

UK PTS

Psychological Treatment of PTSD

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24 March 2009

Overview of workshop

- General considerations
- Trauma focused psychological interventions
- Non-trauma focused interventions
- Current guidelines and evidence base

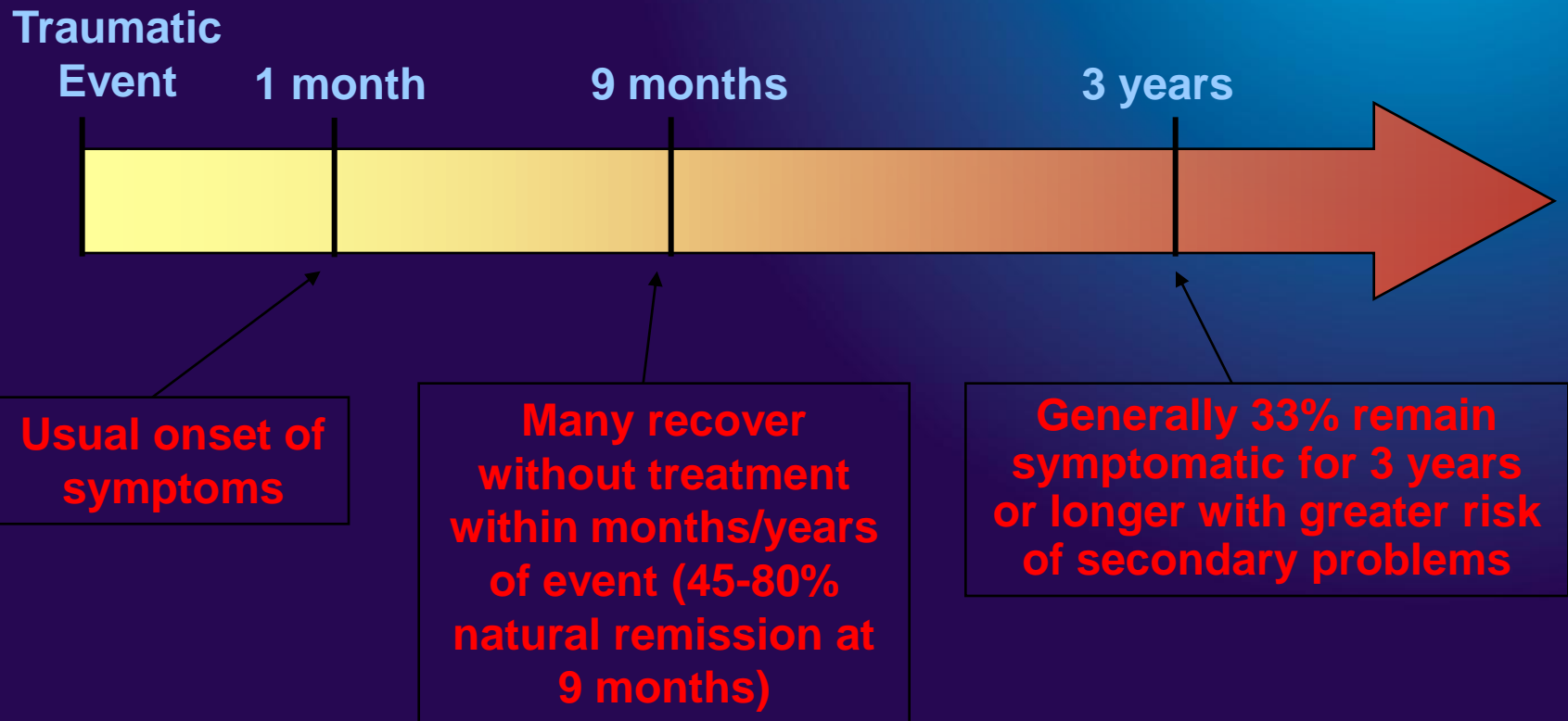
The take home message!

- We have good evidence that PTSD can be treated with trauma focused psychological therapy (TF-CBT & EMDR)
- No good evidence for non-trauma focused psychological therapies
- We need to refine current therapies to reduce drop out rates
- More research on when best to start TFPT

General Considerations

- Where there is suicide risk, manage this before starting the PTSD therapy
- Consider offering 8-12 sessions TFEBT, allowing longer treatment sessions (90mins) when working on the trauma itself
- More than 12 sessions may be necessary if there are multiple traumatic events, traumatic bereavement, chronic disability resulting from the trauma, or co-morbidity
- Treatment should be regular and continuous – usually once a week and delivered by the same person
- Do not routinely offer non-TF interventions (such as relaxation or non-directive therapy) which do not address traumatic memories

What is the natural history of PTSD?



Treatment

- **NICE Guidelines 2005**

‘All people with PTSD should be offered a course of trauma-focused psychological treatment (trauma-focused CBT or EMDR). These treatments should normally be provided on an individual outpatient basis’.

Trauma Focused Interventions

- Prolonged Exposure (Foa)
- EMDR (Shapiro)
- Cognitive Processing Therapy (Resick)
- Cognitive Therapy (Ehlers & Clarke)
- Brief Eclectic Psychotherapy (Gersons)



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Prolonged Exposure

Theoretical basis

- Draws on Emotional Processing Theory (Foa & Kozak, 1986)
 - PTSD occurs as a result of the development of a pathological fear structure concerning the traumatic event
 - This structure contains representations about stimuli, responses and their meaning
 - Any information associated with the trauma activates the fear structure
 - Attempts to avoid activating the fear structure lead to avoidance symptoms of PTSD

Prolonged Exposure

Theoretical basis

- Implications of Emotional Processing Theory for Treatment
 - To be successful, therapy must correct the pathological components of the fear structure
 - Two conditions are necessary for fear reduction
 - The fear structure has to be activated
 - New information has to be provided which is incompatible with the existing pathological elements so that they can be modified

