EFFECTIVE TREATMENTS FOR PTSD

Practice Guidelines from the International Society for Traumatic Stress Studies

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THE GUILFORD PRESS
New York London

1

Introduction

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The treatment guidelines presented in this book were developed under the auspices of the PTSD Treatment Guidelines Task Force established by the Board of Directors of the International Society for Traumatic Stress Studies (ISTSS) in November 1997. Our goal was to develop a set of treatment guidelines based on an extensive review of the clinical and research literature prepared by experts in one field. The book consists of two parts. The first comprises the position papers that describe the salient literature; the second, the much briefer treatment guidelines. These guidelines are intended to inform the clinician on what we determined were the best practices in the treatment of individuals with a diagnosis of posttraumatic stress disorder (PTSD). PTSD is a serious psychological condition that occurs as a result of experiencing a traumatic event. The symptoms that characterize PTSD are reliving the traumatic event or frightening elements of it; avoidance of thoughts, memories, people, and places associated with the event; emotional numbing; and symptoms of elevated arousal. Often accompanied by other psychological disorders, PTSD is a complex condition that can be associated with significant morbidity, disability, and impairment of life functions.

In the development of these practice guidelines, the Task Force *acknowledged* that traumatic experiences can lead to the development of several different disorders, including major depression, specific phobias, disorders of extreme stress not otherwise specified (DESNOS), personality disorders such as borderline anxiety disorder, and panic disorder. Yet the focus of these guidelines is specifically on the treatment of PTSD and its symptoms as defined in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) of the American Psychiatric Association (1994).

It is also recognized that the PTSD diagnostic framework is inherently limiting and these limitations may be particularly salient for survivors of early childhood sexual and physical abuse. Sometimes referred to as DESNOS, people with these histories display a wide range of relational and interpersonal problems that contribute to distressed lives and disability. Yet relatively little is known about the successful treatment of patients with these trauma histories. There is a growing clinical consensus, with a degree of empirical support, that some patients with these histories require multimodal interventions applied consistently over a longer time period.

The Task Force also recognized that PTSD is often accompanied by other psychological conditions and that such comorbidity requires clinical sensitivity, attention, and evaluation at the point of diagnosis and throughout the process of treatment. Disorders of particular concern are substance abuse and major depression, the most frequently co-occurring conditions. Practitioners are referred to the guidelines for these disorders in the development of treatment plans for individuals who manifest multiple disorders and to the integration and summary comments in Chapter 27.

These guidelines are intended for adults, adolescents, and children who have developed PTSD. Their objective is to assist the clinician in providing treatment to these individuals. Because clinicians with diverse professional backgrounds provide mental health treatment for PTSD, the guidelines were developed with interdisciplinary input. Psychologists, psychiatrists, social workers, creative arts therapists, marital therapists, and others actively contributed to, and participated in, the developmental process. Accordingly, the guidelines are suitable for the diversity of clinicians who treat PTSD.

The Task Force explicitly excluded from consideration individuals who are currently involved in violent or abusive relationships. These individuals, ranging from children who are living with an abusive caregiver, to women or men who are currently targets of domestic abuse or violence, to those still living in a war zone, may well meet diagnostic criteria for PTSD. Yet their treatment, and the related forensic and ethical issues that arise, differs fundamentally from those individuals whose traumatic events are over. Individuals who are in the midst of a traumatic situation require special considerations from the clinician. Other practice guidelines will need to be developed for these circumstances.

Little is known about the treatment of PTSD in nonindustrialized countries. Research and scholarly treatises on the topic come largely from the Western industrialized nations. The Task Force acknowledges this cultural limitation explicitly. There is growing recognition that PTSD is a universal response to exposure to traumatic events that is observed in many different cultures and societies. Yet there is a need for systematic research to determine the extent to which the treatments, both psychological and psychopharmacological, that have proven efficacy in Western societies are effective in non-Western cultures.

Finally, clinicians following these guidelines should not limit themselves to only these approaches and techniques. Creative integration of new approaches that have been found to be helpful in other conditions and that have a theoretically sound foundation are encouraged in an effort to optimize treatment outcome.

