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Prolonged Exposure Therapy for PTSD in Sexually Abused Adolescents

Sean Perrin, PhD

Prolonged exposure (PE) therapy is an established treatment for posttraumatic stress disorder (PTSD) in adults, having been used effectively in a variety of clinical contexts and with a wide range



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of trauma-exposed groups (ie, combat veterans and survivors of violence and man-made and natural disasters).¹ Prolonged exposure is a theory-driven approach that involves 2 forms of therapeutic exposure: gradually increasing contact with situations and cues that trigger PTSD symptoms (in vivo exposure) and the voluntary recall of the traumatic event in as much detail as possible (imaginal exposure).² The patient is led through both forms of exposure by the therapist in session, and only then are patient-led, exposure-based homework assignments given. Therapist-led exposure begins after only 1 to 2 sessions involving the provision of a treatment rationale, information about common reactions to trauma, and goal-setting. No further preparation of the patient for exposure (eg, extensive training in arousal reduction skills) is required for PE therapy to be safe, tolerable, and effective with adults.^{1,2}

In this issue of *JAMA*, Foa et al³ report findings from the first trial of PE therapy for PTSD in adolescents who had experienced sexual abuse. Patients (N = 61, all female, aged 13-18 years) were recruited from a rape trauma center, had a history of sexual assault, and had 5 or more current symptoms of PTSD. After an average of 1.5 sessions dealing with safety issues, parental involvement in treatment, and interest in treatment, patients were randomized to receive 14 weeks of PE therapy or supportive counseling. Patients receiving supportive counseling were offered the opportunity to speak about their trauma, but none chose to do so.

After treatment, both groups experienced significant reductions in PTSD and depression and significant improvements in global functioning. However, 83.3% in the PE group no longer met criteria for PTSD diagnosis compared with only 54% in the supportive counseling group. In addition, patients receiving PE were 2 to 3 times more likely to be a “good responder” (conservatively defined as ≥ 2 SD in PTSD symptom change from baseline) than those in supportive counseling (73% vs 27%). Treatment gains were maintained in both groups at 12-month follow-up, as was the superiority of PE therapy over supportive counseling.

There are several notable features about this trial. First, treatment was delivered by master’s-level counselors with no prior experience in PE (or any evidence-based approach to PTSD). Training in PE was limited to a 4-day workshop and then group supervision every 2 weeks by 2 of the authors. Second,

patients in the PE group had a high degree of confidence in the treatment even though it was delivered by novice PE therapists and even after those patients were informed that treatment would quickly progress to exposure to reminders of their sexual abuse. Less than 10% of patients in the PE group did not complete treatment.

The 83% rate of PTSD recovery reported by Foa et al³ is similar to that reported for trauma-focused cognitive behavioral therapy (TF-CBT) in sexually abused 8- to 14-year-olds (79%).⁴ In contrast to PE, patients in TF-CBT progress through modules targeting emotional awareness and expression, coping skills training, cognitive restructuring, personal safety, parent work, and then imaginal exposure to traumatic reminders. Similar to PE, TF-CBT was effectively delivered in 12 to 16 sessions by therapists who were naive to TF-CBT and received only 3 to 4 days of training and weekly supervision.

The current findings are consistent with the large body of evidence supporting PE therapy as a first-line treatment for adults with PTSD arising from a range of traumas.² Although more trials of PE for sexually abused children and adolescents are needed, there is no theoretical or practical reason to assume that PE will not be equally effective for PTSD arising from other types of traumas or in children. Two previous controlled trials of patients with PTSD not related to sexual abuse, one trial using PE with adolescents⁵ and another using exposure plus cognitive restructuring with children and adolescents,⁶ provide some support for such a conclusion. Nevertheless, one potential obstacle to the dissemination of PE and related therapies may be therapists’ beliefs about exposure-based therapies generally and with children in particular.

An increasing body of research indicates that even when therapists are aware that highly effective exposure-focused therapies are available for PTSD, obsessive-compulsive disorder, panic disorder, and other anxiety disorders, they either do not use them or deliver them in suboptimal formats (ie, delaying the onset of exposure in therapy, prioritizing patient-led over therapist-led exposure, and encouraging the use of arousal-reduction strategies during exposure that may inhibit recovery).⁷⁻⁹ The research suggests that these problems of use and delivery are partly related to therapists’ concerns that exposure may significantly worsen or prolong symptoms, is poorly tolerated by patients, and increases the risk of treatment dropout. Such concerns may be heightened when the patient is perceived to be particularly vulnerable because of a history of sexual abuse. These concerns may have the unfortunate consequence of delaying the use of PE therapy in the treatment of adolescents. If adolescent patients fail to expe-

rience symptom relief as a result of delayed treatment, they (and their parents) may disengage from therapy.

Findings from the current report by Foa et al³ should allay therapist concerns about any potential harmful effects of exposure and the need for extensive preparation of the patient for exposure. The heightened arousal that accompanies exposure to traumatic reminders in session usually dissipates within a few sessions and leads to rapid reductions in symptoms between sessions. Thus, the heightened arousal that

many therapists fear causing by leading the patients through exposure exercises is an expected and integral part of the recovery progress.

In the future, greater efforts are needed to increase awareness about the safety, tolerability, and effectiveness of treatments like PE.⁹ Research is also needed to determine the minimum amount of training and supervision for therapists to effectively deliver PE and similar exposure-focused treatments to patients with PTSD and other anxiety disorders.

ARTICLE INFORMATION

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