



## Assessment and Treatment of PTSD

Center for Deployment Psychology  
Uniformed Services University of the Health Sciences



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## Assessment of PTSD



## Diagnostic Criteria (DSM-IV and DSM-5)



## Acute Stress Disorder (ASD): DSM-IV Diagnostic Criteria

### Dissociation (at least 3)

Amnesia, detachment, numbing, reduced awareness of surroundings, derealization, depersonalization

### Re-experiencing (at least 1)

Thoughts, nightmares, flashbacks, emotional reactions, physiological reactions

### Avoidance (at least 1)

Avoid thoughts, avoid reminders

### Arousal (at least 1)

Sleep disturbance, concentration problems, anger, hypervigilance, startle



## Acute Stress Disorder (ASD): DSM-5 Diagnostic Criteria

Presence of **9 (or more)** of the following symptoms from any of the 5 categories:

### INTRUSION

Intrusive memories; distressing dreams; dissociative reactions (e.g. flashbacks); psychological or physiological reactivity to reminders

### NEGATIVE MOOD

Persistent inability to experience positive emotions

### DISSOCIATIVE

Derealization; traumatic amnesia

### AVOIDANCE

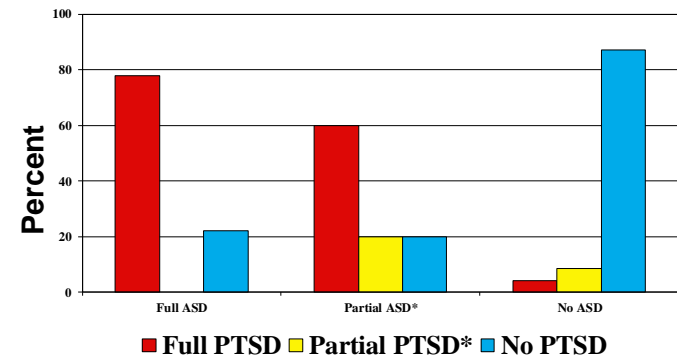
Avoid memories, thoughts, or feelings; avoid external reminders

### AROUSAL

Sleep disturbance; irritability/anger; hypervigilance; concentration; exaggerated startle response



## ASD and PTSD





## PTSD Criteria – DSM-IV

- A: Stressor Criterion
- B: Re-experiencing
- C: Avoidance
- D: Arousal
- E: Time Criterion
- F: Functional Impairment or Distress



*The defining symptoms alone, without connections to the stressor, are not regarded as PTSD (Breslau 2002).*



## PTSD Criteria – DSM-5

- A: Stressor Criterion
- B: Intrusion
- C: Avoidance
- D: Cognition & Mood Alt.
- E: Arousal & Reactivity
- F: Time Criterion
- G: Functional Impairment or Distress



*The defining symptoms alone, without connections to the stressor, are not regarded as PTSD (Breslau 2002).*



## DSM-5: PTSD Criterion A

- A Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
1. Directly experiencing the traumatic event(s).
  2. Witnessing, in person, the event(s) as it occurred to others.
  3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
  4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

**Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related.



## DSM-5: Symptom Criteria for PTSD 1+1+2+2 =PTSD

Intrusion (B)	Avoidance (C)	Negative Alterations in Cognitions and Mood (D)	Arousal (E)
Intrusive, Distressing Recollections	Avoidance of Internal Reminders (memories, thoughts, feelings)	Traumatic Amnesia	Irritable Behavior and Angry Outbursts
Distressing Dreams	Avoidance of External Reminders (people, places, conversations, activities, objects, situations)	Persistent Negative Beliefs and Expectations	Reckless or Self-Destructive Behavior
Dissociative Reactions (e.g. flashbacks)		Persistent Distorted Blame	Hypervigilance
Psychological Distress to Reminders		Persistent Negative Emotional State	Exaggerated Startle Response
Marked Physiological Reactions to Reminders		Diminished Interest	Concentration Difficulties
		Detachment or Estrangement	Sleep Difficulties
		Persistent Inability to have Positive Emotions	
<b>1</b>	<b>1</b>	<b>2</b>	<b>2</b>



## Goals of PTSD Assessment

- Differential diagnoses
- Functional assessment
- Collection of information for case conceptualization / substantiate case
- Treatment planning
- Tracking treatment progress /outcome
- Medical discharge/service connection



Keane et al (2008) for the first 5 points; last point derived from clinical experience



## Differential Diagnoses

- Acute stress disorder
- Substance use disorder
- Schizophrenia/other psychotic disorders
- Mood disorders
- Anxiety disorders (panic, OCD, generalized, simple phobia)
- Somatoform disorders
- Factitious disorder/malingering
- Bipolar disorder
- Dissociative disorders
- Eating disorders
- Sleep disorders
- Impulse control disorders not elsewhere classified
- Adjustment disorder
- Personality disorders
- ADHD
- TBI
- Pathologic grief
- Seizures

