PTSD the way forward

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(*with special thanks to Dr. Walter Busuttil who shared some of his valuable expertise)*

2015

Best Practices for Treatment of Post-Traumatic Stress Disorder

Zeke Ogburn
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CLINICAL PRACTICE
GUIDELINE
for the Treatment of
PTSD

AMERICAN PSYCHOLOGICAL ASSOCIATION

Guideline Development Panel for the Treatment of Posttraumatic Stress Disorder in Adults

Adopted as APA Policy February 24, 2017

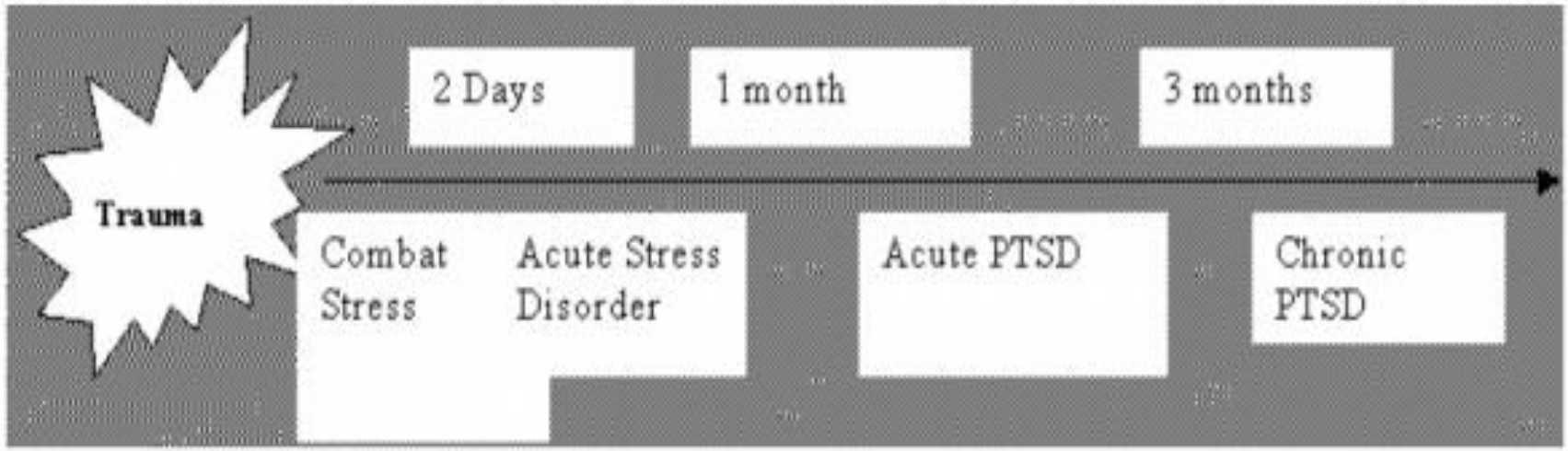
PTSD core symptoms

Table CORE - 1 Common Signs & Symptoms Following Exposure to Trauma

Physical	Cognitive/Mental	Emotional	Behavioral
• Chills • Difficulty breathing • Dizziness • Elevated blood pressure • Fainting • Fatigue • Grinding teeth • Headaches • Muscle tremors • Nausea • Pain • Profuse sweating • Rapid heart rate • Twitches • Weakness	• Blaming someone • Change in alertness • Confusion • Hyper-vigilance • Increased or decreased awareness of surroundings • Intrusive images • Memory problems • Nightmares • Poor abstract thinking • Poor attention • Poor concentration • Poor decision-making • Poor problem solving	• Agitation • Anxiety • Apprehension • Denial • Depression • Emotional shock • Fear • Feeling overwhelmed • Grief • Guilt • Inappropriate emotional response • Irritability • Loss of emotional control	• Increased alcohol consumption • Antisocial acts • Change in activity • Change in communication • Change in sexual functioning • Change in speech pattern • Emotional outbursts • Inability to rest • Change in appetite • Pacing • Startle reflex intensified • Suspiciousness • Social withdrawal

Timelines

Figure 1. Stress Reaction Timeline.



