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Teaching Trauma-Focused Exposure Therapy for PTSD: Critical Clinical Lessons for Novice Exposure Therapists

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Over the past 10 years, our experiences delivering exposure therapy and teaching clinicians to deliver exposure therapy for posttraumatic stress disorder (PTSD) have taught us some important lessons. We will focus on lessons learned as we have attended to clinicians' experiences as they begin to implement and apply the therapy. Specifically, we highlight common therapist expectations including the beliefs that the exposure therapy requires a new set of clinical skills, therapists themselves will experience a high level of distress hearing about traumatic events, and clients will become overly distressed. We then discuss common clinical challenges in the delivery of exposure therapy and illustrate them with case examples. The challenges addressed include finding the appropriate level of therapist involvement in session, handling client distress during treatment, targeting in-session covert avoidance, and helping the client shift from being trauma-focused to being more present and future oriented. Clinicians training exposure therapists and therapists new to the implementation of exposure therapy for PTSD should find this practical discussion of common expectations and initial clinical challenges reassuring and clinically useful.

Keywords: exposure therapy, PTSD, teaching, new therapist

The clinical uptake of effective psychotherapies for posttraumatic stress disorder (PTSD) lags behind what we know about their efficacy. Exposure therapy, one of the best-validated interventions for PTSD (e.g., Institute of Medicine, 2007) remains underutilized by front line clinicians. When asked about their clinical practices, clinicians often cite client factors such as the presence of comorbid disorders and multiple childhood traumas and therapist factors such as fears of client symptom exacerbation and dropout as reasons they would not use exposure therapy (van Minnen, Hendriks, & Olff, 2010). Further, one of the most commonly reported reasons for not utilizing exposure therapy for PTSD is a lack of training and experience (e.g., Becker, Zayfert, & Anderson, 2004). To help bridge this gap, we share our own clinical experiences in learning and training others in exposure therapy for PTSD in order to address common therapist expectations and clinical challenges faced by new and experienced clinicians utilizing exposure therapy. We hope that addressing these common expectations and challenges allays therapist fears, opens a dialogue for clinical discussion of these issues in consultation and supervision, and provides a template of critical teaching points for training other clinicians in exposure therapy.

To set the stage for our discussion of therapist expectations and challenges, we first briefly review the core elements of exposure therapy for PTSD. We then discuss common therapist expectations when starting to implement exposure therapy. Next, we highlight common clinical challenges encountered by therapists, providing case examples of our own therapy successes and failures. Finally, we conclude with some general reflections on our experience in learning and teaching others how to treat PTSD with exposure therapy. It is important to note that clinicians working with children and adolescents using exposure-based therapies for PTSD often share many of the expectations and challenges discussed in this paper and that many of the same principles will apply. That said, our focus here is on working with adults, including those who have experienced childhood trauma.

Overview of Exposure Therapy for PTSD

Common elements of exposure-based treatments for PTSD include breathing retraining, psychoeducation regarding the nature

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of PTSD and related symptoms, in vivo exposure, and imaginal exposure and processing. Therapies that include these elements have a variety of specific names such as trauma-focused cognitive–behavioral therapy, exposure therapy, prolonged exposure, and cognitive–behavioral therapy for PTSD. In this paper, we use the generic term exposure therapy to refer to these variants. At the heart of this therapy is imaginal and in vivo exposure.

Imaginal Exposure

Imaginal exposure refers to repeated and prolonged engagement, revisiting, and processing of the trauma memory, typically done in session for increments of 30–45 minutes (Foa, Hembree, & Rothbaum, 2007; Foa & Rothbaum, 1998). In imaginal exposure, the client is guided by the therapist through a detailed revisiting of the trauma narrative. Instructions include having the client recount aloud the full story of the trauma in the present tense, including as much detail about events, surroundings, sensations, thoughts, and feelings as he or she can remember. When the client completes one full revisiting of the trauma narrative, he or she is instructed to start over again from the beginning, and this is repeated several times over the course of the session. One of the main functions of this repetition is to ultimately diminish the fear response through extinction processes. Throughout revisiting, the therapist helps guide the client toward exploring the most emotionally evocative aspects of the memory by asking probing questions designed to elicit emotions and thoughts. Across sessions, the focus of the revisiting shifts to the most distressing aspects of the memory, termed "hot spots." Following each imaginal exposure, there is an opportunity to "process" the experience; the client and therapist talk about how the exposure went, what it was like for the client, and discuss any unhelpful thoughts or beliefs that may have arisen during the exposure. During this portion of the session, the therapist highlights meaningful work the client did during exposure, helps to address key themes emerging during exposure, and may ask open ended questions to guide examination and shifting of beliefs thought to be central to maintaining the client's PTSD.

In Vivo Exposure

In vivo exposure, which is systematic engagement and interaction with objectively safe trauma reminders in the environment, is often done outside of session, working up a hierarchy of perceived difficulty and distress (Foa et al., 2007; Foa & Rothbaum, 1998). Typically, prior to imaginal exposure and continuing throughout the remaining sessions, the therapist and client work together to identify commonly avoided situations that the client perceives as important to be able to approach. Often these situations target themes such as improving the client's interpersonal or occupational functioning. Each session the client and therapist collaboratively identify which situations to approach, and the client is instructed to approach these situations as homework outside of session, while monitoring distress levels. As with imaginal exposure, over the course of therapy, the focus of the in vivo exposures shifts to the most distressing activities and situations.

