Evidence based psychotherapies for PTSD

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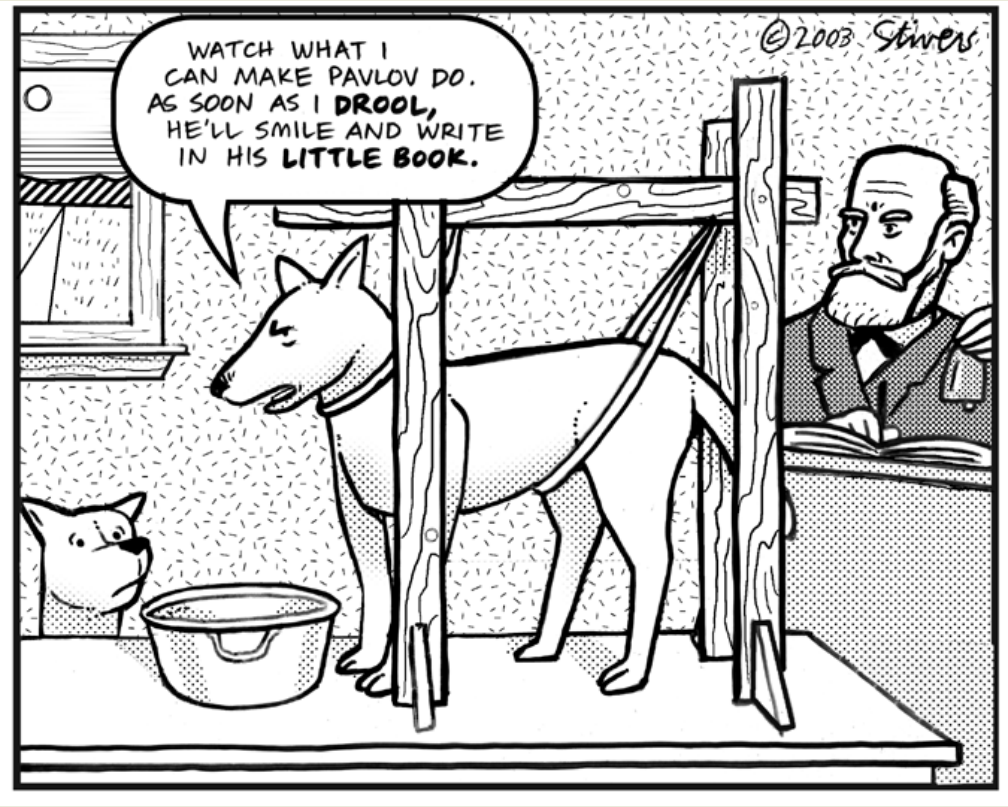
Conflict of interests

- I have no commercial conflicts of interest.
  - I am the current President-Elect for the International Society for Traumatic Stress Studies
  - I receive funding from NIH, USAID, and Department of Defense
  - I am a national trainer in and conduct research on Cognitive Processing Therapy
  - I conduct research on Narrative Exposure Therapy

Course of PTSD

- 40% of people with PTSD recover within the first year after trauma exposure
- 1/3 to 1/2 of those with PTSD do not recover, even after many years
- Duration of PTSD varies according to severity of traumatic stress exposure
- Duration of symptoms is shorter for survivors who obtain treatment (36 vs. 64 months)

PTSD represents a failure of natural recovery. Why?



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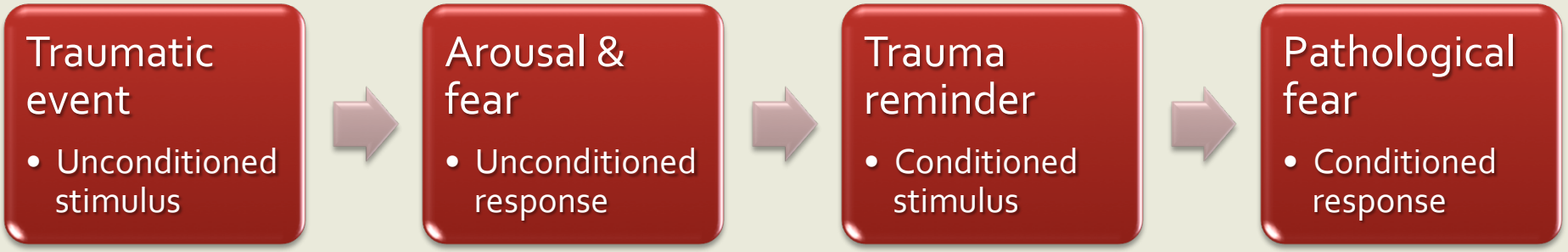
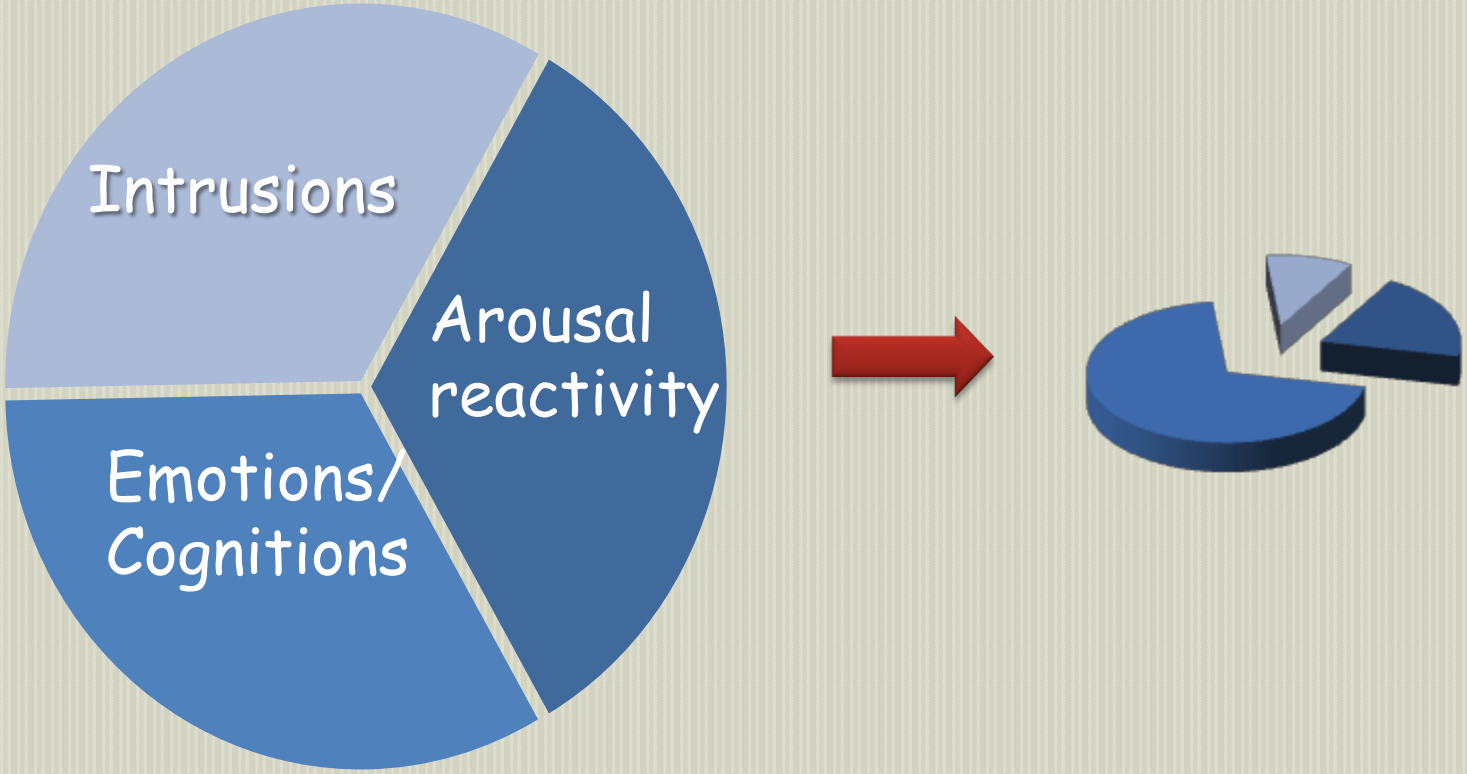
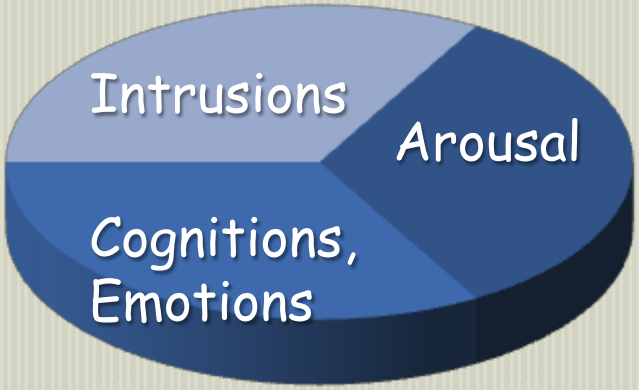


In normal recovery, intrusions and emotions decrease over time and no longer trigger each other.



When intrusions occur, natural emotions and arousal run their course and thoughts have a chance to be examined and corrected. It is an active "approach" process of dealing with the event.