Most of this list is from Blank (1994); some are based on clinical experience



## Multi-method Approach to Assessing PTSD

- Keane et al (2000; 2008) recommend:
  - Structured diagnostic interview
  - Self-report measures
  - Psychophysiological measures if possible
  - Symptoms must be related to Criterion A event
  - Assessment of symptom frequency, intensity & duration
  - A culturally sensitive test battery
  - Indices of functional domains



## Lifetime DSM-IV Psychiatric Comorbidity among Nationally Representative Sample of US Adults

### Prevalence

	No PTSD with trauma n = 26716	PTSD Partial n = 2471	Full PTSD n = 2463
<b>Axis I Disorder</b>			
Any mood disorder	21.8 (.39)	51.3 (1.25)	61.5 (1.33)
Major Depressive Disorder	14.3 (.31)	31.5 (1.008)	35.2 (1.22)
Dysthmic Disorder	2.7 (.12)	7.2 (.58)	10.0 (.74)
Bipolar I Disorder	3.8 (.15)	11.8 (.76)	19.1 (1.02)
Bipolar II Disorder	1.4 (.09)	4.33 (.49)	4.4 (.49)
Any anxiety disorder except PTSD	22.2 (.46)	46.6 (1.16)	59.0 (1.40)
Generalized anxiety disorder	5.6 (.20)	17.6 (.93)	27.9 (1.19)

Pietrzak et al. (2011)



## Lifetime DSM-IV Psychiatric Comorbidity among Nationally Representative Sample of US Adults

### Prevalence

Axis I Disorder	No PTSD with trauma n = 26716	Partial PTSD n = 2471	Full PTSD n = 2463
Panic disorder, with or w/o agoraphobia	5.5 (.18)	18.4 (1.04)	24.2 (1.23)
Agoraphobia without panic disorder	.3 (.04)	.5 (.16)	.7 (.18)
Social phobia	5.9 (.21)	12.6 (.86)	19.4 (1.03)
Specific phobia	13.0 (.35)	27.5 (1.06)	37.3 (1.32)
Any alcohol or drug use disorder	37.0 (.75)	43.3 (1.41)	46.4 (1.31)
Alcohol abuse/dep disorder	34.9 (.75)	40.5 (1.35)	41.8 (1.31)
Drug abuse/dep disorder	11.4 (9.35)	17.4 (1.01)	22.3 (1.17)
Nicotine dep disorder	21.0 (.52)	34.1 (1.32)	37.9 (1.26)
Lifetime suicide attempt	2.3 (.11)	9.2 (.67)	13.9 (.86)

Pietrzak et al. (2011)



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## Knowledge Check

**PTSD is associated with greater physical health problems.**



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## PTSD and Health-Related Problems

- In meta-analysis of 62 studies (civilian, veteran and mixed samples), those with PTSD had more severe and frequent:
  - general health symptoms and medical conditions
  - pain symptoms
  - cardio-respiratory symptoms
  - gastrointestinal symptoms
 than comparison groups.
- These were all significant health outcomes.

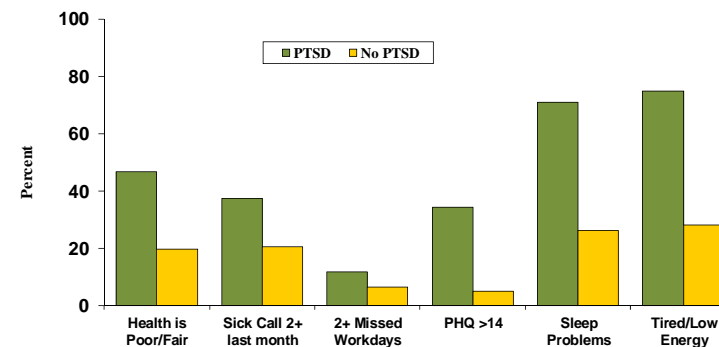
Pacella et al (2013)



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## PTSD and Health-Related Problems



Hoge et al (2007)



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## Knowledge Check

**PTSD is associated with more intimate relationship problems.**



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## PTSD and Intimate Relationship Problems

- Meta-analysis of 31 studies found moderate, positive correlations between PTSD and:
  - discord in intimate relationships
  - physical aggression in intimate relationships
  - psychological aggression in intimate relationships
- Intimate relationship discord and physical aggression were higher in the military (vs civilian) samples

Taft et al (2011)



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## PTSD Can Reduce Social Support



- Emotional Numbing and Detachment
- Hostility and Aggression
- Poor Social Problem Solving
- Distrust of Others



