

Emory University
Prolonged Exposure Consultant Training Program
Consultation Manual

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Section 1: Training Program Background

Mission

The mission of the Emory University Prolonged Exposure (PE) Consultant Training Program is to develop a national network of Peer-Reviewed PE Consultants who can support providers in academic, community, and private practice settings in the development of competencies in the delivery and implementation of PE with patients diagnosed with posttraumatic stress disorder (PTSD).

The training program achieves its mission using a six-month competency-based learning framework that emphasizes consultation-of-consultation. The training program exists within the educational arm of Emory Healthcare Veterans Program (EHVP) and led by a committee of faculty members in the Department of Psychiatry and Behavioral Sciences of Emory University School of Medicine. http://psychiatry.emory.edu/programs/pe_consultant_training/index.html

While PE has demonstrated its effectiveness with diverse populations, this program emphasizes training of clinicians who treat or plan to treat military service members and veterans diagnosed with PTSD. Paramount to the success of this training program is the recognition that implementation of new practices cannot rely solely upon the improvement of therapist skills. Agencies must provide the infrastructure and support for implementation of evidence-based practices. The need for multilevel implementation strategies certainly applies to PE. The Emory University PE Consultant Training Program aims to enhance PE consultation skills at both the trainee and organizational level. That is, in addition to increasing trainees' PE fidelity, consultants-in-training will understand how to work with relevant agencies to improve organizational adoption of PE (e.g., dedicating time and resources to training, permitting patient assessment and weekly sessions of adequate time and length, incentivizing favorable treatment outcomes, and adjusting climate and culture for time-limited trauma-focused therapy).

Terminology

Listed below are specific terms used in this training program. Familiarity with these terms will help readers comprehend this manual and participate in discussions.

- *Consultant Trainers*: Expertly trained PE consultants who will help PE consultants-in-training develop PE-specific consultation competencies.
- *Consultants-in-Training*: Selected applicants of this training program who will develop PE-specific consultation competencies by working with novice PE providers. Those who

successfully complete this training program are certified as *Peer-Reviewed PE Consultants*.

- *Trainees*: Clinicians with introductory knowledge of PE who will receive consultation or supervision from PE consultants-in-training with at least two PE cases. Those who successfully complete two cases and demonstrate at least 80% fidelity across all sessions will be given a *Certificate of Completion* and included in our publicly accessible online registry of competent providers.

Program Components

Implementation science routinely recommends a concentrated episode of didactic instruction (e.g., reading therapist manual followed by two to four-day PE workshop) followed by an ongoing period of consultation with an expert (e.g., Karlin & Cross, 2013) for six months and two patients. Consultation includes reviewing recordings of every session and systematic feedback. This combination of didactic training and consultation has been used in the Veteran Health Administration's rollout of PE for the past decade, which has trained over 2,000 clinicians. However, there are few expert PE consultants outside the VA. This training program was designed to build a network of Peer-Reviewed PE Consultants to improve implementation in private practices, community mental health, and mental health training programs. The program is structured to provide didactic training in how to be a consultant as well as hands-on experience with feedback to develop consultation skills. The total time commitment will be four to seven hours each week for six months. Listed below are all program components.

1. Individual Consultation Meetings with PE Trainees
 - a. Consultants-in-training are expected to recruit or request at least two PE trainees who each meet PE proficiency standards (80% on fidelity forms) for at least two PE cases treated to completion (i.e., four total cases tracked by consultants-in-training).
 - b. Consultation will occur every week over a period of six months. Consultants-in-training will listen to or watch full-session recordings for both their trainees (two cases per trainee) and provide consultation over the phone or in person for 30 or 60 minutes each week per trainee.
2. Weekly Consultant Training Conference Calls (Zoom Videoconferencing)
 - a. All consultants-in-training (five to ten per cohort) and Emory consultant trainers will participate in a 30-minute conference call each week. This call does not include PE trainees.
 - b. Consultants-in-training will be provided the opportunity to ask questions and receive feedback from the experts at Emory regarding challenges faced during their individual consultation.
3. Weekly PE Trainee Conference Calls (Zoom Videoconferencing)
 - a. The consultants-in-training (five to ten) and their trainees, as well as the consultant trainers, will participate in a 60-minute conference call each week.

- b. Case Presentations: Each week, one designated consultant-in-training presents with both of their trainees. The structure will be for the trainees to present an issue (5 to 10 minutes) and be provided with live consultation (5 to 10 minutes). After the trainee's consultant-in-training provides live feedback, other consultants-in-training can weigh in, followed by trainees on the call and Emory Consultant Trainers, if needed. This structure is designed to provide an opportunity for consultants-in-training to demonstrate consultation competencies as a part of their training in the program.
4. Assessment of Consultation Competencies
 - a. Video assessments: Consultants-in-training will review mock PE session and mock consultation meeting videos, identify any PE or consultation related issues and generate strategies to correct issues demonstrated by the mock trainee and/or consultant. Responses will be recorded on a standardized form and reviewed by Emory's consultant trainers at the midpoint and end of the program.
 - b. Written Assessments: Several written assignments will be collected throughout the program. The assignment list can be viewed in the supplemental materials. Assignments will be collected and reviewed at the beginning midpoint and end of the program.
 5. Directory Listing and Certificate
 - a. All consultants-in-training who complete the training program will be listed on an online directory as Peer-Reviewed PE Consultants. They will receive a certificate acknowledging their peer-reviewed competency in PE consultation.
 - b. PE trainees who successfully complete two cases will be listed on an online directory as PE providers and will be given a Certificate of Completion.
 - c. We do not offer continuing education credits for consultants-in-training or their trainees. However, many states allow clinicians to get credit for regularly scheduled consultation such as this training program. Signed affidavits are typically required. All participants are encouraged to review their state's rules and regulations.

