BEHAVORIAL HEALTH DEPARTMENT – PRIMARY CARE CENTER AND FIREWEED
TREATMENT GUIDELINES FOR

PTSD

Revised By: Joanette Sorkin, MD; Geri Chaney, MS, LPC; Marge Garcia, RN; Gabriele Roschlau, LPC; Tara Curry; Shelly Biss, MSW

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Executive Summary

Introduction and statement of Intent

This treatment guideline is intended to assist clinicians in the Behavioral Health department in treatment planning and service delivery for patients with Post Traumatic Stress Disorder (PTSD). It may also assist clinicians treating patients who have some of the signs and symptoms of PTSD but who do not meet the full criteria of PTSD. The treatment guideline is not intended to cover every aspect of clinical practice, but to focus specifically on the treatment models and modalities that clinicians in our outpatient treatment setting could provide. These guidelines were developed through a process of literature review and discussion amongst clinicians in the Behavioral Health department and represent a consensus recommendation for service provision for this disorder. The guideline is intended to inform both clinical and administrative practices with the explicit goals of outlining treatment that is: effective, efficient, culturally relevant and acceptable to clinicians, program managers, and patients

Definition of disorder

Post Traumatic Stress Disorder (PTSD) is characterized by three clusters of symptoms including re-experiencing of the traumatic event, emotional numbness and avoidance, and heightened arousal. To develop PTSD, a person must have witnessed or experienced one or more events in which life or physical integrity were threatened, and to which they reacted with intense fear and horror. They must also have various numbers of symptoms in each of the three categories, the symptoms must cause significant functional impairment, and the symptoms must be related in time and content to the traumatic event/s. (See table 1 for DSM-IV-TR criteria.) Fortunately, most people exposed to these types of events do not develop PTSD and do not require the type of specific, clinical treatment/s outlined in this guideline. For those who do, a number of clinical interventions may be helpful.

Table 1: DSM-IV-TR Classification: 309.81 – Posttraumatic Stress Disorder (PTSD)

A. The person has been exposed to a traumatic event in which both of the following were present:
   1. the person experienced, witnessed, or was confronted with an event or events that involved actual injury, or a threat of injury, or a threat of physical integrity of self or others
   2. the person's response involved intense rear, helplessness, or horror. **Note:** In children, this may be expressed instead as disorganized or agitated behavior.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
   1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In child young children, repetitive play may occur
   2. recurrent distressing dreams of the event. Note: In children, these may be frightening dreams without recognizable content
   3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback of episodes, including those that occur on awakening or when intoxicated.**Note:** In young children, trauma specific reenactment may occur.
   4. intense psychological distress at exposure to internal or external cues that symbolize or resembles a aspect of the traumatic event
   5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
   2. efforts to avoid activities, places or people that arouse recollections of the trauma.
   3. inability to recall an important aspect of the trauma.
   4. markedly diminished interest or participation in significant activities
   5. feeling of detachment or estrangement from others
   6. restricted range of affect (e.g., unable to have loving feelings)
   7. sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or normal life span

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   1. difficulty falling or staying asleep.
   2. irritability or outbursts of anger
   3. difficulty concentrating or mind going blank
   4. hypervigilance
   5. exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if Acute: if duration of symptoms is less than 3 months; or **Chronic:** if duration is 3 months or more

Specify if with delayed onset: if onset of symptoms is at least 6 months after the stressor.

General Goals of treatment

As with treatment of all psychiatric illnesses, the goals of treatment are to reduce or eliminate symptoms and to restore function. For PTSD, remission usually means that the person will react less strongly to people, places, and things that trigger re-experiencing of the traumatic event; they will spend less time avoiding or recovering from the effects of reminders and triggers; they will learn to relax, lower their guard, and trust others to a point that they are able to pursue ordinary human goals such as work and family.

Summary of 1st, 2nd and 3rd line treatment

Based on our own clinical experience and a review of the literature, the BHS clinicians feel that first line treatment for PTSD at this time involves both medication and psychotherapy, specifically an SSRI and CBT with core components of psychoeducation, skills training, cognitive restructuring, and exposure. The psychotherapy can be done in both individual and group formats. We feel that a combination would be ideal for most clients. Education about the disorder and its treatment, skills training, and some cognitive restructuring can be communicated, learned, and practiced in a group setting. These aspects of treatment can be done in a group; therefore we recommend this as first line in our clinic. One component of treatment for this disorder, exposure, should generally not occur in groups, or only in vary carefully matched groups which may be difficult to construct in our setting. The majority of patients with PTSD will need some individual psychotherapy sessions to complete the exposure based parts of treatment necessary to decrease emotional arousal to triggers, and some will need individual sessions for skills acquisition as well because their arousal at the beginning of treatment may be too high in groups to allow learning to take place. This judgment should be based on observation rather than assumption. See “clinical and demographic issues that influence treatment planning” section below.

At the drafting of this guideline, EMDR is a controversial but common form of treatment for PTSD. Because it contains the core elements of education, skills building (“resource installation”), cognitive restructuring, and exposure, and because there are controlled trials that demonstrate efficacy of the treatment overall independent of proposed mechanism of action, we endorse EMDR as a first line psychotherapeutic treatment at this time.