Prolonged Exposure

- **Goal**

- To help the patient emotionally process the trauma by vividly imagining the event and describing it aloud, including the thoughts feelings and sensations which occurred during the trauma

- **Problem**

- The patient may not want to have to confront emotionally painful memories and situations i.e. avoidance

- **Solution**

- You have to sell (and believe) the rationale for the treatment you are proposing

Rationale for PE Treatment

- Patients are being bothered by a memory not a current event
- Traumatic memories tend to be stored as perceptual and affective states, with little verbal representation
- Learning to tolerate the memories of intense emotional experiences is a critical part of recovery

Rationale for PE Treatment

- Merely re-experiencing fragments of the trauma cannot lead to resolution, because the incomplete reliving of perceptual or affective elements of the trauma prevents the construction of integrated memory – one that no longer serves as a trigger for conditioned responses
- Treatment involves translating the nonverbal dissociated realm of traumatic memory into secondary mental processes in which words can provide meaning and form, thereby facilitating the transformation of traumatic memory into narrative memory

Rationale for PE Treatment

- How does PE work?
 - Repeated and prolonged exposure promotes habituation. This allows patients to discover that anxiety diminishes even without avoidance or escape
 - Reliving the trauma in the presence of an empathic therapist helps patients realise that thinking about the trauma is not dangerous

Prolonged Exposure - Preparation

- Psycho-education
 - Normalisation, explanations of symptoms
- Rationale for treatment
- Breathing retraining
- Explanation of SUD ratings

Prolonged Exposure

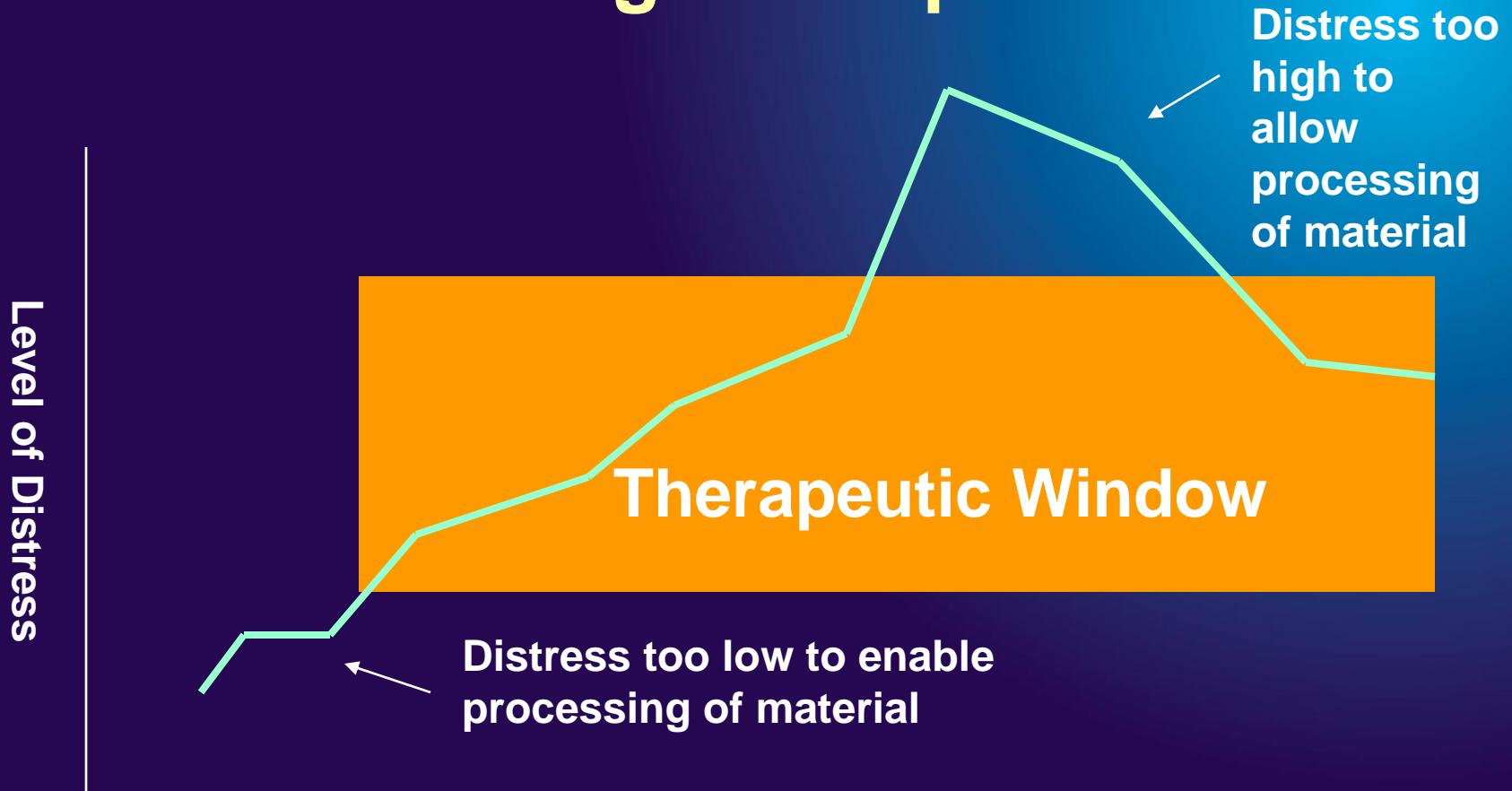
Two key elements which run in parallel

- Imaginal exposure
- In vivo exposure

Imaginal Exposure

- Prolonged approx 45 minutes of Imaginal exposure within the session
- Develop a detailed verbal narrative in the present tense, first person, eyes closed
- Elicit sensory details, emotions & thoughts
- Ask patient how it is affecting them physically
- Ask for regular SUD ratings
- Leave time for discussion
- Homework – listen to taped narrative daily
- Hot spots

