Treatment Options for Post Traumatic Stress Disorder: Effectiveness and Application

Allison L. Franck

Eastern Michigan University Research Conference

November 6, 2014

This literature review focused on five treatment modalities available for treating Post Traumatic Stress Syndrome (PTSD) to aid clinicians in choosing the intervention most appropriate for each of their clients. These treatment options include: Dialectical Behavioral Therapy (DBT), Cognitive Therapy (CBT), Eye Movement Desensitization (EMDR), Prolonged Exposure Therapy (PE), and Seeking Safety (SS). Clinicians need consolidated information on these therapies so they can offer the most effective therapy for the clients suffering from PTSD to reduce the time it takes to see improvements in symptoms, increase the probability of recovery, and shorten overall treatment time.

For my literature review, I searched scholarly articles and books in Eastern Michigan University's (EMU) ESearchLibrary and Psych Info data bases, using search terms, "PTSD," "Dialectical Behavioral Therapy," "Cognitive Behavioral Therapy," "Seeking Safety," "Prolonged Exposure Therapy," "Eye Movement Desensitization Reprocessing," and "trauma." At least two studies for each of the five treatment modalities were located, ranging in dates from 1999-2014, keeping only those studies that utilized measures with acceptable validity and reliability, including the Clinician Administered PTSD Scale (CAPS) for PTSD symptoms, Post Traumatic Stress Diagnostic Scale (PDS), State Trait-anxiety Inventory Treat (STAI) measuring anxiety, and Beck's Depression Inventory (BDI) to assess depression symptoms. Ten studies were retained on treatment of PTSD. The results of each study were examined: the percentage decrease in symptomaology calculated and *p* values were checked for significance.

The outcome of my literature review revealed strengths and weaknesses in the treatments as well as varying levels of effectiveness.

DBT is a therapy focusing on learning the skills associated with emotional regulation, distress tolerance, and interpersonal effectiveness (Linehan, 1993). One strength of this treatment is that it teaches the client skills to deal with the emotional dysregulation and symptoms that can result from PTSD (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). Therefore, this treatment would be most effective if the client is suffering severe forms of PTSD symptoms of suicidal thoughts, self-harming, substance use, depression, and anxiety. One weakness of DBT is the amount of time required for individual therapy, group therapy, and homework components. One study showed that DBT decreased BDI scores by 37%, had a 35 % drop in the CAPS, and showed a significant decreases on the STAI trait scale of $p<.001$ (Bohus, Dyer, Priebe, Kruger, Kleindienst, Schmahl, Niedtfeld, 2012; Steil, Dyer, Priebe, Kleindienst & Bohus, 2011).

SS is a therapy designed for group treatment of co-occurring substance abuse and trauma. The primary goal of SS is safety in relationships and safety in behavior and thinking. Another goal of SS is learning coping skills. Consequently, this treatment is not appropriate for clients needing to process their trauma one on one nor is it suitable for children because of some of the topics covered. One strength of SS is that it is not a processing group therapy but rather a psycho-education therapy group offering members safety from being triggered; another strength is that the group addresses both substance abuse and trauma which many times go hand in hand. (Najavits, 2002). Two weaknesses of SS are that many participants need individual therapy and that the program is long, 25 weeks. (Najavits, 2002). One study showed that the BDI score for those treated with SS decreased by 35% (Norman, Wilkins, Tapert, Lange, & Najavits, 2010). Anderson & Najavits (2014) showed a drop of 40% in CAPS score.

