

Evidence-Based Practices for PTSD

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What is evidence-based practice?

- Evidenced-based practice = integration of best available research with clinical expertise in the context of patient characteristics, culture and preferences
- Purpose is to promote effective practice and enhance public health by applying empirically supported principles of assessment, case formulation, therapeutic relationship and intervention
 - **Report of the 2005 Presidential Task Force on Evidence-Based Practice**
 - **Ronald F. Levant, EdD, MBA, ABPP, President American Psychological Association**
 - **July 1, 2005**

What about empirically supported treatments?

- EBP more comprehensive concept
- “EST start with a specific treatment and ask whether it works for a certain disorder or problem under specific circumstances”
- Specific psychological treatments shown to be efficacious in controlled clinical trials
- Need to take into account treatment efficacy (strength of evidence related to establishing causal link) and clinical utility (related to generalizability, feasibility, costs/benefits)

Levant (2005)

Why are evidence based treatments important?

- Encourage the Veteran to fully participate in his/her recovery, (e.g. informed consumer, empowerment in process, Veteran satisfaction).
- Provide consistency of interventions across the VA sites.
- Empirically demonstrated to be effective.
- Tend to be efficient – they are time-limited.
- Reduce over-utilization of behavioral health resources, as fewer clients receive long-term therapy that may be of diminishing gain.
- The UMHS guidelines require that these services be available to all veterans by the end of 2009

Uniform MH Services Handbook, 2008

1. PURPOSE

This Veterans Health Administration (VHA) Handbook establishes minimum clinical requirements for VHA Mental Health Services. It delineates the essential components of the mental health program that is to be implemented nationally, to ensure that all veterans, wherever they obtain care in VHA, have access to needed mental health services. It also specifies those services that must be provided at each Department of Veterans Affairs (VA) Medical Center and each Community-Based Outpatient Clinic (CBOC). By building the requirements for services on specifications of what must be available to each veteran, no matter where in VHA that they receive care, it is designed to focus on the patient's perspective, and on meeting the care needs for each veteran. *NOTE: Throughout this Handbook, the term mental health services is meant to include services for the evaluation, diagnosis, treatment, and rehabilitation of both substance use disorders and other mental disorders.*

Uniform MH Services Handbook (2008)

- (1) Evidence-based Psychotherapy for PTSD. All veterans with PTSD must have access to Cognitive Processing Therapy (CPT) or Prolonged Exposure (PE) Therapy as designed and shown to be effective.

How were these “picked?”

- Institute of Medicine Report (2007)
- VHA Clinical Practice Guidelines
- PTSD Treatment Guidelines Task Force by International Society for Traumatic Stress Studies

IOM Report (2007)

- Examined 90 RCT (53 for psychotherapy)
- Inadequate evidence to determine effectiveness of any pharmacological treatments reviewed
- Only psychotherapeutic intervention with sufficient evidence to support its efficacy is exposure therapy
- Does not mean that other interventions or treatment modalities were ineffective or harmful; only that studies meeting their research design and data criteria were unavailable

VHA Clinical Practice Guidelines

- Based upon:
 - ISTSS recommendations
 - Expert Consensus Guideline Series: Treatment of Post-traumatic Stress Disorder (Foa et al., 1999)
 - Mental Health and Mass Violence: Evidenced-Based Early Psychological Intervention for Victims/Survivors of Mass Violence. A Workshop to Reach Consensus on Best Practices. National Institute of Mental Health 2002
- The clinical experts and the research team evaluated the evidence for each question and rated the evidence according to criteria proposed by the U.S. Preventive Services Task Force.