Program Requirements

Consultants-in-training

- Mental health providers (e.g., psychologists, psychiatrists, clinical social workers, and mental health counselors).
- Protect up to seven hours per week.
- Previously received formal PE supervision/consultation with tape-reviewed consultation/supervision.
- Strong PE competency (evidenced by two recordings or a recommendation by an expert PE consultant/supervisor).
- If no prior formal supervision/consultation received for PE cases, consultants will be required to complete the 12-month program: six months as a trainee, then six months as a consultant-in-training.

Trainees

- Must be licensed in a mental health profession or have special approval as a trainee.
- Must have completed two-day PE workshop or a close equivalent.
- Must expect to treat at least some post-9/11 veterans in the future.
- Must work in a setting that is agreeable to all requirements and expectations (see example contract in Section 3 of this manual).
- Fulfill expectations
 - Must see patients at least once per week for 8 to 16 weeks using 90-min sessions.
 - Must complete two PE cases within six-month window.
 - Must audio- or video-record all PE sessions.
 - Must transfer or mail recordings to consultant-in-training.
 - Must meet with consultant-in-training at least 30 minutes per week.
 - Must attend and contribute to weekly trainee conference calls.

Program Completion

Consultants-in-Training

- The goal is for consultants-in-training to consult on two complete courses of PE for each of their trainees (4 total) during the consultation program. Video assessments will provide additional opportunity for consultants-in-training to demonstrate competencies if their trainees are unable to recruit enough cases and/or if trainees dropout. The Emory trainers will make graduation decisions on a case-by-case basis considering skills displayed in actual consultation and video assignments.

Trainees

- If a trainee's consultant, along with Emory's consultant trainers, believes the trainee is sufficiently competent in PE to practice PE independently, the trainee will be listed on the training program's registry of competent PE providers, which will be posted publicly on the training program's website. At minimum, trainees must complete two cases during the six-month training period and demonstrate a minimum mean of 80% fidelity across all session rating forms. Completion of a case is defined by delivering at least six sessions and demonstrating all components of the protocol. However, competent trainees must also demonstrate growth during training period and potential for continued growth after training completion. If the trainees' performance falls just short of competence, or if the trainee is unable to demonstrate all components with two patients (e.g., due to late dropout by patient), the consultant-in-training may arrange mock therapy sessions during which the trainee can demonstrate competency. Trainees who are not included in the registry will be encouraged to continue learning PE in other training contexts; however, after the six-month training period, the training program will not retroactively add trainees to the registry.

Application Process

The application process includes two phases. Phase one is an application that includes the applicant's professional background, prior experience with PE, and a brief description of why becoming a PE consultant would be useful to the applicant and his or her agency. The Emory faculty will review phase one applications and then invite a subset to complete phase two applications, which will include a detailed plan for trainee recruitment and consultation logistics as well as the submission of two recordings of their own PE delivery (two different patients, two different stages in protocol).

Applicants to become consultants-in-training are expected to have didactic training in PE such as workshops, formal instruction from an instructor or supervisor in a training program, or other types of foundational training that occurred in similar context. Additionally, applicants are expected to have received supervision/consultation of recorded actual cases as part of training in PE. We will request information related to the person who provided supervision/consultation in PE, as well as the supervision/consultation process. In many cases, we will contact prior supervisors/consultants and request feedback on their applicant's readiness for consultant training.

Recruiting Trainees

Consultants-in-training can provide their own trainees or request that Emory assist in recruiting trainees. Early career clinicians might not be sufficiently established to recruit their own trainees and might not have access to appropriate professional networks. If consultants-in-training recruit their own trainees, they must confirm the trainees have foundational knowledge in PE, preferably from a multi-day didactic. Workshops are often offered by Center for Deployment Psychology, University of Pennsylvania's Center for the Treatment and Study of Anxiety, STRONG STAR, and the National Center for PTSD. Online training is available via MUSC via PE-Web (<http://pe.musc.edu/>). Beyond foundational knowledge, trainees and their leadership need to agree to all requirements. A sample contract is included in Supplemental Materials.

Section 2: Core Competencies in PE Consultation

Overview of Section 2

Consultation is a multifaceted competency that goes far beyond teaching protocol-specific skills and knowledge. This section outlines the core competencies that are expected to be mastered through this consultant training program. These skills involve both global skills related to the consultation process and specific skills related to helping clinicians navigate PE issues. Listed below are five competency domains, each including three behaviorally described skills that are expected of Peer-Reviewed PE Consultants.