Risk Factors

The following characteristics have been reported in studies to be risk factors for the development of PTSD:

Pre-traumatic factors

- Ongoing life stress or demographics
- Lack of social support
- Young age at time of trauma
- Pre-existing psychiatric disorder
- Female gender
- Low socioeconomic status, lower level of education, lower level of intelligence, race (African-American, American Indian, and Pacific Islander)
- Prior trauma exposure (reported abuse in childhood, report of other previous traumatization, report of other adverse childhood factors)
- Family history of psychiatric disorders (genetics).

Peri-traumatic or trauma-related factors

- Severe trauma
- Type of trauma (interpersonal traumas, such as torture, rape, or assault, convey a high risk of PTSD)
- High perceived threat to life
- Community (mass) trauma
- Peri-traumatic dissociation.

Post-traumatic factors

- Ongoing life stress
- Lack of positive social support
- Negative social support (e.g., negative reactions from others)
- Bereavement
- Major loss of resources
- Other post-traumatic factors, including children at home and distressed spouse.

Multiple Traumatisation

- Enduring Personality Change after Catastrophic Stress (ICD-10, 1992)

- Complex PTSD (Disorder of Extreme Stress Not Otherwise Specified (DESNOS – DSM-IV)
- (ICD-11 coming soon)

Enduring Personality Change after Catastrophic Stress (ICD-10, 1992)

- Prolonged exposure to life threat/s
- PTSD may precede the disorder
- *features seen after exposure to threat:*
  - a hostile mistrustful attitude towards the world
  - social withdrawal
  - feelings of emptiness or hopelessness
  - chronic feelings of being on edge or threatened
  - estrangement

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CPTSD/ DESNOS: Disturbance on Three Dimensions

- Symptoms of : PTSD
- Somatic
- Affective
- Dissociation
- Characterological Changes of:

  Control: Traumatic Bonding

  Lens of Fear

  Relationships: Lens of extremity-attachment versus withdrawal

  Identity Changes:

  Self structures

  Internalized images of stress

  Malignant sense of self

  Fragmentation of the self

- Repetition of Harm

  To the self - faulty boundary setting

  By others - battery, abuse

  Of others - become abusers

  Deliberate self harm

Functional Assessment

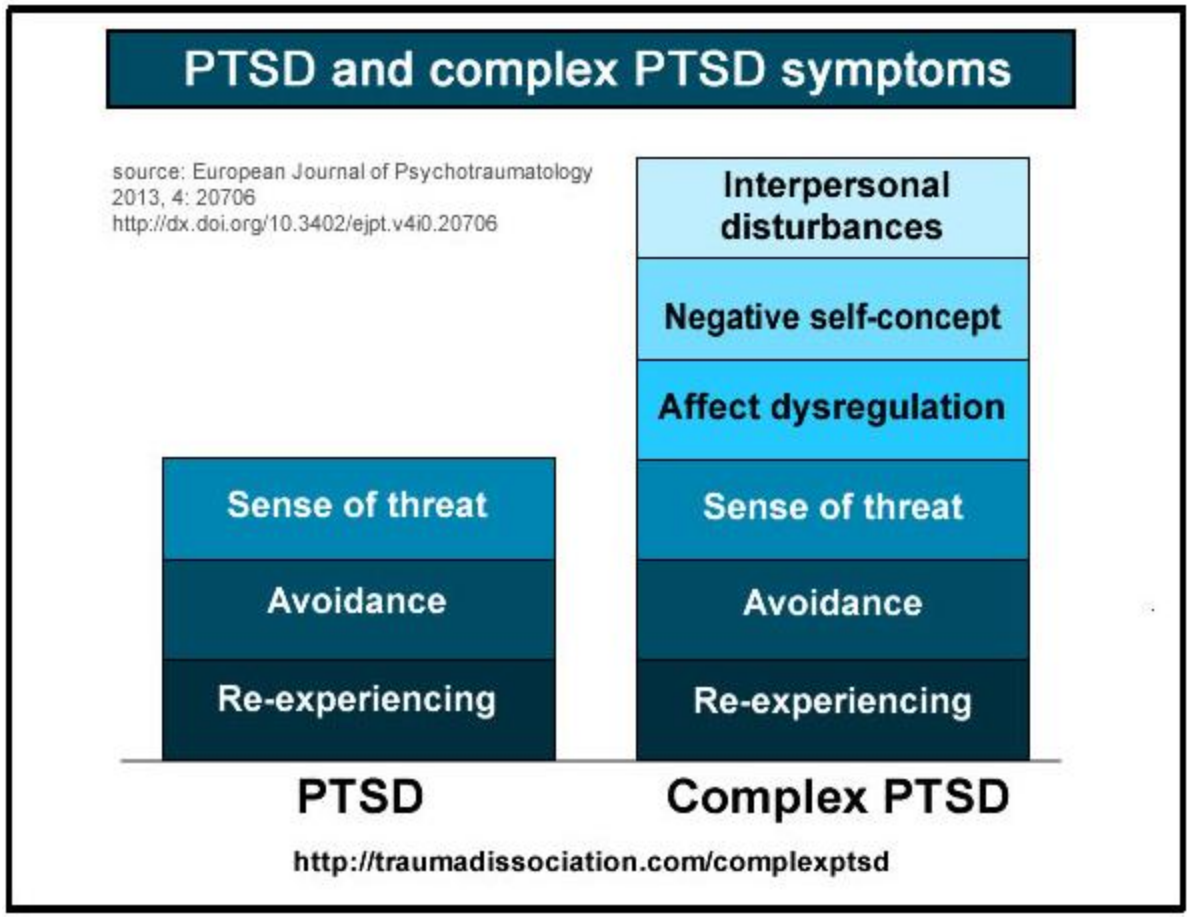
Table B - 2 Components of Functional Assessment

Work	• Is the person unemployed or seeking employment? • If employed, any changes in productivity? • Have co-workers or supervisors commented on any recent changes in appearance, quality of work, or relationships? • Tardiness, loss of motivation, loss of interest? • Been more forgetful, easily distracted?
School	• Changes in grades? • Changes in relationships with friends? • Recent onset or increase in acting out behaviors? • Recent increase in disciplinary actions? • Increased social withdrawal? • Difficulties with concentration and short-term memory?
Marital & Family Relationships	• Negative changes in relationship with significant others? • Irritable or easily angered by family members? • Withdrawal of interest in or time spent with family? • Any violence within the family? • Parenting difficulties? • Sexual function difficulties?
Recreation	• Changes in recreational interests? • Decreased activity level? • Poor motivation to care for self? • Sudden decrease in physical activity? • Anhedonia?
Housing	• Does the person have adequate housing? • Are there appropriate utilities and services (electricity, plumbing, other necessities of daily life)? • Is the housing situation stable?
Legal	• Are there outstanding warrants, restraining orders, or disciplinary actions? • Is the person regularly engaging in or at risk to be involved in illegal activity? • Is patient on probation or parole? • Is there family advocacy/Dept. of Social Services (DSS) involvement?
Financial	• Does the patient have the funds for current necessities, including food, clothing, and shelter? • Is there a stable source of income? • Are there significant outstanding or past-due debts, alimony, child support? • Has the patient filed for bankruptcy? • Does the patient have access to healthcare and/or insurance?
Unit/Community Involvement	• Does the patient need to be put on profile, MEB, or limited duty? • Is patient functional and contributing in the unit environment? • Is there active/satisfying involvement in a community group or organization?