Although they may lack the formal structure and empirical validation of other treatment models, the PTSD work group wishes to encourage clinicians at BHS to incorporate Alaska Native cultural idioms of care into the treatment of this disorder. For example, talking circles may be a specific group modality for providing core treatment components. It may, for example, provide an opportunity to practice containment skills, to rework attributions of cause, effect, and responsibility (cognitive restructuring), and for graded exposure by relaying aspects of the traumatic events/memories over time without judgment or overwhelming emotion.

Approaches for patients who do not respond to initial treatment

PTSD is a complex disorder and recovery is rarely an orderly, linear process. If a patient is not making progress towards treatment goals, the clinician should re-evaluate the patient’s clinical status and consider adding or changing modalities. For example, the patient may have another disorder (e.g. cognitive impairment, substance abuse) that interferes with their ability to acquire and generalize the skills taught in group. The addition of a few individual sessions may be necessary to determine why the patient is not benefiting as expected and to address those problems. Likewise medication may be helpful in targeting some symptoms that interfere with other parts of treatment and recovery. Consultation with the patient and with other members of the treatment team are the first steps in evaluating “non responders.” In general, novel treatments and treatments with less empirical validation than SSRIs and CBT should be pursued only after an adequate trial of the better tested and supported treatments.

Clinical and demographic issues that influence treatment planning

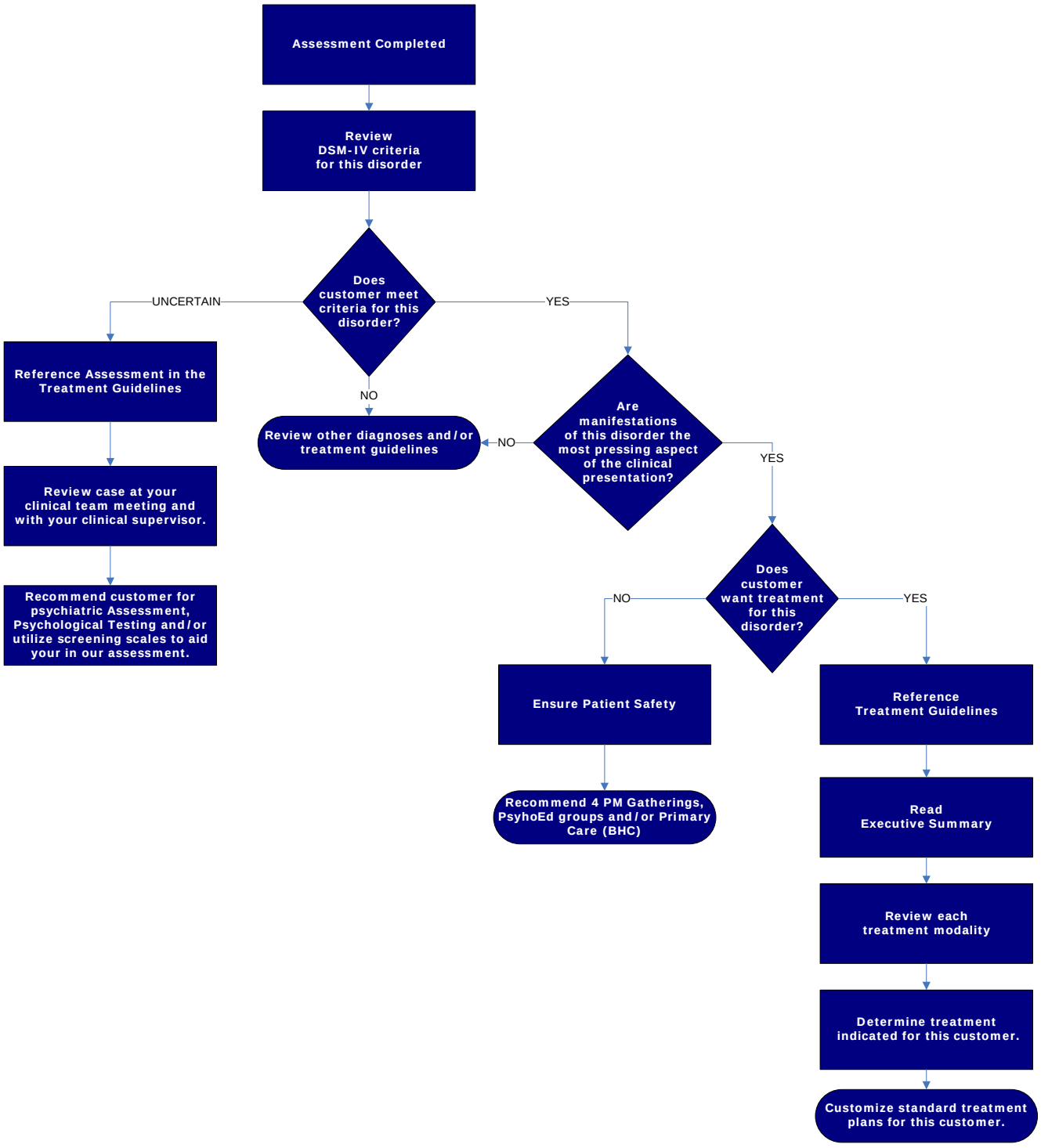
Comorbidity (the presence of more than one diagnosable condition) is the rule rather than the exception. High rates of clinical depression and substance abuse have been found in most studies of people with PTSD. Comorbid Social Phobia and Panic Disorder also appear to be particularly common in our clinical population. Sequential treatment can be ineffective or impractical as symptoms of one disorder frequently overlap with or interfere with treatment of another. Because of this, we tried to keep the number of contraindications to treatment of PTSD in our clinic that relate to signs and symptoms of other disorders to a minimum (e.g. "acute intoxication" rather than "active substance abuse"). However, we recognize that patients with other disorders or other acute clinical issues (dangerousness to self or others) may require a different sequence or intensity of care than the baseline recommendations in this guideline.