PE Consultation Competencies

Competency Domain #1: Consultation Relationship

- Skill #1A: Developing a Self-Reflective and Productive Practice in Consultation
- Skill #1B: Managing Logistics and Other Necessary Consultation Practices
- Skill #1C: Providing Feedback on Performance and Parallel Processing

Competency Domain #2: General Psychotherapy Skills

- Skill #2A: Addressing Trainee's Management of Risk, Patient Engagement, and Motivation
- Skill #2B: Addressing Trainee's Management of Time and Session Content
- Skill #2C: Addressing Trainee's Use of Common Factors
- Skill #2D: Addressing Trainee's Assessment of Psychopathology, Multicultural Factors, and Suitability for PE

Competency Domain #3: Prolonged Exposure Skills

- Skill #3A: Shaping Skills in PE Case Conceptualization
- Skill #3B: Shaping Skills in Psychoeducation Components (PTSD, PE Rationale, SUDs, Common Reactions, and Breathing Retraining)
- Skill #3C: Shaping Skills in In-Vivo Exposure
- Skill #3D: Shaping Skills in Imaginal Exposure
- Skill #3E: Shaping Skills in Processing

Competency Domain #4: Trainee Barriers to Delivery

- Skill #4A: Correcting Unhelpful Trainee Beliefs
- Skill #4B: Addressing Trainee Collusion with Avoidance
- Skill #4C: Refining Trainee Reactions to Trauma
- Skill #4D: Enhancing Trainee Confidence and Well-Being

Competency Domain #5: Implementation

- Skill #5A: Assessing Implementation Context
- Skill #5B: Designing and Monitoring an Implementation Plan

Competency Domain #1: Consultation Relationship

Skill #1A: Developing a Self-Reflective and Productive Practice in Consultation

Expectation: Peer-reviewed PE consultants are able to form context-appropriate professional relationships with trainees that foster learning.

The Emory PE Consultation Program strives to develop a nation-wide network of PE consultants who are skilled at working with PE-trainees with different levels of experience and can scaffold learning depending on trainee knowledge and background. Striving to better understand your trainee's background can help strengthen the consultation relationship and help you understand your trainee's frame of reference and skill set. Many very skilled clinicians have not previously had the opportunity to learn exposure therapies. For example, only 33% of psychologists report being trained in imaginal exposure for PTSD (Becker, Zayfert, & Anderson, 2004), a percentage that is likely less for masters-level clinicians. However, while a clinician may lack experience in a certain area, they may demonstrate other skills that will help them in their PE training, such as ability to develop rapport, background in CBT, eagerness to practice evidence-based care. To develop a productive consultation relationship, a PE consultant should be skilled in utilizing the strengths clinicians already have to improve their training in PE. Further, a capacity for self-reflection and a desire to continue improving therapy skills is important for a PE consultant and consultants-in-training should be skilled at acknowledging the shared learning occurring in a consultation relationship.

- ❖ How will this consultation skill be assessed during the training program?
 - Consultants-in-training will administer and review the *Therapists Beliefs about Exposure Scale* (see Supplemental Materials) and *PE Knowledge Assessment* (distributed separately with answer key) with their trainee early in consultation. Consultants will discuss how they addressed negative trainee beliefs and deficits in knowledge in the weekly consultant training conference call early in the program.
 - The *Measure of Effective Attributes of Trainers* (MEAT; Boyd et al., 2017) (see Supplemental Materials) will be collected from trainees regarding their consultants-in-training at the mid-point and end of the program and consultants-in-training will be given feedback.
 - Consultants-in-training are encouraged to maintain a PE practice during their time consulting including recording their own tapes and attending group supervision to the degree that their clinic allows. Maintaining PE practice for consultants will be discussed throughout the program on the consultation calls.

Skill #1B: Managing Logistics and Other Necessary Consultation Practices

Expectation: Peer-reviewed PE consultants are able to ensure all the necessary components of consultation are arranged.

This training program strongly advocates for a structured approach to consultation. It is critical to relay expectations to trainees, identify ideal training cases, protect time for meetings and

reviewing tapes, and set meeting agendas with experiential activities (e.g., role-playing). After regular meetings have been established and patients have been recruited, it is solely the consultant's responsibility to protect time for regular listening or viewing of the recordings from *all* sessions with corresponding completed fidelity rating sheets (see Supplemental Materials), in order to provide actionable feedback prior to the next PE session. The most effective way of using PE fidelity sheets is to take notes while reviewing the recording and to mark timestamps on comments, when possible, so the trainee can reference this later. Remember to note areas of success, not just areas needing improvement. It is important to set the expectation of and protect agenda time for experiential activities, such as role-plays, in addition to review of the fidelity form notes. Imaginal exposure and processing are two procedures that greatly benefit from role-playing and trainees will benefit from practicing from both the patient and the therapist perspective.

- ❖ How will this consultation skill be assessed during the training program?
 - PE fidelity rating sheets will be submitted by consultants-in-training at the midpoint and end of the program. Issues related to consultation logistics will be addressed during weekly conference calls.

Skill #1C: Providing Feedback on Performance and Parallel Processes

Expectation: Peer-reviewed PE consultants are able to provide constructive feedback on all aspects of learning and delivering PE with special attention toward processes between patient and trainee that are replicated between trainee and consultant (i.e., parallel processes).

Consultants-in-training often report feeling uncomfortable critiquing another clinician's therapy skills, especially common factors of therapy (e.g., building rapport and therapeutic alliance). However, providing feedback on trainee's entire performance is critical to effective consultation. Using the fidelity rating sheets (see Supplemental Materials) facilitates the processes of identifying adherence and non-adherence to the PE protocol but can also be helpful to identify issues related to common factors in therapy. The benchmark for fidelity forms is 80% adherence to the protocol, which most trainees exceed regularly. However, the notes section allows for discussion of other therapy-related issues outside of PE adherence. When giving feedback on deviations from the protocol, it is helpful to sandwich this constructive feedback with praise for moments of faithful and skillful delivery. One helpful strategy is to deliver the scored fidelity rating sheet to the trainee well before the consultation session. This will allow the trainee to digest their performance and formulate questions. Further, it will save time during consultation for discussion on the most important aspects.