THE PROCESS OF DEVELOPING THE GUIDELINES

The process of developing these guidelines was as follows. The Task Force cochairs assembled the Task Force by identifying experts in the major schools of therapy and treatment modalities that are currently used with patients who suffer from PTSD. The Task Force was expanded as additional relevant treatment approaches were identified. Thus, the Task Force represented experts across approaches, theoretical orientations, schools of therapy, and professional training. The focus of the guidelines and their format was determined by the Task Force in a series of meetings.

The Task Force cochairs commissioned position papers on the major treatment areas or modalities from Task Force members. Each paper was to be written by a designated member with assistance from other members or clinicians of their choosing as deemed necessary by that member. The position papers included literature reviews of research and clinical practice.

The literature reviews on each of the topics involved the use of online literature searches such as Published International Literature on Traumatic Stress (PILOTS), MEDLINE, and PsycLIT. The resulting papers adhered to a standard format and were restricted in length. Authors reviewed the literature in their assigned area, presented the clinical findings, reviewed critically the scientific support for the approach, and presented the papers to the Chairs. Completed papers were then distributed to all Task Force members for comments and active discussion. These reviews resulted in further revisions to the papers and these eventually became the chapters in this book.

On the basis of the position papers and careful attention to the literature review, a draft of the brief practice guidelines for each treatment approach was developed. These appear in Part II. In these guidelines, each treatment approach or modality was assigned ratings with respect to strength of evidence regarding its efficacy. These ratings were standardized using a coding system adapted from the Agency for Health Care Policy and Research (AHCPR; U.S. Department of Health and Human Services, Public Health Service). This rating system, presented below, represents an effort to formulate recommendations for practitioners based on the available scientific evidence.

The guidelines were reviewed by all members of the Task Force for concurrence and then presented to the Board of Directors of the ISTSS, sent for review to a broad range of professional associations, presented at a public forum at the annual meeting of the ISTSS, and placed on the ISTSS website

for comments from the membership. Feedback obtained from this iterative process was incorporated into the guidelines.

There are limitations that exist in the scientific literature on PTSD as well as for other mental disorders. Specifically, most studies use inclusion and exclusion criteria in order to define participants appropriately; accordingly, each study may not fully represent the complete spectrum of patients seeking treatment. It is customary, for example, in studies of PTSD treatment to exclude patients with active substance dependence, acute suicidal ideation, neuropsychological deficits, retardation, or cardiovascular disease. Generalization of the findings, and the resulting guidelines, to these populations would not be appropriate.

CLINICAL ISSUES

Type of Trauma

Most randomized clinical trials (RCTs) with combat (mostly Vietnam) veterans showed less treatment efficacy than RCTs with nonveterans whose PTSD was related to other traumatic experiences (e.g., sexual assaults, accidents, natural disasters). Therefore, some experts believe that combat veterans with PTSD are less responsive to treatment than survivors of other traumas. Such a conclusion is premature. The difference between veterans and other PTSD patients may be related to the greater severity and chronicity of their PTSD rather than to differences inherent to combat traumas. Furthermore, the poor treatment response in veterans may be a sampling artifact, since veterans currently receiving treatment at VA hospitals may constitute a self-selected group of chronic patients with multiple impairments. In short, there is no conclusive evidence at this time that PTSD following certain traumas is especially resistant to treatment.

Single versus Multiple Traumas

No clinical studies have been designed to address the question of whether the number of previous traumas predicts treatment response among PTSD patients. Since most treatment studies have been conducted with either military veterans or female adult survivors of sexual assault, many of whom have a history of multiple assaults, it appears that much of the current knowledge about treatment efficacy applies to people who have been traumatized more than once. It would be of great interest to conduct studies comparing individuals with single versus multiple traumas in order to find out whether, as expected, the former would be more responsive to treatment. Recruitment for such studies could be very difficult, however, since the research design would have to control for PTSD severity and chronicity, as well as for comor-

bid diagnoses—each of which may be more predictive of treatment response than number of traumas experienced.

Chronicity of PTSD

There is growing interest in clinical approaches that emphasize prevention, identification of risk factors, early detection of PTSD, and acute intervention. This is because of the idea that, as with many medical and mental disorders, PTSD has a better prognosis if clinical intervention is implemented as early as possible. However, the few studies available to date do not support this view. On the other hand, there is abundant evidence that many people who develop PTSD continue to suffer from the disorder indefinitely. Although it is unclear whether chronic PTSD is inherently (e.g., psychobiologically) different than more acute clinical presentations, it is generally believed that chronic PTSD is more difficult to treat.

