Dealing with complexities: How to use case formulation to improve evidence-based therapy for PTSD

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Plan

• A reminder of what is Cognitive Processing Therapy (CPT)

• Use of case formulation within CPT

• A case

• A bit of data

• Questions
Overview of CPT

• New manual,
• Change in acronyms (CPT, CPT-A).
# CPT versus CPT-A

1. Overview of PTSD and CPT
2. Examining Impact of Trauma
3. Working with Events, Thoughts and Feelings (ABC)
4. Examining the Index Event (ABC)
5. Challenging Questions
6. Patterns of Problematic Thinking
7. Challenging Beliefs
8. Processing Safety
9. Processing Trust
10. Processing Power/Control
11. Processing Esteem
12. Processing Intimacy and Meaning of the Event
Why do we need to meddle with CPT?

• CPT and other evidence-based approaches work for a large number of clients, even complex ones, but…
• We still have dropout and unacceptably high nonresponse rates

• E.g., for CPT in the military
  • Veterans: 62% retained PTSD Dx, dropout 30% (Australia, Forbes et al., 2012)
  • Veterans: 60% retained PTSD, dropout 20% (USA, Monson et al., 2006)
  • Active-duty: 51% retained PTSD, dropout 20-28% (USA, Resick et al., 2017)
Some Challenges

- Ambivalence, -ve beliefs about therapy
- Extreme levels of anxiety / poor distress tolerance
- Significant depression/suicidality
- Severe anger/homicidality
- Substances
- Psychosis
- Personality Disorders
- Cognitive impairment
- Pain
- Traumatic grief
- Safety
- Returning to danger
- Psychosocial stressors and crises
- Logistics (limited access to face to face,.....)
- Compensation
- Criminal justice system

Emotional dysregulation (e.g., significant expression of affect or numbing)

Significant avoidance behaviors (e.g., poor attendance, lack of homework compliance, behavioral avoidance within and outside of the session)

Rigidity in beliefs

Suboptimal engagement / outcome
What are we doing with CPT+CF?

- Using the protocol [if it aint broke, don’t fix]
- Tracking symptoms with PCL and DASS-D
- Flexible therapy length

- Use of Miller’s SRS (and ORS)
- Explicit case formulation with client
- Therapeutic letter

- CF and data-guided deviations
  - Allowing up to 5 (haven’t needed that many yet)
  - Motivational interviewing
  - Depression (behavioural activation)
  - ETOH/substance use
  - Emotional regulation (DBT techniques)
  - Behavioural surveys and experiments (e.g., for rigid beliefs)

Self-reported PTSD symptoms during CPT (Resick et al., 2008)
Case formulation - PTSD

**PROXIMAL AND DISTAL FACTORS**

- **TRAUMA**
  - Index trauma

**STRENGTHS AND RESOURCES**

**THOUGHTS AND MOOD**
  - (Loss of interest, negative thoughts and emotions)

**THOUGHTS**

**FEELINGS**

**AVOIDANCE**
  - (thoughts, people, activities)

**INTRUSIONS**
  - (memories, dreams, flashbacks, images)

**HYPER AROUSAL**
  - (irritable, reckless, startle, concentration, sleep)

**CPT: stuck points interfering with optimal engagement/outcomes?**
Case Study
Complex PTSD

Client, in 40s, female, divorced
Index - CSA
(& multiple and extensive trauma hx)
CAPS 30, PCL 53

MDD, Suicidal Beh Dis, Bipolar, Panic Disorder (past), OCD, GAD, Substance in remission (prescription abuse, due to pain condition)

Recent hospitalisation for self-harm

Treatment likely to be successful: high
[query]

Attendance: poor in first half

Homework completion: poor

Engagement in session: moderate
• tangential
• avoidant of trauma-focus
• regular crises

Beliefs/SPs: rigid, anger (esp. at family), just world beliefs
S1-5 poor attendance & HW, but PCLs decreasing (?)
S5-6 Pain Rx +++, NOT in remission

S6 reformulation, pain, Rx, avoidance
S6-7 pain specialist  
S7-8 SP and behavioural strategies re pain/Rx
S9 NP, MI to address avoidance, attendance, then back to CPT
S13-14 traumas in family, CPT plus distress tolerance materials
S15, PCL consistent with qualitative appearance and new Impact Statement
Recently published pilot data (Nixon & Bralo, 2018, Behavior Therapy)

- N = 23
- Mixed trauma, mainly interpersonal
- 19 completed tx (17% dropout)
- Student therapists
- Av. # of sessions = 10.79
- 7-44% retained PTSD at FU

- Clients’ ratings of CF at beginning of tx correlated with lower PTSD symptoms after controlling for initial severity (rs -.33 to -.78).
More data… CPT vs CPT+CF

• Elizabeth & Nixon (current, N = 82)
  • Mixed trauma (67% interpersonal)

• Comorbid disorders (full criteria)
  • mood (62%)
  • suicidal behaviour disorder (28%)
  • anxiety (31-44%, social – GAD)
  • alcohol abuse (45%)
  • other substances (12%)

• 36% have 1-2 comorbid disorders
• 39% have 3-4 comorbid disorders
• 15% 5+

• 17 years posttrauma (.5 – 55 years)
• 93% prior trauma, 80% of sample prior physical assault, 74% sexual victimization

• CAPS severity = 43.55 (SD = 8.95)
• PCL = 49.60 (SD = 10.75)
• DASS-D = 23.19 (severe) (SD = 11.49)

• Sample includes some veterans, police, and paramedics
Clinical resources

• CPT manual


• National Center for PTSD (USA)
  • Clinician’s Trauma Update Online (CTU-Online)
  • PTSD Research Quarterly
  • [https://www.ptsd.va.gov/professional/publications/index.asp](https://www.ptsd.va.gov/professional/publications/index.asp)
CPT – further training and supervision

• See Cognitive Processing Therapy – Australia website
  • [www.cognitiveprocessingtherapy.org.au](http://www.cognitiveprocessingtherapy.org.au)

• CPT workshops typically 2 days

• Combine with supervision / consultation!
Thank you

Questions/Discussion