The nature of the trauma also influences treatment planning for this disorder, particularly when designing or recommending group treatments. A common treatment goal is reductions of feelings of guilt and shame and their common behavioral manifestations – avoidance, social withdrawal and isolation. Exposure to other people with similar experiences (e.g. other combat veterans or rape victims) can be enormously helpful in decreasing stigma, isolation, and misattributions of blame. However this same exposure risks triggering re-experiencing phenomena and additional avoidance as well as over identification with the victim role. This risk/benefit assessment is individual to each clinical situation and defies simple algorithms for referral to group vs. individual. When in doubt, past history, informed consent, and clinical consultation may be helpful.

Age, gender, and culture also effect choice of treatments. Regarding age, the same elements of CBT stated above have been and can be adapted in some form for children and/or their families. See the sample treatment plans for various ages (appendix ___) for more detail. Inclusion of parents and use of developmentally appropriate activities and methods represent the major age related differences in psychotherapeutic treatment. For differences in pharmacologic intervention, see appropriate section of the guideline. Age related differences in signs, symptoms and evaluation are not within the scope of this guideline. Regarding gender, many of the interventions developed to treat PTSD have focused on female victims of rape, or male combat veterans but there are insufficient data to state a particular format, structure, model or modality works better for a particular gender or trauma type.

Although data are not available on the prevalence of PTSD in the Alaska Native population, clinical experience suggests it is at least as prevalent as in other minority groups with similar socioeconomic status. The unique history of Alaska Native peoples, variation in levels of acculturation, and frequent differences in cultural background and experience between patients and clinicians in our setting create unique challenges to providing effective, efficient, and relevant care. Despite much interest in the notion of "cultural PTSD", there is a paucity of published trials of treatment for PTSD in American Indian or Alaska Native populations. Although they may lack the formal evaluation and empirical validation of other treatment models, concurrent referral to a talking circle or a traditional healer may be appropriate for some patients.

Flow Diagram



Assessment

The Diagnostic Testing team will be reviewing and commenting on the Psychological Testing column for every disorder.

	Psychiatric Assessment	Psychological Testing	Screening/Scales
Indications	▪ Diagnostic dilemma or clarification of co-morbidity ▪ Unmanageable behavior or other symptoms that have not improved with standard interventions ▪ Patients is already on psychotropic medication and is requesting continuation ▪ Patient or guardian requests a second opinion or wishes to consider pharmacologic intervention ▪ Rule out organic cause and/or contributions to symptoms	▪ Diagnostic clarification following assessment by PCP, Psychiatrist or ANP. ▪ Question only answerable by psychological testing ▪ Appropriate physical assessment completed	• Establish baseline and/or monitor treatment effectiveness • Clarify symptoms
Contraindications	▪ Diagnosed severe cognitive disorder or developmental delay and collateral source not available ▪ Consent not available (if patient has guardian) ▪ Patient or guardian has forensic rather than therapeutic goal (i.e. compliance with court or parole requirements, disability determination, etc.)	▪ Extremely dangerous to self and/or others ▪ Untreated psychosis ▪ Initial evaluation / assessment is not done ▪ Referral question not answerable and/or not clear ▪ Any physical causes of the disorder have not been ruled out ▪ Attention span inadequate ▪ School or other source has already conducted psychological testing within the last year ▪ Severely depressed	▪ Limited English proficiency. ▪ Attention span inadequate ▪ Lack of cooperation
Structure	In patients with cognitive impairment who cannot give adequate history, parent or guardian with knowledge of the patient's history must be available for assessment.	▪ Depends on the referral question	▪ Self-administered for adults and adolescents ▪ Completed by Parent and/or care giver for children or incompetent adults. ▪ Consider using the "Impact of Event Scales"

Modalities & Treatment Models

Group Therapy

This modality is not applicable for customer's under 6 years old but is appropriate for the parents.

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
Appropriate first line treatment for: DSM-IV diagnosis of PTSD "sub-threshold PTSD" with trauma-related symptoms or functional impairment and: ▪ Customer is 6 years old or older ▪ Mild to moderate severity ▪ Able to tolerate affect without behavior destructive to group ▪ Sufficient verbal and/or cognitive ability to benefit from treatment	▪ Dangerousness to self or others ▪ Lack of commitment from parent and/or legal guardian ▪ Sexually acting out behaviors ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Severe untreated hyperactivity ▪ Untreated Psychosis ▪ History of chronic or extreme disruptive behavior in groups ▪ Untreated substance dependence ▪ Acute intoxication or withdrawal from alcohol or other substances ▪ Frequent dissociation	• Diagnosed social phobia (May need individual therapy for group preparation) • Relatives or significant others in the same group (unless it is a family group and/or couples group) • Meets CMI or SED criteria without receiving rehab services • Other symptoms or diagnoses eclipse the indication for or safety of this therapy.

