

Massed Delivery of Evidence Based Psychotherapy for PTSD

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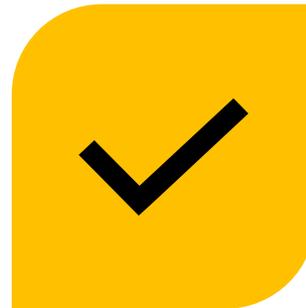
Objectives



SECTION 1: OVERVIEW OF EVIDENCE
BASED PSYCHOTHERAPY FOR PTSD
IMPLEMENTATION AND OUTCOMES



SECTION 2: RESEARCH OUTCOMES
FOR MASSED EBP DELIVERY



SECTION 3: STRATEGIES FOR
IMPLEMENTATION



SECTION 4: FUTURE DIRECTIONS

Why now?



Changes to patients' availability and commitments



Challenges predicting future needs



Importance of responsivity



Team-based care



Innovations to mitigate provider burn-out



Section 1: Overview of Evidence Based Psychotherapy for PTSD Implementation and Outcomes

Clinical Practice Recommendations

Recommendation	Strength	Category
Treatment of PTSD		
Treatment Selection		
9. We recommend individual, manualized trauma-focused psychotherapy (see Recommendation 11) over other pharmacologic and non-pharmacologic interventions for the primary treatment of PTSD.	Strong for	Reviewed, New-added
10. When individual trauma-focused psychotherapy is not readily available or not preferred, we recommend pharmacotherapy (see Recommendation 17) or individual non-trauma-focused psychotherapy (see Recommendation 12). With respect to pharmacotherapy and non-trauma-focused psychotherapy, there is insufficient evidence to recommend one over the other.	Strong for	Reviewed, New-added



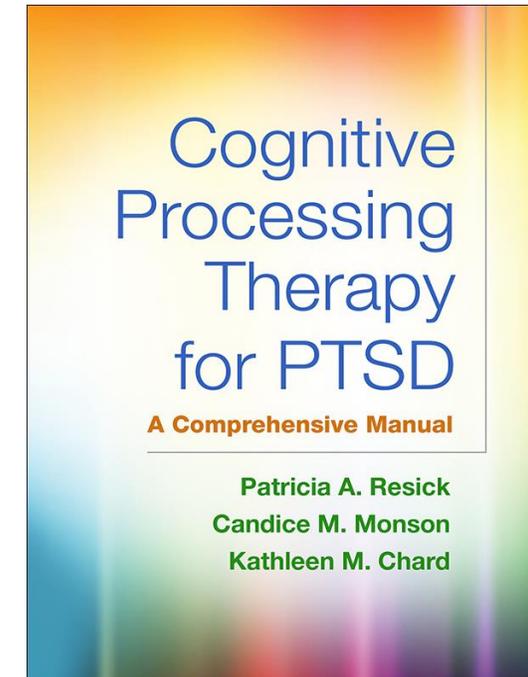
Clinical Practice Recommendations

Recommendation	Strength	Category
Treatment of PTSD (cont.)		
Psychotherapy		
11. For patients with PTSD, we recommend individual, manualized trauma-focused psychotherapies that have a primary component of exposure and/or cognitive restructuring to include Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), specific cognitive behavioral therapies for PTSD, Brief Eclectic Psychotherapy (BEP), Narrative Exposure Therapy (NET), and written narrative exposure.	Strong for	Reviewed, New-replaced
12. We suggest the following individual, manualized non-trauma-focused therapies for patients diagnosed with PTSD: Stress Inoculation Training (SIT), Present-Centered Therapy (PCT), and Interpersonal Psychotherapy (IPT).	Weak for	Reviewed, New-replaced



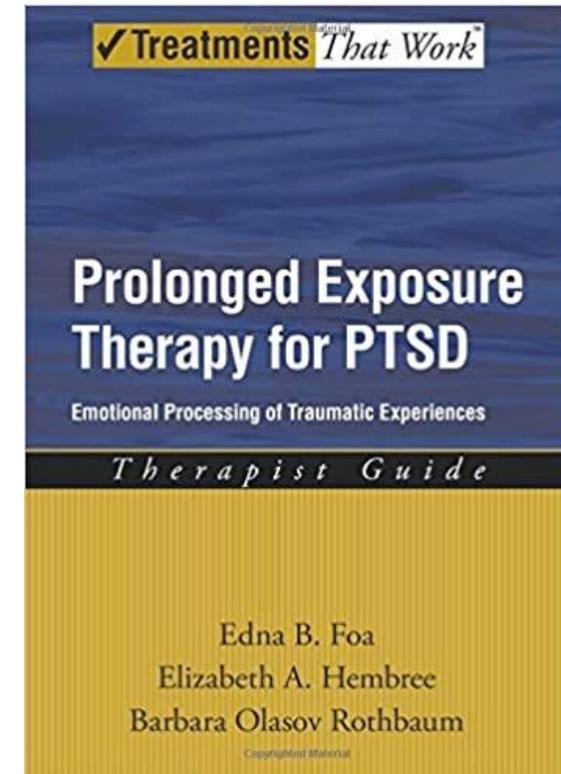
Cognitive Processing Therapy (CPT)

- Cognitions impact emotional responses/behaviors
- Previously developed schemas are activated:
 - **Assimilate** – alter incoming information to match belief
 - **Over-accommodate** – alter beliefs about oneself/world to the extreme
- Accommodating the trauma memory allows for incorporation of new information and a reduction in secondary emotions and negative cognitions
- 12 weekly sessions focused on identifying and learning to challenge “stuck points” that occur when beliefs prevent recovery from a trauma



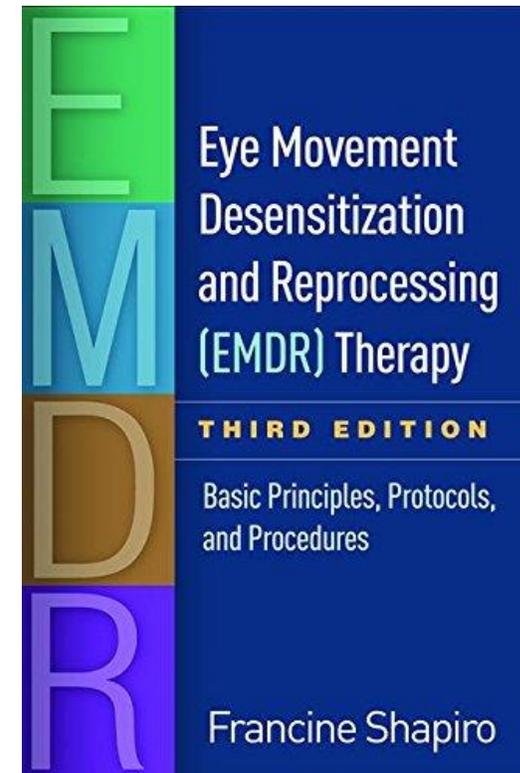
Prolonged Exposure (PE)

