

ONLINE SUPPLEMENTAL CHAPTER 15

The BREATHE Program: A Brief Posttraumatic Stress Disorder Intervention for Persons With Serious Mental Illness in Special Settings

Based on over 40 years of research, the optimal treatment of posttraumatic stress disorder (PTSD) in the general population is generally assumed to require between nine and 16 sessions of trauma-focused therapy such as cognitive restructuring (CR), exposure therapy, or eye movement desensitization and reprocessing (EMDR). Similarly, although some longer-term interventions for PTSD in special populations have been evaluated (Bohus et al., 2013; Cloitre et al., 2010; Najavits, 2002), most research on PTSD in people with serious mental illness (SMI) has evaluated programs of similar length to those developed in the general population (Frueh et al., 2009; Grubaugh et al., 2016; van den Berg et al., 2016; Van den Berg et al., 2015; Van den Berg & van der Gaag, 2012), including the CR for PTSD program (Lu et al., 2009; Mueser, Gottlieb, et al., 2015; Mueser et al., 2008; Rosenberg et al., 2004). In contrast, very little work has examined the effectiveness of briefer interventions for PTSD for either the general population or for people with SMI. Given this background, the notion that a brief intervention could be effective for the treatment of PTSD may be surprising to some readers. Nevertheless, the focus of this chapter is on describing a brief intervention for the treatment of PTSD people with SMI that has good evidence supporting it.

The **Brief, Relaxation, Education and Trauma Healing (BREATHE)** program is a three-session intervention for treating PTSD that is based on the first three sessions of the CR for PTSD program. BREATHE utilizes the same psychoeducation and breathing retraining techniques and handouts/worksheets as the CR program but does not include cognitive restructuring. A detailed clinical manual for delivering the BREATHE program is provided in the online appendix of this book. The BREATHE program may be a useful alternative to implementing the full CR program in some treatment settings, or as a first step towards implementing the full CR program in others. This chapter provides background on the development of the BREATHE intervention and a brief overview of how the program is provided, and addresses different treatment settings and circumstances that merit consideration for implementation of the program.

History and Development of the BREATHE Program

The BREATHE program was developed over a twenty-year period, beginning with our exploration of the effects of brief psychoeducation for people with SMI and PTSD. This was followed by refinement to the intervention, subsequent evaluation, and minor additional refinements.

Starting Point: Brief Psychoeducation for PTSD in Clients with SMI

Our first experience with a brief intervention for PTSD was early in the development and pilot testing of the CR for PTSD program. While our work on the CR program focused mainly on clinically stable clients receiving outpatient services, we became interested in the feasibility

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of providing brief psychoeducation about trauma and PTSD to more symptomatic individuals receiving inpatient psychiatric treatment. We reasoned that such psychoeducation might be helpful to individuals in understanding the role of trauma in some of the symptoms they experienced and could motivate them to seek trauma-focused therapy at a later point, following discharge when their symptoms were more stable.

To provide the psychoeducation, we used the same educational handouts and interactive teaching methods we developed for the CR program and provided these over three individual or group sessions. We also created a video of a therapist providing psychoeducation about PTSD to a client (both actors), with designated pauses to facilitate discussion. We were chiefly interested in whether the inpatient participants could be engaged and retained in the program without any untoward effects, and whether they would be able to effectively learn information about PTSD.

We implemented the program at three acute care units at New Hampshire Hospital (NHH) with individuals who were hospitalized for brief periods of time for treatment of a symptom exacerbation (average length of stay 10 days). Routine screening of trauma and PTSD (using the PCL) was done on consecutive admissions to the hospital, with the brief program offered to patients with probable PTSD based on the PCL. Program sessions were provided by NHH psychologists or pastoral counselors three times per week either individually or in small groups (3-6 patients) co-led by the clinicians, to accommodate the short period in the hospital. To evaluate the feasibility of the program and its effects on learning information about PTSD, we examined attendance rates of patients referred to the program, changes in understanding of PTSD from baseline to post-treatment on the Knowledge of PTSD (KPTSD) test, and satisfaction with the program (Pratt et al., 2005). As we did not view the program as a “treatment” for PTSD, we did not monitor changes in PTSD symptoms.

