggests that Caroline's treatment is generally being approached from a cognitive-behavioral perspective. While this may logically lead to a more traditional CBT case conceptualization (e.g., Persons & Tompkins, 2007), he instead selects Franz Caspar's Plan Analysis formulation method (Caspar, 2007). This method, which ostensibly can be used from any theoretical perspective, is a structured approach that seeks to answer the question, "For what reason does a person behave in a particular way?" As such, it seems a reasonable choice for better understanding behavioral patterns, a fitting goal given Caroline's presentation.

What Kramer describes as an attempt to enhance PE for PTSD using Plan Analysis method seems, in actuality, to be a therapy shaped entirely by this conceptualization. PE becomes secondary, a "technique" to be inserted into the treatment framework determined by the Plan Analysis and resulting directives for a Motive-Oriented Therapeutic Relationship (MOTR), rather than the guiding conception for the treatment. Had this been the explicit plan, or even an option selected after an unsuccessful attempt at comprehensive PE, the approach would have been more systematic. Alternately, I contend that PE could have been adequately implemented as an "add-on" or modular intervention had it not been discontinued so early in the process (this is explained further below).

As I am not as familiar with Caspar's approach, I will comment only briefly on the selection of this case conceptualization method rather than a more typical cognitive-behavioral conceptualization. While a PE-oriented formulation alone may not capture all of the facets of this case, a comprehensive cognitive-behavioral conceptualization (e.g, Persons & Tompkins, 2007; Truax, 2002), which includes the PTSD formulation suggested by PE, would serve a similar purpose to Plan Analysis. While I can certainly understand that a Plan Analysis approach could add valuable information to a more psychodynamic, supportive, or interpersonal approach to therapy, a sound cognitive-behavioral conceptualization should offer similar information about behaviors and their hypothesized function. This information would then guide the therapist not only in choice of intervention, but also in direct therapist actions and responses, much as Caspar's approach does.

Use of Prolonged Exposure in Caroline's Treatment

To further clarify the support for the efficacy and effectiveness of PE, it is important to note that there have been over twenty years of research on this intervention for rape-related

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PTSD (Kramer's report suggests that the treatment received support only after the development of the Foa and Rothbaum manual in 1998). It is also worth noting that an updated version of the treatment manual was published in 2007 (Foa, Hembree, & Rothbaum, 2007). While the original manual may be acceptable for use, it is recommended that clinicians obtain the most recent versions of treatment manuals, as continuing research may result in changes to the protocol. For example, studies on Foa and Rothbaum's 1998 manual found that cognitive therapy is not a necessary component of PE: outcomes were comparable when this intervention was eliminated from the treatment protocol (Foa et al., 2005). The same holds true for relevant assessment measures. For example, to make Caroline's treatment more adherent to protocol and open to comparison with existing outcome data, the Posttraumatic Stress Diagnostic Scale (PDS; Foa, Cashman, Jaycox, & Perry, 1997) should be used to assess presence and severity of PTSD symptoms.

Kramer cites Caroline's depression as a reason for not pursuing PE at the very beginning of treatment. Foa and colleagues state that severe depression that limits functioning or active suicidality are reasons to delay PE, but Caroline's depression did not seem to be at this level of severity (Foa & Rothbaum, 1998). A number of studies have found that depressed symptoms decrease significantly during PE (Foa, Hembree, & Rothbaum, 2007). I contend that Kramer could have considered beginning PE earlier in the treatment course. It would have been interesting to see if both the PTSD and depressive symptoms changed in response to the PE.

