

Intensive treatment of PTSD

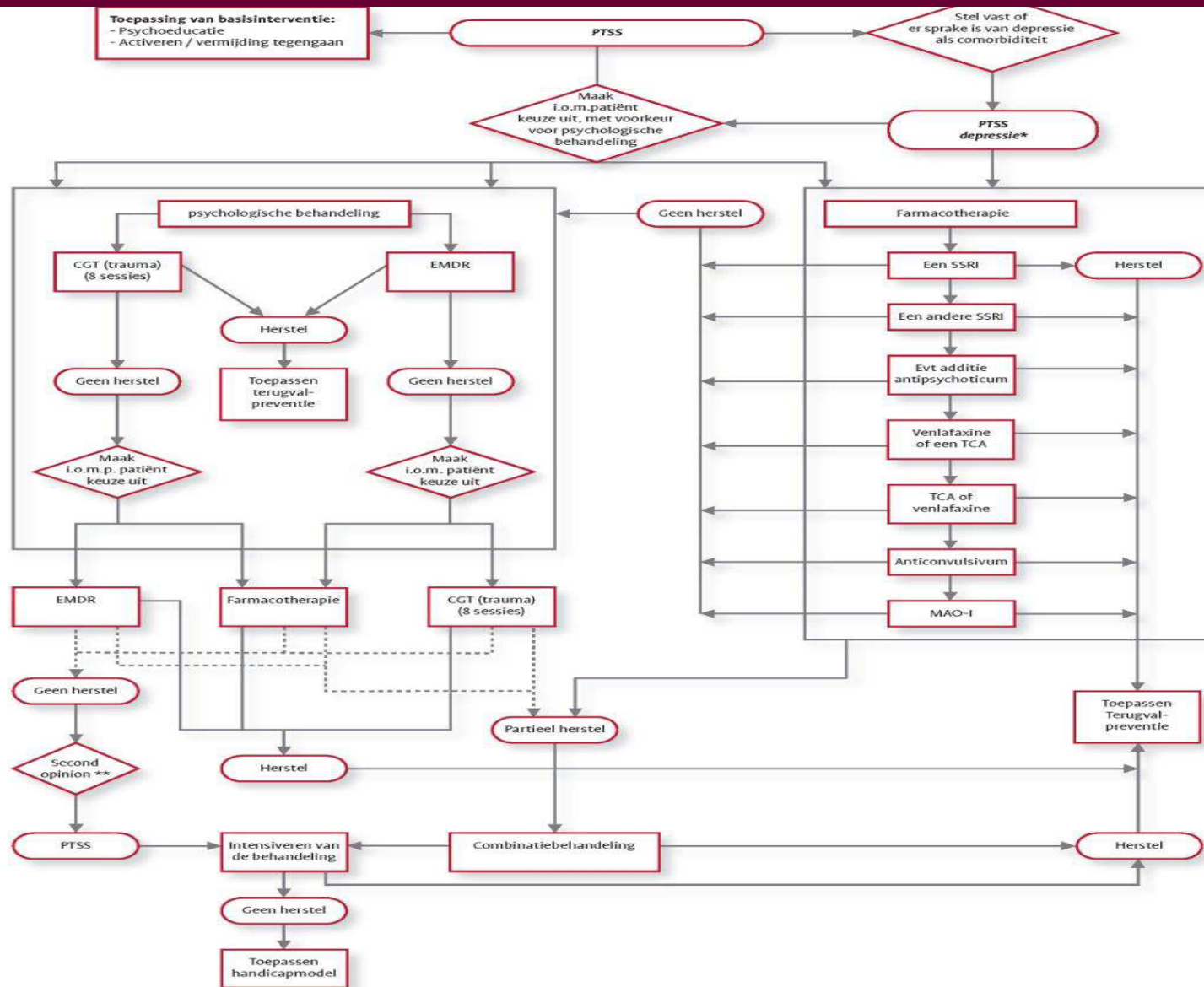
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Research and Expertise (NijCare)

Overview of Dutch Guidelines for Treatment of PTSD



* Indien de depressie voldoende is opgeklaard dan EMDR of CGT
 ** heroverweeg diagnose en second opinion toepassen vanaf de tweede stap in de therapie

Developments within CBT treatments Cohen's d 2009 > Cohen's d 1989

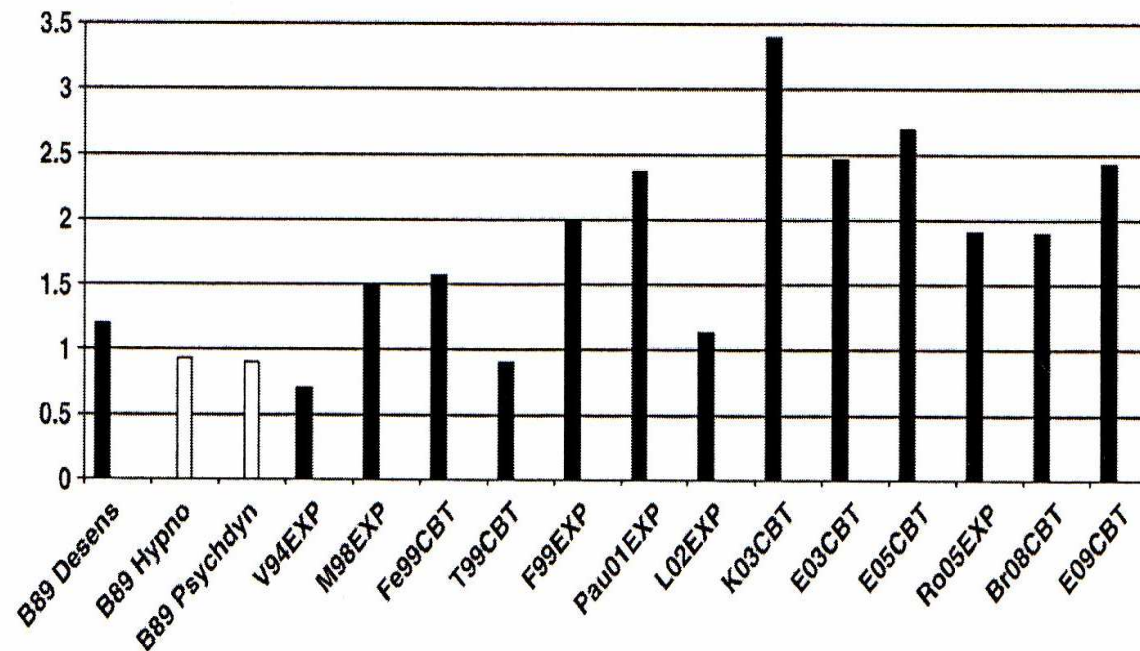


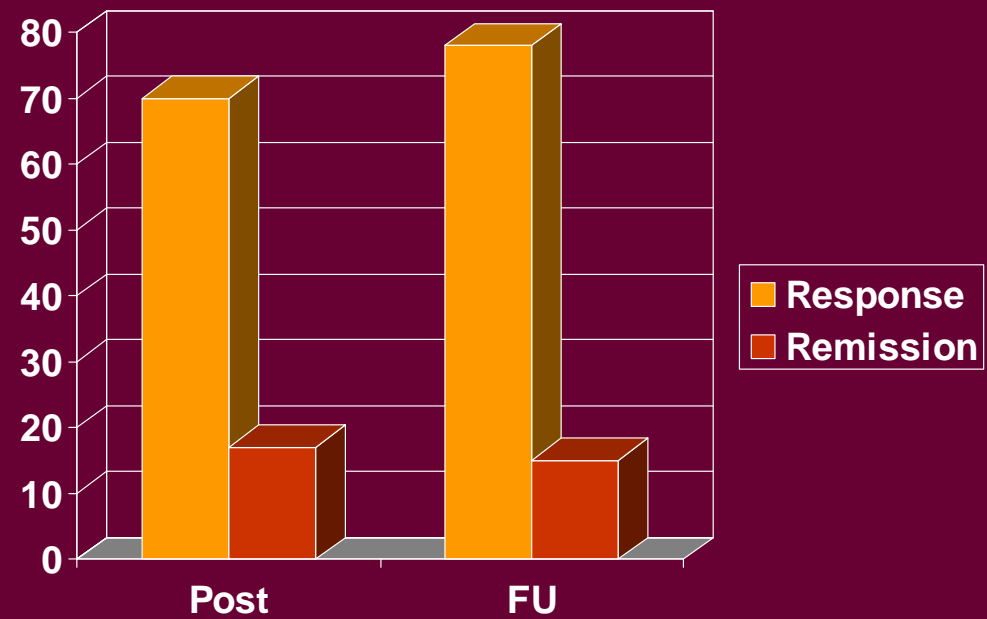
Fig. 2. Effect sizes for changes in PTSD symptoms with treatment for Brom et al.'s (1989) study and for trauma-focused CBT programs (PTSD following trauma in adulthood). In line with Brom et al., effect sizes are based on completers. To ensure the comparison is fair, only studies with similar or lower drop-out rates as in Brom et al. are shown (drop-out rates in parentheses below). However, the pattern would be the same if all trials were shown. Effect sizes were calculated as the pre-post difference in PTSD symptom scores, divided by the pooled standard deviation. Abbreviations: EXP = exposure therapies, CBT = cognitive behavior therapies, Desens = Trauma desensitization, Hypno = hypnotherapy, Psychodyn = psychodynamic therapy; B89 = Brom et al. (1989, 11%). Br08 = Bryant et al. (2008, 17%). E03 = Ehlers et al. (2003, 0%), E05 = Ehlers, Clark, Hackmann, McManus, and Fennell (2005, 0%), E09 = Ehlers et al. (2009, 3%). Fe99 = Fecteau and Nicki (1999, 17%). F99 = Foa et al. (1999, 8%). K03 = Kubany, Hill and Owens (2003; 5%). M98 = Marks et al. (1998, 13%). L02 = Lee et al. (2002, 8%). Ro05 = Rothbaum et al. (2005, 13%). T99 = Tarrier et al. (1999, 11%). V94 = Vaughan et al. (1994, 8%).

