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Assessment and Treatment of PTSD

Center for Deployment Psychology
Uniformed Services University of the Health Sciences

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Learning Objectives

1. Discuss issues of under- and over-reporting of symptoms related to PTSD in a military population.
2. Identify assessment tools and procedures used to assess for PTSD in a military population.
3. Discuss evidence-based treatments for PTSD in a military population.

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

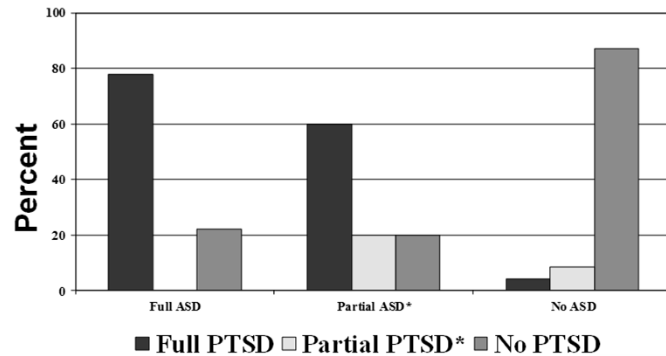
NEGATIVE MOOD
Persistent inability to experience positive emotions

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



Harvey & Bryant (1998)

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 Distressing Dreams Dissociative Reactions (e.g. flashbacks) Psychological Distress to Reminders Marked Physiological Reactions to Reminders	Avoidance of Internal Reminders (memories, thoughts, feelings) Avoidance of External Reminders (people, places, conversations, activities, objects, situations)	Traumatic Amnesia Persistent Negative Beliefs and Expectations Persistent Distorted Blame Persistent Negative Emotional State Diminished Interest Detachment or Estrangement Persistent Inability to have Positive Emotions	Irritable Behavior and Angry Ourbursts Reckless or Self-Destructive Behavior Hypervigiliance Exaggerated Startle Response Concentration Difficulties Sleep Difficulties
1	1	2	2

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

Axis I Disorder	No PTSD with trauma n = 26716	PTSD Partial n = 2471	Full PTSD n = 2463
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 agorophobia	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
Liftetime suicide attempt	2.3 (.11)	9.2 (.67)	13.9 (.86)

Pietrzak et al. (2011)

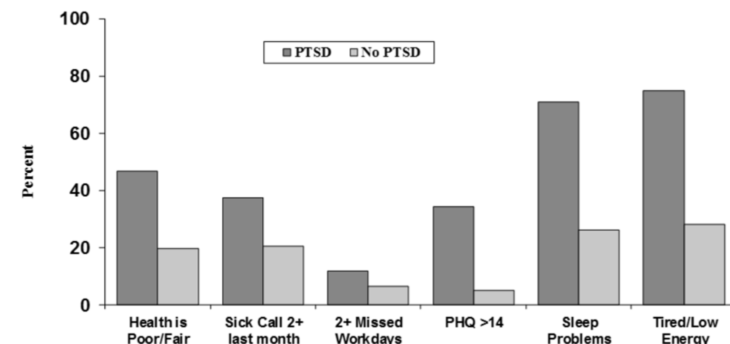
PTSD and Health-Related Problems

- 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)

PTSD and Health-Related Problems



Hoge et al (2007)

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)

PTSD Can Reduce Social Support

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

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.*

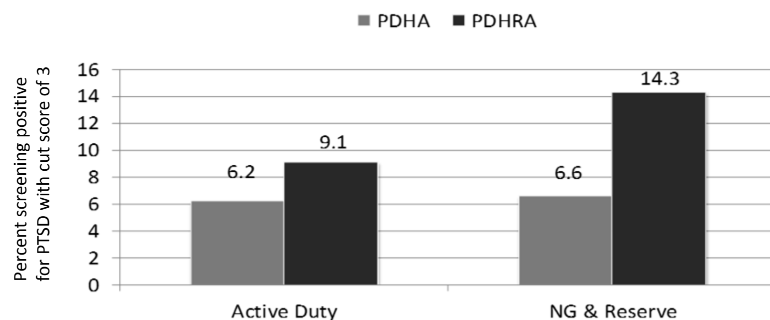
Primary Care PTSD Screen (PC-PTSD) for DSM-IV

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)

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



Milliken et al (2007)

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

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

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.

