Overview of Evidence-Based Psychotherapeutic Interventions for Posttraumatic Stress Disorder

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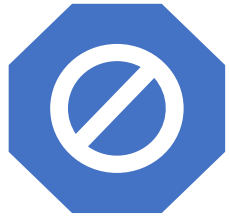

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Faculty/Presenter Disclosure

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Faculty: Megan McElheran, Psy.D.

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Mitigating Potential Bias

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The information presented in this program is based on recent information that is explicitly “evidence-based”.

This Program and its material is peer reviewed and all the recommendations involving clinical medicine are based on evidence that is accepted within the profession; and all scientific research referred to, reported, or used in this CE/CPD activity in support or justification of patient care recommendations conforms to the generally accepted standards

Learning Objectives

By the end of this session, participants will be able to:

Describe current therapeutic interventions for PTSD that have empirical support.

Understand the degrees of evidence supporting the therapeutic interventions for PTSD.

Identify ways to adapt manualized treatments to address clinical complexities that present with PSP.

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Multi-Faceted Approach to Treatment with PSP

Upstream mental health training

Clinicians providing empirically-based treatments for operational stress injuries (OSI's)

Training in, and encouragement to apply daily regulation skills

Reintegration

Culturally competent healthcare professionals

Peer support

Safeguard/annual assessments

Clear pathways to care, including WSIB navigation

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Source of information: A Guide to Guidelines for the Treatment of Posttraumatic Stress Disorder in Adults: An Update

“In the optimal scenario, the decision is informed by scientific evidence, a clinician’s experience and training, and a patient’s preferences and values. These three elements meet the definition of an evidence-based practice provided by the Presidential Task Force on Evidence-Based Practice (APA Presidential Task Force on Evidence-Based Practice, 2006).”

The American Psychological Association (APA;2017), the International Society for Traumatic Stress Studies (ISTSS;2018), the National Institute for Health and Care Excellence (NICE;2018), the Phoenix Australia Centre for Posttraumatic Mental Health (Phoenix Australia Centre for Posttraumatic Mental Health, 2013) , and the U.S. Departments of Veterans Affairs and Defense (VA/DoD;2017).

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Table 1
Clinical Practice Guidelines for Posttraumatic Stress Disorder

Author and date	Guideline name	URL
American Psychological Association, 2017	Clinical Practice Guideline for the Treatment of PTSD in adults	https://www.apa.org/ptsd-guideline/ptsd.pdf
International Society for Traumatic Stress Studies, 2018	ISTSS Posttraumatic Stress Disorder Prevention and Treatment Guidelines: Methodology and Recommendations	http://www.istss.org/getattachment/Treating-Trauma/New-ISTSS-Prevention-and-Treatment-Guidelines/ISTSS_PreventionTreatmentGuidelines_FNL-March-19-2019.pdf.aspx
National Institute for Health and Care Excellence, 2018	Post-traumatic Stress Disorder: Management (update)	https://www.nice.org.uk/guidance/ng116/resources/posttraumatic-stress-disorder-pdf-66141601777861
Phoenix Australia Centre for Posttraumatic Mental Health, 2013	Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder	https://www.phoenixaustralia.org/wp-content/uploads/2015/03/Phoenix-ASD-PTSD-Guidelines.pdf
Department of Veterans Affairs/Department of Defense, 2017	Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder	https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal012418.pdf

Note. PTSD = posttraumatic stress disorder; ISTSS = International Society for Traumatic Stress Studies.

Table 8
Individual Psychotherapy Recommendations for PTSD

Recommendation	APA, 2017	ISTSS, 2018	NICE, 2018	Phoenix Australia Centre for Posttraumatic Mental Health, 2013	VA/DoD, 2017
Strong recommendation	Cognitive behavioral therapy Prolonged Exposure Cognitive Processing Therapy Cognitive therapy	Trauma-focused cognitive behavioral therapy (undifferentiated) Prolonged Exposure Cognitive Processing Therapy Cognitive therapy Eye Movement Desensitization and Reprocessing	Trauma-focused cognitive behavioral interventions including: Cognitive Processing Therapy Cognitive therapy for PTSD Narrative Exposure Therapy Prolonged Exposure Eye Movement Desensitization and Reprocessing (more than 3 months after non-combat-related trauma)	Trauma-focused cognitive behavioral interventions Eye Movement Desensitization and Reprocessing	Trauma-focused therapy Prolonged Exposure Cognitive Processing Therapy Eye Movement Desensitization and Reprocessing Specific cognitive behavioral therapies for PTSD Brief Eclectic Psychotherapy Narrative Exposure Therapy Written Narrative Exposure Interpersonal Psychotherapy Present Centered Therapy Stress Inoculation Training
Moderate recommendation	Brief Eclectic Psychotherapy Eye Movement Desensitization and Reprocessing Narrative Exposure Therapy	Cognitive behavioral therapy without a trauma focus Narrative Exposure Therapy Present Centered Therapy	Eye Movement Desensitization and Reprocessing (1–3 months after non-combat-related trauma)		
Very Low recommendation	Not applicable	Not applicable	Not applicable	Where symptoms have not responded to a range of trauma-focused interventions, evidence-based non-trauma-focused psychological interventions (such as Stress Inoculation Training) should be considered	Not applicable
Insufficient recommendation	Relaxation Seeking Safety	Brief Eclectic Psychotherapy Dialogical Exposure Therapy Emotional Freedom Techniques Interpersonal Psychotherapy Observed and experimental integration Psychodynamic psychotherapy Psychoeducation Relaxation training REM desensitization Supportive counselling	Not applicable		Acceptance and Commitment Therapy Dialectical Behavior Therapy Seeking Safety Skills Training in Affect and Interpersonal Regulation Supportive counselling
Emerging recommendation	Not applicable	Single session cognitive behavioral therapy Reconsolidation of Traumatic Memories Virtual reality therapy Written Exposure Therapy	Not applicable	Not applicable	Not applicable

