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Response to Commentaries on Individualizing Exposure Therapy For PTSD: The Case Of Caroline

Between Manualized Treatments and Principle-Guided Psychotherapy: Illustration in the Case of Caroline

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ABSTRACT

My case study of "Caroline"—a 26 year old presenting with depression, PTSD symptoms, and a history of sexual abuse as a teenager—represents a "third way" between (1) a strict adherence to a manualized treatment, and (2) a principle-guided therapy, in which the therapy follows particular theoretical concepts, but depends on the therapist's clinical judgement to flexibly apply them to the individual case. Specifically, in my therapy with Caroline (Kramer, 2009), I employed Foa and Rothbaum's (1998) cognitive-behavioral, "Prolonged Exposure" (PE) manual for PTSD, but deviated from it in certain ways based upon my evaluation of Caroline's individualized goals and reactions using Grawe and Caspar's "Plan Analysis," which is a cross-theoretical model for assessment and treatment planning. In their commentaries on my case study of Caroline, Caspar (2009) and Haldimann-Balli (see Appendix in Kramer, 2009) support my use of this third way. On the other hand, the other commentators—Muller (2009) and Hembree and Brinen (2009)—critique my handling of the case, arguing that strict adherence to the Foa and Rothbaum manual would have resulted in a more cost-effective therapy. In this article, I respond to the important issues raised by the four commentators.

Key-Words: post-traumatic stress disorder (PTSD); prolonged exposure (PE); Plan Analysis; therapeutic relationship; emotional exposure

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INTRODUCTION

Two important, contrasting models for conducting therapy include (1) manualized treatments, which involve strict adherence to pre-structured procedures for a specified disorder, and (2) principle-guided therapy, in which the therapy follows particular theoretical concepts, but depends on the therapist's clinical judgement to flexibly apply them to the complexities of the individual case. In my therapy with "Caroline" (Kramer, 2009), a 26-year-old client with

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depression and PTSD associated with sexual abuse as a teenager, I employed a "third way" (Caspar, 2009). While using Foa and Rothbaum's (1998) "Prolonged Exposure" (PE) procedural manual as my main treatment, I modified it in response to my evaluation of the client's individualized goals and reactions based on Grawe and Caspar's "Plan Analysis," which is a theoretical model for assessment and treatment planning. In their commentaries on my case study of Caroline, Caspar (2009) and Haldimann-Balli (Appendix in Kramer, 2009) support my use of this third way, while Muller (2009 and Hembree and Brinen (2009) critique my handling of the case, arguing that strict adherence to the Foa and Rothbaum PE manual would have resulted in a more cost-effective therapy. I appreciate the scholarly and thoughtful presentation of each of the commentators' views and find them most important in understanding the dialectic between manualized treatments and principle-guided therapy in contemporary psychotherapy research and theory. In this article, I respond to the issues raised by the various commentators.

As suggested by Muller (2009) and Hembree and Brinen (2009), it is certainly possible that in Caroline's particular case, my modification of the PE manualized procedures may not have been necessary. Indeed, similar cases have been reported where the PE procedure was sufficient and highly successful. Moreover, the research literature shows that PE does not need any add-on elements—at least in many cases—in order to be effective (Foa, Hembree, et al., 2005; Hembree & Brinene, 2009).

However, as underlined by Caspar (2009), no manualized therapeutic procedure yields 100% effectiveness; and this logically implies that the procedure may always be "enhanced," as I intended to do in the case of Caroline. Caspar argues that clinical reality sometimes imposes on the therapist the need for flexible but nevertheless mindful and rigorous handling of the treatment. Generally, then, in "third way" treatment, therapist competence involves both the ability to adhere to the manual and the judgment to know when and how to deviate from it. Competence implies the therapist's "skillfulness in providing a therapeutic milieu … in applying recognized techniques or methods consistent with the goals of treatment," as defined by Shaw et al. (1999, p. 838), and as empirically supported by several studies, e.g., by Despland et al. (2009). Specifically, in accordance with Shaw's definition, the Despland et al. study found that therapist competence in the techniques of psychodynamic psychotherapy was not directly related to therapeutic outcome, but was moderated by the quality of the therapeutic alliance. Similar results have been found for therapist adherence to a manual (Barber, Crits-Christoph, & Luborsky, 1996; Elkin, 1988). Moreover, Wampold (2001) brings to bear a variety of other, persuasive data to argue that the strictly technique-based aspects of therapy, including the therapist's adherence to technique, have a very limited impact on therapeutic outcome.