Exposure = Good & better...however.....

- Some patients improve, but still have residual symptoms and impaired functioning at posttreatment (Zlotnick et al., *Comprehensive Psychiatry*, 2002)

Schnurr et al., 2009, JAMA

- Prolonged exposure
- ($n = 141$)

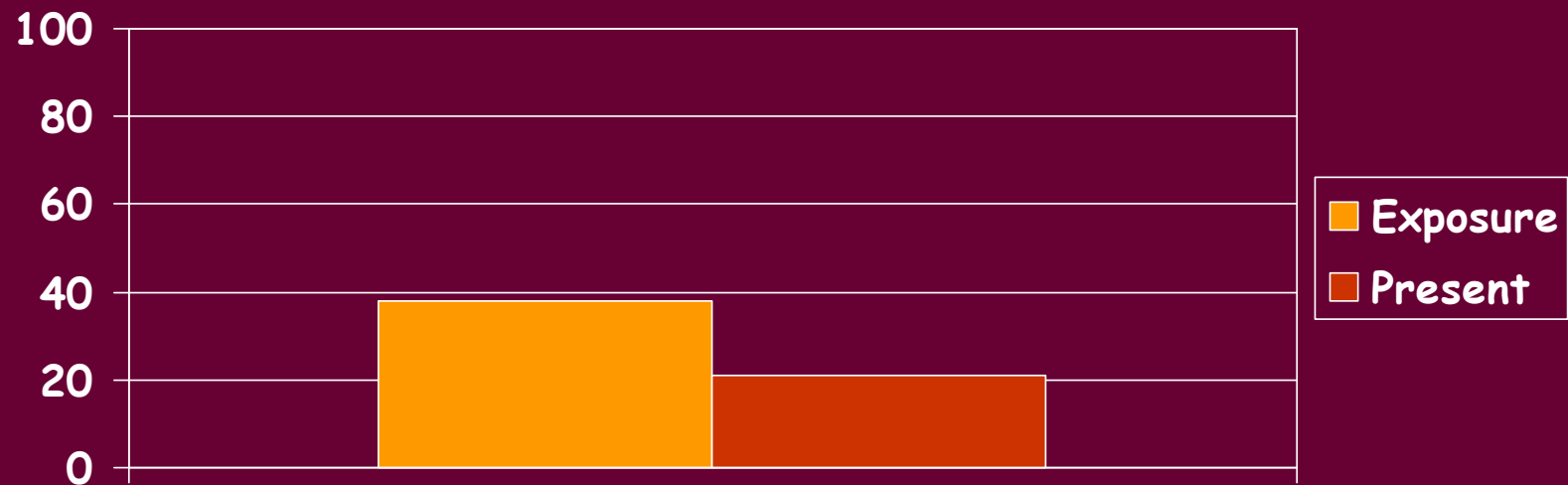


Exposure = Good & better...however.....

- Some patients improve, but still have residual symptoms and impaired functioning at posttreatment (Zlotnick et al., *Comprehensive Psychiatry*, 2002)
- High rate of dropouts (20-40%). However, note that this is comparable with other therapies; see Hembree et al., *Journal of Traumatic Stress*, 2003

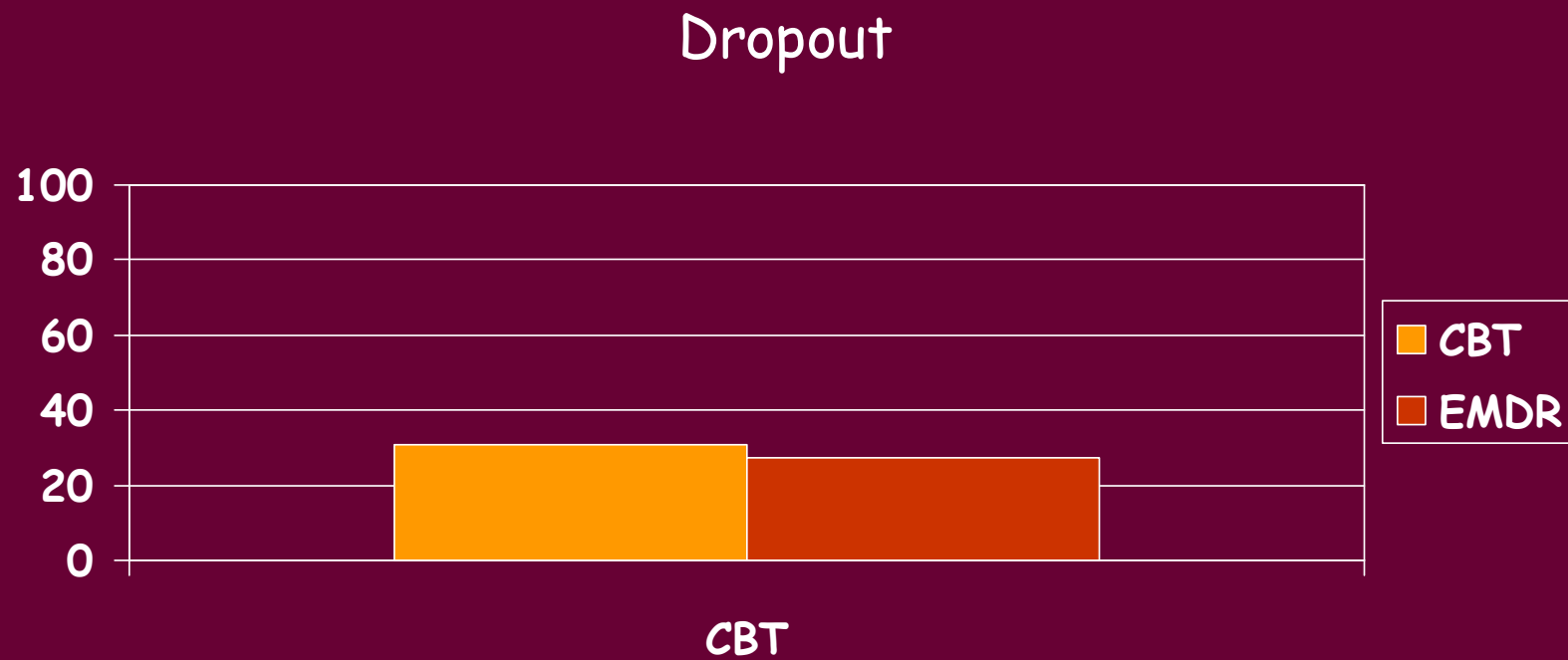
Dropout

Dropout (sign $P = .002$)



Schnurr et al., 2009

Dropout



Seidler & Wagner, 2006

Exposure=Good & better, however.....

- All and all, only about 50% of PTSD patients who are in need of treatment can be adequately helped (Bradley et al., *Am. J. of Psychiatry*, 2005)
- So, there is a need of improvement

How can we achieve improvements?

- Trend: To develop special adapted treatment programs for those who are not likely to improve or who are likely to drop out of treatment
- Aimed at:
 - "Complex PTSD" or Type II trauma
 - Victims of sexual abuse in childhood
 - Patients with co-morbid borderline
 - Severe co-morbidity

Examples

- STAIR before exposure treatment
 - Emotional regulation programs
 - "Stabilisation" treatments
 - "Present-centered" treatments
-
- Typically: before or instead of trauma-focussed treatment

A critical view: is this the right way to go?

- Do we adapt the treatments for the right patients?
- Do adapted treatment programs lead to better end- state functioning?
- Do adapted treatment programs lead to less dropouts?

However, can we identify those patients beforehand?