Imaginal Exposure



In Vivo Exposure

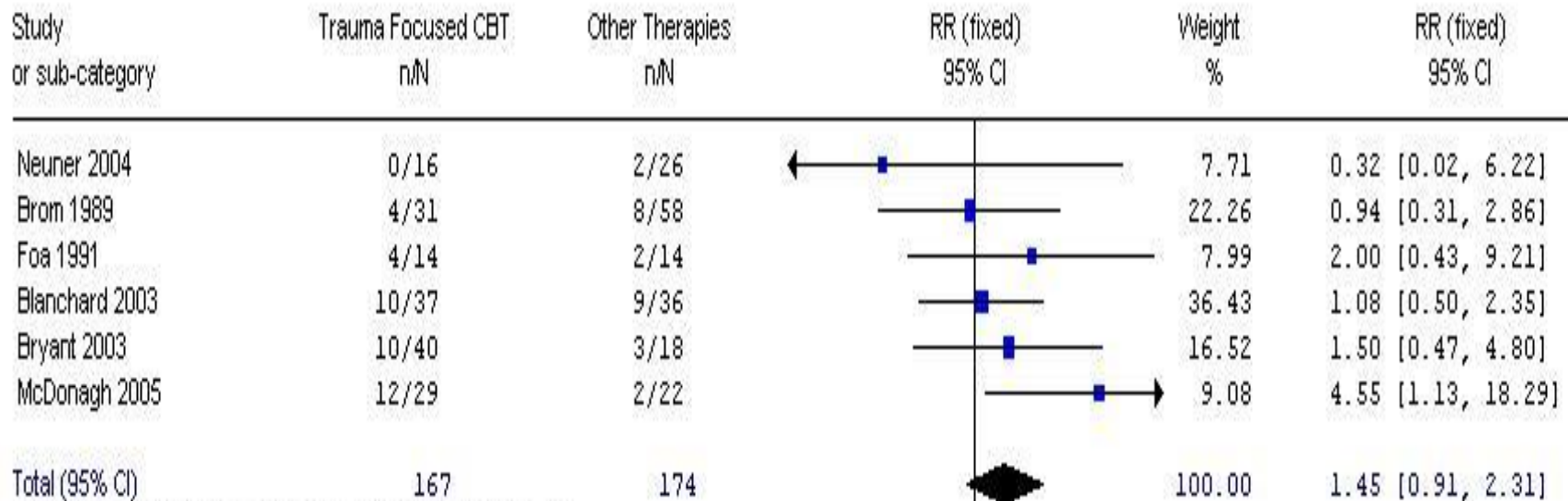
- Exposure to trauma related current cues
- Progress through hierarchy
- Use of SUD ratings
- Improves outcome rather than Imaginal exposure alone

Evidence Base – Exposure Therapy

- Recommended as first line treatment by NICE (2005), Cochrane Review (Bisson & Andrew, 2007), ISTSS practice guidelines (Foa et al, 2009)
- 24 randomised control trials across range of populations
- Combination of imaginal exposure plus in vivo exposure has the strongest evidence base

Dropout TFCBT vs Other therapy

Review: Psychological treatment of chronic post-traumatic stress disorder (PTSD)
 Comparison: 06 Trauma Focused CBT/Exposure Therapy vs Other Therapies (supportive counselling/hypnotherapy/psychodynamic)
 Outcome: 10 Leaving the study early due to any reason



Total events: 40 (Trauma Focused CBT), 26 (Other Therapies)

Test for heterogeneity: $\text{Chi}^2 = 4.91$, $\text{df} = 5$ ($P = 0.43$), $I^2 = 0\%$

Test for overall effect: $Z = 1.55$ ($P = 0.12$)

0.1 0.2 0.5 1 2 5 10

Favours treatment Favours control



Eye Movement Desensitization and Reprocessing (EMDR) Therapy

Francine Shapiro

Francine Shapiro



EMDR-theory

- Traumas upset biochemical balance of brain's information processing system
- Memories are “locked” in the nervous system and require effective processing to release

EMDR-theory cont

- EMDR-integrates eye movements or other BLS with talk therapy techniques to clear emotional, cognitive, & physical blockages-traumas are reprocessed, or “metabolized” with BLS
- May work similar to REM sleep by processing blocked information, allowing the body mind to release it

EMDR-theory

- EMDR may unblock the system using same mechanisms as REM sleep, or through improved hemispheric communication
- Rapid eye movements or bilateral stimulation kick-start effective processing

EMDR-NICE 05

- NICE reported on 11 RCT's
- EMDR vs. wait list & other psychological therapies-no conclusive evidence that EMDR was clinically significant to TFCBT
- Only to be offered after 3 months (TF-CBT initially)
- EMDR may reduce drop-out compared to TF-CBT

EMDR

- Three aims to therapy:
 - Process original incident
 - Identify unhelpful behaviours and triggers for these
 - Install a desirable cognitive and behavioural approach

Phases to EMDR

- 1) Therapist identifies key images and negative appraisals
- 2) Desensitises response to these through bilateral eye movements or bilateral tapping
- 3) Installs a new positive cognition through pairing this with the image during the bilateral stimulation

Therapy Procedure

- Therapist establishes target memories with SUDs ratings for each
- For each memory establishes TICES (target = image, cognition, emotion, sensation)
- Client does not have to talk through the whole incident to reduce distress
- Asked to notice what emerges during bilateral stimulation

Therapeutic Components

- Negative cognitions are self referencing “I” statements e.g. “I am a bad person” “I am weak”
- Cannot be social references e.g. “she doesn’t love me” or statements of emotion “I am frightened”
- Aim is to replace with positive cognitions “I am worthwhile” “I am blameless”

Therapy Procedure

- EMDR Institute suggests typically 3-6 sessions needed for resolution
- 12 sessions recommended for multiple or complex trauma victims
- Sessions last 90 minutes to give time for effective processing
- Clients log material that arises between sessions

