Trauma-focused Psychotherapy after a Trial of Medication for Chronic PTSD:

Pilot Observations*

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Background: *To date, all clinical trials using a single therapeutic modality (psychotherapy or pharmacotherapy) have found that even the best validated treatments for adults with chronic Posttraumatic Stress Disorder (PTSD) leave a substantial proportion of patients with disabling residual symptoms.* Method: *We reviewed the treatment course of three research patients with PTSD who received trauma-focused psychotherapy after experiencing a partial response to medication. Structured diagnostic interviews, validated symptom measures, and standardized treatment approaches were used to assess treatment response.* Results: *All patients partially benefited from medication treatment, and the degree of benefit varied substantially. Also, all patients experienced an additional reduction in PTSD symptoms after a time-limited course of prolonged exposure therapy (PE). This finding differs from anecdotal observations among U.S. War veterans and has never been documented systematically among civilian adults with chronic PTSD.* Conclusion: *Maximizing treatment outcome in adults with chronic PTSD may require additional psychotherapy after a partial medication response, and further study is warranted.*

*Supported by NIMH Grant MH01412 (R.M.), the New York Times Foundation (R.M.), NIMH grant MH-15144 (C.B.), and a NARSAD Young Investigator Award (C.B.).

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INTRODUCTION

Recent large multi-center trials have confirmed earlier reports that the SSRIs are effective for the core symptoms of chronic PTSD in noncombat-related trauma populations (1-4). However, these and other pharmacotherapy trials also suggest that full resolution of PTSD symptoms is rare after SSRI treatment alone (5). For example, Connor et al. (2) examined this question directly in a 12-week trial of fluoxetine (N = 27) vs. placebo (N = 26) by identifying individuals with high end-state functioning at treatment completion. High end-state function was defined by very low scores on the Davidson Trauma Scale, TOP-8 (6) and the Sheehan Disability Scale (7). Eleven (41%) fluoxetine-treated patients met these criteria, compared to 1 (4%) placebo-treated patients, demonstrating that 60% of the sample remained symptomatic after fluoxetine treatment.

In a multi-center randomized clinical trial of sertraline vs. placebo in adults with chronic PTSD (N = 187), the mean score at study completion was 43 (standard deviation 28.1) on the Clinician Administered PTSD Scale (CAPS) (8) after 10 weeks of treatment, demonstrating persistence on average of a moderate degree of residual symptomatology (1).

Finally, in the largest medication trial to date, using paroxetine (N = 551), only approximately one third of adults with chronic PTSD achieved high end-state remission (defined as a CAPS score <20) on either 20 mg daily or 40 mg daily (3).

Trauma-focused psychotherapy trials have yielded similar results. Full resolution of PTSD symptoms after an effective and well-validated psychotherapy, such as prolonged exposure (PE), also occurs only in a minority of patients (5). A recent randomized clinical trial examined the relative efficacy in 96 female assault victims with PTSD of nine sessions of prolonged exposure (PE), stress inoculation training (SIT), their combination, versus a wait-list group (9). At completion of the trial there were no significant differences between active treatments, and all were superior to wait-list. In the intent-to-treat sample, high end-state functioning, defined by the authors as scores on the Posttraumatic Stress Symptoms-Interview (PSS-I<20) (10), State-Trait Anxiety Inventory (STAI-S <40) (11), and the Beck Depression Inventory (BDI < 10) (12), was only achieved by 52% of individuals receiving Prolonged Exposure (PE), 31% receiving Stress Inoculation Training (SIT), 27% receiving both treatments, and 0% of those in the wait-list. Although the authors had hypothesized that a combination of two psychotherapies might enhance outcome, in fact the combination of PE and SIT resulted in reduced outcome, perhaps because

not as much time could be devoted to the exposure-based techniques. Other trials using various empirically validated psychotherapies for PTSD have found similar, or less promising, results (13-20).

Thus, all clinical trials to date using a single modality (psychotherapy or pharmacotherapy) have found that even the best validated treatments for adults with chronic PTSD leave a substantial proportion of patients with disabling residual symptoms. Anecdotal experience suggests this is a very common scenario for which there is little empirical study to guide the decision process. A widely accepted public health model proposes that using medication as an initial treatment approach is the most efficient and easiest to disseminate. However, if, as noted above, this leaves most patients with residual symptoms, this model is called into question. Many clinicians in practice recommend simultaneous treatment with both psychotherapy and medication; however little can be learned from a case report that uses this approach since either treatment could be responsible for the entirety of response.

