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# PTSD AND PSYCHOTHERAPY

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**The majority of patients treated with psychotherapy for PTSD in randomized trials recover or improve. However, several of them continue to have residual symptoms or may even get worse over time. Commonly used therapeutic approaches, particularly cognitive behavioural therapy (CBT), may only provide 'short fixes' that ignore the underlying problems. To deal with the trauma permanently requires integrating the memory of it internally. This usually means making sense of it in a helpful and constructive way.**

Keywords: PTSD, trauma, psychotherapy, treatment

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## Introduction

Posttraumatic stress disorder (PTSD) is one of the most prevalent axis I disorders [1], where psychotherapy is usually a treatment of choice. Concurrent medication can be supportive, but to ‘resolve’ the trauma a psychotherapeutic approach is usually needed. The psychotherapy research literature has focused primarily on cognitive behavior therapy approaches, particularly exposure and cognitive restructuring, and eye movement desensitization and reprocessing (EMDR). This is unfortunate, because psychotherapy works as a communication process, and excluding more communication oriented therapies gives only a limited view on what is possible with psychotherapy.

The missing follow-up studies at extended intervals are of concern when judging the effectiveness of a therapy, given that PTSD is generally a disorder of long duration and frequently co-occurs with many other such disorders. Studies that look at long-term improvements over one to two years are mostly non-existent. Also, there is little information on the progress after therapy. This can lead to the mistaken impression that patients who spontaneously remitted or sought other forms of treatment following an

unsuccessful or partially successful treatment were treatment successes, or that those who initially improved or recovered did not experience a return of symptoms.

## Exposure Therapy

Exposure therapy includes confrontation of memories of the trauma or cues (“triggers”) related to the traumatic event. Exposure therapy is based on the principle of respondent conditioning often termed Pavlovian extinction. The exposure therapist identifies the cognitions, emotions and physiological arousal that accompany a fear-inducing stimulus and then tries to break the pattern of escape that maintains the fear and/or other ‘negative’ emotions. This is done by exposing the patient to progressively stronger fear-inducing stimuli. Usually, techniques are taught which help the patient lower the emotional response and regain a sense of control.

The problems with exposure therapy are manifold. An obvious one is that it requires confronting the image of the traumatizing event, whether internally or externally. Another problem is the “normalization of the trauma”. Extinction of the fears or anxieties mean getting used to the trauma. But no one is supposed to get used to a trauma, that is why it is called a trauma. However, the maybe most serious problem is probably that the successes of exposure therapy frequently unravel over time and do not last.

The limits of exposure therapy are that what happened is never integrated into the individual’s concept of the world and himself or herself in a meaningful way. The effect of a trauma is cured with a change in perspective, even if it is only minuscule, but in the exposure process this can never occur. Meaningful change requires that the individual can make sense of the trauma in a way that strengthens and provides solid grounding to the self.

## Skill Training

Cognitive behavior therapy approaches, other than exposure therapy, focus on developing skills for anxiety management or challenging distorted cognitions. Another treatment approach is eye movement

desensitization and reprocessing (EMDR) [2], in which the patient is asked to develop a mental image of a traumatic event and related negative cognitions while tracking a bilateral stimulus.

The mechanisms of action are largely unknown, although likely possibilities include exposure, other cognitive behavior therapy-like interventions (e.g., choosing and altering a negative belief about the self), and accessing of associative networks as in psychodynamic psychotherapy [3][4]. Reviews and meta-analyses have supported the efficacy of psychotherapy for PTSD, particularly cognitive behavior therapy and, more recently, eye movement desensitization and reprocessing [5][6][7][8][9]. One reason why research has focused strongly on CBT and exposure therapy is that these therapies lend themselves more easily to manualization than other therapies, at least at the present moment, because they require the least information about the interaction between therapist and patient, which adds higher complexity in interpersonal and psychodynamic approaches. But it may well be the decoding of this complexity, which ultimately brings about more permanent therapeutic successes, because it has been known for over a century that the effect of psychotherapy happens in the dynamic between individuals.

## Individual Differences

Although the short-term treatments tested in clinical trials (primarily cognitive behavior therapy) are clearly effective in reducing PTSD symptoms, research has yet to delineate clearly which patients are most likely to respond. Research on prognostic factors is limited, with different studies often finding different predictors [10][11][12][13][14]. Of particular interest from a clinical standpoint is comorbidity, which is the rule rather than the exception in PTSD.