Foa and colleagues go to great pains to emphasize the critical role of exposure in PE for PTSD (Foa, Hembree, & Rothbaum, 2007). *In vivo* exposure is "real life" confrontation of stimuli associated with the trauma that the individual has been avoiding. While Kramer devises an exposure hierarchy, it is limited in nature and includes stimuli that are only tangentially related to the sexual abuse. A more typical hierarchy for this type of trauma includes stimuli such as reading and writing about sexual abuse, visits to the locations where the assault occurred, and pictures of the perpetrator, in addition to the types of exposures Caroline engaged in. Perhaps more importantly, Kramer initiated, and then discontinued imaginal exposure with Caroline. Imaginal exposure is a key component of treatment in that it helps to access the fear structure of the trauma memory. This is a very specific procedure that includes guidelines for both patient and therapist including using the first person and present tense in the narrative and recounting the memory as if it were being "re-lived." It is an intense procedure and requires full therapist commitment because, as is typical with the pervasive avoidance in PTSD, patients may be ambivalent about engaging in it. Kramer explains that one imaginal exposure was pursued but upon the patient's statement that she wished to stop, the explicit PE imaginal exposure was dropped from the treatment. This is problematic in that it reinforces avoidance and may even send the message that the therapist cannot tolerate the intensity, content, or affect present during the re-living.

A Different Type of Exposure

My final assessment of Kramer's case is that Prolonged Exposure for PTSD, of the sort Foa and colleagues intended in their treatment manual, was not actually implemented with Caroline. As mentioned above, the *in vivo* exposures did not include stimuli that were directly related to the trauma or trauma memory. Imaginal exposure was discontinued at the patient's

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request without further attempts or encouragement from the therapist to continue it. This may have reinforced the avoidance of trauma-related memories and emotions, which runs counter to the interventions critical to PE's effectiveness. The therapist also incorporated relaxation and "safe place" imagery techniques that may actually prevent full immersion in the anxiety states necessary for habituation (and thus resolution of PTSD) to occur.

This being said, it is important to note that the patient's symptoms improved significantly. My theory is that exposure of a different sort was applied, perhaps unintentionally, in this case. Barlow and colleagues have been writing of late about a "Unified Protocol" approach to emotional disorders (Allen, McHugh, & Barlow, 2008). Within this protocol, they expound on the notion of "emotion exposures" as a component of treatment. The emotion exposures serve to increase the patient's tolerance for and acceptance of negative affect. Kramer's description of the final, emotionally important sessions with Caroline, and the resulting recordings she listened to at home, seem very much in line with Barlow's approach. It may have been these exposures that brought about the change in her depression and anxiety.

MISCONCEPTIONS ABOUT MANUALIZED TREATMENTS

Manualized psychotherapies continue to be misunderstood, even by those who support their use and attempt to implement them. Manualized therapies cannot seem to break free from their image as "scripts" or "simplistic symptom-reducers" to be seen as comprehensive free-standing therapies or, alternatively, treatment "modules" that embrace and complement all of the "non-specifics" of psychotherapy (e.g., thorough assessment, case formulation, therapeutic alliance, etc.). Though I appreciate the aspirations of the therapy described by Kramer, I fear that yet again a manualized treatment is misunderstood in the process.

Kramer's presentation of the case of Caroline seems to reflect some of the very myths I refer to above. He reasons that there is a need to "enhance" exposure treatment, although as the therapist he does not first attempt the intervention *in toto* to assess its impact with Caroline. Kramer also deems it necessary to step outside the cognitive-behavioral paradigm to seek an alternative case conceptualization and, ultimately, treatment framework. Manualized therapies do not preclude thorough case conceptualizations. In fact, most would encourage case conceptualization prior to selection and implementation of a protocol.

Finally, manualized therapies need to be tailored to the presenting problems and specific features of the patient who is being treated. PE, I argue, is particularly good at this.Yet, the formulation and intervention were not utilized to their full potential in Kramer's case. Perhaps the early discontinuation of the protocol (and, I would venture the patient's reluctance to engage in it) had to do with the therapist's only partial commitment to PE together with an incomplete exposure treatment plan. Finally, manualized treatments presuppose (though, admittedly, may not explicitly state the need for) a working therapeutic alliance. The successful application of exposure, for example, requires support, trust, validation, and encouragement.