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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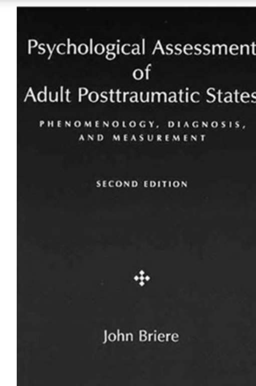
Importance of Clinical Interview



"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)

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)

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)

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)*?** 0 Never 1 Once or twice 2 Once or twice a week 3 Several times a week 4 Daily or almost every day ***Description/Examples*** *(include anything unwarranted and untriggered. Any reminder internal considered untriggered, including pain.)*	**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?** 0 None 1 Mild, minimal distress or disruption of activities 2 Moderate, distress clearly present but still manageable, some disruption of activities 3 Severe, considerable distress, difficulty dismissing memories, marked disruption of activities 4 Extreme, incapacitating distress, cannot dismiss memories, unable to continue activities ***QV (specify)*** ______________________	*F* ____ *I* ____ ***Past month*** *F* ____ *I* ____ *Sx: Y N* ***Lifetime*** *F* ____ *I* ____ *Sx: Y N*

National Center for PTSD Website

National Center for PTSD
Posttraumatic Stress Disorder

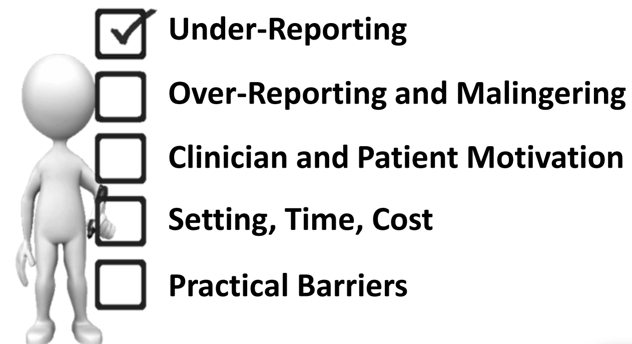
Link to Information about PTSD Assessments Including the CAPS:

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

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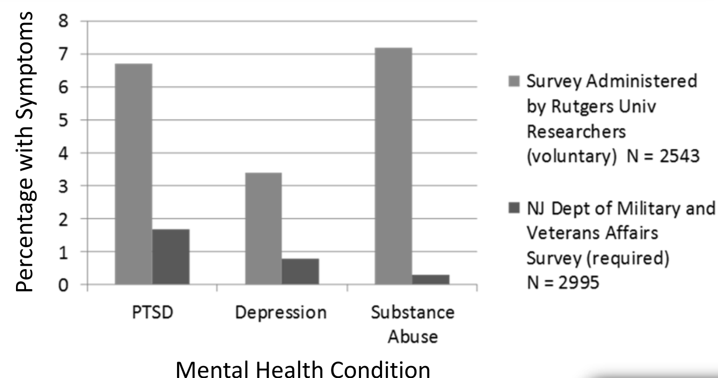
Under-Reporting and Stigma



Kline et al (2010)

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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

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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)

DSM-IV-TR: V65.2 Malingering

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Types of Malingering

Pure malingering	Partial embellishment	False imputation
• Every aspect of the symptom picture is made up	• Existing symptoms are over-reported or remitted symptoms are still endorsed	• Symptoms caused by something else are attributed to subsequent trauma

Over-reporting of existing symptoms is most common after trauma

Resnick (1995) and Appelbaum et al (1997) as cited in Hall et al (2006)

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)

Office of the Surgeon General, Department of the Army. Policy Guidance on the Assessment and Treatment of Post-Traumatic Stress Disorder (PTSD). OTSG/MEDCOM Policy Memo 12-035. April 10, 2012.