In addition to providing feedback on common factors and PE-specific factors, PE consultants need to give special attention to parallel processes (i.e., processes between patient and trainee that replicate between trainee and consultant). Common parallel processes in PE are collusion with avoidance (e.g., not prompting for the disgusting components of trauma memory) and unhelpful thoughts (e.g., belief that patient is too fragile to confront in vivo targets that are objectively safe). Additionally, trainees are often avoidant of consultation practices (e.g., reviewing sessions) and have unhelpful thoughts about themselves and the protocol. Consultants-in-training help trainees confront their fears and challenge unhelpful thoughts. It is effective to

start with normalizing parallel processes as a therapeutic phenomenon that happens to even advanced PE clinicians. Consultants-in-training should help trainees learn their vulnerability to experience certain parallel processes, which will help the trainee adopt a self-reflective approach to PE well after consultation ends. Occasionally, consultants-in-training may have to address their own parallel processes by participating fully in experiential learning opportunities, such as role-plays and group call presentations.

- ❖ How will this consultation skill be assessed during the training program?
 - The weekly consultation presentations will provide an opportunity for consultant trainers to observe this skill during live consultation.
 - Consultants-in-training will also submit *Case Presentation Forms* (see Supplemental Materials) they develop with their trainees to outline PE issues and their approach to feedback.

Competency Domain #2: General Psychotherapy Skills

Skill #2A: Addressing Trainee’s Management of Risk, Patient Engagement, and Motivation

Expectation: Peer-reviewed PE consultants are able to help trainees monitor risk, motivation, and make necessary adjustments to facilitate engagement.

Safety Risk Assessment

Each trainee is expected to be competent in continually monitoring risk and addressing it appropriately (e.g., making a safety plan or referrals). An example safety plan can be found in the Supplemental Materials. PE consultants-in-training should actively discuss with trainees any suspicion of risk. Safety risk includes thoughts or behaviors related to harming oneself as well as others. In PE, patients may be worried that during *in vivo* exposure assignments, they may harm someone else or be harmed themselves. Therapists should be comfortable discussing these types of risk and ensuring patients that they are safe and in control of their behaviors. Consultants should emphasize the importance of gauging actual danger in exposure targets, not just perceived danger.

Management of Motivation and Engagement

Patients with PTSD, by definition, are driven to avoid. And PE, by definition, requires exposure to avoided stimuli and memories. Therefore, PE almost always includes working with patients not motivated for the treatment. It is helpful to not only normalize that dynamic but to help trainees anticipate resistance and incorporate it into their conceptualization of each case. Consultants-in-training will need to assess the many general therapy skills needed to enhance motivation, including the following:

- instilling hope
- validating the valid
- exploring pros and cons of change and maintaining the status quo
- allowing the patient to voice reasons for change
- reinforcing change-oriented talk
- reinforcing completion of tasks

- clarifying values and how exposure might be values-consistent
- asking before giving suggestions.
- voicing support
- praising forward progress
- anticipating avoidance

Often, trainees will persist in the PE protocol despite the patient not giving adequate effort. It is the consultant-in-training's job to detect this process early to prevent this negative outcome. It is typically a better lesson for the trainee *and* the patient to discontinue treatment that is not predicted to achieve improvement than to persist through the entire protocol without receiving any gains. Before discontinuing treatment, consultants should encourage their trainees to have one final session in which a compassionate, yet hard line is drawn with respect to expectations. A helpful strategy is to have trainees make a contract with the patient that outlines expectations and criteria to discontinue therapy after a certain number of contract violations. This contract can be a verbal agreement.

- ❖ How will this consultation skill be assessed during the training program?
 - ❖ The weekly consultation presentations will provide an opportunity for consultant trainers to observe this skill during live consultation.
 - ❖ If needed, video assessment at midpoint and the end of the program will include mock sessions demonstrating a lack of this trainee skill that consultants-in-training will be required to adequately critique.

Skill #2B: Addressing Trainee's Management of Time and Session Content

Expectation: Peer-reviewed PE consultants are able to identify and correct problems related to their trainee's management of session content and time.

A common problem when delivering a manualized treatment like PE is session management. Consultants-in-training should be able to identify and correct problems related to managing session content and time. Time management skills are important to correct early in the training process as time management is critical to every session of PE. Consultants-in-training should review tapes weekly to catch time management deficits early and work to correct them before the next sessions. Helpful ways to correct time management skills is to do role-plays with trainee and reviewing the structure and time frames for each session. Small suggestions, like having a clock behind the patient and discussing the importance of time management in therapy can be helpful for trainees who do not have experience practicing manualized therapy.

- ❖ How will this consultation skill be assessed during the training program?
 - ❖ The weekly consultation presentations will provide an opportunity for consultant trainers to observe this skill during live consultation.
 - ❖ If needed, video assessment at midpoint and the end of the program will include mock sessions demonstrating a lack of this trainee skill that consultants-in-training will be required to adequately critique.

Skill #2C: Addressing Trainee's Use of Common Factors

Expectation: Peer-reviewed PE consultants are able to identify and correct problems related to their trainee's use of psychotherapy common factors.

