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Prolonged Exposure Therapy-Adolescent

Review: February 2023

Note on provider involvement: This provider has not agreed to EIF's terms of reference, and the assessment has not been conducted and published with the full cooperation of the programme provider. Some or all information on this programme has been obtained from publicly available sources, and so assessments may not include all relevant evidence and published information may contain inaccuracies on programme details.

Prolonged Exposure Therapy-Adolescent (PE-A) is a targeted indicated programme for adolescents (between the ages of 13 to 18) who have experienced trauma. It is delivered in outpatient health settings and community centres and aims to support children to develop emotional processing skills to reduce the impact of their traumatic experiences, resulting in a decrease in symptoms associated with posttraumatic stress disorder (PTSD) and other trauma-related conditions.

- PE-A is a form of cognitive behavioural therapy and was adapted from the widely studied and empirically supported adult treatment protocol. It provides psychoeducation about the effectsof trauma and then focuses on helping adolescents to systematically and repeatedly confront trauma-related memories (imaginal exposure) and reminders (in vivo exposure).
- It is intended for adolescents who are exhibiting PTSD and related symptoms.

Evidence rating: **3+**

Cost rating: **NA**

EIF Programme Assessment

Prolonged Exposure Therapy-Adolescent has evidence of a **short-term positive impact** on child outcomes from at least one rigorous evaluation.

Evidence rating: **3+**

What does the evidence rating mean?

Level 3 indicates **evidence of efficacy**. This means the programme can be described as evidence-based: it has evidence from at least one rigorously conducted RCT or QED demonstrating a statistically significant positive impact on at least one child outcome.

This programme does not receive a rating of 4 as it has not yet replicated its results in another rigorously conducted study, where at least one study indicates long-term impacts, and at least one uses measures independent of study participants.

What does the plus mean?

The plus rating indicates that this programme has evidence from at least one level 3 study, along with evidence from other studies rated 2 or better.

Cost rating

NA indicates that the information required to generate a cost rating is not available at this time.

Cost rating: **NA**

Child outcomes

According to the best available evidence for this programme's impact, it can achieve the following positive outcomes for children:

Supporting children's mental health and wellbeing

Decreased PTSD symptoms

Based on study 1, 2

Decreased depressive symptoms

Based on study 1, 2

Increased loss in PTSD diagnosis

Based on study 1

Increased global functioning

Based on study 1

Decreased externalising symptoms

Based on study 1

Decreased conduct problems

Based on study 1

Decreased suicidal ideations

Based on study 1

Reduced PTSD symptom severity at 12 and 24 months follow-up

Based on study 2

Preventing crime, violence and antisocial behaviour

Decreased rule breaking behaviour

Based on study

Decreased aggressive behaviour

Based on study 1

Key programme characteristics

Who is it for?

The best available evidence for this programme relates to the following age-groups:

- Adolescents

How is it delivered?

The best available evidence for this programme relates to implementation through these delivery models:

- Individual

Where is it delivered?

The best available evidence for this programme relates to its implementation in these settings:

- Community centre
- Out-patient health setting

The programme may also be delivered in these settings:

How is it targeted?

The best available evidence for this programme relates to its implementation as:

- Targeted indicated

Where has it been implemented?

United States, South Africa

UK provision

This programme has not been implemented in the UK.

UK evaluation

This programme's best evidence does not include evaluation conducted in the UK.

Spotlight sets

EIF does not currently include this programme within any Spotlight set.

About the programme

What happens during delivery?

How is it delivered?

- Prolonged Exposure Therapy-Adolescent is delivered in once to twice weekly sessions of 60 to 90 minutes duration ineight to 15 sessions. It is delivered by mental health professionals individually to young people.

What happens during the intervention?

- PE-A aims to improve the participants' ability to emotionally process their traumatic experiences and consequently diminish posttraumatic stress disorder and other trauma-related symptoms
- Participants are encouraged to repeatedly approach situations or activities they are avoiding because they remind them of their trauma (in vivo exposure) as well as to revisit the traumatic memory several times through retelling it (imaginal exposure)
- Psychoeducation about common reactions to trauma as well as breathing retraining exercises are also included in the treatment

What are the implementation requirements?

Who can deliver it?

- The practitioner who delivers this programme is a licensed mental health professionalor those working under the supervision of a licensed mental health professional. Psychology, social work, and nursing staff can implement PE-A in their respective roles.

What are the training requirements?

- The practitioners have four full days of programme training.

How are the practitioners supervised?

Not available

What are the systems for maintaining fidelity?

- Training manual
- Video or DVD training
- Face-to-face training
- Fidelity monitoring

Is there a licensing requirement?

Not available

How does it work? (Theory of Change)

How does it work?

