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Using Prolonged Exposure Therapy to Treat Post-Traumatic Stress Disorder a Latina Female with a Complex Trauma History

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Abstract

Hispanics experience more severe and higher rates of PTSD than other ethnic groups. Despite the higher prevalence and more severe symptom presentation, few researchers have focused on the treatment of PTSD with Hispanics despite that the manner in which the disorder manifests may be related to ethnicity. We present the case of a 31 year-old Hispanic female who presented with PTSD. Prolonged Exposure (PE) Therapy was used to successfully treat the client. A number of factors were considered over the course of treatment including language, relevant Hispanic cultural factors, and the client's undocumented status. From this case study we can deduce that 1) PE can be effectively used with Hispanics; 2) treatment should be provided in the client's preferred language; 3) assessment should integrate cultural considerations; and 4) factors or characteristics that are related to culture may surface and the clinician should address these factors or characteristics as needed.

Key words: PTSD, Prolonged Exposure Therapy, Hispanics, Latinos, Cultural Sensitivit.

Novelty and Significance

What is already known about the topic?

- Hispanics experience higher rates of and more intense PTSD and have unique treatment need.

What this paper adds?

- Evidence that Prolonged Exposure Therapy can be used to treatment Hispanics who have PTSD.
- There are cultural factors that may arise throughout the treatment process.

In the United States, an estimated 0.5% to 1% of people experience a rape or sexual assault in their lifetime; in 2009, over 35 million Americans of Hispanic origin reported having experienced a rape or sexual assault at some point in their life (Truman & Rand, 2010). A common squealae of a sexual assault is Post Traumatic Stress Disorder (PTSD: Au,Dickstein, Comer, Salters-Pedneault, & Litz, 2013). The lifetime prevalence of PTSD among the general population is estimated to be 7-8% (National Center for PTSD, 2014). Interestingly Hispanics have been documented to experience more severe (e.g., Marshall, Schell, & Miles, 2009) and higher rates of PTSD than other ethnic groups (Marques, Robinaugh, LeBlanc, & Hinton, 2011). Despite the higher prevalence and more severe symptom presentation, few researchers have focused on the treatment of PTSD with Hispanics despite that the manner in which the disorder manifests may be related to ethnicity. Indeed, Benuto, Olmo, and Reyes (2011) found that among Spanish-Speaking Puerto Rican veterans, symptoms of PTSD are best conceptualized in four different clusters: intrusion, avoidance, numbing, and hyperarousal. This is contrary to the DSM-IV diagnostic criteria, which conceptualizes PTSD as consisting of three

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symptom clusters: re-experiencing, avoidance, and symptoms of increased arousal (APA, 2000). However, in the DSM-5 the criteria have been revised to consist of the following symptom clusters: intrusion symptoms, avoidance, negative cognitions and mood, and arousal and reactivity (APA, 2013). "Numbing" (a factor identified in the Benuto, Olmo, and Reyes [2011] study) fits under the negative cognitions and mood diagnostic criterion in the DSM-% (APA, 2013). Nonetheless, it is not clear that the symptoms under the "numbing" cluster (from the Benuto, Olmo, and Reyes [2011] study) are consistent with the symptoms under the "negative cognitions and mood" cluster in the DSM-5 (APA, 2013). Because treatment is directly focused on the reduction of symptoms and symptom presentation may vary by ethnicity, cultural considerations in the treatment of PTSD among Hispanics may be necessary. In fact, Henslee, Schumacher, Holloman, and Coffey (2009) discussed that Hispanic individuals may have a differential presentation of PTSD symptoms and may present with more severe avoidance and hyperarousal symptoms.