Some patients with chronic PTSD develop a persistent incapacitating mental illness marked by severe and intolerable symptoms; marital, social, and vocational disability; as well as extensive use of psychiatric and community services. Such patients may benefit more from case management and psychosocial rehabilitation than from psycho- or pharmacotherapy (see Chapter 11).

Gender

Although lifetime prevalence rates of PTSD are twice as high for women as for men (10.4% vs. 5%) and women are four times more likely to develop PTSD when exposed to the same trauma, gender differences in response to treatment have not been studied systematically. Therefore, we do not know whether gender is predictive of treatment outcome. It is important to emphasize this point, since, as noted earlier, a superficial review of the treatment literature suggests that women are more responsive to treatment than men. On further inspection, however, several differences between treatment studies with men and women can be noted, making direct comparisons difficult. First, the PTSD of women studied has usually been caused by (childhood or adult) sexual trauma, whereas studies with men have usually involved war veterans. Second, since there are few data on men who are not Vietnam veterans, one cannot generalize the published data regarding veterans to men with other trauma histories. Finally, other factors such as treatment modality, PTSD severity/chronicity, or the presence of comorbid disorders will need to be systematically controlled in future studies before differences in treatment outcome can be attributed to gender. In short, it is impossible to conclude that gender is predictive of treatment response at this time.

Age

Two questions are relevant concerning the effects of age on treatment outcome: (1) Does the age at which the trauma occurred influence response to treatment? and (2) Does the age when treatment began affect treatment outcome? Neither question has been studied systematically; hence, there are no conclusive data on either question. Adults and children have responded to some treatments and not others. Age of traumatization has not predicted treatment outcome in studies published to date.

Children

Children present so many distinct challenges for assessment and treatment that an entire chapter in this volume has been devoted to treatment of children with PTSD . Developmental level is particularly important, since it may influence both the clinical phenomenology of PTSD in children as well as the choice of treatment. In addition, parental factors must be carefully considered when treating children. Developmental biological factors may also influence choice of drug, if pharmacotherapy is indicated, while developmental cognitive factors may influence both assessment strategies and choice of psychotherapy.

Elder Adults

PTSD may have its onset or reoccurrence at any point in the life cycle. It may persist for decades and even intensify in old age. Developmental factors unique to older adults may influence susceptibility to PTSD among the aged. These include a sense of helplessness produced by illness, diminished functional capacity, or social marginalization. Death of loved ones can trigger intrusive recollections of traumatic losses, thereby precipitating a relapse of PTSD symptoms that may have been in remission for decades. Retirement and the life review process of old age can also increase vulnerability to PTSD exacerbation or relapse. Developmental biological factors may influence both the choice and recommended dosage of any drug selected for pharmacotherapy, while cognitive status may influence the approach to both assessment and psychotherapy for older PTSD patients.

FACTORS AFFECTING TREATMENT DECISIONS

At present, few empirical data exist to guide us in the question of how to decide the course of treatment for PTSD. However, some clinical considerations are discussed below, as well as in Chapter 27.

Treatment Goals

All treatments presented in these guidelines have proponents who claim that they are clinically useful for patients with PTSD. The therapeutic goals for each treatment, however, are not necessarily the same. Some treatments (e.g., cognitive-behavioral therapy, pharmacotherapy and eye movement desensitization and reprocessing) target PTSD symptom reduction as the major clinical outcome by which efficacy should be judged. Other treatments (e.g., hypnosis, art therapy, and, possibly, psychoanalysis) emphasize the capacity to enrich the assessment or therapeutic process rather than the ability to improve PTSD symptoms. Still other treatments (e.g., psychosocial rehabilitation) emphasize functional improvement with or without reduction of PTSD symptoms. Finally, some interventions (e.g., hospitalization, substance abuse treatment) focus primarily on severe disruptive behaviors or comorbid disorders that must be addressed before PTSD treatment per se can be initiated.