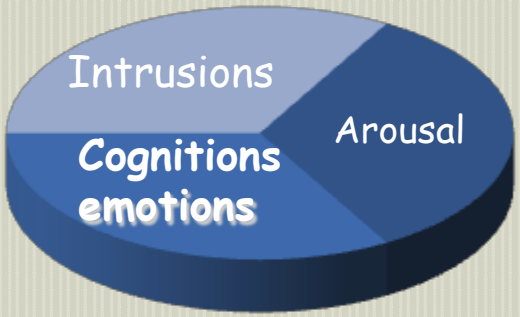
HOWEVER, IN THOSE WHO DON'T RECOVER, STRONG NEGATIVE AFFECT LEADS TO ESCAPE & AVOIDANCE



Core Reactions

Avoidance of external reminders and internal reminders

SUCCESSFUL AVOIDANCE = CHRONIC PTSD

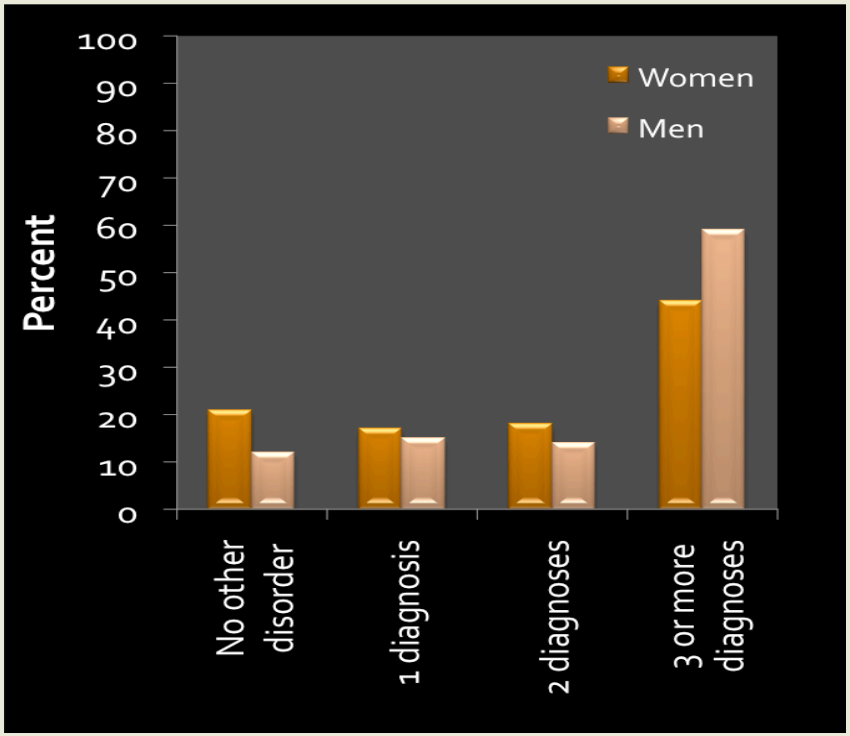


Core Reactions

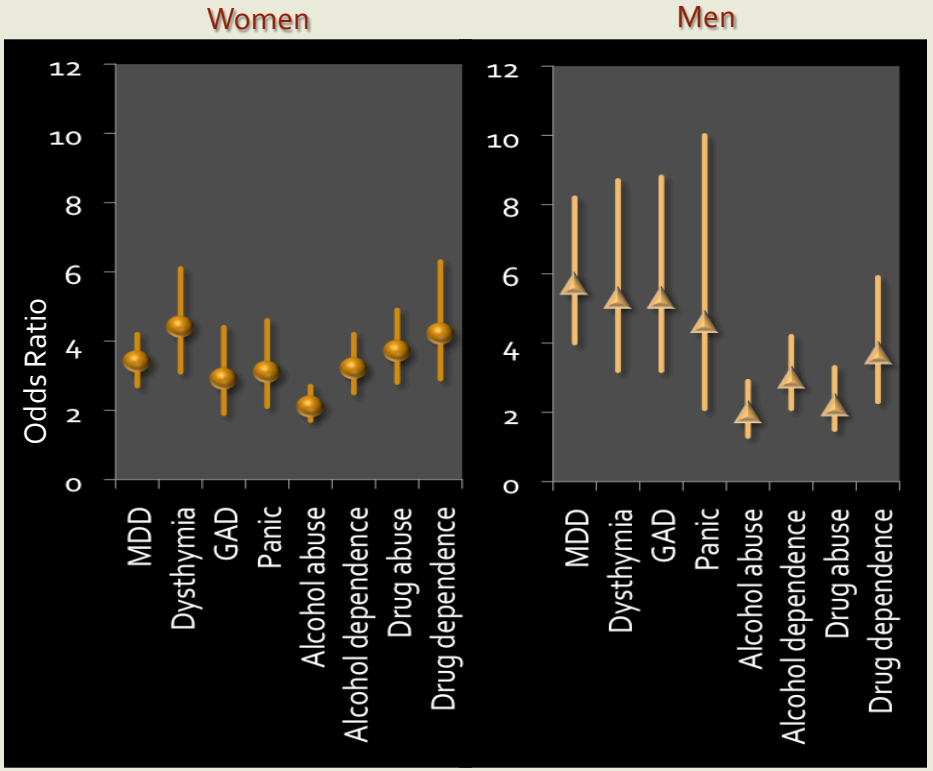
Aggression
Self-harm behaviors
Substance abuse
Binging
Cognitive avoidance
Behavioral avoidance
Dissociation
Emotional suppression
Social withdrawal
Behavioral inhibition
Somatic complaints

Escape/Avoidance

PTSD often presents with other comorbidities and is associated with increased risk of other diagnoses.



Kessler et al., 1995



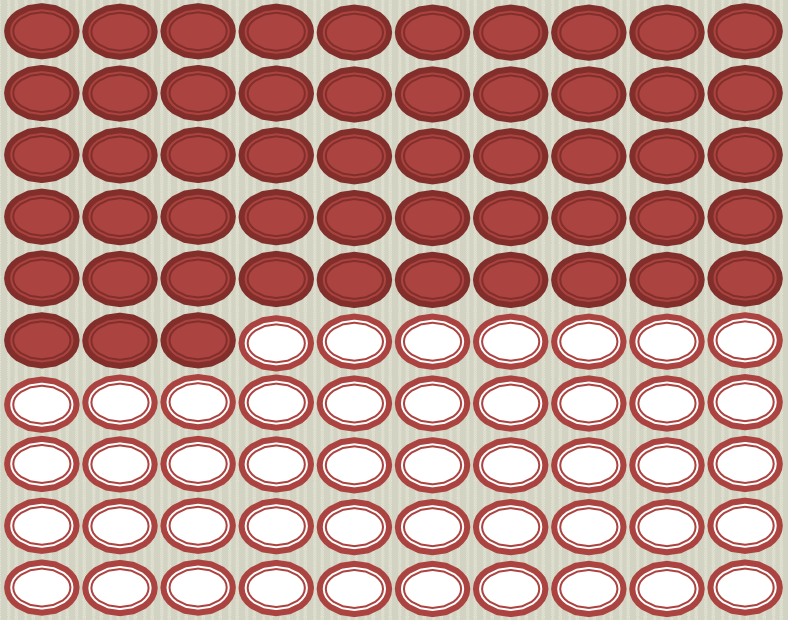
Kessler, 2000

Given the costs of PTSD, what is known about treatment?

Both specific psychotherapies and specific medications are effective for treating PTSD.

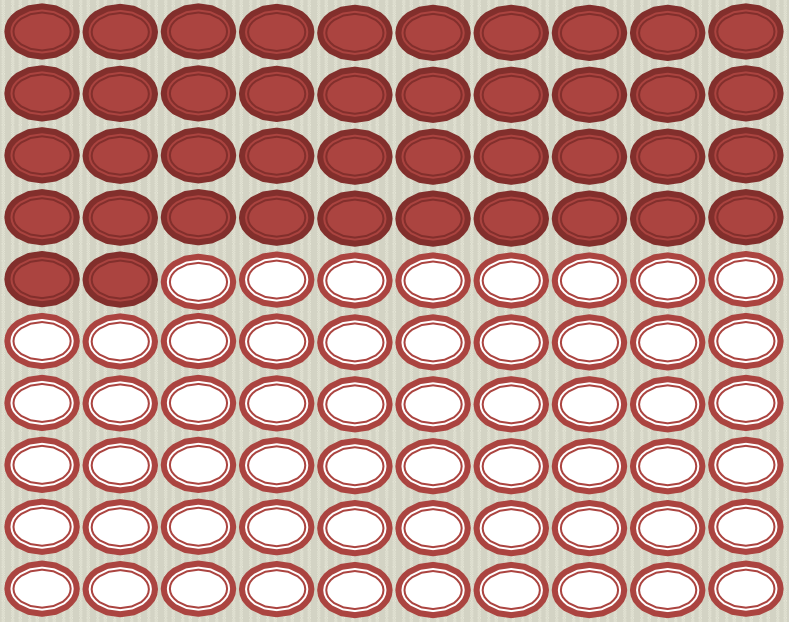
Psychotherapy
(CPT, PE, EMDR)

53 out of 100 people who receive a trauma-focused therapy will no longer have PTSD when they finish treatment.



Medication
(Zoloft, Paxil, Prozac, Effexor)

42 out of 100 people who receive a specific medication will no longer have PTSD when they finish treatment.



ISTSS Clinical Practice Guidelines for the Treatment of PTSD (2018): Psychotherapy

Use individual, manualized trauma-focused psychotherapy, with primary component of exposure and/or cognitive restructuring.

Strong	Standard
• Cognitive Processing Therapy* • Cognitive Therapy • EMDR • Individual CBT with a Trauma Focus (undifferentiated) • Prolonged Exposure*	• CBT without a Trauma Focus • Group CBT with Trauma Focus • Guided Internet-based CBT with a Trauma Focus • Narrative Exposure Therapy • Present Centered Therapy

ISTSS Clinical Practice Guidelines for the Treatment of PTSD (2018): Psychotherapy

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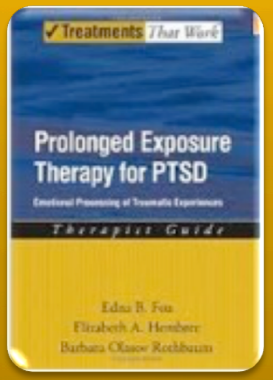
Emerging

- Couples CBT with a Trauma Focus
- Combined Group and individual CBT with a Trauma Focus
- Reconsolidation of Traumatic Memories
- Single Session CBT
- Written Exposure Therapy
- Virtual Reality Therapy

Insufficient Evidence

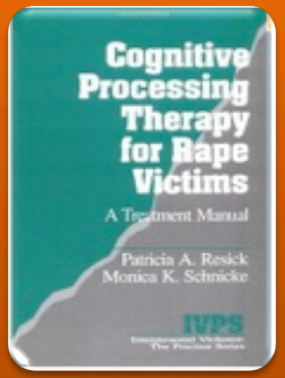
- Brief Eclectic Psychotherapy for PTSD
- Dialogical Exposure Therapy
- Emotional Freedom Techniques
- Interpersonal Therapy
- Group Stabilizing Treatment
- Group Supportive Counseling
- Psychodynamic Psychotherapy
- Psychoeducation
- Relaxation Training
- Supportive Counseling

Trauma-focused cognitive-behavioral Treatments



Prolonged Exposure (Foa)

- Active component is exposure
- Exposure to feared stimuli naturally disconfirms negative cognitions
- Includes imaginal and in vivo exposure



Cognitive Processing Therapy (Resick)

