

# Psychotherapy for PTSD: Implications for the VA

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# Overview of the PTSD psychotherapy literature

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- n There is good evidence for the efficacy of cognitive behavioral treatments for PTSD (as compared to inert psychotherapy conditions).
- n These include: exposure therapy, cognitive processing therapy, EMDR, anxiety management training.
- n Generally such studies have been performed on women, most often victims of interpersonal violence; some trials of women with breast cancer; some studies of men and women following MVA or circumscribed event such as earthquake; some reports on refugees.
- n For a comprehensive review see Bisson & Andrew: 2006, in the Cochrane Collaboration, published by John Wiley & Sons.

# Rationale for CBT in PTSD is logical and compelling

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- n Traumatic events promote negative thoughts and cognitions. These cause distress. Distress perpetuates intrusive and hyperarousal symptoms and leads to avoidance.
- n Recovery occurs via confrontations with trauma, which, in the absence of repeated trauma, disconfirm post-trauma cognitions, lead to a reduction of distress, etc.
- n Behavioral interpretation: Promotes habituation and therefore reduces anxiety.
- n Cognitive interpretation: Avoidance prevents exposure to information that disconfirms cognitive beliefs and perpetuates the cycle of intrusive and hyperarousal symptoms.
- n Theory fits for cases where a one-time event, 'outside the realm of normal experience' results in PTSD, but raises questions about planned, chronic, repeated exposures.

# Cognitive schemas and PTSD

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- n Foa (1997) posits 3 major types of cognitive schemas
  - n The world is (overly) dangerous.
  - n The self is incompetent to minimize damage.
  - n The self is to blame for traumatic exposure.
- n These schemas are posited to result from trauma exposure.
- n Could different events lead to different schemas? Do different types of cognitive schemas lend themselves to different intervention strategies?
- n This model views trauma exposure as the essential pathogen in PTSD.
- n An alternative view is that PTSD is associated with a set of characteristics that are expressed in the presence of trauma. Cognitive schemas may be risk factors that explain why persons don't deploy natural recovery processes following trauma exposure.

# Intervention literature does not necessarily reflect clinical practice

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- n Principles of CBT are incorporated; but therapies not generally used as per the manual, particularly the timetable of 10 sessions.
- n This may be changing as CBT is being taught more in graduate schools.
- n CBT can be thought of as an approach or a technique.
- n CBT may be used at the point in therapy in which both patient and therapist agree that PTSD is the major diagnosis and/or trauma exposure the precipitating problem.
- n Would be good for field to adopt a more uniform understanding of CBT in trauma/PTSD.

# The gap between clinical research and practice

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## n Clinical presentation

- n 'Subjects' vs. 'patients.' Most subjects are not recruited from a treatment setting. Most patients are not motivated to participate in a clinical trial.
- n Exclusion criteria screen out most challenging patients (suicidal, substance abusing, comorbid) raising the question about contraindications of using CBT in PTSD.

## n Protocol issues

- n Greatest evidence for efficacy in studies where active treatment is compared against 'inert' treatment. This is not exactly the same as placebo-controlled.
- n Information about screening, drop-out rates, or intent-to-treat analyses are not always provided. Issues pertaining to treatment fidelity are not clearly understood.

# Overheard... off the record about why clinicians don't use CBT more

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- n Difficult to contradict a patient who claims s/he is not 'ready' to confront traumatic memories.
- n Treatments that require 'homework' are very difficult to 'sell' to patients.
- n Trauma exposure results in a far greater range of social, occupational, functional and interpersonal problems that may or may not occur in the presence of PTSD.
- n Persons exposed to single traumatic events represent different clinical treatment challenges than those who are multiply traumatized, particularly in childhood. Clinicians believe that 'complex trauma' produces different problems than occur in persons with simple PTSD, requiring different solutions.
- n Some distrust about positive efficacy studies where authors have developed the treatment.

