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From Science to Practice:

Strengthening Trauma-Focused Proficiency in Evidence-Based PTSD Treatment

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Today's Agenda

01 **Overview**
What PE & CPT share — and why it matters

02 **PE: Theory, Protocol & Challenges**
Imaginal exposure, in vivo exposure & processing

03 **CPT: Theory, Protocol & Challenges**
Socratic dialogue, natural emotion & stuck point prioritization

04 **Navigating Barriers**
Engagement, avoidance & homework compliance

05 **The New Frontier**
Augmented protocols & the indispensable role of trauma-focused proficiency

06 **Resources & Discussion**

Barriers to Implementation

Trauma-Focused Concerns

- Risk of re-traumatization or symptom exacerbation
- Perceived unsuitability for complex/multiple trauma
- Client readiness and willingness to engage

Protocol-Related Concerns

- Manualized treatment impacts therapeutic alliance
- Not suitable for co-morbid psychiatric diagnoses
- Inability to address emerging client needs
- Concerns about homework adherence

Therapist-Related Issues

- Limited training, resources & professional support
- Secondary traumatization and burnout risk
- Time burden in high-caseload settings

Doran et al., 2019; Finch et al., 2020; Bell et al., 2022

What PE & CPT Have in Common

Shared Structure

- **Individual psychotherapy — one-on-one with therapist**
- **Time-limited — 8 to 15 sessions over 2–4 months**
- **Homework-intensive — daily practice is essential**
- **Trauma-focused — directly processes the trauma**

3 Core Elements of Treatment Success

Address trauma-related cognitions

Engage the trauma memory

Reduce experiential avoidance

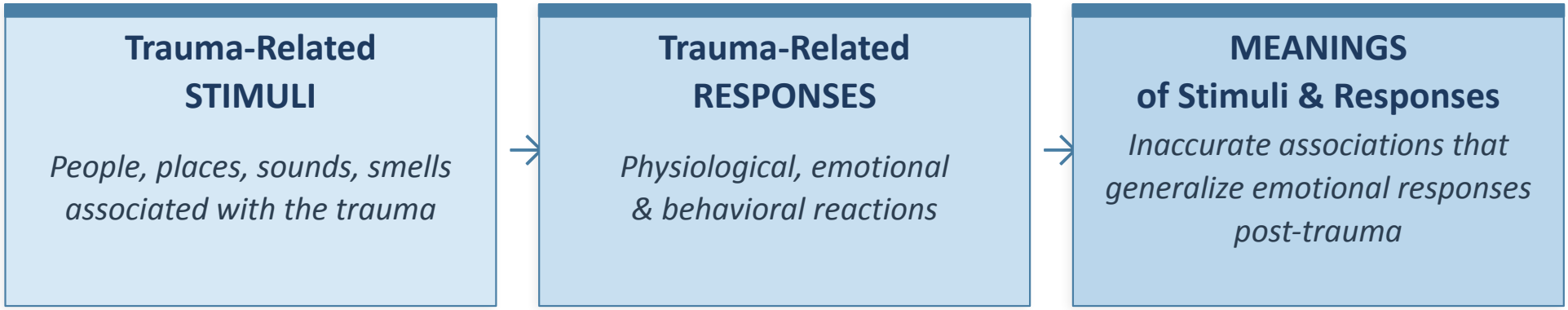
Norman, Hamblen & Schnurr, 2023; Olff et al., 2020

SECTION 1

Prolonged Exposure Therapy (PE)

Emotional Processing Theory · Protocol Overview · Implementation Challenges

Emotional Processing Theory



How PE Promotes Recovery

- **Inaccurate associations can only be modified when new, corrective information is available and incorporated into the emotional structure**
- **Therapeutic exposure activates the trauma memory network, enabling new learning to replace maladaptive associations**
- **PTSD = a disorder of non-recovery driven by avoidance that prevents corrective learning**