PERGAMON

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Prolonged exposure in patients with chronic PTSD:
predictors of treatment outcome and dropout

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No effect on treatment outcome and dropout

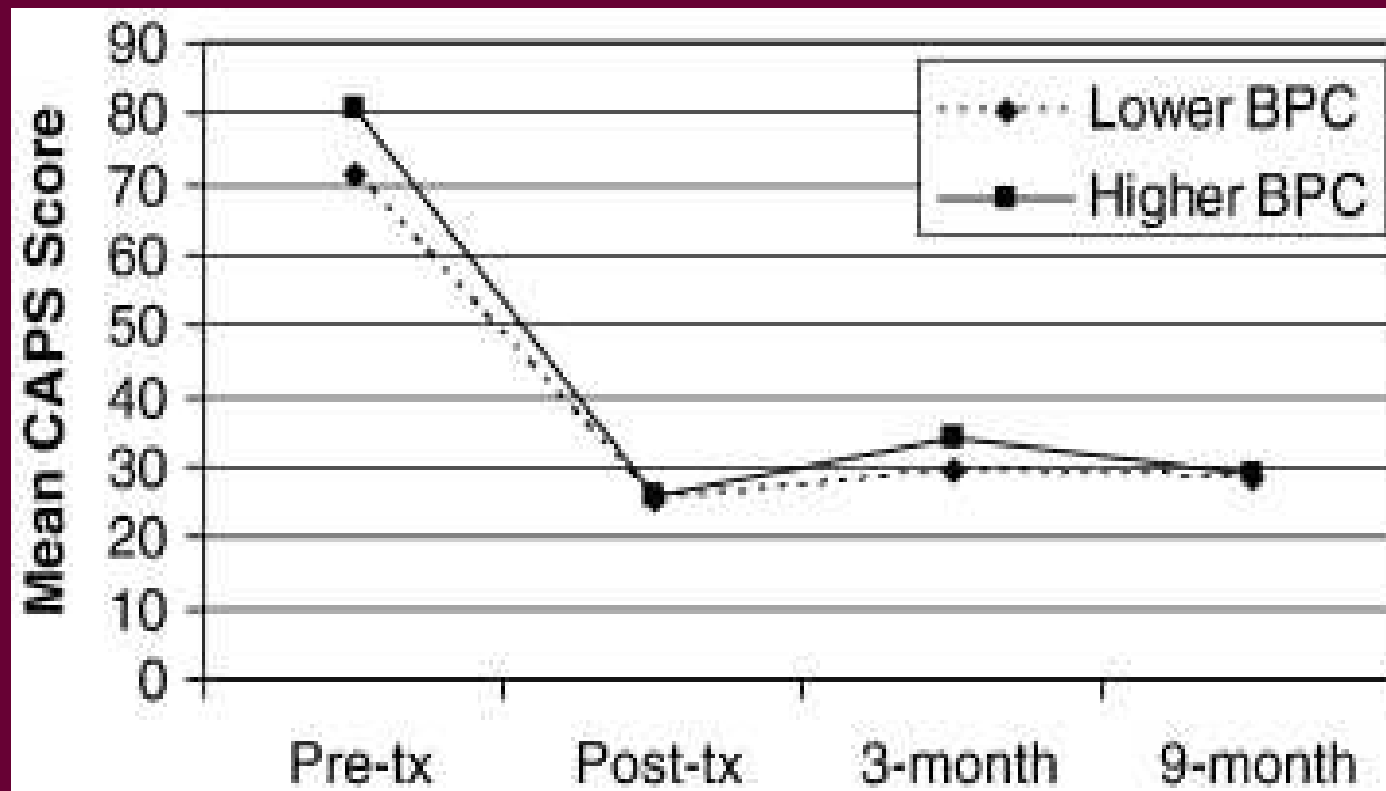
- Demographics
- Depression
- General anxiety
- Personality
- Anger, guilt, shame
- Expectations and motivation for treatment
- Therapeutic relationship

No effect on treatment outcome and dropout

- Trauma characteristics:
 - childhood,
 - multiple,
 - sexual
- Sexual abuse in childhood **No predictor.**
- **Personality disorders**
- Van Minnen, Arntz, & Keijsers, 2002; but see also
- Taylor, Asmundson, & Carleton, 2006; Cahill, Zoellner, Feeny, & Riggs, 2004

Patients with and without borderline personality disorder

Clarke, Rizvi, & Resick, 2008



However

- In some studies in clinical settings, it is found that PTSD patients with borderline PD have higher dropout rates (Zayfert et al., 2005).



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The impact of dissociation and depression on the efficacy of prolonged exposure treatment for PTSD[☆]

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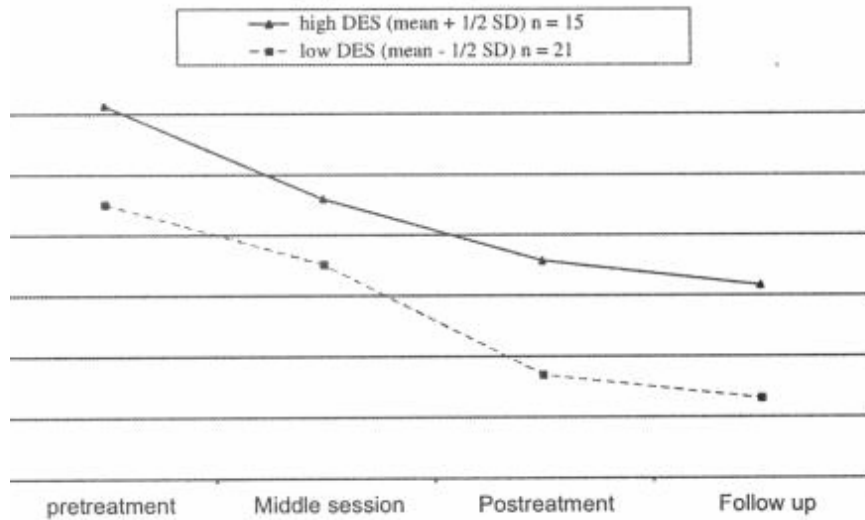
GGZ Nijmegen, Outpatient Clinic of Anxiety Disorders, Tarweweg 2, 6535 AM Nijmegen, The Netherlands

Department of Clinical Psychology, Radboud University Nijmegen, PO Box 9104, 6500 HE Nijmegen, The Netherlands

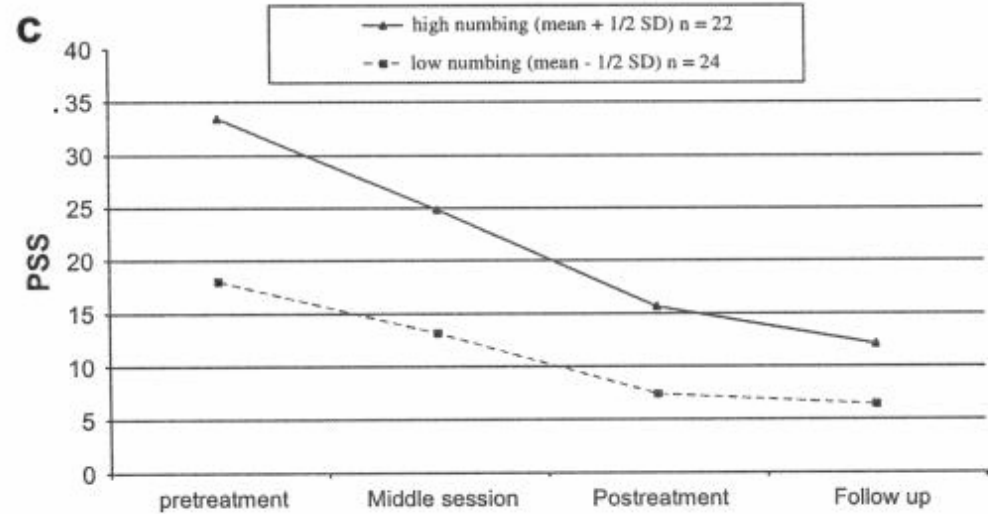
Dropouts

- No effect of dissociation or depression

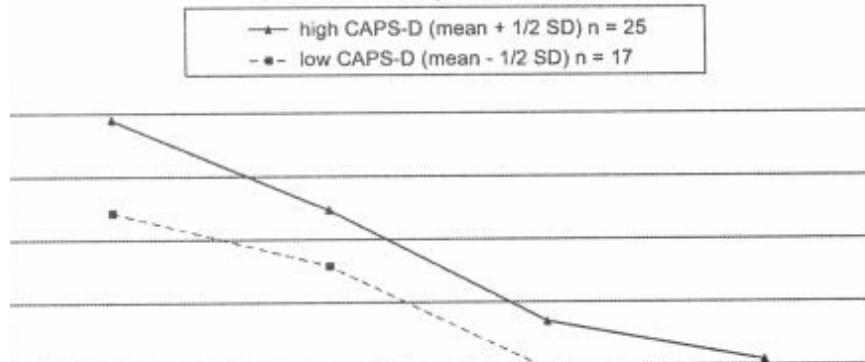
PTSD symptoms in high and low dissociators



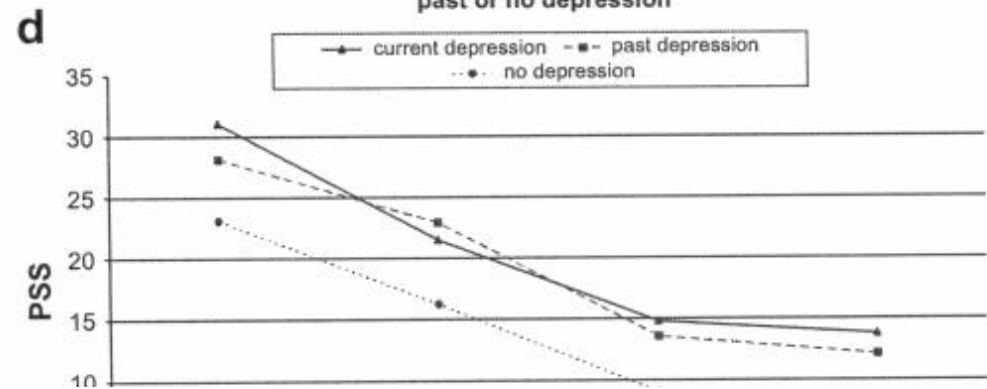
PTSD symptoms in high and low numbing patients



Course of PTSD symptoms in patients with high and low levels of depersonalization



PTSD symptoms in patients with current past or no depression



Conclusions: Do we adapt treatment programs for the right patients?

