Behavioural Activation & PTSD

Wanda L. Smith, Ph.D., C.Psych.
Private Practice
McMaster University, Hamilton
Agenda

- Defining features of PTSD, co-morbidity
- Military related PTSD
- Introduce Cases
- Clinical treatments – PE and CPT
- Behaviour Activation
- ACT - Experiential avoidance & values
Posttraumatic Stress Disorder

DSM-IV-TR diagnostic criteria:

- Exposure to a traumatic event...
- Response of intense fear or helplessness...
- Symptoms:
  - Re-experiencing
  - Avoidance
  - Arousal
- Duration > 1 month
- Significant impairment in functioning.
What makes an event traumatic?

- If the event is unpredictable and uncontrollable
- And, if the event is a severe or catastrophic violation of our fundamental beliefs and expectations about:
  - safety,
  - physical integrity,
  - trust,
  - and justice.

(Antony & Barlow, 2004)
Utoya Island – July 22.2011
Epidemiology & PTSD

Exposure to traumatic events:

- Lifetime trauma exposure = 50–60% (USA)
- PTSD prevalence = 7.8%
- Dose-response relationship, i.e., in countries where exposure is higher, prevalence is higher.

(Kessler et al, 1995)
Development of PTSD

PTSD may be a failure to recover.

Vulnerability – risk factors:

- History
- Severity of traumatic event
- Peri-traumatic experiences
- Post traumatic factors

PTSD persists without treatment.............
PTSD plus....

- PTSD shows the most severe and diverse pattern of co-morbidity.
- Individuals with a current diagnosis of PTSD, 92% met criteria for another current Axis 1 disorder:
  - Depressive Disorder - 77%
  - Substance abuse & dependence - 31%
  - Generalised anxiety disorder - 38%

Brown et al (2001)
Canadian War Experience

- Afghanistan: 38,558 served
- UN & NATO: >125,000 peacekeepers
- WWII (1939-1945): 1 m served; 143,700 surviving, mean age=87y.
- WWI (1914-1918): 650,000 served, no surviving veterans.
Military Contribution to Canada’s International Agenda

1980 – 1989

Post 1990

Indicates Countries where the Canadian Forces have been involved
Predictors of “Probable” PTSD in Military/Veterans

- Number of deployments
- Being seriously wounded
- Younger age
- Number of life stressor (pre and post deployment)
- Greater current stress
- Biological markers (Pre-existing high glucocorticoid receptors)

Hoge et al., 2004, Statistics Canada, 2002; Richardson et al., 2010, Richardson et al., 2006; Pietrzak et al., 2011; Zuiden et al., 2010; Polusny et al., 2011)
Anger and Military-related Anger

- Military training & deployment experiences set individuals apart from others.
- Fear of anger - “loosing it”, “going bolistic”
- The association between anger and combat-related PTSD is a significant clinical and social concern. (Novaco et al, 2002; Forbes et al., 2002, NCPTSD, 2008)
- “The problem most frequently reported by veterans with combat-related PTSD, their spouses, and assessing clinicians” (Biddle, et al., 2002)
- Lower anger levels were associated with better outcomes (Forbes et al., 2005)
Psychiatric Disorders in treatment-seeking veterans

Figure 1. Frequencies of self-reported probable psychiatric disorders and suicidal ideation

Richardson et al., 2012
PTSD Rates in CF-Afghanistan War

What is a common clinical presentation?

Comorbidity Spectrum

- Major depression
- Substance abuse
- Other anxiety disorder
- Psychotic symptoms
- mTBI & Physical injury
- Chronic pain
- Personality disorder/traits
- Other social dysfunctions
Afghanistan - 2006
Co-Morbidity - PTSD plus....