For patients treated first with a medication who have only a partial response, a typical clinical decision involves whether to continue the medication in hopes of continued improvement, augment with a second medication, or recommend a psychotherapy that is effective as a stand-alone treatment in PTSD.

In addition the clinician must decide whether to continue the medication while providing trauma-focused psychotherapy. Augmentation strategies have been successfully studied in major depressive disorder; however, no data is available to inform any of these real-world decisions for patients with PTSD. It is especially troubling that there are no data that might inform a basic clinical model that integrates medication and psychosocial treatment in a treatment algorithm.

We therefore present the treatment course of three patients who experienced substantially varying degrees of improvement on medication, and then experienced further benefit from trauma-focused psychotherapy:

CASE REPORTS

Three patients were treated with trauma-focused psychotherapy in our research clinic (patients 1 and 2 by R.M., patient 3 by J.C.) following the principles of PE therapy of Foa et al. (21).

Informed consent was obtained from all patients to participate in research protocols. All three had partially responded to previous treatment with an SSRI, either provided in an open trial of paroxetine (Patients 1 and 2) (22), or by a psychiatrist prior to the patient's presentation to our clinic

(Patient 3). Number of appointments varied because therapy was being provided in the context of open treatment. However, all patients received the basic elements of exposure therapy, including the taking of a detailed trauma history, psychoeducation about the manifestations of PTSD, provision of the rationale for exposure therapy, guided re-experiencing of the trauma to promote desensitization to the memory, and meaningful exploration of trauma-related images and associations that arose during sessions.

Patient 1

Patient 1, a 43-year-old divorced Caucasian woman living alone, had been raped three years earlier by a friend, and met criteria for PTSD, chronic, and panic disorder with agoraphobia. She presented after having had two years of counseling with a rape counselor with no improvement, and then two other several-month treatments with counselors, also without symptomatic improvement. The patient reported a series of abusive relationships with alcoholic men, and currently was not in a romantic relationship. She described herself even before the rape as an angry person, with relatively unstable friendships, who had difficulty making friends. She did have a few long-term friends, however, and said she was fun to be around when in a good mood. She was not particularly ambitious in her work but had held steady jobs for many years in the past.

After 12 weeks of paroxetine treatment (increased to 60 mg by week 8), she was rated as a nonresponder, although her Davidson Trauma Scale score (DTS) (6) was reduced from 107 to 86 (19.6% reduction). The latter score reflects moderate-severe PTSD symptoms. Subsequently, she also did not respond to a trial of lithium 900 mg for 8 weeks, and only modestly benefited from a trial of phenelzine 60 mg (an MAO inhibitor) with modest reductions in level of anxiety and affective instability. These medications were chosen because of promising reports in the literature. Her medications were then discontinued as she felt the minimal benefits did not compensate for the adverse effects.

Although she had been initially skeptical about psychotherapy (given her previous failed attempts with counselors), as the medication trials progressed and an alliance developed, she expressed a willingness to engage in exposure therapy. A trial of trauma-focused weekly psychotherapy was then conducted over four months during which she narrated the details of the rape and elaborated on the meaning of the event, which included not only a sense of betrayal by the assailant, but also the relative lack of support she had experienced from others after the assault. She also discussed for the first time an episode of sexual molestation as a child by

a relative, which had become newly disturbing after the rape. At treatment completion she was rated moderately improved (DTS score 35) and was not taking medication.

Patient 2

Patient 2, a 44-year-old single Caucasian female living with a female partner, had developed PTSD six months earlier after having fought hand-to-hand with an armed robber while working as a salesperson in a small store. She met criteria for chronic PTSD, current (DTS score, 123); social phobia dating from early childhood with impairment in speaking to groups of people, taking tests, and being interviewed; and major depressive disorder, recurrent, in full remission. The patient stated in fact that she believed "her life had been shaped by social discomfort," but was currently not exposed to situations that evoked social anxiety since she had come to live a relatively isolated life and was working below her capabilities. She described two prior episodes of major depression. The first had culminated in a suicide attempt 24 years earlier after getting divorced, and a second depressive episode had occurred five years earlier after the death of her father.

She had become increasingly socially withdrawn over the years and had few friends during childhood and adolescence, but said once she was comfortable, she could be lively and witty in their company. In fact this was her style in session. She had done well in school but was a "perpetual underachiever" in her work, which she attributed to her social anxieties.

