

Why Can't I Get Good Treatment for my PTSD?¹

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Effective treatments for Posttraumatic Stress Disorder (PTSD) are available but in short supply. There are many reasons for this discrepancy.

Effective Treatments for PTSD

There are a number of treatments that provide relief for the emotional distress and disability associated with PTSD. Cognitive behavioral therapy (CBT) appears to be the best psychological treatment. Four variations of CBT have been found effective. These include stress inoculation training (SIT, Veronen & Kilpatrick, 1983), prolonged exposure (PE, Foa, Dancu, Hembree, Jaycox, Meadows, & Street, 1999), cognitive processing therapy (CPT, Resick & Schnicke, 1992), and cognitive behavioral therapy based on Ehlers and Clark's (2000) cognitive model of PTSD (e.g., Ehlers et al., in press). Such CBT treatments have been shown effective with various different trauma populations. These include sexual assault victims (e.g., Foa et al., 1999; Resick & Schnicke, 1992), adult survivors of childhood abuse (Cloitre, Koenen, Cohen, & Han, 2002), motor vehicle accident survivors (e.g., Blanchard et al., 2003), and veterans (e.g., Frueh, Turner, Beidel, Mirabella, & Jones, 1996).

One controversial but commonly used treatment is eye movement desensitization and reprocessing (EMDR, Shapiro, 1999). EMDR was originally designed for the treatment of PTSD. EMDR has clients engage in lateral eye movements while recalling, in imagination, important portions of a traumatic or disturbing event. As originally described by Shapiro, the therapist uses lateral movements of their index finger to guide clients in making between 10 and 20 rhythmic eye movements while verbally reporting sensations, cognitions, and emotions. This process is repeated until desensitization occurs. The trauma memory is then paired with a positive cognition until the client reports significant levels of belief in the new thought. Shapiro retracted much of the focus on eye movements as the critical component of the treatment in her 1999 paper.

EMDR's claim of rapid recovery from PTSD, often within one session, sparked significant empirical investigations. Currently, we know EMDR is often associated with treatment gains when compared to no treatment conditions in the treatment of PTSD (e.g., Boudewyns & Hyer, 1996; Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998; Rothbaum, 1997). In contrast, a number of studies have found that EMDR is not superior to supportive counseling (e.g., Devilly, Spence, & Rapee, 1998; Lytle, Hazlett-Stevens, & Borkovec, 2002). Whether EMDR is as effective as already established treatments for PTSD (i.e., PE, SIT, CPT) remains unclear. After a review of the literature, Cahill, Carrigan, and Frueh (1999) concluded that the active ingredient of EMDR is repeated imaginal exposure to the trauma and that EMDR has greater effects on subjective ratings of anxiety made by the patient rather than on established psychometric scales.

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A recent meta-analysis of 34 empirical studies of EMDR (Davidson & Parker, 2001) led to several conservative conclusions. First, when EMDR is compared to no treatment, clients appear to be better off with respect to improvement on reliable measures of PTSD symptoms. In addition, EMDR appeared to be reliably superior to nonspecific therapies such as applied relaxation. Third, EMDR was not found to be superior to treatments utilizing different forms of exposure therapy or cognitive behavioral therapy. Fourth, EMDR procedures not utilizing the eye movements that gave the treatment its name are as effective as EMDR with eye movements. Fifth, EMDR proponents have in the past explained away negative findings of trials claiming that the therapists in these negative outcome studies were not appropriately trained in EMDR. The meta-analytic data showed that EMDR results were equivalent independent of whether therapists were trained by the EMDR Institute.

More recently, Taylor et al. (2003) compared EMDR, exposure therapy (a documented treatment of choice for PTSD), and relaxation training with 60 chronic PTSD patients. Therapists were trained via the EMDR Institute. PTSD symptoms declined for all treatments, but exposure therapy was superior to EMDR and relaxation in reduction of both reexperiencing symptoms and avoidance behavior, leading to a lower rate of active PTSD cases in the exposure therapy group at follow-up (15%) than for EMDR (35%), or relaxation (55%). Exposure therapy also led to more rapid reduction in avoidance behavior. This particular empirical study adds to the evidence that exposure therapy is beneficial for chronic PTSD cases, and that EMDR has little unique to offer PTSD cases beyond marginal improvement over the effects of nonspecific treatments. EMDR should not be considered a treatment of choice for PTSD sufferers by rehabilitation coordinators and insurers.