- Traumatic events can develop a fear network leading to escape and avoidance behaviors
- Patients are assisted in confronting safe, but anxiety-evoking situations
- Exposure to feared stimuli results in the activation of the relevant fear structure and provides realistic information about the likelihood of the feared consequence
- Distorted cognitions are also disconfirmed during exposures
 - **Imaginal exposure**
 - ***In-vivo exposure***

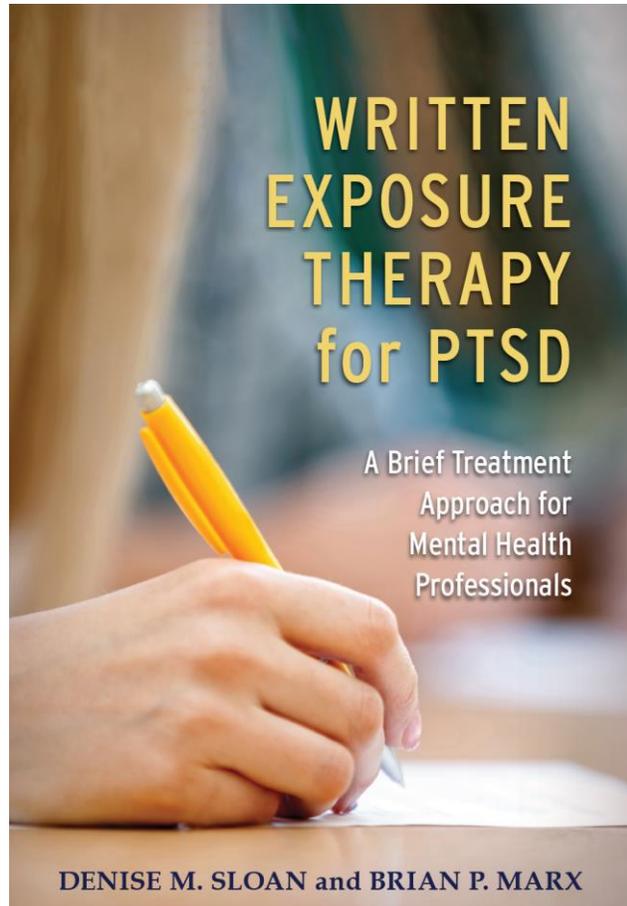


Eye Movement Desensitization and Reprocessing (EMDR)

- Facilitates accessing and processing of traumatic memories and other stressors to bring an adaptive resolution
- EMDR can lead to reformulation of previously held negative beliefs, new learning, reduction of physiological arousal, and development of cognitive insight
- Veteran attends to emotionally disturbing material in-session while simultaneously focusing on an external stimuli (e.g. lateral eye movements, hand-tapping, or audio stimulation)



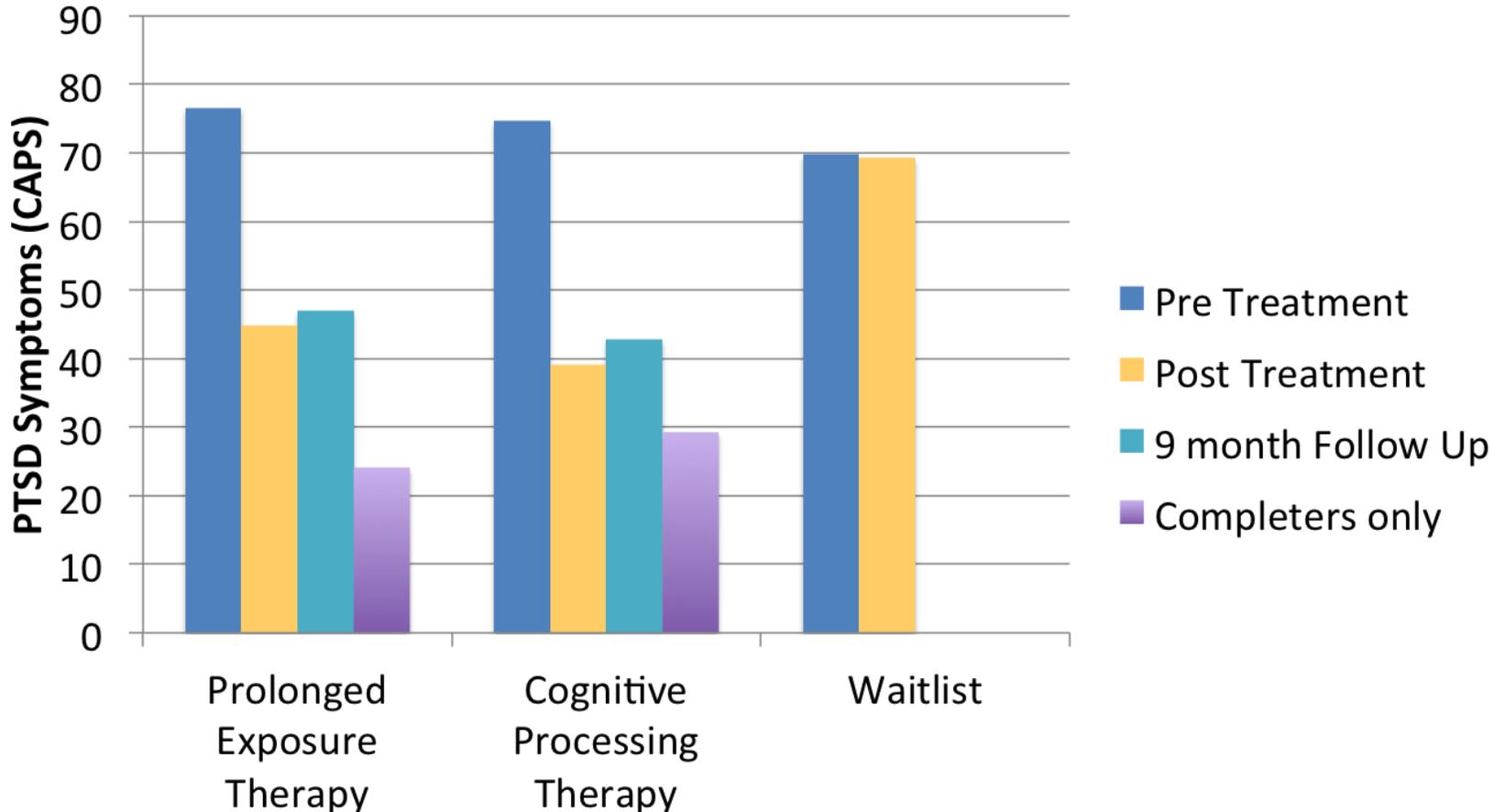
Written exposure therapy



- EBP for PTSD that includes 5 sessions (60 minutes each)
- WET is included as a recommended (first line) PTSD treatment in the VA/DoD Clinical Practice Guidelines for PTSD (2017)
- Significantly reduces the severity of PTSD symptoms in a variety of trauma survivors and low drop-out rates (Sloan et al., 2018)