STRUCTURE

- Groups will be facilitated by a Master's Level Therapist and Case Manager
- For customers 17 years old and below, some age grouping recommended
- For customers 18 years old and above consider adult services
- Age, gender and/or trauma type matching necessary for exposure and possibly for cognitive restructuring phases, may be necessary for earlier phases as well depending on degree of avoidance and hyper-arousal

Duration	60 to 90 minutes for 10 to 15 weeks
Frequency	Once a week
Size	▪ 3 to 9 years old 4 customers per provider ▪ 10 years old and over 8 to 10 customers per provider
Open vs Closed	Open or Closed with windows

TREATMENT MODEL

- For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible.
- CBT consisting of 4 main elements:
  - Psychoeducation, 1-2 weeks
  - Containment skill building, 4 – 6 weeks, (i.e. relaxation and visualization, affect tolerance)
  - Exposure 4-10 wks, (should be done individually or in carefully matched groups)
  - Cognitive restructuring, 2-3 wks
- Psychoeducation and skill building can be done in mixed groups including patients with other anxiety disorders. Movement to the exposure phase of treatment should be contingent on demonstrating containment skills.

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Individual Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
Appropriate first line treatment for: DSM-IV diagnosis of PTSD "sub-threshold PTSD" with trauma-related symptoms or functional impairment and: • Group therapy contraindicated • Sufficient verbal and/or cognitive ability to benefit from treatment • Moderate to Severe severity • Unable to tolerate affect without behavior destructive to group ▪ Customer is 3 years old or older • Recent sexual, physical, abuse and/or neglect	▪ Imminent dangerousness to self or others ▪ Lack of commitment from customer and if customer not competent, lack of commitment from parent and/or legal guardian ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Untreated Psychosis ▪ Acute intoxication or withdrawal from alcohol or other substances	Other symptoms or diagnoses eclipse the indication for or safety of exposure therapy.

STRUCTURE

Duration	60 minutes or 90 minutes for EMDR
Frequency	▪ Weekly or Twice a Month ▪ Up to 8 sessions for treatment ▪ Up to 4 sessions to prepare customer for group therapy

TREATMENT MODEL

- For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible.
- CBT consisting of 4 main elements:
  - Psychoeducation with children and parents (parental involvement is critical)
  - Containment skill building (i.e. relaxation and visualization, affect tolerance)
  - Exposure (direct exploration of the trauma)
  - Cognitive restructuring (exploration and correction of inaccurate attributions regarding the trauma)

Family Therapy / Couples Therapy

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
• First line of treatment for 0 to 5 years old • Disorder is impacting the family and/or relationship • Family dynamic exacerbating or triggering symptoms • Sufficient verbal and/or cognitive ability to benefit from treatment • No buy-in to group and/or individual therapy	▪ Imminent dangerousness to self or others ▪ Lack of commitment from patient, parent and/or legal guardian ▪ Court ordered treatment with no buy in from child and/or guardian ▪ Child abuse investigation incomplete ▪ Untreated Psychosis ▪ Active Domestic violence ▪ Custody dispute ▪ Acute intoxication or withdrawal from alcohol or other substances	

STRUCTURE

Duration	60 minutes
Frequency	▪ Weekly or Twice a Month ▪ Up to 8 sessions for treatment

TREATMENT MODEL

- For customers under 18 years old, parental education and involvement is predictive of good outcome and should be integrated whenever possible.
- Concurrent with group and/or individual treatment for children

Individual Medication Management

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
• Parent and/or legal guardian consent • Current biopsychosocial intake or psychiatric assessment is available.	▪ Refuses Medication Management ▪ Disorder is caused by an untreated physiological disorder. ▪ Acute intoxication or withdrawal from alcohol or other substances	▪ Documented history of medication non-compliance ▪ Benzodiazepines should be used with caution in patients with a history of substance abuse and dependence.

SSRI's are appropriate first line treatment for adults with PTSD. SSRI's have been shown to reduce core symptoms of PTSD, not just the symptoms that overlap with depression and other anxiety disorders. Other antidepressants have not been systematically studied for this indication, but are thought to be effective.

Second generation antipsychotics, mood stabilizers, and anticonvulsants are frequently used to target specific symptoms, but have not been systematically studied in PTSD.

There are a number of small trials with central alpha blocking agents, but again, systematic studies are lacking.

If effective in symptom reduction, medications are typically continued for months and years making the risk of abuse with some drugs a relative contraindication to their use (e.g. benzodiazepines, especially short half-life, lipophilic agents such as xanax)

STRUCTURE

Duration	30 minutes
Frequency	Monthly

There is insufficient evidence on which to make clear recommendations for the duration of pharmacotherapy in this disorder. General Treatment at this time is probably 6-12 months beyond resolution of symptoms, and indefinitely if symptoms have improved but not resolved, or have returned when the drug is discontinued.

Most medications must be taken daily, some more frequently. Follow up appointments or phone check within 2 weeks of initiation of treatment is usually recommended. Minimum frequency of visits is every 3 months to ensure continued benefit and safety.

TREATMENT MODEL

Recommended concurrent with psychotherapy and/or psychoeducation.

Group Medication Management

Need for parent and/or guardian presence makes group medication management impractical for customers 0 to 18 years old.