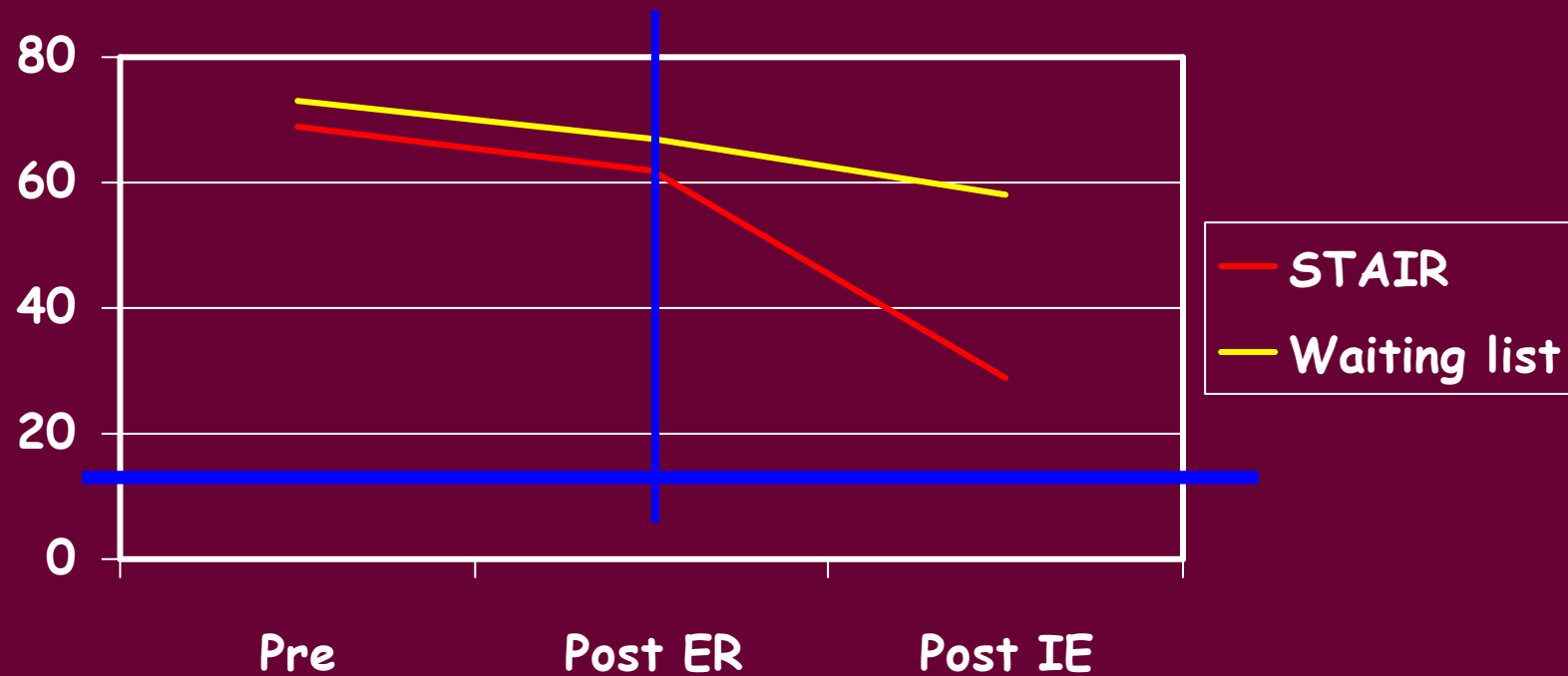
- Maybe. Maybe not. At this moment, it is difficult to indicate beforehand for whom it is and for whom CBT isn't effective
- So, adaptations for special trauma groups seems not very efficient

But suppose we do it anyway...

- Do patients have better end state-functioning after an adapted program?

Cloitre's STAIR program

(Cloitre et al, 2002)



Frueh et al 2009. PTSD in Schizophrenia and schizoaffective disorder

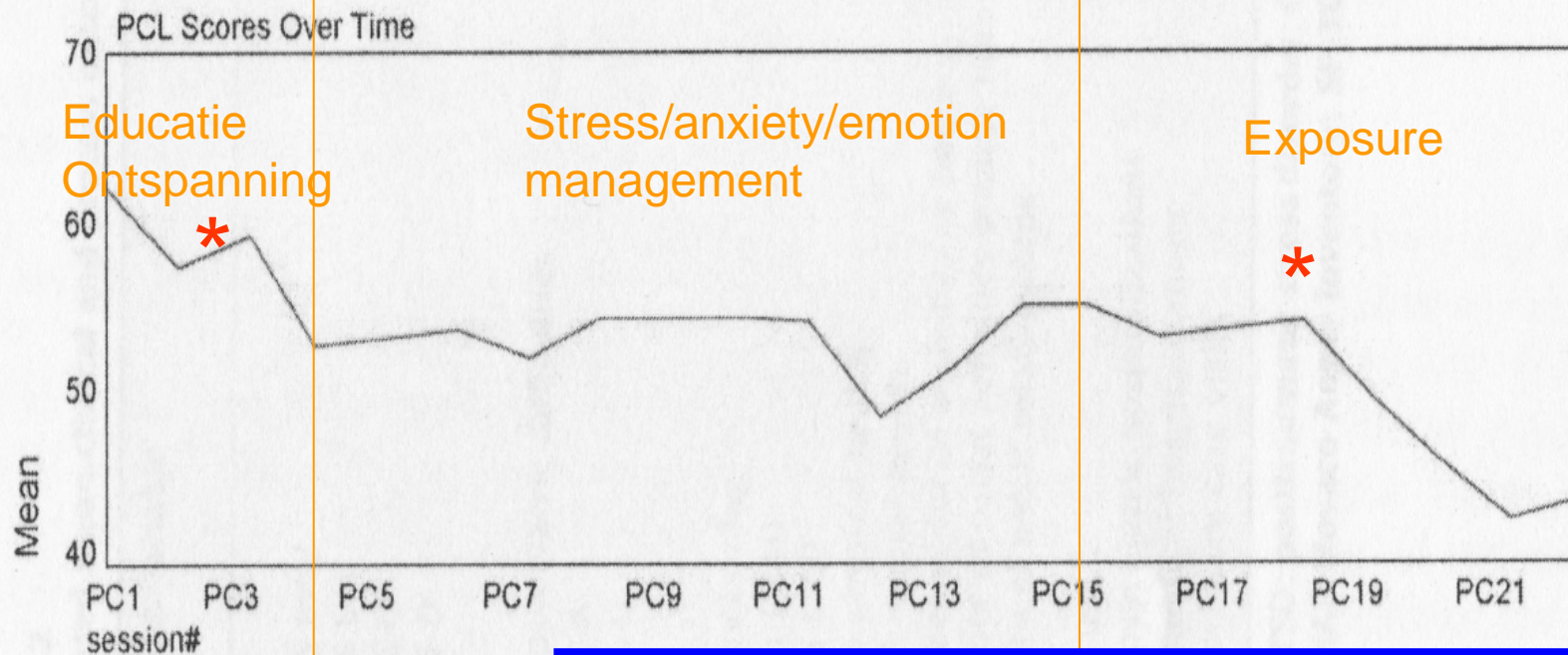


Fig. 1. Posttraumatic stress checklist (PCL) observed scores for completers ($n = 13$) by session.

But suppose we do it anyway...