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OPTIMAL USE OF MANUALS IN "REAL-WORLD" CLINICAL PRACTICE

Given that I fault Kramer for his less-than-adherent use of PE in Caroline's treatment, it is only fair that I offer my suggestions for thorough implementation of a manualized treatment in a real-world setting. I am approaching this discussion from the position of a cognitive-behavioral therapist, but most of these ideas apply to manualized psychotherapies based in other theoretical traditions. Many of these concepts apply in research settings, but they are expanded to encompass such features as comorbidity and complex environmental and social stressors.

Case Conceptualization

The first step in any CBT protocol is the development of an individualized case formulation based on thorough assessment of history (including factors that contributed to social learning and schema development) and presenting symptoms. The assessment often includes structured measures such as interviews and self-report instruments. Using a model I deem "Comprehensive Principle-Guided Cognitive Behavioral Therapy" (CPCBT), the case conceptualization includes comments about the hypothesized biological and genetic factors, proposed causes and triggers, and maintenance factors.

The detailed conceptualization may also include other contributing factors such as relationships, environmental stressors, and skills deficits. If criteria for certain symptoms, syndromes, or disorders are met, these are also noted. All of these factors are understood from a cognitive and behavioral perspective through the application of relevant theories. The conceptualization drives the treatment plan and the selection of interventions. Empirically supported treatment interventions are incorporated into the treatment plan whenever possible. With the case of Caroline, it seems that Kramer selected PE based on the patient's report of PTSD history and symptoms, without *first* creating the case conceptualization and then selecting the relevant interventions. Completing the conceptualization first may have lead to a purposeful selection of the "emotion exposures" that I contend he used and had success with, rather than to PE, which he eventually abandoned.

Use of Treatment Manuals

Given that the comprehensive model I describe above involves empirically-supported treatment manuals and protocols whenever possible, there are guidelines that may be helpful in selection of these interventions. Even when a manual is used in a "community" or "real world" setting, we must strive to adhere to the concepts set out in the manual. These specific interventions are prescribed for a reason. When we move too far away from them or modify them extensively, they are no longer empirically supported. That being said, there are ways to use manuals flexibly and creatively while keeping within the boundaries of the interventions therein (Kendall et al., 1998).

As described above, a comprehensive case formulation may lead to the use of a treatment manual for a specific problem or to the use of different manuals for multiple problems. Manuals are best used one at a time, as it is difficult to implement them simultaneously. Manualized

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treatments can be sequenced in the course of therapy and utilized as "modules" (Allen et al., 2008). Still other manualized treatments provide a principle-guided approach within which other complementary manuals can be used. For example, Linehan's dialectical behavior therapy (Linehan, 1993), a principle-based treatment, may serve as the general approach to therapy and PE may be implemented at a certain phase of the treatment.

Once a therapist decides that a manual will be used, it is incumbent upon them to individualize the content of the manual for the particular case. For example, the treatment is not just "exposure and response prevention for obsessive compulsive disorder," it becomes "individualized exposure and response prevention for Jane Doe's presentation of obsessive compulsive disorder." This individualized application of the treatment manual calls for continual assessment, tailoring of specific interventions, and feedback from the patient (Kendall et al., 1998). Finally, in the actual clinical provision of the manualized treatment, the clinician should be utilizing the "non-specific" therapy skills inherent in all psychotherapies such as listening, validation, education, support, and development of the therapeutic alliance.

CONCLUSION

Kramer's (2009) case study of the treatment of Caroline is an example of the application of an empirically-supported, manualized psychotherapy in a "real world" clinical setting. The clinician aspires to apply the treatment within a systematic case conceptualization in a way that is responsive to the wishes of the patient. As this case demonstrates, and is very likely happening in clinics everywhere, implementation does not always follow the manual.

The frontline clinical use of empirically-supported, manualized treatments, regardless of their theoretical underpinnings, is in its infancy. Kramer's case study provides an example of the dilemmas and possible pitfalls a clinician may face when attempting to apply a manualized treatment in a flexible way. This commentary addresses these concerns and offers a framework for the optimal implementation of manualized treatments in clinical practice. It is my hope that clinicians will continue to talk about their experiences in this realm, much as Kramer has, to further the development and systematization of these therapies.

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