Treatment of PTSD

Treatment of PTSD is the major criterion by which all clinical practice is evaluated in these guidelines. Some treatments appear to reduce all clusters of PTSD symptoms, while others seem to be effective in attenuating one symptom cluster (e.g., intrusion [B], avoidant/numbing [C], or arousal [D] symptoms) but not others. Chapter 2 discusses state-of-the-art methods for assessing and monitoring PTSD symptom severity during a treatment trial. Some experts have challenged the focus on specific symptoms when evaluating various therapeutic approaches, arguing that the best gauge of clinical efficacy is the capacity of a given treatment to produce global improvement in PTSD rather than specific symptom reduction. In these guidelines, however, the major criterion for treatment efficacy is reduction of PTSD symptoms, although clinical global improvement is indicated when available.

Comorbidity

As with other mental disorders, patients with PTSD usually have at least one other psychiatric disorder. Indeed, U.S. epidemiological findings indicate that 80% of patients with lifetime PTSD suffer from lifetime depression, another anxiety disorder, or chemical abuse/dependency. Good clinical practice dictates that the best treatment is one that might be expected to ameliorate both PTSD and comorbid symptoms. Therefore, the presence of a specific comorbid disorder may prompt a clinician to choose one particular treatment rather than another. This matter is addressed in more detail in Chapter 27. Again, it must be emphasized, however, that treatment of PTSD is the major criterion by which all the clinical practices have been evaluated.

Suicidality

Self-destructive and impulsive behaviors, while not part of the core PTSD symptom complex, are recognized as associated features of this disorder that may profoundly affect clinical management. Therefore, the routine assessment of all patients presenting with PTSD should include a careful evaluation of current suicidal ideation and past history of suicidal attempts. Risk factors for suicide should also be assessed, such as current depression and substance abuse. If significant suicidality is present, it must be addressed before any other treatment is initiated. If the patient cannot be safely managed as an outpatient, hospitalization should be the immediate clinical focus. If suicidality is secondary to depression and/or substance abuse, clinical attention must focus on either or both conditions before initiating treatment for PTSD.

Chemical Abuse/Dependence

Lifetime prevalence rates of alcohol abuse/dependence among men and women with PTSD are approximately 52% and 28%, respectively, while lifetime prevalence rates for drug abuse/dependence are 35% and 27%, respectively. Such comorbid disorders not only complicate treatment but in some cases might also exacerbate PTSD itself. In addition, a number of legal substances such as nicotine, caffeine, and sympathomimetics (e.g., nasal decongestants) may interfere with treatment and, therefore, should be carefully assessed with all PTSD patients. In many cases, if significant chemical abuse/dependency is present, it should be addressed before PTSD treatment is initiated.

Concurrent General Medical Conditions

There is mounting evidence that traumatized individuals appear to be at greater risk of developing medical illnesses. Compared to nontraumatized individuals, trauma survivors report more medical symptoms, use more medical services, have more medical illnesses detected during a physical examination, and display higher mortality. A few studies suggest that such adverse medical consequences may be mediated by PTSD. This has generated recent interest in screening primary and specialty medical patients for both a trauma history and for PTSD symptoms. This work is in its infancy, however, and there are no data on treatment of PTSD among patients seeking medical or surgical care.

Disability and Functional Impairment

PTSD sufferers differ greatly from one another with respect to symptom severity, chronicity, complexity, comorbidity, associated symptoms, and func-

tional impairment. These differences may affect both the choice of treatment and the clinical goals. For some patients with chronic PTSD, functional improvement may be much more important than reduction of PTSD symptoms. In others (especially those who have been subjected to protracted child sexual abuse or torture), clinical interventions often need to focus primarily on symptoms of dissociation, impulsivity, affect liability, somatization, interpersonal difficulties, or pathological changes in identity. Therefore, although the major emphasis in these guidelines is on reduction of core PTSD symptoms, clinicians may find that functional improvement is the most important or appropriate clinical priority for some patients.

Indications for Hospitalization

Inpatient treatment should be considered when the individual is in imminent danger of harming self or others, has destabilized or relapsed significantly in the ability to function, is in the throes of major psychosocial stressors, and/or is in need of specialized observation/evaluation in a secure environment. Elective hospitalization on a specialized inpatient treatment program is reviewed at length in a chapter devoted entirely to this topic (see Chapter 10). The general recommendation is that such a hospitalization must occur in collaboration with outpatient providers and be integrated into the overall long-term treatment plan that has been developed. Our basic philosophy is that a focus on the past trauma is only in the interest of the future. The goal of treatment is to facilitate efforts to create a life that can move beyond the current immobilization and preoccupation produced by the trauma.