PE is a therapy based on "in vivo" and "imaginal" exposure to the trauma. The client is exposed to reminders of the trauma such as people, places, and things and learns how to effectively tolerate these situations instead of avoidance as well as repeatedly re-counting the

trauma until they can do so without feeling distress (Foa, Dancu, Hembree, Jaycos, Meadows, & Street, 1999). One strength of PE is that through repeated telling of the trauma the distress levels can quickly lower and so do some of the symptoms of PTSD (Foa, Hembree & Rothbaum, 2007). This repeated telling of the trauma and the confronting of avoidance issues makes it suitable for clients with single or ongoing trauma experiences and the quick decrease in symptoms can benefit clients with PTSD from combat exposure. One weakness of PE is that the exposure portion of the therapy can illicit powerful emotions and cause the client temporary distress (Foa, et al., 2007). PE showed significant improvements in BDI scores and a 50% drop in the CAPS score. (Rothbaum, Astin, & Marsteller, 2005). PE clients also scored significantly lower on a STAI-S with $p<.01$, a 35% decrease (Foa et al., 1999).

EMDR is an exposure therapy using external stimuli, such as watching a moving finger, while thinking a negative thought about the trauma (Taylor, Thordarson, Federoff, Maxfield, Lovell, & Ogrodniczuk, 2003). The client not only describes the thoughts of the trauma but also the physical sensations that they are feeling. Slowly, the clinician adds positive thoughts to replace the negative ones (EMDR Institute, n.d.). One strength of EMDR is that results can be seen in very few sessions (Shapiro & Forrest, 2007). Another strength of EMDR is that the client only has to reveal as much of the trauma that they feel comfortable and still reap the benefits of the treatment (van der Kolk et al., 2007). This treatment could be beneficial to younger children because they are not re-traumatized by having to reveal the aspects of the trauma which they aren't comfortable sharing, but can still reap the benefits of the therapy. EMDR has shown to have a significant decrease in the BDI score, a 50% drop in CAPS score, and significant change in STAI score, $p=.45$ (Rothbaum et al., 2005; Perez-Dandieu & Tapia, 2014).

CBT is a psychotherapy where the distorted thoughts of the trauma are challenged and replaced with realistic thoughts. A strength of CBT's effectiveness with PTSD is that it teaches the client to recognize and correct irrational thoughts and thinking patterns. Therefore, this treatment could be suited for those suffering from the PTSD symptoms of low self-esteem, blame, and other cognitive distortions as a result of the trauma. One downside of CBT is that it takes more time before the client begins to feel a lessening of the symptoms of PTSD and also the retention rate of CBT therapy is only about 75% (Ehlers, Clark, Hackmann, McManus, & Fennell, 2005). Ehlers et al. (2005) showed that 71% did not meet the criteria for PTSD after treatment. In a study by Ehlers & Clark (2010), the PDS score dropped 74% and the BDI score decreased by 78%.

This research project achieved its goal of incorporating information to allow comparisons of five different treatments for PTSD. This information can be made available to clinicians and families so that they can become aware of the treatment options and make informed decisions on which therapy could be most appropriate for a particular client or family member. My literature review is unique in that it evaluates the therapies not only on the statistical results of studies, but also on clinical strengths and weaknesses of each therapy.

If I were to repeat this research study, I would expand it to include studies using other valid and reliable test scales available for measuring the effects of PTSD. I would also include some of the new cutting edge therapies such as Mindfulness and incorporate the use of medication (such as Prazon for nightmares) when they can improve the effectiveness of the therapies.

Works Cited

Anderson, M. & Najavits, L. (2014). Does Seeking Safety reduce PTSD symptoms in women receiving phsycial disability compensatation? *Rehabilitation Psychology, 59* (3), 349-353.

Bohus, M., Dyer, A., Priebe, K., Kruger, A., Kleindienst, N., Schmahl, C., Niedtfeld, I. & Steil, R. (2012). Dialectical Behavioral Therapy for Post Traumatic Stress Disorder afer childhood sexual abuse in patients with and without Borderline Personality Disorder: A randomised controlled trial. *Psychotherapy and Psychosomatics, 24* (1), 221-233.

Ehlers, A. & Clark, D. (2010). Intensive Cognitive Therapy for PTSD: A feasibility study. *Behavioral and Cognitive Psychotherapy, 38,* 383-398.

Ehlers, A., Clark, D., Hackmann, A., McManus, F. & Fennell, M. (2005). Cognitive therapy for post-traumatic stress disorder: Development and evaluation. *Behaviour Research and Therapy, 43,* 413-431.