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## PTSD Self-Report Measures for DSM-IV

- Primary Care PTSD Screen (PC-PTSD) = 4 items
- PTSD Check List (PCL) - Military and Civilian versions = 17 items\*
- Impact of Event Scale - Revised (IES-R) = 22 items
- Mississippi Scale for PTSD - Combat and Civilian versions = 35 items
- PTSD Symptom Scale Self Report (PSS-SR) = 17 items
- Posttraumatic Diagnostic Scale (PDS) = 49 items
- PK Scale of the MMPI-2 = 46 items
- PTSD Cognitions Inventory (PTCI) = 36 items

*\*Note: The PCL for DSM-5 is available and discussed later. Copies of the PCL for both the DSM-IV and DSM-5 are found in your handouts.*



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## Primary Care PTSD Screen (PC-PTSD) for DSM-IV

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to? **YES / NO**
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? **YES / NO**
3. Were constantly on guard, watchful, or easily startled? **YES / NO**
4. Felt numb or detached from others, activities, or your surroundings? **YES / NO**

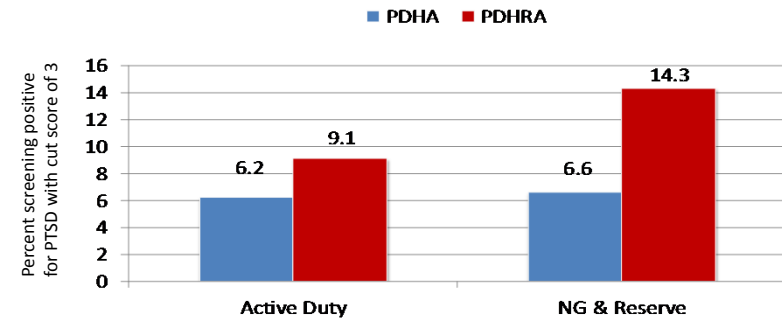
Prins et al (2003)



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## Study on PDHA & PDHRA: Close-Up of PC-PTSD Items



Milliken et al (2007)



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## Review PCL for DSM-IV and DSM-5

Have participants refer to their handouts of the PCL for DSM-IV and the PCL for DSM-5

Link to information about the PCL for DSM-5 as it compares to the PCL for DSM-IV

<http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp>



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## Changes to PCL for DSM-5

- A2 removed
- 4 symptom clusters instead of 3
- 3 new items about symptoms added
  - Blaming your self or someone else for what happened
  - Having strong negative feelings (e.g., fear, horror, guilt or shame)
  - Taking too many risks or doing things that could cause harm
- Scale changed from 1-5 to 0-4
  - Old range: 17 – 85; New range: 0 - 80
- Not different versions except it can be used with or without criterion A questions imbedded at the beginning



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## Sample Items from Other PTSD Self-Report Measures for DSM-IV

**Impact of Events Scale-R (IES-R)** (0 to 4 - not at all to extremely; can use means of subscales)

*Any reminder brought back feelings about it.*

*I tried not to talk about it.*

*I felt as if it hadn't happened or wasn't real.*

**Mississippi Combat Scale** (10 reverse scored items; 1 to 5 - not at all true to extremely true)

*I am able to get emotionally close to others.*

*I fall asleep, stay asleep and awaken only when the alarm goes off.*

*I am frightened by my urges.*

**PTSD Cognitions Inventory (PTCI)** (1 to 7 - totally agree to totally disagree)

*I can't trust that I will do the right thing.*

*I am a weak person.*

*The world is a dangerous place.*



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## What Makes a Good Screen?

- Relatively **quick and easy** to administer
  - Automated vs. in-person
- **Reading level** and language are **appropriate**
  - Meaning of items is clear
  - Can't be easily memorized/faked
- **Reliable** or consistent across time and populations
- **Valid** or assesses what it is designed to



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## What Makes a Good Screen?

- **Sensitive** – Captures the true positive rate of PTSD; Correctly identifies those individuals with PTSD (low number of false negatives)
- **Specific** – Captures the true negative rate of PTSD; Correctly identifies those individuals without PTSD (low number of false positives)



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## Use of the PC-PTSD Screen with GWOT Veterans

- Cut Score of 3 Maximized Efficiency

Cutoff	Sensitivity	Specificity	Efficiency
1)	.93	.72	.65
2)	.89	.79	.75
3)	.83	.85	.85
4)	.67	.90	.85

Using base score of 25%, Calhoun et al (2010)

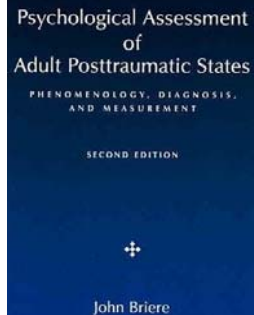


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## Importance of Clinical Interview



*“No psychological test can replace the focused attention, visible empathy, and extensive clinical experience of a well-trained and seasoned trauma clinician.”(p. 121)*

Briere (2004)



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## Why Assess Trauma History?