Sloan & Marx, 2019

Treatment Works



PTSD EBP Outcomes and Completion Rates

- **CPT and PE are equally effective** at the reduction of PTSD symptomology (Resick, Nishith, Weaver, Astin, & Feuer, 2002; Rutt, Oehlert, Krieshok, & Lichtenberg, 2018; Watts et al, 2013)
- Drop out from evidence-based treatment for PTSD proves problematic as **20-36% of patients do not complete PTSD treatment** (Imel, Laska, Jakcupcak, & Simpson, 2013; Szafranski et al., 2015)
- Veterans offered CPT or PE in a VAMC PTSD clinic (Kehle-Forbes, Meis, & Spont, 2016)
 - **39% of veterans dropped out of PTSD evidence-based treatment**, most before the third session

Barriers and Challenges to EBPs



Drop out rates



Perceived readiness (Hamblen et al., 2015)



Need for more positive support (Meis et al., 2019)



Stigma



Patient “logistical” barriers

Family, work, time,
transportation



Clinician time constraints

Scheduling difficulties, caseload
burden



Section 2: Research Outcomes for Massed EBP Delivery

Common models of delivery

Individual EBP 3-5 days per week alone

Combination of individual and group EBP 3-5 times per week (modifications to protocols)

Individual EBP 3-5 times per week plus additional group interventions

Individual EBP 3-5 days per
week alone

JAMA | Original Investigation

Effect of Prolonged Exposure Therapy Delivered Over 2 Weeks vs 8 Weeks vs Present-Centered Therapy on PTSD Symptom Severity in Military Personnel A Randomized Clinical Trial

Edna B. Foa, PhD; Carmen R. McLean, PhD; Yinglin Zeng, PhD; David Rosenfield, PhD; Elna Yadin, PhD; Jeffrey S. Yervin, PhD; Jim Mintz, PhD; Stacy Young-McCaughan, RN, PhD; Elias V. Bouda, PhD; Katherine A. Dondanville, PsyD; Brooke A. Fina, MSW; Brittany N. Hall-Clark, PhD; Tracy Lichner, PhD; Brett T. Litz, PhD; John Reachs, PhD; Edward C. Wright, PhD; Alan L. Peterson, PhD; for the STRONG STAR Consortium

IMPORTANCE Effective and efficient treatment is needed for posttraumatic stress disorder (PTSD) in active duty military personnel.

OBJECTIVE To examine the effects of massed prolonged exposure therapy (massed therapy), spaced prolonged exposure therapy (spaced therapy), present-centered therapy (PCT), and a minimal-contact control (MCC) on PTSD severity.

DESIGN, SETTING, AND PARTICIPANTS Randomized clinical trial conducted at Fort Hood, Texas, from January 2011 through July 2016 and enrolling 370 military personnel with PTSD who had returned from Iraq, Afghanistan, or both. Final follow-up was July 11, 2016.

 [Editorial page 343](#)

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 [CME Quiz at
jamanetwork.com/learning
and CME Questions page 401](#)

Research - Foa et al. (2018)

- RCT of 366 active duty military personnel with PTSD
- Treatment groups (randomized)
 1. PE delivered in massed format (10 sessions over 2 weeks)
 2. Spaced therapy (10 sessions over 8 weeks)
 3. PCT (non-trauma-focused therapy involving identifying daily stressors; 10 sessions over 8 weeks)
 4. Minimal Contact Control (MCC) telephone calls from therapists (1x/wk for 4 weeks)
- Findings
 - Massed delivery reduced PTSD symptom severity more than MCC
 - Massed delivery was noninferior to spaced therapy (concern that daily PE would be too emotionally taxing was not supported)
 - No significant difference between spaced therapy and PCT

Research - Hendriks et al. (2018)



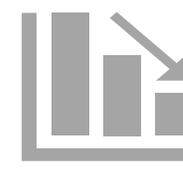
Participants (n=73)

Chronic PTSD
Likely ICD-11 dx of Complex PTSD
following multiple interpersonal
trauma
History of multiple treatment
attempts



Massed delivery

12 90-minute sessions over 4 days
(intensive phase)
4 weekly 90-minute booster sessions
(booster phase)



Results

Significant decrease in Baseline-
posttreatment PTSD symptom
severity
Effects maintained at 3-month and
6-month follow-up
No drop out during intensive phase
and 5% drop out during booster
phase
Between-session fear habituation
was predictive of fast responder
trajectory

Outpatient PTSD Clinic: Salt Lake City

CPT offered on accelerated schedule (3-5x/week) as part of normal clinic operations

Follows regular treatment manual aside from timing

Sample:

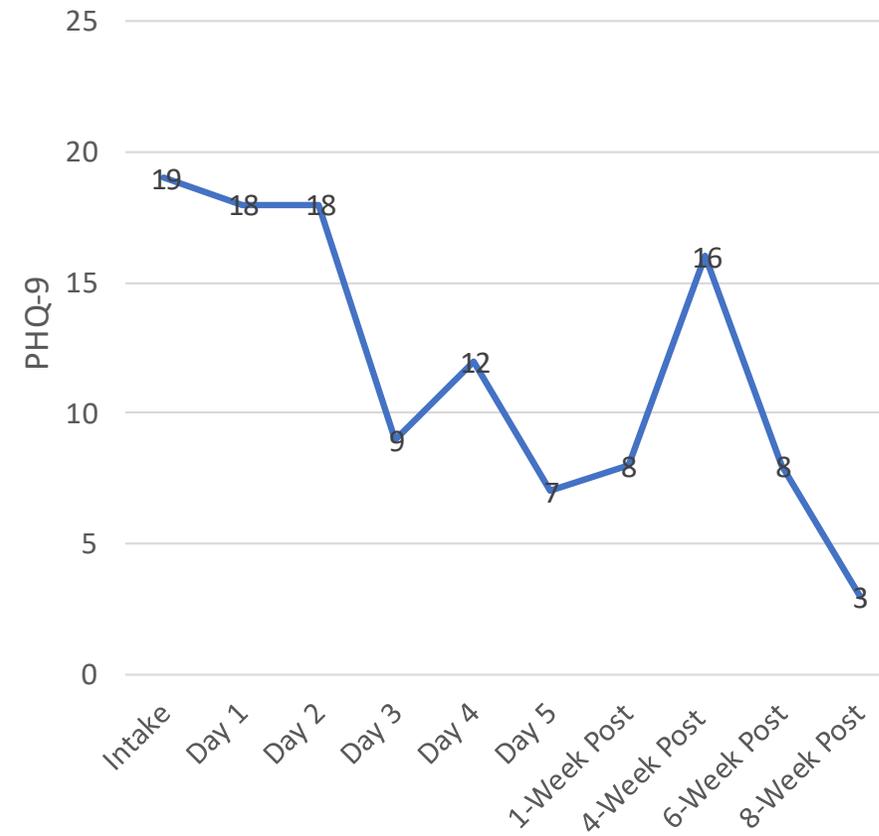
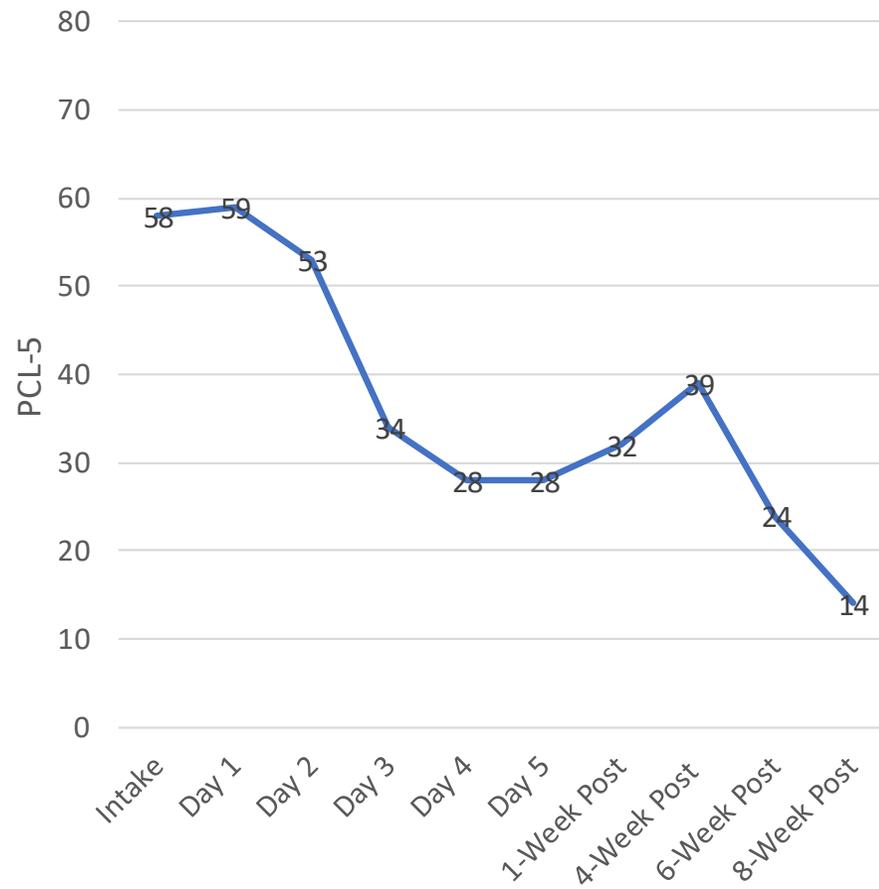
- 27 total, mixed gender, trauma types, etc.
- 13 televideo; 14 face to face