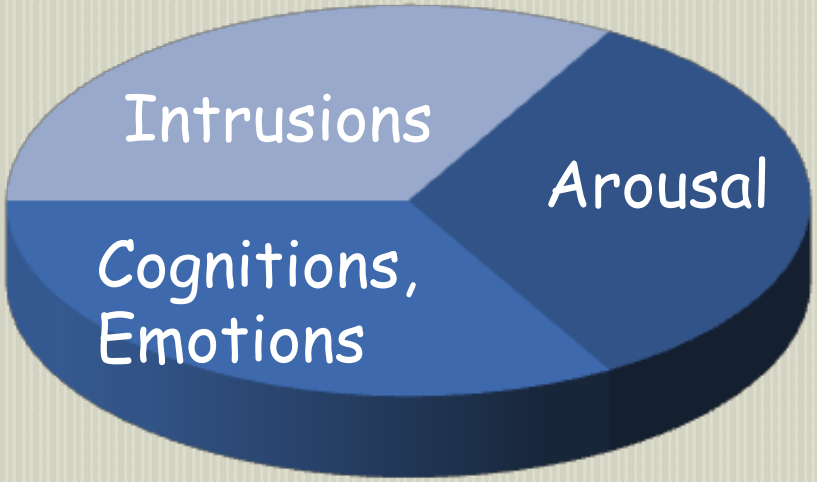
- Active component is cognitive restructuring in context of emotional processing
- CPT effective w/ fewer (or no) exposure sessions
- Changes in beliefs lead to changes in emotions and symptoms

Commonalities

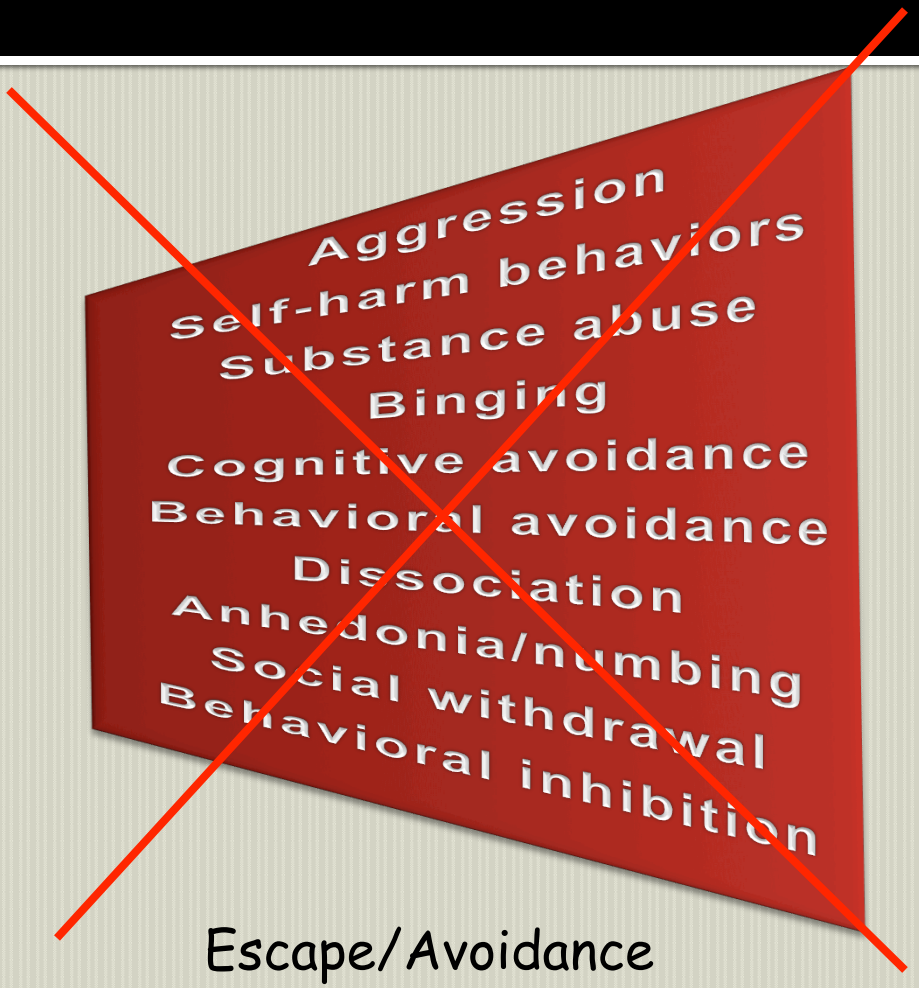
- ✓ Imaginal Exposure
- ✓ In Vivo Exposure
- ✓ Cognitive Reprocessing

Commonalities across adult psychotherapies?

1. PREVENT AVOIDANCE

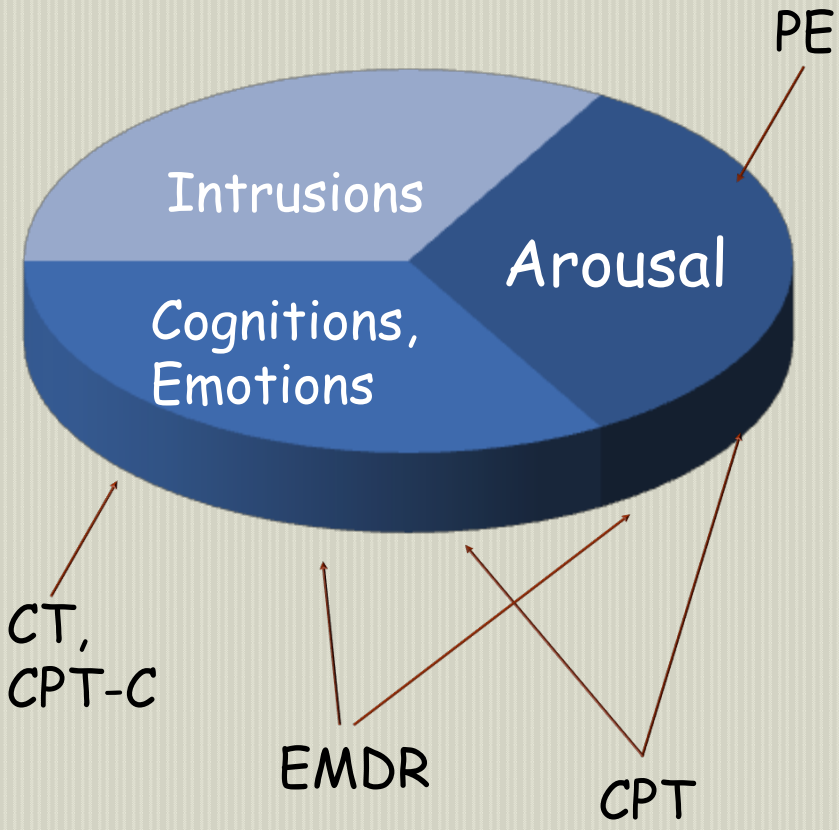


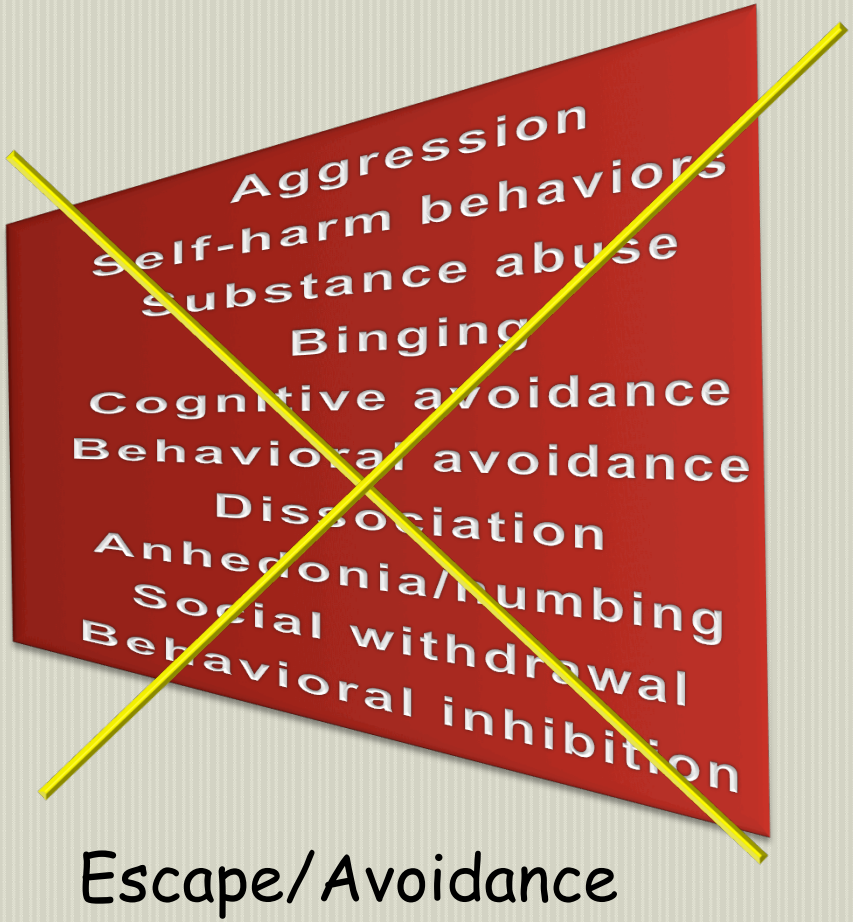
Core Symptom Clusters



Escape/Avoidance

2. INTERVENE INTO ONE OR MORE OF CORE SYMPTOM CLUSTERS





RCT INCLUSION/EXCLUSION CRITERIA

INCLUSION

- PTSD diagnosis
- 18 years of age
- At least 3 months post-trauma
- Stable psychiatric medication 1-2 months