Despite the push in the field towards evidence-based practice (Chambless & Ollendick, 2001; Lilienfeld & O'Donohue, 2007; Ollendick, 2012) and the clear emphasis on the provision of culturally sensitive interventions (American Psychological Association, 2002), there is very little research in terms of the provision of evidence-based interventions to Hispanics (Benuto & O'Donohue, Under Review). Indeed the majority of the research on Hispanics is focused on etiological factors and epidemiological characteristics of disorders as opposed to on treatment outcome (Benuto & Leany, 2011). In fact a review of the extant literature revealed only a single study (Hinton, Hofmann, Rivera, Otto, & Pollack, 2011) that compared culturally adapted Cognitive Behavioral Therapy (CA-CBT) to Applied Muscle Relaxation (AMR) among Latinas (N = 24) who were diagnosed with PTSD. Through the cultural adaptation process Hinton and colleagues identified key CBT techniques (e.g., modifying catastrophic cognitions about PTSD and anxiety symptoms) that could be adapted for treating this population including adding content that is specific to cultural syndromes, including culture-specific analogies, discussing culturally idioms of distress etc. Results from this study indicated that the CA-CBT group experienced greater treatment gains than the AMR group as evidenced by lower anxiety scores on standardized measures (e.g., the PTSD Checklist) suggesting that addressing cultural factors can improve treatment outcome. In addition to the above, Kichic, Verga, and Reyes-Rabanillo (2011) also discussed having culturally adapted the Prolonged Exposure treatment protocol and while they did not conduct an empirical investigation, they did note the importance of including family members when using exposure-based Cognitive Behavioral Therapy (CBT) with Puerto Rican veterans.

Although many newer treatments for PTSD are now emerging (e.g., Mindfulness, Acceptance and Commitment Therapy; Cukor, Spitalnick, Difede, Rizzo, & Rothbaum, 2009), there are still only a few empirically-supported treatments. According to the latest Chambless Report these treatments include Prolonged Exposure (PE), Eye Movement Desensitization and Reprocessing, and Stress Inoculation Training (Chambless *et al*., 1998). Furthermore, according to the Institute of Medicine (IOM; 2008), exposure therapy is the only treatment with sufficient evidence demonstrating its efficacy to currently warrant recommendation for use. Other treatments such as EMDR, cognitive restructuring, and coping skills training did not have sufficient evidence to warrant recommendation.

Given that only CBT has been expressly examined with Hispanics, an investigation of how exposure therapy works with Hispanics is necessary.

Case Introduction

The client was a 31 year-old Hispanic female who was referred to psychotherapy by child protective services after she filed a police report indicating that her then-boyfriend was molesting her daughter. While the client was initially seeking services for her daughter, during the intake she expressed extreme distress regarding the abuse perpetrated against her daughter and was invited to come in for an intake herself (her daughter received treatment from a different therapist in the same clinic).

Presenting Complaints/Symptoms & Initial Assessment

The client presented with self-reported distress regarding the abuse that was perpetrated against her daughter. She was interviewed separate from her daughter and was tearful throughout the session. She shared that her then-boyfriend had come home late and that she heard him arrive. When he did not come to bed immediately she got up to see where he had gone. She reported that she noticed that there was light coming from her daughter's bedroom and that she walked in and witnessed him touching her daughter. She confronted him immediately and he denied that he had been doing anything inappropriate. She turned to her daughter and asked her what had happened and then turned to look at her then-boyfriend who was gesturing to her daughter not to say anything. She immediately called the police who questioned her daughter and eventually her then-boyfriend admitted to the abuse. The client expressed guilt and self-blame for what had happened to her daughter and shared that she too had been sexually assaulted and did not want this to impact her daughter in the same way it had impacted her.

History

The client reported that she was raised in an intact family in Latin America and always felt loved by her parents. She reported that her relationships with her five older siblings were "so-so", indicated that she was an average student in elementary and middle school (she did not attend high school), and stated that she had few friends throughout her childhood. She indicated that when she was 12 she was raped and that she was raped a second time as an adult (she reported PTSD-related symptoms related to both rapes). The client indicated that she married when she was still a teenager as she was pregnant and that for the first part of her marriage things were good. She reported that when she was in her mid-twenties she and her husband entered the United States undocumented and that when she was 26 she began having an affair with a married man and later left him because she did not want to be responsible for the end of his marriage. Subsequently she and her husband (the father of her children) separated and she moved to New Mexico. The man she had been having an affair with continued to pursue her and she eventually moved back to Arizona to be with him. She described that

initially he was the "perfect father" to her daughter and at the outset of them moving in together everything was good. She reported that they later experienced a great deal of conflict and that he would be gone for long periods of time. At intake five weeks has lapsed since she found him in her daughter's bedroom. At the time of intake he was incarcerated and awaiting trial.