Results:

- 25 completers, 2 dropout = ~7% (both dropouts reported significant gains – 16 and 18 point drops on PCL5)
- PCL5 – average drop of 22.08 (52.35 – 30.27)
- PHQ9 – average drop of 7.73 (17.44 - 9.71)

Weinstein (unpublished data)

Delivering CPT In a Single Week: Case study

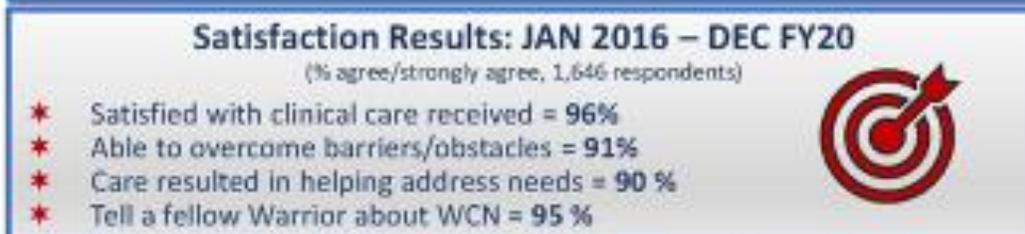
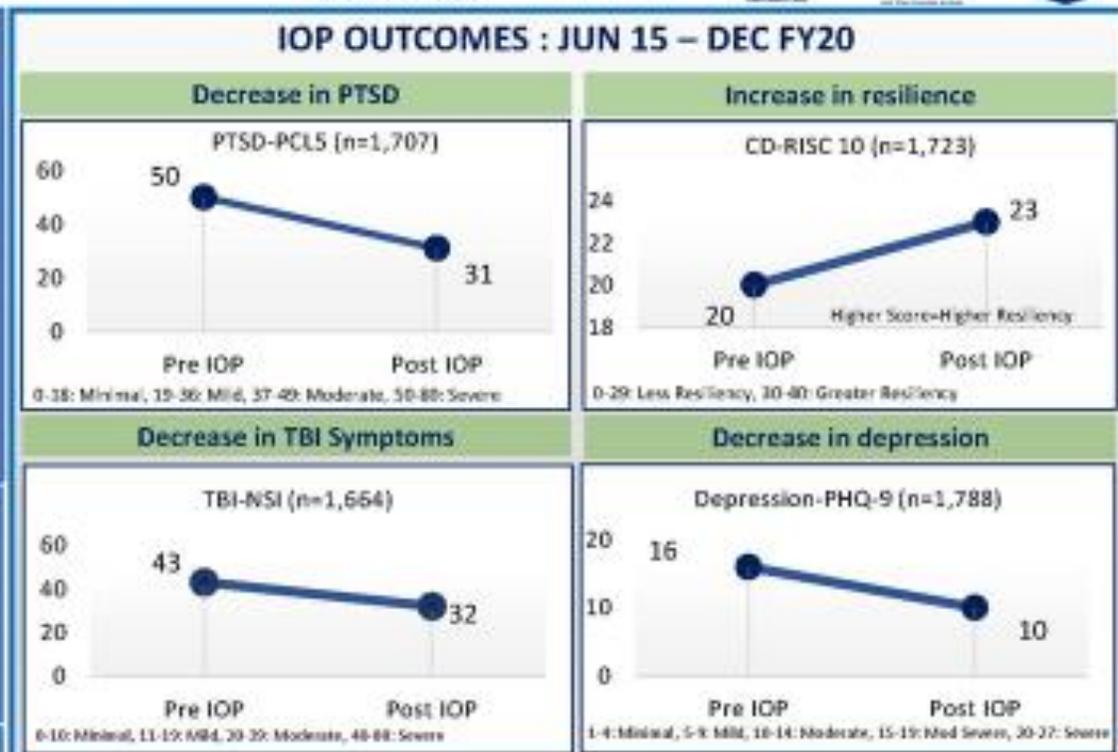
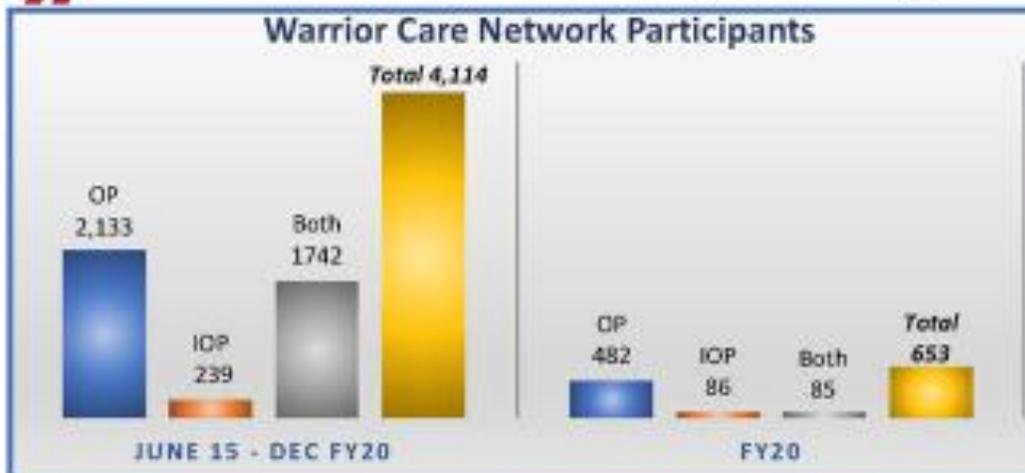


