EVIDENCED BASED PRACTICES FOR PTSD IN THE VETERAN POPULATION

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Objectives

Identify	Identify symptoms of Post Traumatic Stress Disorder, discuss prevalence rates, and discuss risk and protective factors
Discuss	Discuss evidenced based trauma treatments: Cognitive Processing Therapy, Prolonged Exposure, and Eye Movement Desensitization and Reprocessing, and their utilization within the veteran population
Discuss	Discuss cultural implications

DSM 5 PTSD SYMPTOMS

Traumatic Event – Criterion A

Exposure to actual or threatened death, serious injury, or sexual violence by:

1. Directly experiencing
2. Witnessing
3. Learning that a close family member or friend has experienced a traumatic event
4. Repeated or extreme exposure to aversive details of a traumatic event (e.g. first responders, medics)

Not everyone who meets one of the criteria above will develop PTSD.

Other criteria needed for diagnosis

- Intrusive symptoms associated with the traumatic event
- Persistent avoidance of anything that remind the person of the traumatic event
- Negative changes in thoughts and mood
- Significant changes in reactions and arousal when reminded of the traumatic event
- The symptoms above must last longer than a month
- The symptoms above cause a great deal of distress and impairment in important areas of functioning
- The disturbance is not the result of substance use or other medical condition
- If dissociative symptoms or depersonalization or derealization exist, a specifier can be added

National Center for PTSD

White Board Videos

What is PTSD

PREVALENCE RATES

How Common is PTSD?

The United States projected lifetime risk for PTSD is 8.7%

This rate is higher among veterans, first responders, and emergency medical personnel

The highest rates of PTSD include one-third to one-half of the survivors of rape, combat, captivity, and genocide.

Prevalence of PTSD

	Lifetime Prevalence Rate		
Population	Total Adult Population	Women	Men
Americans age 18 and older	6.8%	9.7%	3.6%
Vietnam Era	-	30.9%	26.9%
Theater Veteran's (boots on the ground)	-	8.1%	15.2%
Gulf War	10.1%	-	-
OEF/OIF	13.8%	-	-

RISK AND PROGNOSTIC FACTORS

Factors that lead to vulnerability to PTSD

If prior to the trauma one has:

- Childhood emotional problems
- Prior mental disorder
- Lower socioeconomic status
- Lower education
- Exposure to prior trauma
- Family history of psychiatric problems
- Age at time of trauma (younger being more vulnerable)
- Female

At the time of the trauma:

- Severity of the trauma
- Perceived threat
- Interpersonal violence
- Witnessing atrocities
- Killing the enemy
- Dissociation that continues

If after the trauma one has:

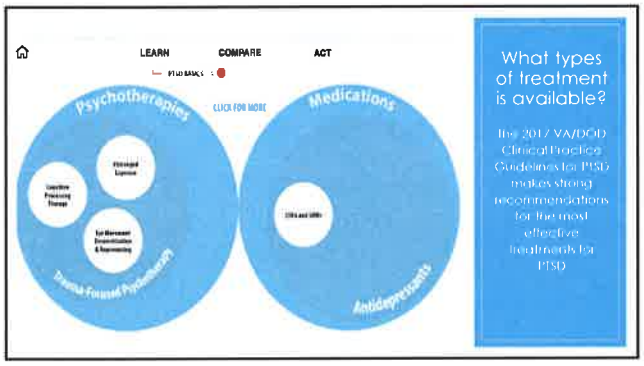
- Negative self thoughts
- Poor coping skills
- Repeated exposure to reminders
- Additional trauma or loss

The good news

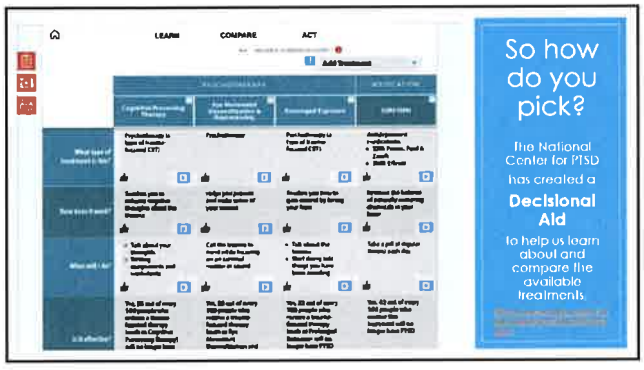
Social Support

before and after the traumatic experience plays a large role in facilitating the person's progress following a trauma

TREATMENTS


LEARN
COMPARE
ACT
Psychotherapies
CLICK FOR MORE
Medications
Antidepressants
What types of treatment is available?
The 2017 VA/DOD Clinical Practice Guidelines for PTSD makes strong recommendations for the most effective treatments for PTSD


EVIDENCE-BASED TREATMENTS
What is Evidence Based Treatment?