Imaginal and in vivo exposure are the primary tool in reducing client avoidance of memories, emotions, and situations and in correcting unhelpful thoughts and beliefs about the self, others, and the world that maintain PTSD. Through these components, fear responses diminish and crucial new inhibitory learning occurs, including changes in beliefs (e.g., Craske et al., 2008; Foa & Kozak, 1986; Hofmann, 2008).

Therapist Resources for Learning Exposure Therapy for PTSD

A variety of resources are available for therapists interested in learning how to conduct exposure therapy for PTSD (e.g., Feeny, Hembree, & Zoellner, 2003; Hembree, Rauch, & Foa, 2003; Jaycox, Zoellner, & Foa, 2002), including workshops and training seminars as well as treatment manuals and videos. These include therapist and client books such as *Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences Therapist Guide (Treatments That Work)* by Foa et al. (2007) and the accompanying client guide *Reclaiming Your Life from a Traumatic Experience: A Prolonged Exposure Treatment Program Workbook (Treatments That Work)* by Rothbaum, Foa, and Hembree (2007). These books provide a strong foundation for understanding the principles of exposure applied to PTSD and step-by-step procedures for implementation. Yet, often the clinician's own experience in implementing the treatment is not the direct focus of these resources. Sharing such clinical experiences, as we seek to do here, provides a rich source of information for trainers and clinicians as they start to implement exposure therapy.

Common Therapist Expectations

All of us have preconceived expectations of what a therapy will be like before we actually implement it ourselves. One of us (L.Z.), though trained in exposure therapy for the anxiety disorders, initially never wanted to do exposure to the trauma memories in PTSD because she could not imagine how having someone go back to the trauma memory would be anything but retraumatizing for the client. Now, based on experience, she believes the exact opposite; exposure therapy focuses on the very heart of the problem for trauma survivors, the memory of what happened. Going back to the memory and revisiting it is not creating new "monsters" for the client. Those "monsters" are already there; rather, exposure is bringing into the room the very heart of the problems; the memory. To not address the trauma memory leaves the "therapeutic elephant in the room" unaddressed. Retraumatization is a misconception of some new therapists. To address this "elephant," the memory, is not retraumatizing, but instead one of the most helpful things for many clients with PTSD. In a similar vein, below, we address common initial clinical misconceptions including fears that clients will not be able to handle the distress, exposure therapy being "technique" but not "rapport heavy," and fears that we as therapists will not be able to handle a client's distress. Addressing these expectations for ourselves and in supervision and consultation can help normalize these feelings and remove barriers to using the exposure therapy for the first time and in the future.

Clinician Expectation: My Client Will Experience Intolerable Distress

In our teaching and supervision, perhaps one of the greatest concerns voiced among novice exposure therapists is that clients

will be "overengaged" in early sessions and will experience severe anxiety reactions such as extreme distress, dissociation, or panic. Frequently, clinicians new to exposure therapy assume that these types of responses are the modal reaction for trauma survivors when approaching a trauma memory or trauma-related fears for the first time. Clinicians, for example, sometimes ask what to do if their client runs from the room or begins to dissociate. It is important that exacerbation of PTSD symptoms over the course of exposure does not occur in most clients (approximately 11%); and when it does, it is not extreme, is temporary, and is not related to either treatment dropout or eventual outcome (e.g., Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002). Although these reactions are possible, more often than not, clients demonstrate what we would term underengagement, rather than overengagement, when approaching trauma-related memories. That is, rather than experiencing overwhelming emotion, clients provide a rote or sanitized version of the traumatic event that fails to evoke strong emotions. This is problematic because, as proposed by emotional processing theory (Foa & Kozak, 1986) and generally supported in empirical research (e.g., Foa, Riggs, Massie, & Yarczower, 1995), fear activation must occur in order for exposure to be effective. Clients must be at a level of engagement where significant, yet tolerable, distress is experienced. As a clinician, often the most difficult task is to help increase (not decrease) clients' engagement with the trauma memory. Existing clinical manuals thoroughly discuss handling both underengagement and overengagement. There are simple techniques that the therapist can use to help reduce or enhance engagement with the memory (e.g., shift from present to past tense during revisiting). Thus, contrary to common clinical expectations, one of the main therapeutic issues is handling underengagement rather than handling the much more rare experience of extreme distress or panic.

Clinician Expectation: There Is So Much Didactic Content and So Many Things to Do in Sessions

We have often seen that clinicians new to exposure therapy focus too much on implementing the techniques of in vivo and imaginal exposure and lose sight of the importance of general clinical skills like listening, attending to the therapeutic relationship, and being supportive. When clinicians first apply a manualized treatment, it is easy to put too strong a focus on the manual, putting aside general clinical skills and instincts. However, as with any effective psychotherapy, when conducting exposure therapy for PTSD, strong general clinical skills, such as the ability to form a supportive therapeutic alliance, should form the foundation of the therapy. If a strong therapeutic alliance is not in place, it makes it difficult to encourage a client to approach the issues that are feared and avoided. Therapists who have good foundational clinical skills are in a very good position to be skillful in the delivery of exposure therapy. Further, clinicians who have experience working with highly anxious or distressed clients, such as those with obsessive–compulsive or panic disorder, can easily translate this wealth of experience into helping the client with PTSD handle trauma-related distress. More specifically, many therapeutic skills such as being confident, being calm, appealing to the treatment rationale, and supporting short-term distress when approaching feared stimuli are identical across the treatment of anxiety disorders. Therefore, not only do good general clinical skills provide the foundation for effective exposure therapy for PTSD, but also the same skills used in the treatment of other anxiety disorders readily apply to the treatment of PTSD.