WHAT TREATMENTS ARE INCLUDED IN THE GUIDELINES?

The treatment for trauma-related disturbances has been discussed extensively in the literature for over 100 years. This rich literature has provided us with much clinical wisdom. In the last two decades, several treatments for PTSD have been studied using experimental and statistical methods. Thus, at the present time, we have both clinical and scientific knowledge about what treatment modalities help patients with posttrauma problems. Accordingly, the guidelines contain a variety of psychotherapies and pharmacotherapies that have been practiced with trauma victims who suffer trauma-related symptoms.

The scientific and clinical evidence for the efficacy of these therapies in reducing PTSD and related symptoms vary greatly from one another. However, the study of treatment efficacy for PTSD is still in its initial stage relative to other mental disorders; consequently, the Task Force decided to include in

the guidelines both therapies that have been found effective by well-controlled studies and therapies that have long history of practice with traumatized individuals but have not yet been subjected to empirical testing.

CLINICAL RESEARCH ISSUES

What Are Well-Controlled Studies?

Many studies have been conducted to ascertain the efficacy of various treatments in reducing PTSD, only relatively few studies to date have employed rigorous methods. Well-controlled studies should have the following features:

1. *Clearly defined target symptoms.* Merely experiencing a trauma is not an indication for treatment in and of itself. Significant trauma-related symptoms, such as the presence of PTSD or depression, should be present to justify treatment. Whatever the target symptom or syndrome, it should be defined clearly so that appropriate measures can be employed to assess improvement. In addition to ascertaining diagnostic status, it is also important to specify a threshold of symptom severity as an inclusion criterion for entering treatment.

A related issue to target symptoms is the importance of delineating inclusion and exclusion criteria. Delineation of inclusion–exclusion criteria can be of assistance both in examining predictors of outcome and in evaluating the efficacy of the treatment and its generalizability beyond the studied sample. If a treatment is effective regardless of sample differences, it proves more robust and therefore a more useful treatment.

2. *Reliable and valid measures.* Once target symptoms have been identified and the population defined, measures with good psychometric properties should be employed (see earlier discussion on measures). For studies targeting a particular diagnosis, assessment should include instruments designed to yield diagnoses as well as instruments that assess symptom severity.

3. *Use of blind evaluators.* Early studies of treatment of traumatized individuals relied primarily on therapist and patient reports to evaluate treatment efficacy and introduced expectancy and demand biases into the evaluation. The use of blind evaluators is a current requirement for a credible treatment outcome study. Two procedures are involved in keeping an evaluator blind. First, the evaluator should not be the same person conducting the treatment. Second, patients should be trained not to reveal their treatment condition during the evaluation so as not to bias the blind evaluator's ratings.

4. *Assessor training.* The reliability and validity of an assessment depends largely on the skill of the evaluator; thus, training of assessors is critical and a minimum criterion should be specified. This includes demonstrating inter-

rater reliability and calibrating assessment procedures over the course of the study to prevent evaluator drift.

5. *Manualized, replicable, specific treatment programs.* It is also important that the treatment chosen is designed to address the target problem defined by inclusion criteria. Thus, if PTSD is the disorder targeted for treatment, employing a treatment specifically developed for PTSD would be most appropriate. Detailed treatment manuals are of utmost importance in evaluating treatment efficacy because they help to ensure consistent treatment delivery across patients and across therapists, and afford replicability of the treatment to determine generalizability.

6. *Unbiased assignment to treatment.* To eliminate one potential source of bias, neither patients nor therapists should be allowed to choose the patient's treatment condition. Instead, patients should be assigned randomly to treatment condition, or assigned via a stratified sampling approach. This helps to ensure that observed differences or similarities among treatments are due to the techniques employed rather than to extraneous factors. To separate the effects of treatment from therapists, each treatment should be delivered by at least two therapists, and patients should be randomly assigned to therapists within each condition.

7. *Treatment adherence.* The final component of a well-controlled study is the use of treatment adherence ratings. These ratings inform as to whether the treatments were carried out as planned, and whether components of one treatment condition drifted into another.

