Plenary #2

PTSD Treatment Guidelines and Clinical Care: The Significance of Relationship

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PTSD Treatment Guidelines and Clinical Care: 
The Significance of Relationship 
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Disclosure


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- Presenter chaired:

  - American Psychological Association Clinical Practice Guidelines for the Treatment of PTSD (2017) and

  - Joint APA Division 56 and ISSTD Professional Practice Guidelines for complex trauma (under review)

Background

- Evidence-based practice (EBP) has been debated for years between researchers and practitioners in American Psychological Association (APA)

- APA defined evidence base as:

  - Research findings
  - Clinician judgment
  - Client preference and context

  (APA Task Force on EBP, 2006)
Background

Two types of treatment guidelines, per APA (2016)

- Clinical Practice Guidelines (CPGs)
- Professional Practice Guidelines (PPGs)

Note: Treatment guidelines in mental health used to be a blend of the two

Clinical Practice Guidelines (CPGs)

- Based on:
  - Systematic Review of Literature
    - Outcome research re: efficacy
    - Randomized Control Trials (RCTs)
      - Evaluated stringently
      - Criteria for inclusion
    - Analyzed by appointed panel
      - COIs & expertise, multidisciplinary
      - Recommendations made

Clinical Practice Guidelines in Medicine and Mental/Behavioral Health

- A long history
- A wide variety of topics available
- Recent emergence in mental/behavioral health
  - “First generation”: more a blending of CPGs and PPGs
  - “Current generation”: more emphasis on RCTs and methodological stringency

(Institute of Medicine, 2011 a & b)
Background

Professional Practice Guidelines (PPGs)

Based on:

- Available research findings
- Authoritative writing on the topic
- Clinician consensus
- “How to” rather than strictly “What to do/not do” / “What does the evidence tell us”
- Needs of the individual/population
- Context and intersectionality
- Needs for specialized training
- Cautions

“Classic” PTSD: DSM-5

- Criterion A restricted definition of PTEs
- 4 additional criteria:
  - Re-experiencing
  - Numbing
  - Avoidance and changed cognition
  - Hyper-arousal
  - Dissociative Sub-type included

Treatment Guidelines For “Classic” PTSD

- American Psychological Association (APA, 2017)
- Australian Centre for Posttraumatic Mental Health (now Phoenix) (2007, 2013)
- Institute of Medicine, (IOM, 2006)
- National Institute of Clinical Excellence (NICE, UK, 2005)
- American Psychiatric Association (APA, 2003)
- Clinical Efficiency Support Team (CREST, Northern Ireland, 2003)
- Journal of Clinical Psychiatry (JCP, 1999)
Complex PTSD: *ICD-11*

- Expands the definition of PTEs to include emotional/developmental trauma to Criterion A
- Meets criteria for PTSD (sibling disorder)
- 3 additional criteria:
  - Emotional dysregulation
  - Self identity and development
  - Meaning-making and spirituality
  - Relationship difficulties and insecurity

PPGs for Complex PTSD

- CREST, 2003
- Courtois, Ford, & Cloitre, 2009
- Australian Guidelines (Keselman & Stavropolous, 2012)
- ISTSS Complex Trauma Expert Consensus Survey, (Cloitre et al., 2011, *JTS*)
- ISTSS Expert Consensus Guidelines for Complex PTSD (Cloitre et al., 2012)—available at ISTSS.org
- UK Posttraumatic Society
  - (McFetrick et al., 2017)
- Joint APA Division 56 and ISSTD guidelines (Courtois et al., forthcoming, 2018)

Other Relevant PPGs

- Dissociative Disorders
  - Children (*ISSD*, 2001)
- Delayed memory issues
  - Courtois (1999; Mollon, 2004)
Overview of the IOM Process for Guideline Development Using APA as Model

Disclaimer/Preamble

APA PTSD in Adults: The Process

Systematic Review for PTSD CPG
- Followed IOM best practices for conducting SR
- Topic nominated by APA
- Systematic Review (SR) funded by Agency for Healthcare Research and Quality (AHRQ)
- SR conducted by independent RTI-NC Evidence-Based Practice Center
- Panel did not commission the review; used recent existing review
- Panel had input into key questions
APA PTSD in Adults

**Critical and Important Treatment Outcomes Determined by Panel Members**

- **Critical**: essential and necessary to treatment decision making process
  - PTSD symptom reduction and serious harms (adverse events)

- **Important**: significant but not critical for making a decision
  - Remission (no symptoms), loss of diagnosis, quality of life, disability or functional impairment, prevention or reduction of comorbid medical or psychiatric conditions, adverse events leading to treatment discontinuation, other adverse events, burdens