1. Helps you learn if traumatic events have occurred and the specific nature, risk factors, and severity.
2. You learn how your client coped and adapted.
3. You learn if your client is currently being exposed to ongoing threat.

Frueh et al (2012)



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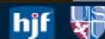


## Tips for Assessing Trauma History

- Assess current psychological and personal circumstances. Is client stable enough to discuss trauma history without unraveling?
- Prepare client for the topic/questions you'll ask so there aren't surprises.
- Express confidence with genuine interest and empathy.
- Normalize that trauma occurs frequently in the general population.
- Help client disclose trauma memories honestly while managing emotions.
- Help client feel a sense of accomplishment and increased understanding of past events.



Frueh et al (2012)



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## What If Client Asks if You Have Served and You Haven't?

*Communicate honestly and non-defensively. Emphasize how you want to learn from them about what you need to know to help. Acknowledge they're the expert on their military experience and you're genuinely interested in learning and listening.*



Frueh et al (2012)



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## PTSD Structured Interviews for DSM-IV

- Clinician-Administered PTSD Scale (CAPS)
- PTSD Symptom Scale - Interview (PSS-I)
- Structured Clinical Interview for DSM-IV (SCID)
  - PTSD Module
- Mini International Neuropsychiatric Interview (MINI)
  - PTSD Module



## CAPS Sample Item for DSM-IV

Criterion B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

1. (B-1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

Frequency	Intensity	Past week
In the past month/week have you had unwanted memories of (EVENT)? What were they like? (What did you remember?) [IF NOT CLEAR] (Did they ever occur while you were awake, or only in dreams?) [EXCLUDE IF MEMORIES OCCURRED ONLY DURING DREAMS] How often have you had these memories in the past month (week)?	How much distress or discomfort did these memories cause you? Were you able to put them out of your mind and think about something else? (How hard did you have to try?) How much did they interfere with your life?	F ____ I ____
0 Never	0 None	Past month
1 Once or twice	1 Mild, minimal distress or disruption of activities	F ____
2 Once or twice a week	2 Moderate, distress clearly present but still manageable, some disruption of activities	I ____
3 Several times a week	3 Severe, considerable distress, difficulty dismissing memories, marked disruption of activities	Sr: Y N
4 Daily or almost every day	4 Extreme, incapacitating distress, cannot dismiss memories, unable to continue activities	Lifetime
<b>Description Examples</b> (include anything unwarranted and untriggered. Any reminder internal considered untriggered, including pain.)	<b>QV (specify)</b> _____	F ____ I ____ Sr: Y N



## National Center for PTSD Website

National  
Center for  
**PTSD**  
Posttraumatic  
Stress Disorder

Link to Information about PTSD Assessments Including the CAPS:

<http://www.ptsd.va.gov/professional/pages/assessments/assessment.asp>




## At Minimum, Consider the Following 5 Questions

1. Does the constellation of symptoms meet the DSM-5 diagnostic criteria for this disorder?
2. Does the traumatic stressor reflect exposure to actual or threatened death, serious injury, or sexual violence as described under Criterion A?
3. What is the pre-incident/traumatic event psychiatric history of the Service Member?
4. Is the PTSD diagnosis based exclusively on the subjective verbal reporting of symptoms by the service member? Or exclusively on the subjective written reporting of symptoms?
5. What is the Service Member's current level of functional impairment, if any?



## Additional Considerations

- 
- Under-Reporting
  - Over-Reporting and Malingering
  - Clinician and Patient Motivation
  - Setting, Time, Cost
  - Practical Barriers



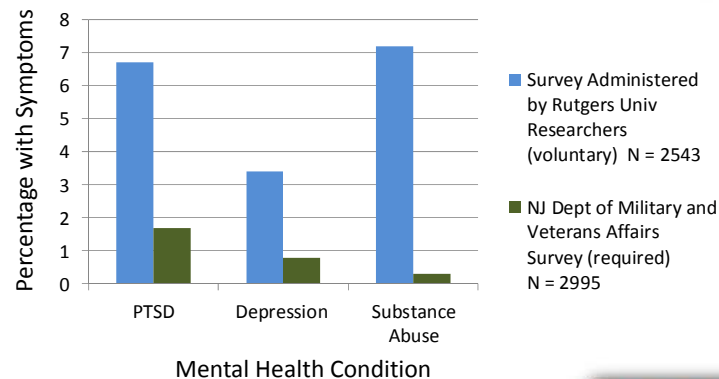
## Under-Reporting

Why would a Service Member under-report PTSD symptoms?