## Interim thought

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- n Even before we entertain the question of relevance to the VA, it is noteworthy that the use of CBT for the treatment of civilian PTSD is not a 'slam-dunk.'**

# Do evidence-based PTSD treatments work for combat veterans (VA patients)?

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- n Review of the literature on psychotherapy for PTSD in veterans is scant.
- n The reason for this shortage is not at all clear, but is worthy of reflection.
- n A few important studies have emerged in recent years:
  - n Cooperative Study #420.
  - n RCT Cognitive Processing Therapy
  - n RCT EMDR studies
  - n Open Trial Virtual Reality Treatment
  - n Prospective Psychodynamic Study

# VA Cooperative Study 420: Exposure vs. present-centered group therapy

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- n Schnur et al., Arch Gen Psychiatry, 2003
- n RCT, compared trauma-focused exposure therapy vs. a present-centered treatment that avoided trauma confrontation.
- n Both groups showed improvement over time, though effects were moderate.
- n Groups did not differ in outcome. Significantly more persons dropped out of the trauma-focused group.
- n Notable for being a large study (n=360)

# Randomized clinical trial of cognitive processing therapy

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- n Monson et al, J Consult Clin Psychol, 2006
- n Compared CPT vs. waitlist in a group of 60 veterans (54 men, 6 women).
- n Encouraging effects: 40% no longer had diagnosis of PTSD and 50% were appreciably better.
- n Importantly, no relationship between PTSD disability and outcome.
- n Drop out rate was 20% CPT and 13% WL.

## Two RCT trials for EMDR

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- n Carlson et al., J Trauma Stress, 1998; Devilly et al., Behavior Therapy, 1998.
- n First study compared EMDR (n=10) to biofeedback (n=13) or routine clinical care (n=12). Significant treatment effects in the EMDR condition maintained at 3 month follow-up.
- n Second study on 51 veterans compared EMDR with and without eye movements to supportive psychotherapy. Only two sessions, but EMDR did not result in an improved outcome that was maintained at 6 months.
- n Very small n's; unclear whether two sessions worth of EMDR can really result in needed gains.

# Open trial of Virtual Reality treatment

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- n Rothbaum et al, J Clin Psychiatry, 2001.
- n Proposed as an alternative to typical imaginal exposure treatments.
- n Veterans exposed to virtual environments – e.g., where helicopter flies over virtual Vietnam, and clearing in jungle.
- n Statistically significant reduction from baseline in 8 participants that was maintained at follow-up.
- n Treatment may hold promise for veterans, but there has been no follow-up RCT as of yet.

# Prospective study of psychodynamic group therapy

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- n Britvic et al., Croat med J, 2006
- n Five year study of 59 (non-US) veterans who met weekly in group psychotherapy. 42 completed the study.
- n Not a VA or U.S. study
- n PTSD symptoms reduced, but other neurotic symptoms and defense mechanisms were not.
- n Study noteworthy for many reasons, but suggests that reducing PTSD symptoms may not represent sufficient treatment gains for veterans.

## Should CBT treatments with efficacy in non-combat PTSD be used in veterans?

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- n This is an empirical question and should be answered on the basis of data. Not enough data are available.
- n There are many reasons to suspect that treatment of combat trauma would differ from other types of events.
- n There should be predictions about whether modalities would work in veterans based on stated similarities and differences between combat veterans and civilian populations, and ideally, direct comparisons.
  - n Gender
  - n Trauma type – training for combat
  - n Nature and severity of other related problems

# Are combat veterans treatment resistant?

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- n Or rather, is PTSD in combat veterans more severe (or chronic) than PTSD in civilians?
- n Are veterans who use the VA a self-selected group?
- n Do compensation claims interfere with treatment?
- n Are comorbid conditions that would otherwise explain treatment resistance overlooked?
  - n Pretraumatic factors
  - n Traumatic brain injury
  - n Medical and psychiatric conditions
  - n Substance use/abuse, nicotine use, other poor lifestyle choices

# Barriers to performing well-controlled studies be done at a VA

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- n Does VA 'culture' makes treatment studies difficult to perform?
- n Veterans have expectations about the VA and how they wish to avail them-selves of services; clinicians wish to be responsive to veterans.
- n Attitudes about the 'ethics' of research may be a factor, but given lack of clear evidence-based data, this is misplaced.
- n The overly-beaurocratic process of subject protection is a deterrent for everyone.
- n Practically, in examining the criteria for well-controlled studies, some may be difficult to implement (e.g. clearly defined target symptoms, use of blind evaluators, unbiased assignment to treatment, treatment adherence).
- n Should different standards apply in intervention studies with veterans?
- n Can we use a service research approach to learn even if RCT's cannot be performed?