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.

Hall et al (2006)

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

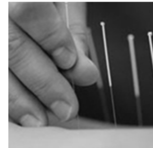
- **Trauma-Focused Psychotherapies:**
  - Exposure-based therapies (e.g., Prolonged Exposure)
  - Cognitive-based therapies (e.g., Cognitive Processing Therapy, Cognitive Restructuring)
  - Eye Movement Desensitization Processing (EMDR)
  - Combinations of cognitive and exposure therapy
- **Stress Inoculation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

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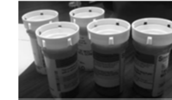
Main Findings

- 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)

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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=102-1.52)
  - *SIT and desensitization* were less studied (g=.73-1.37)

Watts et al (2013)

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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)

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.

Medication

2013 Meta-Anaylsis

- 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)

2013 Meta-Anaylsis

- 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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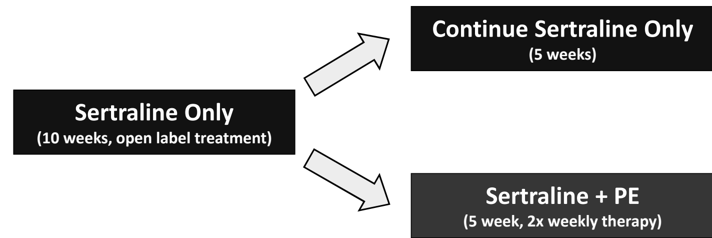
Study's Design: Augmentation of Sertraline with PE



Rothbaum et al (2006)

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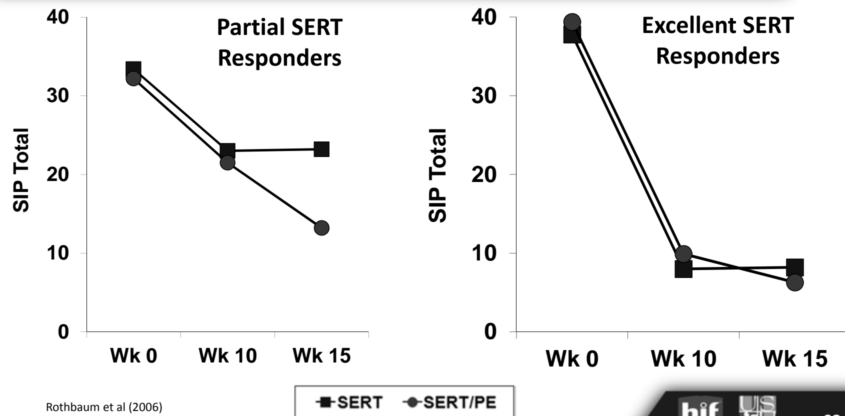
Augmentation with PE in Partial and Excellent Sertraline (SERT) Responders



Rothbaum et al (2006)

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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.

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!

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/Q9lCDt

bit.ly/QUpirQ

Cognitive Processing Therapy

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

1. Pretreatment assessment and pretreatment issues
2. Education regarding PTSD, thoughts, and emotions
3. Processing the trauma
4. Learning to challenge
5. Trauma themes
6. Facing the future

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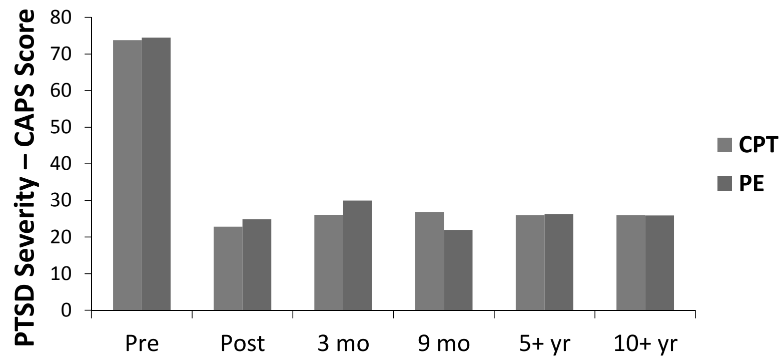
CPT and PE Follow-up