All therapy, regardless of modality, requires good therapy skills (e.g., the abilities to develop rapport, align with patient, empathize, and listen). Consultants-in-training should address their trainee's ability to build rapport with their patients and increase their motivation while maintaining fidelity to the PE protocol. One common barrier to trainees utilizing their general therapy skills is effort allocated to learning the content of the protocol. This may lead to early PE therapists tending to be over instructional and not as warm or empathetic as they may be in a different modality. This skill will come with time as therapists get comfortable with the protocol. In the meantime, consultants-in-training can help facilitate the development of this skill by:

- Highlighting trainees positive therapeutic or conversation skills.
 - Role-playing how to address PE session content while also building rapport and motivation.
 - Helping trainee become very familiar with the PE protocol so that difficulty communicating session content does not impede the use of common factors.
- ❖ How will this consultation skill be assessed during the training program?
 - ❖ The weekly consultation presentations will provide an opportunity for consultant trainers to observe this skill during live consultation.
 - ❖ If needed, video assessment at midpoint and the end of the program will include mock sessions demonstrating a lack of this trainee skill that consultants-in-training will be required to adequately critique.

Skill #2D: Addressing Trainee's Assessment of Psychopathology, Multicultural Factors, and Suitability for PE

Expectation: Peer-reviewed PE consultants are able to identify and correct problems related to the trainee's assessment of psychopathology (especially PTSD) and suitability for PE, as well as the trainee's multicultural responsiveness.

Conducting effective PE is contingent on an appropriate assessment of PTSD that accounts for cultural and other background factors (e.g., comorbid pathology and trauma type). After PE is initiated with a patient, consultants-in-training must have a continued dialogue with their trainees about these factors. Consultants-in-training desiring more direction regarding multiculturalism are encouraged to read an article written by La Roche and Maxie (2003), which proposes 10 multicultural considerations. For example, one general consideration is: "Cultural differences should be addressed as assets that can help in the therapeutic process (p. 183)." In PE, this consideration is especially important as the demographic presentation of the therapist may serve as a form of in-vivo exposure for the patient. Consultants-in-training should help trainees identify any cultural, demographic, or background information that needs to be considered to appropriately assess for PTSD symptoms and PE suitability.

- ❖ How will this consultation skill be assessed during the training program?

- ❖ The weekly consultation presentations will provide an opportunity for consultant trainers to observe this skill during live consultation.
- ❖ If needed, video assessment at midpoint and the end of the program will include mock sessions demonstrating a lack of this trainee skill that consultants-in-training will be required to adequately critique.

Competency Domain #3: Prolonged Exposure Skills

Skill #3A: Shaping Skills in PE Case Conceptualization

Expectation: Peer-reviewed PE consultants are able to advocate for evidence-based assessment and support the use of emotional processing theory during case conceptualization.

Evidence-based practice requires evidence-based assessment. Trainees should be familiar with the DSM diagnosis of PTSD and be able to assess if a patient has PTSD. However, these prerequisites are often not sufficiently fulfilled, as clinicians and clinics do not always have the time, resources, or expertise to administer and interpret empirically supported PTSD-specific assessment tools. While training in assessment and diagnosis of PTSD is outside the scope of PE consultation, PE consultants can certainly point trainees in the right direction.

- The gold standard assessment tool is a semi-structured clinical interview called the *Clinician Administered PTSD Scale for DSM-5 (CAPS-5)*; Weathers, Blake et al., 2013). Currently, free online training is available for the CAPS-5 by the US Veteran Affairs National Center for PTSD (see online resources in Section 3 for a web link).
- The gold standard self-report strategy to measure symptoms severity from week to week is administering the *Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5)*; Weathers, Litz et al., 2013) and the *Patient Health Questionnaire – 9-Item Version (PHQ-9)*; Kroenke, Spitzer, & Williams, 2001). The links to obtain each of these scales from the publishers are below. These scales should be administered each week.
 - <https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>
 - www.pfizer.com/phq-9
- If a full CAPS-5 is not possible, then use of the PCL-5 with focused follow-up questions in session to ensure report is linked to a specific trauma and anchored in the correct period with specific instances of symptom occurrence in mind is recommended.

Evidence suggests fear-based processes of intrusive reexperiencing and avoidance are the core features of PTSD, which have downstream effects of distress and dysphoria (Zoellner, Pruitt, Farach, & Jun, 2014). A strong theoretical understanding of emotional processing theory (Foa, Hembree, Rothbaum, & Rauch, 2019; Foa Hubbert, & Cahill, 2006; Foa & Kozak, 1987) will help the trainee understand what the patient needs to learn with each exposure assignment and how the trainee can facilitate that learning.

Listed below are signs that suggest a trainee needs to remediate his or her understanding of emotional processing theory:

- Trainee believes all trauma results in pathology.
 - Trainee expresses a need for the patient to be “ready.”
 - Trainee is not familiar with learning theory and how avoidance prevents learning and exposure facilitates learning.
 - Trainee does not recognize PTSD as a disorder resulting from lack of natural recovery due to avoidance and unhelpful thoughts.
 - Trainee does not want to start imaginal exposures with the index trauma related to the most re-experiencing distress and dysfunction.
 - Trainee does not recognize safety behaviors interfering with extinction.
 - Trainee does not encourage patient to experience high levels of distress.
- ❖ How will this consultation skill be assessed during the training program?
 - ❖ The weekly consultation presentations will provide an opportunity for consultant trainers to observe this skill during live consultation.
 - ❖ If needed, video assessment at midpoint and the end of the program will include mock sessions demonstrating a lack of this trainee skill that consultants-in-training will be required to adequately critique.

Skill #3B: Shaping Skills in Psychoeducation Components (PTSD, PE Rationale, SUDs, Common Reactions, and Breathing Retraining)

Expectation: Peer-reviewed PE consultants are able to recognize trainee errors in PE psychoeducation and formulate a learning strategy that will reduce likelihood of the same error repeating.