- Depression, with suicidal ideation
- Substance abuse & dependence
- Panic attacks, Agoraphobia, Social anxiety, OCD
- Chronic Pain
- ANGER & hostility, excessive
- Feelings of mistrust & betrayal
- Feelings of guilt, shame and disgust, intense
- Interpersonal relationships impaired, marital distress
- Work performance, poor or unable to work

adapted from Leahy & Holland (2000)
Basic principles of treatment

1. Stabilisation

2. Trauma focused psychotherapy

3. Rehabilitation Reintegration
1 – Stabilisation

GOAL

Improve current functioning
Establish a trusting relationship

Psychoeducation

Teach problem solving strategies

Assess and treat co-morbidities
Therapeutic Relationship

- Psychotherapy requires a sound therapeutic alliance.
- Warmth, empathy, caring, genuine regard & competence are critical.
- Building trust & rapport starts in the 1st session.

Therapeutic relationship

Embracing the least judgmental conceptualization of patient behavior is an important strategy for facilitating the therapeutic relationship and developing a positive view of your patients.

Linehan, 1993
Therapeutic Relationship

- Compassion, acceptance, empathy, respect & the ability to stay psychologically present even in the midst of strong emotions.
- Therapeutic relationships are strong, open, accepting, mutual, respectful and loving, i.e., relationships are intense, personal and meaningful.
- Boundaries are natural, non-arbitrary and linked to workability.

*Hayes, Strosahl & Wilson (1999)*
Psychological Treatment of PTSD
CBT Treatments for PTSD

Core components:

- *Psychoeducation* – information about the cognitive behavioural formulation of PTSD.


- *Cognitive restructuring* – cognitive processing therapy (Resick & Schnicke, 1993).
Exposure Therapy

- Set of techniques designed to help clients confront their feared object, situation, memories &/or images. Goal is reduction of avoidance & the promotion of mastery.

- Exposure:
  - Graduated exposure
  - Imaginal exposure to trauma memory & related cues
  - *In vivo* exposure to avoided situations.

- Prolonged exposure:
  - Prolonged, repeated exposure to trauma memory.
  - Repeated *in vivo* exposure to situations avoided.
Cognitive Processing Therapy

- Focuses on appraisal of traumatic event and emotions resulting from event
- Involves writing narratives targeting the processing of guilt and shame.
- Goal - refrain from assimilation and assist in accomodation w/o overaccomodation.
Research findings for CBT & PTSD

- For a variety of trauma populations including childhood abuse, sexual assault, MVA, veterans, CBT consisting of some form of exposure and/or cognitive restructuring, appears to be more effective than no treatment or supportive counseling.
- No clear evidence that any form of CBT is superior to other forms.
- CBT that includes exposure has amassed the greatest amount of empirical support.
- Exposure is the cornerstone of treatment for PTSD & should form the basis for all treatment protocols.
But.....................
Despite the progress that has been achieved in the treatment of PTSD, many patients do not benefit from the first line of treatment. The phenomenon of treatment resistance has been particularly noted among Vietnam veterans...but other trauma populations have their share of treatment failures.

Foa, Keane, Friedman & Cohen (2009) p18
Functional Analysis of Depression
Depression, like infantile autism (Ferster, 1961), appears to be an especially appropriate field for the behavioral psychologist because of the missing items of behavior that are so prominent.

The depressed person engages in a high frequency of avoidance and escape from aversive stimuli... along with the reduced frequency of positively reinforced behavior.

Ferster (1973)
Behaviour Therapy

Behavioural Model postulates:

- Depression does not live inside a person, rather, depression is a problem between a person & their life.
- Depression results from too few pleasant & too many negative person-environmental interactions.

Ferster (1973); Lewinsohn (1974)
Behavioural Activation
Behavioural activation is a brief structured treatment for depression that aims to activate clients in specific ways that will increase rewarding experiences in their lives.

