EFFECTIVE TREATMENTS FOR PTSD

Practice Guidelines from the International Society for Traumatic Stress Studies

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Integration and Summary

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In this book, we have attempted to provide critical reviews of the various treatment approaches to posttraumatic stress disorder (PTSD). Each chapter is dedicated to a specific approach, leaving unaddressed the important clinical questions of how patients' needs dictate choices between treatment approaches or their integration. While the treatment guidelines for any given approach indicate the degree of empirical support available for that treatment, empirical data on combination treatments in PTSD are extremely rare and mostly descriptive. Similarly, there are only few systematic comparisons between treatment modalities (see, e.g., Brom, Kleber, & Defares, 1989; Foa, Rothbaum, Riggs., & Murdock, 1991).

Despite the scarce empirical studies, many PTSD patients do receive more than one form of therapy (e.g., pharmacotherapy and some form of psychotherapy). As no current intervention claims to have curative effect on PTSD (as would be true for other mental disorders), treatment combinations, hierarchy, and integration are important topics to be considered.

It can be argued that PTSD is a relatively "new" disorder; therefore, it is only a matter of time before knowledge on treatment combinations and integration will become available. While this may be true, studies of treatment combinations are few, even in more established disorders such as depression and obsessive-compulsive disorder (OCD), and panic disorder. This may be due not only to focused theoretical or commercial interests but also to the fact that well-controlled studies of combined therapies are complex, expensive, and require very large samples. Moreover, such studies have not always been conclusive. For example, the results of the National Institute of

Mental Health (NIMH) collaborative study of the treatment of depression (Imber et al., 1990), in which two forms of psychotherapy, cognitive therapy and interpersonal therapy, were compared with pharmacotherapy and with placebo-management condition, suggested that patient and disease characteristics contributed to the general outcome as much as factors related to treatment modality (Elkin et al., 1989). Moreover, there are many ways in which several treatment modalities can be combined, and therefore an almost endless number of combinations to study. For example, the failure to find that the combination of cognitive-behavioral therapy and pharmacotherapy were not more effective than cognitive-behavioral therapy alone in treating OCD may have been due to the fact that the treatments were introduced simultaneously rather than sequentially (Kozak, Leibowitz, & Foa, 2000). At present, therefore, the integration of treatment techniques remains the art of the clinician.

As many clinicians know, the exercise of such "art" has many constraints. Not all clinicians are skilled in providing different techniques: Psychologists customarily do not prescribe medication, and few psychiatrists are adequately trained in cognitive-behavioral therapy. Moreover, not all patients desire, or have the resources to engage in more than one form of therapy. Importantly, as with other mental disorders, the patients with PTSD that present to clinics pose unique and heterogeneous problems that require flexible solutions, including amendments to treatment protocols. Epitomizing these clinical dilemmas is the dictum: *Science is mainly generic, whereas Reality is always specific*. By analogy, when implementing the treatments discussed in the various chapters of this book in one's clinical practice, it is not a generic "PTSD" that one treats, but rather a particular PTSD patient, or group of patients, in a particular life situation and clinical setting.

QUESTIONS ADDRESSED IN THIS CHAPTER

- How should one choose among treatment modalities?
- What can one expect from treatment, and how does one define realistic goals?
- How can one combine various treatment techniques?
- How does one approach complex clinical pictures and comorbid conditions?
- How long should a treatment be followed? Booster sessions? Follow-up?
- Are there features of PTSD that require a special approach that cuts across treatment modalities?
- How does one make sense of clinical difficulties and assess failure?

In this concluding chapter, we provide an overview to assist the clinician in evaluating the information provided in each of the previous chapters. We also attempt to help the clinician know how to optimize the treatment of individual patients with PTSD. To this end, we address the above questions. We begin, however, by outlining what we have learned from each of the chapters and what questions are left open.

GENERAL ISSUES

One of the first general lessons learned from this book is that there is a need for more research. Most chapters conclude that the available empirical evidence does not permit strong conclusions about the efficacy of the treatment approach addressed. In many chapters, therefore, the ensuing recommendations are tentative and based on clinical impression and expert opinion. Lack of evidence, however, should not be confounded with negative evidence (i.e., evidence of lack of efficacy), and the reader should not conclude that only treatments that are heavily researched are likely to help his or her patients. Indeed, although lack of evidence limits the degree to which a particular treatment can be endorsed in these practice guidelines, it should not be interpreted to mean that a lightly researched treatment is ineffective.

A second general point is that most treatment approaches described earlier are not specific to PTSD, but rather are based on principles, theories, or basic experiments that apply for other mental disorders as well. By analogy, when clinicians are called to choose between treatment options, they must firstly use their general skills and knowledge as diagnostician and therapist. *The treatment of PTSD, therefore, is to be applied by skilled clinicians only.*

Finally, as noted in the Introduction, diagnosis and careful evaluation must precede treatment. In the case of PTSD these should include the following:

1. Formal diagnoses of PTSD and comorbid disorders.
2. Determination of the most disturbing problem, which may or may not be the PTSD symptoms themselves (e.g., marriage breaking up, violence, depression).
3. Evaluation of the patient's resources (e.g., stable family, work, housing) and his or her deficiencies (e.g., substance misuse, poverty, ongoing traumatization).
4. Evaluation of the patient's motivation and ability to commit to the prescribed course of the selected therapy and to its particular demands (e.g., complete homework assignments in cognitive-behavioral therapy, adhere to the medication regimen). *Indeed, engaging patients*

with PTSD in the therapeutic process (or in complying with prescribed medication) is the first and critical stage of the treatment.