THE RATIONALE FOR DEVIATING FROM THE PE MANUAL

I have to agree with Muller (2009, p. 32) that I employed "less-than-adherent use" of manualized PE therapy with Caroline. On the other hand, I do not view my incomplete adherence as inadvertent or as a mistake, but rather as a deliberate, third-way adaptation of the manual in accordance with Caroline's needs. Specifically, my deviation from the manual was guided by at least two general treatment principles, or mechanisms of change: emotional

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exposure and quality of the therapeutic relationship. In reviewing these, I will first summarize the point at which I deviated from PE manual, and then consider each principle in turn.

A Crucial Choice Point in the Therapy

As I described in my case study of Caroline, at the beginning of therapy the client was 26 years old and experiencing clinically significant depression and PTSD symptoms, in part deriving from a history of sexual abuse by her maternal grandfather. I employed Foa and Rothbaum's (1998) PE manual for treating her PTSD symptoms. Specifically, during sessions 21-23, I socialized Caroline into the cognitive-behavioral model of PTSD before starting *in-vivo* exposure to treat her contemporary, PTSD-related behavioral avoidance patterns. This focused on exposure to contemporary social situations involving men, such as going to a snack bar or a disco, and this phase of the exposure treatment went well. What followed is quoted below from my case study (Kramer, 2009):

> The next step was to prepare Caroline for *in sensu* (imaginative) exposure to the abuse-related events that had taken place during her adolescence and their sequelae. In Caroline's case this would have involved making an audio tape while she was talking about the past abusive situation in the therapy and then re-listening to it at home as homework, according to the principle of habituation of feared stimuli (Foa, & Rothbaum, 1998). At this point, around session 24 and in anticipation of this process, Caroline began vomiting again, and the same specific supportive strategies were necessary to deal with this problem as were used during sessions 16-20. …
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> As recommended by Foa and Rothbaum (1998), Caroline had to talk about the past abusive situation in therapy and then re-listen to the audio tape of the session as homework. In line with this, I began to regularly tape-record the sessions in anticipation of Caroline talking about the past abuse, starting in session 25, and to have Caroline re-listen to them.
>
> Caroline had major distress in reaction to this arrangement, and the whole 26th session was devoted to the problems she encountered with re-listening to the tape of the 25th session. In the 26th session, Caroline mentioned that while listening to the tape at home, she thought of herself as being a 12-year-old child, dangerously vulnerable and helpless, and at the mercy of adults. This upsetting feeling was explored more fully and was linked to the presumed feelings she had towards her abusive grandfather, as well as to the assumed underlying interpersonal Plan or schema of hurt avoidance. . . [Following from my analysis of my therapeutic relationship with the client], I spelled out these links to the patient and also underlined explicitly that for me it was very important that Caroline was not being hurt at the present moment in therapy . …
>
> Once Caroline fully calmed down and agreed to focus on the hurt avoidance theme within therapy, I began raising questions about thoughts of herself as being a 12-year-old child, dangerously vulnerable and helpless, and at the mercy of adults. Very rapidly, she acknowledged the absurdity in the thought, especially with regard to me, the current therapist. In order to test her insight, I played the devil's advocate and said that based on her abuse experience, it is fully understandable to have these thoughts and it is fully understandable to mistrust even the most caring therapist—also reminding her that her grandfather was most caring in the beginning. Caroline responded, with some humor, by

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countering my argument and declaring that things are very different now and she felt much different—much better—now at the end of this session (session 26).

Based on Caroline's upset anticipation of the *in sensu* exposure, we then agreed not to proceed with it as previously planned, but to maintain tape-recording of at least the next 10 sessions and, as homework, to have Caroline listen at home to each session in the days following it. Caroline also agreed to report in the following sessions all thoughts she had while listening to the previous session's tape at home, since these thoughts were important information, as was shown in session 26. I praised Caroline for sharing and exploring her challenging reactions in response to listening to the tape (Kramer, 2009, pp. 13-14).

Principle 1: Emotional Exposure

Emotional exposure—i.e., increasing a client's tolerance for and acceptance of negative affect—is a slightly different kind of exposure that is necessary for PE, and has been described by Allen, McHugh and Barlow (2008; cited by Muller, 2009). Emotional exposure as a general principle of psychotherapy is similar to what Grawe (1997) has called "problem actuation" within the therapeutic relationship. (For an overview of this principle, see Grawe, 2004, and Smith, Regli & Grawe, 1999). Also, Orlinsky, Ronnestad, and Willutski (2004) have called this therapeutic principle "experiential confrontation."