Clinician Expectation: Exposure Techniques Will Produce Vicarious Traumatization

Another concern we hear from clinicians is how they are going to handle hearing the details of various traumatic events and witnessing the accompanying client distress. After starting to deliver exposure therapy, most therapists are surprised to find that they are not as distressed or dysregulated as they expected to be. One of the main reasons for this is that the focus in therapy is primarily on the *client* and helping the client manage his or her affect. That is, contrary to the expectation that the therapist sits and passively listens to the details of the trauma story, instead the therapist actively employs his or her clinical skills by simultaneously monitoring how the client is doing (e.g., how distressed they are), paying attention to what is being said or not said (e.g., content, tone, pacing), and attempting to identify underlying themes or issues that are emerging for later processing. The amount of therapist work, even in the midst of listening, helps mitigate the therapist's own distress during revisiting. Additionally, just as repeated exposure decreases a client's distress, the therapist's distress also decreases with repeated exposure to listening to the client's memory. Because of this, many therapists are surprised at their own ability to hear about traumatic events, be empathetic and supportive, and be present for their clients to promote engagement with the trauma memory.

Summary

It is common that clinicians new to exposure therapy expect it to be therapeutically constraining and dominated by high levels of distress for both the client and the therapist. We have heard seasoned therapists remark that they would never want to treat PTSD, to be continually reminded of trauma and the intense pain of others. Yet, after implementing exposure therapy, therapists often recognize that this focused treatment does not have to fit the stereotype of manualized treatments as technique heavy and mechanized and that exposure therapy not only allows for but also requires strong general clinical skills. For instance, clients and therapists are able to bring their own unique personalities to the therapy room and, once a sound therapeutic relationship has been established, can even use levity as a useful therapeutic tool (e.g., respectfully joking with the client about his or her amazing capacity to avoid trauma-related situations). Additionally, therapists come to see first hand that this treatment helps clients by providing them with the opportunity to approach their traumatic memory in a safe therapeutic environment. Indeed, because clients have the experience that other people in their lives avoid discussing their traumatic experiences or behave as though they are walking on eggshells, an in-depth, warm, yet matter-of-fact discussion about the trauma and subsequent sequelae with an engaged therapist can be quite relieving and validating for the client. With an understanding of both the treatment rationale and the importance of general clinical skills, such as building a strong therapeutic alliance, therapists often find that it can be extremely rewarding to do exposure-based treatment with individuals with PTSD.

Common Challenges in Learning Exposure Therapy

In this next section, we shift to common, practical challenges that therapists experience when they first start to implement exposure therapy. These challenges include how directive a therapist ought to be during therapy, how to manage distress, how to identify and address pieces of missing trauma-related information from the narrative, and, finally, how to help clients make the critical shift in focus from the past to the present and future. To illustrate these, we provide case examples from our learning experiences and discuss general principles for overcoming these challenges.

Less Can Be More: Being Directive When Conducting Exposure Therapy

In our experience, often when clinicians think of cognitive–behavioral therapy (CBT) and exposure-based therapies, they think of a highly directive therapist. Although to some extent this is true, more often than not, the therapist follows the client's thoughts and feelings rather than vice versa. Indeed, a "less is more" mentality regarding directiveness provides a more powerful learning experience because the client is focusing on the aspects of the trauma memory that are most salient to him or her and can begin to recognize and alter the associated unhelpful thoughts and behaviors, rather than the therapist deciding on the most important place to focus and directly attempting to change the client's maladaptive thoughts and behaviors. More direct therapist involvement is typically employed when approaching the most distressing issues (e.g., memory hot spots) and when the therapy hits roadblocks rather than in the typical course of therapy.

Similar to other forms of CBT treatment, exposure therapy for PTSD is a collaborative process; a true team effort aimed at improving the client's symptoms and quality of life. Thus, well-executed exposure treatment requires the therapist to provide necessary warmth and empathy and to strike an appropriate balance between allowing the client to take the lead and actively moving the client forward in the face of roadblocks. Particularly in imaginal exposure, both during the imaginal revisiting and the processing, the therapist needs to strike this balance between leading and following. This issue of balance will be illustrated with two case examples: one focusing on imaginal exposure and one focusing on processing the traumatic memory following imaginal exposure.