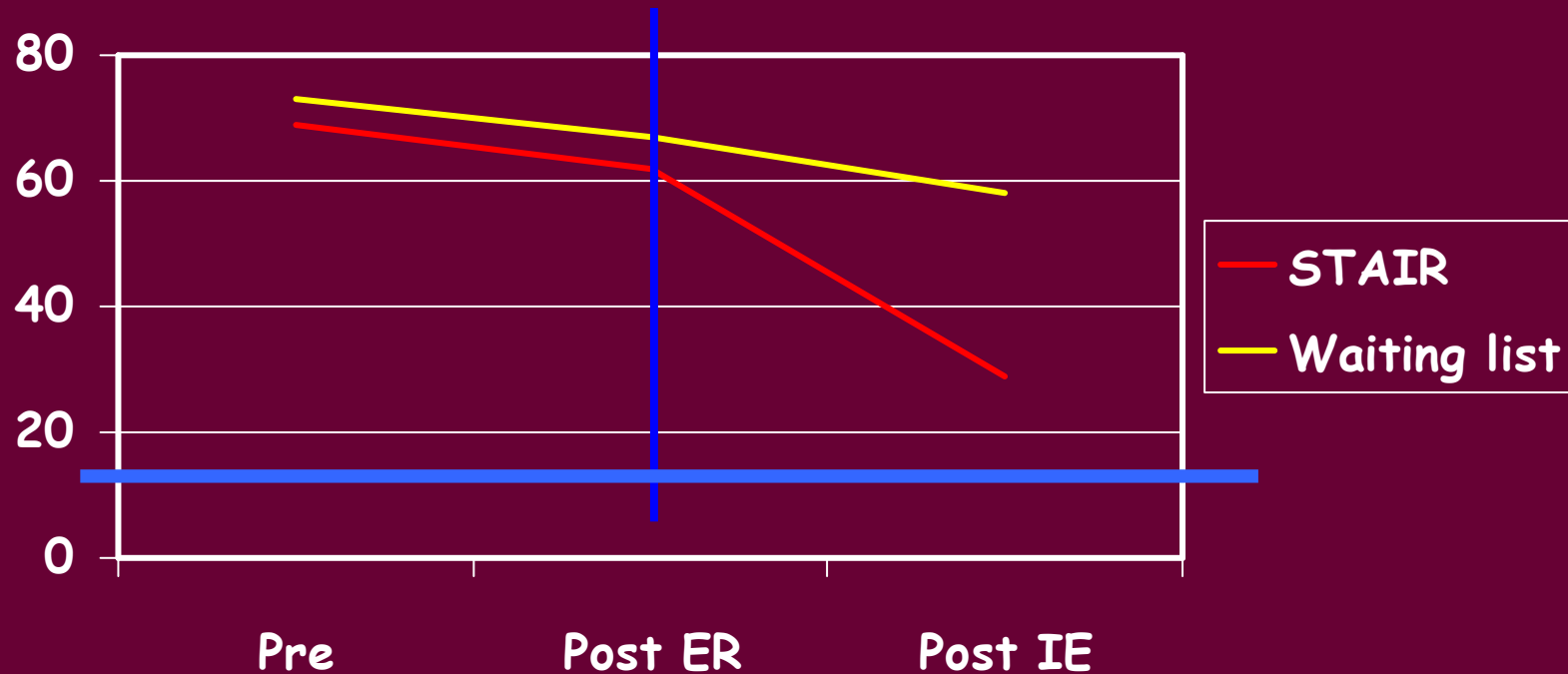
- Do patients have better end state-functioning after an adapted program?
- No,
 - PTSD symptom reduction is only seen after trauma focussed CBT treatment
 - No better results on end-state functioning

But suppose we do it anyway...

- Do patients drop out less during an adapted program?

Cloitre's STAIR program

(Cloitre et al, 2002)



Dropout rate = 29% (versus 11% WL)

Frueh et al 2009. PTSD in Schizophrenia and schizoaffective disorder

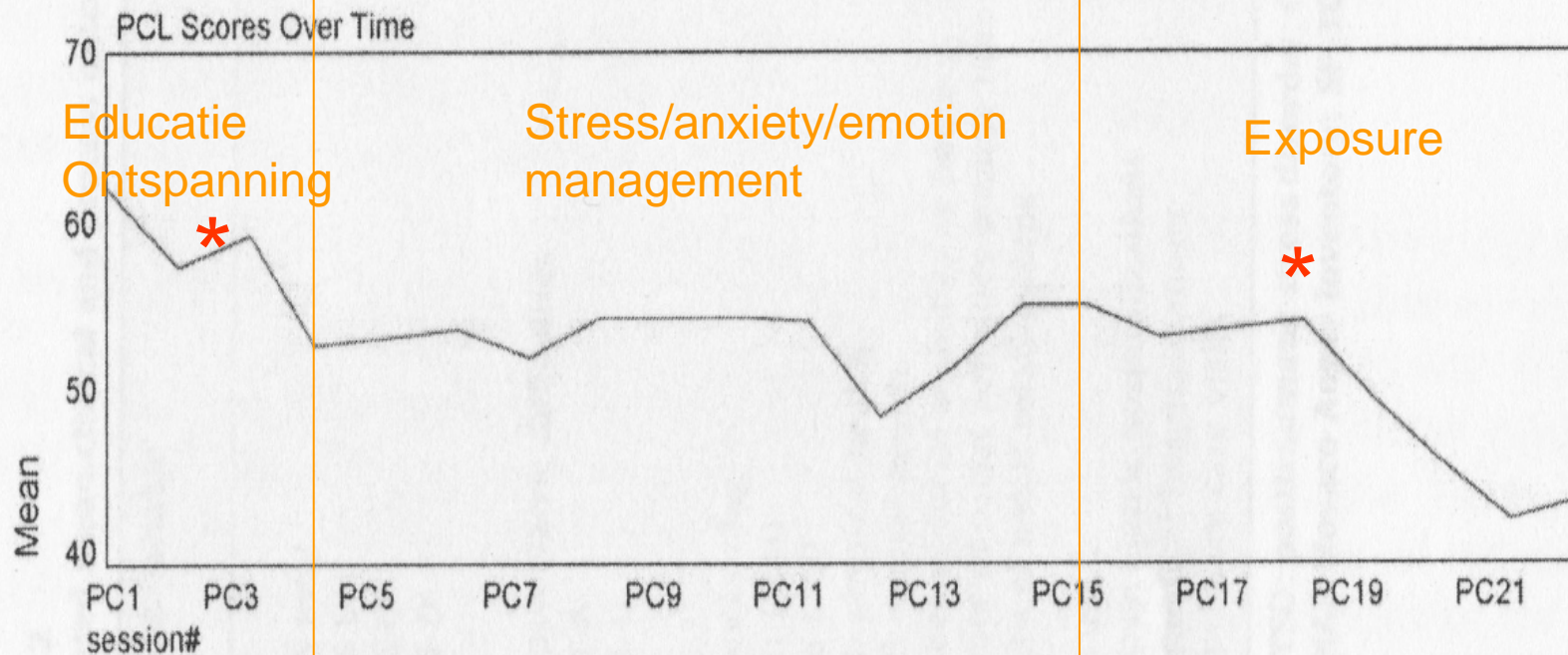
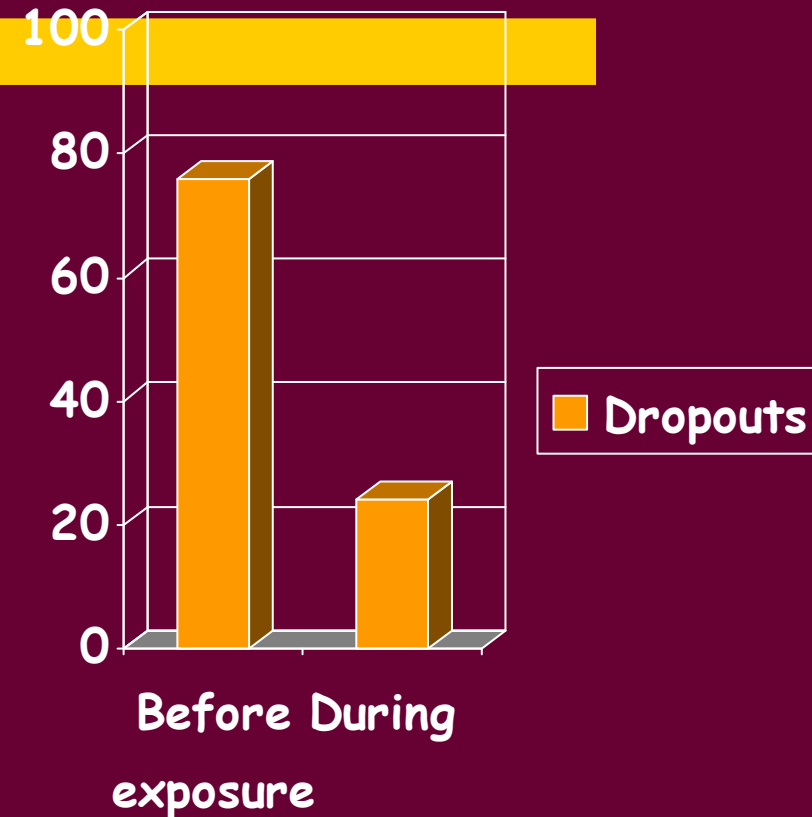


Fig. 1. Posttraumatic stress checklist (PCL) observed scores for completers ($n = 13$) by session.

Dropout rate 35%

Drop-out due to exposure?

- 76% dropouts dropped out before the start of exposure
- *Zayfert et al., JOTS, 2005*



But suppose we do it anyway...