In open treatment with paroxetine 40 mg daily over 12 weeks, she was rated very much improved, (final DTS score 19), but continued to experience subjective distress related to the assault. She was particularly disturbed by her inability to remember specific events during the assault, including the appearance of the gunman's face (criterion C); by recurrent nightmares of a "blank face" (criterion B); and by increased anxiety in social situations relative to her usual level of functioning prior to the assault.

In addition to her enthusiasm about the medication's benefits, she had always been amenable to psychotherapy as well. In particular, she was annoyed by the residual symptoms and felt therapy might help with these. After three months of exposure-based therapy focused on re-experiencing the assault, she had remembered the robber's appearance and the details of the assault. She realized through the re-experiencing techniques that she had experienced severe depersonalization during the robbery and physical struggle, including an inexplicable "paralysis" of her arms when he asked

for the money from the cash register. This seemed to account for her initial memory deficits, and she was no longer preoccupied with trying to remember exactly what had happened. Her final DTS score was 7.

Patient 3

Patient 3, a 26-year-old single Dominican woman, had been well and gainfully employed until being raped at gunpoint in her own apartment five months earlier. Prior to the rape she also had plans to continue the college education that she had begun in the Dominican Republic. She had been a social, trusting, hard-working person with many friends. Immediately after the rape she developed severe PTSD symptoms, major depression, disabling dissociative symptoms, and trichotillomania. Treatment with paroxetine up to 60 mg and olanzapine up to 20 mg for eight weeks prior to presentation to our clinic had resulted in moderate improvement in depressive symptoms, insomnia, and hyperarousal, but intrusive and avoidant and dissociative symptoms remained. Olanzapine had been chosen for its nonspecific sedating properties and because of case reports of its efficacy in PTSD. CAPS score was 72 on these dosages of paroxetine and olanzapine.

Since the medications had only been partially effective, she was motivated to begin psychotherapy. Not surprisingly, she was reluctant to discuss details of the rape, and attributed this in part to having a male therapist. Unfortunately, there were no Spanish-speaking female therapists in the clinic. In addition, she noted she had been closer to the women in her family than to her very strict and abusive father (there were no brothers). However, she persisted with the treatment and made slow, steady progress over 12 sessions of PE following the manual of Foa et al. (20) while continuing paroxetine at 40mg daily. In addition, during the course of PE treatment, 50 mg HS of trazodone was added to her medication regimen for severe insomnia related to recurrent, vivid, and terrifying nightmares. She dreamed of heavily armed, masked men knocking at her door trying to break into her apartment as she remained paralyzed in terror looking through the peephole of her door. While trazodone apparently alleviated some of her hyperarousal symptoms, she continued to complain of sleep problems and recurrent nightmares, which were addressed in prolonged imaginal exposure through repeated narration of the dream.

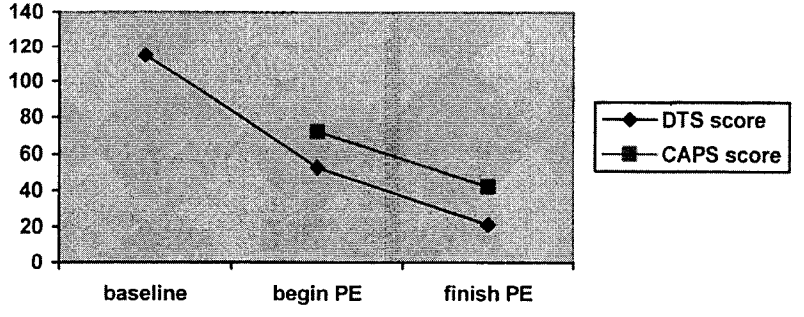
The patient's specific symptoms were severe behavioral avoidance, dissociation, and somatic complaints, including nausea, headache, stomach cramps, and coldness in her hands and feet. She tended to focus on

somatic symptoms in session and was particularly reluctant to engage in either imaginal exposure in session or in vivo exercises at home. In session she became considerably more comfortable narrating the traumatic event, but continued to have great difficulty completing out-of-session exposures. Treatment was complicated by two major losses during this period of time: her best friend was murdered in a robbery, and a close relative passed away. The patient's need to address these losses took precedence during several sessions and compounded the patient's difficulty in overcoming the rape. Near the end of treatment she associated being beaten by her father "for being a bad girl" with being "punished" by getting raped because she had been out late, against her father's repeated warnings during childhood. She had a powerful sense of guilt and responsibility for the rape (which is not uncommon among rape victims). After completion of treatment the patient's CAPS score was 42 with residual avoidance, reexperiencing and dissociative symptoms that seemed primarily due to failure to habituate to environmental cues, as well as the difficulties of processing multiple losses. She was referred back to her referring physician for ongoing medication management.