OVERVIEW OF THE CHAPTERS

Acute Interventions and Debriefing

Various early interventions have been employed with individuals who have undergone recent traumatic experiences. The only treatment modality addressed in this chapter is psychological debriefing (PD). The available empirical data suggest that debriefing does not reduce the incidence of PTSD or the severity of PTSD symptoms, as recorded several months to 1 year following trauma. The reader should not, however, conclude that any early treatment of trauma survivors is of no help. Indeed, studies indicate efficacy of front-line treatment of soldiers with combat stress reactions (Solomon & Benbenishty, 1986), early cognitive treatment of road accident victims (Bryant, Harvey, Dang, Sackville, & Basten, 1998), and female assault survivors. Thus, while some early interventions may be useful, others are not.

It is important to note that PD is often employed with groups of trauma survivors who do not have formal diagnoses of PTSD, and sometimes with entire cohorts of survivors regardless of their levels of distress. Consequently, the question of whether preventive treatment should be provided to all trauma survivors or only to those with identifiable symptoms (or dysfunction) remains open. Other questions left unanswered include the following: (1) Is any single and short "immediate" intervention expected to have enough power to reverse the complex causation of PTSD? (2) What is the optimal time for introducing preventive interventions? and (3) Should such interventions be clinical in nature or should they address situational and social stressors that occur shortly after the trauma (e.g., relocation, uncertainty, pain, and rejecting attitudes of others)?

Given the paucity of controlled trials on PD and the many complex questions that have yet to be systematically addressed, in this regard, it is much too early to conclude that PD is an ineffective intervention for all acutely traumatized individuals. Even if subsequent studies confirm these early findings, however, and indicate that PD reduces neither the incidence nor severity of PTSD, we must be careful not to misinterpret the practical implications of such results. These same studies have also shown that the vast majority of people who receive PD report that this intervention facilitated their recovery from acute posttraumatic distress. Since most traumatized people do not develop PTSD, one possibility is that PD is very useful for many posttraumatic survivors but not for those at greatest risk for developing PTSD. In short, whether PD is effective, what clinical outcomes should be expected, when PD should be administered, who should receive it, and whether it can prevent the later development of PTSD are still open questions.

Cognitive-Behavioral Therapy

The various forms of behavioral, cognitive, and cognitive-behavioral techniques (CBT) are the most studied interventions for PTSD. Rothbaum and colleagues (Chapters 4 and 16) concluded that CBT techniques are clearly effective. However, not all patients who receive CBT benefit from treatment, and it is yet unclear what factors predict success. First, as with any other treatment, the therapists must be trained in the various interventions that come under the heading of CBT, and some interventions (e.g., cognitive therapy) require more training than others (e.g., relaxation). Second, the treatment is demanding for both the therapist and the patient, since it requires that the therapist be disciplined and focus on employing the particular intervention rather than attend to issues that are extraneous to the treatment goals. Third, the patient needs to be motivated and able to adhere to treatment requirements, including active engagement with the treatment demands both during the session and at home. Most of the studies have been conducted in specialty clinics, where therapists are highly trained and experienced in motivating their patients to comply with treatment demands. Foa and her colleagues are conducting a study to examine the transportability of exposure therapy and cognitive therapy to community clinics that serve female survivors of rape. Preliminary results are encouraging: After 2 weeks of intensive training, counselors in those clinics are achieving outcomes comparable to those of experts. It should be noted, however, that throughout the study, the community counselors have been supervised regularly by experts in CBT.

It is important to note that the administration of CBT, like the administration of any therapy for PTSD, needs to adhere to general, responsible clinical practices such as careful assessment of suicidality that may dictate preliminary therapy (e.g., the administration of medication or short-term hospitalization). Likewise, patients inundated with personal problems may require attention for those problems before attending to their PTSD symptoms. This means that whereas some patients are ready to participate in a straight CBT protocol, others require a global treatment plan in which CBT is only one of several therapeutic components.

While several CBT studies compare the efficacy of specific interventions (e.g., cognitive therapy, exposure) and their combinations, no studies have examined the combination of CBT with other treatment approaches (e.g., pharmacotherapy, marital therapy). Most studies have only monitored relatively short-term follow-up (up to 1 year); therefore, the long-term stability of CBT effects on PTSD have not yet been established. Thus, we do not know to what extent patients require "booster sessions" in order to maintain

the treatment effects beyond 1 year. Also, because CBT programs routinely include several components, the relative contribution of each to the program success is as yet unknown. In this respect, we do not know to what extent it is crucial to focus the treatment on the recollections of the traumatic event (reliving or imaginal exposure) or on its current consequences (e.g., avoidance and negative self-perception). Finally, studies indicate that exposure therapy has modest effects on male Veterans with PTSD as compared to female assault victims. Is this differential efficacy due to gender differences, trauma differences (e.g., combat vs. sexual trauma), or does it suggest differences in PTSD severity or comorbidity? We do not have answers to these questions because information about factors that predict treatment response is scarce. Such information., however, is crucial for the clinical management of patients and decisions about treatment implementation.

It is important to note that CBT therapists routinely measure and monitor progress during therapy (e.g., by repeated evaluation of subjective distress during exposure, inspecting homework diaries during cognitive therapy). Our knowledge about all treatments would be greatly enhanced if this practice were adopted by therapists using other approaches.