PE-A is based on cognitive behavioural therapy and aims to promote the client's ability to emotionally process their traumatic experiences and consequently diminish posttraumatic stress disorder (PTSD) and other trauma-related symptoms

Intended outcomes

Supporting children's mental health and wellbeing

About the evidence

Prolonged Exposure Therapy for Adolescents' most rigorous evidence comes from two RCTs which was conducted in the USA and South Africa.
The studies identified statistically significant positive impact on a number of child outcomes.
This programme has evidence from at least one rigorously conducted ?RCT? along with evidence from an additional comparison group study. Consequently , the programme receives a 3+ rating overall.

Study 1

Citation: Foa et al., 2013; Zandberg et al., 2016; Brown et al., 2020

Design: RCT

Country: United States

Sample: This RCT involved sixty-one female adolescents (13-18 years old) who were exhibiting PTSD symptoms for longer than three months and were seeking treatment at a rape crisis centre.

Timing: Interim measurement (mid-treatment) Post-test 3-,6-,12-month follow-up

Child outcomes:

- Increased loss in PTSD diagnosis
- Increased global functioning
- Decreased externalising symptoms
- Decreased aggressive behaviour
- Decreased conduct problems
- Decreased suicidal ideations

Other outcomes:

- None measured

Study rating: 3

Study 1a - Foa, E. B., McLean, C. M., Capaldi, S., & Rosenfield, D. (2013). Prolonged exposure vs supportive counselling for sexual abuses related PTSD in adolescent girls: A randomized clinical trial. JAMA, 310(24), 2650-2657. doi:10.1001/jama.2013.282829

Study 1b - Zandberg, L., Kaczkurkin, A. N., McLean, C. P., Rescorla, L., Yadin, E., & Foa, E. B. (2016). Treatment of adolescent PTSD: The impact of prolonged exposure versus client?centered therapy on co?occurring emotional and behavioral problems. Journal of traumatic stress, 29(6), 507-514.

Study 1c - Brown, L. A., Belli, G., Suzuki, N., Capaldi, S., & Foa, E. B. (2019). Reduction in suicidal ideation from prolonged exposure therapy for adolescents. Journal of Clinical Child & Adolescent Psychology.

Study design and sample

The first study is a rigorously conducted ?RCT?. This study involved random assignment of 61 adolescents to a PE-A treatment group and a 'supportive counselling' control group. This study was conducted in the US, with a sample of girls aged 13 to 18 (average age 15) who were exhibiting PTSD symptoms for longer than three months and were seeking treatment at a rape crisis centre. More than half (56%) were Black, 18% were White, 16% were Hispanic, 7% provided no response, and 3% were biracial.

Measures

- The presence of PTSD diagnosis was measured using the Schedule of Affective Disorders and Schizophrenia for School-Age Children (diagnostic interview).
- PTSD symptoms severity were measured using the Child PTSD Symptom Scale–Interview (diagnostic interview) and the Child PTSD Symptom Scale–Self-Report (self-report).
- Depressive symptoms were measured using the Children's Depression Inventory (self-report).
- Global functioning was measured using the Children's Global Assessment Scale (direct assessment).

Findings

This study identified statistically significant positive impact on a number of ?child? outcomes. These include:

- Decreased PTSD symptoms
- Decreased depressive symptoms
- Loss of PTSD diagnosis
- Increased global functioning

Study 1b and 1c describes additional outcomes from study 1a described above. In this case:

- At 3-,6-, and 12-month post-intervention, emotional and behavioural problems were measured using the Youth Self-report Scale (self-report)
- Suicidal ideations were measured using the Children's Depression Inventory (self-report)

These studies identified statistically significant positive impact on a number of ?child? outcomes. These include:

- Decreased externalising symptoms
- Decreased suicidal ideations
- Decreased rule breaking behaviour
- Decreased aggressive behaviour
- Decreased conduct problems

Study 2

Citation: Rossouw et al., 2020

Design: RCT

Country: South Africa

Sample: Sixty-three adolescents (13-18 years old) were exhibiting PTSD symptoms for longer than three months.

Timing: post-test 3-, 6-, 12-, 24-month follow-up

Child outcomes:

- Reduced PTSD symptom severity at 12 and 24 months follow-up

Other outcomes:

- None measured

Study rating: 2+

Rossouw, J., Yadin, E., Alexander, D., & Seedat, S. (2020). Long-term follow-up of a randomised controlled trial of prolonged exposure therapy and supportive counselling for post-traumatic stress disorder in adolescents: a task-shifted intervention. *Psychological Medicine*, 1-9.

Study design and sample

This study involved random assignment of 63 adolescents to a PE-A treatment group and a 'supportive counselling' control group. This study was conducted in South Africa, with a sample of adolescents aged 13 to 18 (average age 15) who were exhibiting PTSD symptoms for longer than three months. The majority (83%) were female.

Measures

- The presence of PTSD diagnosis was measured using the Mini International Neuropsychiatric Interview for Children and Adolescents (diagnostic interview).
- PTSD symptoms severity were measured using the Child PTSD Symptom Scale–Interview (diagnostic interview) and the Child PTSD Symptom Scale–Self-Report (self-report).
- Depressive symptoms were measured using the Children's Depression Inventory (self-report).
- Global functioning was measured using the Children's Global Assessment Scale (direct assessment).