Foa, Hembree, Rothbaum & Rauch, 2019

PE Protocol at a Glance

COMPONENT 1
Psychoeducation

Sessions 1–2

- Treatment rationale & overview
- Common trauma reactions
- Breathing retraining exercise

COMPONENT 2
In Vivo Exposure

Sessions 2–end

- Develop SUDS scale & hierarchy
- Systematically approach avoided situations
- Review & refine weekly

COMPONENT 3
Imaginal Exposure

Sessions 3–end

- Revisit trauma memory aloud in session
- Process experience with therapist
- Listen to recording as homework

Foa, Hembree, Rothbaum & Rauch, 2019

PE — IMPLEMENTATION CHALLENGES

Three Core Challenges in Prolonged Exposure

Imaginal Exposure · Processing · In Vivo Exposure

Prompting in Imaginal Exposure: Finding Balance

Procedure & Purpose

- **Client revisits trauma memory aloud, in present tense, with emotional engagement**
- **Activates the emotional network so corrective information can be incorporated**
- **Therapist's role: monitor, support, and titrate emotional response**

> ***Key question when listening:***
> *"What's preventing this person from coming to terms with their trauma?"*

Challenge: How active should I be?

- **Start with sensory/contextual details as scaffolding — "What do you see? What do you hear?"**
- **Then prompt for internal experiences — thoughts, feelings, body sensations**
- **Prompts should be brief, timed, and in present tense — frequent/lengthy prompts disrupt engagement**
- **Identify key themes during IE to explore in processing: self-blame, danger, distrust**

Foa, Hembree, Rothbaum & Rauch, 2019; Brown, Zandberg & Foa, 2019

Processing of Imaginal Exposure: Maintaining the Frame

What is Processing?

Interactive dialogue immediately following IE — not simply 'checking in,' but a structured opportunity for the client to reflect on the trauma and integrate new learning.

Challenge: How do I keep the focus on processing?

- **Begin with client's experience of revisiting — then shift to the content of the memory**
- **Ask what they learned from IE before raising your own observations or questions**
- **Use open-ended questions and reflective listening to support new understanding — don't challenge directly**
- **Encourage elaboration of emerging insights; highlight shifts in thinking to differentiate then vs. now**
- **Explore unhelpful beliefs by helping the client arrive at new perspectives in their own time**

Foa, Hembree, Rothbaum & Rauch, 2019; Brown, Zandberg & Foa, 2019

In Vivo Exposure (IV): Enhancing Specificity

Procedure & Purpose

- **Systematically approach trauma-related avoided situations in real life**
- **Disconfirm danger — learn the avoided situation is safe**
- **Break the avoidance cycle; reduce PTSD maintenance**

> ***Example: "Going to the store"***
> *Location · Day · Time · Alone or with someone · Specific aisles · Interacting with clerks*

Challenge: How precise should I be?

- **Take one activity and manipulate variables to create a range of items with increasing distress**
- **Confirm the client has access to the activity and can engage for an extended period, multiple times/week**
- **Be explicit when assigning homework — identify 2–3 items and review the client's schedule**
- **If client struggles with an item, review prior successes and break down activity into smaller steps**

Foa, Hembree, Rothbaum & Rauch, 2019

SECTION 2

Cognitive Processing Therapy (CPT)

Cognitive Theory of PTSD · Protocol Overview · Implementation Challenges

Cognitive Theory of PTSD

ASSIMILATED Stuck Points

Past-oriented beliefs about why the trauma occurred

"It was my fault."
"I should have done more."

→

OVER-ACCOMMODATED Stuck Points

Present/future beliefs resulting from the trauma

"The world is dangerous."
"I can't trust anyone."

→

ACCOMMODATION (Goal)

Balanced, realistic beliefs about self, others & world

"I survived."
"I can feel safe again."

The goal of CPT is to help clients move from stuck points toward accommodation through Socratic dialogue and cognitive restructuring.