INDICATIONS	CONTRAINDICATIONS	RELATIVE CONTRAINDICATIONS
▪ If symptoms stable and patient cannot return to primary care for maintenance treatment, group medication management should be considered. ▪ History of non-compliance ▪ Able to tolerate affect without behavior destructive to group ▪ Frequently misses scheduled appointments	▪ Acute dangerousness to self or others ▪ Untreated psychosis ▪ Sexually acting out behaviors ▪ No child care available ▪ Severe untreated hyperactivity	▪ Diagnosed social phobia (May need individual therapy for group preparation) ▪ Relatives or significant others in the same group (unless it is a family group and/or couples group) ▪ Meets CMI or SED criteria without receiving rehab services

STRUCTURE

Duration	▪ 90 minutes ▪ 8 to 12 weeks for customer over 17 years old
Frequency	Once a week
Size	8 to 10 customers per clinician
Open vs Closed	Open

Psychoeducational Groups

This modality is not applicable for customer's under 6 years old but is appropriate for the parents.

INDICATIONS	CONTRAINDICATIONS
▪ Sufficient verbal and/or cognitive ability to benefit from treatment ▪ Able to tolerate affect without behavior destructive to group ▪ Could benefit from skills development	▪ Dangerousness to self or others ▪ Sexually acting out behaviors ▪ Untreated Psychosis ▪ History chronic or extreme disruptive behavior in groups ▪ Untreated substance dependence ▪ Severe untreated hyperactivity

STRUCTURE

Groups will be facilitated by 1 to 2 Case Managers.

Duration	60 to 90 minutes for up to 8 weeks
Frequency	Once a week
Open vs Closed	Open

Case Management

All Ages	
Assessment	▪ Collect psychosocial history ▪ Collect collateral history and/or past treatment records ▪ Obtain patient and/or guardian consent ▪ Liaison with outside agencies and/or link to community resources ▪ Administer standardized scales ▪ Lead orientation to services ▪ Review and/or conduct client initial screening and tirage
Treatment	▪ Psychosocial education ▪ Maintain supportive contact ▪ Triage current clients in crisis ▪ Crisis management (e.g. triage, risk assessment, skills coaching, referrals when needed) ▪ Community liaison work and coordination of care ▪ Manage charts ▪ Provide aspects of treatment ▪ Assist with group preparation ▪ Draft treatment plans ▪ Follow-up when customer fails to keep appointments. ▪ Encourage medication and treatment compliance
Follow-up	▪ Liaison with outside agencies ▪ Link to community resources ▪ Gather and disseminate information from external referral sources

Referral

INDICATIONS
- Services needed are not available within SCF
- Meets CMI criteria and not receiving rehab services
- Legal custody or other issues predominate
- Needed treatment is available elsewhere.

CONTRAINDICATIONS
Meets criteria for treatment within SCF clinic system

Primary Care

INDICATIONS
- Refuses specialty mental health care
- Specialty Mental Health care not available
- Uncomplicated Medication Management
- Maintenance Medication Management

CONTRAINDICATIONS
Higher intensity services needed to ensure safety to patient or others

Appendix A: Glossary

Term or Acronym	Term Definition
Acute Intoxication	A reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. Clinically significant maladaptive behavior or psychological changes that are due to the effect of the substance on the central nervous system and develop during or shortly after use of the substance. (Adapted from DSM-IV)
Acute Withdrawal	A substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged. (Adapted from DSM-IV)
CBT	Cognitive Behavioral Therapy
Closed Group	Customers may enter only at initial formation of group.
Closed Group with Windows	Customer enrollment available intermittently
Eclipse	Overshadow, for example, when the symptoms and dysfunction related to one disorder overshadow another making treatment of one more pressing.
Exposure Therapy	Exposure therapy (Haug et al, 2003) with or without response inhibition is most cited as effective for specific phobia, obsessive compulsive disorder and PTSD. Generally, these run 10 -12 sessions with each session targeting a specific skill, exposure level and cognitive reframing. Manuals are available to guide clinical work.
Intervention	Any thoughtful action taken by a clinician or customer with the purpose of addressing a perceived problem or therapeutic goal
IPT	Interpersonal Therapy
NOS	Not Otherwise Specified
Open Group	Participants can enter at any time.
PDD	Pervasive Developmental Disorder
Play Therapy	Play therapy is a form of psychotherapy for children who have been traumatized. It encourages children to explore their emotions and conflicts through play, rather than verbal expression.
Psychiatric Assessment	Formal assessment by a psychiatrist or ANP
Psychoeducation	teaching and training about the disease or problem for which the customer or family member is seeking treatment. Psychoeducation is frequently presumed to be part of all forms of assessment and treatment, yet additional interventions that emphasize education about an illness are often shown to improve outcomes over treatment as usual. Psychoeducation can be incorporated into many treatments, but can be viewed as an intervention in its own right and can be delivered by non-professional staff such as case managers or health educators.
Psychological Testing	Formal psychological assessment which includes clinical interview and appropriate tests conducted by a psychologist and/or psychometrician. This testing is standardized and normed.
Screening/Scales	Brief, easily administered screening and scales which do not require advance training to interpret.
Social Rhythm Therapy	A structured psychotherapy combining elements of behavioral therapy and psychoeducation and shown to reduce rates of relapse and rehospitalization in bipolar disorder

