PTSD and TBI: What are the Treatment Options

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Outline

- What is PTSD
- PTSD and the courts/criminal behavior
- Data on TBI and comorbidity
- Treatment planning with court order patients
- Evidence based care for PTSD
Response to Trauma and Stress

Following trauma many problems may occur and interact

- PTSD
- Depression
- Physical Health Problems
- Substance Abuse
- Anxiety Panic
- Relationship Problems
PTSD

• Requires:
  ▫ Event that threatened or caused death, physical injury, threat to physical integrity.
  ▫ Responded with fear, helplessness, or horror
    • Recently, this criteria has been removed, but is seen in most cases even if they don’t use the words.

• Symptoms:
  ▫ Reexperiencing of a specific event/s
  ▫ Avoidance
  ▫ Negative alterations in thoughts and mood
  ▫ Alterations in arousal and reactivity

• Must impair function for at least one month
Normal Reaction vs. Pathology

• Most individuals exposed to traumatic situations, do not develop PTSD.

• The manifestation of some symptoms during the first 30-90 days after a traumatic experience is not uncommon and is generally part of the normal stress response.

• However, a pattern of symptoms that begin to interfere with work, home life or interpersonal relationships marks PTSD.

• Persistent symptoms that either do not improve or worsen, even if considered normal initially, become problematic when they do not remit over time.
Criminal Behavior and PTSD

- Symptoms of PTSD and comorbid disorders may increase chance that a person may experience some legal problems.
  - Anger and irritability
  - Hyperarousal/ perception of threat and danger
  - Startle
  - Feelings of disconnection/ isolation and lack of support
  - Intrusions, including flashbacks

- Majority of patients with PTSD do not have problems with the law and are not violent.
Criminal Behavior and PTSD

- Data suggests that PTSD may be linked to violence and aggression (e.g., Kulka et al., 1988; Lasko et al., 1994; Orcutt et al., 2003).
  - Substance use can increase risk

- Presence of PTSD does not suggest criminality and criminal behavior does not mean that symptoms are the cause of the behavior.
Anger & PTSD

• Elevated levels of anger often seen in trauma survivors and has been shown to be related to severity of PTSD (e.g., Riggs et al., 1992).

• Anger is central feature in survival response

• Relationship between anger and PTSD stronger in military samples, but not specific to it (e.g., Orth & Wieland, 2006)

• Anger levels decrease with treatment of PTSD even if it is not directly targeted (Cahill et al., 2003; Stapleton et al., 2006)
Substance Use Disorders and PTSD

- Why the link between PTSD and substance use?
  - High Risk Hypothesis
  - Susceptibility Hypothesis
  - Self-medication Hypothesis (most support)

- Often conceptualized as avoidance in trauma focused therapy

- Data on prevalence varies, but it is estimated that:
  - 20% seeking help for PTSD have a substance use disorder
  - ~33% of veterans seeking help for SUD have PTSD.
  - 30–59% of women with SUD have PTSD (Najavits, Weiss, & Shaw, 1997)
Traumatic Brain Injury (TBI)

• ~1.7 million people sustain a TBI annually
  ▫ Vast majority don’t require hospitalization
  

• Symptoms and course can vary significantly
  ▫ Can include irritability, changes in mood, behavioral changes

• Many symptoms overlap with PTSD
Rates of mTBI and PTSD among OIF/OEF Veterans

- Reported rates of both PTSD and mTBI vary according to the study and may be underreported
  - TBI rates estimated at approaching 20% (Sayer et al., 2009)
    - The majority of these cases are in the mild range of severity
    - Evidence indicates that the majority of these cases resolve within weeks or months
PTSD and TBI

- Studies looking at rates of PTSD following TBI vary considerably
  - Depending on methods for diagnosing PTSD rates reported between ~3-30% with interview and ~18-59% with self-report (Gill et al., 2014).

- PTSD maybe less likely in cases with longer periods of unconsciousness (Glaesser et al., 2004).
Assessment and Treatment with Court Ordered Patients

- Important to consider history of symptoms and behaviors
  - Helps to reduce impact of secondary gain
  - Provides information about potential function of behaviors

- Treatment plans should be symptom/diagnosis based

- Trauma focused therapies can be effective, but are only therapeutic when patients are willing
  - Education and rationale are provided to patient and they be strongly encouraged, but not forced.
Assessment and Treatment with Court Ordered Patients

- PTSD therapies are short-term and involve work outside of the therapy office
  - Goal is to help person reconnect and engage in their life
  - Important that they practice skills in their environment

- Consistent messages from team (treatment team and courts) is important to help combat avoidance
PTSD Treatment
Clinical practice guidelines

- Prolonged Exposure and Cognitive Processing Therapy have been supported as first line treatments for PTSD
  - VA/DOD PTSD Treatment guideline (VA/DOD, 2004, 2010)
  - National Institute of Clinical Excellence (NICE, 2005)
  - International Society of Traumatic Stress Studies (ISTSS, 2009)
  - Institute of Medicine (IOM, 2007)

- Selective Serotonin Reuptake Inhibitors (SSRIs) are also supported first-line treatment- Zoloft and Paxil
Prolonged Exposure (PE) Treatment Procedures

- Psychoeducation: Education about treatment and common reactions to trauma; breathing training
- Repeated *in vivo* exposure
- Imaginal exposure
- Processing of the revisiting and *in vivo* exposure experiences
PE Rationale

- **Exposure:**
  - Challenges belief that anxiety lasts forever
  - Challenges belief that memories, people, places, and situations are dangerous
  - Results in reduction of anxiety without engaging in habitual avoidance behaviors
  - Helps process traumatic experience(s)
  - Enhances sense of control
Cognitive Processing Therapy (CPT)

- Psychoeducation
- Impact Statement
- Trauma Account
- Cognitive Challenge
  - Identify stuck points
  - Safety, trust, power/control, esteem, intimacy
CPT Rationale

- Trauma events change one’s perceptions about the world, themselves, and other people
  - “The world is dangerous”
  - “It’s all my fault”
- Trauma victims with PTSD have a distorted sense of:
  - Safety, Trust, Intimacy, Power/Control, Self-Esteem
- These distortions keep people stuck in their PTSD symptoms and therefore must be modified to accurately fit the context/reality of situations
Initial Data on Outcomes with PTSD/TBI

- Sripada et al., 2013
  - Examined clinical sample from a VA clinic of PTSD patient who received PE and data from a pilot study
  - Compared outcomes of participants with and w/out a history of mTBI
  - Showed that PE was effective in reducing PTSD symptoms and mTBI status did not impact efficacy.
The Good News:

- PTSD can be a chronic disorder, but with the right treatment patients can get significantly better, including no longer meeting criteria for the disorder post-treatment.

- For example, Rauch et al. (2009) found that 80 % of veterans treated with Prolonged Exposure (PE) therapy achieved clinically significant reductions in their PTSD symptoms and 50 % no longer met criteria for PTSD.

- Data from VA roll out training of PE demonstrated that the percentage of veterans screening positive dropped from 87.6% to 46.2% (Eftekhar et al., 2013).
The Good News:

- Monson et al. (2006) found that 40% of a veteran sample receiving Cognitive Processing Therapy (CPT) did not meet criteria for PTSD compared to 3% for a wait-list control group.

- 50% of the veterans receiving CPT had a significant reduction in their symptoms, compared to 10% of the wait-list control group.
References

References