Phase 1: Psychoeducation

PTSD reactions, impact of trauma on beliefs, meaning of trauma

Phase 2: Processing Trauma

Utilize Socratic dialogue to identify & challenge stuck points

Phase 3: Challenging Stuck Points

Develop skills to self-challenge SPs & generate balanced beliefs

CPT — IMPLEMENTATION CHALLENGES

Three Core Challenges in Cognitive Processing Therapy

Socratic Questioning · Natural Emotion · Stuck Point Prioritization

CPT Challenge: Mastering Socratic Questioning

Guiding Principle: Ask, Don't Tell

Therapist approach: curious, warm, collaborative — SQ guides the client to new understanding rather than providing it

- **Ask sufficient questions to identify a clear, concise stuck point — converting to an 'if/then' statement is often helpful**
- **Focus on clarifying questions to establish context before challenging or evaluating evidence**
- **Explore the client's reasoning, including their intention during the event and expectations based on prior experience**
- **If the client struggles to relinquish a SP, explore its underlying function — holding on often serves a protective purpose**
- **When the client generates a helpful alternative belief, briefly recap the cognitive change process to reinforce understanding**

Resick, Monson & Chard, 2024; Galovski, Nixon & Kaysen, 2020

CPT Challenge: Fostering Natural Emotions

Two Types of Emotion in CPT

Natural Emotions

Directly linked to the trauma itself — must be experienced to dissipate. Socratic dialogue around assimilated SPs elicits these feelings.

Manufactured Emotions

Associated with stuck points — resolve as SPs are corrected through cognitive restructuring.

In-Session Strategies

- **Allow the client to pause and sit with their emotion — don't rush past it**
- **Ask the client to name the feeling or describe associated physical sensations**
- **Validate the emotion within the context of the trauma**
- **Encourage experience of natural emotions during homework and revisit during review**

Resick, Monson & Chard, 2024; Galovski, Nixon & Kaysen, 2020

CPT Challenge: Prioritizing Assimilated Stuck Points

Why Address Assimilated SPs First?

- **Assimilated SPs are closely linked to trauma details and shape over-accommodated SPs — addressing them first sets the stage for later work**
- **Exploring them places the trauma in context and enhances understanding of the client's reactions and choices at the time of the event**
- **Most are rooted in hindsight bias, outcome-based reasoning, and difficulty differentiating levels of responsibility**

Clinical Strategies

- **Initially use mostly clarifying questions to explore whether it was possible for the client to change the outcome**
- **Acknowledge OA SPs that surface early — add to the SP log and return to them in later sessions**
- **If the client intellectually understands but still feels the same, explore the function of the SP and continue to challenge**

Resick, Monson & Chard, 2024; Galovski, Nixon & Kaysen, 2020

COMMON CHALLENGES — PE & CPT

Navigating Barriers Across Both Protocols

Treatment Engagement · Addressing Avoidance · Homework Compliance

Navigating Barriers: Key Principles

Fidelity & Flexibility

Adapt treatment to individual needs while ensuring modifications remain consistent with underlying theory and evidence-based cornerstones

Shared Decision Making

Collaborative, client-centered approach fosters sense of control and enhances engagement; include client perspectives and wishes

Therapeutic Alliance & Solid Rationale

Strong alliance and compelling treatment rationale provide the foundation for addressing obstacles throughout therapy

Consistent Reinforcement

Provide encouragement, support, and positive feedback for all efforts and successes — not just completed homework

Foa et al., 2019; Galovski, Nixon & Kaysen, 2020

Treatment Engagement

Psychoeducation, transparent rationale, and collaborative goal-setting are key to fostering early treatment engagement.

- **Begin by addressing why treatment is worth pursuing and highlight evidence of treatment gains**
- **Provide a solid protocol overview; address client concerns about emotional impact directly**
- **Psychoeducation about PTSD symptoms that fuel reluctance (guilt, shame) enhances motivation**
- **Don't rule out treatment due to co-occurring stressors — assess and manage alongside treatment**

NCPTSD Resources:

Clinical resources, psychoeducation articles & videos, PE Coach & CPT Coach mobile apps

Norman et al., 2020; Resick, Monson & Chard, 2024; Foa, Hembree, Rothbaum & Rauch, 2019

Addressing Avoidance

Avoidance is both a core symptom of PTSD and the primary barrier to treatment success — addressing it directly is essential.