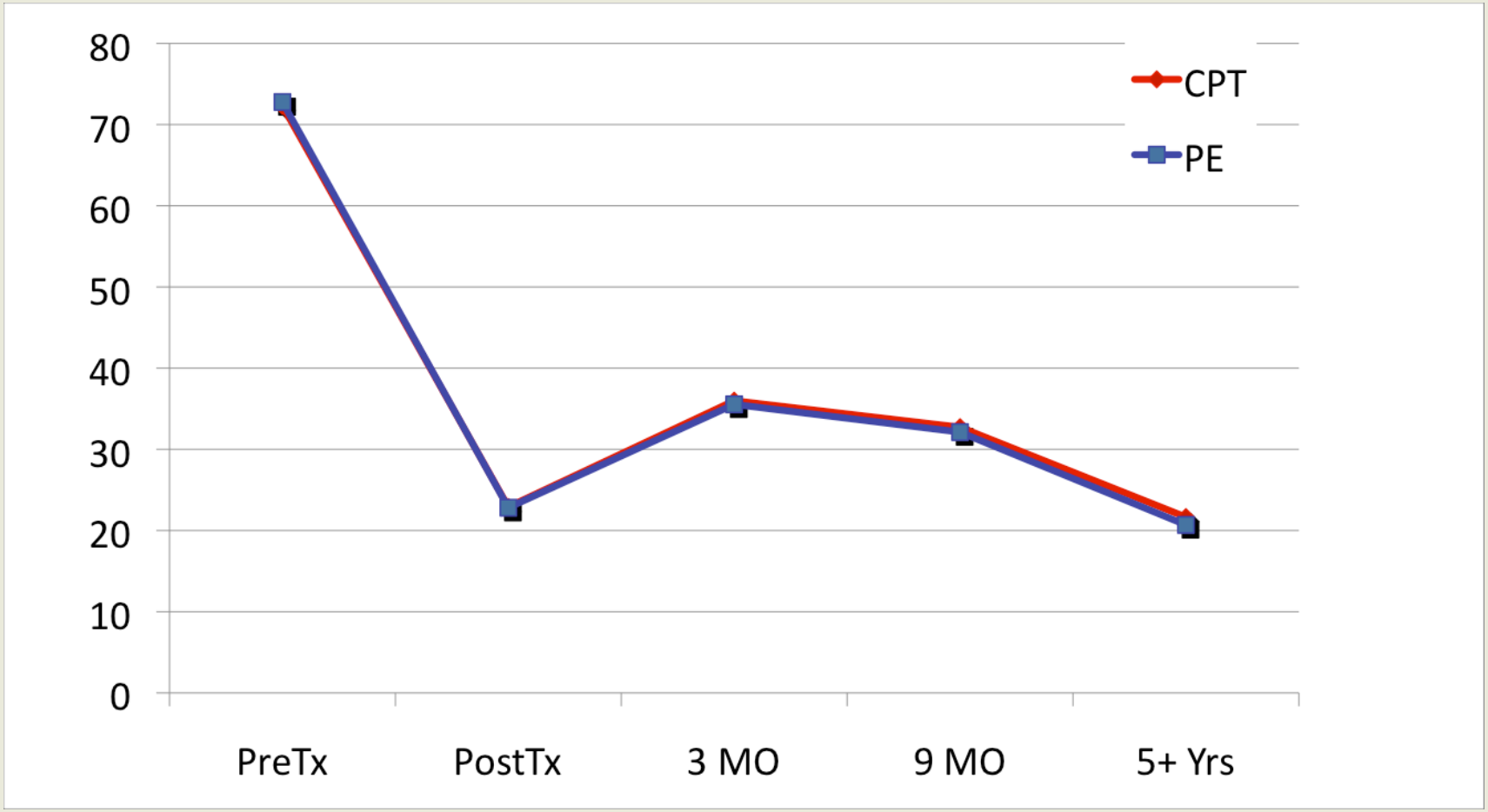
EXCLUSION

- Imminent SI/HI
- Uncontrolled Mania
- Uncontrolled Psychosis
- Substance Dependence
- Severe cognitive impairment
- Current involvement in violent relationship (some studies)

***<u>Not</u> Exclusion Criteria:**

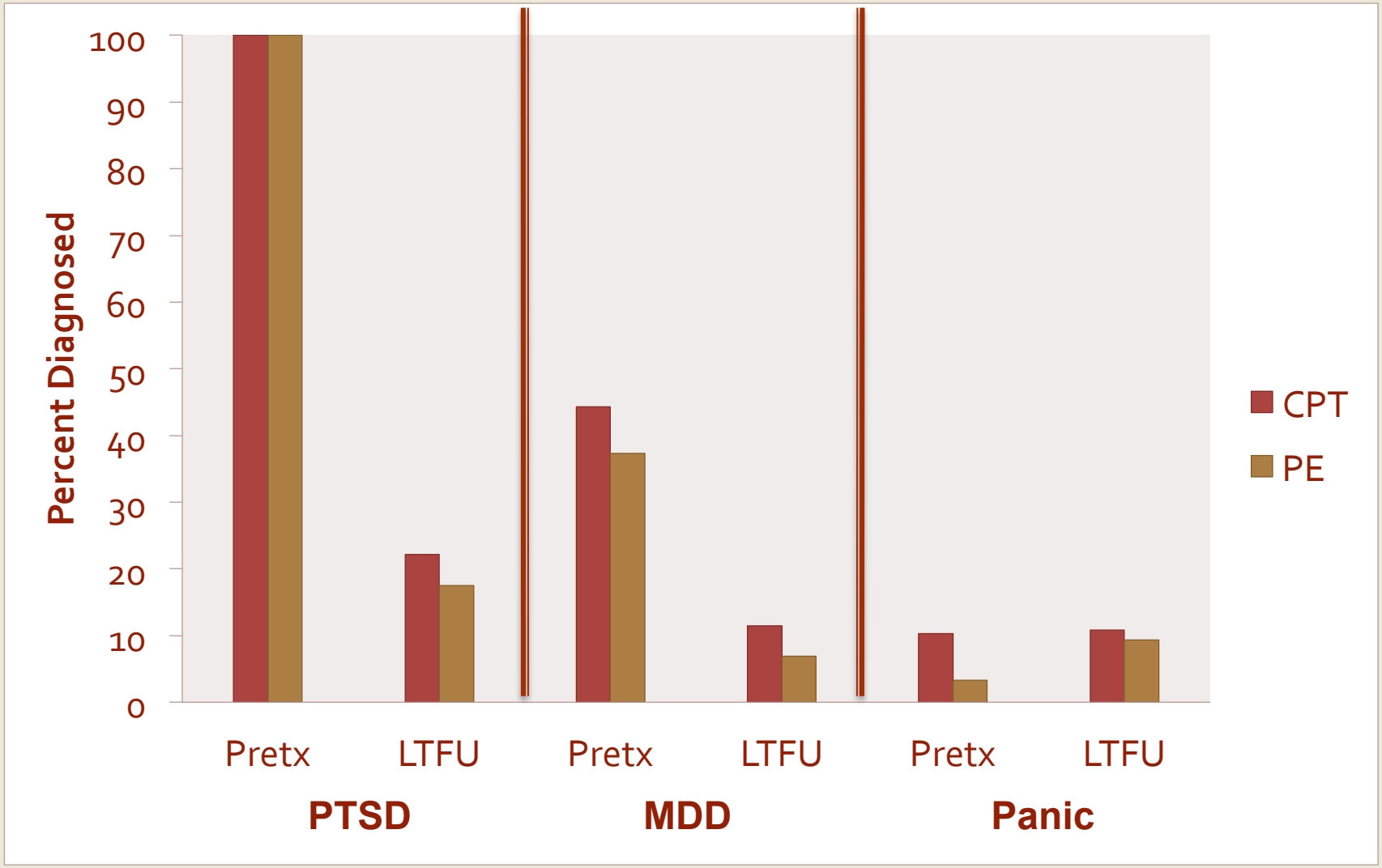
Personality Disorders, Substance Use/Abuse, Dissociation, Depression, Panic, other comorbid conditions, history of multiple traumas

PTSD Over Time: CAPS Interview



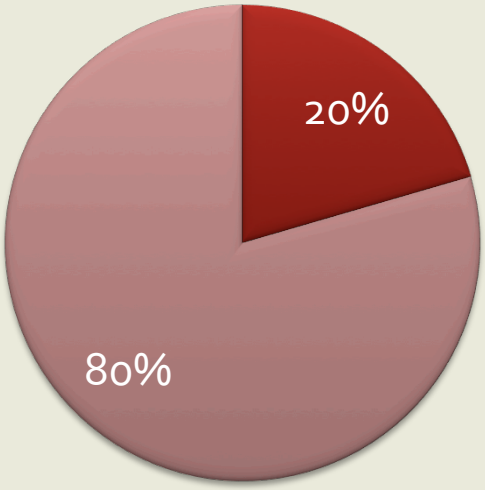
Resick et al. 2011

Based on a lack of a psychiatric diagnosis long after the end of treatment CPT and PE have high rates of a "cure"

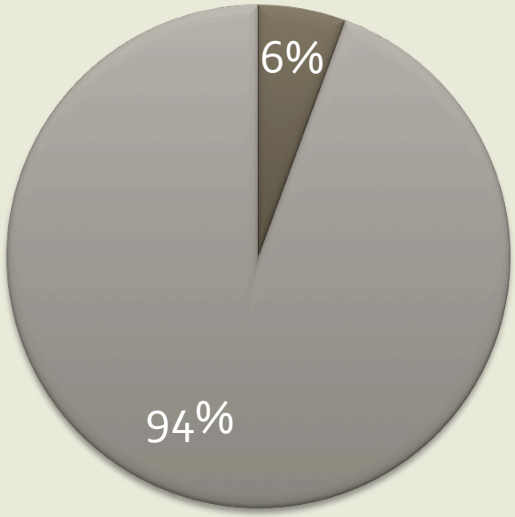


For those participants who successfully completed treatment relatively few relapsed 5-10 years following treatment.

Cognitive Processing Therapy



Prolonged Exposure



There was a trend for PE to have less relapse than CPT at LTFU, $X^2(1, N=75)$ 3.8, $p=.057$.

Outcomes beyond PTSD

Studies have demonstrated that CPT/PE results include:

Improvements in:

- Depression
- Suicidal ideation
- Health concerns
- Dissociation
- Occupational function/economic status
- Social/leisure involvement
- Intimacy/Sexual concerns
- Startle Response

Prolonged Exposure

Prolonged Exposure

1. Education and then client is taught breathing retraining.

2. Currently feared situations are ranked into a hierarchy and the client is assigned to begin *in vivo* exposures in safe situations, with a coach if needed.