Findings

This study identified statistically significant positive impact on a number of ?child? outcomes. These include:

- Decreased PTSD symptoms
- Decreased depressive symptoms

Other studies

The following studies were identified for this programme but did not count towards the programme's overall evidence rating. A programme receives the same rating as its most robust study or studies.

Rossouw, J., Yadin, E., Alexander, D., & Seedat, S. (2018). Prolonged exposure therapy and supportive counselling for posttraumatic stress disorder in adolescents in a community-based sample, including experiences of stakeholders: study protocol for a comparative randomized controlled trial using task-shifting. *BMC psychiatry*, 18(1), 1-16.

Protocol for study 2

McLean, C. P., Su, Y. J., Carpenter, J. K., & Foa, E. B. (2017). Changes in PTSD and depression during prolonged exposure and client-centered therapy for PTSD in adolescents. *Journal of Clinical Child & Adolescent Psychology*, 46(4), 500-510.

Secondary analysis of data from study 1 to explore mediators

Capaldi, S., Asnaani, A., Zandberg, L. J., Carpenter, J. K., & Foa, E. B. (2016). Therapeutic alliance during prolonged exposure versus client?centered therapy for adolescent posttraumatic stress disorder. *Journal of Clinical Psychology*, 72(10), 1026-1036.

Comparison of rate of improvement in adolescent-rated therapeutic alliance in study 1 in both study arms

McLean, C. P., Su, Y. J., Carpenter, J. K., & Foa, E. B. (2015a). Changes in PTSD and depression during Prolonged Exposure and Client-Centered Therapy for PTSD in adolescents. *Journal of Clinical Child & Adolescent Psychology*. Advance online publication. doi:10.1080/15374416.2015.1012722

Study investigates the relationship between changes in PTSD and depression during PE for adolescent (PE-A) and client-centered Therapy (CCT)

McLean, C. P., Yeh, R., Rosenfield, D., & Foa, E. B. (2015b). Changes in negative cognitions mediate PTSD symptom reductions during client-centered therapy and prolonged exposure for adolescents. *Behaviour Research and Therapy*, 68, 64-69. doi:10.1016/j.brat.2015.03.008

Secondary analysis of data from study 1

Aderka, I. M., Foa, E. B., Applebaum, E., Shafran, N., & Gilboa-Schechtman, E. (2011a). Direction of influence between posttraumatic and depressive symptoms during prolonged exposure therapy among children and adolescents. *Journal of Consulting and Clinical Psychology*, 79(3), 421-425. doi:10.1037/a0023318

Multilevel mediational analyses to examine the temporal sequencing of posttraumatic and depressive symptoms during prolonged exposure (PE) therapy for posttraumatic stress disorder (PTSD) among children and adolescents

Aderka, I. M., Appelbaum-Namdar, E., Shafran, N., & Gilboa-Schechtman, E. (2011b). Sudden gains in prolonged exposure for children and adolescents with posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 79(4), 441-446. doi: 10.1037/a0024112

Exploration of sudden gains in sixty three young people receiving PE-A (age 8 to 17)

Gilboa-Schechtman, E., Foa, E. B., Shafran, N., Aderka, I. M., Powers, M. B., Rachamim, L., Rosenbach, L., Yadin, E., & Apter, A. (2010). Prolonged Exposure versus dynamic therapy for adolescent PTSD: A pilot randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, 49, 1034-1042.

Pilot RCT

Guidebook

The EIF Guidebook provides information about early intervention programmes that have at least preliminary evidence of achieving positive outcomes for children. It provides information based on EIF's assessment of the strength of evidence for a programme's effectiveness, and on detail about programmes shared with us by those who design, run and deliver them.

The Guidebook serves an important starting point for commissioners to find out more about effective early interventions, and for programme providers to find out more about what good evidence of impact looks like and how it can be captured. As just one of our key resources for commissioners and practitioners, the Guidebook is an essential part of EIF's work to support the development of and investment in effective early intervention programmes.

Our assessment of the evidence for a programme's effectiveness can inform and support certain parts of a commissioning decision, but it is not a substitute for professional judgment. Evidence about what has worked in the past offers no guarantee that an approach will work in all circumstances. Crucially, the Guidebook is not a market comparison website: ratings and other information should not be interpreted as a specific recommendation, kite mark or endorsement for any programme.

How to read the Guidebook

EIF evidence standards

About the EIF Guidebook

EIF

The Early Intervention Foundation (EIF) is an independent charity and a member of the What Works network. We support the use of effective early intervention for children, young people and their families: identifying signals of risk, and responding with effective interventions to improve outcomes, reduce hardship and save the public money in the long term.

We work by generating evidence and knowledge of what works in our field, putting this information in the hands of commissioners, practitioners and policymakers, and supporting the adoption of the evidence in local areas and relevant sectors.

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