Outcomes to consider

Table 3. *Outcomes Considered by the Panel* **Outcome Considered**	**Decision**
PTSD symptom reduction	Critical
Serious harms (adverse events)	Critical
Remission (no longer having symptoms)	Important
Loss of PTSD diagnosis	Important
Quality of life	Important
Disability or functional impairment	Important
Prevention or reduction of comorbid medical or psychiatric conditions	Important
Adverse events leading to withdrawals (treatment discontinuation)	Important
Other adverse events	Important
Burdens	Important
Return to work or return to active duty	Not included
Maintenance of treatment gains	Not included
Aggressive behavior	Not included
Peer support	Not included

Moving towards ICD-11



Moral Injury

- The perceived **philosophical meaning related to the impact of trauma exposure** was seen by Janoff-Boulman (1985) as an aetiological factor for PTSD. This was described as a 'shattering' of well held positive values and assumptions about the world, oneself and others.

- Incorporated within the diagnostic criteria for PTSD in the Diagnostic Statistical Manual (DSM) since DSM-III-revised (1987) and further developed and formally included in the most recent Fifth Edition (DSM-V; 2013) are concepts such as **guilt relating to acts of commission and omission as well as negative cognitive change following trauma exposure.**

- The relatively new concept **of Moral Injury (Litz et al, 2009) expands on Janoff-Boulmann's concepts and guilt symptoms and was reported by military medical staff and chaplains operating close to combat.**

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Moral Injury

- **Ethical, moral and religious challenges caused by violations to deeply held beliefs.** Military operations and training emphasize mission aims, with suppression of individual needs and beliefs.
- **Usually arises from cumulative events. –** collateral damage; bystander to ongoing atrocities, ***powerless when their own leaders and colleagues flaunt the rules of engagement.***
- **Perceived organisational or personal betrayal -** ethical dilemmas resulting in chronic feelings of guilt, anger and frustration.
- Can take time to sink in and state that ***a healthy mind that can empathise is a requirement for its development.***
- **Moral Injury does <u>not</u> lead to, or amount to, diagnosable mental illness**, although in some moral injury may form part of a mental illnesses presentation including PTSD.
- **Intervention**:
  - generate an understanding of moral codes of conduct and emotions that are linked to this;
  - the effect of shame on social behaviour, and self-forgiveness.
  - Access to spiritual help working in conjunction with therapy interventions is advised.
  - A modified exposure treatment approach is also included.

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REVIEW ARTICLE

Treatment of military-related post-traumatic stress disorder: challenges, innovations, and the way forward

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ABSTRACT

Post-traumatic stress disorder (PTSD) is one of the common mental disorders in military and veteran populations. Considerable research and clinical opinion has been focused on understanding the relationship between PTSD and military service and the implications for prevention, treatment, and management. This paper examines factors associated with the development of PTSD in this population, considers issues relating to engagement in treatment, and discusses the empirical support for best practice evidence-based treatment. The paper goes on to explore the challenges in those areas, with particular reference to treatment engagement and barriers to care, as well as treatment non-response. The final section addresses innovative solutions to these challenges through improvements in agreed terminology and definitions, strategies to increase engagement, early identification approaches, understanding predictors of treatment outcome, and innovations in treatment. Treatment innovations include enhancing existing treatments, emerging non-trauma-focused interventions, novel pharmacotherapy, personalized medicine approaches, advancing functional outcomes, family intervention and support, and attention to physical health.

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KEYWORDS
PTSD; military; veteran; treatment; trauma

Current Treatment

Earlier international PTSD treatment guidelines consistently found trauma-focused cognitive behavioural therapies, such as Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), and Eye-Movement Desensitization and Reprocessing (EMDR) to be the gold standard for treatment (Australian Centre for Posttraumatic Mental Health, 2013). More recent guidelines expand the number of treatments with high levels of evidence. For example, the guideline jointly developed by the Department of Veterans Affairs and the Department of Defense (2017) in the US gave the strongest recommendation to trauma-focused psychotherapies such as PE, CPT, and EMDR, but also included a range of additional therapies in this recommendation (e.g. written narrative exposure, Brief Eclectic Therapy). The recent update of the UK National Institute for Clinical Excellence (NICE) PTSD Guideline differs slightly in endorsing PE and CPT with the strongest recommendations, but giving a slightly lower rating to EMDR specifically in relation to military veterans who have been traumatized as a result of combat, in view of the more limited evidence base for EMDR in this population (NICE, 2018). Taken together, the consistent findings across several guidelines from different countries recommend that trauma-focused psychological interventions should be the first line of treatment for PTSD.