I think that it is possible to understand the whole PE segment with Caroline (sessions 21 to 27) in terms of emotional exposure for three reasons. First, the PE rationale was explained to Carolyn, as a means pursuing the objective of emotional exposure, as well as to ensure her understanding and motivation about the procedure. Second, the full PE *in vivo* exposure phase was successfully conducted. Third, the PE imaginative exposure phase was partially implemented, then amended, respecting my understanding of my therapeutic relationship with Carolyn via Caspar's concept of the Motive-Oriented Therapeutic Relationship (MOTR), but still by pursuing the same objective of emotional exposure. In line with the concept of the third-way model of treatment, in my view I did not fundamentally change the therapeutic strategy at session 26, but only modulated it, as a function of the second treatment principle, quality of the therapeutic relationship.

Contrary to Hembree and Brinen's (2009) commentary, I believe that as the therapist I did not avoid emotional exposure as a treatment principle. In my view, if avoidance of affect-laden contents, together with Carolyn's behavioral avoidance, had been practiced in Caroline's therapy, poor therapeutic results would have ensued. The principle of emotional exposure may be particularly necessary in the treatment of clients presenting with PTSD or other anxiety disorders where the avoidance component is an important psychopathological feature. In the case of Caroline, at the end of treatment, avoidance was almost entirely absent, and thus the outcome of her therapy was highly positive.

Principle 2: Quality of the Therapeutic Relationship

The second treatment principle that relates to my decision to deviate from the PE manual is the quality of the therapeutic relationship, which was invoked by several of the commentators

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on my case study (e.g., Muller, 2009). This principle has also been researched in a series of psychotherapy studies (for reviews, see Lambert & Ogles, 2004; Martin, Garske, & Davis, 2000; and Wampold, 2001; for the link between therapist competence, therapeutic alliance, and outcome, see the previously cited study by Despland et al., 2009). In the case of Caroline, I applied Plan Analysis, an integrative individualized procedure of case conceptualization independent of any specific psychotherapy approach (Caspar, 2007, 2009), in which I focused in particular on Caroline's emotional and relationship stakes in the psychotherapy. Plan Anaylsis helps the therapist to create an individualized therapeutic relationship, the Motive-Oriented Therapeutic Relationship (MOTR), with the client. Such an individualized therapeutic relationship goes beyond the non-specific relationship principles of "listening, validation, education, support and development of the therapeutic alliance" (Muller, 2009, p. 33), by individualizing and tailoring these principles, as shown in the case of Caroline. Thus, the MOTR is a suitable operationalization of the general psychotherapy principle of the quality of the therapeutic relationship (Grawe, 2004).

CONCLUSION

For Caroline, my third-way treatment was highly effective, as shown by the significant decrease in symptoms between the intake session and session 29—eight sessions after the start of formal PE, and three sessions after my individualizing of the procedure. As I have outlined above, I hypothesize that it was the process of emotional exposure together with my individualized relationship with Caroline that gave rise to the excellent results. In other words, I hypothesize that negative emotions related to the trauma and correlated with particular experiences in the therapeutic interaction culminated in high-level emotional activation in and between sessions, which was facilitated by me as the therapist as guided by my Plan Analysis of the client's interpersonal reactions in the therapy relationship. It seems to me likely that these two aspects—emotional exposure and the quality of the therapeutic relationship—were responsible for clinical change in Caroline.

As mentioned by Hembree and Brinen (2009) and Kramer (2009), the length of Caroline's treatment was quite different from that usually reported in clinical trials on PE, most conducted in the U.S .(e.g., Foa, Dancu, et al., 1999). In Switzerland, the length of treatment for such a severe case as Caroline (40 sessions) is considered typical. Due to my affiliation with public mental health services, the treatment was entirely reimbursed by the insurance company, excepting a 10% fee per session charged to Caroline. The choice of a third way for this client, between a manualized treatment and a principle-guided psychotherapy, may be culturally influenced (Caspar, 2009), but may also represent a personal choice by myself and my supervisors (see Ambühl, 1992 and Haldimann-Balli, in Kramer [2009]). Whether a strict adherence to the PE manual in a PTSD case like Caroline's, with a complex and severe symptomatic presenting picture, would have resulted in as or even more effective a treatment in a shorter period of time, as suggested by Hembree and Brinen (2009), is an empirical question.

In closing, I would like to thank all four sets of commentators for their spelling out alternative interpretations of my case study of Caroline and, in the process, raising important,

more general issues and data questions about the Prolonged Exposure, manualized treatment for PTSD.

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