Clinical Practice Guidelines

- Significant benefit:
 - Cognitive Therapy
 - Exposure Therapy
 - Stress Inoculation Therapy
 - Eye Movement Desensitization Reprocessing
- Some benefit:
 - Imagery Rehearsal Therapy
 - Psychodynamic Therapy
 - PTSD Patient Education

ISTSS Recommendations (2005)

- Treatment involving exposure therapy with cognitive therapy or stress inoculation training recommended as first-line treatment for chronic PTSD
- Relaxation training, biofeedback and assertiveness training useful as ancillary interventions in certain patients
- DBT skills training prior to trauma-focused interventions may be useful for those with difficulty tolerating traumatic-focused interventions

Cognitive Processing Therapy

- Information adapted from Chard (2009) presentation and Resick, Monson and Chard (2008)

Cognitive Processing Therapy

- CPT is a cognitive behavioral therapy
- Can be individual or group-based.
- Individual is typically 12 weekly 50-minute sessions
- Group may be 90-120 minute session.
- Identifies “stuck points” that occur when beliefs prevent recovery from a trauma.
- CPT typically includes a written review of the trauma to overcome “stuck points”.
- There is a version of CPT that does not include a trauma review (CPT-C (cognitive)).

Treatment Rationale

- PTSD attributed to “stalling out” of natural process of recovery
- Avoidance of trauma memory keeps the patient stuck which prevents them from working through problematic, trauma-related thoughts
- Cognitive-focused techniques are used to help patients move past “stuck points” and progress toward recovery

How does CPT work?

- Education about PTSD, thoughts, and emotions
- Trauma processing for the purpose of:
- Event-specific cognitive techniques to achieve more balanced thinking about the self, trauma, others and the world (“stuck points”)

Recommended Clients

- Recommended for those with:
 - PTSD and co-morbid diagnoses (e.g., depression, anxiety, substance use)
- Not recommended for:
 - Active suicidal behavior
 - Current psychosis
 - No memory of trauma event

Focus on Cognitive Theory

- We take in information and work to organize it in an attempt to understand, predict and control
- Most people taught “just world” hypothesis by parents, teachers, religions, cultures
- Believe that good behavior rewarded and bad behavior or mistakes punished
- Traumas are incongruent with our beliefs/schemas
- Intrusive symptoms as a result of inability to accommodate this information

Focus on Cognitive Theory

- Important that trauma memory is incorporated and people have one of following possibilities:
 - Information matches and is incorporated
 - Change view of world/themselves to incorporate the new information (e.g., “I must be a bad person”)
 - Change too much and interpret everything in light of this new information (e.g., “All men are bad people”)

Assimilation

- Beliefs prior to trauma:
 - “It is a just world”
 - “People can be trusted”
 - “I am in control”
- Following trauma if “stuck”
 - “I must have done something bad to deserve this”
 - “It is my fault”
 - “I could have prevented this”
 - “I am a bad person”
 - “I have no control over anything”

Over-accommodation

- Beliefs following trauma:
 - “I can’t get close to anyone”
 - “The world is completely unsafe”
 - “I am powerless and unsafe”

Stuck points

- Black and white
- Thoughts not feelings
- All or nothing
- If/then statements
- Thought behind the moral statement or Golden Rule
- Concise

What about emotions?

- Therapist needs to encourage/permit natural emotions to run their course; typically dissipate quickly
- If manufactured, assist clients in changing their thinking (e.g., “I am bad” versus “I did a bad thing”)

How does CPT work?

- Challenging avoidance
- Dissipation of natural emotions
- Change in thinking about meaning of event changes the manufactured emotions instantly (no habituation necessary)
- Learn not to over-generalize their thinking about a single bad event to all people or themselves as people

Session content

- Education
- Constructing impact statement (e.g., why do they believe trauma occurred, how has it impacted their lives)
- A-B-C worksheets and Socratic questions to generate alternative thoughts and consequent feelings
- Challenging questions
- Noticing patterns of problematic thinking
- Exploring trauma themes: safety, trust, power/control, esteem, intimacy

When to use CPT-C

- Personal preference client
- Minimal recollection of event
- Refusal to write account
- Impending deployment/not enough time to finish
- Conceptualization of case warrants more cognitive restructuring
- Conducting group psychotherapy

Research on CPT

- Four randomized clinical trials and several effectiveness studies
 - Rape victims (Resick et al., 2002)
 - Child sexual abuse (Chard, 2005)
 - Veterans (Monson et al., 2006)
 - Rape and assault (Resick et al., 2008)