Term or Acronym	Term Definition
Structural Family Therapy (SFT)	Structural Family Therapy is a model of treatment in which a family is viewed as a system with interdependent parts. In this treatment model, the family system is understood in terms of the repetitive patterns of interaction between the parts. From such a perspective, the goal of structural family therapy is to identify maladaptive or ineffective patterns of interactions, then alter them to improve functioning of the subparts and the whole.
TBI	Traumatic Brain Injury
Treatment Modality	For purposes of this guideline, we have defined "modality" as the structure in which the customer receives treatment, for example, individual psychotherapy, group psychotherapy, or psychoeducation.
Treatment Model	For purposes of this guideline, we have defined the "model" of care as the underlying theoretical approach to clinical intervention, for example, Cognitive Behavioral Therapy, Insight Oriented Therapy, Interpersonal Therapy.
Untreated Psychosis	For the purposes of this treatment guideline, we define untreated psychosis as psychotic symptoms that are prominent, disruptive in some way, and for which the customer is not accepting or engaging in care that would mitigate such symptoms. The diagnosis of a psychotic disorder or the presence of psychotic symptoms at some point in the course of illness or treatment should not be a barrier to participation in treatment that might be helpful. However, nor should a customer with a significant psychotic disorder be treated with some forms of psychotherapy from which they are not likely to benefit. Clinical judgment will be needed in selecting appropriate treatment for each customer.
Untreated Substance Dependence	Because "dual diagnosis" is the norm, rather than the exception in behavioral health settings, customers with substance abuse problems should not be excluded, a priori, from participation in treatment for other mental health conditions. However, the impact of their substance use on their capacity to participate in treatment must be assessed on an ongoing basis. Customers with current substance dependence may not be appropriate candidates for some forms of treatment.

Appendix B: Literature Summary

Evidence Based Clinical Guidelines
Southcentral Foundation Research Project
Summary Sheet
POST TRAUMATIC STRESS DISORDER

Diagnosis: Post Traumatic Stress Disorder 309.81. Reactions that arise from exposure to an event that threatens death or serious injury or self integrity AND generates intense fear, helplessness and horror. Symptoms fall within three areas generally known as 1) re-experiencing of the trauma; 2) avoidance of associates or triggering stimuli; and 3) hyperarousal states. Some authors outline a fourth dimension particular to the fragmentation of self identity.

General Information: Post Traumatic Stress Disorder (PTSD) commands a rich and diverse literature. At the highest severity end of the Trauma Spectrum Disorders (Bremner, 2002), PTSD is a resultant of an overwhelming trauma event within a matrix of personality, environmental and psychological aspects of the individual. The diagnosis of this particular disorder necessitates identifiable stress events, all three of the above areas of reaction in varying quantities and severe interruption of social and productivity life. Not all individuals exposed to trauma develop PTSD. Some literature suggest that one diagnostic benchmark to help anticipate the onset of long term PTSD was the amount of dissociation during the trauma (positively correlated) (Bremner and Brett, 1997). Individual differences are important in the development of PTSD. Some personality disorders like borderline and histrionic are associated with higher stress reactivity and possibly fall on the trauma-spectrum (Schmahl et al, 2002). Further complicating this diagnosis is that children manifest significantly different symptomology for stress/trauma related disorders prompting a call for alternative criteria (Scheeringa et al, 2003).

Group Therapy and PTSD: There is little evidence about the effectiveness of group on PTSD. One study determined that for veterans, group therapy specific to trauma was negatively associated with outcome (Schnurr, 2003). No citations were evidence-based specific to group and this diagnostic category. Saltzman WR., Pynos, RS., et al. 2003, cite a school based four part program that includes a psychoeducation/process group format. It is preceded by significant individual work. Most of the evidence was about individual therapy and its models.

Individual Therapy and PTSD: Much has been written about therapy with PTSD. The evidence is that exposure therapy, both in vivo and imaginal, are the most effective (Davidson and Parker, 2002; Bryant, 2003). Sherman, 2004 writing in *Family Practice News* cites evidence that exposure therapy is better than drugs for PTSD. This was an eight week treatment study. The Cochrane Review notes that pharmacotherapy for PTSD is generally successful using SSRIs. There is a caution that some medication exacerbate the symptoms and vigilance is required (2004).

Brief Therapy Models and PTSD: One type of brief therapy used in trauma work is known as Debriefing. Stress debriefing programming has been use extensively and often in the face of trauma and stress. This is technique allows for expression of feelings, re-framing of the incidence and the re-establishment of self efficacy. Research on one type and a common experience for clients, the one session debriefing intervention, is reported not only to not be effective but indications are that it actually increases the PTSD incidence within the cohort. (Cochrane Review, 2001). Many of the individual treatments are short term, 8 sessions (Sherman, 2004), and 12 sessions (Mueser et al, in press). Since CBT is seen as an essential component and philosophical underpinning of exposure therapy and for that matter longer term debriefing, brief application of CBT, under 20 sessions is noted as sufficient term of therapy. Compton (2002) cited the research on brief intervention with children with PTSD or prodromal PTSD with note trauma events. Although there is not a favored empirically supported report, all showed promise. The general structure is CBT with increase parental interventions, education and reduction in blaming. Some of these have manuals available.

Professional Status in Brief Therapy: Although no specific research was found, brief therapy mechanics can be taught. There is no evidence that I found, that paraprofessionals could not be taught to execute the foci of treatment. There are obviously some advantages to experience and education in that the theoretical underpinnings are understood, ability to draw on numerous models, and diagnostic abilities are more honed. Some of the common factors supporting all good therapy though are not the exclusive domain of professionally trained practitioners.

Structure of most Brief Therapy: Only one Manualized treatment was found for PTSD with SMI clients in this limited search. Mueser et al, (in press), has a 12 session combination program that includes psychoeducation about PTSD and its symptoms in the client's life, breathing retraining and Cognitive Restructuring. The manual is step-wise and included structured homework, problem solution focus and thought challenging targeting during therapy sessions. While only under research, the concept and initial conclusion is that this is a promising practice. Hamblen et al, have presented three case studies in a publication (in press).