A total of 98 patients were referred to the program and participated in at least one session, approximately equal numbers of men and women, of whom about one-third had a schizophrenia-spectrum disorder and half had a major mood disorder. Of these patients, 13% attended two sessions, and 71% attended all three sessions. The primary reason for not completing the program was when patients were discharged or transferred to another unit. Negative reactions to the program or adverse events were not observed. The 70 patients who completed the program showed highly significant increases in knowledge of PTSD. Participants also showed high satisfaction with program, with over 75% reporting they learned more about PTSD, problems related to trauma, and treatments, that the information was helpful and easy to understand, and that they would recommend the program to a friend. In addition, 49% of the participants indicated that they felt they were better able to cope with their trauma-related problems, and 35% reported feeling less distressed about their symptoms.

The results supported the feasibility of the brief psychoeducation program, with patients showing increases in their understanding of PTSD and expressing high satisfaction with the program. Clinicians observed that many patients appreciated the opportunity to learn more about trauma and PTSD symptoms, and that it often appeared to allay patients’ fears and concerns about what their PTSD symptoms were and what it meant to have them. Furthermore, a significant percentage of patients indicated that the program reduced their distress and improved their coping with trauma-related problems.

Evolution of BREATHE Program and Empirical Support

We expected that the brief psychoeducation program described above would be well tolerated by the participants and increase their understanding of the nature of trauma and PTSD. However, we were somewhat surprised by how many participants reported that the intervention helped them cope better with their symptoms and reduced their distress. We hypothesized that integrating breathing retraining into the brief psychoeducation program, as is done in the first three sessions of the CR for PTSD program, might further increase its clinical impact on PTSD symptoms. In addition, considering the brevity and relative simplicity of the program, we were interested in evaluating its utility as a clinical service when provided to persons with SMI and PTSD on an outpatient basis.

The brief intervention was standardized in a clinician manual following the same basic engagement and teaching strategies (and handouts and worksheets) as the first three sessions of the CR for PTSD program. After several years of conducting research and obtaining clinical experience with the brief intervention, we renamed it the Brief, Relaxation, Education and Trauma Healing (BREATHE) program. Minor modifications have been made in the program over the years, such as updating the manual to conform with changes in the DSM-5 criteria for the diagnosis of PTSD, but the essential ingredients of the program have remained the same.

Three different studies of BREATHE have been conducted with clients with SMI and PTSD living in the community to: 1) examine the feasibility of providing BREATHE in a small (N=18) open trial (Nishith et al., 2015), 2) compare the effects of the BREATHE program with the CR for PTSD program on PTSD and other outcomes in a large (N=201) (Mueser, Gottlieb, et al., 2015) randomized controlled trial, and 3) evaluate the feasibility and impact of implementing and integrating the BREATHE program into routine clinical services in an even larger (N=211) open trial (Mueser et al., in press). Highlights of the findings are provided below.

High Feasibility and Acceptability of BREATHE

Across all three studies there was abundant evidence that BREATHE could be implemented successfully in diverse populations of clients with SMI and PTSD. First, clients showed a high level of interest in the program when it was offered to them. For example, in the large open trial of BREATHE, of the 233 clients who were offered the program, 211 (91%) wanted to participate and attended the first session (Mueser et al., in press). Second, clients appeared to like the program, with fewer than 10% of those who came to the first BREATHE session dropping out, and most going on to complete all three sessions of the program. Third, these high attendance rates were consistent with the high levels of reported client program satisfaction from the large open trial, where BREATHE intervention completers rated on average a 9 out of 10 on a scale of how helpful they found the program (Mueser et al., in press).