APA: PTSD in Adults

- **PTSD Guideline Recommendations**
  - Recommendations are strong or conditional based on strength of evidence, balance of benefits versus harms/burdens, patient values and preferences, applicability
  - Recommendations for psychological and pharmacological interventions
  - Relatively limited evidence in the SR directly comparing treatments; especially psychological interventions and medications

Overview and Comparison of Most Recent CPGs:

- American Psychological Association (2017)
- US DoD VA (2017)
- Phoenix, Australia (2017)
APA: PTSD in Adults

**Strong Recommendations for these Psychological Interventions**
- CBT-mixed
- Cognitive Processing Therapy
- Cognitive Therapy
- Prolonged Exposure

**Conditional Recommendations for These Psychological Interventions**
- Brief Eclectic Psychotherapy
- Eye Movement Desensitization and Reprocessing Therapy
- Narrative Exposure Therapy

**Recommendations for Psychopharmacotherapy**
- Conditional recommendation
  - Fluoxetine
  - Paroxetine
  - Sertraline
  - Venlafaxine
- No recommendation
  - Risperidone
  - Topiramate
APA: PTSD in Adults

**Comparative Effectiveness**

- Suggests PE over relaxation*
- Suggests CBT over relaxation
- Strongly recommends either PE or Exposure plus cognitive restructuring
- Insufficient evidence to recommend for or against Seeking Safety versus active controls
- Suggests either venlafaxine ER or sertraline

DoD VA Revision (2017)

**How to Use the CPG**

- Can be used in a variety of ways
- Clinicians can study and consider latest info on management of PTSD and whether to incorporate into their practice
- As education

From The DOD VA Guidelines

- The guideline is not intended as a standard of care and should not be used as such. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advances and patterns evolve. Today there is variation among state regulations, and the guideline does not cover the variety of ever-changing state regulations that may be pertinent.
DoD VA Revision (2017)

- Psychotherapy over medication
- 40 recommendations
  - General Clinical Management
  - Diagnosis and Assessment of PTSD
  - Prevention of PTSD
  - Treatment of PTSD
  - Discussion of recommendations: for DOD/VA patients, patient-centered care, shared decision-making, collaborative care

DoD VA Revision (2017)

- Treatment of PTSD (with algorithms)
  - Treatment Selection
  - Psychotherapy
  - Pharmacotherapy
  - Augmentation Therapy
  - Prazosin
  - Combination Therapy
  - Non-pharmacologic Biological Treatments
  - Complementary and Integrative Treatments
  - Technology-based Interventions
  - PTSD with Co-occurring Conditions

Phoenix Australia Centre for Posttraumatic Mental Health 2013

- For ASD & PTSD
- For children & adolescents as well as adults
- 10 recommendations for adults, graded by strength of evidence
Phoenix Australia Centre for Posttraumatic Mental Health 2013

1. Early one session psychological intervention in acute phase not recommended-B
2. Within initial 4 weeks of ASD/PTSD symptoms, consider individual trauma-focused CBT (PE or CT)-C
3. For adults with PTSD, offer CBT or EMDR-A
4. Where symptoms have not responded to TF interventions, consider evidence-based non trauma-focused interventions (SIT)-D
5. Group CBT provided as adjunctive but not an alternative to individual TFT-C

Phoenix Australia Centre for Posttraumatic Mental Health 2013

6. Internet delivered TFT/CBT offered in preference to no intervention-C
7. For exposure to PTEs, drug treatment should not be used as a preventive-C
8. The routine use of psychopharm tx for ASD or early PTSD is not recommended-D
9. Drug treatment should not be preferentially used as a routine first treatment for adults over TFT CBT or EMDR-B
10. Where medication is considered for PTSD tx, SSRI’s should be considered as first choice-C

Note: Hypnosis only receives mention in ISTSS Guidelines
Other Sources of Information for Clinicians

- Meta-analyses of different treatments and of emerging treatments (i.e., Metcalf et al., 2017)
- Cochrane Reviews
- National Registry of Evidence-based Programs and Practices (NREPP, SAMHSA)
- Evidence-based and suggested
- APA Division 12
  - Evidence-based listing
- APA Division 12 & 29
  - Evidence base of relationship variables
- Treatment developers’ research base

Despite All of These Guidelines, There Remain Huge Research and Application Gaps

Recent Editorial in JAMA re: Trauma-Focused Treatment

- Present-focused therapy (PCT) vs. trauma-focused therapies:
  - “Margins of difference are small to negligible”
- Interpersonal Therapy (IPT) which centers on functioning in interpersonal relationships
  - Produces efficacy comparable to that of PE in treating PTSD

(Hoge & Chard, 2018, p. 343)
Recent Editorial in JAMA

“While the field evolves, clinicians and patients should feel reassured that a range of good options, both trauma- and non-trauma focused, is available for treating patients with PTSD.