ASSESSMENT AND TREATMENT

Because the client witnessed the abuse of her daughter and she herself was a victim of sexual assault, she was administered the civilian version of the PTSD Checklist-Civilian (PCL-C: Weathers, Litz, Herman, Huska, & Keane, 1993) and obtained a score of 55 suggesting the presence of PTSD symptoms; this was consistent with what she reported during the clinical interview. She was also administered the Patient Health Questionnaire (PHQ-9: Manea, Gilbody, & McMillan, 2012) and obtained a score of 18 suggesting moderately severe Major Depression (no suicidal ideation was present). During the intake it became apparent that the PTSD symptoms she was experiencing were related to both the prior sexual assaults she had experienced and her witnessing the abuse that was perpetrated against her daughter. When she was asked which traumatic event she felt was impacting her the most at the time of the intake she reported that witnessing the abuse that her ex-boyfriend had perpetrated against her daughter. As such this was the central focus of treatment. The client experienced a steady decrease in symptoms across treatment. Please see Table 1 and Figure 1 for details.

Case Conceptualization

Given the client's description of past trauma, her witnessing of a traumatic event (the abuse of her daughter during which she felt extreme fear), and her presentation of symptoms that were consistent with PTSD (intrusive recollections of the event, psychological distress when exposed to reminders of the trauma, avoidance of thoughts and reminders of the trauma, hypervigilance, and difficulty sleeping) she was diagnosed with PTSD. There were several factors that made the case complex including the client's undocumented status, limited social support system (she had no friends and all of her family lived out of state or in Latin America), her trauma history, and her financial situation (she was financially dependent on her ex-boyfriend and after he was arrested she had to rent a room from someone she had met at church). The client reported self-blame and guilt given that the perpetrator was her ex-boyfriend whom she had left her daughter's father to be with.

Course of Treatment & Assessment of Progress

A formal intake was conducted with the client subsequent to the initial intake that was scheduled to gather information relevant to her daughter's treatment. After intake, the client was seen for seven treatment sessions during which Prolonged Exposure Therapy was administered. Prolonged Exposure Therapy is a form of exposure therapy

designed to decrease excessive anxiety by confronting avoided thoughts, situations, activities, or people, which are realistically safe. The client is first provided with psychoeducation about PTSD and Prolonged Exposure and is taught relaxation skills (via breathing); subsequently an in-vivo exposure hierarchy is created and the client is asked to confront safe situations that are on the hierarchy in a systematic manner; lastly the client engages in imaginal exposure and the traumatic memory is reprocessed in session with the therapist. All sessions are recorded and the client listens to the audio of the session throughout the week (Foa & McLean, 2011). Table 1 offers an overview of the treatment process.

During each imaginal exposure the clients Subjective Units of Discomfort (SUDs) were tracked at approximately 10-minute intervals. Figure 1 offers an overview of the client's SUDs over the course of the imaginal exposures conducted. After each imaginal exposure the traumatic memory was re-processed and there was a heavy emphasis on discussing the beliefs that she held that were unhelpful or inaccurate. The client expressed a lot of self-blame and guilt and reported that she perceived herself as weak. At the conclusion of treatment she shared that her self-image had greatly improved and she felt empowered and strong. During treatment the client was referred to legal services to file for a U-Visa (victims of certain crimes can qualify for temporary legal status and work eligibility in the United States: U.S. Immigration Support, 2012).

Culturally Relevant Factors

Language was a major cultural factor that was addressed by the use of a fully bilingual therapist. All treatment sessions were administered in Spanish. In addition to language there were a number of cultural factors that arose including the Hispanic cultural values of familism (Miles, Shih, Tucker, Zhou, & D'Amico, 2012) punishment/self-blame (Katerndahl, Burge, Kellogg, & Parra, 2005; Pole, Best, Metzler, & Marmar, 2005), and patriarchy (Kemp & Rasbridge, 2004).