Improvements in PTSD After BREATHE

Participation in the BREATHE program was associated with substantial reductions in PTSD symptoms and diagnosis, both at the end of treatment and at follow-ups ranging from three months (Mueser et al., in press; Nishith et al., 2015) to one year (Mueser, Gottlieb, et al.,

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2015). For example, in the first open trial of BREATHE, only 33% of clients with PTSD had the diagnosis at post-treatment and the 3-month follow-up. In the controlled trial of BREATHE in which all clients met criteria for severe PTSD at baseline, at post-treatment 36% no longer had severe PTSD and 27% no longer had a PTSD diagnosis (Mueser, Gottlieb, et al., 2015). One year later, even fewer clients met criteria for severe PTSD (47%) or any PTSD diagnosis (30%). In the large open trial of BREATHE, clients who completed the program demonstrated large and clinically significant improvements on self-rated PTSD symptom severity from the baseline to 3-month follow-up assessment (Mueser et al., in press).

In the controlled study that compared BREATHE with the CR for PTSD program (Mueser, Gottlieb, et al., 2015), participants who received the full CR program did improve more on PTSD outcomes than those who received BREATHE. However, participants who received BREATHE in this study improved significantly more on PTSD than similar participants in a previous controlled trial of the CR program who received only usual services (Mueser et al., 2008). The findings indicated a clear clinical benefit for clients with SMI and PTSD who received the BREATHE program (see Chapter 2, section on Research on the CR for PTSD Program and Figure 2.1 for further details).

Improvements in Other Symptoms After BREATHE

Similar to improvements in PTSD, participants in BREATHE experienced significant reductions in other symptoms as well. Improvements in depression, the symptom with the strongest association with PTSD symptoms, were especially prominent. For example, in all three studies participants began the BREATHE program with average scores on the Beck Depression Inventory-II (Beck et al., 1988) in the “severe” depression range, which fell to the lower end of the “moderate” depression range at the end of follow-up for two of the studies (Mueser et al., in press; Mueser, Gottlieb, et al., 2015) and to the “mild” depression range for the third study (Nishith et al., 2015).

Other Clinical Applications of the BREATHE Program

The brevity and relative simplicity of the BREATHE program suggest that it may be useful in other clinical populations of persons with PTSD. For example, one recent study evaluated providing BREATHE via telehealth to 30 individuals in the general population living in the community with PTSD (Lu, Caldwell, et al., 2023). Retention in the program was high and participants showed significant reductions in PTSD symptoms, depression, anxiety, other psychiatric symptoms, and internalized stigma at post-treatment that were maintained at a three-month follow-up.

Another recent example has been the adaptation of the BREATHE program to provide it in primary care settings to adolescents who have been identified as having PTSD (Srivastava et al., 2022). The rationale for the approach is that PTSD can be easily screened for and detected in primary care settings where adolescents typically receive most of their medical treatment, but follow through on referrals to psychiatric treatment are low (Banh et al., 2008). Integrating behavioral healthcare into the primary care setting, especially when brief treatment is feasible, is one solution to this problem (Straus & Sarvet, 2014). An open pilot study of the BREATHE program adapted for adolescents and provided in a primary care setting found high feasibility,

acceptability, and satisfaction with the program in 20 participants, who also showed significant improvements in PTSD and other symptoms (Ng et al., 2023).

Another population and setting where the BREATHE program may meet a unique need is in the treatment of PTSD in low income and lower-resourced countries. In such countries, longer-term psychotherapeutic interventions lasting more than a few sessions are generally not available, and the feasibility of implementing such programs is low due to the limited number of mental health professionals. The BREATHE program may provide a viable alternative to the CR for PTSD program or other evidence-based programs for the treatment of PTSD in such countries. To explore this, two projects are currently underway to culturally adapt the BREATHE program for the treatment of people with SMI and PTSD living in Ethiopia and Botswana, to evaluate its feasibility, and to conduct a preliminary controlled trials of its effects (Molebatsi et al., 2021; Ng et al., 2021).

How Does the BREATHE Program Work?