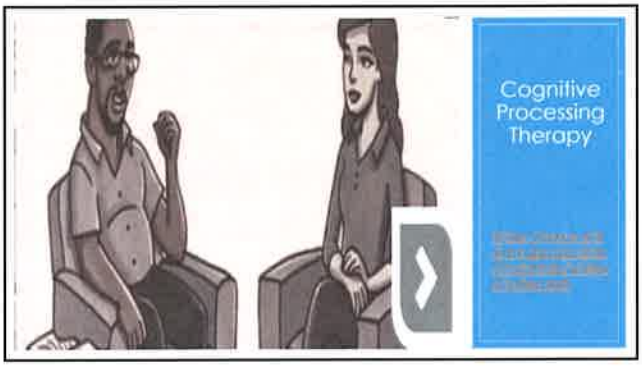


But do they work?

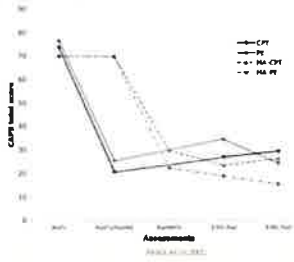
The national center for PTSD compiled data from 26 randomized controlled trials on trauma-focused psychotherapy

From this it is estimated that 50% of people diagnosed with PTSD who received an Evidence Based trauma-focused therapy will no longer have PTSD after about 3 months.

A CLOSER LOOK AT THE THERAPIES



What does the research show?



Rationale

PTSD symptoms are attributed to a "stalling out" in the natural recovery process

→

Avoidance of trauma memory keeps Veteran stuck which prevents them from completely working through problematic, trauma-related thoughts

→

Cognitive-focused techniques are used to help patient move past "stuck points" and progress toward recovery

So how does CPT work?

- Challenging avoidance
- Cessation of natural emotions
- Change in thinking about meaning of event changes manufactured emotions instantly (no habituation required)
- Clients learn to not over-generalize their thinking about a single bad event to all people or to themselves

Flow of Therapy

Education regarding PTSD, thoughts, and emotions	Impact Statement
	ABC Worksheet
Processing the Trauma	Optional: Written Account
Learning to Challenge	Challenging Questions
	Problematic Patterns
Change and Facing the Future	Changing Beliefs
	Trauma Themes

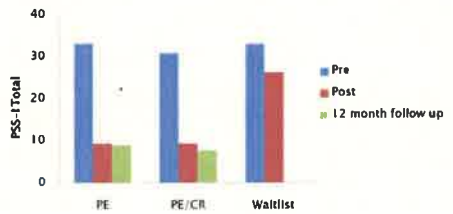
Meta-analysis of Prolonged Exposure

Across 13 studies and 675 patients:	
	Effect Size
Reduction in PTSD symptoms	
At post-treatment	1.08
At follow-up	.68
Reduction in depression, anxiety, social adjustment, quality of life	
At post-treatment	.77
At follow-up	.41

"A therapist can expect that his/her average PE treated patient will fare better than 86% of patients treated with supportive counseling and similar unstructured talk therapies."

Powers et al, 2010

What does the research show?

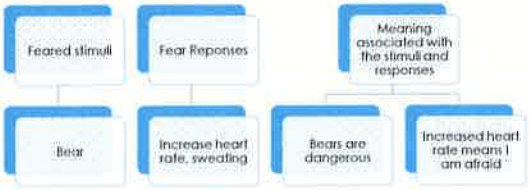


Foa et al., 2005

Rationale

- Trauma-focused therapy
- Helps emotionally process event
- Re-engage with situations that have been avoided

Emotional Processing



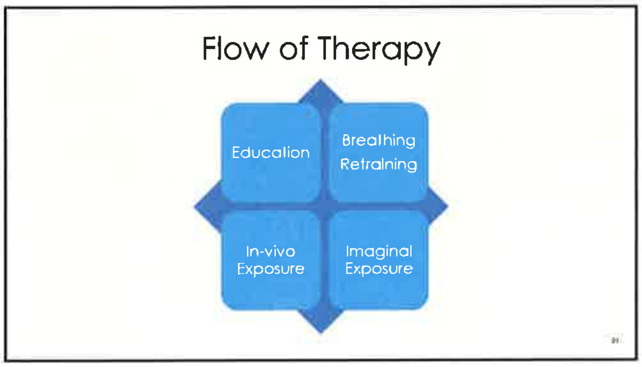
Emotional Processing

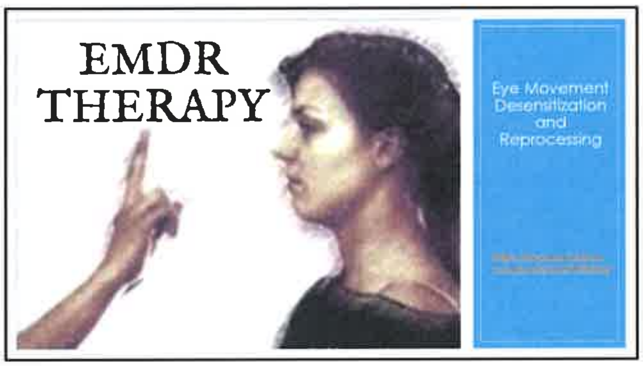
How Does Exposure Therapy Work?