Massed EBPs: Combination of Individual and Group Protocol Delivery



Warrior Care Network

Warrior Care Network Monthly Status Report: DEC FY2020

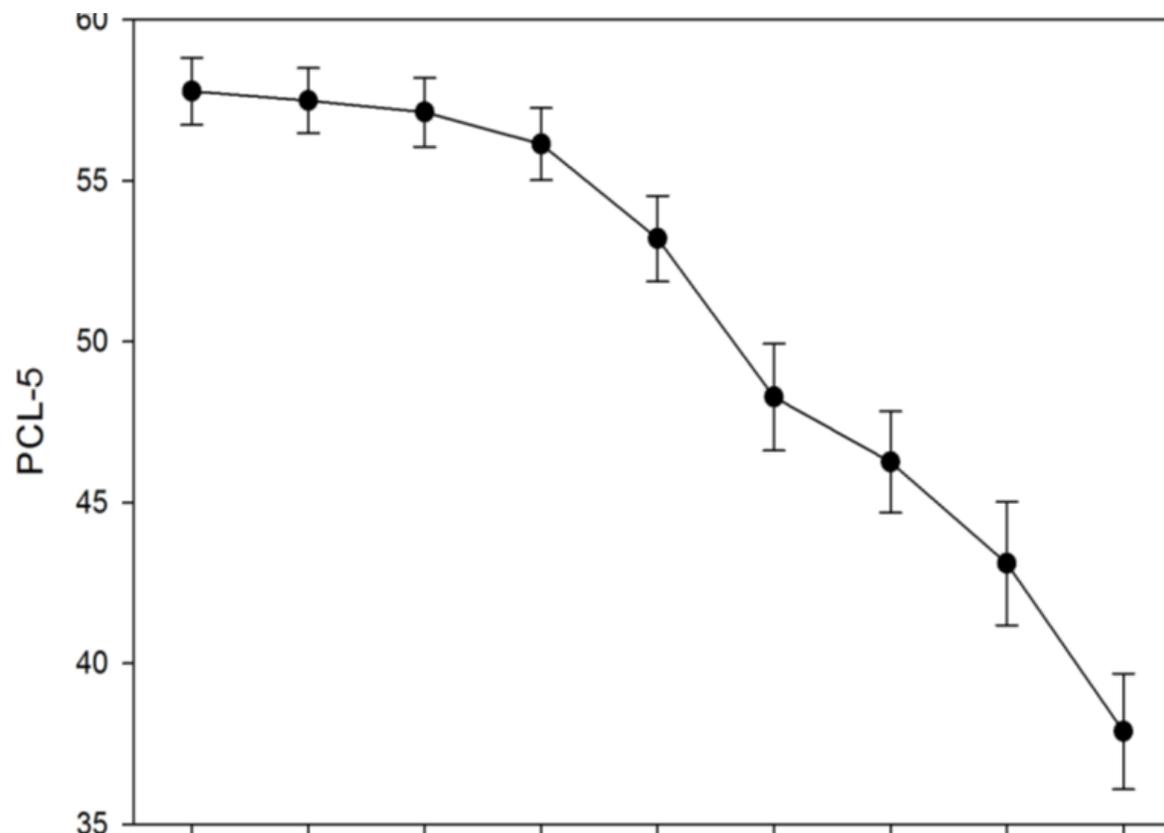




Road Home: Warrior Care Network



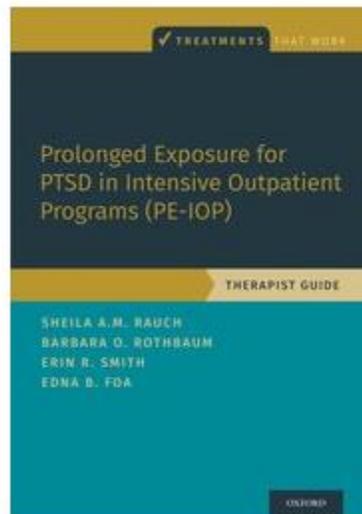
- 92% who start the program complete
- PTSD and depression symptoms decrease significantly over the course of the 3-week program
- 58% fall below the suggested cutoff for PTSD based on the PCL-5 by the end of the 3 weeks
- Pre-post PCL d is 1.53, $p < .001$
- Pre-post PHQ is 1.09, $p < .001$
- Pre-12mo PCL is 1.29, $p < .001$
- Pre-12mo PHQ is 1.18, $p < .001$
- Feasible treatment option
- Those with MST and non-MST respond equally well (Lofgreen et al, 2020)