In the Hispanic culture there is a large emphasis on the family unit and the family is expected to stay together (Landale and Oropesa 2007; Ellison, Wolfinger, & Ramos-Wada, 2013). As indicated above, this client reported a large amount of guilt both because she had exposed her daughter to the perpetrator and also because she had an affair with him. She expressed that she felt as though she was being punished for her "sins." Indeed this is consistent with Hispanic cultural beliefs whereby the perspective is held that one can be punished for indiscretions that one commits (Wong & Hernandez, 2009). Moreover, because the client violated a cultural norm by having an affair and then leaving her husband to be with her lover (which is inconsistent with the Hispanic cultural value of monogamy: Oswalt & Wyatt, 2011), she reported a great deal of guilt associated with this. The client's cognitive distortions (which surfaced during the re-processing of the traumatic memory) were largely related to the above factors and focused on self-blame and guilt over what had happened to her daughter. In addition to a heavy emphasis on the family, Hispanic culture is patriarchal in nature and in traditional Hispanic relationships the male is expected to be the head of the household (Pardo, Weisfeld, Hill, & Slatcher, 2012) and the female is expected to abide

Table 1. Course of Treatment & Assessment of Progress.

Session	Focus/Content	Homework	Assessment
Week 1: Intake	-Clinical interview, trauma interview, & assessment.		PCL-C= 55 PHQ-9= 18
Week 2	-Psychoeducation about PTSD and behavioral activation (to treat depressed mood). -Discussion on expanding social support.	-Listen to audio of the session. -Practice relaxation exercises. -Engage in pleasant activities. -Attend church to expand social support.	-
Week 3	-Review rationale for treatment. -Construct an in-vivo exposure hierarchy. -Identify Subjective Units of Discomfort (SUDS) anchor points.	-Listen to audio of the session. -Practice relaxation exercises. -Practice 2 items on the in-vivo exposure hierarchy. -Engage in pleasant activities.	-
Week 4	-Client arrived 30 minutes late to session. -Client's decreased score on the PCL-C was discussed with her. She reported feeling better but that she still has intrusive recollections of the event, engages in lots of efforts to not think about the trauma, has disinterest in some activities she used to enjoy, feels emotionally numb, and experiences irritability and hypervigilance.	-Practice relaxation exercises. -Practice 2 items on the in-vivo exposure hierarchy. -Engage in pleasant activities.	PCL-C= 39
Week 5	-Imaginal Exposure was implemented. -SUDs ranged from 15-80 and reduced to 65 by the end of a 35-minutes of exposure. -During the reprocessing of the traumatic memory, client's cognitive distortions were challenged.	-Listen to audio of the session in its entirety once and to the imaginal exposure daily. -Practice relaxation exercises. -In-vivo exposure hierarchy. -Engage in pleasant activities.	
Week 6	-Imaginal Exposure was implemented -SUDs ranged from 35-55 and reduced to 35 by the end of a 40-minute exposure -During the reprocessing of the traumatic memory, client's cognitive distortions were again challenged	-Listen to audio of the session in its entirety once and to the imaginal exposure daily. -Practice relaxation exercises. -In-vivo exposure hierarchy. -Engage in pleasant activities.	
Week 7	-The Imaginal Exposure "Hot Spots" procedure was implemented. -SUDs remained stable at 19 throughout the 30-minute exposure. -It was noted that the client's cognitive distortions were substantially reduced.	-Practice relaxation exercises. -Engage in pleasant activities.	PCL-C= 23
Week 8	-Progress in treatment was reviewed and the client reported improved mood and no anxiety. -A final imaginal exposure was conducted and the client integrated her new beliefs/thoughts about the sexual abuse of her daughter into her trauma narrative. -SUDS ranged from 0-3.	-Practice relaxation exercises. -Engage in pleasant activities. -Follow-up session was scheduled for three months ou.t	PCL-C= 17 PHQ-9= 0