Francine Shapiro

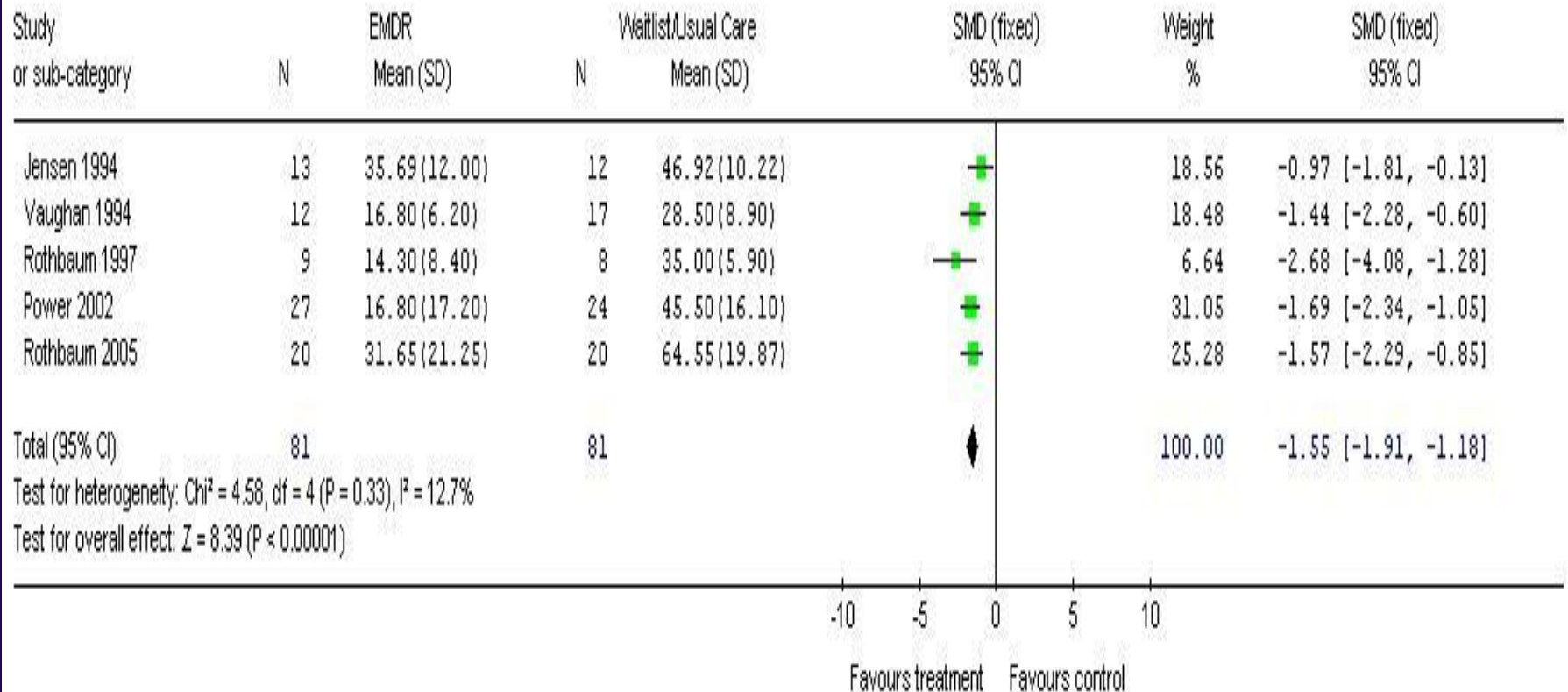


EMDR vs WL/Usual Care

Review: Psychological treatment of chronic post-traumatic stress disorder (PTSD)