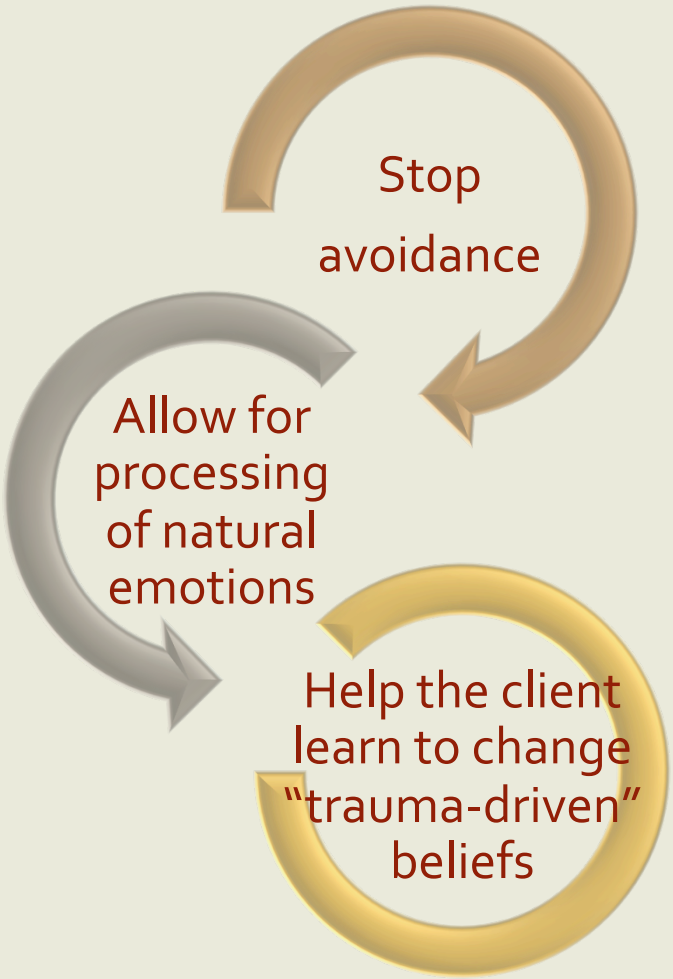
3. Client is instructed to retell the trauma by imagining it as vividly as possible and describing it aloud using the present tense.

Prolonged Exposure

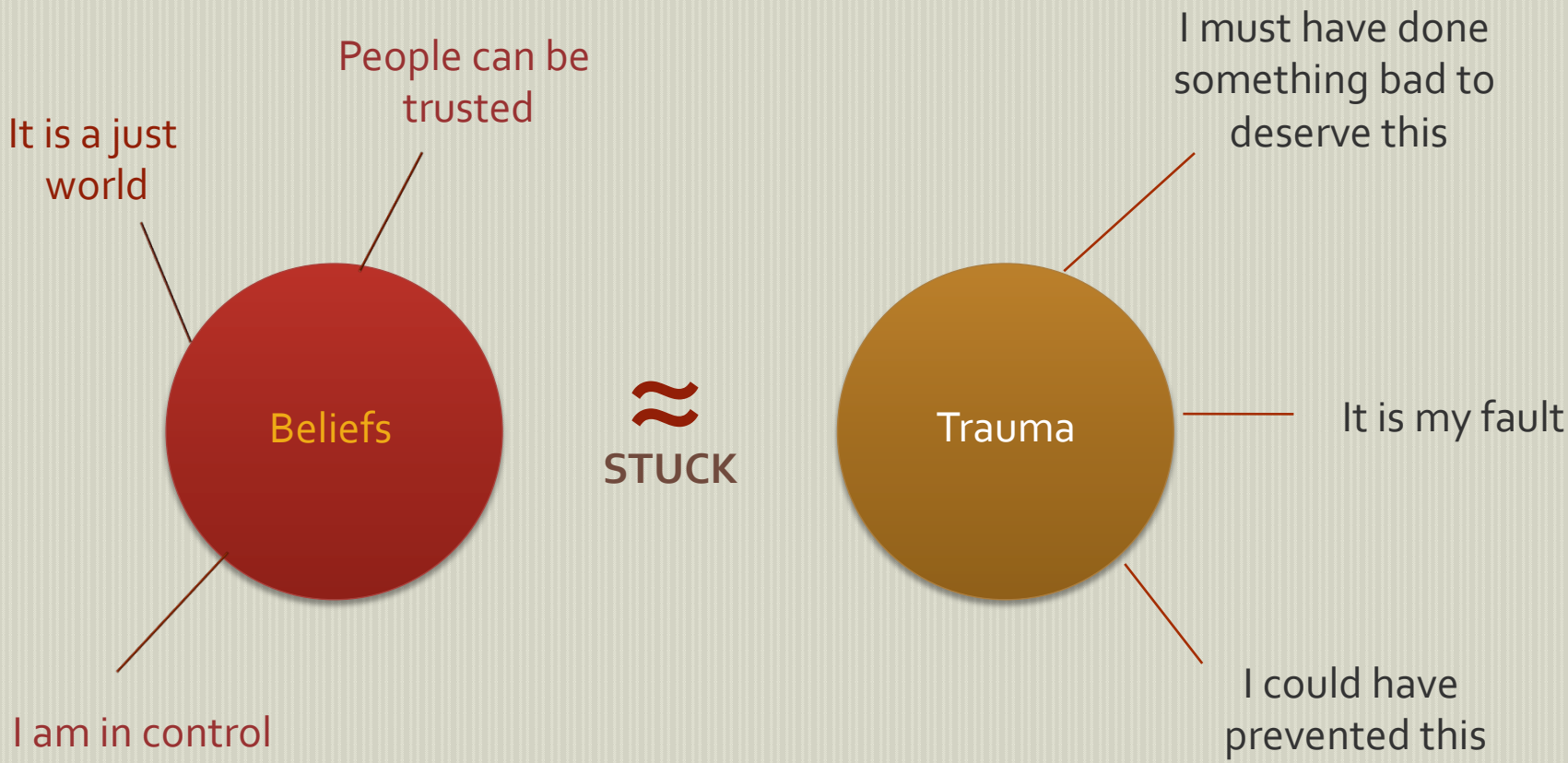
4. Repeat trauma scenario several times for a total of 60 minutes per session for seven sessions.
5. Client's narratives are tape recorded. Homework: Listen to tape daily.
6. Continue *in vivo* exposure in safe situations through hierarchy.

Cognitive Processing Therapy

In CPT the therapist works on 3 major tasks.



Individuals try to make sense of what happened during the traumatic event in light of their prior beliefs.