- Stigma
- Concerned about the effects on career, security clearance, what others will think
- Wants to stay in the fight
- Isn't aware of the symptoms or don't see them as such
- Doesn't understand what is being asked
- Lack of motivation



## Under-Reporting and Stigma



## Over-Reporting

Why would a Service Member over-report PTSD symptoms?

- Garner attention and enhance self perception (Burkett et al, 1998; Holzer et al, 2003) and may adopt "sick role" (Satel, 2011).
- PTSD diagnosis provides validation of sacrifices made during deployment (Sayer et al, 2004)
- To some, PTSD diagnosis is "badge of honor;" achievements may not be noted unless diagnosed (Blake, 2010)
- Personality dynamics
- Service connection disability /medical discharge

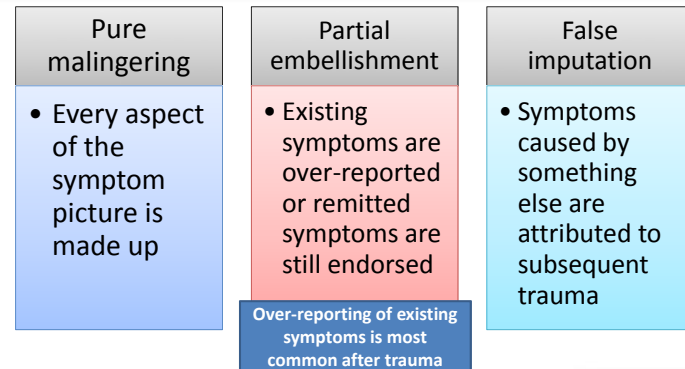


## What is Malingering?

“The essential feature of malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military duty, avoiding work, obtaining financial compensation, evading criminal prosecution, or obtaining drugs.” (p. 739)



## Types of Malingering



## Army Policy: Malingering

“Although there has been debate on the role of symptom exaggeration or malingering for secondary gain in DoD and VA PTSD Disability Evaluation System (DES) processes, there is considerable evidence that this is rare and unlikely to be a major factor in the vast majority of disability determinations.” (p. 5)



## What Might Distinguish Somebody Who Is Malingering?


“The malingerer tells all of his/her story and wears his/her PTSD conspicuously, while the true sufferer is usually slow to seek treatment and is quiet about his/her symptoms.” (p. 529)

Somebody who is not malingering:

- Often has been encouraged by friends and family to get help.
- Pursues help for other reasons like anxiety, anger, depression.
- Avoids talking about what is bothering him/her.
- Discounts the severity of trauma.
- Reduces his or her role in the trauma.




## Additional Considerations

- 
- Mere history of trauma doesn't mean PTSD
  - Non-PTSD complaint may bring client to you
  - PTSD may be triggered by non-traumatic stressor
  - Negative contact with other providers may affect client's trust
  - Latent or delayed onset PTSD(?)



## Additional Considerations

- 
- Discomfort discussing reactions/trauma
  - Lack of awareness of symptoms
  - Our own reactions to asking about trauma
  - Other factors(?)



## Take Home Points

- A clinical interview should be used in conjunction with self-report measures to diagnosis PTSD.
- PTSD self-report measures are helpful for tracking treatment outcome pre-, during and post-treatment.
- Stigma and career concerns, among other things, may affect how Service Members report PTSD symptoms.
- When performing a PTSD assessment, consider differential diagnoses, comorbid conditions, and functional domains
- Because therapist variables may affect the assessment process, monitor them and remember the goals.



## Overview of Evidence-Based Treatments for PTSD





## Evidence-Based Treatments for PTSD Recommended by DoD/VHA Practice Guideline

- **Trauma-Focused Psychotherapies:**
  - Exposure-based therapies (e.g., Prolonged Exposure)
  - Cognitive-based therapies (e.g., Cognitive Processing Therapy, Cognitive Restructuring)
  - Eye Movement Desensitization Processing (EMDR)
  - Combinations of cognitive and exposure therapy
- **Stress Inoculation Training (SIT):** Anxiety management package
- **Medications:** Selective Serotonin Reuptake Inhibitors (SSRIs) and Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)

VA/DoD Clinical Practice Guideline for The Management of PTSD (2010)



## 2013 Meta-Analysis of RCTs on PTSD

### Psychotherapy:

- CBT
  - Primarily cognitive
  - Primarily exposure
  - Mixed exposure
  - SIT & Desensitization
- Eye movement desensitization and reprocessing
- Psychodynamic Therapy
- Hypnotherapy
- Self-help
- Biofeedback
- Group

