VIEWPOINT

The Meaning of Evidence-Based Treatments for Veterans With Posttraumatic Stress Disorder

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Steenkamp's Viewpoint[1] reminds us that "evidence-based" psychotherapy for posttraumatic stress disorder (PTSD) encompasses clinical judgment and patient preferences as much as it does evidence from randomized clinical trials. This is a welcome perspective for clinicians working in settings such as Veterans Affairs (VA), where they are mandated by policy to provide prolonged exposure or cognitive processing therapy (CPT) as first-line treatments for veterans with PTSD.[2]

The mandate to prioritize prolonged exposure and CPT is based on overly strict interpretations of clinical practice guidelines that in actuality include much broader, more clinically sensitive recommendations for a wide range of trauma- and nontrauma-focused treatment options.[3] These interpretations have become so influential that health policy makers and many clinicians have come to assume that unless prolonged exposure or CPT is prescribed and "delivered with fidelity to their established protocols,"[4] veterans with PTSD are not receiving adequate care. Accordingly, health care professionals within VA and military treatment facilities are now highly trained to use prolonged exposure and CPT. These treatments are tracked with institutional performance measures and imparted to younger therapists under supervision. Furthermore, because a large proportion of funded research at academic VA and military facilities is aimed at optimizing the efficacy of prolonged exposure and CPT, recruitment of patients is incentivized toward these modalities, as opposed to other internationally accepted trauma-focused treatments, such as, for example, eye movement desensitization and reprocessing.

Although health policies and institutional metrics have emphasized prolonged exposure and CPT, military-related PTSD and disabling comorbidities remain intractable problems even for veterans receiving care. Moreover, engagement with these treatments remains low and drop-out rates are high,[5] raising important questions concerning whether these treatments are as effective as claimed. Steenkamp points out that prolonged exposure and CPT trials involving veterans have not been definitive.[1] Effect sizes are small, especially when compared with active control conditions (eg, present-centered or interpersonal approaches), and chronic symptoms often persist.[6] In many trials, a 12-point decrement on the Clinician-Administered PTSD Scale is considered a clinically meaningful response, yet is well within the range of variation for a chronic disorder. Veterans often have scores around 80 when treatment is initiated, and a 12-point decrease would still indicate severe disease.[7]

A bigger problem is that the population studied in randomized clinical trials is not always representative of individuals seeking treatment in VA and military settings due to restrictive inclusion criteria. Veterans with PTSD often present with severe symptoms related to suicidality, impulsivity, ongoing life stressors, or comorbid conditions (eg, traumatic brain injuries, substance use disorders, chronic pain, or medical illness). These are often explicit exclusions from the clinical trials upon which recommendations of evidence-based treatments are made. Thus, the mandate to use prolonged exposure and CPT in normative clinical settings is not, strictly speaking, based on evidence from comparable patients.

In clinical practice, some veterans have adverse responses to prolonged exposure or CPT, such as worsening of symptoms, hospitalization, or disengagement from treatment. There is little discussion or surveillance of negative outcomes of trauma-focused treatments. However, even under the best scenarios, in which these treatments have resulted in significant symptom reduction, the veteran's clinical status may not be one in which treatment is no longer required.[6]

Indeed, a veteran may achieve PTSD symptom improvement but still feel alienated from civilian life. Many veterans experience complex grief, loss, despair, or existential guilt due to events they have witnessed or participated in. As a result, their spiritual, moral, or interpersonal connections may be challenged. Processing traumatic events (one or several) does not necessarily achieve the veteran's goals of meaningful integration of their experiences, reintegration into family or society, or projecting a positive future.

It should also be noted that combat veterans may be reluctant to let go of their physiological hypervigilance or emotional detachment because these served them well during deployment (eg, in the form of situational awareness or emotional control under fire). The professional discipline of critical appraisal and not letting one's guard down ensures mission effectiveness, minimizes mistakes, and promotes survival in the field. In contrast to victims of interpersonal violence, rape, torture, or natural disasters, combat veterans experience events within a context of occupational comradery and shared purpose and do not want to completely shed the experiences of their military service. They are defined by their deployment in positive and complex ways, and may not even wish to rid themselves of intrusive war memories. Thus, the perspective that combat-related PTSD requires an approach that targets extinction of fear memories is overly narrow. Moreover, it can feel disingenuous to veterans to conceptualize legitimate concerns (reinforced by training and experience) involving issues such as guilt, blame, mistrust, control, safety, or sense of self as maladaptive or problematic beliefs.

Finally, treatment and health services outcomes for prolonged exposure and CPT focus largely on PTSD symptom reduction or fidelity to a 12-session

treatment course.[5] For combat veterans, treatment outcomes need to be expanded beyond symptom reduction toward other meaningful goals, often requiring many more treatment sessions. These goals include learning to engage with present challenges without withdrawal or rage, developing behaviors that promote physical health, restoring interpersonal connections with partners and other family members, and optimizing functioning in vocational, academic, and social settings. It is challenging to replace grief, guilt, and emotional numbing with joy, acceptance, and the capacity for intimacy. However, these issues are often the focus of PTSD treatment with combat veterans. They must be addressed through careful staging, beginning, of course, with taking whatever time is necessary to build therapeutic alliance until safety and trust is assured, and with commitment to continued support (preferably from the same therapist) for as long as the veteran needs it.

Steenkamp's Viewpoint is a necessary protest to current establishment perspectives.[1] It highlights the need for a more balanced and nuanced approach to clinical services, research, and policy. Evidence-based, trauma-focused approaches should be provided when clinically warranted, with buy-in from the patient, but these treatments are not always the most important intervention to do first or sometimes ever. Clinicians need flexibility to develop and apply integrated and individualized treatment strategies, acknowledging different stages in an often lengthy recovery process. Health policies should support such customized approaches rather than promoting an unrealistic expectation that a single course of manualized treatment is optimal or sufficient.

The assertion that prolonged exposure and CPT should be the dominant evidence-based treatments for war-related PTSD is simplistic in the face of coexisting physical, psychological, social, interpersonal, spiritual, and occupational concerns of veterans who seek care, and may at times be unhelpful or contraindicated. The most harmful consequence of current recommendations is that they present the illusion that we have sufficient treatments available to address the problems facing combat veterans. This is not the case. We need to better understand what motivates veterans to engage in and remain in treatment, and expand patient choice in clinical decision making. It is incumbent upon us to consider a wider range of modalities that also meet the definition of "evidence-based," and further explore novel strategies, or modular approaches that deliver components of evidence-based treatments in individualized ways.

ARTICLE INFORMATION

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