## Type of Trauma

Consistent with previous reviews and research [56][57], treatments for combat-related PTSD showed the lowest effect sizes. These findings could have multiple explanations, including a greater severity of pathology of veterans who seek treatment at Veterans Administration hospitals, and the tendency to limit

disclosure upon returning home, which limits opportunities for both exposure and social support. There may also be a potential for secondary gains, including disability-based income.

Similar to the problem of reporting comorbidity, few studies report data on complete trauma history, which is problematic in light of research suggesting that history of prior or multiple traumatic events affects severity of PTSD and response to subsequent traumas [58]. Often in research, there is only mention of broad categories rather than the specific circumstances of the trauma.

## Co-Morbidity

Studying PTSD in an urban population, Breslau and colleagues [15] reported that 83% of individuals with PTSD met criteria for one or more other disorders. The most common comorbid conditions include depression, substance abuse, and other anxiety disorders [1][15]. Patients with PTSD are also frequently comorbid for axis II disorders and vice versa. For example, Yen et al. [16] found a 35% lifetime prevalence of PTSD among patients with personality disorders who reported any traumatic event and also found an association between severity of traumatic exposure and severity of personality disorder. Despite these high rates of comorbidity, empirical research addressing treatment effectiveness for patients presenting with specific patterns of comorbidity is sparse.

A treatment that produces an initial response, or a response that holds for 3 to 6 months after termination, may or may not be an efficacious treatment for a disorder such as PTSD, which tends to be longstanding.

A multidimensional meta-analytic approach has the advantage of calling attention to a number of nuances that may qualify conclusions about outcome or generalizability.

exclusion criteria, comorbidity, type of trauma, criteria for successful outcome, follow-up data, and differential efficacy of specific treatments. It is worth noting that many of these issues are not specific to the PTSD literature and are equally applicable to psychotherapy and pharmacotherapy research for many disorders.

Clinical trials for PTSD have excluded roughly 30% of patients referred for treatment. This exclusion rate is lower than exclusion rates in controlled trials for many other disorders, such as depression [17]. Nevertheless, it raises questions about generalizability to the population of patients treated for PTSD in the community because it is likely an underestimate. In many cases we were unable to determine the extent of prescreening either by telephone or by criteria given to potential referral sources. Our preliminary finding of a positive relationship between number of exclusion criteria and outcome suggests caution in unqualified generalizations about treatment of choice for patients with PTSD, who are a very heterogeneous group [50].

The lack of systematic data on axis I and axis II comorbidity also makes it difficult to specify for which patients the research literature is likely to apply. Overall, data are more available on axis I than axis II comorbidity, although few studies have focused on the potential impact of comorbidity or have had adequate power to detect moderators of outcome.

The treatment guidelines from the International Society for Traumatic Stress Studies [51] essentially concur regarding the lack of adequate empirical data to guide treatments for comorbid disorders and suggest the possibility of adding modules to cognitive behavior therapy approaches to address specific forms of comorbidity.

Although this may prove to be an effective strategy, it relies on the assumption that disorders are relatively independent of one another and hence can be understood using an essentially additive model of comorbidity, a model that is not supported by basic science research on PTSD or other psychiatric disorders [52]. Although most studies did not exclude patients with axis II comorbidity, the common confluence of exclusion criteria for suicide risk and substance abuse/dependence is likely to exclude many patients with borderline features, the presence of which may or may not moderate treatment outcome [53][54].

There is a lack of studies addressing the issue of treatment of PTSD with comorbid psychotic symptoms, despite research indicating that PTSD and psychotic symptoms commonly co-occur [55]. Ruling out psychosis is also not always a simple matter in patients with severe or complex PTSD.

It is unknown whether the tendency of clinicians in community settings not to use empirically supported therapies such as exposure for PTSD reflects a lack of familiarity with the outcome data or the difficulty

of applying such treatments to the polysymptomatic patients that are the norm in everyday practice. At this point, however, we would offer three suggestions for future research (which apply to treatment research for virtually all disorders [52]). First, researchers should take much more care in both detailing and justifying exclusion criteria and procedures (e.g., specifying information given to potential referral sources and the number of patients included/excluded at each stage). Second, future studies should impose only those exclusion criteria that are medically necessary or that a reasonable clinician in practice would impose (e.g., organic brain disorders, schizophrenia) and use correlational analyses to identify potential moderators of treatment response. Rather than excluding patients with suicidality for ethical or other reasons, researchers need to build into their treatment protocols contingencies for treating suicidality in PTSD patients, given that suicidality is not an infrequent symptom in PTSD patients.