PTSD guidelines and meta-analyses (e.g., Jones, Burdett, Green, & Greenberg, 2017; Lee et al., 2016)

2016). Consistent with this, new evidence indicating little difference between sertraline plus enhanced medication management, PE plus placebo, and PE plus sertraline (Rauch et al., 2019) suggests that, as the direct comparison evidence base confirms, more nuanced recommendations will emerge. Despite this, all current guidelines continue to emphasize the role of medication and recommend its use, where indicated, in stabilization or where first-line treatments are not available, not acceptable, or have not worked.

APA Recommendations

Table 1. *Summary of Recommendations of the APA Guideline Development Panel for the Treatment of PTSD*

Psychotherapy	**Strength of Recommendation**
For adult patients with PTSD, the panel strongly recommends that clinicians offer one of the following psychotherapies/interventions (listed alphabetically): • cognitive behavioral therapy- (CBT)[6] • cognitive processing therapy (CPT) • cognitive therapy (CT) • prolonged exposure therapy (PE)	Strong For
For adult patients with PTSD, the panel suggests that clinicians offer one of the following psychotherapies/interventions (listed alphabetically): • brief eclectic psychotherapy (BEP) • eye movement desensitization and reprocessing therapy (EMDR) • narrative exposure therapy (NET)	Conditional
For adult patients with PTSD, there is insufficient evidence to recommend for or against clinicians offering the following psychotherapies/interventions (listed alphabetically): • relaxation (RX) • Seeking Safety (SS)	Insufficient
Pharmacotherapy	
For adult patients with PTSD, the panel suggests that clinicians offer one of the following (listed alphabetically): • fluoxetine • paroxetine • sertraline • venlafaxine	Conditional
There is insufficient evidence to recommend for or against clinicians offering the following medications (listed alphabetically) for treatment of adults with PTSD. • risperidone • topiramate	Insufficient
Comparative Effectiveness	
For adult patients with PTSD, the panel recommends clinicians offer either prolonged exposure or prolonged exposure plus cognitive restructuring when both are being considered.	Strong For
For adult patients with PTSD, the panel recommends clinicians offering either venlafaxine ER or sertraline when both are being considered.[7]	Strong For
For adult patients with PTSD, the panel suggests clinicians offer CBT rather than relaxation when both CBT and relaxation are being considered.	Conditional For
For adult patients with PTSD, the panel suggests clinicians offer prolonged exposure therapy rather than relaxation when both prolonged exposure therapy and relaxation are being considered.	Conditional For
For adult patients with PTSD, the panel concludes that the evidence is insufficient to recommend for or against clinicians offering Seeking Safety versus active controls.	Insufficient

These recommendations and this clinical practice guideline is not intended to set a standard of care but rather to be a general guide to best practices. A clinical practice guideline can facilitate decision making for both provider and patient.

[6] The RTI UNC review refers to this as CBT-mixed therapy. CBT-Mixed is a category that includes interventions using aspects of CBT that do not fit neatly into the other CBT categories. It will be referred to in the present document as CBT.

[7] The recommendation for the comparison between venlafaxine ER vs sertraline is different than the recommendation for Seeking Safety vs active controls, even though there is moderate evidence of no difference between the two treatments being compared for both comparisons (i.e., venalfaxine ER vs sertraline and Seeking Safety vs active controls). The reason the recommendations are different for venlafaxine ER vs sertraline than for Seeking Safety vs active controls is that the panel made a conditional recommendation for venlafaxine compared to no intervention and a conditional recommendation for sertraline compared to no intervention but did not make any recommendations for Seeking Safety compared to no intervention or active controls compared to no intervention because there was insufficient/very low evidence. In other words, the panel believed that because there was evidence that both venlafaxine and sertraline had demonstrated efficacy compared to inactive intervention, it was reasonable to recommend either treatment when both are being considered. However, because neither Seeking Safety nor active controls had demonstrated efficacy compared to no intervention, the panel concluded that evidence was insufficient to recommend for or against either treatment.

https://www.ptsd.va.gov/professional/continuing_ed/STAIR_online_training.asp
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Author(s): Marylene Cloitre, PhD

Psychological First Aid
Five elements of PFA *(drawn from research on risk and resilience, field experience and expert agreement).*

1. safety
2. calm
3. connectedness
4. self-efficacy and group efficacy
5. hope.

