Evolution of PTSD Treatment over the Past 20 Years Within VA

Irene Powch, Ph.D.
Psychologist, PTSD Team, PVAMC
Assistant Professor, Psychiatry, OHSU
Grand Rounds, OHSU
September 24, 2013
Disclaimer

- I am not representing any official views of the VA or DoD
- I am focusing on the evolution of psychotherapy treatment for PTSD
- Anything beyond summary of published information is based on my own experience in a limited number of VA’s
In the 1970’s the VA did not recognize or treat effects of traumatic war stress.

There was no diagnosis in the DSM-II for the difficulties Vietnam Veterans were experiencing upon or soon after their return stateside.
Timeline

• 1978 (35 years ago)
  – Charles Figley’s book is first to address the “nameless phenomenon”

• 1979 (34 years ago)
  – Congress mandates the creation of “vet centers” (mostly peer run rap groups)
1980’s

- 1980 (33 years ago)
  - DSM-III finally includes PTSD as a diagnosis
  - Foa studies how people process traumatic information (rape)
- 1982 (31 years ago)
  - Keane finds imaginal flooding reduces PTSD sx's (combat)
- 1985 (28 years ago)
  - Am Lake VA PTSTP is established (one of 22 Residential tx prs)
- 1987 (26 years ago)
  - DSM-IIIR
- 1988 (25 years ago)
  - NVVRS (Kulka et al) is published
- 1989 (24 years ago)
  - VA establishes the National Center for PTSD (5 sites)
Early 1990’s

- 1994 (19 years ago)
  - DSM-IV
  - Researchers found that trauma is not rare; therefore the “outside the range of human experience” part of the definition of Trauma is dropped, and a more subjective requirement is added: “experienced horror, fear, or helplessness at the time of the event”
Early 1990’s in the Trenches

- Long-term PTSD Residential Treatment Programs are in full-swing (22 around the country)
- Clinicians are grappling with the change in definition of trauma from “outside the range of human experience” to a more subjective definition “experienced horror, fear, or helplessness at the time of the event”
- Many outpatient VA’s are providing primarily medications, some inpatient stabilization
- Vet Centers are providing mostly peer counseling
- Unsystematic mix of trauma focus, skill focus, and support at all but National Center
Late 1990’s

• 1997 (16 years ago)
  – Fontana & Rosenheck *Am J Psyc* slams long-stay PTSD Residential Tx programs
  – Outcome study found that long-stay specialized PTSD units did not improve sx’s upon completion any more than brief PTSD Treatment units or general psychiatric units, and that at 1 year f/u veterans in short-term stay programs showed significantly more improvement than those in long-stay programs, despite the 82.4% greater cost of the long-stay programs.
Late 1990’s to Early 2000’s in the Trenches

• Mass closures of PTSD Residential Programs follow the Fontana & Rosenheck findings.
• PTSD Teams are scattered, most treatment is outpatient
• Many programs overreact and abandon trauma focused treatments in favor of present focused skills building
• Clinicians experience intense productivity pressures → more groups, shorter appointments (often 20 minute to half hr)
• No treatment for Women Veterans at most VA PCT’s, including Portland’s PTSD Team
Early 2000’s

• 2000 (13 years ago)
  – First comprehensive practice guideline for treating PTSD is produced by VA National Center for PTSD in collaboration with the ISTSS
    * By 2000, 12 studies had tested exposure therapy. All finding positive results; 8 of these received the highest AHCPR rating for methodological rigor.
  • Based on this, the Practice Guidelines for the International Society of Traumatic Stress Studies (Foa, Kean, & Friedman, 2000, p79) concluded that “exposure therapy should be considered as the first line of treatment unless reasons exist for ruling it out”
  – DSM-IV-TR
Early 2000’s at the National Center for PTSD

• 2001 (12 years ago)
  – Women's issues come to the forefront: Congressionally-mandated Military Sexual Trauma project is launched this year.
  – VA Cooperative Studies launches the largest psychotherapy RCT in history (PE vs Present Centered Therapy) in partnership with DoD and it focuses on Women Veterans.
  – At the 11 participating VA Sites, for four years, 8 to 10 women veterans a year benefitted from ten 90-minute individual therapy sessions (half of these with trauma processing).
Late 2000’s

• 2007 (6 years ago)
  – 2006 JCCP publication on effectiveness of CPT in Veteran population
  – 2007 JAMA publication on effectiveness of PE in Women Veteran population
  – PE and CPT Dissemination is launched at direction of VA OMHS
Post 2008 in the Trenches

- Starting with VA, then moving to Vet Centers, clinicians are trained to provide PE and CPT
- PE: 40 hour training plus 2 supervised cases (half year weekly consultation calls)
- CPT: 14 hour training plus 2 supervised cases (half year weekly consultation calls)
- Managers must allow for adequate session length for the 2 training cases; eventually performance standards include number of EBT’s sessions the Team is providing.
A 2010 meta-analytic review of 13 published RCTs of PE for PTSD (675 participants) found that the average PE treated patient faired better than 86% of patients in control conditions at posttreatment on PTSD symptoms.