The apparent effectiveness of the three-session BREATHE program at improving PTSD (and other) symptoms should not come as a complete surprise as it includes the same therapy components as the first three sessions of the full CR for PTSD program (psychoeducation and breathing retraining). Routine symptom monitoring every three sessions in the CR for PTSD program has revealed a significant reduction in both of PTSD symptom severity (on the PCL) and depression (on the BDI-II) from the beginning of the first to the fourth session (Lu et al., 2012), with continued reductions in symptoms thereafter. For some clients, this initial relief from PTSD symptoms may be sufficient to not require the lengthier CR program and learning cognitive restructuring.

The same mechanisms underlying the clinical benefits of the first three sessions of the CR program may explain how the BREATHE program works (as described in Chapter 2). First, providing information about trauma and PTSD, including the nature of PTSD symptoms and the prevalence of the PTSD diagnosis, serves to “normalize” PTSD as a common reaction to trauma that is no one’s fault and that conveys to the person that “they are not alone” in their experience. This information can alleviate the self-blame many trauma victims feel for having PTSD symptoms or for having “not gotten over their trauma” by now, as well as relieve other concerns about their symptoms such as that they were “going crazy.” Furthermore, psychoeducation about PTSD lets people know that the disorder is well understood by mental health professionals, which can instill hope for effective treatment for it.

Second, the breathing retraining skill taught in the first session, which is practiced and honed by the client over the next two sessions, has relatively rapid effects on both reducing anxiety as well as over-arousal symptoms of PTSD. Anxiety is usually the most prominent negative feeling associated with PTSD, which can be overwhelming and incapacitating to individuals, at times precipitating panic attacks or immobilizing individuals. Teaching breathing retraining gives people a tool they can begin to use within a few sessions to better manage and reduce their anxious feelings.

In addition to the effects of breathing retraining on anxiety, this skill can also reduce the over-arousal symptoms of PTSD, such as hypervigilance, exaggerated startle responses, anger outbursts, and difficulty sleeping. Since clients are taught to initially practice breathing retraining when they are not feeling especially stressed or anxious in order to more easily learn the skill,

this practice may serve to reduce some of the chronic over-arousal symptoms of PTSD that occur even in the absence of significant anxiety. Relief from severe over-arousal symptoms may reduce overall distress related to PTSD.

Third, aside from the short-term effects of breathing retraining on anxiety and over-arousal symptoms, over the longer-term use of this skill (as well as the psychoeducation) may undo the exaggerated fight or flight response people with PTSD have in the face of perceived threat. That is, as over-arousal symptoms (and anticipatory anxiety) decrease, so too do inflated perceptions of risk in everyday situations, and the avoidance of those situations. As individuals gradually reduce their avoidance of previously feared situations they become exposed to new and corrective information about the safety of those situations, which can contribute to further reductions in avoidance behavior. The new information people learn as they encounter previously avoided situations can lead to changes in trauma-related beliefs they have about themselves (e.g., “I’m a weak person”, “I’m an easy target”) or other people in those situations (e.g., Nobody can be trusted”). In this way, long-held trauma-related beliefs may change over the course of the BREATHE program (and after) in some clients with PTSD without ever directly targeting those beliefs for change (e.g., via cognitive restructuring).

Clinical Implementation of BREATHE Program

The BREATHE program can be implemented following most of the suggestions for providing the CR for PTSD program outlined in Chapter 4, with a few modifications. The brevity of the BREATHE program and the fact that it does not involve significant trauma-focused work means that it can be offered more flexibly than the CR for PTSD program. Thus, while we recommend not beginning the CR program until the client has some degree of clinical stability (as defined by not having been hospitalized within the past two months or not having made a suicide attempt), the BREATHE program can be provided during periods of greater clinical instability, including during an inpatient stay for symptom stabilization. For some individuals, inpatient treatment with the BREATHE program may be especially beneficial as it can be provided safely and has the potential of reducing PTSD symptom burden which may have contributed to the hospitalization. In addition, while the CR program is usually provided on a weekly basis, more frequent BREATHE sessions may be conducted (e.g., 2 sessions in a week) if circumstances warrant, such as the client having a discharge date less than three weeks from their first BREATHE session.