Pharmacotherapy

Research has identified a number of pharmacological agents capable of significantly reducing PTSD symptoms, mainly among the antidepressants. Questions remain regarding other categories of drugs, including antiadrenergic agents, anticonvulsants, the new generation of antipsychotics, and drugs yet to be tested that normalize neuropeptide components of the human stress response. Importantly, the pharmacotherapy of PTSD, like that of most other anxiety disorders, seems capable of controlling symptoms yet does not have clear effect on the course of the disorder. In that sense, hopes for recovery, as opposed to remission, are not supported by current research. Pharmacotherapy, however, may open the way for psychological and social therapies through which the patient may gain further advantage (e.g., by challenging avoidance). It is also notable that the agents currently recommended as first-line treatment for PTSD—the selective serotonin reuptake inhibitors (SSRIs)—have other applications (such as major depression, obsessive–compulsive disorder, panic disorder, eating disorders, etc.). These, and other drugs, should therefore be considered neuromodulators rather than "antidepressants."

Among questions left open in drug therapy of PTSD is how to handle treatment resistance. Would augmentation techniques, such as the ones used in resistant depression, also work in PTSD? Another important question concerns the maintenance of treatment effects across time. As a clinician, one sees many PTSD patients who continue to take medication prescribed years

earlier. This is particularly true for drugs that induce sleep and other tranquilizers. Research on relapse following discontinuation of pharmacotherapy has been very productive in other areas of psychiatry and should be conducted for PTSD as well. Another clinical observation is that patients with PTSD are often treated with several compounds. Unfortunately, there has been no research on pharmacotherapy with more than one drug, despite the fact that polypharmacy is a common clinical practice. Clearly, this is an important future area for research.

Unlike many other disorders, PTSD has an identifiable starting point; hence, it may be amenable to preventive pharmacotherapy. Preventive pharmacotherapy, however, has not been studied (yet one is often tempted to treat a recent trauma survivor with medication; e.g., in order to reduce insomnia or intense physiological arousal). New agents are being developed, including some that affect important psychobiological abnormalities not targeted by current drugs in use, such as modulators of the "stress" axes of the brain (e.g., corticotropin-releasing factor, hypothalamic–pituitary–adrenal and locus coeruleus norepinephrine systems). The clinician should remain attentive to innovations and news in this field.

Treatment of Children and Adolescents

Most treatment modalities for adults have been tried with children, with various degrees of success and lesser degrees of evidential certainty, due to fewer systematic studies. This chapter underscores several important issues related to childhood trauma and its treatment. First, the provision of treatment to a traumatized child requires the identification of a trauma-related disorder and a help-seeking behavior by a caring adult. Yet for many traumatized children, the traumas are inflicted by the caregivers themselves or occur in an environment that may misinterpret or overlook children's symptoms. Thus, many traumatized children do not have access to treatment. Second, many studies on childhood traumatization have focused on the reactions to one-time, salient events (e.g., hurricanes, bus kidnapping), which are much less frequent than ongoing, long-term trauma associated domestic violence, abuse, or neglect. Many children are exposed to extremely traumatic events that go unnoticed for years. Chapter 6 focuses on treatment of children whose traumatic experiences have ended before the start of treatment (because research with children has emphasized such traumas). We have very little data on the efficacy of interventions for the child who is exposed to ongoing traumas. Finally, developmental arrest, personality changes, and incubation of future vulnerabilities may be frequent consequences of childhood trauma that are as clinically significant as overt PTSD symptoms. Unfortunately, little is known about the incidence, prevalence, prevention, or treatment of such consequences.

Eye Movement Desensitization and Reprocessing

Research suggest that EMDR is more effective than wait-list controls and techniques such as applied muscle relaxation and standard clinical care at a health maintenance organization (HMO) clinic. However, as noted in Table 6.1 of Chapter 6, most of the existing studies suffer from methodological problems that limit the interpretation of their results. Of particular concern is the absence of a blind, independent assessor in all but one study, and the absence of PTSD diagnosis in many of the studies' patients. The efficacy of EMDR relative to CBT has been examined in only one study, indicating the superiority of the latter (see Chapter 4). Several studies comparing the efficacy of exposure therapy (the most investigated psychosocial treatment for PTSD) and EMDR are being conducted, and their results will certainly advance our knowledge in this area. Such studies are of particular theoretical and practical interest because EMDR, as well as most of the studied CBT programs, included a variant of exposure to the traumatic memory. It is of value to know to what extent such exposure is a necessary component of an effective treatment for PTSD and whether the length of exposure (prolonged vs. interrupted) influences therapeutic outcome.

It is important to note that several of the eight stages of EMDR include components that overlap with other therapies, such as obtaining a patient's history, treatment planning, establishing a therapeutic relationship, education about PTSD, assessment, identifying maladaptive and adaptive cognitions, and imaging the traumatic memory. At the same time, as noted in Chapter 7, the studies evaluating the role of the unique component of EMDR (i.e., the eye movements) failed to find this component an essential ingredient of the treatment. Future studies will further shed light on this issue.

In summary, research suggests that EMDR is an effective treatment for PTSD. Whether its efficacy stems from the fact that it is yet another variant of exposure therapy (with some ingredients of cognitive therapy) or that it is based on new principles is unclear.