Note. To make comparisons across the recommendations, the authors created their own strength of recommendation categories. Only rows for which there were recommendations were included in the table. APA = American Psychological Association; ISTSS = International Society for Traumatic Stress Studies; NICE = National Institute for Health and Care Excellence; VA/DoD = Department of Veterans Affairs and Department of Defense; PTSD = posttraumatic stress disorder.

Cognitive Behavioral Therapy

Psychological treatment indicated for a range of psychological conditions
Robust empirical base that indicates the utility of CBT for treating diverse psychological conditions, and may outperform other therapies and pharmacology

The therapy has as its foundation core principles:

- Psychological problems develop and are potentially maintained by unhelpful thought patterns and distorted interpretations
- Psychological problems may also be developed and/or maintained by ineffective patterns of behavior
- People struggling with psychological problems may improve by learning new coping behaviors and ways of thinking
- Employs diverse cognitive and behavioral procedures to address these issues

Cognitive Therapy

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An application of CBT focused primarily on memories of traumatic events and negative evaluations of traumatic situations and their sequelae

It theorizes that the person struggling with symptoms of PTSD has insufficiently cognitively processed the traumatic event, and is left with memories and cognitions that contribute to a persistent feeling of unsafety

- Either related to negative evaluations of the traumatic event and its impact or,
- Negatively impacted the person's memory of the trauma
- Either one can negatively influence cognitive and behavioral coping responses
- Involves assessment of post-trauma cognitions paired with narrative and written exposure of traumatic events

Cognitive Processing Therapy

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Specific type of CBT: big C, small b

Involves 12 treatment sessions focused on evaluating and modifying upsetting cognitions that have developed since the traumatic event

By changing thoughts, can change emotions and behaviors

Begins with focusing on how the traumatic event impacted the individual

Will assess the types of cognitions that have been contributing to ongoing trauma-related fears, and other ways to think about the issues that are causing difficulty

Homework is assigned

Consider functioning across domains of safety, trust, control, self-esteem and intimacy

Written exposure to the traumatic experience may be included

Prolonged Exposure

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A CBT therapy: small c, Big B

A therapy that teaches clients to approach trauma-related memories and fears through the use of exposure procedures

Enhances emotional processing of memories of traumatic situations

Reduces trauma-related avoidance by helping clients approach anxiety producing situations through behavioral exposure

Treatment is usually 8-15 sessions

Involves completion of in vivo and imaginal exposure, with each session allowing for time to process what emerged during imaginal exposure

Eye Movement Desensitization and Reprocessing (EMDR)

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Guided by Adaptive Information Processing theory
Typically 6-12 sessions
Conceptualizes trauma memories as incompletely processed and thus continue to manifest in emotions, thoughts, memories and behaviors due to insufficient processing
When trauma-related memories are activated, symptoms of PTSD emerge
Attempts to use bilateral stimulation to support processing of trauma memories, with the goal of changing how these memories are stored
Eight phase approach

Additional Therapies for Consideration (VA/DoD)

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- Brief Eclectic Therapy
- Narrative Exposure Therapy
- Written Exposure Therapy
- Interpersonal Psychotherapy: potentially improved outcomes for clients with comorbid depression
- Present Centered Therapy
- Stress Inoculation

Emerging Therapies

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- Accelerated Resolution Therapy
- Somatic Processing Therapy
- Psychedelic-Assisted Therapy, MDMA specifically

Therapeutic Challenges in PTSD Treatment with PSP

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- Chronicity of trauma exposure
- Cultures of Pseudo-Stoicism
- Resource shortages interfere with psychological processing
- Lack of culturally competent health professionals (often a burden in rural and remote areas)
- Trauma relativism
- Potential pressures from third-parties

Take Home Messages

Treatment of PTSD with PSP is COMPLEX!!!!!

Treatment modification is the norm, not the exception

Effective treatment may be expected to be longer-term and should be contemplated as multi-modal

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