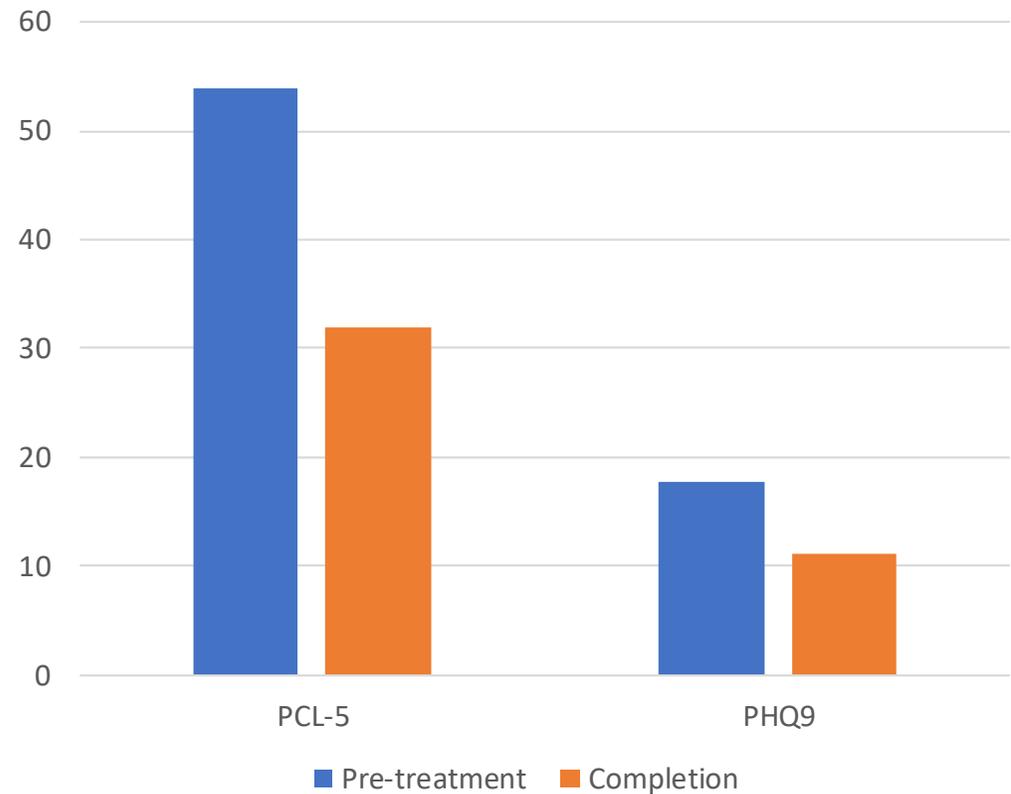
Emory Outcomes

Veterans Program

- Completion rate = 96.3%
- Patient satisfaction = 95%
- Clinically significant change and gains sustained post treatment
- PCL5 decrease = 22.4 (Maples-Keller et al, 2019)



PTSD and Depression Scores over IOP treatment



Research - Bryan et al. (2018)



Open-label, prospective cohort pilot trial

20 U.S. military personnel and Veterans with PTSD/subthreshold PTSD



12 daily sessions of CPT during two-week period of time



Results

PTSD severity significantly reduced at posttreatment and 6 month follow-up
Slight decline in depression, but not statistically significant; reliable change in PHQ-8 in 21.7%

Suicidal ideation significantly decreased at 6 month follow-up (reliable change in 55.6%)

Other Interventions

- Written Exposure Therapy: conducted over subsequent days
- Cognitive Therapy for PTSD intensive program (Ehlers et al. 2010)
 - 18 hours of therapy over 5-7 days
 - Feasible and acceptable
 - Comparable results as standard weekly cognitive therapy and in follow up study massed delivery more effective (Murray et al., 2017)



Individual EBP as Part of Program

Cleveland VAMC PTSD IOP

The target population for this level of care are Veterans who require higher level of structure and support that either do not meet full criteria for acceptance into a residential level of care or refuse to participate in residential programs. In addition, to provide options to Veterans seeking more rapid resolution of symptoms. The redesign was proposed to :

1. Minimize barriers to access by eliminating a cohort-model of treatment (weekly admissions);
2. Improve individualized care planning by providing additional options within treatment (e.g., type of Evidence-based psychotherapy; length of program; outpatient or residential);
3. Decrease length of time to complete intensive treatment with the anticipated benefit of decrease in frequency of adverse events and decreased drop-out;
4. Provide opportunities/access for intensive PTSD treatment locally for women and Veterans without co-occurring substance-use disorder.
5. Increase annual capacity for options in intensive treatment

Daily Schedule for Both Programs

Time	Intervention	Notes
8:15-9	AM check-in	
9-12	PE/CPT sessions	PE at either 9 or 10:30; CPT at either 9, 10, 11
9-12	Practice or psychiatrist	When not in individual session
10-11 M&F	SUD aftercare (OPTIONAL)	Optional for those with co-occurring SUD
11-12 M&F	Early recovery skills for SUD (OPTIONAL)	Optional for those with co-occurring SUD
12-1	lunch	
1-1:30	PM check-in #1	
1:30-3	Group exposure/outing	Therapeutic outings to practice skills
3-3:30	PM check-in #2	

Early Results: Cleveland

REASON FOR IOP PARTICIPATION	PERCENTAGE
Lack of success at lower level of care	31.8%
Minimal coping skills	18.2%
Significant co-occurring mental health diagnosis (not SUD)	31.8%
Co-occurring substance use disorder/high risk of relapse	36.4%
Lack of supports	54.5%
Did not respond to previous IOP or residential program	18.2%
Need for increased structure	40.9%
Veteran preference	63.6%
Transportation barriers and required a bed	9.1%
Recommended for residential but Veteran refused/declined	4.5%
Not accepted into “traditional” residential program	27.3%
Veteran need to complete treatment more rapidly	18.2%

Clinical outcomes

Completion rate TAU



Completion rate IOP

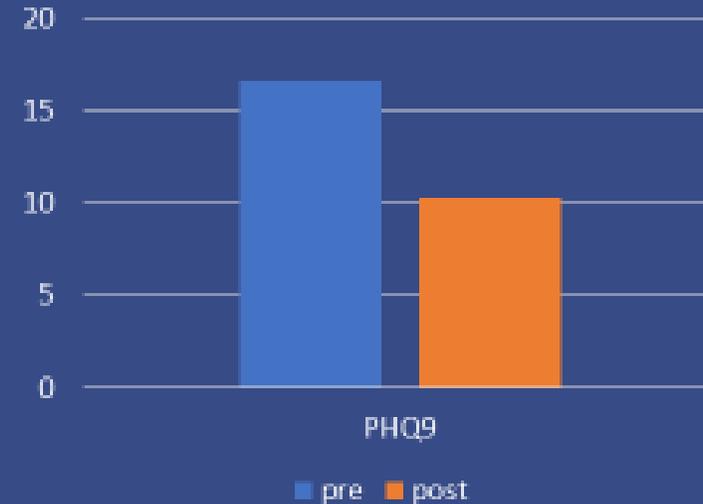


PTSD Checklist-5 scores



82.05% clinically significant decreased in PTSD symptoms (10-point decrease)

Depression scores (PHQ9)



61.54% clinically significant decreased in depression symptoms (5-point decrease)

Early Results: Cleveland pilot data

Preparation sessions for program participation:

- Average 0.9 per Veteran
- 50% had no prep sessions

Off protocol sessions:

- 4 total for all participants in pilot

Additional skills work as part of individual sessions:

- Grounding/mindfulness: 7
- Relapse prevention: 4
- Suicide safety planning: 1

Negative treatment events:

- Increase in suicide risk: 1
- Increase substance use: 1
- No incidents of:
 - Self-directed violence (non-suicidal intent)
 - Acts of violence towards others
 - Property destruction
 - Mental health hospitalization
 - Psychosis/mania exacerbation

San Diego VAMC: Massed EBP for PTSD in Substance Use Program

- Veterans with PTSD offered opportunity to engage in either CPT or PE 3x per week while admitted into residential SUD program
- Early study, 100% completion (Norman et al., 2016)
- Option to also participate in PTSD track groups:
 1. In vivo exposure group
 2. Trauma-focused CBT group (based on CPT model with open enrollment)
 3. PTSD skills

	n=199	n=75	n= 52	n= 38
	<u>Overall Sample</u>	<u>Group Only</u>	<u>CPT</u>	<u>PE</u>
Change in PCL-5	19.89	18.84	19.44	19.55
Change in PHQ9	9.09	9.81	6.08	8.29

EMDR-Based Programs

Daily EMDR and PE individual sessions over two weeks, plus psychoeducation and physical activities (Van Woudenberg et al., 2018):

- Post-treatment 82.9% of patients demonstrated a clinically meaningful response; 54.9% a loss of diagnosis; low drop-out rate of 2.3%
- Post-treatment to 6-month follow-up demonstrated a small, but significant increase in CAPS-5 scores and no difference between post-treatment to 6-month follow-up on PCL

5 day intensive EMDR plus yoga (Mayaris Zepeda Méndez et al., 2018):

- Medium-effect size change in PCL
- 9/11 patients that completed treatment reported recovery or improvement

Week-long EMDR and Equine-assisted psychotherapy, yoga, narrative writing (Steele et al., 2018):

- Pre- to post-treatment small to large effect size changes in PTSD, depression, moral injury, dissociation, and adult attachment



Section 3: Strategies for Implementation

Modifications to Protocol: CPT



The CPT protocol requires minimal modifications/adaptations when delivered individually in massed format.