Comparison: 09 EMDR vs Waitlist/Usual Care

Outcome: 01 Severity of PTSD symptoms - Clinician

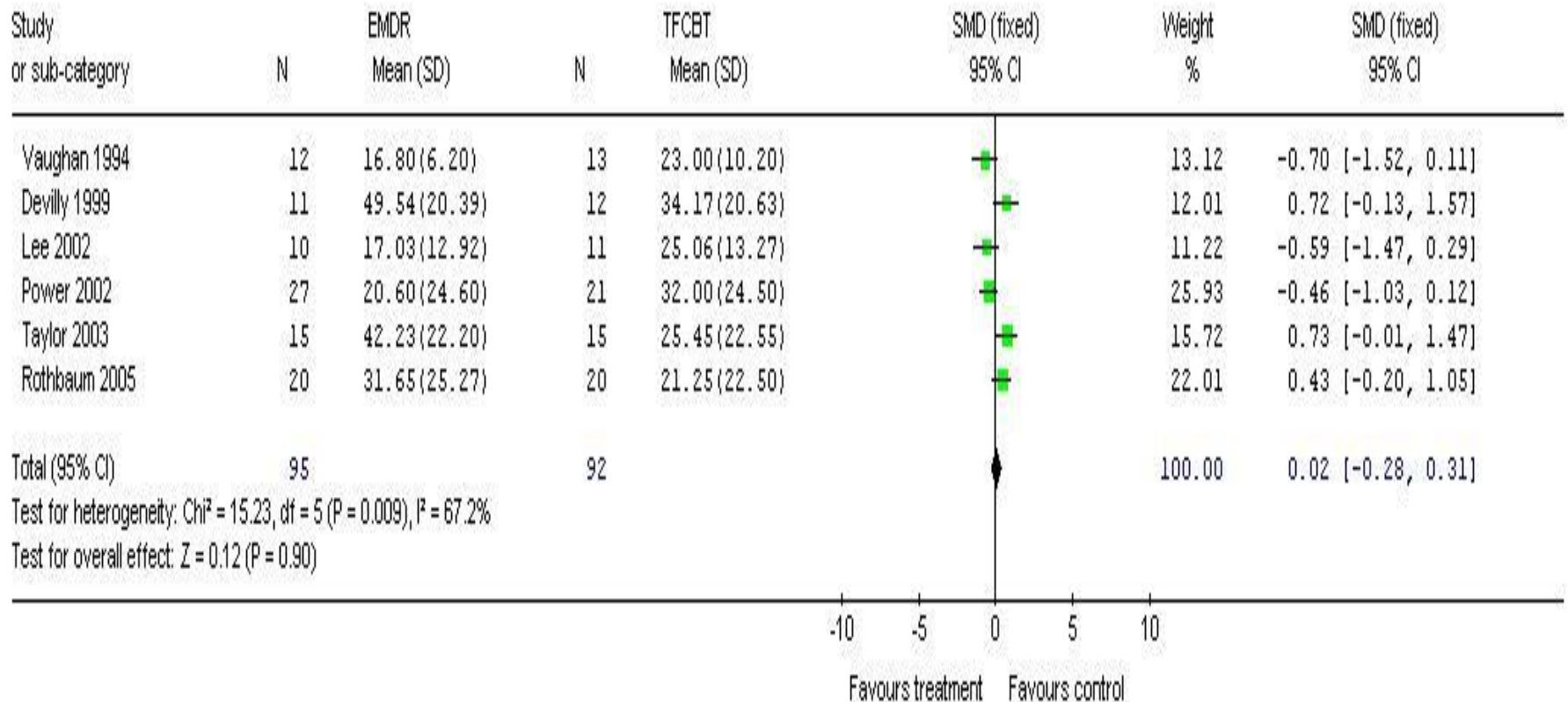


EMDR vs TFCBT

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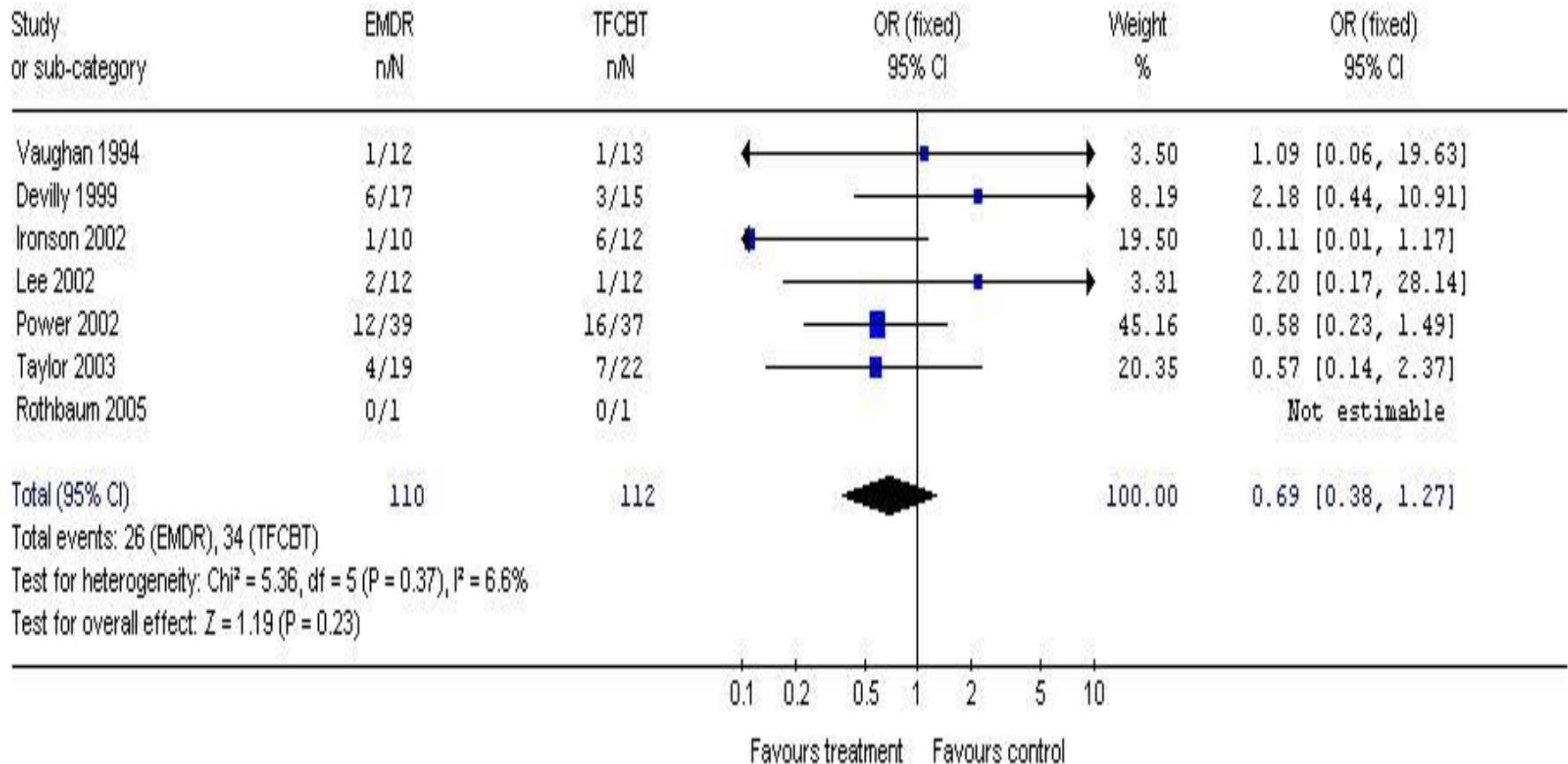
Comparison: 10 EMDR vs Trauma Focused CBT

Outcome: 01 Severity of PTSD symptoms - clinician



Dropout EMDR vs TFCBT

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Cognitive Processing Therapy (CPT)

Resick & Schnicke (1992)

- Originally developed for use with rape victims
- Addresses both cognitive & emotional consequences of trauma
- Combines a variant of exposure therapy and cognitive restructuring
- Involves the patient producing a detailed, written narrative account