*Martell, Dimidjian & Herman-Dunn (2010)*
Empirical support for BA

- 150 Ss
- Examined BA (WAS) vs BA & CT (at) vs BA & CT (at & core beliefs).
- Results showed no differences in treatments – acute or at 2 year follow-up.
Randomized Trial of Behavioral Activation, Cognitive Therapy, and Antidepressant Medication in the Acute Treatment of Adults With Major Depression


Abstract

Antidepressant medication is considered the current standard for severe depression, and cognitive therapy is the most widely investigated psychosocial treatment for depression. However, not all patients want to take medication, and cognitive therapy has not demonstrated consistent efficacy across trials. Moreover, dismantling designs have suggested that behavioral components may account for the efficacy of cognitive therapy. The present study tested the efficacy of behavioral activation by comparing it with cognitive therapy and antidepressant medication in a randomized placebo-controlled design in adults with major depressive disorder (N = 241). In addition, it examined the importance of initial severity as a moderator of treatment outcome. Among more severely depressed patients, behavioral activation was comparable to antidepressant medication, and both significantly outperformed cognitive therapy. The implications of these findings for the evaluation of current treatment guidelines and dissemination are discussed.
Behavioural Activation Books

1. Depression in Context
   Strategies for Guided Action
   Christopher R. Martell
   Michael E. Addis
   Neil S. Jacobson

2. Overcoming Depression One Step at a Time
   The New Behavioral Activation Approach to Getting Your Life Back
   Michael E. Addis, Ph.D.
   Christopher R. Martell, Ph.D., ABPP

3. Behavioral Activation for Depression
   A Clinician’s Guide
   Christopher R. Martell
   Sona Dimidjian
   Ruth Herman-Dunn
10 Core Principles of BA

1. Key to changing how people feel is helping them change what they do.

2. Life changes can lead to depression, short term coping strategies may keep people stuck.

3. Clues to figuring out what will be antidepressant lie in what precedes and follows client’s important behaviours.

4. Structure & schedule activities that follow a plan, not a mood.

5. Change will be easier when starting small.
10 Core Principles of BA

6. Emphasise activities that are naturally reinforcing.
7. Act as a coach.
8. Emphasise a problem solving empirical approach & recognise that all results are useful.
9. Don’t just talk, do!
10. Troubleshoot possible & actual barriers to activation.
BA Protocol

- Psychoeducation – the impact of PTSD & depressive symptoms on Quality of Life.
- ID treatment goals.
- Conduct functional analysis of avoidance behaviours to identify barriers to activity.
- Activity scheduling - Institute weekly goal setting & problem solving to promote successive steps toward activation.
- Monitor/track engagement and mood.
Behavioural Activation and PTSD
Behavioral Activation as an Early Intervention for Posttraumatic Stress Disorder and Depression Among Physically Injured Trauma Survivors

Amy W. Wagner, Douglas F. Zatzick, Angela Ghesquiere, and Gregory J. Jurkovich
University of Washington and Harborview Medical Center

This paper describes an adaptation of behavioral activation (BA) for the early intervention of posttraumatic stress disorder (PTSD) and depression among physically injured survivors of traumatic injury, and presents pilot data on a small randomized effectiveness trial (N=8). The application of BA to PTSD is based on the theory that increases in guided activity may break patterns of avoidance that can maintain PTSD. Compared to treatment as usual (TAU), those who received BA showed improvement in PTSD symptom severity from pre- to posttreatment, and there was a trend for the BA group to score better than the TAU group on physical functioning. Contrary to expectation, this brief adaptation did not have an impact on depression. Implications of these results for the effective early intervention after trauma are discussed.
A Pilot Study of Behavioral Activation for Veterans With Posttraumatic Stress Disorder

Matthew Jakupcak  
Seattle VA Puget Sound Health Care System

Lisa J. Roberts  
Vistarion TeleHealthcare, LLC

Christopher Martell  
University of Washington

Patrick Mulick  
 Gonzaga University

Scott Michael and Richard Reed  
Seattle VA Puget Sound Health Care System

Kimberly F. Balsam and Dan Yoshimoto  
University of Washington

Miles McFall  
Seattle VA Puget Sound Health Care System and University of Washington