As PTSD is frequently under-detected in clinical settings serving the SMI population, routine screening of all clients for trauma and PTSD is recommended (e.g., with the Difficult Life Events Questionnaire and the PTSD Checklist [PCL]), as in the CR program. Referral of clients with probable PTSD to a clinician who is trained to provide the BREATHE program, as well as the engagement of clients in BREATHE, similarly follow the same procedures as those described in Chapter 4 and 5 for the CR program.

A slight modification of the symptom monitoring procedures for the BREATHE program is called for with the second assessment. As the BREATHE program only has three sessions, the second (and final) monitoring of PTSD and depressive symptoms is conducted at the end of the third session, immediately following the termination part of the session. It is common for clients in the BREATHE program to continue to improve in PTSD symptoms after completion of the program (Mueser et al., in press; Mueser, Gottlieb, et al., 2015; Nishith et al., 2015), and

therefore it is recommended that a follow-up assessment be completed using the same measures, preferably three months after the last session.

When Should BREATHE vs. the CR for PTSD Program be Provided?

There are a number of different treatment settings and circumstances that merit practical consideration for implementing the BREATHE program instead of the CR for PTSD program, or as a first step towards implementing the CR program. These considerations are discussed below.

Programs Serving Transient or Difficult to Engage Populations

Some treatment programs serve individuals who are difficult to reach or engage in sustained treatment. For example, programs serving individuals who are homeless often have difficulty finding, engaging, and retaining them in treatment. Relatedly, some programs serve clinical populations that despite stable housing are facing multiple other challenges in their lives (e.g., poverty, difficulties related to children or caring for an ill family member, legal problems), resulting in frequent “no-show” or cancelled appointments with outpatient providers. In these types of treatment settings, the BREATHE program might be considered to be a practical alternative to providing the lengthier CR program. It is easier to get a client to complete two or all three of the BREATHE sessions, than the minimum six sessions of the CR program used to define clinical “exposure” to the program (Mueser, Gottlieb, et al., 2015; Mueser et al., 2008), much less the 12-16 recommended number of sessions.

For example, we conducted our NJ randomized controlled trial comparing the CR for PTSD program with the BREATHE program at five sites in a large behavioral health agency, three of which were partial hospital programs and two which were psychiatry outpatient departments; all programs served predominantly poor, urban, and minority populations of persons with SMI (Mueser, Gottlieb, et al., 2015). The rate of therapy appointment cancellations or “no shows” at the two outpatient departments was very high, with approximately 50% of all appointments missed (Slade et al., 2017). At these two sites, 88% of the participants in BREATHE received either two or all three sessions, whereas only 48% of those in the CR program received the minimum recommended dosage of 6 sessions. In comparison, rates of exposure to both the BREATHE and CR programs were high in the partial hospital programs. Thus, in settings with high rates of cancelled appointments such as the two psychiatry outpatient departments, offering the BREATHE program rather than the full CR program may be more economical (in terms of reducing missed sessions and lost clinician time), and less frustrating to both clinicians and clients.

Assertive Community Treatment (ACT) Programs

ACT is a treatment model that was developed to serve individuals with SMI in the community who typically did not access treatment at local community mental health centers, and were prone to frequent relapses, rehospitalizations, and housing instability (Allness & Knoedler, 1998; Stein & Santos, 1998). The basic philosophy of ACT programs is “if you can’t get somebody to the mental health center for treatment, bring the treatment to them in the community.” This is accomplished by having a multidisciplinary team of mental health

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professionals provide the broad range of services an individual requires through mobile outreach in the community (e.g., medication checks, case management), in the natural settings where the client spends their time (e.g., at home, in a park, at a coffee shop). Because most ACT services are provided in the community and the program serves a high-need population, the typical client to clinician ratio on an ACT team is usually 10:1, rather than 30:1 (or larger) as is the case in typical services. Intensive case management is a similar community-based model to the ACT program that focuses on serving more symptomatic and impaired clients (Mohamed, 2013).