Directedness during imaginal exposure. The therapist's role during imaginal exposure can appear deceptively passive; however, successful imaginal exposure requires the active monitoring and titration of the client's level of engagement in revisiting the trauma. For even the most experienced exposure therapist, subtly guiding the client to engage with the themes that are most relevant while simultaneously not pushing too far or too fast can be challenging. When therapists are skillfully asking questions during imaginal exposure, they are asking purposefully timed questions aimed at helping the client to explore relevant thoughts, emotions, and details about the traumatic experience. In general, asking questions during imaginal exposure increases in frequency over the sessions, as the client delves into the more difficult pieces of the memory and works up to tolerating and exploring the most difficult, but important, themes. A novice therapist may even feel voyeuristic when asking for explicit details about the trauma when in fact this is useful for the client. When direct questioning during imaginal exposure is done artfully and skillfully, it can propel the client to explore salient and important aspects of the memory that may ultimately be some of the most crucial aspects of successful recovery. Nevertheless, not working in conjunction with the client can result in the client feeling pushed and unheard. This is illustrated in the case of Elizabeth, as described by her therapist:

> Elizabeth, a 35-year-old Caucasian woman, was involved in the illegal drug trade with her husband, stealing money for drugs and selling drugs. During a drug deal, she was held at gunpoint by four men. During our first imaginal exposure session, Elizabeth displayed strong negative emotions directed at her ex-husband for putting her life in danger, stating "He only cared about the drugs, not about me" and "How could he do that to me?" These comments were all about her anger and not about how terrified she was in the situation. Although I did not address this in that first imaginal exposure session, I suspected that her anger was likely covering up her feelings of fear, as I believed the anger was most likely secondary to her fear of ever being that vulnerable again. In our next imaginal exposure, I was more directive, attempting to shift the focus of her recounting from anger to fear by asking questions to direct her focus to threat, such as "What are you thinking as you see the gun?" and "How do you feel as he pulls out the gun?" As I did this, her voice tone became more neutral and she stopped adding details in each retelling despite my probing. Afterward, Elizabeth expressed doubts about the treatment being a good option for her, stating "I don't really see the point in this" and "Is this what we are going to do every week?" After this session, Elizabeth did not return. Although her fear was an important target in treatment, my early push to focus on how afraid she must have been in this situation most likely invalidated her strong reactions of anger.

As illustrated with Elizabeth, being overly directive and probing too much too early on in treatment can evoke feelings of reluctance in the client, or a sense of not being heard, and subsequently impair confidence in the imaginal exposure process, the therapist, and ultimately impact the client's commitment to the treatment. As said earlier, at the beginning of therapy, less direct questioning is often better than more. One simple way of encouraging more in-depth exploration without being overly directive early in therapy is to encourage the client to include all of the important details of the memory by suggesting, "If something is in your memory, you should say it out loud." This allows the client to have time to recount the memory at his or her own pace and often allows for salient issues to emerge on their own.

When hearing a trauma narrative, it is easy for therapists to presume what might be the most difficult or distressing parts of the experience. Yet, it is important that therapists remember that the "hot spots" or emotion-laden pieces of the memory may not be as they appear and being too strongly attached to a notion of where the emotion "should be" can be detrimental to therapy. Further, although looking for emotion and distress during recounting can be a useful guide, at times, it can also be helpful to look for what is not there. An absence of emotion can be just as indicative of an important piece of the memory as high emotion. It is crucial that the therapist work with the client to come to a mutual agreement about the most potent and impactful pieces of the memory. In hindsight, if the therapist had been less directive and allowed Elizabeth to explore her own salient themes of anger and betrayal by her husband, and, even addressed the anger during processing, exploration of her fear would most likely have naturally followed.

Directedness during processing of imaginal exposure. After each session of imaginal exposure, the therapist and client engage in "processing" of the experience, identifying key themes and exploring and shifting unhelpful beliefs. This is another point where the therapist must determine how active a role to take. Some clients, when imaginal exposure ends, are quick to bring up new insights and discuss emotional experiences easily. Other clients, perhaps less psychologically minded or emotionally expressive, respond rather reservedly to initial questions of "What did you notice?" or "What stood out today?" making general statements that do not appear to evolve or pertain to core themes. It is with these clients, in particular, that therapists have a tendency to shift into a more directive processing mode right away. In this circumstance, therapeutic work may look like more overt cognitive restructuring, forgetting the importance of "less is more" therapist involvement. The case of George, as described by his therapist, readily illustrates this issue:

> George, a 45-year-old Hispanic married father of two, experienced childhood sexual abuse beginning at the age of three. George held a strong spiritually based belief that people draw all of their life experiences to them. Consequently, he carried a lot of self-blame for the abuse he endured as a child. He said things like: "I asked for this," "This happened because I'm weak," and "I'm a magnet for abuse." As part of processing, I directed his attention to these beliefs, discussing the reasonableness that a three year-old could be that powerful, reminding him of the cognitive and physical limitations of such a small child. Whenever I challenged his beliefs directly, I was met with strong resistance. George said things like, "[I] didn't understand what had happened to him," and "The fact that it was my fault isn't going to change." Indirectly his beliefs appeared to actually strengthen. In light of this, I chose to step back from explicitly addressing this theme during the processing, in the hope that he would explore it himself as our work progressed. Indeed, later in treatment when my focus was much less directive, he did come to explore his role more realistically and closely. As I asked more open-ended questions like, "What did you notice during the imaginal?" and "Do you see things the same or differently now?" he began to report being annoyed by his self-blame and surprised how hard he was on himself when he was just a little boy.