For early responders or those attempting to complete in under 12 sessions, two themes/modules may be combined into one session.



For homework, Veterans complete three worksheets per day.

Modifications to Protocol: Prolonged Exposure



Prolonged Exposure (PE): minimal protocol modifications are required when delivering individually in massed format.



It is recommended that homework be assigned as follows:



Session 1 recording: listen to entire session once



Session 2 recording: listen to entire session once



Sessions 3 and up: listen to imaginal exposure daily and processing at least once



In-vivo exposures: 2-3 per day

Logistics with implementation



SCHEDULING
CONCERNS



CLINICAL
COVERAGE

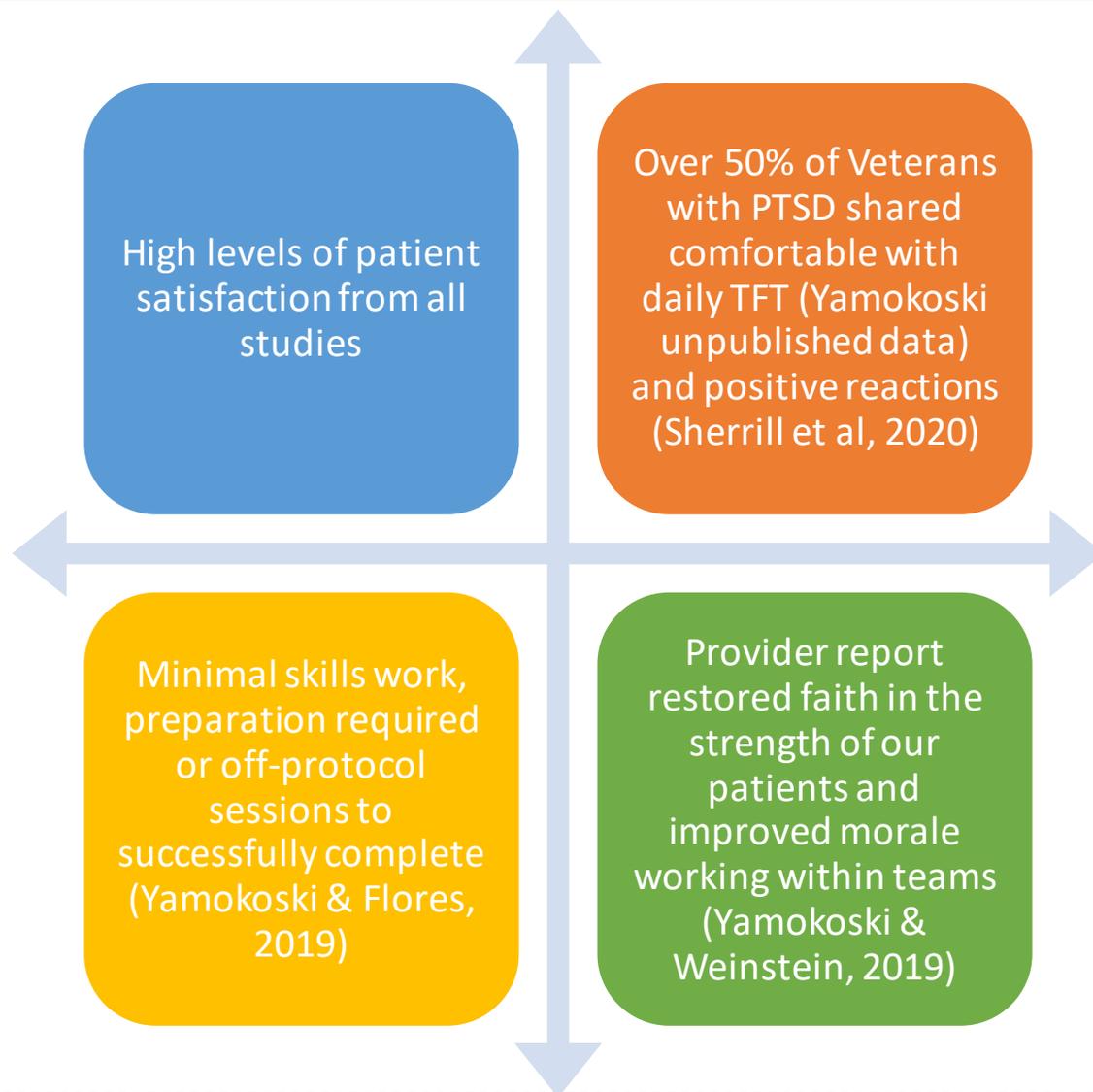


STAFFING NEEDS



STEP-WISE
IMPLEMENTATION

Willingness and Perceptions of Readiness



Considerations for virtual implementation: Preparing and/or transitioning program



- Research on telehealth and EBPs
- New challenges and stressors related to COVID-19
- Patient selection considerations
- Selection of platform
- Options for back up if technology failure
- Development of group content
- Emergency procedures

Considerations for virtual implementation: Conducting program/intervention



- Concerns about privacy
- Pre-admission/orientation
- Providing materials to participants
- Consideration of impact on group content and processes
- Measurement-based care
- Examples
- Preliminary findings



Section 4: Future Directions

Dismantling Studies



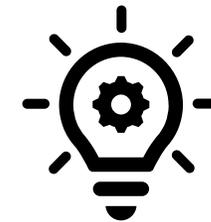
STRONG STAR Consortium and the Consortium to Alleviate PTSD (CAP; lead investigator: Alan Peterson, Ph.D.)

- Massed PE alone (daily over three weeks) compared to massed PE as part of IOP
- Military and Veteran sample
- Goal: randomize and treat 100

Shorter Programs

RCT in progress: Massed CPT with active duty military over five days (Wachen et al, 2019)

- Goal: 140 active duty, military service members
- Random assignment to standard or massed CPT over five days (both using the 12 session protocol)
- Standard CPT: 60-minute Individual sessions 2x/week for 6 weeks
- Massed CPT: Intensive outpatient setting (combined group and individual) in 12 60-minute sessions over 5 days.