Psychoeducation is a fundamental component of PE and provided throughout the protocol, especially the first two sessions. The amount of psychoeducation to review in PE can be a challenge for new trainees, especially those who are less familiar with manualized, behavioral interventions. Skilled PE providers are able to discuss every required aspect of psychoeducation while maintaining an open-ended conversation, building rapport, and increasing motivation for treatment all within session time parameters of the first two sessions that are constrained by other time-intensive components (e.g., developing an in vivo hierarchy). Please refer to the PE manual for a description of required psychoeducational components (Chapter 3, Foa et al., 2019). Additional resources are Dr. Peter Tuerk’s mock therapy videos available on YouTube that demonstrate this skill (https://www.youtube.com/channel/UCeOV12puzfjY6SYs_qV50GQ). Consultants-in-training are referred to the “PE Pitfalls and Strategies” document in the Supplemental Materials to see a list of common mistakes that trainees make in PE and strategies for consultants to use to prevent or correct issues throughout consultation.

- ❖ How will this consultation skill be assessed during the training program?
 - ❖ The weekly consultation presentations will provide an opportunity for consultant trainers to observe this skill during live consultation.
 - ❖ If needed, video assessment at midpoint and the end of the program will include mock sessions demonstrating a lack of this trainee skill that consultants-in-training will be required to adequately critique.

Skill #3C: Shaping Skills in In-Vivo Exposure

Expectation: Peer-reviewed PE consultants are able to recognize trainee errors in the facilitation of in vivo exposure and formulate a learning strategy that will reduce likelihood of the same error repeating.

In vivo exposure practice is critical to facilitating patient's habituation to a traumatic memory and assisting with generalizing treatment gains to everyday life. A strong in vivo hierarchy is a critical component of successful PE and is often a struggle for new PE providers. Consultants can play a pivotal role in helping trainees prepare for in vivo work early in treatment to prevent common pitfalls related to this PE component. Because the in vivo hierarchy is developed in session two and could potentially derail progress if done insufficiently, it is important to discuss and practice the in vivo hierarchy early in the consultation relationship. See the "PE Pitfalls and Strategies" section of the supplemental materials for specific examples.

- Consultants-in-training should help trainees learn to creatively identify potential in vivo targets and expand seemingly singular activities (e.g., going to the grocery store) into multiple refined in vivos (e.g., staying in the grocery store for 45 minutes, without a cart, when its busy).
 - Practicing through role-plays and writing assignments (e.g., design your own hierarchy) are useful strategies to help trainees develop this skill.
 - Remember that difficulties with constructing an in vivo hierarchy may also be a sign of lack of avoidance symptoms which may require revisiting of assessment/diagnostic skills.
- ❖ How will this consultation skill be assessed during the training program?
 - ❖ The weekly consultation presentations will provide an opportunity for consultant trainers to observe this skill during live consultation.
 - ❖ If needed, video assessment at midpoint and the end of the program will include mock sessions demonstrating a lack of this trainee skill that consultants-in-training will be required to adequately critique.

Skill #3D: Shaping Skills in Imaginal Exposure

Expectation: Peer-reviewed PE consultants are able to recognize trainee errors in the facilitation of imaginal exposure and formulate a learning strategy that will reduce likelihood of the same error repeating.

Imaginal exposure is the "hook" of PE that ties the treatment together and provides a powerful learning opportunity for patients. Because this component of PE is less structured, dependent on patient presentation, and requires practice to master, trainees new to PE will likely struggle in different ways delivering imaginal, especially when they are first starting out. See the "PE Pitfalls and Strategies" section of the Supplemental Materials for specific examples.

- Keep in mind that there is an art to imaginal that can only be developed through practice and that role-plays are critical to helping trainees gain this practice.

- Notice the many ways trainees will collude with avoidance at this point in treatment (e.g., postponing imaginal until session 4) and address them as early as possible.
 - Confidence building is critical here and consultants-in-training can build confidence didactically (e.g., through discussing the myths of exposure being harmful) and experientially through modeling calm and confidence when discussing starting imaginings.
 - Remember that treatment is robust and while difficulties during imaginal should be corrected, they are not likely to derail treatment progress.
- ❖ How will this consultation skill be assessed during the training program?
 - ❖ The weekly consultation presentations will provide an opportunity for consultant trainers to observe this skill during live consultation.
 - ❖ If needed, video assessment at midpoint and the end of the program will include mock sessions demonstrating a lack of this trainee skill that consultants-in-training will be required to adequately critique.

Skill #3E: Shaping Skills in Processing

Expectation: Peer-reviewed PE consultants are able to recognize trainee errors in the facilitation of processing and formulate a learning strategy that will reduce likelihood of the same error repeating.

Like imaginal exposure, processing is an unstructured treatment component that takes practice to master. This can especially be the case if a trainee has a cognitive therapy background and is used to the Socratic questioning approach in CBT. Again, please see the “PE Pitfalls and Strategies” section of the supplemental materials for specific examples of problems that arise related to processing.

- The practice of processing involves learning how to say a lot with few words. This requires following the patients lead, reflecting on important statements, and helping patient consolidate themes from the processing.
 - Consultants-in-training can help facilitate the development of this skill through demonstrating it in role-plays or even having trainees’ practice non-directive speech in everyday conversations.
 - Providing specific time-stamped feedback on trainee recordings about when they said too much or where/how they could have explored more with a patient is helpful.
- ❖ How will this consultation skill be assessed during the training program?
 - ❖ The weekly consultation presentations will provide an opportunity for consultant trainers to observe this skill during live consultation.
 - ❖ If needed, video assessment at midpoint and the end of the program will include mock sessions demonstrating a lack of this trainee skill that consultants-in-training will be required to adequately critique.