Group Therapy

Interestingly, studies of the efficacy of group psychotherapy seem to indicate that interventions addressing the trauma directly produce similar effects to those of interventions that do not address the trauma, such as assertive training and supportive interventions: All active group interventions yielded significant improvement relative to no-treatment or wait-list controls. Moreover, similar effect size was evident across group therapies despite major differences in outcome measures. As noted by the authors of Chapter 8, "Group psychotherapy, regardless of the nature of the therapy, is associated with favorable outcomes in a range of symptom domains" (p. 168). If true, does group therapy act via nonspecific effects? Or is group therapy, of any sort, particularly useful in PTSD because it provides a unique format in which individuals can normalize their posttraumatic distress, receive social support through the group process, and acquire the empowerment needed to overcome the adverse consequences of their symptoms?

Aware of these issues, the authors of Chapter 8 suggest that future research should evaluate specific group processes in controlled studies with larger samples, in which patients are randomly assigned to different conditions. Such studies are likely to inform us about the extent to which generic aspects of group processes, such as verbalizing, sharing, providing and receiving support, and structuring communication, are responsible for the across-the-board positive outcome found in the various studies.

Psychodynamic Therapy

Chapter 9 provides a thoughtful review of theory and treatment techniques. In this way, it allows the reader to reflect on the role of basic interpersonal processes and interaction between therapist and patient in the treatment of PTSD. Indeed, one of the strengths of the psychodynamic approach is its focus on generic elements of therapeutic encounters, including therapy for PTSD. On the other hand, there is very little empirical research on the efficacy of psychodynamic treatment for PTSD. This is partly due to the fact that typical goals of psychodynamically oriented psychotherapy are to affect factors such as the capacity for human relatedness or one's incomplete view of one's past rather than reduction of symptoms of specific disorders such as PTSD (which is the aim of therapies such as CBT and medication), for which we do not have satisfactory assessment methodology. Given the current emphasis of the practice guidelines on PTSD, Chapter 9 does not focus on those patients for whom such therapies might provide the best approach: the repeatedly traumatized, deeply injured, and chronically impaired survivors of protracted interpersonal trauma, sometimes diagnosed with "complex PTSD." Such patients' most salient problems have less to do with DSM-IV PTSD symptoms and more to do with interpersonal and intrapsychic deficiencies, mistrust of others, self-devaluation, dissociation, somatization, impulsivity, self-destructive behavior, and poor affective modulation. It should be clearly stated, therefore, that the effectiveness of psychodynamic psychotherapies for "complex PTSD" and related problems is simply not addressed in this book. This is yet another, open question requiring further research.

Inpatient Treatment

Inpatient treatment, rather than being a form of treatment, is a setting and a milieu within which many forms of therapy can be provided to handle crisis situations. It is often, therefore, a "platform" used for the treatment of acute

episodes or exacerbation related to the course of PTSD and comorbid disorders. Moreover, those who require inpatient admission are often the most severe cases of PTSD, whose conditions need to be stabilized before specific interventions can take place. As such, the expected outcome of inpatient admission is not limited to "treating PTSD" but often extends to comorbid conditions, adverse social behavior, homelessness, and social drift (Shalev, 1997). Indeed, inpatient interventions are not treatments unto themselves but serve a specific function in the longitudinal course of ongoing outpatient therapy. This function may be for crisis intervention, relapse prevention, diagnostic reassessment, or a specific set of intense procedures designed to inform or accelerate resumption of postdischarge treatment. At its best, inpatient treatment should be carefully coordinated with outpatient therapy, and discharge planning should be initiated as soon as possible after admission. Improvements on some PTSD outcome indices have been noted in some reports of inpatient admissions, yet, in general, such assessments have not been systematically carried out utilizing instruments with satisfactory psychometric properties.

Little is known about deliberate and planned inpatient admissions designed to intensely address PTSD symptoms, or to engage the patient in pharmaco- or psychotherapy in this setting. Nor do we know much about how to ensure continuity of care between inpatient and outpatient treatment, which may be important in securing the long-term success of inpatient treatment. These are all important questions that have had little systematic evaluation. It should be noted, however, that such interventions have recently been provided successfully to inpatient cohorts of Australian Vietnam veterans hospitalized at the Australian Department of Veterans Affairs Center for War-Related PTSD (Creamer, Morris, Biddle, & Elliott, 1999), with more positive results.

Psychosocial Rehabilitation

Psychosocial rehabilitation techniques have proved valuable with severe mentally ill (SMI) patients, especially with regard to work therapy and case management. Indeed, an emerging empirical literature demonstrates the efficacy of such approaches with schizophrenic and affectively disordered patients in a variety of public-sector programs. Since PTSD is often a comorbid disorder for such patients (Mueser et al., 1998), and since severe and chronic PTSD patients are often found among SMI cohorts and in homeless shelters (Friedman & Rosenheck, 1996), it makes sense to design and test psychosocial rehabilitation programs. Such treatments would have some distinctive therapeutic components given the unique social avoidance, hyperarousal, and other psychopathology of PTSD in comparison to other psychiatric disorders. Most importantly, patients referred for such treatment would be evaluated primarily in terms of self-care, independent living, family function, social skills, and maintenance of gainful employment, rather than in terms of reduced PTSD symptoms. We hope that these specific areas will be evaluated systematically and that rehabilitation techniques specific to PTSD-related impairments will be developed and studied.

Hypnosis

As noted in Chapter 12, hypnosis is one of the oldest psychotherapy techniques that have been applied to trauma-related disturbances. This rich history makes hypnosis a natural candidate when the therapist considers therapeutic options. Yet despite this fascinating history on which the authors rely in their clear description of how to integrate hypnosis into the general treatment of PTSD, we have very little empirical evidence for the efficacy of this technique. The authors recommend hypnosis as an adjunctive procedure rather than as a stand-alone treatment; this, too, awaits empirical support.