A pilot study was conducted to investigate the feasibility and effectiveness of behavioral activation (BA) therapy for veterans with posttraumatic stress disorder (PTSD). Eleven veterans seeking treatment at a Veterans Administration outpatient PTSD clinic were enrolled in the study protocol, consisting of 16-weekly individual sessions of BA. Nine veterans completed the protocol, one participant completed 15 sessions, and one dropped out after one session. Clinician-rated PTSD symptom severity showed significant pre- to posttreatment improvement and was associated with a moderate effect size. A number of participants also were improved on measures of depression and quality of life, but changes did not reach statistical significance. Findings suggest that BA is a well-tolerated, potentially beneficial intervention for veterans with chronic symptoms of PTSD.
Behavioral Activation as a Primary Care-Based Treatment for PTSD and Depression Among Returning Veterans

Matthew Jakupcak  
VA Puget Sound Health Care System, VISN-20 Northwest Mental Illness Research, Education, and Clinical Center, and University of Washington

Amy Wagner  
Portland VA Medical Center

Autumn Paulson  
VA Puget Sound Health Care System and VISN-20 Northwest Mental Illness Research, Education, and Clinical Center

Alethea Vatra and Miles McFall  
VA Puget Sound Health Care System, VISN-20 Northwest Mental Illness Research, Education, and Clinical Center, and University of Washington

This preliminary study examined treatment-satisfaction and potential therapeutic benefits of Behavioral Activation as a primary care-based treatment for posttraumatic stress disorder (PTSD) and depression among Iraq and Afghanistan War veterans. Eight veterans were enrolled, 6 completed at least 4 sessions, and 5 veterans completed posttreatment and 3-month follow-up assessments after receiving 5–8 weekly sessions of Behavioral Activation delivered in a specialty postdeployment primary care clinic. Significant and meaningful reductions in PTSD symptoms were found on structured clinical assessments and self-report measures. Posttraumatic stress disorder treatment gains (measured by structured clinical assessments) were maintained at 3-month follow-up. The majority of veterans demonstrated meaningful improvements on depression and quality of life and veterans reported a high satisfaction with treatment.
Is BA = in vivo exposure?

BA:

- Activities are chosen for their value not relationship to trauma.
- Activities which are naturally reinforcing are chosen.
Acceptance & Commitment Therapy

- ACT is a behaviourally based intervention designed to target & reduce experiential avoidance & cognitive entanglement while encouraging clients to make life-enhancing behavioural changes which are in accord with their personal values.

- Building empirical support for ACT – 56 RCT’s & recognised for treatment of depression, chronic pain & substance abuse.

*Hayes et al, 1999, 2005, 2007*
Experiential Avoidance & PTSD

- Experiential avoidance - efforts made to change, eliminate &/or avoid negative internal experiences such as thoughts, emotions, memories & sensations, with PTSD, that remind the individual of the trauma.
- PTSD includes avoidance of internal experiences & avoidance of places or things that remind the individual of the trauma that may cue the internal experiences.
- EA may be the key mechanism in the development & maintenance of PTSD.
Lack of clarity of values and losing a sense of direction in life

Feeling stuck and unable to live a meaningful life

Experiential Avoidance

Losing Contact with the present

Psychological rigidity

Fusion

Conceptual Self
The Target of ACT

To make experiential contact with previously avoided private events without excessive verbal involvement and control – and to make powerful life enhancing choices.
Choosing a valued direction in life

Acceptance

Defusion

Living in the present

Psychological Flexibility

Commitment to live a life with meaning according to chosen values

Self as the Context
Valuing – Key Points

- All ACT techniques are eventually subordinated to helping the client live in accordance with his/her chosen values.
- Helping the client identify valued life goals & implement them in the face of emotional obstacles both directs & dignifies ACT.
- Values cannot be fully satisfied, permanently achieved or held like an object.
- Values will never be finished.
- Values are a direction............
Questions, Comments......

Wanda L. Smith
smithwa@mcmaster.ca