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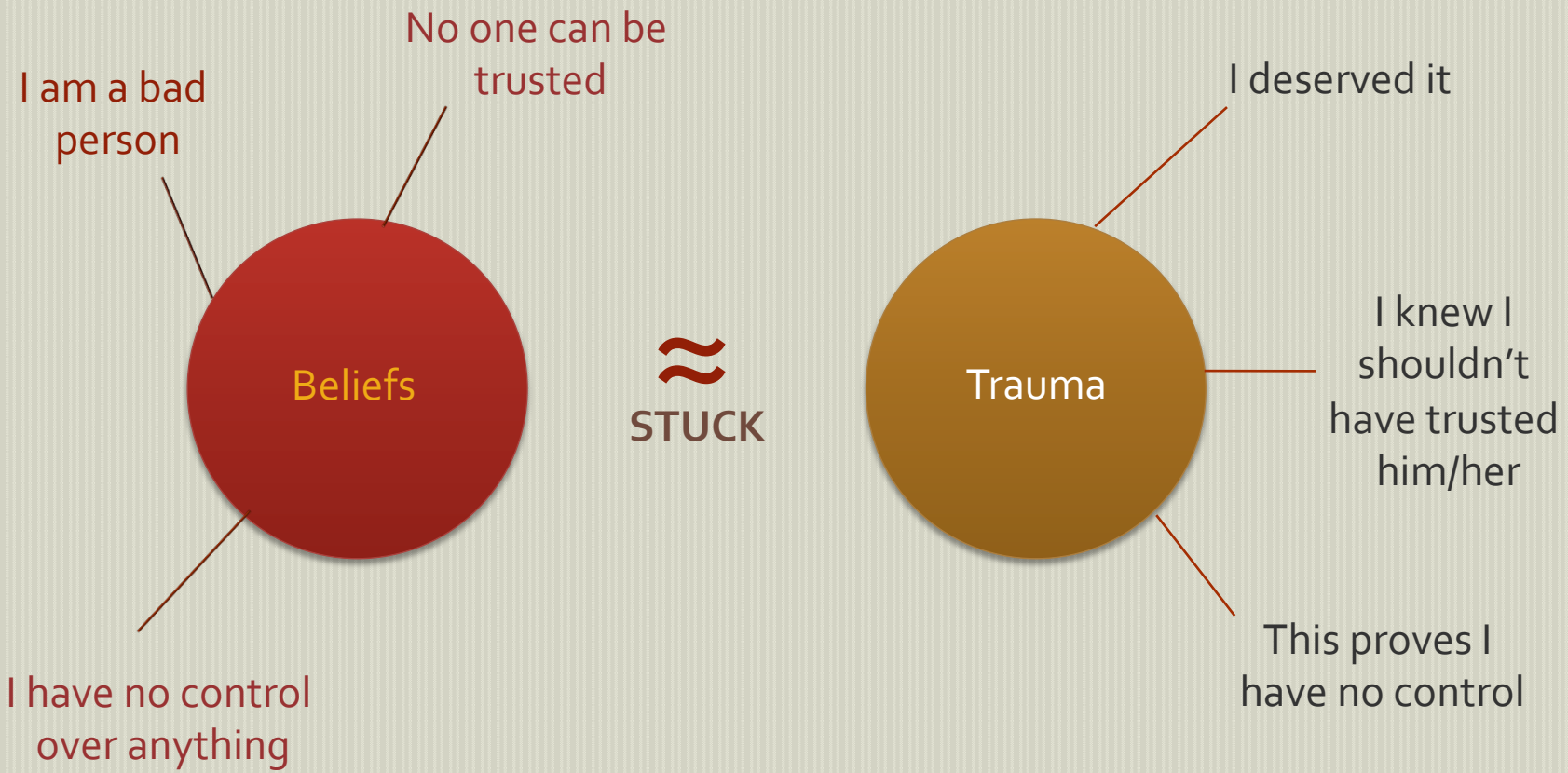
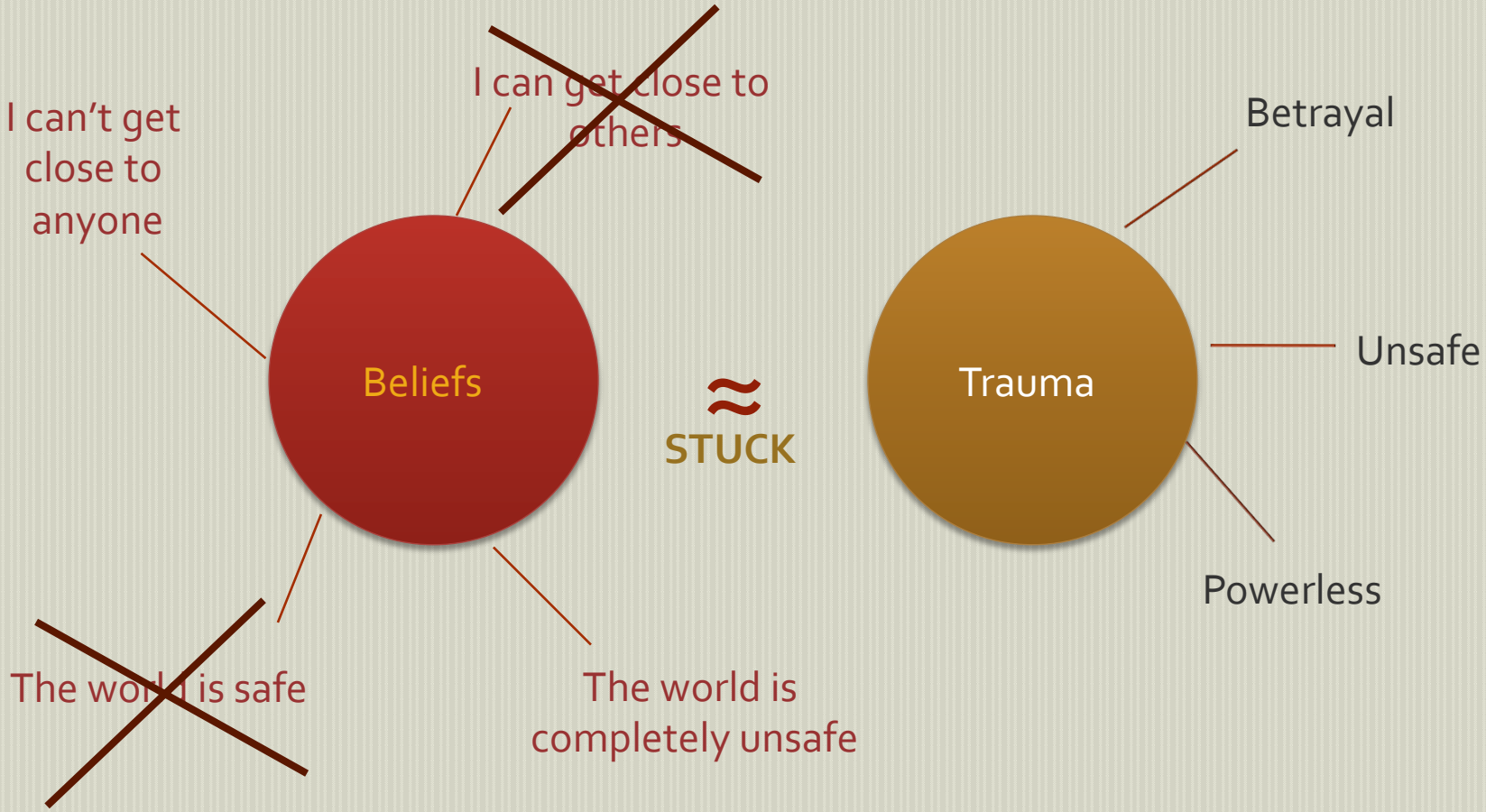
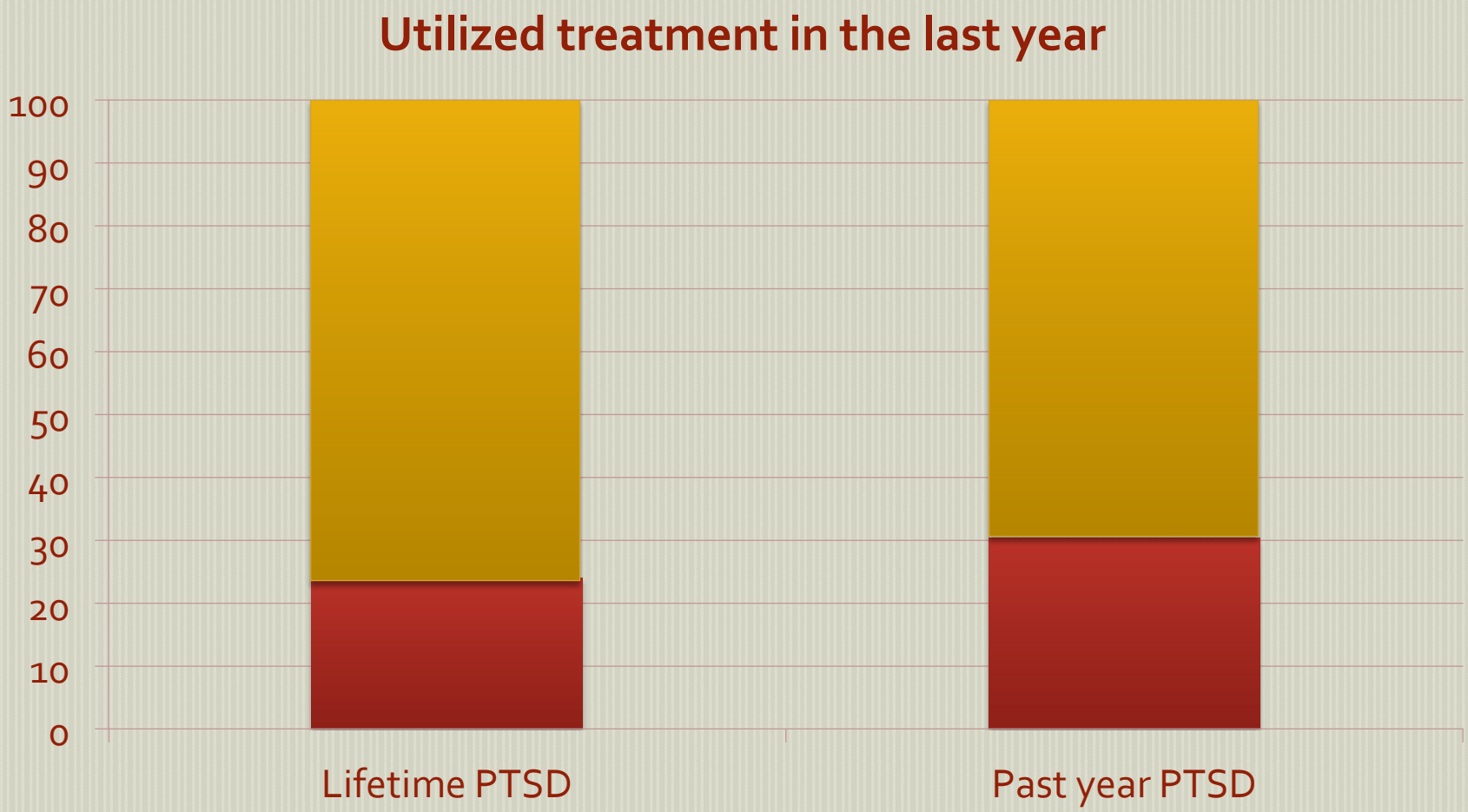


Individuals also may change their beliefs about the self/world in an extreme way in light of the trauma



So what's the catch?

Most of those who could benefit from care will never receive it.



Hale et al., 2017

How Relevant are These Approaches to Diverse Cultural and Ethnic Groups?

Diverse Cultural Groups and EBPs: A *GOOD* FIT

- Evidence that EBPs and Cultural Competence may be more complementary than disparate Huey & Polo, 2008; (Whaley & Davis, 2007).
- CBT approaches, specifically, have the strongest evidence.
- Ethnic minority youth respond best to txs that are highly structured, time-limited, pragmatic, & goal-oriented (Ho, 1992).
- Adaptations: Risky if core components are substituted or compromised in favor of untested adaptations (Huey & Polo, 2008).

Maintain EBPs in original form, apply culturally-responsive elements already incorporated into protocol *(Huey & Polo, 2008).*

Effectiveness of Cognitive Processing Therapy for PTSD with Refugees in Community Setting

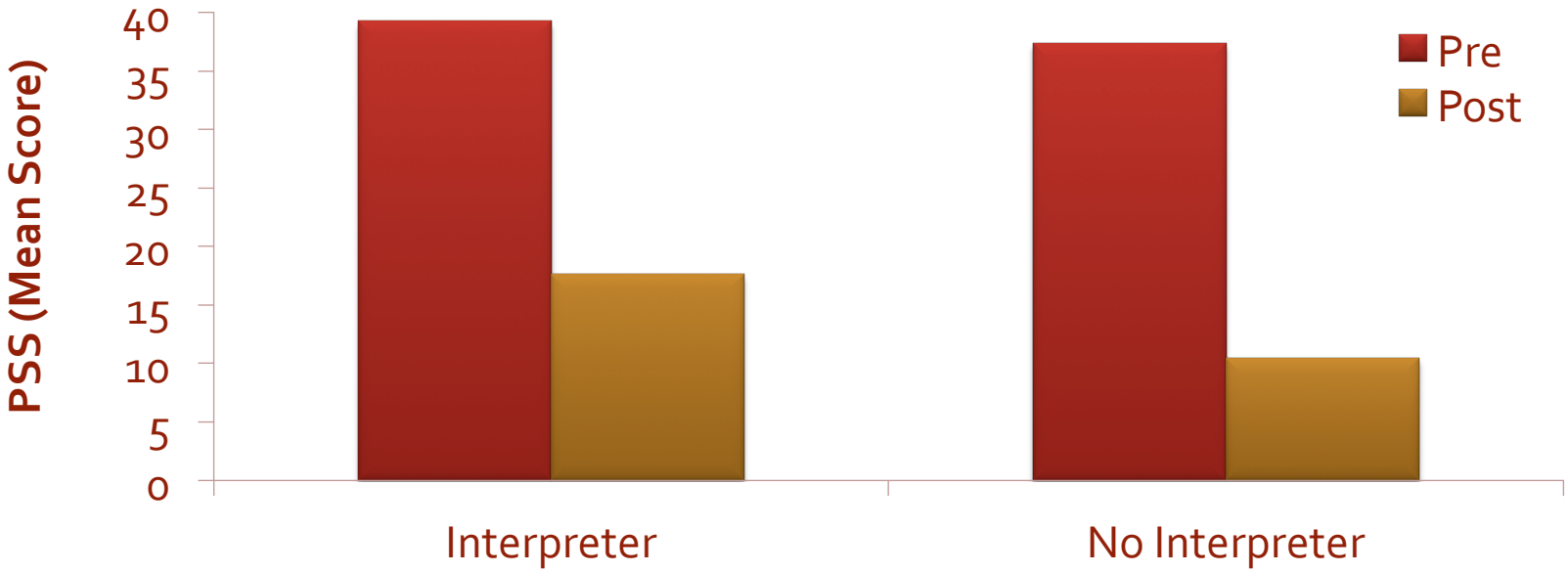
- Service-based Community Organization
- 5 female therapists
  - Masters-level
  - Received weekly individual supervision
- 7 interpreters
  - All participated in training for medical interpreters
  - Same interpreter worked with a case from start to end
  - 25 used interpreter, 28 had fluent therapist
- 83% of treatment in participants' homes
- PTSD Symptom Scale administered verbally at intake and termination