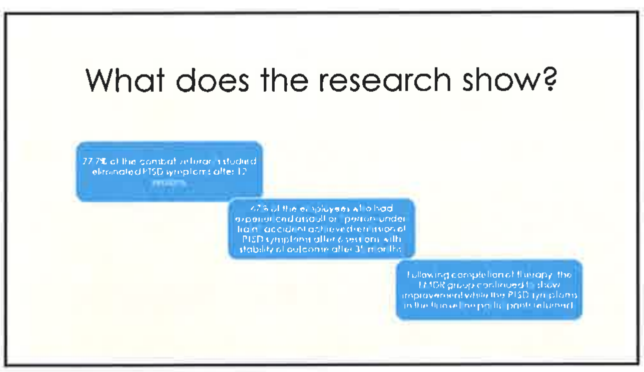
Imaginal exposure *enhances emotional processing of trauma*

In-vivo exposure *helps to re-engage with activities, people, situations that are avoided due to the trauma*

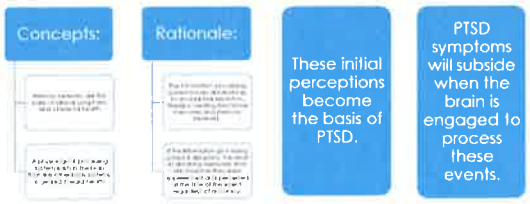
Both help to modify dysfunctional, negative cognitions underlying PTSD and reduce trauma related distress


Flow of Therapy
Education
Breathing Retraining
In-vivo Exposure
Imaginal Exposure


EMDR THERAPY
Eye Movement Desensitization and Reprocessing


What does the research show?

Adaptive Information Processing (AIP) Model



Bilateral Stimulation

Purpose:

- Used to stimulate both halves of the brain.
- Decreases the vividness of the traumatic image
- Allows for reduced emotional reaction
- Makes it easier to reprocess the memories with positive information.

Types:

- Eye Movements
- Touch
- Sound

Flow of Therapy

Client History	• Background and suitability for EMDR • Identifying processing targets
Preparation	• Preparing for processing of targets • Stabilize and increase access to positive affects
Assessment	• Access the target for EMDR processing by stimulating primary aspects of the memory
Desensitization	• Process experiences toward an adaptive resolution with complete assimilation of memories
Installation	• Increase connections to positive cognitive networks • Increase generalization effects within associated memories
Body Scan	• Complete processing of any residual disturbance associated with the target
Closure	• Ensure client stability for completion of session and between sessions
Reevaluation	• Treatment effects • Ensure comprehensive processing over time

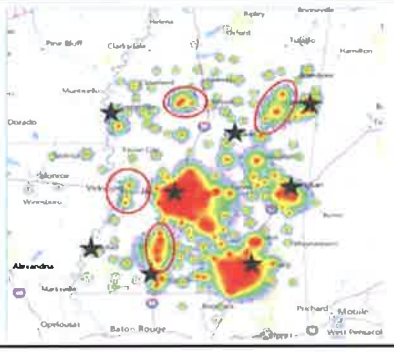
DIVERSITY

Highly structured	Therapist led	Practice Assignment completion
Values empiricism	Values less extreme thinking	Needs regular attendance

Ways that EBPs can be challenging cross-culturally

Client, not the therapist, supplies the answers	Ask, don't assume (Socratic questioning)	Although it is set up to be a 12 session protocol, this can be lengthened
Although it is trauma-focused, clients also apply the skills to current stressors and concerns	Encourages use of auxiliary resources (supportive therapist, mediation, religious community, concurrent substance use treatment, family support)	

Ways that EBPs lends itself to culturally sensitive interventions



What is Telemental Health?

"The term telemental health services typically refers to behavioral health services that are provided using communication technology."

Benefits of Telemental Health

- Technology is rapidly increasing system coverage area, thereby increasing the reach to rural veterans
- Patient benefits with regard to lost employment time, as well as transportation costs and time
- Satisfaction with service delivery is high among patients and providers
- Efficacy data in telemental health: supportive
- Lower cost: Without sacrificing quality of care
- Decreased hospitalization utilization by an average of approximately 25% (Godleski, 2012)

Veteran Considerations

- Not adequate sensory abilities to participate
- No active suicidal or homicidal ideation with or without high lethality
- No active psychosis or uncontrolled substance use disorder
- Established primary care provider and/or mental health point of contact at local CBOC

How to refer to VA

- Veterans who have never enrolled with a VA Medical Center will need to bring their DD214 and ID to any VAMC or Community Based Outpatient Clinic to complete enrollment forms.
- Enrolled veterans can be referred directly to most programs. Other programs require referral from a VA provider.
- At Jackson VAMC, enrollment is located in Module A, just inside the west entrance. Contact Number: 601-362-4471

Resources

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