Limitations of Well-Controlled Studies

While controlled studies are essential for evaluating the efficacy of a given treatment approach, the data emerging from such studies are by no means without problems. The stringent requirements of such studies can render unrepresentative samples; therefore, the generalizablity of the results may be limited. For example, the requirement of random assignments to studies that include placebo may be acceptable to some patients but not to others and the factors that lead someone to enroll in such studies may be germane to how well he or she responds to treatment. Differential rates of dropout also need to be considered when evaluating the studies that have been completed. Some treatments by their very nature are powerful and/or may not be consistent with the patient's expectations of treatment, leading to dropouts. This can and should influence conclusions.

Another source of bias in knowledge derived from controlled studies is that certain treatment approaches are more amenable for some studies than others. For example, short-term and structured treatments such as cognitive-behavioral therapy and medication are more suitable for controlled trials than longer, less structured treatments. As a result, knowledge about the efficacy of the former is more available than that of the latter.

What Is Effect Size?

There are many ways to calculate the effectiveness of a given treatment in ameliorating the target disorder. One way is to examine how many treated people lose their diagnosis. Another way is to calculate reduction in symptom severity from pre- to posttreatment or to follow-up. Effect size is a statistical method that was developed to evaluate in a standardized manner how much, on the average, a given treatment program reduced the severity of the target symptoms severity. Using an effect size method enables us to compare efficacy of different types of treatments across studies. This method was applied to all empirical studies discussed in this volume.

To enhance comparability among the position papers, procedures for calculating and presenting effect sizes were standardized in two ways. First, a single effect size statistic was adopted: a member of Cohen's *d* family of effect size estimators known as Hedges's unbiased *g*. Like Cohen's *d*, Hedges's unbiased *g* is easy to conceptualize. It is based on the standardized difference between two means, typically the mean of a treatment sample minus the mean of a comparison sample divided by pooled standard deviations of the two samples. Therefore, each whole number represents one standard deviation away from the comparison sample mean. For example, if $g = 0.5$, the mean of the treatment sample would be estimated to be one-half standard deviation above the comparison sample. Unlike Cohen's *d*, which systematically overestimates when used with small samples, Hedges's unbiased *g* includes a mathematical adjustment for small sample bias. To further ease comparability, the signs of all effect sizes were then adjusted such that positive effect sizes always represent better outcome than the comparison group.

Second, a hierarchical procedure was adopted for selecting the studies to be included in each position paper. This was done because studies that utilize different kinds of comparison groups produce effect sizes that are not directly comparable, even when utilizing the same effect size statistic. If enough studies that utilized comparison groups such as a waiting list or a nonspecific control treatment were available for inclusion in a position paper, studies utilizing other comparison group types were not included. If the number of "no treatment" comparison studies was inadequate for drawing conclusions, studies utilizing "placebo" comparison groups were included with the caution that the effect sizes calculated from these studies would tend to be smaller in comparison, even if the treatments were equally effective. Only if enough studies of either type were not available would purely within-subjects design in which there was no comparison group be included. In these designs, the only way to calculate a standardized difference effect size is to estimate a comparison group's scores by using the pretreatment scores of the treatment group. Because these estimated scores are not independent, effect sizes resulting from these calculations are inflated compared to effect sizes from the other two comparison group types and should not be compared directly with them.

The State of Current Knowledge About Treatment of PTSD

Research on treatment efficacy for PTSD began in the early 1980s, with the introduction of the disorder into DSM-III. Since then, many case reports and studies have been published. These studies vary with respect to their methodological rigor; therefore, the strength of conclusions that can be drawn from them is different for different treatments. In general, psychotherapy, specifically, cognitive-behavioral therapy, and medication, specifically, selective serotonin reuptake inhibitors, have both been shown to be effective treatments for PTSD. However, the absence of evidence for a technique or approach does not imply that it does not work, only that it has not yet been subjected to rigorous scientific scrutiny.

There is some research evidence that psychodynamic psychotherapy, hypnotherapy, and eye movement desensitization and reprocessing are also effective, but the studies are either less numerous or less well controlled. Controlled research on other approaches to treating PTSD is needed and many ongoing projects exist internationally at the time of publication of these guidelines. Most conclusions on the treatment of PTSD are based upon efficacy trials and should be viewed cautiously as a result. The field awaits the completion of effectiveness trials to determine the extent to which findings in controlled treatment trials generalize to other clinical environments. As with all disorders, periodic updates of these guidelines are needed to track progress in the field.