There are several reasons why it might be preferable to implement the BREATHE program on an ACT team rather than the full CR for PTSD program. First, the clients served by ACT teams tend to be more symptomatic and disorganized than those who receive usual outpatient mental health services, which can make it more difficult to engage them and maintain a sense of continuity over the treatment sessions in a psychotherapy program lasting 3-4 months like the CR program. The simpler and less ambitious three-session BREATHE program may be more suited to what most clients on ACT teams can be expected to begin and end. Second, most of the staff members on ACT teams are Bachelor's degree-level mental health professionals who, while experienced working with the SMI population, are not clinicians. As clinicians have the most appropriate experience for delivering psychotherapeutic treatment for PTSD on ACT teams, providing the BREATHE program might be a more efficient use of their valuable time. Third, with the limited number of clinicians on ACT teams, their role on the team may be more vulnerable to the effects of staff turnover. The shorter period of time required to train clinicians in the BREATHE program compared to the CR program may make it a better fit with the staffing needs of ACT teams.

Settings Providing Treatment for Brief Periods of Time

Some treatment programs serve individuals for relatively brief periods of time that would be unsuitable for providing the full CR program. For example, acute care inpatient treatment, (such as that provided at New Hampshire Hospital as described above) is often provided to individuals to stabilize their symptoms following a relapse, and frequently lasts between a week or two and several months. There is not enough time to provide the full CR program in such settings, but there is sufficient time to provide the BREATHE program, especially if multiple sessions are offered weekly in programs with relatively short stays. Examples of other settings in which treatment is provided for relatively brief periods of time and BREATHE may be a practical treatment option include state or county jails, homeless shelters that provide mental health services, or mobile mental health programs that may regularly visit and provide services in rural communities for several days at a time.

Agencies with High Staff Turnover

The mental health workforce is ever-changing, with experienced and trained clinicians often moving onto either higher jobs in the agency or other jobs and requiring the hiring and training of new clinicians. Shortages in the mental health workforce have increasingly become a concern in recent years (Bureau of Health Workforce, 2022; Olfson, 2016), with these problems exacerbated by high turnover of mental health staff (Fukui et al., 2020; Yanchus et al., 2017). Agencies that have either a significant shortage of mental health staff, resulting in overburdening

existing staff with additional clinical responsibilities, or a high turnover of clinicians, may consider implementing the BREATHE program to save on the time and expense required by the full CR program. This option could be the primary solution for agencies that suffer chronic workforce shortages or rapid turnover, or a temporary solution to a temporary problem for agencies that expect to overcome these workforce issues, with subsequent training in the cognitive restructuring component of the full CR program provided at a later date, as described in the section below.

Phased Implementation of the CR for PTSD Program

A different option for implementing the BREATHE program is for an agency to provide it as one step in a more gradual process towards implementing the full CR for PTSD program. That is, rather than initially providing the more extensive training required to implement the CR program, the training can be broken up into two phases, with the first phase focused on the screening and assessment of trauma and PTSD, and the implementation of the BREATHE intervention. The second phase of training can then focus on implementing the full CR program.

There are several advantages to taking a phased approach to implementing the full CR program, beginning with the BREATHE program. First, it gives clinicians more time to hone their assessment skills, and to learn how to teach breathing retraining and provide psychoeducation about PTSD to their clients. These skills serve as the foundation for the CR program and taking time to focus on mastering just them may be a good investment. Second, implementing the CR program requires a certain amount of system change within a mental health agency. For example, a reliable and standard method for screening and assessing trauma and PTSD in clients with SMI needs to be implemented, supervision of clinicians treating PTSD within the organization needs to be arranged, and other administrative modifications may be needed such as creating new forms and procedures for tracking trauma-focused interventions and outcomes. Implementing the BREATHE program first allows more time to accomplish these tasks and to troubleshoot obstacles within the agency before taking on the full CR program.