Competency Domain #4: Trainee Barriers to Delivery

Skill #4A: Correcting Unhelpful Trainee Beliefs

Expectation: Peer-reviewed PE consultants are able to identify and correct trainee beliefs that interfere with treatment fidelity.

One of the most critical roles of consultants is to identify and address unhelpful trainee beliefs about PE, such as “exposure works poorly with complex cases” and “it is important to give patients relaxation strategies to manage distress during exposure.” These beliefs – some explicit, some implicit – often lead to problematic outcomes: promoting use of safety behaviors, constructing unambitious hierarchies, conducting inadequate exposures, experiencing high dropout, and in some cases, not offering PE in the first place. Trainees with concerns about exposure tend to exclude patients based upon characteristics such as comorbidities, high levels of distress, reluctance to do exposure, and therapist-perceived emotional fragility. An efficient method to assess your trainee’s unhelpful beliefs is to have them complete the Therapist Beliefs of Exposure Scale (Deacon et al. 2013), which is provided in the Supplement Materials.

After detecting unhelpful trainee beliefs, consultants need to arrange learning experiences to shape these beliefs. Shaping unhelpful beliefs can be described by four different strategies, which are each described below.

1. Lending confidence when trainees are not confident in model or their skills.
 2. Normalizing trainee avoidance of patient distress.
 3. Using parallel processes to help trainee understand the learning process.
 4. Reframing concerns about the ethics of using exposure therapy.
- ❖ How will this consultation skill be assessed during the training program?
 - ❖ The weekly consultation presentations will provide an opportunity for consultant trainers to observe this skill during live consultation.
 - ❖ If needed, video assessment at midpoint and the end of the program will include mock sessions demonstrating a lack of this trainee skill that consultants-in-training will be required to adequately critique.

Skill #4B: Addressing Trainee Collusion with Avoidance

Expectation: Peer-reviewed PE consultants are able to identify and correct trainee avoidance that interferes with treatment fidelity.

Trainee avoidance of therapeutic elements of PE is remarkably common. It might reflect lack of understanding of emotional processing theory, lack of success in exposure therapy, lack of appreciation of empirical literature, lack of self-reflection, etc. Regardless of the source, trainee avoidance is detrimental to PE success as it encourages patient avoidance, which will maintain PTSD symptoms.

Just like PE clinicians are trained to not “fragilize” their patients, consultants-in-training should encourage trainees to not fragilize themselves. If the patient can handle it, the clinician certainly can. The patient is disclosing the trauma to the clinician because the patient perceives the clinician as a person who can handle it. We strongly advise against trainees developing the

practice of refusing to work with certain trauma types. Referring a patient to another PE provider communicates the message that the memory is dangerous.

Some specific skills for consultants-in-training to address trainee avoidance include:

- Have an early conversation with trainee about colluding with avoidance, how common it is, and how it is the responsibility of the consultant-in-training to identify it in real time.
 - Clarify that the consultant-in-training is responsible for holding the trainee accountable for preventing avoidance until the trainee demonstrates that he or she has learned to detect and change their avoidant behavior.
 - Monitor subtle patient avoidance strategies that are co-opted by trainees: editorializing, using rhetoric, acting aggressively, feigning ignorance or forgetting, somaticizing, and being sarcastic.
 - Ensure that you, as the consultant-in-training, do not further add to collusion of avoidance by regularly engaging in all expectations (e.g., conducting a role-play live on the trainee call).
- ❖ How will this consultation skill be assessed during the training program?
 - ❖ The weekly consultation presentations will provide an opportunity for consultant trainers to observe this skill during live consultation.
 - ❖ If needed, video assessment at midpoint and the end of the program will include mock sessions demonstrating a lack of this trainee skill that consultants-in-training will be required to adequately critique.

Skill #4C: Refining Trainee Reactions to Trauma

Expectation: Peer-reviewed PE consultants are able to use discussions and exercises to shape the skill of being present, attentive, and accepting of patient's experience during the disclosure of traumatic events.

In PE, one of the most critical dialogs with patients is the patient's first disclosure of the traumatic event. During the first disclosure, the patient will closely monitor the clinician's reaction, which can signal how the patient should or needs to react. Four common yet problematic reactions by trainees are horror, sadness, pity, and indifference. Refining a trainee's reaction to trauma is a perfect area to practice role-plays. Before role-playing, trainees should be reminded that the process of extinction occurs within the trainee, too, not just the patient. A part of learning PE is to develop the skill of responding to trauma narratives without judgment or involuntary displays of emotion. With repeated practice, the trainee can learn to be a steady and safe presence that helps patients feel comfortable enough to discuss the worst days of their lives. Consultants-in-training should monitor attempts to be stoic and unemotional, which are also problematic. Three role-plays are especially helpful:

- The consultant-in-training can describe an index trauma that includes disgusting aspects of the human anatomy or of a violent encounter while having the trainee monitor his or her internal experience of disgust. After this exercise, the consultant-in-training and trainee can discuss how this increased disgust could facilitate colluding with patient

avoidance while it is also possible to continue prompting for emotional engagement even when they feel disgust.