4 patients	Monday	Tuesday	Wednesday	Thursday	Friday	
8:00am-8:30am	Questionnaires	Questionnaires	Questionnaires	Questionnaires	Questionnaires	
8:30am-10:00am	Group: CPT 1	Group: CPT 3	Group: CPT 6	Group: CPT 9	Group: CPT 11	
10:00am-11:00am	Practice	Practice	Practice	Practice	Practice	
11:00am-12:00pm	Cohort A - Individual: CPT 2	Cohort B - Practice***	Cohort A - Practice***	Cohort B - Individual: CPT 4	Cohort A - Individual: CPT 7	Cohort B - Practice***
12:00pm-12:30pm	BREAK	BREAK	BREAK	BREAK	BREAK	
12:30pm-1:30pm	Cohort A - Practice	Cohort B - Individual: CPT 2	Cohort A - Individual: CPT 4	Cohort B - Practice	Cohort A - Practice	Cohort B - Individual: CPT 7
1:30pm-2:30pm	Cohort A - Free to leave	Cohort B - Practice	Cohort A - Practice	Cohort B - Practice***	Cohort A - Practice***	Cohort B - Practice
2:30pm-4:00pm	Free to leave	Group: CPT 5	Group: CPT 8	Free to leave	Graduation (2:30pm-3:00pm)	

Implementation Plans within VHA



DEVELOPMENT OF IOP LEVEL OF CARE
BASED ON MASSED EBP DELIVERY



PILOTED AND PLANS TO SPREAD TO
ADDITIONAL MEDICAL CENTERS AS BOTH
IOP AND INDIVIDUAL MASSED EBPS



ACCEPTABLE, FEASIBLE AND EFFECTIVE
IN PILOT STUDY



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FOR PROVIDERS WHO TREAT VETERANS

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**Please enter your
questions in the Q&A box
and be sure to include your
email address.**

The lines are muted to avoid background noise.



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Employee Education System

VHA TRAIN

Welcome users of VHA TRAIN!

To obtain continuing education credit
please return to www.vha.train.org
after the lecture.

TRAIN help desk: VHATRAIN@va.gov



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CEU Process for users of VHA TRAIN (non-VA)

Registration → Attendance → Evaluation → Certificate



*Register in
TRAIN.*



*Listen to the
lecture.*



*Return to
TRAIN for
evaluation.*



*Follow the
directions to
print
certificate.*

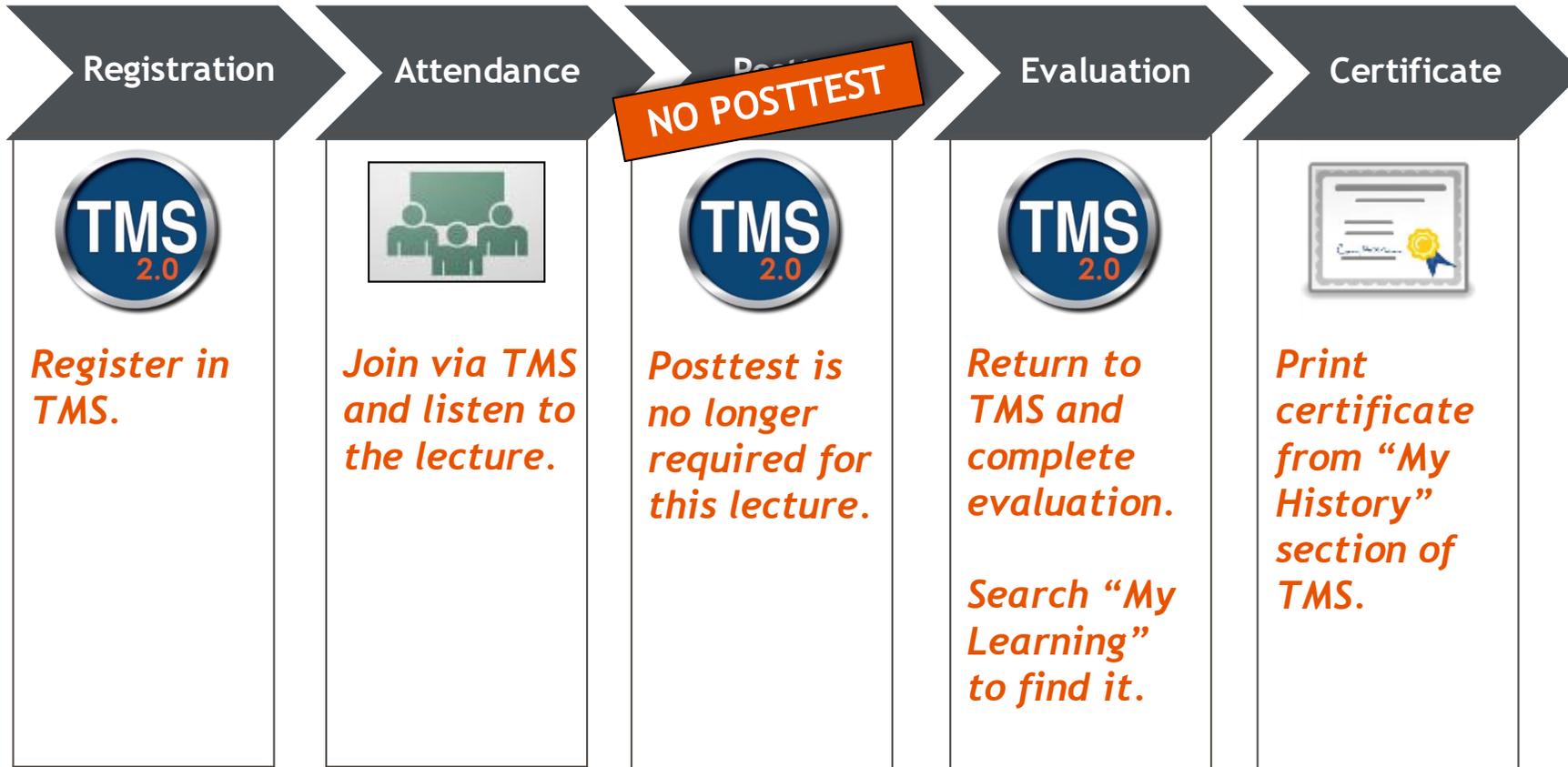
TRAIN help desk: **VHATRAN@va.gov**



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CEU Process (for VA employees)



PTSD Consultation Program

We can help

HEALTHCARE PROVIDERS:

- Are you treating Veterans with PTSD? **We can help**
- Do you have questions about the mental health effects of the COVID-19 pandemic? **We can help**
- Are you looking for ways to care for yourself and your colleagues? **We can help**



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UPCOMING TOPICS

August 19	<i>Clinical Considerations and Guidance for the Treatment of trauma, PTSD, and co-occurring minority stress among LGBTQ individuals</i>	Nicholas Livingston, PhD
September 16	<i>Racism-related Stress and Trauma: Definitions and Interventions</i>	Juliette McClendon, PhD
October 21	<i>Case Conceptualization in the Treatment of PTSD</i>	Gayle Iwamasa, PhD

SAVE THE DATE: Third Wednesday of the Month from 2-3PM (ET)

For more information and to subscribe to announcements and reminders
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