Schultz et al., 2006

Sample Characteristics

- 53 adults
  - 46 women, 7 men
- Ages ranged 18-69 (*M* = 45.8, *SD* = 12.1)
- 9 emigrated from Afghanistan, 44 from Yugoslavia
- Education ranged from 0-18 years (*M* = 6.9, *SD* = 5.2)
- Multiply traumatized
  - Civil war, loss of loved ones, witnessing atrocities, & torture (*n* = 35)
- Length of treatment negotiated
  - Average sessions were 1.5-2 hours in length
  - Average number of sessions was 17

Treatment Outcome and Interpreter Effects on PTSD symptoms



Participants had a significant decrease in symptoms over time, $F(1,51) = 267.4$, $p < .001$, (overall effect size of 2.6)

No effect for interpreter (equal benefit)

Cultural modifications - Bosnians

- Added breathing relaxation and other relaxation strategies in session 1
- Simplified materials as needed
- Fears about verbalizing traumatic experiences
  - Written account added later into the protocol and did not focus on the worst trauma
  - Sometimes used imaginal rather than written exposure
- Used in-vivo exposures
- Protocol was lengthened (avg 17 sessions)

CPT has been adapted for use in low/medium resource settings

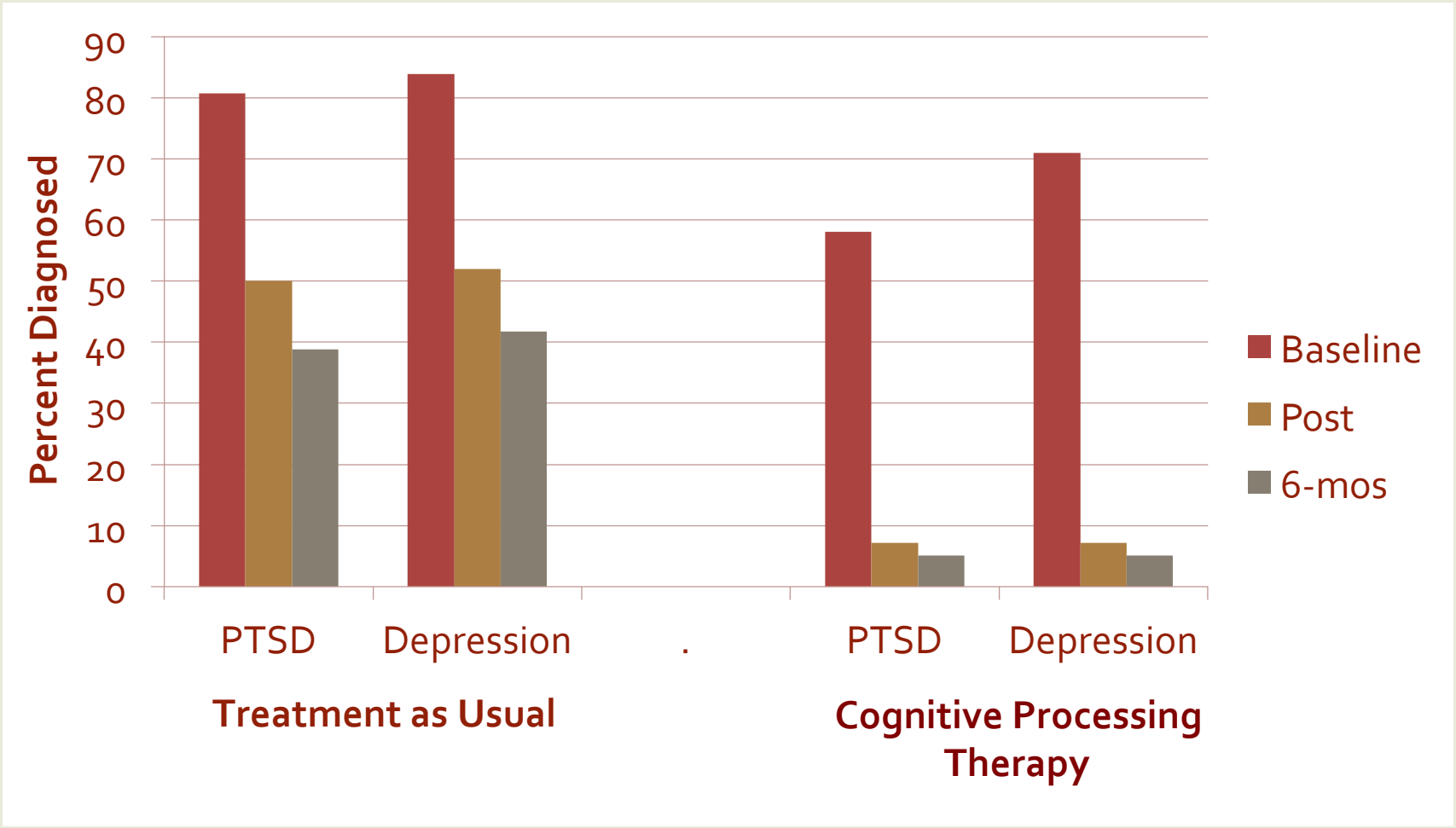
- Iraq
  - Implemented by community health workers
  - Clients were survivors of torture
  - Included men and women
  - Northern Iraq, large portion illiterate
  - Individual therapy
  - With the account
- Democratic Republic of Congo
  - Implemented by community health workers
  - Clients were female rape victims
  - High rates of CSA, IPV, and marital rape
  - Almost entirely illiterate
  - Group CPT
  - Without the account

Bass et al., 2013; Bolton et al., 2014; Kaysen et al., 2011; Weiss et al., 2015

Modifications to CPT Protocol

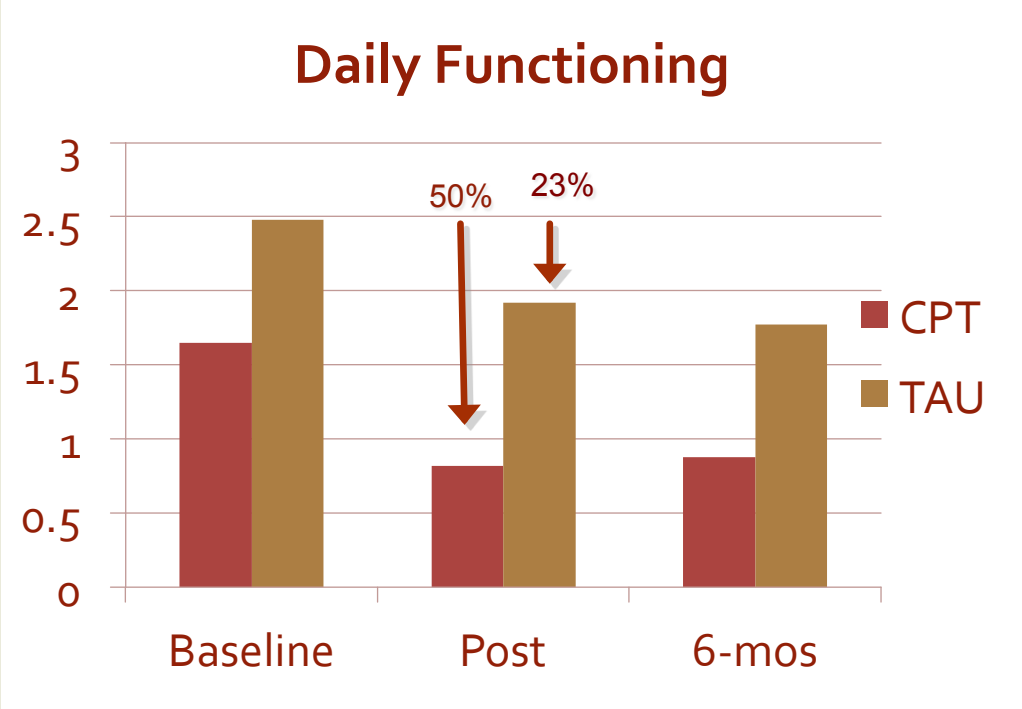
- Illiteracy
  - Picture cues
  - Simplify skills for memorization
  - Group exercises modified for illiteracy
- Abstraction more difficult
  - Removed Patterns of Problematic Thinking
- Homework – "small work"
- Intimacy – caring
- Esteem – respect

CPT was significantly more likely to result in remission of diagnoses.



