resolution
rebuilding lives
registered charity no. 1133188

PTSD Resolution
Service Description & Evidence

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1. Introduction

UK registered charity PTSD Resolution presents a description of its UK services and supporting evidence of the effectiveness of the therapy that is delivered to treat military Post Traumatic Stress Disorder (PTSD). This paper intends to establish:-

1. That the therapeutic intervention/ programme which is offered is within the National Institute for Health and Clinical Excellence (NICE) guidelines on the treatment and management of Post-Traumatic Stress Disorder (PTSD).
2. The psychological theory on which delivered therapy is based.
3. The evidence base, from published studies and Resolution's outcome data, that supports the therapeutic work.

2. PTSD Resolution: Treatment Profile

PTSD Resolution is a UK Registered charity (No. 1133188) that provides therapy to help veterans and returning members of the Reservists who are struggling to reintegrate into a normal work and family life because of military post traumatic stress suffered as a result of service in the armed forces.

Key service features of the PTSD Resolution programme are as follows:-

1. Nationwide outreach programme of 200 therapists, qualified in HGT (Human Givens Therapy), under the Governance of the Human Givens Institute (HGI) and the PTSD Resolution referral service
2. Treatment protocol is effective: of those who reach a mutually-agreed end of treatment, more than 80 per cent experience symptom reduction to a sub-clinical level in terms of the Impact of Events Score - Extended (IES-E)
3. Brief therapy: an average of just three to four one-hour therapy sessions are usually required, to achieve the results in 2) above
4. Out-patient treatment: this supports existing family and work routines and relationships
5. No waiting lists: immediacy and convenience. Therapy can usually begin within days
6. Confidential service: privacy overcomes operational sensitivities
7. 'Non-intrusive': no requirement for patients to re-tell or re-live the traumatic events, which can be a bar to veterans agreeing to treatment, and can otherwise compound the emotional distress.

The PTSD Resolution programme complements the work of other armed forces' charities, because treatment resolves the immediate mental health issues that may be barriers to successful reintegration and resettlement, as well as other help and treatment that may be required.

3: The mode of therapy offered by PTSD Resolution

PTSD Resolution is a referral service for Trauma-focused psychological treatment. The treatment mode used by Resolution differs in some vital respects from standard forms of trauma-focussed cognitive behavioural therapy (TF-CBT) available on the NHS in the UK, though there is nothing in the HG approach that a TF-CBT therapist would not theoretically be able to use if adequately trained. TF-CBT is a treatment for psychological trauma recommended by the National Institute for Health and Clinical Excellence (NICE).

So what are the distinctions, apart from local treatment without waiting lists, between the form and practice of TF-CBT employed as a first-line treatment by PTSD Resolution and that generally available in the NHS?

Whilst all successful treatment for post-traumatic symptoms is likely to involve some element of re-exposure to the traumatic memories, what distinguishes the Resolution protocol is that the primary mode of re-exposure is visualisation rather than verbal re-living, and that it is achieved at lowered states of emotional arousal. Other protocols for exposure tend to begin with verbally-stimulated re-experiencing and might use some form of imaginal exposure or visualisation later.

Verbal re-exposure and the avoidance behaviour this arouses is, anecdotally, one of the reasons why many veterans tend to wait so long before entering treatment. Therefore PTSD Resolution's protocol might be expected to improve tolerability and reduce resistance to the prospect of entering treatment.

Imaginal re-exposure without recounting out loud is also, anecdotally, useful for those ex-service personnel who do not wish to or are not able to talk about their experiences, and is likely to protect the psychotherapists to some degree from 'burnout' or vicarious traumatisation.

In TF-CBT success rates depend on a number of factors, as with all psychological treatments. The most appropriate summary of evidence supporting TF-CBT is contained inside CG026, NICE guideline for PTSD.

4: Treatment Availability

A major factor determining the outcome for veterans continues to be the availability of treatment. Despite recent Government initiatives there are still waiting lists for trauma treatment in most parts of the UK. Some areas still have no trauma specialists in post. Other charitable services and some NHS Trusts have long waiting lists; also, entry criteria may exclude some veterans such as those who are drinking heavily or using other drugs, who are violent, in prison or on the Sex Offenders' Register.

PTSD Resolution's importance is not, therefore, just its particular form of trauma-focused treatment: PTSD Resolution is unique in that it provides an outreach programme for treatment immediately, without cost and wherever veteran's are located, to some of the most vulnerable members of society, who are in psychological difficulties because of their service to their country.

5: Compliance with NICE Guidelines (CG026)

The Resolution therapeutic intervention programme compliance with National Institute for Health and Clinical Excellence guidelines on the treatment and management of PTSD is tabled below. The Resolution protocol for trauma accommodates appropriate levels of flexibility in the amount of time therapists may allocate to each element of the treatment protocol, according to evaluated need. The core treatment for post-traumatic symptoms consists of:-

Treatment element	CG026 reference
Psycho-education about trauma that normalises the sufferer's symptoms and presents a rationale for the intervention	5.2.1 Cognitive-behavioural therapies
Relaxation training, including breathing retraining, to relax patient as preparation for re-exposure	5.2.1.3 Stress management
Graduated re-exposure, conducted as imaginal exposure in the visual mode without recounting out loud, while the patient is still relaxed.	5.2.1.1 Exposure
Discussing interpretations of the events and rehearsing cognitive and physical strategies for coping with reminders of them in future.	5.2.1.2 Cognitive therapy 5.2.1.3 Stress management

Patients are encouraged, where appropriate and when symptoms are under control, to take steps towards re-connecting with family and friends, going back into work and re-starting other kinds of social interactions that may have been in abeyance.