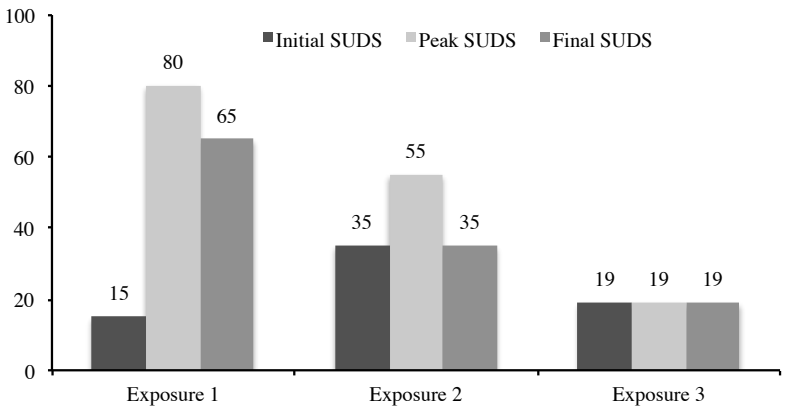

Figure 1. SUDS Across Imaginal Exposures.

by the concept of marianismo (the gender role expectations of Latina women: Castillo, Perez, Castillo, & Ghosheh, 2010) and care for the home and the children (Skogrand, Hatch, & Singh, 2005). While this cultural characteristic is not exclusive to the Hispanic culture in the case of this client, she and her ex-boyfriend did ascribe to these roles. This complicated things for her as when he was arrested she found herself in a financial predicament whereby she did not have a strong work history or a skill set that made it easy for her to obtain employment. Moreover her lack of mastery of English and her undocumented status made it difficult for her to find employment. The client perceived herself as "weak" and incapable of caring for her daughter at the outset of treatment but at the completion of treatment she viewed herself as "strong" for having overcome such a difficult ordeal and also as independent as she was able to find a means to provide for her daughter. With regard to the Hispanic cultural value of familism, the client was extraordinarily socially isolated as her family all lived in Latin America (and she could not travel to see them nor could they travel to see her as none of her family members possessed a visa to travel to the U.S.) or out of state and she had not made friends since moving in with her then-boyfriend. This may also have some cultural relevance as the Hispanic culture tends to be very focused on the nuclear and extended family and other relationships tend to take a secondary role (Smith, 2000). Nonetheless, the client was able to make friends at church and at follow-up described that she felt that she had a strong social support system.

Lastly, the client had a strong anxiety reaction to a secondary trauma. While, this could be related to her complex trauma history (there is evidence that PTSD can develop more severely when there is a history of trauma: Hagenaars, Fisch, & van Minnen, 2011) Hispanics have been noted to experience more severe PTSD than other ethnic groups (Rosenheck, & Fontana, 1996). The client's initial score on the PCL-C (55) was just above the recommended 50-point cut off score for a diagnosis of PTSD (Karstoft, Anderson, Bertelsen, & Madsen, 2013) her presentation in session suggested that she was in a great deal of emotional distress (e.g., crying, self-report, report of her SUDS). This could have some cultural relevance, as the dependent measures used to assess treatment outcomes may not be appropriate for use with cultural minorities (Cardemil, 2010a; Cardemil, 2010b). Her high level of emotional distress was consistent with Henslee, Schumacher, Holloman, and Coffey's (2009) indication that Hispanic individuals may have a differential presentation of PTSD symptoms and may present with more severe avoidance and hyperarousal symptoms. Indeed, the client reported avoiding even pleasant activities that previously enjoyed (like taking a walk through a park that she and her daughter loved) because she had previously engaged in such activities with the perpetrator and they reminded her of him.