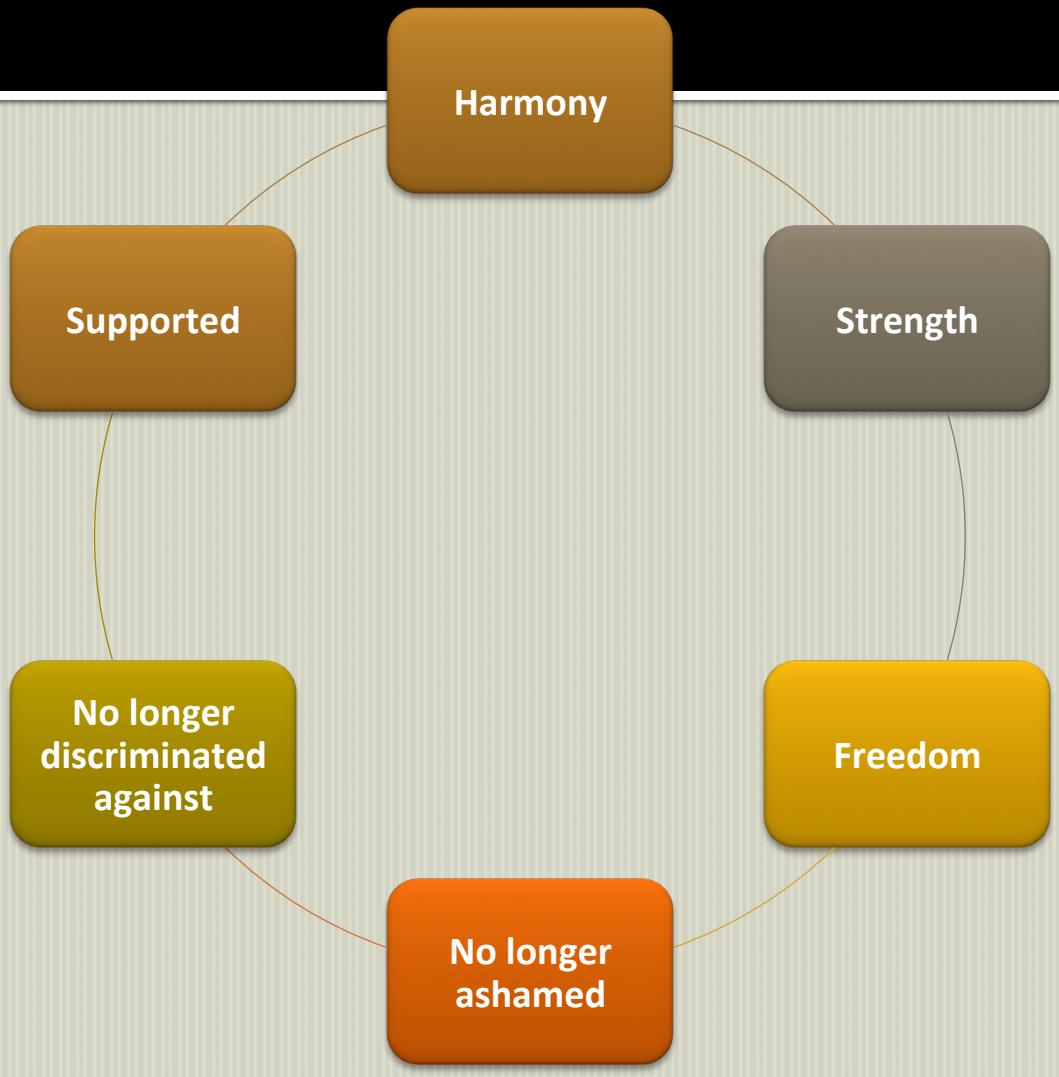
Bass, J., Annan, J., Murray, S.M., Kaysen, D., Griffiths, S., Cetinoglu, T., Wachter, K., Murray, L.K., & Bolton, P.A. (2013). Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence. New England Journal of Medicine, 368(23), 2182-2191

Women who received CPT also reported significant and sustained functional improvements



	CPT Mean (SD)	TAU Mean (SD)	Effect Size
Average Functioning score			
Baseline	1.65 (0.69)	2.48 (0.82)	(<0.001)
Post intervention	0.82 (0.67)	1.92 (0.89)	1.29 (<0.001)
6-month follow up	0.88 (0.70)	1.77 (0.87)	1.06 (<0.001)

WHAT THE WOMEN TOLD US THEY GAINED



Therapists found the structure and content of CPT helpful.

Organized structure and standard topics provides guidance and reinforces therapists' feelings of competency

Did not have to spend as much time "figuring out what to cover"

CPT tools/images allowed therapists to explain more abstract concepts of feelings and thoughts.

Standard topics for each session allowed participants to uncover aspects of their life disrupted by trauma.

Weekly symptom monitoring helped therapists monitor client improvement and address problems.

Resources

Want more information on these treatments?

A Learning Resource for CPT

CPTWeb
A web-based learning course for
COGNITIVE PROCESSING THERAPY

Access at:
http://cpt.musc.edu/index

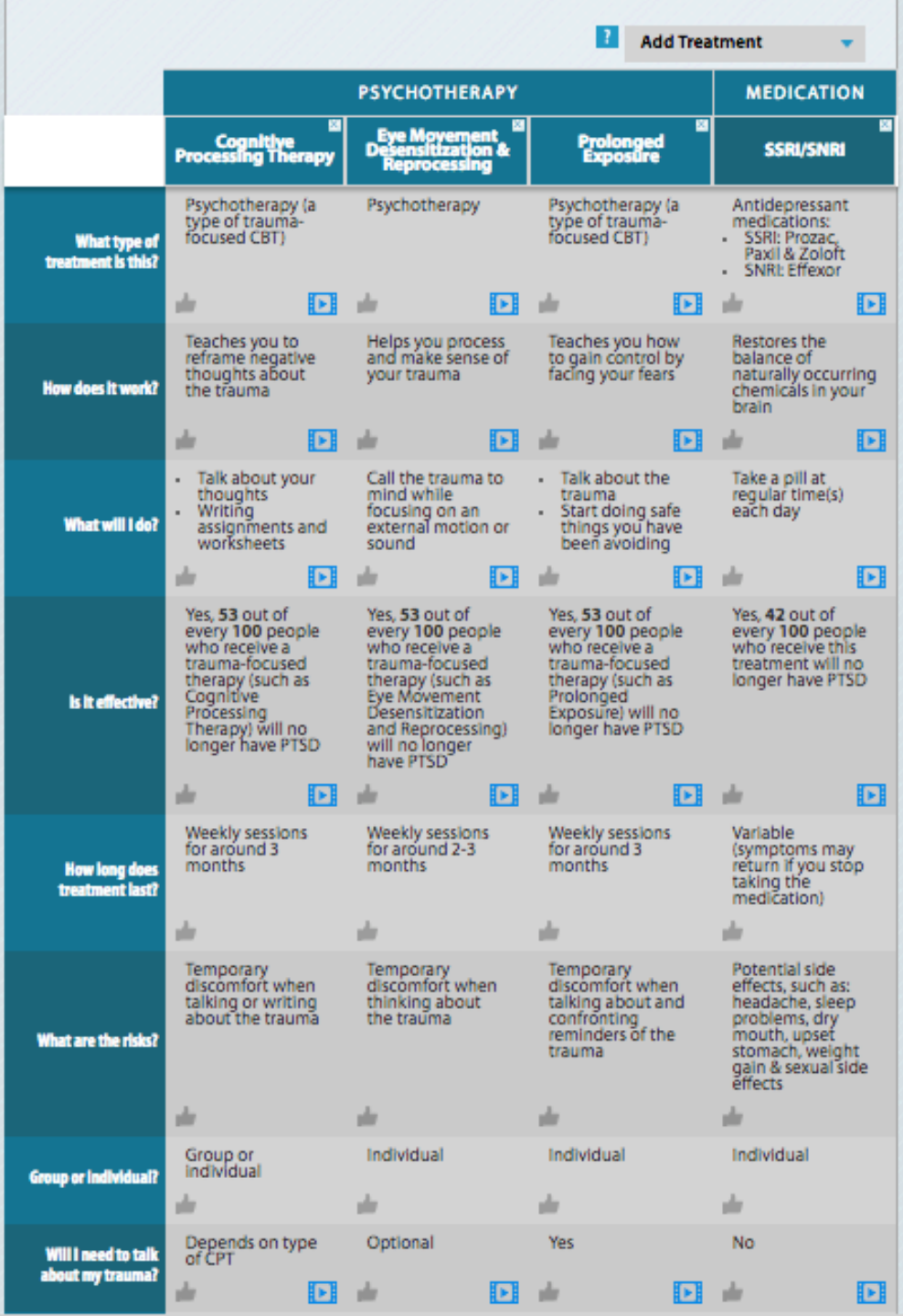
- Web-based learning
- Learn at own pace
- Concise explanations
- Video demonstrations
- Therapy scripts
- Core skills
- Resources
- Links
- 9 hours of CE
- Free of charge

CPT Web-based Training

http://cpt.musc.edu/index

Treatment Resources

- **VA Decision Tool**
  - www.ptsd.va.gov/apps/decisionaid/compare.aspx
- **PTSD Coach**
  - www.ptsd.va.gov/apps/ptsdcoachonline/default.htm
- **CPT and PE Coach**
- **International Society for Traumatic Stress Studies**
  - www.istss.org



Add Treatment

	PSYCHOTHERAPY			MEDICATION
	Cognitive Processing Therapy	Eye Movement Desensitization & Reprocessing	Prolonged Exposure	SSRI/SNRI
What type of treatment is this?	Psychotherapy (a type of trauma-focused CBT)	Psychotherapy	Psychotherapy (a type of trauma-focused CBT)	Antidepressant medications: • SSRI: Prozac, Paxil & Zoloft • SNRI: Effexor
How does it work?	Teaches you to reframe negative thoughts about the trauma	Helps you process and make sense of your trauma	Teaches you how to gain control by facing your fears	Restores the balance of naturally occurring chemicals in your brain
What will I do?	• Talk about your thoughts • Writing assignments and worksheets	Call the trauma to mind while focusing on an external motion or sound	• Talk about the trauma • Start doing safe things you have been avoiding	Take a pill at regular time(s) each day
Is it effective?	Yes, **53** out of every **100** people who receive a trauma-focused therapy (such as Cognitive Processing Therapy) will no longer have PTSD	Yes, **53** out of every **100** people who receive a trauma-focused therapy (such as Eye Movement Desensitization and Reprocessing) will no longer have PTSD	Yes, **53** out of every **100** people who receive a trauma-focused therapy (such as Prolonged Exposure) will no longer have PTSD	Yes, **42** out of every **100** people who receive this treatment will no longer have PTSD
How long does treatment last?	Weekly sessions for around 3 months	Weekly sessions for around 2-3 months	Weekly sessions for around 3 months	Variable (symptoms may return if you stop taking the medication)
What are the risks?	Temporary discomfort when talking or writing about the trauma	Temporary discomfort when thinking about the trauma	Temporary discomfort when talking about and confronting reminders of the trauma	Potential side effects, such as: headache, sleep problems, dry mouth, upset stomach, weight gain & sexual side effects
Group or individual?	Group or individual	Individual	Individual	Individual
Will I need to talk about my trauma?	Depends on type of CPT	Optional	Yes	No

PTSD is responsive to treatment and most of those who could benefit never get care.

PTSD is responsive to brief focused treatments.

Treatment effects also seem to improve comorbid symptoms.

Once treated, PTSD does not seem to reoccur.

PTSD treatments appear well tolerated in some diverse populations (refugees in the U.S., developing world)

Questions?