Post-traumatic stress disorder: Assessment, management and treatment resistance

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Post Traumatic Stress Disorder

- Exposure to traumatic event
- Characteristic symptoms
- Acute 1-3 months, chronic > 3 months
- Co-morbidity > 50%
- Prevalence 7% lifetime, 3.5% one year
- 50% recovery in two years
- Chronic enduring disorder in around a third

Assessment

- Full history, examination, other information
  - Biological, psychological, social, risk
- Standardised measures
  - CAPS, IES-R, PSS-SR
- No assumptions
- NB range of presentations
- Explore history of trauma with examples
- Re-experiencing and hyperarousal screen
  - Trauma Screening Questionnaire
Prevention and Management

- Prevention
  - No effective formal psychological or pharmacological intervention for all
  - Practical, pragmatic, empathic support

- Management
  - Develop plan after full assessment
  - Psychological, social and biological

Acute Stress Disorder and Acute PTSD

Roberts et al, in press

Acute PTSD

- Prolonged exposure, cognitive therapy, escitalopram 10-20mg, placebo, wait list (bi-weekly telephone)
- 4220 screened, 1470 +ve, 753 interviewed, 397 invited for Rx, 289 randomised
- 152 agreed to any intervention, 118 to anything but SSRI, 19 SSRI c’ind’d
- 12% SSRI non completers, 26% PE

Shalev et al (2007)
• WL had delayed PE at 4 months if indicated
  – Same outcome at 8 months as PE
• 30% treated still had PTSD at 8 months
• Treatment decliners similar
• 12% screen –ve developed PTSD
Treatment of Chronic PTSD - Existing Practice

• Majority treated with medication
  – 77% with PTSD alone
  – 89% if co-morbid with depression
• Many psychotherapeutic modalities in use
• Often delays and gatekeepers before treatment can commence

Clinician Ratings (v placebo)

CAPS–SX Reductions in Means
Antiadrenergics

• Neylan et al (2006)
  – 63 US veterans with chronic PTSD
  – Guanfacine (alpha 2 agonist) vs placebo
  – 8 weeks
• Raskind et al (2007)
  – 40 US veterans with chronic PTSD and distressing trauma nightmares
  – Prazosin (alpha 1 antagonist) vs placebo
  – 8 weeks

Antiadrenergics

TFCBT Approaches

• Exposure
  – The therapist helps the PTSD sufferer to confront their traumatic memories (written or verbal narrative, detailed recounting of the traumatic experience, repetition).
  – In vivo repeated exposure to avoided and fear-evoking situations that are now safe but which are associated with the trauma.
TFCBT Approaches

- Cognitive Therapy
  - Focus on the identification and modification of misinterpretations that lead the PTSD sufferer to overestimate current threat (fear).
  - Also focus on modification of beliefs related to other aspects of the experience and how the individual interprets their behaviour during the trauma (e.g., issues concerning guilt and shame).

Non-TF CBT Approaches

- Stress Management
  - Relaxation training.
  - Breathing retraining.
  - Positive thinking and self-talk.
  - Assertiveness training.
  - Thought stopping.
  - Stress inoculation training.

EMDR

- Standardised, trauma-focused, procedure with several elements, always involving the use of bilateral physical stimulation (eye movements, taps or tones), hypothesised to stimulate the individual’s own information processing in order to help integrate the targeted event as an adaptive contextualised memory.
TFCBT vs WL/Usual Care

EMDR vs WL/Usual Care

EMDR vs TFCBT

Bisson et al, in prep
TFCBT vs WL/Usual Care Depression

Chronic PTSD - Clinician Ratings (v wait list or placebo)

NICE Guidelines

- First line
  - Individual TFCBT or EMDR
  - Usually 8-12 sessions, some 90 minutes
- Second line
  - Alternative trauma-focused treatment
  - Drug augmentation
- Other indications for drugs
  - Patient choice
  - Serious ongoing threat
Comorbidities

- Depression
  - Treat PTSD first unless too severe to engage or high suicide risk
- Substance Dependence
  - Treat substance dependence first
- Traumatic Grief
  - Usually treat PTSD first
- Personality Disorder
  - Treat PTSD but often longer treatment

Refugees, asylum seekers and continuing threat (e.g. domestic violence)

- Often complex issues
- NB cultural, linguistic and other factors
- Phase one
  - Accommodation, benefits, separation, emotional stabilisation
- Phase two
  - Trauma focused, e.g. testimony, narrative exposure
- Phase three
  - Often integration to new community

Treatment Resistance

- Reassess
- Address other factors
  - Stabilisation, social issues, physical issues
- Consider alternative TFPT or prolonged TFPT
- Pharmacological augmentation
  - Antidepressant
  - Antipsychotic
  - Anti adrenergic
  - Mood stabiliser
- Other psychological treatment
- Chronic disease management
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Dear Dr Bisson