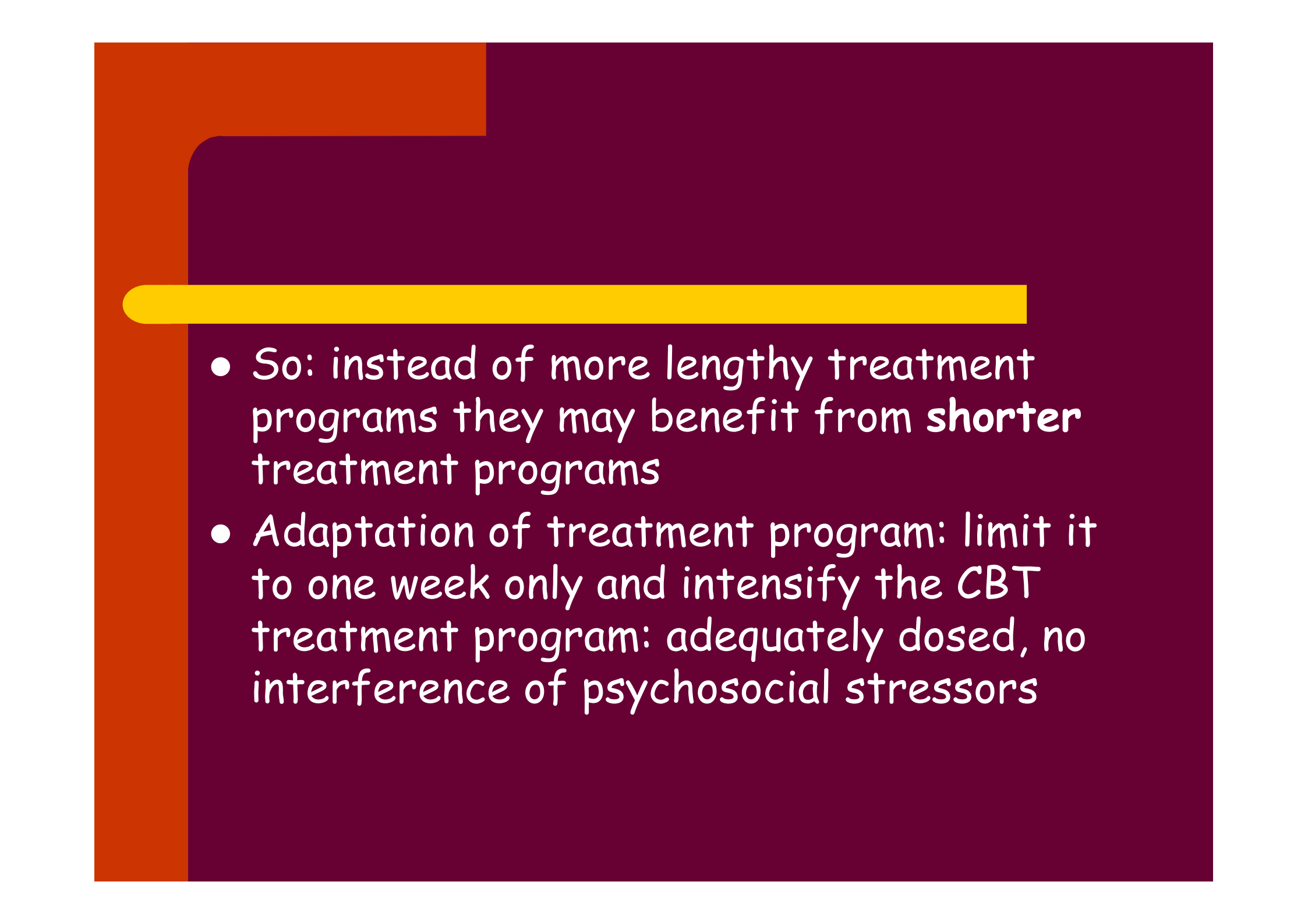
- Do patients drop out less during an adapted program?
- No,
 - Drop-out rates are the same
 - Drop-out before exposure: drop-out is not per se related to trauma-focused therapy

How can we achieve better results and prevent dropouts?

- Dropouts and treatment outcome are not predictable from psychopathology, or trauma characteristics
- Alternative explanations: more practical, more psychosocial stressors?

How can we achieve better results and prevent dropouts?

- Some (complex) PTSD patients have more psychosocial stressors, like illness, low income, unstable relationships
- Psychosocial stressors interfere with treatment compliance, adequate dose, regularity in treatment sessions, etc.
- The longer the therapy, the more chance of low dose or dropping out of treatment

- 
- So: instead of more lengthy treatment programs they may benefit from shorter treatment programs
 - Adaptation of treatment program: limit it to one week only and intensify the CBT treatment program: adequately dosed, no interference of psychosocial stressors

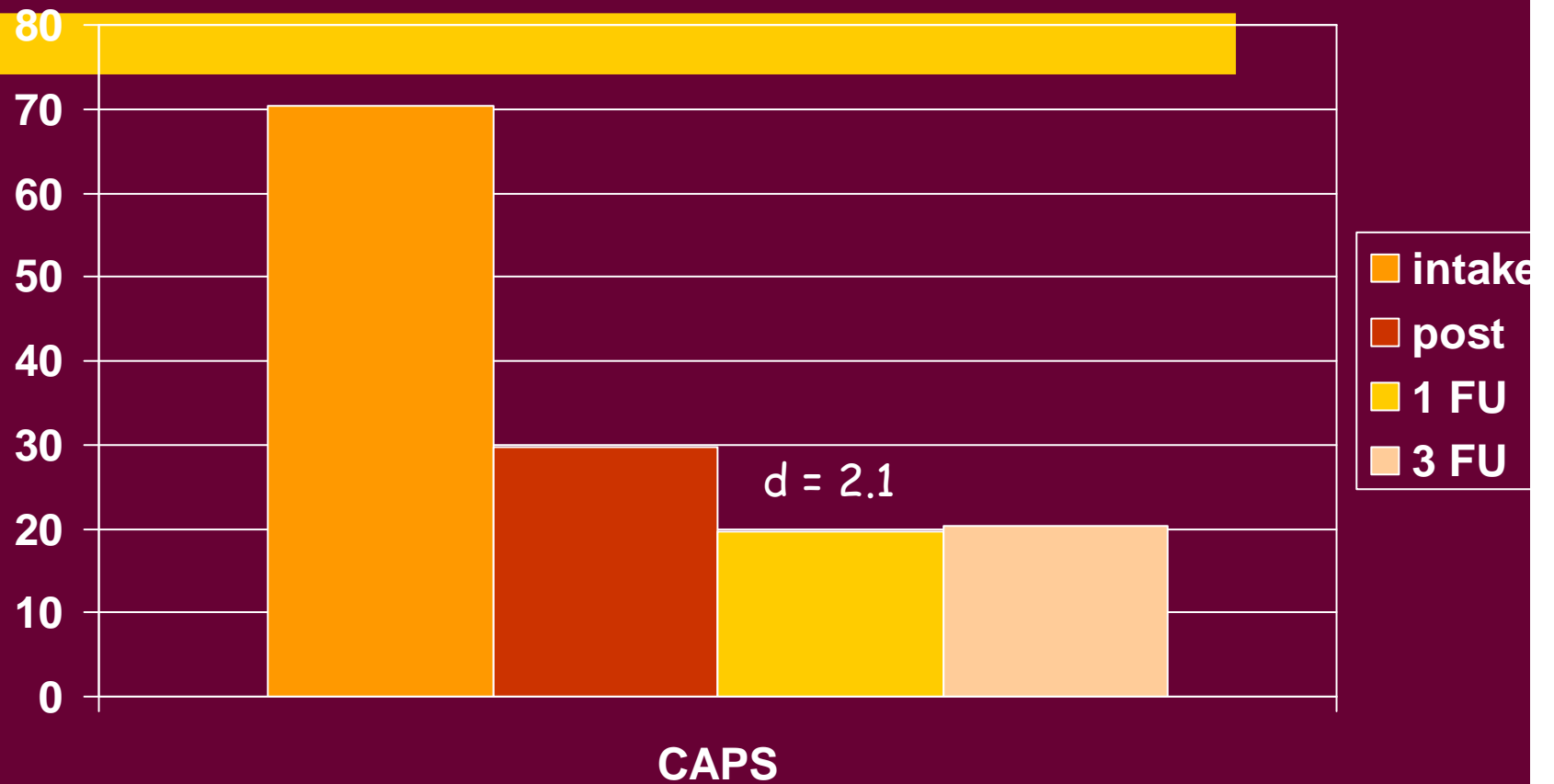
No intensive programs for PTSD

- Why not?
- OCD, Panic..
- PTSD: processing trauma takes time..too much burden... too much exposure may be dangerous and have adverse effects...

Is it feasible to treat within short period, trauma processing?