Cognitive Processing Therapy

Theoretical basis

- Draws on cognitive models as well as information processing theory
- Two keys processes
 - Assimilation – the event is altered to fit into existing belief system e.g. “ I must have provoked him”
 - Accommodation – belief system is changed to take account of the traumatic event e.g. “sometimes bad things happen to innocent people” c.f. over accommodation e.g. “no-one can be trusted”

Cognitive Processing Therapy

“The goal is to assist the patient in refraining from assimilating (distorting the event to fit prior beliefs) and in accommodating schemata to the new information without over-accommodation”

Resick & Schnicke, 1996, p17

Cognitive Processing Therapy

- Key components
 - “stuck points”
 - Impact statement
 - Written account of trauma
 - Areas of interpersonal functioning
 - Safety
 - Trust
 - Power & control
 - Esteem
 - Intimacy

Cognitive Processing Therapy

12 session protocol

1. Introduction & education
2. The meaning of the event
3. Identification of thoughts and feelings
4. Remembering the trauma
5. Identification of stuck points
6. Challenging questions
7. Faulty thinking patterns
8. Safety issues
9. Trust issues
10. Power and control issues
11. Esteem issues
12. intimacy issues and the meaning of the event

Cognitive Processing Therapy

Case Example – Liz - 28 yrs

Trauma -Raped 3 years ago by acquaintance

Immediate response -Didn't report rape. Only told one friend. Moved city

Coping – Containment. Effective until work colleague confided

Referral – Depressed, paracetamol overdose 2 months previously, heavy alcohol use, “can't get it out of my head”

Cognitive Processing Therapy

- Impact statement

Please write at least one page on what it means to you that you were raped. Please consider the effects the rape has had on your beliefs about yourself, your beliefs about others, and your beliefs about the world. Please also consider the following topics while writing your answer: safety, trust, power and competence, esteem and intimacy

Cognitive Processing Therapy

Impact statement – assigned week one

"It's turned my life upside down. I thought I had it sussed and all I had to do was not think about it and I would be okay but I can't control the memories any more. I'm angry that it affects me like this years later. I should be able to cope. I am normally the one helping others and now I can't even do that. I feel useless and I no longer know who I am. I am tired of trying to pretend but I am scared not to in case I crumble completely. My boyfriend hates me drinking but it's the only way I can make myself go out in the evening. Even then I hate crowds and have to sit with my back to the wall so I can see what going on. I don't feel anyone understands but then how could they when they don't even know what happened to me".

Cognitive Processing Therapy

Impact statement – assigned week eleven

“Being raped was something I never thought would happen to me. I was ashamed and blamed myself for being in the situation where I was vulnerable. I am beginning to realise that the blame doesn't lie with me it never has. I still wish it hadn't happened because I lost something precious but I am not going to let it define me. I am not going to let it stop me going out or having friends even though I will choose them carefully. Not only did he rape me but he imprisoned me within myself and now it's time to emerge and live again”.

Evidence Base - CPT

- 4 “gold standard” studies
 - E.g. RCT - Resick et al (2002) CPT vs. PE vs. WL
 - CPT comparable to PE on PTSD symptom reduction and superior to WL but statistically better than PE on 2 measures of guilt
 - Resick et al (2008) dismantling study – CPT-C vs. WA vs. CPT.
 - PTSD symptoms reduced in all 3 conditions but CPT-C superior to WA. No differences between CPT and WA or CPT-C. Conclusion – adding the written component did not improve outcome

Cognitive Therapy

- Ehlers & Clarke Model (2000)
 - Persistent PTSD occurs only if individuals process the traumatic event and /or its sequelae in a way which produces a sense of current threat
 - Two processes lead to a sense of current threat
 - 1. Individual differences in the appraisal of the trauma and /or its sequelae
 - 2. Individual differences in the nature of the memory for the event and its link to other autobiographical memories
 - The perception of current threat results in a series of behavioural and cognitive responses