Marital and Family Therapy

Marital and family therapy for PTSD encompasses two approaches: supportive and active (or "systemic"). One problem with assessing family therapy for PTSD is that reduction in PTSD symptoms may not be the appropriate outcome measure for this therapy. While PTSD-related distress may be alleviated when family relationships improve, such an outcome is not specific to PTSD and can be seen in other disorders such as schizophrenia.

The impact of PTSD on families is extensive. Treating vicarious traumatization of family members, therefore, may be very important. On the other hand, family therapy that focuses primarily on the PTSD sufferer, without fortifying the family, may not address other family members' needs for support. It would seem that there is a critical role for marital and family therapy that attempts to achieve a clinically meaningful balance between addressing dysfunctional symptoms and behavior of the PTSD patient and the distress of family members whose needs also require attention. This is a very important area for future research.

Creative Therapies

As with hypnosis, rehabilitation, and marital and family therapies, creative arts therapies address important dimensions of PTSD and may often be effective during impasses that other treatment techniques fail to affect. The reader, therefore, is invited to consider the information provided about these techniques and their specific targets, as these may apply for his or her patients. Better efficacy on PTSD symptoms may be achieved once a breakthrough is attained via creative arts therapies. Interestingly, creative arts therapies do not escape from the typical problems of treating PTSD, that is, the

balance between addressing current problems (e.g., alexithymia) or delving into past trauma, and between uncovering and reshaping traumatic material and finding new, "future-oriented" ways of expression. While the techniques described in Chapter 14 may capture the imagination of the therapist, it is important to keep in mind that, as with many other therapies discussed in this volume, empirical evidence for the efficacy of creative arts therapies with PTSD and other related symptoms is not available.

Now that we have briefly reviewed the chapters on each specific treatment emphasized the importance of defining relevant and achievable goals at the outset of treatment, and described dimensions of therapy that cut across specific treatment approaches, we are ready to tackle the key questions enunciated at the beginning of this chapter. Here, there are very few experimental data to guide our answers. But practicing clinicians cannot wait for slow-paced scientific research to come to the rescue. Patients suffering from PTSD demand treatment immediately. Decisions must be made about choice of treatment, treatment combinations, reasonable expectations from treatment, length of treatment and follow-up, PTSD-specific treatment issues that cut across treatment modalities, how to approach complex clinical pictures and comorbid conditions, how to make sense of clinical difficulties and, most importantly, how to assess failure.

CHOOSING A GOAL FOR TREATMENT

As noted earlier, the choice of treatment should be informed by the patient's needs, abilities, and preferences. The first step in making a decision about choice of treatment involves defining the treatment goals and considering whether or not they are obtainable. With most patients, PTSD symptoms will be among the main targets. But in some patients, comorbid symptoms and conduct may need to be addressed first. For many patients, symptom reduction is the major focus of treatment. For some, however, stabilization and prevention of relapse may take precedence. In some cases, the initial goal of treatment is to help patients realize that they need to address their PTSD problems by seeking psychological or medical treatment (e.g., instead of drinking or acting out). For others, stressful life events or adverse life conditions may have to be addressed first, in order to bring reactivation or deterioration of PTSD to a halt. Finally, while the patients themselves are the identified focus, treatment may need to involve other individuals, such as family members and others who are reciprocally involved in a significant relationship that has been adversely affected by the expression of PTSD symptoms.

- ***How should one choose among treatment modalities?*** Currently, there are no clear guidelines for choosing among treatment modalities. However, several criteria for making such choices can be recommended. Among those, expected efficacy should be the first one, since without such efficacy, the core concept of "treatment" is violated. That is why this practice guideline has placed such emphasis on efficacy throughout this volume. Following efficacy, one should evaluate the effectiveness of specific treatments on associated disorders and conditions. Potential difficulties, side effects, and negative effects of treatment must also be considered. Acceptability and consent should come next, followed by an evaluation of cost, length, and cultural appropriateness of the treatment. Finally, one should evaluate one's own resources and skills, as well as potential forensic implications of treatment. These general considerations have special implications for the treatment of traumatized survivors with PTSD.

Criteria for choosing treatment of PTSD

- Expected efficacy against PTSD
- Associated disorders and conditions
- Difficulties, side effects, negative effects
- Acceptability and consent
- Cultural appropriateness
- Length, cost, and availability of resources
- Legal, administrative, and forensic implications

Efficacy, as used here, relates specifically to prevention, amelioration, or eradication of PTSD symptoms. All things being equal, the treatment selected should be one that has proven successful in empirical trials.

Associated disorders and conditions relate to all or some dimensions and associated features of PTSD, such as depression, suicidality, violent behavior, or drinking habits. In some cases, treatment may have to stabilize an unstable condition (or patient) to prevent adverse events (loss of job) or conduct (drinking) before addressing PTSD per se. For example, suicidal behavior may require hospitalization; alcohol dependence, detoxification; depression, antidepressant medication; and marital disruption, couple therapy. Whenever possible, it is desirable to select a treatment that might be expected to ameliorate the urgent problem and the PTSD simultaneously. For example, an SSRI would be a good choice for both depression and PTSD. Systemic marital therapy might address the marital crisis and PTSD simultaneously. Hospitalization would be indicated for suicidal symptoms but might also provide an opportunity to initiate PTSD treatment. And combined alcoholism/PTSD group treatment might be the best choice when drinking behavior is the most urgent problem.