### Somatic:

- Acupuncture
- Transcranial magnetic stimulation



### Medications:

- Antidepressants
  - Paroxetine
  - Fluoxetine
  - Sertraline
  - Citalopram
- Atypical antipsychotics
  - Risperidone
  - Olanzapine
- Mood stabilizers
- Antiadrenergic agents
  - Prazosin
  - Guanfacine
- Benzodiazepines

Watts et al (2013)



## Main Findings

- Treatments that were effective and had the largest amount of evidence were:
  - Cognitive Behavioral Therapies (CBTs)
  - Eye Movement Desensitization Reprocessing (EMDR)
  - Medications
    - Antidepressants
    - Atypical antipsychotics
- Studies with more women or fewer veterans had larger effects. This was true for psychotherapy studies and medication trials.



Watts et al (2013)



## Main Findings

- For CBTs:
  - *Primarily cognitive therapies (CPT, other cognitive therapy)* were most studied and had largest effects ( $g=1.08-1.63$ )
  - *Primarily exposure therapies (PE, simulator-based exposure therapy, other exposure therapy, and narrative exposure therapy)* had large effects ( $g=.80-1.69$ )
  - *Mixed CBT (exposure and skills therapy, exposure and cognitive therapy, exposure and psychodynamic)* had large effects ( $g=1.02-1.52$ )
  - *SIT and desensitization* were less studied ( $g=.73-1.37$ )

Watts et al (2013)



## Less Studied Modalities

- Psychotherapies
  - Psychodynamic
  - Hypnotherapy
  - Self-Help
  - Biofeedback
  - Resilience therapy
  - Group
- Somatic
  - Acupuncture
  - Transcranial magnetic stimulation



Watts et al (2013)



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## Top 5 Reasons Returning US Military Personnel Fail to Seek Treatment for Mental Health Problems

1. Medications have significant side effects.
2. Treatment could negatively affect their career.
3. Treatment could cause denial of security clearance.
4. Family and friends are more helpful than mental health providers
5. Coworkers may lose confidence in their ability

Harrison et al (2010)



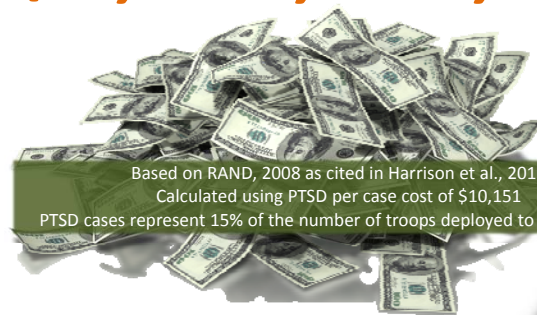
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## Projection of Resources Necessary to Treat US Troop Forces Deployed in Iraq for PTSD

# \$1,097,312,949

2003-2008



Based on RAND, 2008 as cited in Harrison et al., 2010  
 Calculated using PTSD per case cost of \$10,151  
 PTSD cases represent 15% of the number of troops deployed to Iraq per year



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## PTSD Treatments We Will Discuss

1. Medication
2. Cognitive Processing Therapy (CPT)
3. Prolonged Exposure Therapy (PE)
4. Eye Movement Desensitization Reprocessing Therapy (EMDR)

*At the end, we will quickly review supplemental, free apps to help manage PTSD symptoms.*



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## Medication



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## 2013 Meta-Analysis

- Largest effect sizes found in 2 medications studied most:
  - Antidepressants ( $g=.43$ )
  - Atypical antipsychotics ( $g=.36$ )
- Among antidepressants:
  - Only SSRIs and Venlafaxine were superior to placebos
  - For SSRIs, significant effect sizes varied:
    - paroxetine ( $g=.74$ ), fluoxetine ( $g=.43$ ) and sertraline ( $g=.41$ )
  - Non-significant effect for citalopram ( $g=-.71$ )

Watts et al (2013)



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## 2013 Meta-Analysis

- Among antipsychotics:
  - Only Risperidone was superior to placebo (and showed varied effects depending on designs)
- Among anticonvulsants, only Topiramate showed efficacy
- Other medications (anticonvulsants, benzodiazepines and antiadrenergic drugs) did not differ statistically from placebo.