- **Validate the urge to avoid — avoidance reduces anxiety short-term but maintains PTSD long-term**
- **Consistently label avoidance as a PTSD symptom to externalize and destigmatize**
- **Approach avoidance as a team effort between therapist and client**
- **Identify the primary fear driving avoidance; return to treatment rationale to address it directly**

NCPTSD CE Resource:
Avoiding Avoidance in PTSD Treatment — CE webinar on promoting new learning with compassion

Norman et al., 2020; Resick, Monson & Chard, 2024; Foa, Hembree, Rothbaum & Rauch, 2019

Homework Compliance

Research indicates homework adherence is directly related to better treatment outcomes.

- **Emphasize that majority of therapeutic work takes place outside of session — frame during treatment planning so the client can make an informed commitment**
- **Problem-solve both practical barriers (time, privacy) and clinical barriers (PTSD symptoms, co-morbidities)**
- **Provide consistent positive feedback for efforts made, not just completed assignments**
- **Utilize reminders and between-session phone calls for support, encouragement, and problem-solving**

NCPTSD Free Mobile Apps:

PE Coach · CPT Coach — session reminders, homework tracking, self-report measures

Resick, Monson & Chard, 2024; Foa, Hembree, Rothbaum & Rauch, 2019; Galovski, Nixon & Kaysen, 2020

SECTION 3

The New Frontier of PTSD Therapy

Massed Treatment, Augmented Protocols, & The Indispensable Role of Trauma-Focused Proficiency

Massed & Intensive Formats: Expanding Access

- **Standard PE and CPT are delivered weekly over 2–3 months**
- **Massed formats deliver the same evidence-based protocol compressed into daily sessions over 1–2 weeks**
- **Growing evidence shows massed delivery produces equivalent outcomes to standard weekly therapy and lower drop out rates**
- **RCT of massed PE saw less than 5% dropout compared to nearly 17% in standard weekly delivery (Dell et al., 2023)**
- **Massed CPT delivered via telehealth produced rapid, large, and durable reductions in PTSD, depression, and anxiety (Baez et al., 2026)**
- **Format flexibility allows clinicians to match delivery to the client's life**

Dell et al., 2023; Baez et al., 2026; Sandanapitchai & Nixon, 2025

Augmented Protocols: MDMA-Assisted Therapy

- **Phase 3 trials showed high response and remission rates, but FDA declined approval in August 2024 due to concerns about blinding, safety monitoring, and trial methodology**
- **A third Phase 3 trial has been requested before approval can be reconsidered**
- **MDMA is not a standalone treatment but designed to be paired with psychotherapy to enhance emotional processing and reduce avoidance**
- **Emerging research is now explicitly combining MDMA with PE and CPT — the first pilot data from MDMA + massed PE shows promising early results (Maples-Keller et al, 2026)**
- **Trauma-focused therapy skills remain central — MDMA's proposed role is to enhance the very mechanisms PE and CPT target**

Morland et al., 2026

Beyond MDMA: Other Emerging Approaches

Psilocybin:

- **Early-stage research suggests psilocybin may create a window of enhanced emotional openness and neuroplasticity**
- **Active trials are now exploring its combination with massed CPT and massed PE; a promising but still very early area of investigation**

Cannabinoids/CBD:

- **Widely used by trauma survivors seeking relief, particularly veterans**
- **Current evidence does not support cannabinoids as an effective standalone PTSD treatment; researchers are exploring whether CBD may enhance extinction learning when combined with PE**

Virtual Reality:

- **VR-assisted exposure therapy offers an immersive alternative for clients who struggle to engage with traditional imaginal exposure**
- **Current evidence suggests it is comparable to standard PE, with potential value as an access and engagement tool rather than a superior treatment**