Multi-Cultural Considerations: The literature on multi-cultural adaptation of evidence based treatments was less than complimentary. Nagayama Hall, 2001, reviewing the empirically supported literature plainly states: "there is not adequate empirical evidence that any of these empirically support therapies is effective with ethnic minority populations" (p.502). Bernal and Scharron-Del-Rio, (2001) earlier noted the same conclusion and called for a more "pluralistic" methodology in developing evidence based and culturally sensitive treatments. The overall consensus is that, even lacking specific cultural treatments, the application of evidence supported interventions is better than using non-supported techniques.

Pharmacological Interventions: As previously stated, the Cochrane Review suggest that SSRI treatments are the preferred and most effective. This is supported by Bremner (2002).

Manuals: Mueser et al, from Dartmouth Medical School and New Hampshire-Dartmouth Psychiatric Research Center, have a manual in press. One can possibly get a copy by requesting a reprint of the therapist manual at

Kim T. Mueser Ph.D.
NH-Dartmouth Psychiatric Research Center
Main Building
105 Pleasant St.
Concord, NH, 03301

References:

Bernal, G., Scharron-Del-Rio, M., Are Empirically Supported Treatment Valid for Ethnic Minorities? Toward An Alternative Approach for Treatment Research. *Cultural Diversity and Ethnic Minority Psychology*, Nov 2001, Vol. 7, No. 4, 328-342

Bryant RA., Moulds, MI., Guthrie, RM., et al., Imaginal exposure ablong and imaginal exposure with cognitive restructuring in treatment of posttraumatic stress disorders. *Journal of Consulting and Clinical Psychology* 2003, Vol. 71, 706-712

Bremner, JD., Brett, E., Trauma-related dissociative states and long-term psychopathology in posttraumatic stress disorder. *Journal of Traumatic Stress,* Vol 10 No. 1, 1997 37-49

Cochrane Review: Pharmacotherapy for Post Traumatic Stress Disorder. Authors: Stein, Zungu-Dirwayi et al. Issue 3, 2004

Cochrane Review: Psychological Debriefing for Preventing Post Traumatic Stress Disorder. Authors: Bisson RS., Wessely, S., Issue 3, 2004

Compton SN, Burns, BJ, Egger, HL., Review of the Evidence Base for Treatment of Childhood Psychopathology: Internalizing Disorders. *Journal of Consulting and Clinical Psychology* 2002, Vol 70, NO. 6, 1240-1266

Davidson PR., Parker, KC., Review: eye movement desensitization and reprocessing is not better than exposure therapies for anxiety or trauma. *Evidence-Based Mental Health*, Feb 2002 Vol 5, 13

Hamblen, JL., Jankowski, MK., et al., Cognitive-Behavioral Treatment for PTSD in People with Severe Mental Illness: Three Case Studies. In press

Miller KE., Therapy Options of Post Traumatic Stress Disorder *American Family Physician*, May 2004 Vol 69 2239-40

Mueser, KT., Rosenberg, SD., Jankowski, K., et al., A cognitive-behavioral treatment program for Posttraumatic Stress Disorder in Persons with Severe mental Illness. In press

Nagayama Hall, GC. Psychotherapy Research with Ethnic Minorities Empirical , Ethical and Conceptual Issues. *Journal of Consulting and Clinical Psychology*, June 2001, Vol. 69, No. 3, 502-510

Najavit, LM et al., Therapist Satisfaction with Four Manual-Based Treatment on a National Multisite Trail: An exploratory Study. *Psychotherapy: Theory, Research, Practice and Training* 2004, Vol. 41, No. 1, 26-37

Rosenberg, SD., Mueser, KT., Salyers, MP., Acker, K., Cognitive-Behavioral Treatment of PTSD in Sever Mental Illness: Result of a Pilot Study. In press

Saltzman WR., Pynoos, RS., et al., School-Based Trauma and Grief Intervention for Adolescents Ther Prevention Researcher April 2003, Vol 10 No. 2, 8-10

Scheeringa, MS., Zeanah, CH., et al., New findings of alternative criteria for PTSD in preschool children. *Journal of the American Academy of Child and Adolescent Psychiatry*, May 2003 Vol 42, 561-71

Schmahl, CG., Elzinga, BM., Bremner, JD., Individual differences in psychophysiological reactivity in adults with childhood abuse. *Clinical Psychology and Psychotherapy,* Vol 9 2002, 271-276

Schnurr, PP., Freidman, MJ., Foy, DW., et al., Randomized trial of trauma-focused group therapy for posttraumatic stress disorder. Results from a Department of Veterans Affairs cooperative study. *Archives of General Psychiatry* 2003, Vol. 60, 481-489

Sherman, C., Exposure therapy better than drugs for PTSD: 8 weeks treatment. *Family Practice News*, June 15, 2004 Vol 34, 36

Books

The End of Stress as We Know It (2002) Bruce McEwen, Joseph Henry Press Washington DC

Psychotraumatology (1995) Eds George S. Everly, Jr. and Jeffry M. Lating, Pleum Press, New York

Short-Term Psychotherapy Groups for Children: Adapting Group Processes for Specific Problems (1999) Ed. Charles E. Schaefer. Jason Aronson Inc, Northvale New Jersey