Side effects include those effects pertinent to each treatment technique (e.g., loss of appetite with some drugs) as well as those pertinent to PTSD (e.g., reactivation of symptoms during explorative therapy). Difficulties, side

effects, and negative effects may also result from interactions between therapists and traumatized patients. One should remember that PTSD is associated with increased physiological and psychological reactivity, which can be specific (e.g., related to one's traumatic experiences) or nonspecific (e.g., generated by environmental demands).

Contrasting with prevalent views, *acceptability* and *consent* are neither categorical (yes or no) nor a priori statements given by the patient at the outset of therapy. Acceptability and consent, particularly in PTSD, are dynamic processes that are often fragile and brittle. Trust may have to be renewed, or regained, explicitly or implicitly, at each treatment encounter, particularly in survivors of dehumanizing, man-made traumata. Furthermore, patient preference must be weighed carefully in the choice of treatment. For example., some patients may be strongly opposed to any type of trauma focus (e.g., exposure) treatment that will necessitate intense work on traumatic memories. Others may refuse to take medications. In both cases, therapists' beliefs about what treatments are best must be subordinated to the likelihood that a patient will accept and comply with the treatment that has been prescribed. Acceptability across *cultural boundaries* is particularly relevant in the case of refugees, who may or may not be prepared to accept the way in which their suffering is appraised and treated in another culture (e.g., as a mental disorder). Cross-gender problems may be seen in survivors of gender-related traumata. Indeed, many trauma survivors may wonder how much their therapist can "truly understand" and genuinely relate to their traumatic experiences, which they often perceive as ineffable.

Conceptually, issues of *cost* and *availability of resources* are extremely important in many societies, especially in poorer nations and in inner-city ghettos within wealthier nations. The cost of some SSRIs may be prohibitive in Third-World countries and poor provinces. The likelihood of finding a skilled psychologist or psychiatrist is very low in disaster areas in Africa or in Central and South America. Child psychiatrists are rare across the world. Indeed, in any mass disaster, the number of victims is likely to overwhelm the best efforts to provide skilled professional help. While such shortages may exist in other conditions as well (e.g., AIDS), there are currently no simplified treatment protocols for PTSD, such as, for example, those emerging for the prevention of AIDS in poorer countries. The development of low-cost treatment for traumatized survivors with PTSD is a major task for the future of our field.

Finally, for many traumatized individuals, *legal, administrative,* or *forensic* elements are likely to be (or to become) associated with the treatment. Prevalent examples are litigation, financial coverage for the treatment, recognition of disability and entitlement for pension, reparations, and/or compensation. There are many ways in which such elements can be linked with, or affect, the conduct of treatment and its expected outcome. Therapists should identify such issues and make their implications for therapy explicit in each individual case.

• ***What to expect from treatment and how to define realistic goals?*** Given the variety of expected outcomes, it is important to clearly define specific goals for the treatment of PTSD and share these goals with the patient. Treatment goals should, first of all, be *realistic* (i.e., both desirable and obtainable). In most cases, a reduction of PTSD symptoms will be among the central targets, but clinicians should be aware of the effect size of each therapy as a boundary to expectations. In other cases, comorbid symptoms and behaviors may take precedence. In some instances, stabilization and prevention of relapse is paramount. Sometimes, a preliminary goal should be set, such as getting the patient to choose psychological or medical treatment instead of, for example, isolation, drinking, or acting out. Other times, current stressors and life events may have to be addressed first (e.g., in order to bring a reactivation to an end). Finally, significant others whose distress, conduct, or attitudes are associated with the patient's condition may join the treatment. In general, one may recommend to see the therapy of PTSD as *oriented toward changing behavior, rather than symptoms.*

In all instances, treatment goals should be *predefined, adhered to,* and *evaluated,* such that if one treatment modality fails, this can be acknowledged, the causes sought out, and alternatives offered. The need to tie treatment techniques to desired goals is of paramount importance, as presented in the various chapters within this practice guideline. When empirical evidence is missing, it becomes a matter of clinical wisdom to choose the right tool. Such choices should be *explicit,* based on information contained in each of the book chapters, *patient-oriented,* and *flexible.* Given PTSD's chronic course, attention should be given to long-term goals, for which continuity of care and the right sequencing of interventions is mandatory.

• ***How can one combine various treatment techniques?*** Combined treatments are the rule rather than exception for PTSD, despite the fact that there is very few empirical data support this practice. Indeed, in one of the few studies pertinent to this question, Foa and associates (1991) found that both psychological exposure and stress inoculation therapy (SIT) had better outcomes than a combined approach in which rape survivors received both prolonged exposure and SIT concurrently. Although this provocative result raises as many questions as it answers (e.g., would the prolonged exposure and SIT combination have proven superior had treatment been extended beyond the brief, 9-week experimental protocol?), it clearly shows that combined treatments demand systematic evaluation in rigorous clinical trials. In practice, most CBT approaches combine several different modalities, as do most pharmacotherapeutic approaches in which PTSD patients frequently receive two or more different types of drugs. Another common clinical occurrence is that many PTSD patients who receive some sort of individual psychotherapy also receive at least one medication. Such patients may receive group, marital, or family therapy, in addition to individual psychothera-

py and drug treatment. Although there are generally good clinical indications for prescribing combined treatments, we must recognize that such clinical practices must eventually be tested in rigorous experimental protocols.