As illustrated by the case of George, client-directed "organic" shifts in beliefs are often more powerful and durable changes than those directed or spoon-fed by therapists. A common mistake of new therapists is to do too much of the work for clients during the processing, including telling them how they should think or feel, rather than allowing clients to arrive at these conclusions on their own. One of the central goals of exposure therapy is that in approaching the trauma memory clients have the opportunity for new learning; learning that they can tolerate the memory, that the memory itself cannot hurt them, and that persistent rigid post-trauma beliefs about the self, others, and the world can be unhelpful and inaccurate. Unlike directive cognitive restructuring techniques, cognitive change in the processing of the imaginal exposure occurs when therapists work with clients to support their own processing of the event.

As part of a solid case conceptualization, the therapist helps the client identify relevant themes such as self-blame, guilt, and shame, and gently guides the client in these directions. During imaginal exposure, it is often useful for the therapist to write down key pieces of the memory or statements by the client to then reference in processing. These can be simple statements offered to stimulate discussion such as "Today I noticed that. . ." or "I noticed at one point you mentioned. . .and then another point you mentioned. . ." These types of simple statements, directly reflecting what the client said during imaginal exposure, are often enough to stimulate meaningful comments and insights from the client. A therapist can also "bookmark" a theme before engaging in active work on it during later processing (e.g., "It sounds like you are blaming yourself for what happened. We will come back to that, as it sounds like it's contributing to your ongoing distress.").

As illustrated in the cases above, a dynamic level of involvement of the exposure therapist is crucial to successful treatment. The therapist must understand the client and where he or she is coming from in order to best identify a level of involvement and directiveness that will be most useful in moving the therapy forward. With that said, as can be seen in these examples, the common tendency for new therapists is to be too directive, not allowing the client to sufficiently lead where the therapy goes.

Responding to Client Distress

As mentioned above, therapists new to exposure treatment often have concerns that, in asking someone to revisit the trauma memory, the client will become so distressed that he or she will not be able to tolerate the distress. In conducting workshops on exposure therapy for PTSD and in clinical supervision, we've seen firsthand that this is a common concern. For this reason, therapists express reluctance to try exposure-based treatment or think that exposure may only be appropriate for a limited subset of clients with PTSD, imagining that the clients they typically see would not be able to handle exposure. The case of Virginia, as described by her therapist, illustrates this problem, how the therapist's own uncertainty of whether or not the client could tolerate the distress impacted how she managed the client's distress.

> My very first client with PTSD, Virginia, was a Caucasian woman in her early 40's. Having run away from home when she was a teenager, her target trauma was her first sexual experience of forced intercourse with the man who was providing her housing and financial support. When we met, she had not spoken to anyone about this incident. Virginia was very nervous about starting imaginal exposure and very upset that she could not remember certain details of the assault. In the first imaginal exposure, I tried to reassure her that she need not worry about missing details and to just focus on what she remembered. As Virginia became distressed, I started to become concerned what I was saying was similar to the things her perpetrator had said to her such as "Just do it. Don't worry. Focus on me" and that in encouraging her to continue, I was being coercive just as he had been. This scared me. I decided that the exposure was too distressing, too much like the trauma itself, and that we should stop. It was not until I got into supervision that it became clear to me I had made a clinical error. Ultimately, although well intentioned, in stopping her imaginal exposure, I inadvertently strengthened her belief that the memory itself was dangerous. In her next session, she was reluctant to engage in imaginal exposure and was affectively flat as she revisited the event; and after that, it took several weeks for her to come back and continue with treatment. Virginia said she decided to come back to treatment because she was just so sick of her symptoms. She also reported being afraid that the memory was too difficult to face, but with gentle encouragement, she was able to reengage in revisiting the memory, and was able to successfully complete treatment.

As Virginia's case illustrates, when a therapist does not have prior experience listening to traumatic events, it is often difficult to determine whether the client is successfully revisiting a painful memory (which is what we want to see), or whether he or she is reliving what happened (which is not what we want to see), and needs to be less engaged in the memory. Prior to obtaining direct personal experience, new therapists can follow general guidelines on how to recognize optimal engagement and identify overengagement so as to know when it is appropriate to intervene. A client who is at an optimal level of engagement is connected to the memory on an emotional level, but is also aware that he or she is safely grounded in the present. Alternatively, a client who is overengaged with the memory looks like he or she is out of control of the experience and not present with the therapist in the room, that is, he or she is actually back reliving the event rather than revisiting it. When the client needs to be less engaged with the memory, instead of stopping the imaginal exposure, there are a wide range of therapist strategies that the therapist should first apply to help the client reduce engagement and successfully recount the traumatic event. These include shifting the client's language from present tense ("I'm lying on the bed.") to past tense ("I was lying on the bed."), opening his or her eyes, holding something in his or her hand to remember that he or she is not back there, or even writing about the event rather than telling (see Hembree et al., 2003, for a discussion). Any of these variations would have helped the client better modulate her distress and successfully complete imaginal exposure.