Combined Treatments

There are no studies that systematically examined the value of combining psychotherapy with medication, or combinations of medications. Research on other disorders (e.g., depression) has shown benefits from combination approaches. Only a couple of studies examine whether programs that include a wide variety of cognitive-behavioral therapy techniques yield better outcome over programs that include fewer techniques. On the whole, these studies do not support the administration of more complex programs. Despite the scarcity of knowledge, clinical wisdom dictates the use of combined treatments for some patients. Many patients with PTSD also suffer from depression. If the depression is moderate to severe, a combination of psychotherapy and medication is often desired.

THE CODING SYSTEM

To help the clinician in evaluating the treatment approaches presented in the guidelines, the following coding system was devised to denote the strength of the evidence for each approach.

Each recommendation is identified as falling into one of six categories of endorsements, each indicated by a letter. The six categories represent varying levels of evidence for the use of a specific treatment procedure, or for a specific recommendation. This system was adopted from the Agency of Health Care Policy and Research (AHCPR) classification of Level of Evidence.

Level A: Evidence is based upon randomized, well-controlled clinical trials for individuals with PTSD.

Level B: Evidence is based upon well-designed clinical studies, without randomization or placebo comparison for individuals with PTSD.

Level C: Evidence is based on service and naturalistic clinical studies, combined with clinical observations that are sufficiently compelling to warrant use of the treatment technique or follow the specific recommendation.

Level D: Evidence is based on long-standing and widespread clinical practice that has not been subjected to empirical tests in PTSD.

Level E: Evidence is based on long-standing practice by circumscribed groups of clinicians that has not been subjected to empirical tests in PTSD.

Level F: Evidence is based on recently developed treatment that has not been subjected to clinical or empirical tests in PTSD.

TREATMENT CONSIDERATIONS

Therapist Training

To utilize most appropriately the information contained in these guidelines, individuals should be professionally trained and licensed in their state or country. Typical training would include a graduate-level degree, a clinical internship or its equivalent, and past supervision in the specific technique or approach employed.

Choice of Treatment Setting

Most treatments for PTSD take place in an outpatient setting, such as psychiatric or psychological clinics and counseling centers. However, an inpatient setting may be required when the patient manifests a significant tendency for suicidality or severe comorbid disorders (e.g., psychotic episode, severe borderline personality). The treatment setting should be determined during the initial diagnostic evaluation. Careful monitoring of the patient's mental status throughout treatment may indicate the appropriateness of changes in the treatment setting.

Treatment Management

A comprehensive diagnostic evaluation should precede treatment to determine the presence of PTSD and whether PTSD symptoms constitute the predominant problem of the patient. Once the diagnosis is ascertained, irrespective of the treatment chosen, the clinician should establish a professional milieu. First, the clinician must form and maintain a therapeutic alliance. Special attention should be given to trust and safety issues. Many individuals with PTSD have difficulties trusting others, especially if the trauma had interpersonal aspects (e.g., assault, rape). Other patients have related problems in recognizing and respecting personal boundaries when they enter a therapeutic relationship. Therefore, during the first stage of therapy, attention should be directed to these sensitive issues, providing reassurance that the patient's welfare is the priority in the therapeutic relationship. Second, the therapist should demonstrate concern with the patient's physical safety when planning the treatment, such as appraising the safety of places selected for exposure exercises, or monitoring the safety of the woman who has just left an abusive relationship. Third, the clinician should provide education and reassurance with regard to the PTSD symptoms and related problems. Fourth, the patient's PTSD symptoms and general functioning should be monitored over time. Fifth, comorbid conditions should be identified and addressed. When necessary, it is important to work with other health professionals and with the patient's family members and significant others. Many patients with PTSD require dependable and steady therapeutic relationships because their symptoms do not remit completely and can exacerbate with anniversary reactions and trauma reminders. For these reasons, it is important to assure the patient of the continued availability of his or her therapist. Finally, many patients with PTSD have ongoing crises in their lives and may need to rely intermittently upon a supportive therapist. Crises that arise during the course of therapy have clear implications for the sequencing of treatments for that patient. For some patients, starts and pauses in treatment may characterize the only way that they can engage the process of change. Acknowledging this and accounting for this in designing a treatment plan may avert problems during the intensive therapeutic phase. Additional treatment considerations are presented in Chapter 27.