An etiological treatment approach postulates that given the complex psychological, biological, and social abnormalities associated with this disorder, it is not unreasonable to consider different therapeutic approaches to target different symptoms. Such an approach sees each (e.g., individual, drug, group, etc.) treatment as complementary and of equal value. On the other hand, a pragmatic rationale for combining treatments might consider individual psychotherapy the major vehicle for improvement, with other treatments playing an adjunctive role (e.g., pharmacotherapy reducing intrusion or arousal symptoms so that individual psychotherapy can progress; or couple therapy keeping social support intact so that psychotherapy will not be disrupted by a marital crisis).

The lack of empirical evidence supporting combined approaches should not be interpreted as evidence against the efficacy of such treatments. Given the importance of this issue and the widespread prevalence of combined PTSD treatment in current clinical practice, we strongly recommend that treatments be introduced one at a time. After the therapist has chosen (and the patient has accepted) a specific initial treatment, there must be an adequate clinical trial of this approach to determine its effectiveness. If clinical goals are achieved, there is no need for additional treatments. If treatment is ineffective, or if it produces intolerable side effects, it must be discontinued and a different approach initiated. In the usual clinical scenario, however, patients achieve enough improvement to suggest that the initial treatment was effective but insufficient improvement to be satisfied with the results. This is the time to introduce a second treatment, while maintaining the first treatment as initially prescribed. Again, treatment success (or failure) will be determined if predefined goals have been achieved. If so, efforts should be made to reduce or terminate the first treatment, since it may have been superceded by the more potent, second treatment.

A common problem is that once started, a treatment may be maintained indefinitely even though its usefulness is questionable. We believe that combined treatments probably have a very important place in PTSD treatment and must be clarified by future research. We also believe that any treatment, combined or not, should be evaluated periodically to ensure that it is still needed to maintain desirable clinical outcomes.

• ***How to approach complex clinical pictures and comorbid conditions?*** We have already discussed complex clinical conditions in which psychiatric crises must be addressed before initiating treatment for PTSD. These include suicidal behavior, alcohol dependence, incapacitating depression, and marital disruption (see the section on choosing treatment for PTSD). We have also discussed combined treatments in which two or more clinical approaches have been prescribed for PTSD. These two issues must be reconsidered when PTSD is associated with at least one comorbid psychiatric disorder. This is a very common challenge in the diagnosis and treatment of PTSD, since 80% of all PTSD patients will have had at least one other DSM-IV Axis I psychiatric disorder in the course of their lives (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Most commonly, PTSD is associated with comorbid affective (e.g., depression, dysthymia) or anxiety (panic, social phobia, obsessive–compulsive) disorders or alcohol/drug abuse/dependency. In addition, the high prevalence of PTSD among severely mentally ill patients with schizophrenia and chronic affective illness is beginning to be recognized (Mueser et al., 1998). Finally, comorbid personality, and dissociative and somatoform disorders (often associated with prolonged childhood trauma) are another treatment challenge frequently seen in clinical practice.

As with so many important clinical questions under discussion, there are no empirical data to guide recommendations for treating PTSD associated with comorbid conditions. On the other hand, there is a rich empirical literature on treatment of many of these comorbid conditions themselves (e.g., depression, panic disorder, OCD, etc.). Therefore, we draw on such clinical findings in order to make a few suggestions.

The efficacy of pharmacotherapy for affective disorders, panic, social phobia, OCD, and schizophrenia is well-established. Cognitive-behavioral treatment is also very effective in depression and the aforementioned anxiety disorders. Finally, detoxification and a variety of alcohol/drug rehabilitation protocols are widely available. In short, empirical support for the efficacy of treatments for the DSM-IV Axis I disorders most frequently comorbid with PTSD is generally stronger than support for treatment of PTSD itself. This is at least partly due to the fact that clinical trials in PTSD have only been carried out during the past 10–15 years, whereas treatment research for these comorbid disorders has extended over a much longer time frame.

There are several ways to design a treatment plan when PTSD is associated with a comorbid disorder. Given the dictum "less is more," pharmacotherapists and CBT practitioners should start with a single treatment that might be expected to normalize both disorders simultaneously. For example, an SSRI would appear to be a logical first choice when PTSD is comorbid with depression, panic disorder, or OCD. Similarly, a CBT protocol for PTSD could incorporate specific modules that address panic, social phobia, and OCD. CBT can also incorporate relapse prevention components (Foy, Ruzek, Glynn, Riney, & Gusman, 1997) to address alcohol/drug abuse/dependency. Finally, we recommend simultaneous treatment of PTSD and comorbid chemical abuse/dependency (Kofoed, Friedman, & Peck, 1993) rather than the conventional approach, in which they are treated sequentially, usually starting with detoxification and alcohol/drug rehabilitation before progressing to PTSD treatment (except in extreme cases when the severity of addiction or chemical dependency makes PTSD treatment impossible).

These guidelines do not apply when the therapist's choice of PTSD treatment is without proven efficacy with the comorbid disorder. Indeed, if the preferred approach is EMDR, psychodynamic, group, or marital therapy, a separate treatment must be prescribed for the comorbid disorder. If the comorbid disorder is the first order of business because of urgency or severity, it must be addressed before PTSI) treatment can begin. For example, if PTSD is comorbid with severe depression, antidepressant medication might be the best initial step. PTSD treatment should be delayed until depressive symptoms are under control. At that point, EMDR, psychodynamic, group, or marital therapy can be initiated. As detailed previously (see the section on combined treatments), we recommend that all treatments (whether for the comorbid disorder or for PTSD) be introduced one at a time and be given an adequate clinical trial before adding or discontinuing other treatments. We also reiterate our recommendation that all treatments (for PTSD as well as for comorbid disorders) be evaluated periodically to ensure that they are still needed to maintain desirable clinical outcomes.