# Difficult to talk about psychotherapy without mentioning pharmacotherapy

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- n Need to better understanding of the relationship between psychotherapy and pharmacotherapy in the treatment of PTSD in general and in veterans.
- n In contrast to 'civilians' who usually express that they do not wish to take a medication, many chronic VA patients seem to want a prescription.
- n In the VA, different clinicians administer medications and psychotherapy.
- n When pharmacotherapy and psychotherapy are not well-integrated treatments, this provides a confusing message for the veteran patient.

# Acknowledging the social psychology of combat trauma

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- n The power (advantages and disadvantages) of belonging to a group.
  - n Veterans feel understood by peers; is this an indication or contraindication for group therapy?
  - n Homogenization of symptoms and disability. Groups help maintain status quo: should they optimally be used for relapse prevention or wellness models?
  - n Does being in a group impede or enhance recovery? Need to compare against individual psychotherapy.
- n The impact of society's response to the veterans (war hero vs. 'baby killer').
- n The centrality of family work: Repairing families disrupted by combat and/or deployment.
- n Concrete services build trust.

# Barriers to care: Lessons from returning OIF/OEF veterans

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- n Currently active soldiers understand that their records are not confidential. This is a barrier.
- n Recently returning veterans do not trust the government to 'fix' problems that they caused. Focus groups can help identify what veterans feel they need.
- n Family members often urge mental health treatment.
- n There IS a stigma to receiving mental health services; services available are different from services needed.
- n Mental health needs should be incorporated into the bigger picture of health care in a more seamless manner.

# Stigma results from an unclear pitch. Is the problem really combat exposure?

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- n Most persons exposed to combat do not develop this condition. What is the current understanding of this by both veterans and their clinicians?
- n What are the implications for screening, deployment, education, treatment, disability claims?
- n Are most veterans disabled because of PTSD or self-damaging behaviors / poor coping skills.?
- n Are veterans suffering because of damage done by deployment? Because they cannot get lives on track?
- n Are there specific problems associated with deployment vs. combat vs. PTSD?

# Establishing recommendations for treatment of combat veterans at the VA

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- n Data obtained on the treatment of civilians with PTSD should not be used in establishing recommendations for the treatment of combat veterans.
- n More data are needed.
- n Research efforts designed to differentiate between veterans with better vs. worse outcomes or describing the normal range of outcomes, are particularly informative.
- n However, the 'translational' process that allows us to understand the implications for treatment of these data needs to be better established.

# Increasing knowledge about treatment of combat veterans

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- n More data can be obtained and utilized within the context of Q and A, program evaluation, etc.
- n The VA infrastructure is conducive to long-term follow-up that can be done as part of service-research.
- n Incentives should be provided for clinicians/programs who use state of the art assessments and treatments for PTSD and report on this.
- n VA leadership in local VA's can mobilize clinical infrastructures to support and promote such work.
- n When should veterans be eligible for PTSD disability?

# Obtaining knowledge from the existing clinical infrastructure

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- n Little is known about the treatments that are actually being used at VAs even in specialized treatment programs.
- n With some incentive, some number of PCT's would collect pre and post treatment assessments, choosing from prespecified treatment modalities based on specific expertise.
- n Academic researchers within the VA could suggest instruments to be administered periodically and reported yearly, that could be exported to a database and evaluated.
- n A main void in clinical charts are the pre-military data that would provide an important baseline, and could be available with the patient's/veteran's consent.
- n De-identified data obtained by NEPEC needs to be more broadly available, and possibly form the basis for research proposals that would target key questions in collaboration with NEPEC.

# Suggestions for future research

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- n The MERIT mechanism is inadequate for providing resources for treatment studies.
- n The cooperative studies mechanism is too cumbersome. Smaller units of VA's within VISNs could more easily form multi-site treatment initiatives, but this would require a specific funding mechanism.
- n Investigators funded for clinical neuroscience studies should receive opportunities for supplements in which treatment solutions that represent extensions of the biologic findings are tested. The VA has spent millions to understand pathophysiology, but there is no adequate mechanism for translating new knowledge back to clinical care.
- n Integration of mental health and primary care is critical.
- n The VA can be a leader in effectiveness research, which, for its constituents, is likely to be of greater relevance than efficacy trials.