Treatment Resistance

Despite the progress that has been achieved in the treatment of PTSD, many patients do not benefit from the first line of treatment. The phenomenon of treatment resistance has been particularly noted among Vietnam War veterans receiving VA treatment in the United States, but other trauma populations have their share of treatment failures. It seems that patients with perva-

sive dysfunction and/or high comorbidity are especially resistant to first-line therapy. These patients may be especially good candidates for programs that include multiple treatment modalities such as meditation, psychotherapy, family therapy, and rehabilitation therapy.

Readiness for Treatment

Several factors deter many traumatized individuals with acute PTSD from seeking treatment for the disorder: They assume that the symptoms will dissipate with time; they feel that nothing can help them, or that there is an element of shame surrounding their traumatic experiences. Accordingly, attempts to offer treatment in this initial stage often fail. Even when PTSD becomes chronic, many sufferers do not seek treatment or present to treatment with related symptoms such as depression. Therefore, after diagnosing the disorder, a crucial first step in preparing the patient for treatment of PTSD is educating him or her about the disorder and its high rates among trauma survivors. Many sufferers are reluctant to enter treatment because they view their PTSD symptoms as a personal failure. For many patients, normalization of their symptoms results in immediate relief and reduces their reluctance to enter treatment.

Some patients are reluctant to enter treatment because it often entails discussing the traumatic event either during the assessment or in therapy. The clinician should encourage patients to express their misgivings and be sensitive to the distress they experience when discussing or recounting their traumatic experiences, so that their concerns can be addressed in the first stage of therapy.

VALIDITY OF MEMORIES OF TRAUMATIC EVENTS

To receive the diagnosis of PTSD, one must first be exposed to a traumatic event. Treatment of PTSD typically involves the processing of this event, its meaning, and its consequences. All the methods in the guidelines presuppose the existence of a verifiable and valid traumatic event. The guidelines do not address the use of any of these approaches in an effort to recover unconscious memories of past traumatic events.

The Task Force does acknowledge that memories for traumatic events are sometimes not reported, or are forgotten by individuals who seek mental health treatment. Yet because of lack of scientific evidence, the Task Force does *not* support the position that the presence of some of the symptoms of PTSD (e.g., emotional numbing, concentration problems, etc.) is clear evidence that the patient experienced a traumatic event. Therefore, the Task Force does not support the use of these guidelines to assist in the recovery of forgotten traumatic memories.

HOW TO USE THE GUIDELINES

These guidelines summarize the state of the art in the treatment of PTSD to inform mental health professionals of the care of patients with PTSD. They begin at the point where the patient has been diagnosed as having PTSD, according to the criteria in DSM-IV. The guidelines also assume that the patient has been evaluated for comorbid disorders. The guidelines include treatments with various degrees of evidence for their efficacy, indicated by the coding system described earlier and the conclusions section for each treatment approach.

The clinician is encouraged to adopt treatments that have been proven effective. However, it is important to remember that several treatments with proven efficacy (e.g., medication, cognitive-behavioral therapy) are available. Also, many treatments that have not been evaluated in well-controlled studies have been practiced extensively and, thus, have accumulated clinical evidence for their efficacy. The distinction between clinical wisdom and scientific knowledge is emphasized here. Not all of the art of psychotherapy has been examined in randomized, controlled clinical trials. Experienced and sensitive clinicians are often in the best position to determine the nature and the timing of specific psychological and psychopharmacological interventions.

We recognize that not all treatments are universally effective. Even the best treatments we have to offer fail in certain circumstances. Clinicians are encouraged to assess systematically patients who are not responding to interventions to determine the presence of undisclosed or undetected conditions that might be responsible for a nonresponse. Detection of factors related to a lack of full participation in a treatment plan may also assist the clinician in understanding a poor outcome. Given that several treatments for PTSD have empirical support, the clinician can sequentially apply these to optimize treatment success.

Finally, the choice of treatment approach should be decided by the clinical circumstances presented by the specific patient (e.g., the presence of comorbid disorders and the patient's preferences) as well as by the efficacy of the treatment modality. Much has been learned about the treatment of PTSD in the past 20 years, and much more still needs to be learned. Clinicians are encouraged to incorporate into their clinical practice the approaches that have proven efficacy. In this way, the public health of society will be enhanced. This is the goal of the ISTSS and its production of these treatment guidelines.