Although drug trials for PTSD have lagged behind psychological treatment trials and are only in a preliminary stage of investigation, increasing evidence supports the effectiveness of selective serotonin reuptake inhibitors (SSRIs) and monoamine oxidase inhibitors (MAOIs) in reducing PTSD symptomatology. Davidson, Rothbaum, van der Kolk, Sikes, and Farfel (2001) found that sertraline outperformed placebo over a 12-week period. Davidson, Landerman, Farfel, and Clary (2002), within a 12 week treatment trial, found that sertraline outperformed placebo on the vast majority of PTSD symptoms, particularly with the numbing and arousal clusters of symptoms. Fluvoxamine has also demonstrated some effectiveness for PTSD symptoms, particularly with combat-related trauma (e.g., Escalona, Canive, Calais, & Davidson, 2002). Nefazodone has been shown to decrease PTSD symptoms in combat veterans (Garfield, Fichtner, Leveroni, & Mahableshwarkar, 2001). Overall, it appears that the family of SSRI anti-depressants demonstrates moderate but clinically significant improvement in PTSD symptoms across a wide variety of trauma populations. Gaffney (2003) suggests that SSRIs may be more effective with the depressive symptoms that are often associated with PTSD. The International Consensus Group on Depression and Anxiety along with a group of PTSD experts recommend SSRIs as the first-line class of pharmaceutical treatment for PTSD, with such treatment recommended for at least 12 months (Ballenger et al., 2000).

How often are Effective Treatments Used by Clinicians?

Sadly, few clinicians use the best treatments for PTSD. From the summary above, the reader can tell that variations of Cognitive Behavioural Therapy are reliably effective and that exposure therapy is a prominent and effective ingredient in decreasing PTSD symptoms. In fact, the vast majority of licensed psychologists do not use prolonged imaginal exposure (perhaps the most consistently documented efficacious treatment for PTSD) on any of their PTSD patients. In a survey of licensed psychologists in the United States, Becker, Zayfert, and Anderson (2004) found that 83% of their sample never used imaginal exposure therapy with their PTSD patients.

There are likely a number of reasons for this reluctance by many clinicians to use exposure therapy. First, most clinicians are not trained in the application of exposure therapy or for that matter in other variants of CBT. Appropriate training in such therapies involves a combination of graduate level academic training in basic psychological science (e.g., learning theory, social psychology, cognitive psychology), as well as supervised experience with a skilled CBT practitioner. Both these educational experiences are in short supply. Psychology internship training with strong emphases in CBT treatments generally, not to mention CBT for PTSD, can be found in only a handful of training sites in Canada. Although accreditation bodies for both graduate programs in Clinical Psychology and Psychiatry Residency programs are urging more training in these treatment modalities, there is a shortage of appropriate faculty in university psychology and psychiatry departments to train competent practitioners in this important area.

Second, all CBT interventions are relatively structured treatments that require focused session agendas and a degree of assertiveness by the clinician. Some clinicians find such structured treatments overly restrictive, not allowing them sufficient flexibility in their interactions with clients. Other clinicians find themselves overwhelmed by the diffuse emotional distress of some PTSD sufferers and find it hard to assertively hold to a treatment plan.

Third, most CBT interventions that use either imaginal exposure or naturalistic exposure (e.g., actual exposure to car travel or other situations that elicit fear) generate at least momentary distress in clients during such exposure. Many clinicians are surprisingly uncomfortable seeing their clients cry or otherwise express emotional distress in the office and are thus reluctant to use treatments that elicit even short term distress.

Fourth, some clinicians mistrust CBT interventions because of either their theoretical orientation (e.g., clinicians who describe their orientation as psychodynamic), or because of ignorance of the scientific foundations and implementation of CBT treatments.

Fifth, within Canada, psychological treatments for mental health problems are seldom covered by provincial health insurance plans. Thus, most PTSD sufferers (indeed

most people with any anxiety or stress-related disorder) are relegated to receiving pharmaceutical treatments as their first option because that is the treatment with which their family physician or psychiatrist is familiar and for which they have the training.

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