- PE is effective in “real world” VA clinical contexts, not only in pristine clinical trials.
  - Turek et al., *J Anx Disord* 2010

- PE results in clinical improvements beyond PTSD symptoms, including improvements in: depression, quality of life, sleep, reported physical health symptoms, social function, and posttraumatic growth, including increased sense of new possibilities and personal strength.
The Two EBT’s for PTSD

• Cognitive Processing Therapy
  – 12 weekly sessions (individual, group, both)
  – Targets those beliefs that were fundamentally changed by the trauma(s)

• Prolonged Exposure Therapy
  – 10 weekly sessions (individual)
  – Directly disarms the power of traumatic memories and triggers by safely and systematically confronting avoidance
Other EBT’s

• Dialectical Behavior Therapy (DBT)
  – Targets emotion regulation, impulsivity, and interpersonal effectiveness (setting boundaries, assertiveness, etc.)

• Seeking Safety
  – Targets PTSD and Substance Use Disorders

• Acceptance and Commitment Therapy (ACT)
  – Promotes living a life of value even with symptoms
  – Your thoughts are nothing more than thoughts
2013

• Next large therapy RCT planned by VA Cooperative Studies Program is a treatment matching study of PE and CPT

• Other studies focus on:
  – adapting existing treatments for PTSD to populations with various co-diagnoses
  – focusing on specific populations: ex. Geriatric
  – disseminating to populations that may best be reached with telehealth
  – complementary treatments that calm the hyperarousal system (eg. acupuncture, mindfulness, yoga)
2013 in the Trenches

• Portland VA’s PCT has 10 certified PE and CPT therapists

• A typical therapist’s week includes:
  – 3 individual PE cases
  – 3 individual CPT cases (usually in conjunction with CPT group)
  – One “Symptom Management” Group (typically 18 veterans)
  – One support group (typically 10 veterans)
  – One specialty group (in vivo, CPT, Growth, Mindfulness, etc.)
  – One new individual assessment/consult
  – Several veterans not yet ready for a trauma focused EBT
We’ve come a long way, Baby!
Reflection

• A triumph of the focus of the past half decade is that it has legitimized PTSD therapy treatment and justified 60 to 90 minute sessions for trauma focused therapy treatment.

• A pitfall to be cautious of going forward is not to swing the pendulum too far such that these EBTs are all we offer because there are as many veterans with PTSD and other complications that need other approaches as there are veterans who are ready for an EBT.

• We should also be mindful to not rigidify treatments so much that we lose the centrality of the therapeutic relationship.
Reflection

• I see integration of recent research in neuroscience and attachment with the trauma processing therapies as an important next step in the evolution of PTSD Treatment...

• Perhaps the future may hold an integration of Eastern and Western approaches to healing from the effects of trauma...
Edna Foa earned her Ph.D. in 1970 from University of Missouri (APA Accredited) in Clinical Psychology and Personality. She is a professor of Clinical Psychology at University of Pennsylvania. In 1980 while on Sabbatical, she began the inquiry that led to the development of PE.

Patricia Resick earned her Ph.D. in 1976 from the University of Georgia (APA Accredited) in Clinical Psychology. She is a professor of Psychiatry and Psychology at Boston University. She developed CPT, which is an adaptation of a well-established therapy developed by Aaron Beck (professor emeritus in dept of psychiatry at University of Pennsylvania).

Francine Shapiro earned her Ph.D. in 1988 from the Professional School of Psychological Studies, San Diego (not APA Accredited at the time). She does not have an academic affiliation. In 1987, while still a graduate student she made the chance observation while taking a walk at the beach that moving her eyes from side to side appeared to reduce the disturbance of negative thoughts and memories.
• 1995 -- Sandra Wilson, Robert Tinker and Lee Becker published the first randomized study with appropriate clients who were given the appropriate amount of treatment. The study appeared in the Journal of Consulting and Clinical Psychology and the title was “Eye movement desensitization and reprocessing (EMDR) treatment for psychologically traumatized individuals”. (Two of the authors are not affiliated with any university; Lee Becker was a professor of sociology at the University of Colorado).