• ***How long should a treatment be followed?*** We know very little about long-term maintenance of favorable treatment outcomes for two major reasons: because we lack the relevant scientific data, and because of the nature of PTSD itself. First, with few exceptions, most posttreatment outcome studies rarely monitor clinical status beyond 6 months. Clearly, long-term research is needed to help us develop reasonable expectations for longitudinal maintenance of therapeutic gains. With regard to pharmacotherapy, the classic research design is a discontinuation study in which successfully medicated patients are randomized to a placebo or continuation drug condition to determine relapse rates with and without treatment over a long follow-up period. With regard to CBT, EMDR, and other time-limited psychotherapies, the operative questions are (1) how long can the beneficial outcomes from treatment be sustained; and (2) can treatment benefits be fortified by periodic booster sessions, and, if so, how often and for how tong should such booster sessions be scheduled?

Second, people who have recovered from an episode of PTSD are at greater risk for subsequent episodes if exposed to traumatic or trauma-related stimuli in the future. It is our hope that the coping skills acquired from psychotherapy will make individuals less vulnerable to future relapse than people with PTSD who have not received such treatment. An important focus for the future, therefore, must be to design interventions that will foster resilience and prevent relapse. In the long run, such treatments will be much more valuable than approaches limited to amelioration of current symptomatology.

• ***Are there features of PTSD that require special attention beyond the active ingredient of treatment?*** No matter what treatment or combination of treatments seem best, there are several unique features of PTSD that diagnosticians and therapists must keep in mind. The initial assessment must be approached cautiously, since patients are asked to retrieve and relate traumatic memories against which they have developed a wide variety of cognitive, emotional, and behavioral defenses. Clinicians must respect such defenses, establish an atmosphere of trust and security, and show patience as reluctant patients' traumatic narratives unfold. The understandable ambivalence exhibited by PTSD patients between their desire for symptom relief and their fear that therapy, itself, will be toxic, by reexposing them to into intolerable thoughts, memories, and feelings, is the usual context in which the therapeutic contract must be negotiated. Realistic treatment goals must be carefully discussed. The staging and pace of treatment must be carefully considered. For severe and chronic PTSD, especially when associated with protracted trauma (as in childhood sexual abuse), it is often necessary to evaluate issues of safety and security in the home environment as well as in the therapist's office. For example, trauma-focused psychotherapy is not advisable for patients who continue to be traumatized (e.g., because of ongoing domestic violence or physical/sexual abuse). In such cases, the initial phase of treatment is the establishment of safety and security. It is only after this has been achieved that exposure or some other trauma-focused treatment can be initiated. It is important to remember in this regard that, for reasons addressed previously, trauma-focused treatment is not necessarily the treatment of choice for everyone.

Trust is an important concern for all PTSD patients, so therapists must demonstrate trustworthiness as well as professional competence. Negotiating a therapeutic contract that clearly specifies the process, time frame, and goals of treatment is one way to accomplish this. Another way is to avoid making promises that may be difficult to keep. For example, one should never promise a full recovery, since it is unlikely to occur and the risk of relapse is an ever-present possibility, even following complete remission of symptoms. This is another way to build trust, establish credibility, and generate appropriate expectations.

Attention to these matters is a prerequisite for any effective therapeutic alliance with PTSD patients.

• ***How to understand treatment resistance and failure?*** As with many mental disorders, PTSD, particularly in its chronic phase, is often resistant to treatment. Despite repeated descriptions of difficulties and poor treatment outcomes in PTSD, *treatment resistance* is poorly defined for this disorder. Specifically, the following questions have not received convincing answers: Which treatments are being "resisted," which symptoms are particularly tenacious, when is it clear that a treatment is ineffective, and what should by done in such case (e.g., add more treatment, change dose, or start a new therapeutic approach)? These questions are especially difficult to answer

because of the heterogeneity of treatment approaches to PTSD and traumatized populations (e.g., survivors of prolonged atrocities, along with survivors of short incidents).

It is not surprising, therefore, in more recent studies (e.g., Davidson et al., 1998) to find not only larger effect size of treatment but also an unexpected placebo response. At the same time, CBT has proven effective with a variety of PTSD patients, including those with prolonged PTSD. With the advent of specific treatment protocols, better quantification of outcome, and delivery of treatment to larger numbers of individuals, treatment resistance might be better described.

For the time being, the known reasons for treatment resistance in PTSD include those seen in other disorders (e.g., chronicity, comorbidity, poor compliance, adverse life circumstances), along with more specific, yet poorly explored reasons (e.g., extreme or repeated traumatization, traumatization during critical developmental stages, etc.). No clear guidelines can be given to clinicians who encounter treatment resistance in their patients except to use their clinical wisdom to probe and eventually improve their approach to the patient, to find out what could have gone wrong (too fast or too slow an exploration, incomplete mapping of current life stressors, lack of home practice, over- or underdosage of medication), and to use the variety of options offered in this book to refine and enrich their versatility as therapists.

CONCLUSION

These practice guidelines are a work in progress. Although there has been considerably more research on CBT, pharmacotherapy, and EMDR than other treatments, on balance, we know relatively little about PTSD monotherapy and next to nothing about combined treatment approaches. The good news is the rapid growth of rigorous clinical research in recent years. Indeed, we fully expect that many questions posed throughout this book will have solid empirical answers within the foreseeable future. Until that time, we hope that the analyses of treatment research and recommendations by experts within this practice guideline will assist clinicians in the trenches and promote more effective treatment of PTSD.

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