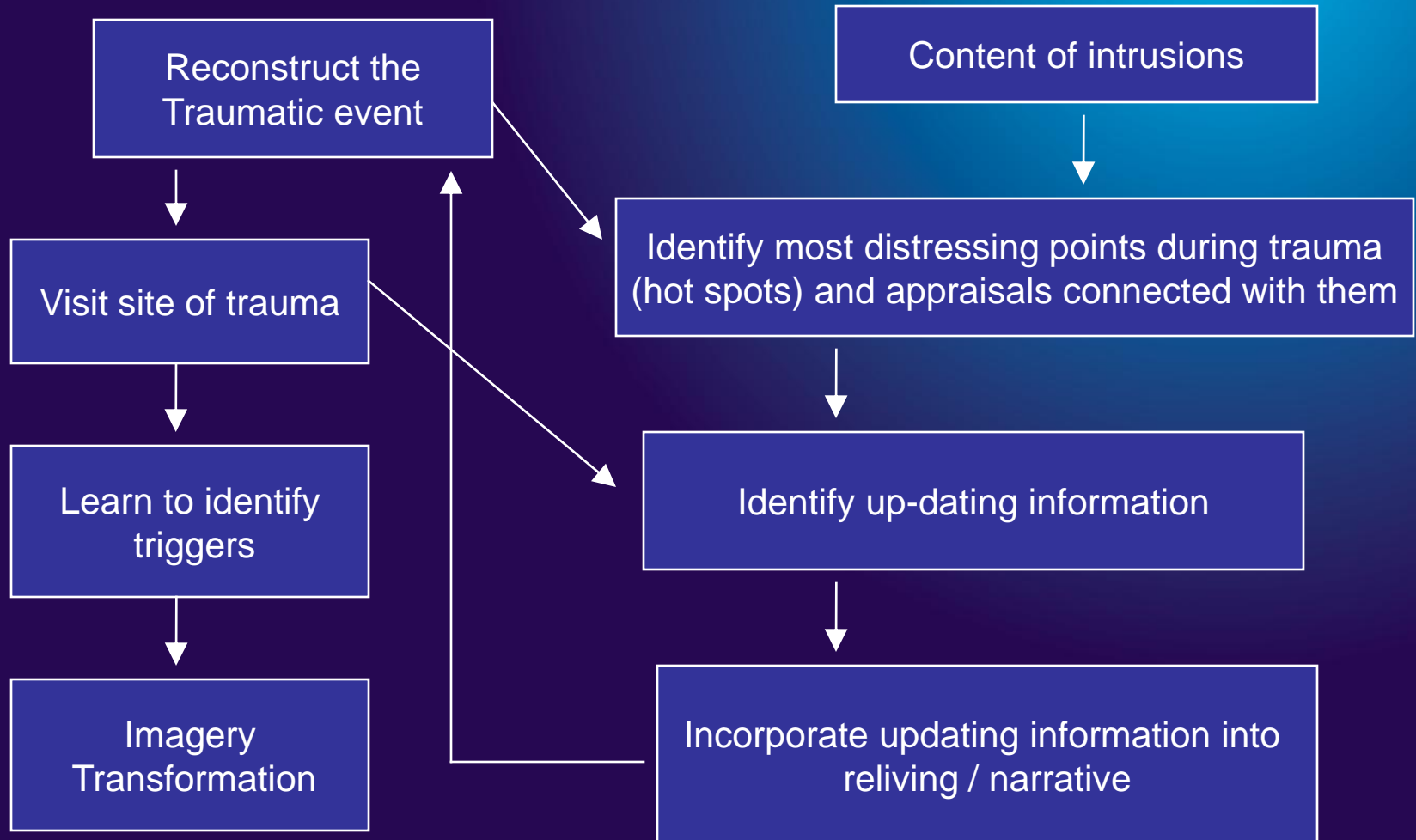
Cognitive Therapy

- Treatment implications
 - The trauma memory needs to be elaborated and integrated to reduce intrusive re-experiencing
 - Appraisals of the trauma or its sequelae which maintain the current sense of threat need to be modified
 - Dysfunctional behavioural and cognitive strategies which prevent memory elaboration, exacerbate symptoms or hinder reassessment of problematic appraisals need to be dropped

Cognitive Therapy

Reducing the ease of involuntary
Trauma memories

Changing appraisals of
the trauma



Evidence Base – Cognitive Therapy

- 9 studies, 7 RCTs - consistent support for CT
 - E.g. Marks et al (1998) no difference between CT vs. EX vs. combination but all better than RLX
 - E.g. Ehlers et al (2003) CT more effective than self-help booklet or WL and no dropouts
 - Resick et al (2008) CPT dismantling study. CPT-C equivalent to full CPT version



Brief Eclectic Psychotherapy (BEP)

Berthold Gersons

Brief Eclectic Psychotherapy (BEP) is efficacious

BEP has been shown effective in two RCTs:

- Gersons et al (2000): police officers
- Lindauer et al (2005): mixed civilian population

In reducing:

- PTSD (all 3 symptom clusters)
- Depressive symptoms
- Biological measures

Effect of psychotherapy on biological measures

- The more improvement on IES-R => higher increase cortisol levels
(Olf et al, in prep)
- Heart rate response to trauma script significantly reduced after BEP
(Lindauer et al, 2005)
- BEP effects measures of functional activity in the brain
(Lindauer et al, 2005)

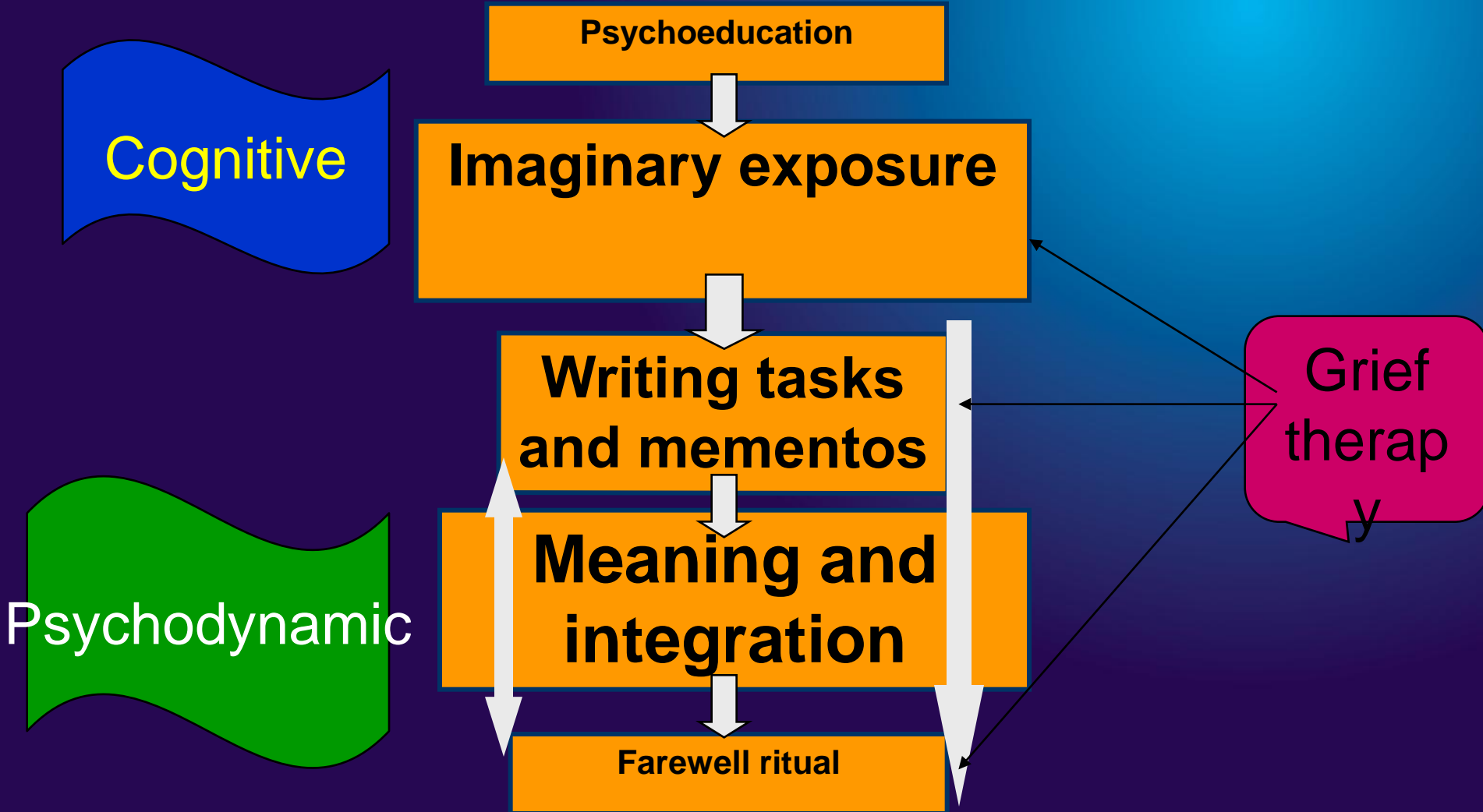
Brief Eclectic Psychotherapy (BEP)