A final advantage of providing training in the CR program in two phases is that it sets the stage for an organization to choose to treat PTSD in a stepped approach, which is probably the most efficient and effective approach possible. Stepped treatment approaches are when a sequence of treatments are provided for a particular condition one at a time (or adding one treatment to the next) in a stepwise fashion, with the targeted outcome evaluated after each step, and the next step in treatment provided only if sufficient improvement has not occurred (Davison, 2000; Ho et al., 2016). Usually the briefest, simplest, or least disruptive treatment is provided first, followed by more complex interventions. Stepped care is common in medicine and is becoming increasingly more common in the treatment of psychiatric disorders (Kopelovich et al., 2019; Sobell & Sobell, 2000; van't Veer-Tazelaar et al., 2009; Zatzick et al., 2011). This approach recognizes that not everyone with a particular disorder requires the most empirically supported intervention as the first-line treatment if briefer, less invasive, and less expensive but nevertheless effective alternative interventions exist. By providing less intensive treatments first and monitoring outcomes to determine when further treatment is required, stepped care can save valuable clinician time and impose less burden on clients.

Stepped treatment for PTSD in persons with SMI can be provided by first giving people the BREATHE program and then following completion, reassessing PTSD symptoms to

determine whether additional treatment with the CR for PTSD program is needed and desired. Considering that PTSD symptoms usually continue to improve after completing the BREATHE program, it is recommended that the PCL be re-administered one-month after the third BREATHE session, and that continued treatment with the remainder of the CR program be considered for clients who continue to have probable PTSD on the PCL at this assessment. Some clients who still meet PCL criteria for probable PTSD after completing the BREATHE program may want to wait longer to see if their PTSD symptoms improve further, while others may feel ready to move onto the CR program. Taking a one-month break from therapy to wait and determine whether additional treatment for PTSD is needed is feasible without losing the rapport and therapeutic alliance developed over the three sessions of the BREATHE program.

When implementing a stepped care approach based on the BREATHE and CR for PTSD programs, at the one-month PTSD reassessment meeting it is recommended that the therapist re-administer the PCL, score it, and explain whether the person still meets criteria for probable PTSD. This can lead into a discussion of any changes in PTSD symptom severity since the last assessment a month ago, possible reasons for any further reductions, and (for clients who still have probable PTSD) the option of further treatment with the rest of the CR program. If the client is interested in resuming treatment, the therapist can begin by providing an orientation to the CR program (as described in Chapter 5), modified to account for the breathing retraining and psychoeducation components of the program covered in BREATHE.

For clients who want to resume therapy by beginning the CR program, it is recommended that the therapist spend some additional time preparing the client by reviewing their use of the breathing retraining skill and exploring possible goals for treatment in the program. This breathing retraining review and goal-setting (which requires about 30 minutes) can be accomplished as either part of the follow-up session conducted one month after completing the BREATHE program or in a separate session prior to the session in which cognitive restructuring is introduced.

If the client reports during this discussion that they have continued to use of the breathing retraining skill (and accompanying benefit), no further attention is needed on the topic. If the client indicates a drop-off in their use of breathing retraining or limited benefits from using it, the therapist can explore possible reasons for this and take steps to address them, such as re-engaging the client in practicing the skill in session, making modifications to the skill as needed, and troubleshooting obstacles to more effective use. After reviewing the client's use of breathing retraining, the therapist can briefly discuss some of the information about PTSD and its effects on the person's life that was previously covered in BREATHE as a prelude to exploring and identifying how the client would like their life to be different as a result of better managing their PTSD. This lays the groundwork for establishing specific goals for treatment, as discussed in Chapter 6.

Clinical Vignette

James was a 36-year old cisgender Black man with a diagnosis of schizoaffective disorder who was living in a homeless shelter and was receiving mental health services from a mobile outreach team operated by a local community mental health center. James had lived on the streets for several months before agreeing to move into a shelter a month ago. He had a

history of alcohol and drug use disorder, which was in partial remission (heroin), however he intermittently continued to use alcohol, as well as marijuana.