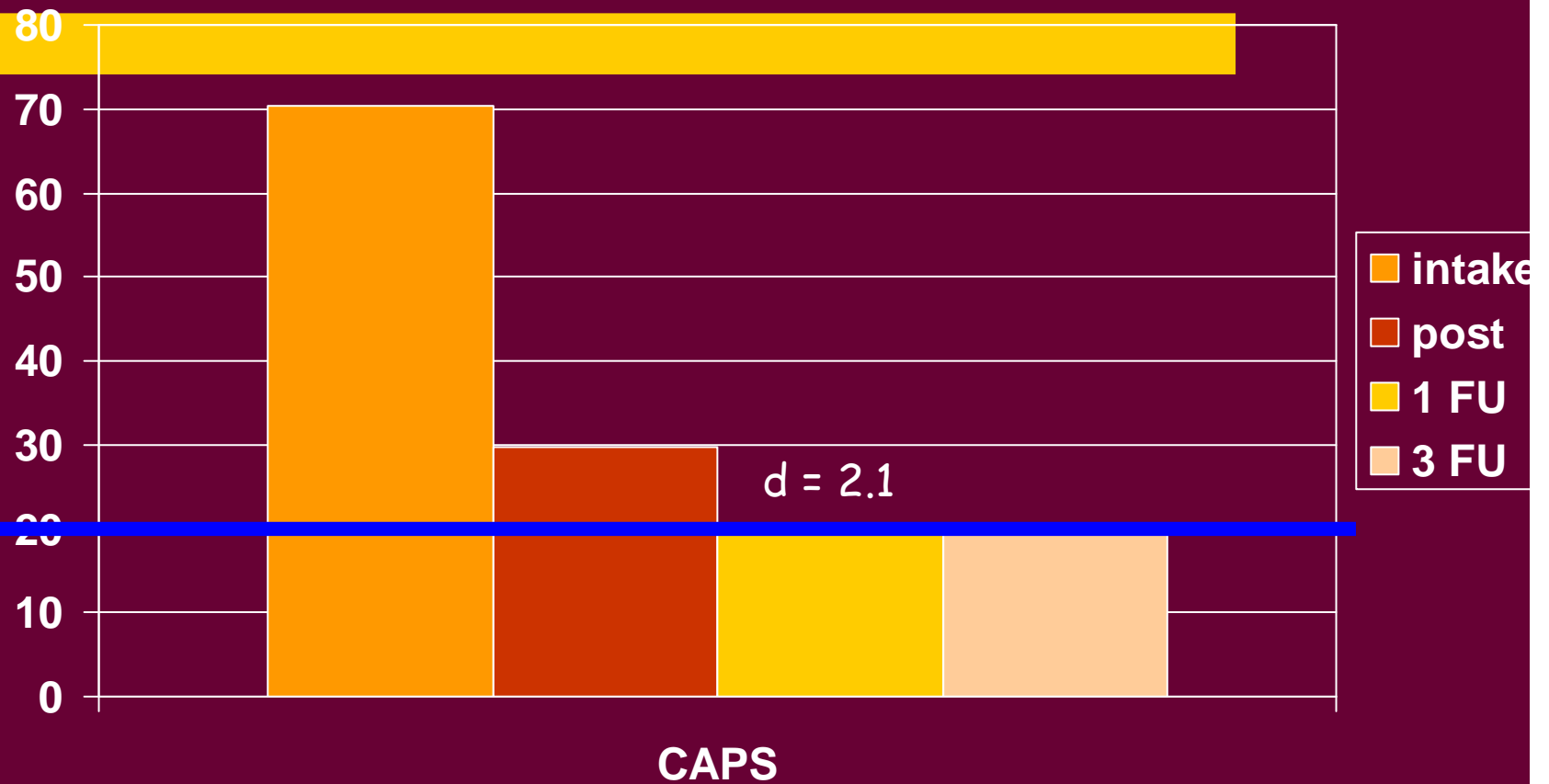
- Ehlers et al (in press) conducted intensive treatment in PTSD-patients with 1 discrete trauma in adulthood.
- N = 14
- 18 hours of CBT within 5-7 working days

Ehlers et al., (n=14)



$**p = .01$

Ehlers et al., (n=14) End state



** $p = .01$

Ehlers et al., dropouts

- No dropouts

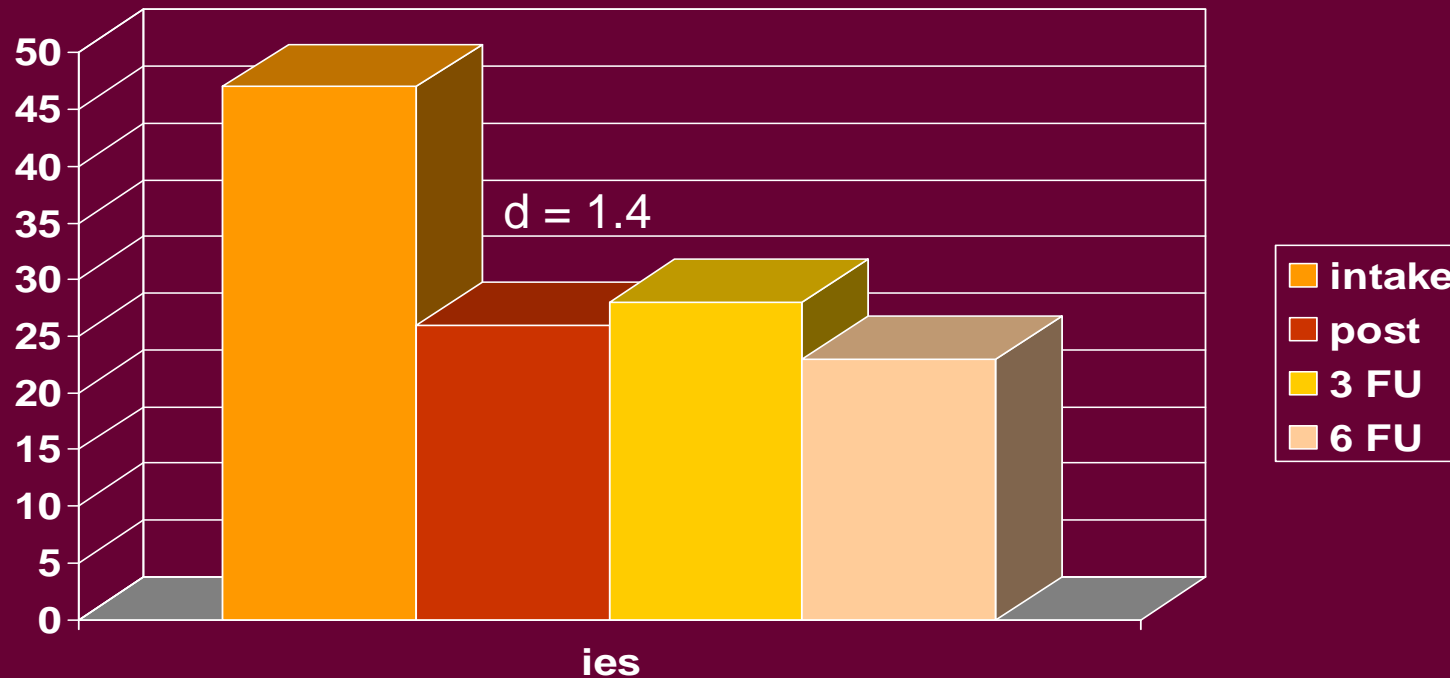
Is intensive exposure treatment possible and feasible in more complex trauma?

- 5 working days
- 8.30-16.30, every day same structure
- Individual
- Sleeping in hotel (limit interference psychosocial stressors)
- Processing one trauma a day:
 - Prolonged Imaginal exposure
 - Exposure in Vivo
 - Exposure by drawings and narrative reconstructing
 - Exposure by self-dialogue

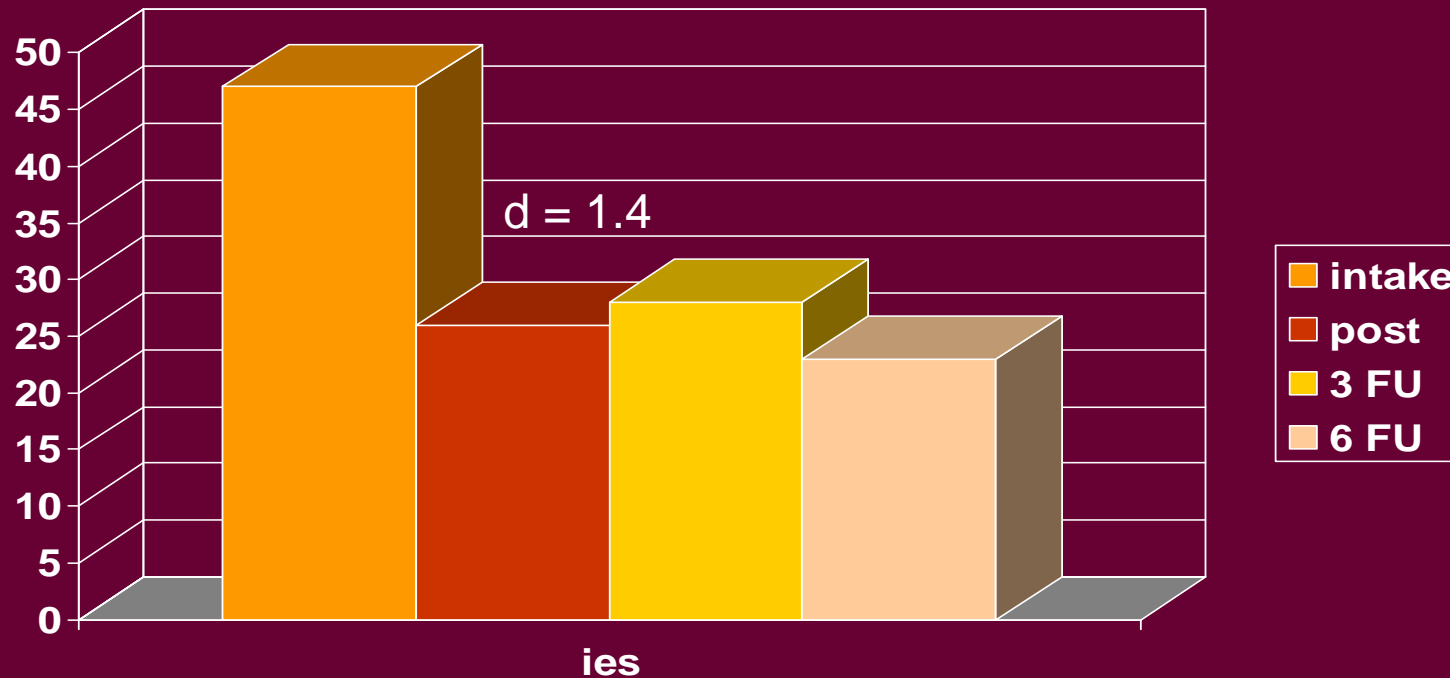
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Effects Intensive Trauma Therapy in PTSD Patients ($n = 72$) (Gantt & Tinnin, 2007)