Resick et al (2012)

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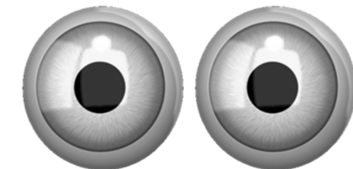
Eye Movement Desensitization Reprocessing (EMDR)



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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

Eye Movement Desensitization Reprocessing (EMDR)

Steps:

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

Eye Movement Desensitization Reprocessing (EMDR)

Step 3: Assessment

Therapist asks patient to identify:

a. Target or visual image of the trauma memory and related emotions and sensations

b. Negative belief related to the trauma memory

c. Positive belief he /she would like to have about self

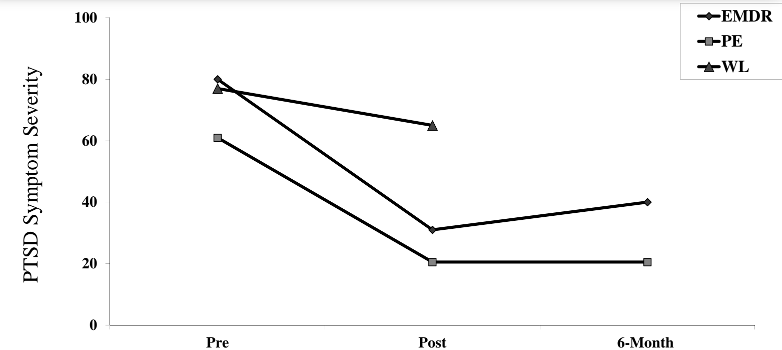
Steps 4 & 5: Reprocessing, Desensitization, and Installation

a. Therapist has patient recall target image while using a set of rapid bilateral eye movements for brief period

b. Therapist asks patient for reactions and associations.

c. Therapist repeats procedures to facilitate “digestion” of trauma

PE and EMDR Outcomes



Rothbaum et al (2005)

Supplemental, Free Apps: Psychoeducation: PTSD Coach

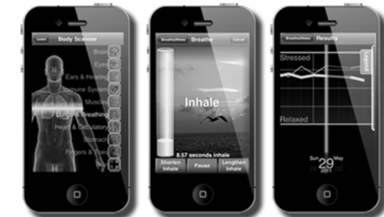
- Learn about PTSD
- Self Assessment
- Manage Symptoms
- Find Support

http://bit.ly/Vkd1Fw

http://bit.ly/MfVUzD

Courtesy: National Center for Telehealth and Technology (T2)

Supplemental, Free Apps: Relaxation: Breathe 2 Relax



http://bit.ly/VScmuJ

http://bit.ly/TncPo6

Courtesy: National Center for Telehealth and Technology (T2)

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.

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

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.

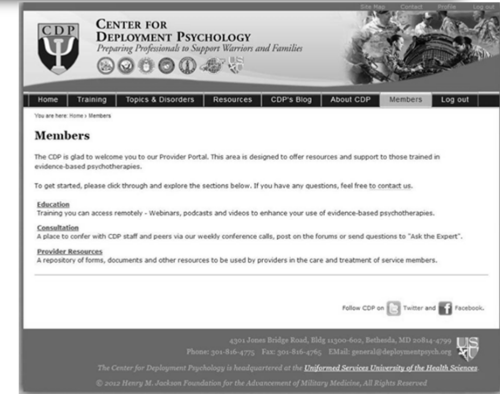
Provider Support

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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