- a brief problem-focused psychotherapy
- 16 sessions
- 45-60 minutes
- each session is a well described step in different phases of the treatment.

Why eclectic?

- Limitations of:
 - psychodynamic treatment
 - pharmacological treatment
 - prolonged exposure
- BEP: gathering of effective techniques of different psychotherapeutic views

Brief *Eclectic* Psychotherapy



BEP-12 sessions

- Session 1-4
- Explanation of goals & content of the therapy
- Psycho-education
- Recounting the traumatic experience with eyes closed first person, present tense very slowly for 15-20 min's-aim vivid & sensory remembrance of the event with associated feelings

BEP-12 sessions

- Session 5-12
- Discussion of written assignment-e.g. how has traumatic event changed your life, view of world, view of self/others-may relate to previous early life experiences (angry letter)
- Practical problem solving to 'Real World' issues e.g. resuming work, reactions of others etc....

BEP-12 sessions

- Session 11-12
- Preparation of farewell ritual & date. Plan discussed in detail-need to take ritual slowly, what it will mean?
- Review of BEP-relapse prevention plan.
- Ending of the therapeutic relationship

Background details

- 44 yr divorced lady with 4 children
- Referred by GP following 21yr son's suicide by hanging 26 weeks previously
- Two previous attempts of suicide by son
- Nightmares, flashbacks, intrusive images of son
- Cognitive avoidance of above, & people

Previous Psychiatric History

- Prescribed paroxetine 20mg for 2.5 yrs, switched to venlafaxine 75mg for 1 yr for work related stress
- Difficulty in reducing medication due to side effects
- Episodes of self-harm since 2000 when commenced on anti-depressants

Diagnosis

- Chronic PTSD with co-morbid major depressive disorder, panic disorder without agoraphobia

Management Plan

- Prescribed 'Overcoming Traumatic Stress' from C&V book from prescription scheme
- Telephone numbers for bereavement groups, counselling, CRUISE
- Wait list for TFPT
- Recommended GP re-start anti-depressants if patient willing?

Brief *Eclectic* Psychotherapy

Psychoeducation

Cognitive

Imaginary exposure

Writing tasks
and mementos

Meaning and
integration

Farewell ritual

Grief
therapy

Psychodynamic



Non-Trauma Focused Interventions

- Stress Inoculation Training (SIT)
- Hypnotherapy
- Psychodynamic Psychotherapy
- Interpersonal Therapy (IPT)

Stress Inoculation Training

- Developed by Meichenbaum (1974)
- Modified by Kilpatrick Veronen & Resick (1982) to treat rape survivors
- Package of measures to control anxiety
- Techniques include education, progressive muscular relaxation, thought stopping, breathing retraining, problem solving, guided self-dialogue, in vivo exposure, covert modelling and role plays
- Goal is to manage the anxiety which has become conditioned at the time of the trauma. By using the skills taught, avoidance and anxiety are reduced.

Evidence Base - SIT

- Strongest support for female rape victims
- E.g. Foa et al (1999) Sit vs. EX vs. Ex + SIT vs. WL. SIT effective in reducing PTSD symptoms and comparable in efficacy to EX

Psychodynamic therapies

- Emphasis on resolving the unconscious conflicts provoked by the stressful event, by re-engage normal mechanisms of adaptation.
- To understand the meaning of the stressful event, within the individuals personality, attitudes and early experiences
- Only one RCT testing its efficacy in PTSD (Brom, 1989)



Interpersonal Therapy

- PTSD is the consequence of exposure to a traumatic life event which results in disturbed emotions and disrupted interpersonal relations and detachment
- IPT is a life event therapy which addresses the connection between disturbance in mood and interpersonal functioning
- Focus on the *interpersonal sequelae of trauma* rather than reprocessing
- Problematic interpersonal functioning may increase vulnerability and exacerbate symptoms
- IPT can improve interpersonal adaptation to loss and change associated with trauma

What is the site of this famous crash?



Hypnotherapy

- Aims-to enhance control over trauma-related emotional distress & hyper arousal symptoms
- To facilitate the recollection of details of the traumatic event
- Adjunct to other therapies
- One RCT in PTSD (Brom, 1989)

Summary

- We have good evidence that PTSD can be treated with trauma focused psychological therapy (TF-CBT & EMDR)
- No good evidence for non-trauma focused psychological therapies
- We need to refine current therapies to reduce drop out
- More research on when best to start TFPT

Contact details

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