Clinicians should consider not only how they optimize delivery of core components of trauma-focused care but also how to enhance the nonspecific benefits of therapeutic encounters.”

(Hoge & Chard, 2018)

Recent Editorial in JAMA

“One note of caution for health policy makers and clinicians to consider is not to overinterpret clinical practice guidelines as gospel. Such guidelines prioritize clinicians’ judgment and patient preferences and effectively become outdated as soon as they are written.”

(Hoge & Chard, 2018, p. 344)

Therapist Critiques

800+ comments to APA draft posted on the web
Blog comments/critiques
- Too much reliance on IOM standards
- Do they apply outside of medicine?
- Too much reliance on RCTs and not on other sources of info
- Favors CBT over other treatments
- There is much more to PTSD than symptoms
- Fear of misuse by insurance companies
- One size or techniques (or even one therapist) does not fit all
- Limited or no attention to Evidence Based Relationship and Responsiveness Variables (EBRs)
“Common” Factors Research Missing in These Guidelines

- Evidence-based Relationship Variables (ERBs)
- APA Division 12 & 29
  - Research on relationships variables

Dual Aims of ERB’s:
1. Identify elements of effective therapy relationships
2. Identify effective responses to tailor or adapt therapy to the individual patient

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% of (Total) Psychotherapy Outcome Variance Attributable to Therapeutic Factors

- Other Factors: 25%
- Individual Therapist: 7%
- Treatment Method: 9%
- Therapy Relationship: 12%
- Patient Contribution: 10%
- Unexplained Variance: 40%

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What Works in Evidence-Based Relationships?

Decades of research and experience show that the relationship itself works—
But, it is not the only thing
Effective Elements of the Therapy Relationship

Demonstrably and Probably Effective
Alliance in individual psychotherapy
Alliance in youth therapy
Alliance in couple & family therapy
Cohesion in group therapy
Empathy
Goal consensus
Collaboration
Collecting client feedback
Positive regard/affirmation

(Norcross, 2011, 2014)

Results Of An SR of ERBs on Treatment Outcome for Adults with Trauma

19 studies
Alliance was predictive of or associated with a reduction in various symptomatology
More research needed on therapist client characteristics (i.e., client preference and feedback, management of transference and countertransference, etc).

(Ellis, Simiola, Brown, Courtois, & Cook, 2017)

From Attachment and Neuroscience Studies

Responsive other
Keeping the other in mind
Internalizing the other
Body-brain attunement
Right brain to right brain
Somatosensory/implicit
Mirroring and regulation
Co-regulation to auto-regulation
Eyes
Breathing
Posture
Mutual curiosity and mindfulness to strengthen self and build mentalization/consciousness
Being in the moment together
What Works in Evidence-Based Responsiveness?
(a/k/a customization, matching, tailoring)

- Reactance Level of Client
- Stages of Change
- Preferences
- Coping Style
- Culture
- Religion/Spirituality

What Is A Clinician To Do With All of This Information?

Some Suggested Approaches

- Have basic training on trauma and its treatment
  - Competencies have been identified
- Use your therapeutic orientation as your base
- Get certification in one or more EB trauma treatment method that appeals to you
- Stay informed about guideline findings and what has the strongest evidence base
  - Methods
  - Relationship/responsiveness variables
  - Know that this information will continue to be updated and that treatment will evolve
Some Suggested Approaches

- Know that “one size treatment does not fit all”
- Check out integrated treatments
  - Use informed consent/refusal—especially important with anything that is experimental
    - Client preference
    - Client contextual variables
  - Initial focus on safety and stability
  - Switch approaches when primary mode is not working
  - Adjunctive therapies?
  - Complimentary and integrative therapies?

Some Suggested Approaches

- Maintain a high degree of self-awareness and health
  - Treating the traumatized is not for the faint-hearted
  - Work on your own secure (or earned secure) attachment status
    - Be responsive not reactive
  - Have and maintain a support system
    - Personal and professional
  - Continue to learn
    - From our clients and about ourselves

Conclusion

- “It’s a jungle out there”
- Knowledge of the terrain helps
- Staying updated helps
- Be able to justify your treatment methods, recommendations, and choices
  - Be sure you have training in implementing
- Partner and collaborate with clients
- Operate from a philosophy of trauma-informed care
- Our clients deserve no less


Listing of Treatment Guidelines for PTSD