DISCUSSION

In three patients who had received partial benefit from medication treatment, trauma-focused, time-limited psychotherapy following a modified exposure model resulted in further decreases in PTSD symptoms (Figure 1). These treatments included the standard educational and trauma-history modules (22), and may have also devoted more time to individualized

Figure 1.
ADDING PSYCHOTHERAPY TO MEDICATION TREATMENT (N = 2 FOR DAVIDSON TRAUMA SCALE, N = 1 FOR CAPS SCORE)
CAPS = CLINICIAN-ADMINISTERED PTSD SCALE
PE = PROLONGED EXPOSURE THERAPY



exploration of the meaning of the traumatic event than is traditionally recommended in exposure-based therapies.

These results are encouraging because they suggest that combination treatment strategies have promise in the treatment of PTSD. The mean symptom reduction in the psychotherapy phase (31.5 points on the DTS, 30 points on the CAPS) was clinically significant. However, as a series of case reports, the dramatic range of symptom severity that remained after medication trials has more heuristic value. In fact, these three cases illustrate three qualitatively distinct clinical scenarios that are familiar to most clinicians specializing in the treatment of trauma patients.

The first patient received minimal benefit from pharmacotherapy with an SSRI, lithium, or phenelzine, and so medication was discontinued. However, she greatly benefited from trauma-focused psychotherapy. Her symptoms seemed to be primary related to unresolved anger and a sense of betrayal by important men in her life.

The second patient, who did not have a personal relationship with the assailant, was greatly improved after open treatment with paroxetine no longer met criteria for full PTSD, but still had residual symptoms that were subjectively distressing (23). These were further reduced in therapy after she realized the role of peritraumatic dissociation and the limitations it placed on her memory of the event. Psyehotherapy also resulted in additional reductions on the CAPS.

The third patient experienced only moderate benefit from an SSRI, and only moderate benefit from psychotherapy. She was left with residual avoidance, reexperiencing, and dissociation that seemed primarily due to a failure to habituate to environmental trauma cues. The patient's many psychosocial crises and limited social support network during the treatment may have also contributed to the persistence of her symptoms. However, after an additional year of medication management during which time she resolved other conflicts in her life, she was free of all symptoms.

A number of important clinical issues arise in time-limited psychotherapy, and this is no exception. An important component to PE is its time-limited nature. Patients are frequently reminded the session number as a way to enhance motivation. It is worth noting that follow-up studies in PE have shown continued improvement six months after termination, as if the psychotherapy promotes the gradual recovery seen in those who recover spontaneously after trauma.

Maintenance of gains does not appear as robust in the use of SSRIs if discontinued after only 6 months. Davidson et al. recently found a relapse

rate of 26% vs. 5% when patients were switched to placebo from sertraline in double-blind fashion (24).

All cases began with medication and then added psychotherapy, but of course the reverse is equally reasonable. There are several considerations in selecting a particular order of the two treatments, or choosing to begin simultaneously with both. Our approach is to present both options to patients along with advantages (e.g., medication treatment is less time-consuming but relapse may be more likely if psychotherapy is not also undertaken) and disadvantages (e.g., exposure therapy temporarily causes an increase in anxiety and requires confronting the details of the trauma) of each. Experts have recommended combination treatment if patients are severely ill or have comorbidity, such as major depressive disorder or panic disorder, that is significantly impairing or would interfere with trauma-focused psychotherapy.

It is important to recognize that a trauma-focused therapy can be "retraumatizing" if not properly preceded by an educational and alliance-building phase as is recommended in Foa's manual. We have treated a number of individuals who after years of here-and-now focused psychotherapy but no improvement in PTSD, benefited from exposure therapy, although there is no evidence to date that a reasonable psychotherapy would be harmful.

This report possesses all the limitations of a case series. Since there was no comparison group, and treatments were not rigorously monitored for manual adherence or standardized across patients, we cannot conclude that PE specifically can produce further gains in symptom reduction after a clinical response to medication. However, this is the first case-report series to document a substantial degree of improvement from trauma-focused psychotherapy in patients who had only partially benefited from medication using a sequential combination-treatment design. These observations warrant systematic study in future research.

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