EMDR Institute Inc. (n.d.). *Frequently Asked Questions*. Retrieved from EMDR Institute Inc.: http://www.emdr.com/faqs.html

Feske, U. (2008). Treating low income women with Post Traumatic Stress Disorder: A pilot study comparing Prolonged Exposure therapy and treatment as usual conducted by community therapists. *Journal of Interpersonal Violence, 23* (8), 1027-1040.

Foa, E., Dancu, C., Hembree, E., Jaycos, L., Meadows, E., & Street, G. (1999). A comparison of exposure therapy, stress inoculation training, and their combination for reducing Post Traumatic Stress Disorder in female assault victims. *Journal of Counsulting and Clinical Psychology, 67* (2), 194-200.

Foa, E., Hembree, E. & Rothbaum (2007). *Prolonged Exposure Therapy for PTSD.* New York: Oxford.

Korn, D. (2009). EMDR and the treatment of complex PTSD: A review. *Journal of EMDR Practice and Research, suppl. Special Issue on the 20th Anniversary of EMDR, 3* (4), 264-278.

Linehan, M., Armstrong, H., Suarez, A., Allmon, D. & Heard, H. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *General Psychiatry, 48 (*2), 1060-1064.

Linehan, M. (1993). *Cognitive Behavioral Treament of Borderline Personality Disorder.* New York: Guilford Press.

Lynch, S., Heath, N., Matthew, K. & Cepeda, G. (2012). Seeking Safety: An intervention for trauma-exposed incarcerated women? *Journal of Trauma and Dissociation 13* (88), 88-101.

Monson, C. & Shnaider, P. (2014). *Treating PTSD with Cognitive-Behavioral Therapies: Interventions that Work.* Washington D.C.: American Psychological Association.

Najavits, L. (2002). *Seeking Safety.* New York: Guilford.

Norman, S., Wilkins, K., Tapert, S., Lange, A. & Najavits, L. (2010). A pilot study of Seeking Safety therapy with OEF/OIF veterns. *Journal of Psychoactive Drugs, 4* (1), 83-87.

Perez-Dandieu, B. & Gerald, T. (2013). Treating trauma in addiction with EMDR: A pilot study. *Journal of Psychoactive Drugs,* 37-41.

Rothbaum, B., Astin, M. & Marsteller, F. (2005). Prolonged Exposure versus Eye Movement Desensitization and Reprocessing (EMDR) for PTSD rape victims. *Journa of Traumatic Stress, 18* (6), 67-616.

Sanderson, C. (2008). *Dialectal Behavioral Therapy Frequetnty Asked Questions.* Retrieved from The Linehan Institue Behavrioal Tech: http://behavioraltech.org/downloads/dbtFaq_Cons.pdf

Shapiro, F. & Forrest M. (1997). *EMDR: The Breakthough Therapy for Overcoming Anxiety, Stress, and Trauma.* New York: BasicBooks.

Steil, R., Dyer, A., Priebe, K., Kleindienst, N. & Bohus, M. (2013). Dialectical Behavioral Therapy for Post Traumatic Stress Disorder related to childhood sexual abuse: A pilot study of an intensive residential treatment program. *Journal of Traumatic Stress, 24* (1), 2011.

Taylor, S., Thordarson, D., Federoff, I., Maxfield, L., Lovell, K. & Ogrodniczuk, J. (2003). Comparative efficacy, speed, and adverse effects of three PTSD treatments: Exposure therapy, EMDR, and relaxation training. *Journal of Consulting and Clinical Psychology, 71* (2), 330-338.

van der Kolk, B., Spinazzola, J., Blaustein, M., Hooper, J., Hooper, E., Korn, D. & Simpson, W. (2007). A randomized clinical trial of Eye Movement Desensitization and Reprocessing, fluxetine, and pill placebo in the treatment of Posttraumtic Stress Disorder: Treatment effects and long-term maintenance. *Journal of Clinical Psychiatry, 68* (1), 37-46.