Effects Intensive Trauma Therapy in PTSD Patients ($n = 72$) (Gantt & Tinnin, 2007)

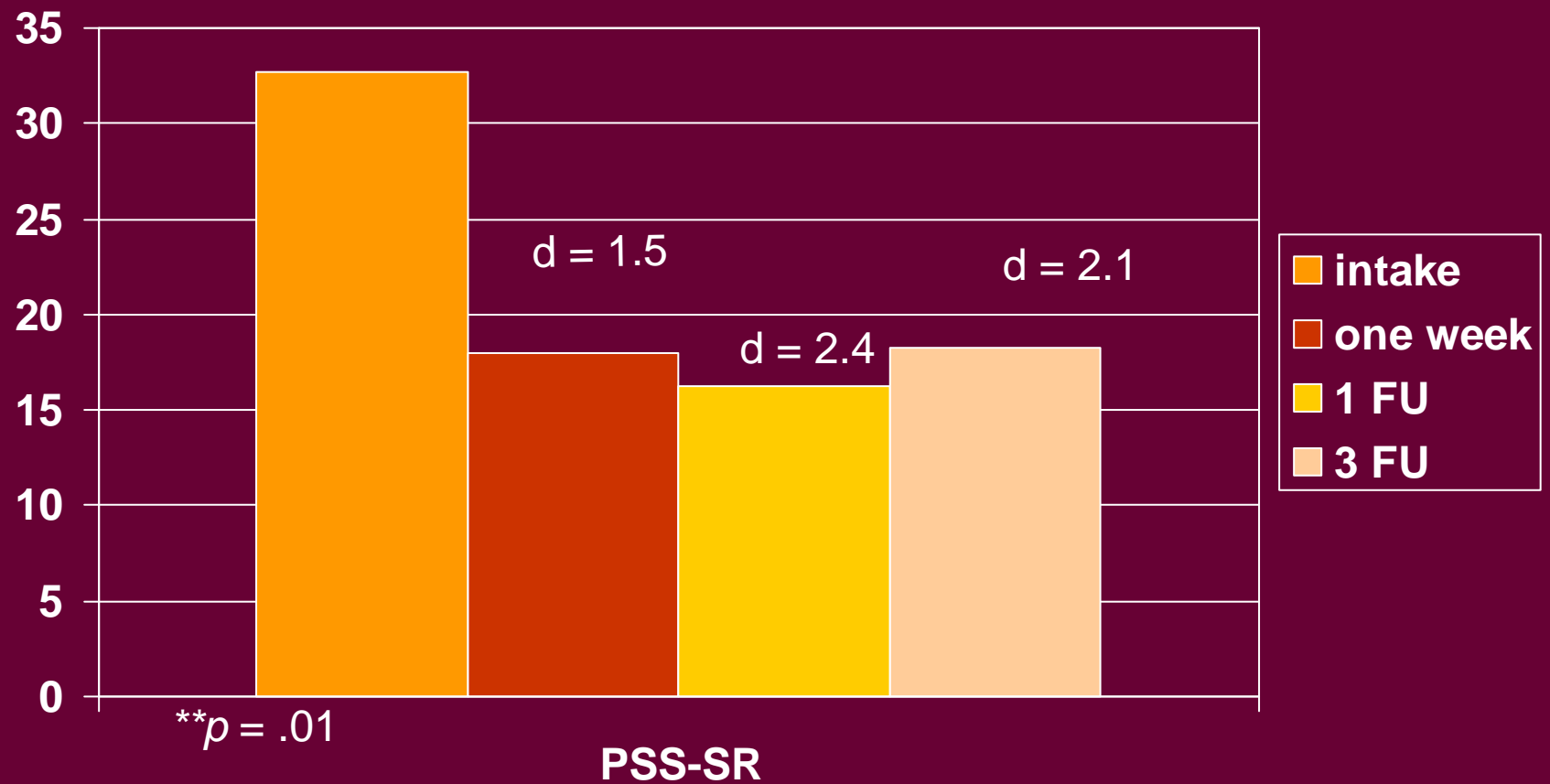


Drop out rate 3%

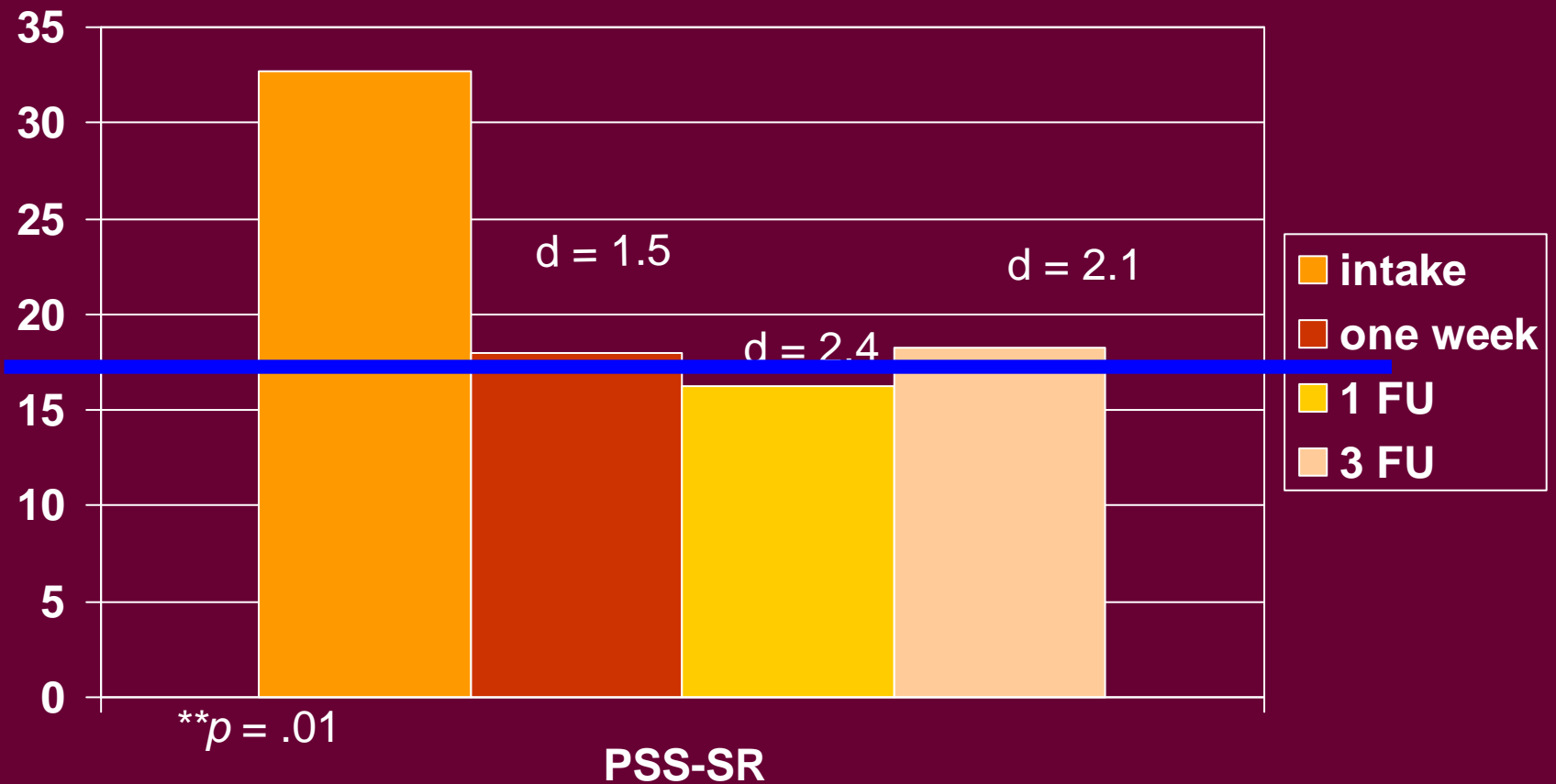
Is intensive exposure treatment possible and feasible in more complex trauma?

- 4 patients;
 - Women
 - Severe sexual and physical abuse and emotional neglect in childhood
 - Revictimized in adolescence and adulthood
 - High prevalence of several co-morbid disorders like borderline personality disorder, drug- and alcohol abuse, depression, conversion disorder, dissociative disorders, anxiety disorder, suicidal behaviour, psychotic features
 - Long treatment history > 10 years, including several admissions to psychiatric hospitals, outpatient treatments
 - Failed CBT or EMDR outpatient treatment

Effect Intensive Treatment ($n = 4$)



Effect Intensive Treatment ($n = 4$) End state



Effect Intensive Treatment ($n = 4$)

Drop out

- No dropouts

Conclusions

- It is possible to intensify the PTSD treatment, even for very complex patients.
- **Advantages:**
- Short time; Lowering risks that are associated with PTSD, like suicide (2.7) and revictimization (2x)
- Good end-state
- Lower dropout rates
- Promising!

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- Rianne de Kleine
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