The Art and Science of Brief Psychotherapies: A Practitioner guide (2004). Dewan, Steenbarger and Greenberg. American Psychiatric Publishing, Washington, DC

Does Stress Damage the Brain?; Understanding Trauma-Related Disorders from a Mind-Body Perspective. (2002) Bremner, J. Douglas, WW Norton & Company, New York

Appendix C: Sample Treatment Plans

Treatment Plan for PTSD (under 13 years old)

Summary List of Problems:
1. Hyper-arousal/anxiety
2. Intrusions/Avoidance
3. Inaccurate attributions regarding trauma
4. Parent/guardian's emotional reaction to traumatic event and/or inability to be supportive

Problem #1:
Hyper-arousal/anxiety (Sleep Problems, nightmares, bedwetting, startle response, muscle tension, anxiety, difficulty concentrating)

Goal:
Develop relaxation and self soothing skills to decrease physical arousal and anxiety by 25-50%

Objectives:
1. Progressive muscle relaxation
2. Thought Stopping
3. Deep breathing
4. Positive Imagery

Problem #2:
Intrusions/Avoidance – (avoidance of thoughts/feelings about trauma, avoidance of activities, people, places associated to trauma-sense of detachment, lack of interest)

Goal:
Direct exploration of trauma to reduce symptoms by 25-50%

Objectives:
1. Express facts/feelings surrounding the trauma by using play therapy, story telling, painting, drawing etc.
2. Help child explore his/her understanding of happened to him/her

Problem #3:
Inaccurate attributions regarding trauma (Cognitive distortions, feelings of guilt /shame/anger/responsibility etc)

Goal:
Replace/correct unproductive thoughts/beliefs with more functional ones to improve coping abilities by 25-50%

Objectives:
1. Identify and replace negative self talk
2. Challenge distortions regarding trauma to reduce distortions by 25-50%
3. Address feeling of survivor guilt

Problem #4:
Parent/guardian's emotional reaction to traumatic event and/or inability to be supportive

Goal:
Decrease parent/guardian's emotional reaction and increase supportive role by 25-50% by helping parent to understand how PTSD develops and impacts their child

Objectives:
1. Conduct family sessions to facilitate family members giving emotional support to child
2. Direct psychoeducation of trauma process
3. Teach parents how to manage child's PTSD symptoms

Treatment Plan for PTSD (over 12 years old)

Summary list of problems:
1. PTSD Diagnosis
2. Hyper-arousal/anxiety
3. Cognitive distortions
4. Intrusions/Avoidance

Problem #1:
Confusion, lack of understanding and coping difficulties related to the diagnosis of PTSD.

Goal:
Psychoeducation related to the development, effects, and treatment of PTSD to assist with clarity, understanding on effects in daily life and ability to give informed consent to treatment as the means of increasing life quality post-trauma by at least fifty percent.

Objectives:
1. Client will increase knowledge of etiology and development of Posttraumatic Stress Disorder by at least 75 percent.
2. Client will learn about the primary symptoms of Posttraumatic Stress Disorder, internal/external trauma triggers, and dysfunctional physiological, emotional, cognitive, and behavioral responses to these triggers.
3. Client will be informed about all the treatment components, treatment outcome, and therapy commitment expectations so he/she can give informed consent to treatment.

Problem #2:
Sleep problems, nightmares, startle response, hyper-vigilance, muscle tension, anxious feelings, and difficulty concentrating

Goal:
Develop relaxation and self-soothing skills that decrease physical arousal and anxiety by at least fifty percent

Objectives:
1. Client will learn re-breathing techniques and meditation skills to decrease anxiety/arousal by at least fifty percent.
2. Client will develop progressive muscle relaxations skills and autogenic skills to decrease muscle tension, stress, and sleep difficulties by at least fifty percent
3. Client will learn visualization/containment skills (safe place, container, light stream imagery) to manage anxious feelings and improve concentration by at least fifty percent

Problem # 3:
Cognitive distortions, maladaptive core beliefs that increase PTSD symptoms and result in misassumptions about the self, the world and people and also contribute to low self-esteem and feelings of shame, guilt, and displaced anger

Goal:
Replace unproductive thoughts/beliefs with more functional ones to improve coping abilities by at least fifty percent.

Objectives:
1. Client will gain understanding of the most common distortions associated with PTSD and their effects on maintaining/increasing symptoms
2. Client will learn to identify his/her specific dysfunctional thoughts through use of a daily thought record and analyze the information to identify irrational core beliefs and effects
3. Client will learn to dispute irrational thoughts/beliefs and replace with positive cognitions to increase coping and functioning by fifty percent

Problem # 4:
Unprocessed trauma memories that get triggered in the present and result in intense psychological and physical distress such as flashbacks, intrusive thoughts, feeling out of control, avoidance of stimuli, negative cognitions, physical hyper-arousal

Goal:
Desensitization and reprocessing of trauma memories that will result in adaptive resolution of primary trauma aspects.

Objectives:
1. Client will identify aspects (images, thoughts, feelings, physical sensations) associated with specific trauma memories to be de-sensitized and measure his/her degree of distress on the Subjective Units of Distress Scale (SUDS Scale 1-10)
2. Client will cooperate with; eye movements, ABS or other exposure interventions until trauma memory disturbance is decreased by ninety percent or to SUDS of 1 or 0.
3. Client will learn to integrate trauma aspects while increasing positive cognitions to 7 on the Validity of Cognition scale (Voc Scale 1-7) or by fifty percent.