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Behavioral Approaches to Overcoming PTSD

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As readers of April's column titled "Surge in Mental Health Conditions in War Veterans" know, posttraumatic stress disorder (PTSD) is a problem for many military veterans returning from Iraq and Afghanistan. PTSD is also a significant issue in civilian life, where it affects more women than men, and is usually precipitated by physical attack, adult rape, or even childhood sexual molestation.^{1,2}

Whatever the circumstances that lead to PTSD, the symptoms of this anxiety disorder are essentially the same: recurrent and intrusive distressing recollections of the event(s); flashbacks; intense psychological and physiological distress on exposure to internal or external cues that symbolize or resemble some part of the traumatic event; and persistent avoidance mechanisms, including detachment and a restricted range of affects. There are usually persistent symptoms of increased arousal that may include sleep difficulties, irritability, difficulty in concentrating, hypervigilance, and exaggerated startle reaction.³

Treatment of persons with PTSD may include both medication and specialized psychotherapy. I will describe several treatments and then review some studies that attempt to compare efficacy of treatments.

Reprocessing a Traumatic Memory

Eye movement desensitization and reprocessing (EMDR) is a fairly new, eclectic therapy developed by Francine Shapiro, PhD.⁴ It is a manualized method using, among other techniques, relaxation exercises, safe-place exercising, cognitive restructuring, future projections, and imaginal exposure of the trauma combined with sensory stimulation. The theory is that when a traumatic or distressing experience occurs, it may overwhelm the usual ways of coping, and the memory of the event is inadequately processed; the memory is dysfunctionally stored in an isolated memory network. An unprocessed memory of a traumatic event can retain high levels of sensory and emotional intensity, causing recurring sensory flashbacks and other symptoms of PTSD.

Once the client has reestablished contact with the disturbing material, the therapist induces a bilateral stimulation, usually involving moving the fingers back and forth in front of the client's face after instructing the client to follow the movement with his or her eyes. Bilateral stimulation may also be induced through auditory or tactile stimuli. EMDR is believed to work directly with the memory networks to enhance information processing by forging associations between the distressing memory and more adaptive parts of the brain containing more positive and realistic information.

During the processing phases of EMDR, the client attends to the disturbing memory in multiple brief exposures of 15 to 30 seconds while simultaneously focusing on the dual attentional stimulus. New trauma memories that arise during exposure to the index trauma are dealt with in a similar way. Eventually, the treated person is able to deal with the original trauma with better perspective and insight, free of cognitive distortion, emotional distress, and physiological arousal.

Exposure Desensitizing and Cognitive Restructuring

Another method is trauma-focused cognitive-behavioral therapy (TF-CBT), which includes stimulus confrontation and cognitive restructuring.⁵ In a typical session, the client is asked to describe the traumatic experience and relive it in his imagination, all the while describing the disturbing material. Homework may include having to listen to an audiotape of one of the early therapy sessions. If possible, the client is also asked to practice in vivo exposure.

Four main components are usually involved: education about the nature of trauma and trauma reactions; training in controlled breathing; imaginal exposure to the memory of the traumatic event, both in therapy and as homework; and in vivo exposure to trauma reminders, typically conducted as homework.

At the end of each imaginal exposure session, the therapist spends 15 to 20 minutes discussing with patients their experiences during the imaginal exposure, with a focus on new information or insights patients may have acquired resulting from the exercise. This type of treatment usually involves 9 to 12 individual sessions held once or twice weekly, with each lasting about 90 minutes.⁶

Efficacy of PTSD Treatments

Recently issued practice guidelines and meta-analyses have designated EMDR as a first-line psychotherapy for PTSD. A recent Cochrane meta-analysis of PTSD treatments concluded that EMDR and TF-CBT have the best evidence of efficacy at present and should be made available to persons with PTSD.⁷ Other non-trauma-focused treatments did not reduce PTSD symptoms as significantly.

In an earlier meta-analysis of 61 treatment outcome trials for PTSD (including drug therapies, CBT, EMDR, relaxation training, hypnotherapy, and dynamic therapy), psychological therapies were more efficacious than medication (including SSRIs), and both were more efficacious than controls.⁸

A randomized clinical trial recently compared outcomes in 88 patients with diagnosed PTSD treated with either 8 weeks of [fluoxetine](#) ([Drug information on fluoxetine](#)), EMDR, or placebo in pill form.⁹ All patients underwent weekly assessments during the active treatment phase. At the end of treatment, the psychotherapy intervention was somewhat more successful than pharmacotherapy. Eighty-eight percent of EMDR, 81% of fluoxetine, and 65% of placebo completers lost their PTSD diagnosis, and 29% of EMDR, 15% of fluoxetine, and 12% of placebo completers became asymptomatic. More interestingly, at a 6-month follow-up after treatment cessation, the EMDR group continued to improve, with 57% now asymptomatic, whereas (not surprisingly) none in the fluoxetine group was asymptomatic (the placebo group was not followed).

Conclusion

In the short run, just paying attention to patients with PTSD is helpful, but for more long-term benefit some form of exposure-based treatment, such as EMDR or TF-CBT, may be necessary. The combination of SSRIs and psychotherapy to treat persons with PTSD, while widely used in practice, has not been systematically studied.

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