- **Reassurance, keep families together, information, crisis intervention and support; empower.**

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- **Aims of PFA**

1. **Humane caring and compassionate.**
2. **Addresses emotional and practical needs and concerns above all else.**
3. **Builds people's own capacity to recover; by supporting people and helping them to identify their immediate needs and their strengths and abilities to meet these needs.**
4. **One of the most important research findings is that a person's belief in their ability to cope can predict their outcome.**
5. **Typically people who do better after trauma are those who are optimistic, positive and feel confident that life and self are predictable, or who display other hopeful beliefs.**

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ANZJP

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1–3
DOI: 10.1177/0004867416679737

Psychosocial recovery following community disasters: An international collaboration

David Forbes[1], Meaghan O'Donnell[1] and Richard A Bryant[2]

Ample evidence demonstrates that disasters of both natural (e.g. floods, bushfires, earthquakes) and human origin (e.g. interpersonal violence, terrorism, major life-threatening accidents) can result in adverse mental health outcomes among those directly or indirectly exposed (North and Pfefferbaum, 2013). While the majority

disaster with a view to (1) preventing disorder where possible, (2) intervening early for those who develop initial symptoms and (3) facilitating access to treatment for those with diagnosable conditions. Multiple challenges arise in attempting to deliver this type of response in the context of a complex and chaotic post-disaster setting, and

only because psychological dysfunction at this level causes significant distress, economic loss and functional impairment but also because these adjustment problems pose a risk for escalation into serious psychiatric disorders if not effectively addressed. Moreover, in the aftermath of disaster, there can be substantial numbers of

The International Program for Promoting Adjustment and Resilience (interPAR): a brief psychosocial intervention for disaster and trauma survivors.

O'Donnell, M[1]., Lau, W[1]., Bryant, R[2]., Bisson, J[3]., Burke, S[4]., Busuttil, W[5]., Coghlan, A[6]., Creamer, M[7]., Egleton, N[8]., Gray, D[9]., Greenberg, N[10]., McDermott, B[11]., McFarlane, A.C[12]., Monson, C[13]., Phelps, A[1]., Ruzek, J[14]., Schnurr, P[14]., Ugsang, J[15]., Watson, P[14]., Whitton, S[6]., Williams, R[16]., and Forbes, D[1].

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Treatment: the Military as an Example: Access; Engagement; Completion

Despite the availability of good mental health services offered to serviceman, many report they were unable to present for help with mental health problems during their military service.

- Did not think I had a problem
- Failed to accept the problem
- Feared losing career, I think I can sort this out myself
- Macho image and stiff upper lip.
- Stigma of mental ill-health
- Coped with mental health symptoms by drinking alcohol to excess.
- Failure to engage in treatment
- High drop outs from treatment
- Systemic failure to provide clinical services
- Lack of clinicians with expertise
- High co-morbidity – increases with chronicity

Nice Guideline Update (December 2018)

- https://www.nice.org.uk/guidance/ng116
- https://www.nice.org.uk/guidance/ng116/chapter/Recommendations#care-for-people-with-ptsd-and-complex-needs
- Note pgs 132-3 Evidence for early intervention for TFCBT more robust than EMDR which is not recommended.
- Note page 154 limited evidence for MBSR
- Note EMDR not recommended for combat veterans

1.6.18 Consider EMDR for adults with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented between 1 and 3 months after a non-combat-related trauma if the person has a preference for EMDR. **[2018]**