Sometimes stopping feels like the "safest" thing to do. However, choosing to terminate an exposure is only one of many strategies, and most likely one of the last choices a therapist should make to modulate distress. The costs of stopping imaginal exposure include potentially reinforcing the sense that the memory is dangerous and that the client cannot handle it. Even if the exposure was stopped, the therapist should, if at all possible, help the client reengage successfully with the memory in the session when it was stopped rather than waiting to the next session, applying variations of the techniques described above. This said, we never force a client to revisit the memory, though we clearly explain the short-term benefits of stopping the exposure versus the long-term benefits of restarting it.

The case of Elliot, as described by his therapist, illustrates how persisting with imaginal exposure, despite the client's distress and concern that he would vomit, led in the end to successful treatment of his PTSD.

> Elliot was a 25-year-old Caucasian man who had served in Iraq for two years. He was most troubled by having witnessed a vehicle containing his fellow soldiers explode as a result of an improvised explosive device. When we began working on hotspots, we focused on trying to keep his friend alive by administering cardiopulmonary resuscitation. Immediately after he began exposure to the hot spot, he felt sick to his stomach because the taste of blood in his mouth and the smell of burning flesh were so vivid to him. He asked if he could end the exposure because he felt nauseous, but I encouraged him to continue, reminding him that our goal was to stop avoiding the memory. He requested that I move the trashcan closer to him in case he needed to vomit, which I did. I also suggested that he open his eyes to make the memory less vivid. He paused in the middle of his revisiting every few minutes, putting his head in the trashcan and making gagging sounds, though he never vomited. It became clear that the trashcan was serving as a means to disengage from the memory. I brought this up to Elliot at the next session and asked him what was the worst thing that could happen. He replied that he was worried about vomiting on me. We discussed that, if this was the worst thing that could happen, it was okay and I had a spare change of clothes. We both laughed. This not only lightened the mood, but it also forced Elliot to explicitly think through the worst-case scenario and accept that it would be okay. We left the trashcan on the other side of the room, and Elliot was able to recount the hotspot with several repetitions. At the end of the imaginal exposure, I was ready to proclaim that it was a success when Elliot hurled himself across the room and vomited in the trashcan. I wondered whether I had pushed him too far. To my surprise, he was not upset. Although something close to his worst-case scenario had just happened, he now also had proof that he could handle talking through the worst part of his trauma memory, even if the consequences this time were unpleasant.

As illustrated by the case of Elliot, even though he asked to stop the exposure, the therapist was able to use other strategies to modulate his distress so that he could stop avoiding the memory and begin to learn that he could even tolerate his worst-case scenario. It is also important to note that vomiting during imaginal exposure is a very, very rare occurrence. In particular, conditioning that occurs with olfactory or gustatory cues is often powerful and easily retrieved. Thus, remembering the taste of blood and the smell of burning flesh most likely triggered a gag reflex for Elliot.

More broadly, a new therapist is working without direct personal experience of what optimal emotional engagement feels like in the therapeutic room, without firsthand experience of how effective exposure treatment can be, and without the sense of how resilient most clients truly are. If at all possible, one teaching tool is to have new therapists watch tapes of overengagement, with the therapist successfully attenuating it, tapes of optimal engagement, and tapes of underengagement, again with the therapist successfully increasing engagement. When conducting exposure therapy for the first time, perhaps the best adage for a new therapist is to remind him or herself what we tell our clients, "Exposure works." Finally, it is easy to "fragilize" the client, wanting to protect the client from undue emotional distress, as he or she has "experienced enough trauma," and forgetting that for the first exposure a client often modulates his or her distress well on their own by simply allowing the client to control the content and pacing. As with the case of Elliot, the more we as therapists convey that the memory of the event will not harm the client and that the client has the resources to both tolerate the memory and succeed the easier approaching the memory will be for the client.

Identifying Missing Pieces of the Puzzle

Another common challenge for therapists is figuring out whether or not they have the full story about what happened to a client. Our clinical stance is always to believe what our clients say to us and to assume that there are many reasons for missing bits and pieces of a trauma memory (e.g., where attention was focused, childhood forgetting, shock, substances, or trauma to the head). Typically, we do not push for filling in the "gaps" but encourage the client to accept what he or she does and does not remember; however, there are times when things just don't make sense. Clinically, this can be important as it may indicate that the client is holding something back that is meaningful to his or her recov-

ery. As with most other psychotherapies, the therapist must be attuned to his or her own clinical instincts as to when a client is holding something important back or when things just do not add up. This type of covert avoidance can occur during imaginal exposure.

For most clients, typical avoidance during imaginal exposure takes the form of not including sensory or emotional details of the most potent piece of the memory. This usually resolves with probing questions from the therapist, appeals to the treatment rationale, or repeatedly revisiting the experience over time. Yet, for some clients, the task of recounting the trauma memory is so daunting due to intense emotions such as fear, guilt, and shame that they may engage in hard to identify forms of avoidance to prevent emotionally connecting with the experience. In some cases, avoidance of the memory may include omission of specific details about the traumatic experience. This avoidance can be obvious (e.g., saying "and then he raped me" and skipping over all that happened during the rape) or at other times more subtle (e.g., failing to say that the assailant made her say "I love you."). This type of avoidance can be both difficult to identify and challenging to address. Leah, as described by her therapist, is a case that illustrates just how tricky identifying covert avoidance and encouraging the client to be forthcoming can be:

> Leah was a 20-year-old African American woman who had experienced childhood sexual abuse from her stepfather from an early age until she left home as a teenager. Although her mother and siblings were aware of the abuse, no one did anything to stop it, thereby communicating an acceptance of her stepfather's behavior. In addition, their silence contributed to Leah's feelings of guilt and shame that she must have been contributing to the abuse and "was too weak to stop it." Although we developed a strong therapeutic alliance, I struggled with getting Leah to emotionally connect with the memories of her abuse. She would willingly recount the trauma memory, but would often take long pauses and open her eyes if she began to cry. When asked, Leah reported that when she began to feel strong fear or shame she would begin conjuring up images of her dog to avoid the feelings associated with revisiting the memory. Over the course of therapy, as we were seeing very little change in her symptoms, it became clear that there were key things she was not willing or able to say about what happened to her during her abuse. At one point in response to my querying about a particular detail, she simply said there were "things I still haven't told you or anybody else." The cumulative effect was that her shame and guilt did not change over the course of therapy, and she reported a belief that imaginal exposure was not effective. At the end of 10 weeks of therapy, even though she made considerable gains with in vivo exposure, Leah was still experiencing notable PTSD reexperiencing symptoms, most likely due to her lack of emotional engagement and my inability to help her be more forthcoming with potentially crucial details regarding her abuse.

As illustrated in this case, when there is a reasonable belief that something is being left out, the therapist ought to explicitly query whether or not something is being omitted from the revisiting. This is hard because a new therapist often feels caught between wanting to take the client at his or her word and also wanting to fully understand the barriers to emotionally engaging with the memory. Most noteworthy, in the example above, the client's reexperiencing symptoms were not decreasing. This is easily tracked by having clients fill out a brief self-report of PTSD symptoms each session for the previous week, such as the PTSD Checklist (PCL, Weathers, Litz, Herman, Huska, & Keane, 1993) or the PTSD Symptom Scale – Self-Report (PSS-SR, Foa, Riggs, Dancu, & Rothbaum, 1993). The lack of expected decrease in symptoms over time triggered the therapist's more in-depth examination of what was happening during imaginal exposure. Paying attention to indications of avoidance, such as prolonged pauses, and noting that something is being pushed down and details are not being verbalized, is crucial to not allowing the client to continue patterns of avoidance that are deeply ingrained. This can be challenging at times, as therapists often are afraid of disturbing the therapeutic alliance and invalidating how hard it is to engage in imaginal exposure. Yet, if these fears stop the therapist from labeling covert avoidance and how it is impacting progress, it can result in the therapist encouraging underengagement by complimenting half-hearted efforts and not explicitly outlining why the treatment is not helping symptoms.

It is crucial that the process is collaborative, warm, and supportive. Often, the avoidance is centered around something the client has never told anyone before and is overshadowed by negative beliefs about him or herself (e.g., "I'm a horrible person."). Conveying a nonjudgmental attitude, appealing to some of these possible beliefs about oneself, and normalizing the presence of "things unspoken" may help facilitate disclosure. This is all done in the context of a strong appeal to the treatment rationale and the collaborative nature of the therapeutic relationship. Ultimately, the therapist needs to create an atmosphere where the client may approach these avoided pieces so that "unfinished business" or "unspoken horrors" do not remain for the client.

Shifting From Focusing on the Past to the Present and Future

A final common clinical issue that often arises with individuals with PTSD is their thoughts are so focused on the past that they cannot see or experience the future, and thus are, in many respects, stuck in the past. The clinical question then becomes how best to help individuals come to terms with the past so that they can move forward in the future.

It often takes individuals months and frequently years to seek treatment for PTSD, struggling with the traumatic event and the resulting distress over that time. Thus, a strong identification with the traumatic event is not uncommon, and it is not rare to see clients with PTSD who have taken on the identity of the victim or survivor to the exclusion of pursuing future goals. Examples of this include the war veteran who years after being discharged still routinely wears fatigues and regalia or a childhood abuse survivor who continues to define him or herself as the caretaker of his or her adult siblings whom he or she protected from the abuse. Helping clients better separate their current identity from that of the past or further create a new identity can be extremely therapeutic. However, it can also be quite challenging. At times, this shift may occur naturally from repeated engagement with the memory, through processing the experience with the therapist highlighting the differences between circumstances then and now, and through in vivo exercises, which reinforce making changes and moving forward beyond the traumatic event. When this happens, clients may say things like, "What happened to me does not define WHO I am," or "I'm more than just a combat soldier." At other times, this shift does not come about naturally and instead requires active intervention and direct targeting on the part of the therapist. Trying to

encourage clients to let go of the traumatic experience as the defining characteristic of their identity may on one level seem contradictory to encouraging engagement with the experience as much as possible. However, keeping in mind the larger, overarching goal of treatment, which is to give clients better control over the memory, helping clients to put the experience in their past is consistent with the theory guiding exposure. The case of Emma, as described by her therapist, readily illustrates this issue:

> Emma, a 50 year-old Caucasian woman presenting for treatment after surviving her fourth rape, identified strongly as a rape survivor. In one sense, this empowered her to live her life as a survivor and inspired her to want to work with young girls who were experiencing family difficulties. On the other hand, being a rape survivor became so entwined with her self-identity that it was difficult for her to see herself as anything else, despite the fact that she was a successful health care professional and mother. As a result, she often inappropriately disclosed her experiences of sexual assault, exhibiting a high level of emotion that was difficult for those around her to tolerate. This behavior was harmful to both her professional and interpersonal relationships. At her place of employment, she reported that her boss told her to "try and keep her personal life at home" because she was making her coworkers and the young women she was working with uncomfortable. In social situations, Emma would often disclose intimate details about her rapes and show a high level of emotion that made others "uncomfortable" and often resulted in people terminating relationships with her suddenly, something that frustrated and confused her. Throughout the course of treatment, she began to be able to discuss the rapes without extreme dysregulated emotional behavior, which we both considered an important shift. In addition, through in vivo assignments, she moved forward in pursuing her goal of going back to school and had increased her level of engagement with her children. Yet, she did not alter her problematic disclosing behavior.

Originally, I thought her disclosure issues were attributable to how distressed she was, and thus I did not directly work with her on reducing these disclosures. My fear that I would invalidate her identity as a survivor, an identity that in many ways empowered her, stopped me from pursuing this during her in vivo exposure homework assignments. At termination of treatment, she was still openly disclosing highly personal details (e.g., the child she conceived during the rape and subsequently aborted; her status as a survivor of multiple rapes) to people that were mere acquaintances and had made little progress with her other goals such as finding a satisfying romantic relationship. In retrospect, I believe that I did not sufficiently highlight the role her disclosure and identity as a victim played in her interpersonal difficulties, and thus she continued to attempt to attach and connect with people in a manner that served to push them away.

As evident in the case of Emma, progress can be limited by holding on too strongly to an identity as a trauma survivor. No doubt, traumatic events are powerful experiences that often alter an individual's life in a variety of ways, sometimes inspiring or motivating the client to make changes for the better or to recognize the courage and strength that he or she possesses. Notwithstanding, when the trauma itself becomes the core of the person's identity, to the exclusion of other character traits and life experiences, then it can become problematic for the individual to lead a balanced life in which he or she can integrate his or her past traumatic experience with his or her current roles (e.g., friend, parent, career) in life. Often over the course of treatment, this shift occurs naturally from defining oneself as a victim or survivor, to defining oneself more broadly as a person with many traits and experiences.

Among the most effective approaches to help a client to make the past-present distinction is to directly address the behaviors that seem "stuck in the past," such as disclosing without discretion versus being controlled and selective in choosing with whom to share important details. This can raise insight as to how identifying with the trauma on the surface may seem helpful but may actually be keeping the client stuck in the past. When doing this, the therapist must clearly validate the major impact that event had on the client's life. Asking simple questions that remind the client of the aspects of his or her life and identity before the trauma and what he or she wants life to look like in the future can also help the client to move forward. It is important, the therapist does not need to know *how* the client needs to think differently to move forward, but can help the client discover that by asking questions such as, "How do you think you need to think about this in order to get past it? . . . What do you need to do to be able to think like that?" With the issue of inappropriate disclosure, for example, in session role-playing of appropriate behaviors and in vivo homework assignments in which the client observes the reactions of and notes the expectations of others can be enormously beneficial in fostering realistic expectations and roles in interpersonal relationships. Ultimately, when a client overidentifies with the trauma, this is a tricky situation in which the therapist needs to tread very lightly so as to not invalidate the client; yet, not addressing this, particularly when it is clearly impairing functioning, is a clinical misstep.

In Closing: Reminding Therapists About Resilience and Courage

In this paper, we have tried to outline some of our own training experiences, missteps, and fears in the hope of helping clinicians who train others in exposure therapy and those learning to apply exposure therapy in the treatment of PTSD for the first time. One of the most profound realizations working with a wide range of multiply traumatized men and women with PTSD is how much stronger and more resilient our clients are than we ever expected. What do we mean by this? As hinted at earlier, often, as a therapist, it is easy to conceptualize someone who has undergone a horrific event as psychologically fragile; needing to be handled with "kid gloves." Yet, it is useful to remember that he or she has already showed a great deal of courage and strength. He or she has made it through the event, chosen to acknowledge the source of his or her current problems, and is actively seeking help. With this personal resilience and therapist support, a client is able to approach the things that make him or her afraid. Some clinicians are afraid to ever ask the question or hear the answer to, "What actually happened?" For individuals with PTSD, exposure therapy provides a means to directly and therapeutically approach this question, without "dancing around" sensitive topics, either because of our own discomfort as a therapist or because of fear of making the client feel uncomfortable. If there ever was a proverbial "elephant in the room," in PTSD treatment, it is the trauma memory itself. Approaching this difficult topic in a sensitive, nonjudgmental, nondismissive atmosphere within the solid therapeutic alliance is often the best therapeutic approach for the client with PTSD.

Working with individuals who have survived traumatic events is no doubt challenging but is also inherently rewarding. As exposure

therapists, our role is to guide our clients through the difficulty of approaching the memories of their trauma and other trauma-related fears in order to help them regain their lives: A challenge that takes a high level of understanding, skill, and effort on the part of the clinician. In our experience, working with these clients is more often than not a highly gratifying clinical experience, teaching us about human resilience, strength, and courage in the face of adversity.

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