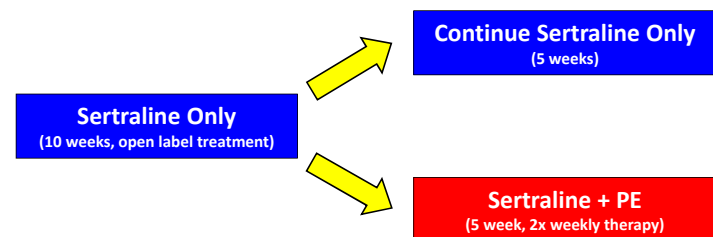
Watts et al (2013)



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## Study's Design: Augmentation of Sertraline with PE



Rothbaum et al (2006)

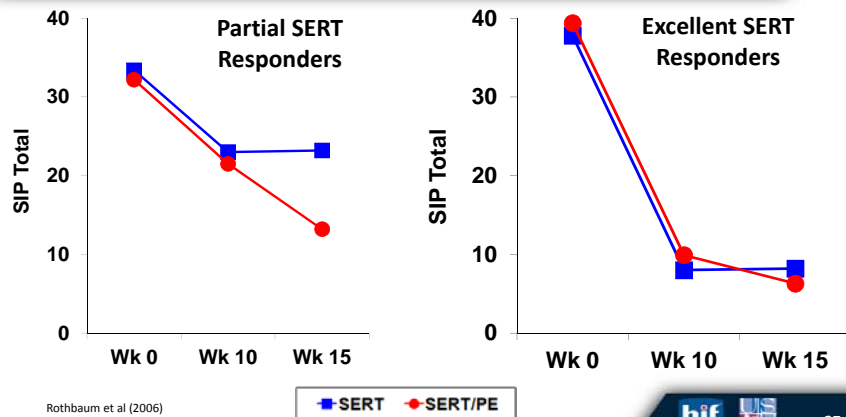


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## Augmentation with PE in Partial and Excellent Sertraline (SERT) Responders



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## Prolonged Exposure Therapy (PE)



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## Prolonged Exposure Therapy (PE)

Two main factors serve to prolong and worsen post-trauma problems:

- 1) **Avoidance** of trauma-related material including triggers, feelings, activities, thoughts, images, and situations.
- 2) The presence of **inaccurate or unrealistic thoughts and beliefs**.  
 "The world is unpredictably dangerous."  
 "I can't cope."

**Avoidance prevents the client from processing the trauma and modifying cognitions.**



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## Prolonged Exposure Therapy (PE)

- Approx. 10 sessions
- 90 minutes each
- Structured
- Homework
- Taping /recording

Breathing Retraining

Education about Common Reactions

In-Vivo Exposure

Imaginal Exposure

*Confront, confront, confront what you want to avoid!*

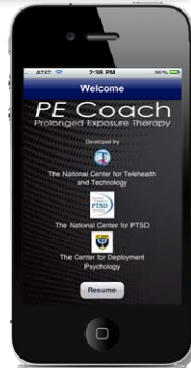


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## PE Coach app

- Installed on **client's** phone/tablet
- Used as adjunct to PE treatment
  - Rationale handouts
  - Homework assignment, tracking sheets
  - Record/review session audio
  - Appointment scheduling
- Free on iOS and Android platforms



<http://bit.ly/Q9ICDt>

[bit.ly/QUpirQ](http://bit.ly/QUpirQ)



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## Cognitive Processing Therapy



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## Cognitive Processing Therapy Is...

a short-term evidence-based treatment for PTSD

a specific protocol that is a form of cognitive behavioral treatment

predominantly cognitive and may or may not include a written account

a treatment that can be conducted in groups or individually



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## Phases of CPT Treatment

Pretreatment assessment and pretreatment issues

Education regarding PTSD, thoughts, and emotions

Processing the trauma

Learning to challenge

Trauma themes

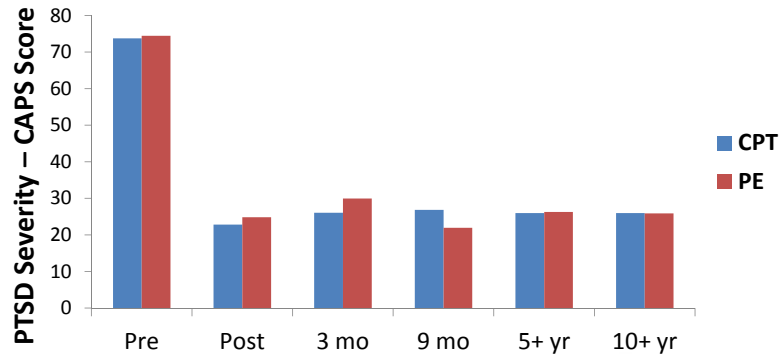
Facing the future



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## CPT and PE Follow-up



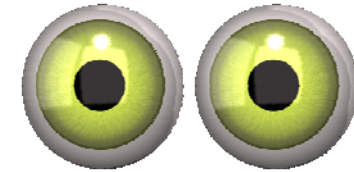
Resick et al (2012)



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## Eye Movement Desensitization Reprocessing (EMDR)



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## Eye Movement Desensitization Reprocessing (EMDR)