A staff member of the mobile outreach team conducted the PTSD screening with James using the Difficult Life Events Inventory (DLEI; Chapter 3), followed by the PTSD Checklist (PCL-5). James reported experiencing a number of different traumatic events on the DLEI, including physical abuse as a child, a car accident, having been in a life-threatening flood, being robbed at gunpoint, and having been shot and injured during another robbery. He reported that this last event (shot and injured during a robbery), which had occurred two years ago, was currently the most distressing one, and therefore the PCL was completed based on that index event. James' PCL-5 total score was 58, far exceeding the cut-off score of 33 which indicates probable PTSD. His most severe symptoms included intrusive memories of the attack, anxiety when exposed to stimuli that reminded him of the assault and avoidance of related situations, nightmares, self-blame, feeling cut off and isolated from others, and multiple over-arousal symptoms (e.g., difficulties sleeping and exaggerated startle response). James also reported that he sometimes hears voices that threaten him and thought that some of those voices were the person who shot him. The clinician who conducted the assessment described the BREATHE program to James, who was interested and agreed to participate in it.

James and his clinician met in a spare room at the homeless shelter for the three sessions of the BREATHE program, which they were able to complete in three weeks. James was readily engaged in the psychoeducation about PTSD, and expressed surprise that his symptoms were so common in others who had experienced trauma. He was relieved to learn that he wasn't to blame for his symptoms or what had happened to him. James quickly took to the breathing retraining skill for its calming effect, which he practiced on his own in a quiet place at the shelter for home assignments. James said the breathing retraining skill was particularly helpful in reducing his over-arousal symptoms, especially his sleep difficulties and feeling "keyed up" much of the time. At the end of the third session James was administered the PCL-5 again, and his total score had decreased to 33. Another assessment was conducted three months later and his PCL-5 total score had further decreased to 22, well below the "probable PTSD" cutoff of 33.

Summary and Conclusions

The Brief, Relaxation, Education and Trauma Healing (BREATHE) program is a three-session intervention for PTSD that is based on the breathing retraining and psychoeducational components of the CR for PTSD program (utilizing the same handouts and worksheets), minus the cognitive restructuring component. A detailed session-by-session manual guiding the implementation of the BREATHE program is provided in the online appendix of this book. The effectiveness of the BREATHE program is supported by several research studies. Although the CR for PTSD program has even stronger effects on improving PTSD outcomes than the BREATHE program, most clients benefit from BREATHE and for some it is sufficient treatment for their PTSD.

The briefer duration of BREATHE and the lower level of resources required to train clinicians to provide it suggest several settings and circumstances in which it may be preferable to provide the BREATHE program rather than the CR for PTSD program. Treatment settings in which clients receive treatment for relatively brief periods of time (e.g., acute inpatient hospitals, jails) or that serve client populations that are either highly transient (e.g., homeless persons) or

difficult to engage (e.g., highly stressed clients living in urban areas with high rates of cancellation) may be well suited for the BREATHE program. Assertive community treatment (ACT) teams with limited resources to provide individual therapy to often highly symptomatic clients may also benefit from implementation of the BREATHE program. Mental health agencies with a high turnover of clinical staff may also find BREATHE a better match for their needs because of the reduced time required to train clinicians in the program.

Clinical training in the BREATHE program can also be conducted as the first part of a two-stage plan to implement the full CR for PTSD program. By first providing training in the screening and assessment of PTSD, and delivery of the BREATHE program, therapists can gain competence in these fundamental skills, and agencies can develop the necessary resources and structures to support trauma-focused work on PTSD (e.g., routine screening for trauma and PTSD, referral processes, on-site supervision, charting treatment in medical records) before moving onto the more comprehensive CR for PTSD program. Finally, staged implementation by providing training in the BREATHE program first and then later followed by training in the rest of the CR program give agencies the option of treating PTSD in clients with SMI using a stepped care approach (i.e., clients with PTSD first receive BREATHE, and then only those who continue to have PTSD are offered the rest of the CR program).

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