Follow-up

The client was also seen three months after treatment was completed for a follow-up appointment. At follow-up the client scored a 20 on the PCL-C and a 0 on the PHQ-9 indicating that she did not meet criteria for a mental health diagnoses. Please see Figure 2 for specifics regarding the client's scores on the PLC-C and PHQ-9. While

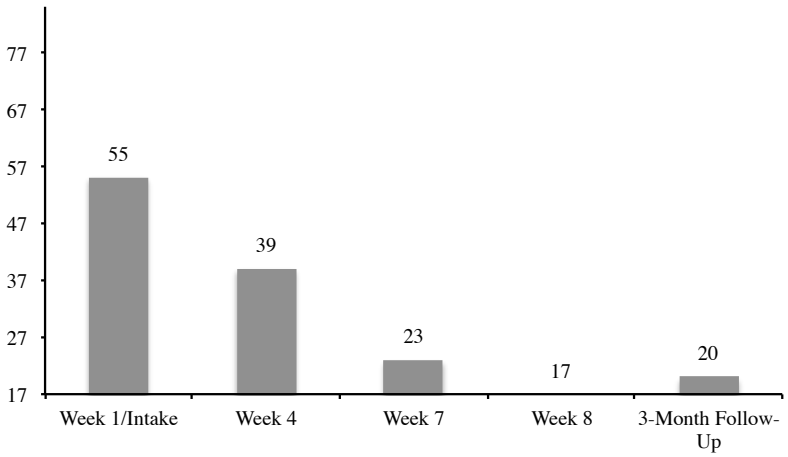

Figure 2. PCL-C Scores Across Treatment.

the client did report some financial stressors at follow-up she indicated that she was using the skills she learned in therapy to cope with her stress. She also reported that she had sustained the social support system she had built over the course of treatment.

DISCUSSION

This case highlights the treatment success that can be achieved when empirically supported treatments are used with ethnic minority clients. Similar to Hinton and colleagues' (2011) findings, in this case a number of techniques that are commonly used in the treatment of PTSD (e.g., modifying catastrophic cognitions about PTSD and anxiety symptoms) were adapted to be more consistent with Hispanic cultural characteristics (i.e., discussing cultural syndromes and using cultural idioms of distress). For example the concept of nervios was used to help the client understand her anxiety reaction to the traumas she had experienced. It is important to note that while Foa and McLean (2011) specified that Prolonged Exposure Therapy typically consist of eight to 15 sessions, the client in this case study experienced a significant reduction of symptoms over the course of seven treatment sessions. It is unclear why the client experienced such a quick reduction in symptoms and it does not appear to have cultural underpinnings. Nonetheless, the results form this case study suggests that Prolonged Exposure Therapy is an effective treatment for Hispanics who have PTSD.

The field of clinical psychology is currently focused on evidence-based practice (Chambless & Ollendick, 2001; Lilienfeld & O'Donohue, 2007; Ollendick, 2012). However, some have questioned the generalizability of empirically supported treatments to cultural minorities because of the culture values and assumptions represented in these treatments (Benish, Quintana, & Wampold, 2011) and because the dependent measures used to assess treatment outcomes may not be appropriate for use with cultural minorities (Cardemil, 2010). While aspects of this case study suggest that cultural factors will inevitably surface in treatment, the use of Prolonged Exposure Therapy (which has

been deemed an EST: Nayak, Powers, & Foa, 2012) resulted in a clinically significant reduction of symptoms for a Hispanic female who was suffering from PTSD. Indeed at the conclusion of treatment and at follow-up the client did not meet diagnostic criteria for a mental health diagnosis. It is worth noting that services were provided to the client in her language of preference (Spanish). Where it is not possible due to an absence of a bilingual therapist to provide a client with treatment in their language of preference (or proficiency) a translator can be used to provide services (Brisset, Leanza, & Laforest, 2013). From this case study we can offer the following recommendations for clinicians who work with Hispanics who are suffering from PTSD: (a) When possible the treatment provider and the client should speak the same language however where this is not possible, a professional translator can be used to interpret. There are guidelines for how translators should work in mental health settings (see Tribe & Lane, 2009; d'Ardenne & Farmer, 2009); (b) The Hispanic client may have a differential presentation of PTSD symptoms (e.g., s/he may present with a strong pattern of avoidance, symptoms may be more severe etc.); (c) Scores on standardized questionnaires should be supplemented with a clinical interview to ensure that an accurate diagnosis is made; (c) Factors or characteristics that are related to culture may surface and the clinician should address these factors or characteristics as needed; and (d) The clinician should use ESTs to treat PTSD.

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