Prolonged exposure

- Information taken from Eftekhari & Ruzek (2009) presentation

Prolonged Exposure

- Individually-based
- Includes psycho-education about common reactions to trauma
- Includes In Vivo (real world) exposure
- Includes imaginal exposure to the trauma
- Breathing retraining
- 90 minute session, 8-15 sessions

Emotional Processing Theory

- Fear structure is a program for escaping danger and includes information about:
 - Stimuli
 - Responses
 - Meaning of stimuli and responses

Emotional processing theory

- Trauma memory is a specific structure that includes representations of:
 - Stimuli present during the trauma
 - Physiological and behavioral responses that occurred during the trauma
 - Meanings associated with these stimuli and responses
 - Associations among stimulus, response and meaning representations may be either realistic or unrealistic

Early trauma structure

- Large number of stimuli
- Excessive responses (PTSD symptoms)
- Erroneous associations between stimuli and “danger”
- Erroneous associations between responses and “incompetent”
- Fragmented and poorly organized relationships among representations

Early PTSD symptoms

- Trauma reminders in daily life activate trauma memory and associated emotions (danger) and “self-competence”
- Activation of trauma memory reflected in re-experiencing symptoms and arousal
- Re-experiencing and arousal motivate avoidance behaviors

Chronic PTSD

- Persistent cognitive and behavioral avoidance prevents change in the trauma memory by:
 - Limiting activation of the trauma memory
 - Limiting exposure to corrective information
 - Limiting articulation of the trauma memory and this preventing organization of the memory

Recovery process

- Key therapeutic elements:
 - Accessing the structure (activation/engagement)
 - Availability of corrective information

When is exposure appropriate?

- Chronic, trauma-related intrusive and distressing thoughts, images, memories, and/or nightmares
- Chronic trauma related avoidance (behavioral, cognitive, or emotional)
- Accompanying hyperarousal
- Primary PTSD with other comorbid disorders

Contraindications

- Current psychosis
- Current substance dependence
- High risk of suicidal behavior or current self-injurious behavior
- Current high risk of domestic violence
- Lack of clear memory or insufficient memory of the event

Rationale

- Focus is upon trauma-related symptoms and difficulties
- Factors that prolong post-trauma reactions:
 - Avoidance of trauma related thoughts, feelings, memories, situations and activities
 - Inaccurate and unhelpful trauma-related beliefs and thoughts
- Avoidance prevents processing trauma

In Vivo exposure

- Trauma related stress and avoidance are sometimes unrealistic or excessive
- Avoidance prolongs PTSD reactions and prevents processing trauma
- Repeated in-vivo exposure:
 - Reduces distress (i.e., habituation)
 - Changes beliefs about the situation, incompetence of self, anxiety lasting indefinitely
 - Increases self-competence and mastery

Imaginal exposure

- Helps process the trauma (i.e., organize, make sense of it, digest it)
- Helps distinguish between “thinking” about the trauma and actually re-encountering it
- Results in habituation so that trauma can be remembered without intense, disruptive distress
- Fosters realization that engaging in the trauma memory does not result in loss of control or “going crazy”
- Enhances sense of self-control and personal competence

Imaginal exposure

- Designed to enhance client's ability to access all of the salient aspects of the trauma memory (i.e., events, thoughts, emotions, sensory experience)
- Promote emotional engagement with trauma memory
- Invite narration of memory in client's own words and with as little direction and prompting by therapist as possible
- Selection of core/index trauma

Common questions/concerns:

- Symptom exacerbation:
 - Minority show reliable exacerbation (10.5% in PTSD symptoms, 21.1% in anxiety, 9.2% in depressive sx)
 - Exacerbation not associated with treatment drop out or poorer outcomes
- Dropout rate: no statistically significant difference in rates between other active treatments
- Therapist care:
 - Remind self of what you tell client (PE works, memories cannot hurt like the trauma did)
 - Focus on client
 - Habituation
 - Work with team

Other treatments:

- EMDR
- Stress Inoculation
- Complimentary and Alternative medicine

Some resources

- Cynthia.yamokoski@va.gov
- (216)791-3800 ext. 6937
- National Center for PTSD: www.ncptsd.gov