- The trainee can describe their patient's index trauma and the consultant-in-training can model how the clinician's subtle display of valid emotions can be used to reinforce engagement and provide corrective information. After this exercise, the consultant-in-training and trainee can discuss how the subtle emotional display influenced the content of the narrative and emotion experienced.
- The trainee can practice providing empathic feedback without false reassurance while the consultant-in-training describes an index trauma with many embedded unhelpful beliefs (e.g., "I deserved the abuse and it will happen again"). After this exercise, the consultant-in-training and trainee can discuss how it is possible to express empathy regarding the fact that the traumatic event happened without invalidating unhelpful beliefs.

- ❖ How will this consultation skill be assessed during the training program?
 - ❖ The weekly consultation presentations will provide an opportunity for consultant trainers to observe this skill during live consultation.
 - ❖ If needed, video assessment at midpoint and the end of the program will include mock sessions demonstrating a lack of this trainee skill that consultants-in-training will be required to adequately critique.

Skill #4D: Enhancing Trainee Confidence and Well-Being

Expectation: Peer-reviewed PE consultants are able to help trainees enhance their confidence when delivering PE.

Established PE clinicians have a sturdy understanding that talking about traumas is not the same as experiencing a trauma and they are confident that treatment will work. They develop this understanding through watching their patients overcome their distress related to talking about the trauma. Some novice PE clinicians, on the other hand, report low confidence that they will be able to help their patients reduce their distress. Consultants-in-training should regularly use emotional processing theory to remind trainees that their own unhelpful beliefs and drives to avoid will decrease with repeated practice of delivering the treatment as designed. While trainee confidence will increase through experience, consultants-in-training should also monitor trainee's well-being and willingness to be open and vulnerable during consultation. Treating patients with PTSD is always challenging, especially when learning a new protocol. Consultants-in-training should discuss opportunities to practice self-care at work and away from work, as well as reaching out to trusted colleagues to help cope with struggles that might arise. In some cases, this trusted colleague will be the consultant-in-training.

- ❖ How will this consultation skill be assessed during the training program?
 - ❖ The weekly consultation presentations will provide an opportunity for consultant trainers to observe this skill during live consultation.
 - ❖ If needed, video assessment at midpoint and the end of the program will include mock sessions demonstrating a lack of this trainee skill that consultants-in-training will be required to adequately critique.

Competency Domain #5: Implementation

Skill #5A: Assessing Implementation Context

Expectation: Peer-reviewed PE consultants are able to identify factors related to clinic culture that might impact implementation of PE.

As a consultant-in-training, you are not just tasked with teaching PE but with potentially helping settings implement this practice. This requires you to know the trainee's context and its readiness to adopt PE. One helpful tool to assess the "implementation climate" is an 18-item self-report called the Implementation Climate Scale (Ehrhart, Aarons, & Farahnak, 2014). Additionally, the following questions are helpful to assess qualitative information about your trainee's context:

- Why is providing PE important to you and colleagues?
- Are patients currently offered exposure therapy? If so, describe the process.
- Can you provide PE weekly and for 90 minutes? If not, how can this be resolved?
- Are there obstacles to providing exposure therapy? If so, what are some solutions?
- Can you record your patient's imaginal exposures and share recordings with a consultant?
- Can you think of reasons why exposure therapy should not be offered?

If a consultant-in-training is working with a trainee who is in an independent community practice, the trainee may need additional assistance developing referral streams for PTSD cases. Consultants-in-training need to share resources and networks and use understanding of PTSD to identify potential referral streams such as Veterans Affairs Hospitals and Clinics, police and fire departments, local medical clinics and primary care facilities, or organizations serving highly traumatized or underserved areas. Depending on the community setting, trainees will have varying potential referral streams. One job of the consultant-in-training may be to help community therapists develop and maintain their referral streams to ensure their PE practice can be continued into the future.

- ❖ How will this consultation skill be assessed during the training program?
 - ❖ The weekly consultation presentations will provide an opportunity for consultant trainers to observe this skill during live consultation.
 - ❖ If needed, video assessment at midpoint and the end of the program will include mock sessions demonstrating a lack of this trainee skill that consultants-in-training will be required to adequately critique.

Skill #5B: Designing and Monitoring an Implementation Plan

Expectation: Peer-reviewed PE consultants are able to collaborate with clinicians to improve referral flow and manage competing clinical priorities.

Assuming the clinic has at least some capacity for change to support implementation, and assuming clinic leadership is at least somewhat supportive of implementation, the next step is

making an implementation plan or “blueprint.” Implementation plans are highly specific to a given clinic. Consultants-in-training will learn to apply evidence-based implementation strategies to help their trainees develop and sustain a PE practice. These specific strategies are outlined below. Worksheets for consultants-in-training to use with their trainees to help develop the implementation plan can be found in the Supplemental Materials.

- 1) Identifying stakeholder needs
 - a. Three stakeholder categories:
 - i. Patients
 - ii. Providers
 - iii. Clinic management
 - b. Using the stakeholder map worksheet (see Supplemental Materials), consultants-in-training should work with their trainees to identify the following:
 - i. The needs of each stakeholder
 - ii. How each stakeholder envisions implementation of PE
 - iii. And the risks to each stakeholder if high-quality PE is not implemented
 - 2) Develop implementation strategy
 - a. Using the implementation plan worksheet (see Supplemental Materials), consultants-in-training should work with their trainees to identify the **people, policies, methods and resources** needed to implement PE in the clinicians unique setting.
- ❖ How will this consultation skill be assessed during the training program?
- ❖ The implementation plan will be shared with consultant trainers at the beginning of the program. Progress on the implementation plan will be checked midway and at the end of the program. At the end of the program, the consultant-in-training will update the plan to identify how PE implementation will be maintained at the clinic going forward.