McGowan et al., 2025; Meshkat et al., 2025; Wilson et al., 2026; VA ESP Systematic Review, 2025

The Indispensable Role of Trauma-Focused Proficiency

1

Deep Knowledge of Trauma Impact

Multidimensional understanding of how trauma affects cognition, emotion, and behavior

2

Foundational Skills in Processing Trauma

Guided & effective memory processing; ensuring safety and clinical efficacy

3

Therapeutic Alliance & Empathy

Cultivating trust; managing emotional intensity; validating the client's experience

4

Optimized Treatment Outcomes

Targeted, tailored modifications that maintain fidelity while meeting individual needs

Training & Clinical Resources

- **National Center for PTSD | www.ptsd.va.gov**

  Clinical resources, assessment tools, consultation & CE, mobile apps (PE Coach, CPT Coach), client education}

- **CPT for PTSD | www.cptforptsd.com**

  Training & consultation, provider resources, materials & worksheets

- **Prolonged Exposure, UPenn CTSA | www.med.upenn.edu/ctsa/workshops_ptsd.html**

  Training & consultation, CE workshops and webinars

- **International Society of Traumatic Stress Studies (ISTSS) | www.istss.org**

  Clinical practice guidelines, treatment resources, CE & professional membership

Recommended Reading

- Bruce, M. J., Pagán, A. F., & Acierno, R. (2025). State of the science: Evidence-based treatments for PTSD via telehealth. *Journal of Traumatic Stress, 38*(1), 5–15. https://doi.org/10.1002/jts.23074
- Burback, L., et al. (2024). Treatment of PTSD: A state-of-the-art review. *Current Neuropharmacology*, 22, 557–635. https://doi.org/10.2174/1570159X21666230428091433
- Hooyer, K., et al. (2024). "Pitching" PTSD treatment. *Journal of Traumatic Stress*, 37, 901–912. https://doi.org/10.1002/jts.23058
- Kehle-Forbes, S. M., et al. (2025). "It made me feel more alive": Quality of life following trauma-focused therapy. *Journal of Traumatic Stress,* 38, 158–164. https://doi.org/10.1002/jts.23091
- McLean, C. P., & Foa, E. B. (2024). State of the science: Prolonged exposure therapy for PTSD. *Journal of Traumatic Stress, 37*(4), 535–550. https://doi.org/10.1002/jts.23046
- Morland, L. A., et al. (2026). State of the science: MDMA-assisted psychotherapy for PTSD. *Journal of Traumatic Stress*, 39, 173–187. https://doi.org/10.1002/jts.70060
- Resick, P. A., et al. (2024). State of the science of cognitive processing therapy. *Behavior Therapy*, 55, 1205–1221. https://doi.org/10.1016/j.beth.2024.04.003
- Sandanapitchai, P., & Nixon, R. D. V. (2025). Exploring structural adaptations to CPT: A systematic review and meta-analysis. *Behavior Therapy*, 56, 948–963. https://doi.org/10.1016/j.beth.2025.03.003

References

Full reference list and recommended reading list available on the MOPA conference website.

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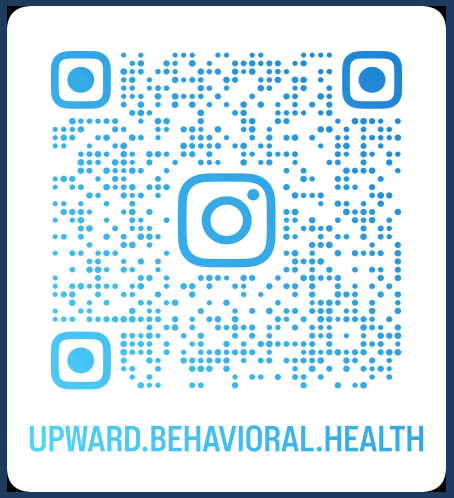
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