Third, to the extent that researchers exclude patients with co-occurring conditions such as substance abuse, they need to state clearly the population of patients to whom they expect the results to generalize.

## Criteria for Successful Outcome

Although we attempted to meta-analyze success and recovery, we could do so only very imperfectly because of two related problems. The first is the ambiguous meaning of no longer meeting PTSD criteria after treatment, given that a higher percentage of patients lost the PTSD diagnosis than demonstrated investigator-defined improvement, a situation very different from treatments of many other disorders [17][18], where substantially more patients improve than fully recover. The ambiguity reflects the fact that patients can fall below diagnostic thresholds by changing only one or two symptoms while remaining highly symptomatic. Indeed, nearly 40% of supportive therapy comparison subjects who completed treatment no longer met criteria for PTSD, and raw posttreatment scores for patients in active conditions indicated substantial residual symptoms. Several recent studies find that subthreshold PTSD is associated with significant impairment in work and social functioning as well as suicide attempts [59][60], underscoring the importance of clarifying and achieving consensus on standards for improvement and recovery across studies.

## Differential Efficacy

We did not find support for differential efficacy across cognitive behavior treatments (e.g., those with or without exposure) or between cognitive behavior therapy and eye movement desensitization and reprocessing. Several potential explanations may account for these findings. The first is the dearth of research comparing a wide enough range of treatments and statistical power to provide definitive answers [61]. Second, to control for length of treatment, the majority of studies comparing exposure to other cognitive behavior therapy approaches have condensed two treatments into the same number of sessions as each alone, raising questions about whether either treatment component is of adequate “dose.” Third, many treatments for PTSD share not only factors common to all psychotherapeutic approaches (the common factors traditionally described in the treatment literature; for such factors in PTSD, see reference 62) but also factors common to brief treatments focused on helping patients deal with traumatic events. For example, exposure may not only foster habituation or extinction but may also provide an opportunity for rethinking previous interpretations of the traumatic event. Similarly, therapy designed to address faulty cognitions or maladaptive coping strategies may indirectly foster exposure. Even psychodynamic treatments employ an exposure model to treat trauma, suggesting that patients need to confront their fears and be able to think freely and openly about them. Finally, different kinds of treatment may be more efficacious for different kinds of patients, although the search for such patient-by-treatment interactions has as yet been disappointing (63).

## Conclusion

A variety of treatments, primarily exposure, other cognitive behaviour therapy approaches, and eye movement desensitization and reprocessing, are highly efficacious in reducing PTSD symptoms in the short term. However, the drop out rates tend to be high and to what extent the positive effects are sustained beyond 6–12 months is unknown.

It is also unknown to what extent CBT, exposure therapy and EMDR are the most effective treatments for polysymptomatic patients with repeated childhood traumas, for which the focus of exposure is less clear

and the broader impact on personality is likely to be more pervasive. In any case, most forms of trauma are likely to lead to changes in how individuals see themselves and the world around them, issues which cannot be addressed in the therapeutic approaches associated with CBT.

Several studies suggest [61] that several factors in treatment design and reporting limit our capacity to draw more directly clinically applicable conclusions from the current treatment literature on PTSD. This has to do with the lack of reported variables, which can play a role in finding out what works and using any insight gained in therapy.

The widespread use of wait-list and inert control conditions is highly problematic, as such control conditions do not rule out the common factors [65] that constitute the major threat to internal validity of these studies and do not control obvious confounds such as clinician commitment and belief in the treatment. The two most common control conditions other than wait list have been relaxation therapy and supportive psychotherapy, neither of which has been intended (and presumably perceived by the research therapists conducting them) to succeed. At this point, it seems to us unwise to design any further studies with any form of controls other than genuine therapies with committed therapists, preferably treatments as practiced in the community, working with samples of patients resembling those seen in the community. If researchers hope to convince experienced clinicians to make greater use of treatments studied in the laboratory, they need to demonstrate that such treatments are in fact superior to what clinicians are already doing in private practice or other settings with the opportunity for more open-ended care.



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