- Imagine the traumatic event
- Engage in lateral eye movements
- Focus on changes to image
- Repeat eye movements
- Generate alternative cognitive appraisal
- Focus on the alternative appraisal
- Repeat eye movements



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## Eye Movement Desensitization Reprocessing (EMDR)



### Steps:

- History and treatment planning
- Preparation
- Assessment
- Reprocessing, Desensitization and Installation
- Same as Step 4
- Body Scan
- Closure
- Reevaluation



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## Eye Movement Desensitization Reprocessing (EMDR)

### Step 3: Assessment

Therapist asks patient to identify:

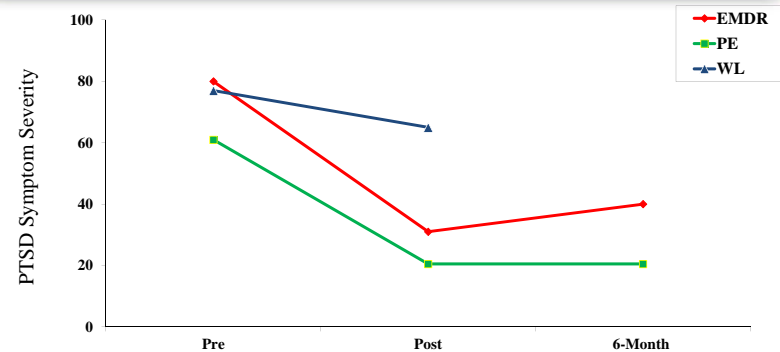
- Target or visual image of the trauma memory and related emotions and sensations
- Negative belief related to the trauma memory
- Positive belief he /she would like to have about self

### Steps 4 & 5: Reprocessing, Desensitization, and Installation

- Therapist has patient recall target image while using a set of rapid bilateral eye movements for brief period
- Therapist asks patient for reactions and associations.
- Therapist repeats procedures to facilitate "digestion" of trauma



## PE and EMDR Outcomes



Rothbaum et al (2005)



## Supplemental, Free Apps: Psychoeducation: PTSD Coach



- Learn about PTSD
- Self Assessment
- Manage Symptoms
- Find Support



<http://bit.ly/Vkd1Fw>



<http://bit.ly/MfVUzD>



## Supplemental, Free Apps: Relaxation: Breathe 2 Relax



<http://bit.ly/VScmuJ>



<http://bit.ly/TncPo6>



## Take Home Points

- Various effective evidence-based treatments for PTSD are available, including **PE, CPT, EMDR, and medication.**
- Service Members and Veterans **deserve access** to these treatments.



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## CDP Website: Deploymentpsych.org

### Features include:

- Descriptions and schedules of upcoming training events
- Blog updated daily with a range of relevant content
- Articles by subject matter experts related to deployment psychology, including PTSD, mTBI, depression, and insomnia
- Other resources and information for behavioral health providers
- Links to CDP's Facebook page and Twitter feed



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## Online Learning

The following online courses are located on the CDP's website at:  
Deploymentpsych.org/training/online-courses

**NOTE: All of these courses can be taken for free or for CE Credits for a fee**

- Cognitive Processing Therapy (CPT) for PTSD in Veterans and Military Personnel (1.25 CE Credits)
- Prolonged Exposure Therapy for PTSD in Veterans and Military Personnel (1.25 CE Credits)
- Epidemiology of PTSD in Veterans: Working with Service Members and Veterans with PTSD (1.5 CE Credits)
- Provider Resiliency and Self-Care: An Ethical Issue (1 CE Credit)
- Military Cultural Competence (1.25 CE Credits)
- The Impact of Deployment and Combat Stress on Families and Children, Part 1 (2.25 CE Credits)
- The Impact of Deployment and Combat Stress on Families and Children, Part 2 (1.75 CE Credits)
- The Fundamentals of Traumatic Brain Injury (TBI) (1.5 CE Credits)
- Identification, Prevention, & Treatment of Suicidal Behavior in Service Members & Veterans (2.25 CE Credits)
- Depression in Service Members and Veterans (1.25 CE Credits)

*All of these courses and several others are contained in the Serving Our Veterans Behavioral Health Certificate program, which also includes 20+ hours of Continuing Education Credits for \$350.*



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## Provider Support

CDP's "Provider Portal" is exclusively for individuals trained by the CDP in evidence-based psychotherapies (e.g., CPT, PE, and CBT-I)

### Features cover topics including:

- Consultation message boards
- Hosted consultation calls
- Printable fact-sheets, manuals, handouts, and other materials
- FAQs and on-on-one interaction with answers from SMEs
- Videos, webinars, and other multimedia training aids

Participants in CDP's evidence-based training will automatically receive an email instructing them how to activate their user name and access the "Provider Portal" section at Deploymentpsych.org.



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## How to Contact Us

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