This is the same therapeutic model used in the NHS Rewind clinic at Milton Keynes PCT, although Resolution offers more sessions than the NHS.

6: Clinical Governance and the Relationship between PTSD Resolution, the Human Givens Institute (HGI) and Human Givens Therapy (HGT)

Resolution uses the Human Givens registered network of therapists to deliver treatment. This network provides a well-defined but highly flexible system (HGT) for delivering Trauma-focussed therapy, a consistent approach across a group of over 200 therapists, and a system of regulation and governance at the therapist level.

7: The Human Givens Institute (HGI)

The HGI (www.hgi.org.uk) provides the Clinical Governance framework for administering therapists operating under the PTSD Resolution referral system. HGI requires that therapists:-

1. Carry appropriate professional risks insurance, (and it keeps copies of their insurance certificates).
2. Carry out certain hours of accredited CPD activities and keeps a central record of each therapist's CPD hours each year
3. Act in accordance with their ethics policy and is answerable to their Ethics Committee, which carries out enquiries into any complaints that may arise. This committee may if necessary discipline therapists, including barring them from practising as an accredited HG therapist and removing them from the public register.
4. Undertake the necessary periods of supervision.

PTSD Resolution also carries professional risks insurance in a 'clinic' policy, makes additional advice and supervision available to therapists at any time, and has its own clinical governance committee consisting of:

1. Dr. Ian Walton. Dr Walton is a GP with special interest in mental health, and is a trustee of PrimHe (Primary Care Mental Health and education), which provides the RCGP accredited MSc and the advanced diploma in primary care mental health, in association with Staffordshire University, for (General) Practitioners.
2. Iain Caldwell. Iain is CEO of Starfish Health and Wellbeing, and is a mental health consultant, trainer and therapist.
3. Dr. Mike Beard. Mike is CEO of Naming Elephants, a social enterprise which enables individuals, schools and organisations to make positive changes using an approach based in neuroscience, psychology and learning theory.
4. Patrick Rea. Mr Rea is a trustee of Resolution and represents the other Trustees on the CG committee.

8: Human Givens Therapy (HGT)

The Human Givens approach to counselling and psychotherapy is not a therapeutic approach in itself, but a ‘wrapper’; a philosophical framework within which therapy might be expected to act in the interests of the patient. Within this wrapper practitioners have access to a palette of brief therapeutic techniques that can be used, with the agreement of the client, as the need arises.

The brief therapeutic techniques used within HGT would all be recognisable to a modern CBT therapist, in as far as there is any one such sort of a thing, CBT having absorbed a large number of heterogeneous elements from other therapies including relaxation, mindfulness, and, increasingly, visualisation. With the arrival of modern TF-CBT approaches such as Imagery Rescripting and Reprocessing Therapy (e.g. Smucker 2005) CBT has, to some degree, caught up with the HGT approach, though the particular order of events in a Resolution session is still probably unique to HGT. A typical arc of therapy for a Resolution client might include:

1. rapport-building and ‘hearing’ the patient,
2. solving (where possible, and with the help of other agencies as appropriate) such immediate practical problems as might be causing sufficient arousal to prevent therapy getting under way,
3. setting goals for the therapeutic process,
4. psycho-education to give the client tools with which to manage emotional arousal, recognise and intervene in emotionally-driven behaviour and thought processes
5. achieving symptom reduction, generally through progressive re-exposure in a calm state, reconditioning the patient to be able to remember the traumatic events while remaining calm, together with developing a new set of explanations with which to interpret events, thoughts and feelings,
6. setting goals for behavioural change,
7. further therapeutic work to achieve such change including where appropriate further visualisation or in-vivo work,
8. progressively handing responsibility for maintaining changed behaviour to the client, with further support available as needed.

Within this arc there will generally be particular sessions or parts of sessions that are particularly focussed on trauma symptom reduction.

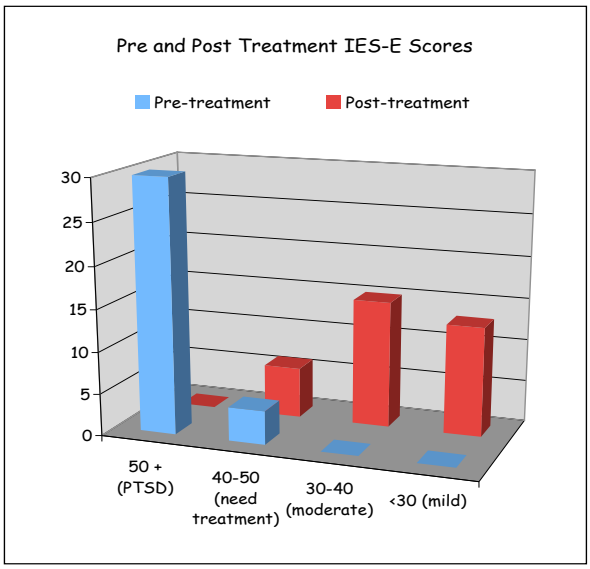
9: Evidence base for the this model in trauma

A: Resolution's own outcome data.

PTSD Resolution records data on every patient case. All patients are scaled using validated instruments from the Department of Health Outcomes Compendium (NIMH 2009), before, during and after treatment, except where the individuals are unable to face the process of scaling at time 1.

Therapists encourage patients to complete an IES-E (now an IES as it is simpler and the two instruments correlate well) at the start of each session, as well as CORE-10 at the start of each session and the end of treatment. CORE results are recorded into the Human Givens Institute Practice Research Network database (www.hgiprn.org) and IES-E (IES) scores are collated by PTSD Resolution. The initial outcome data is presented below.

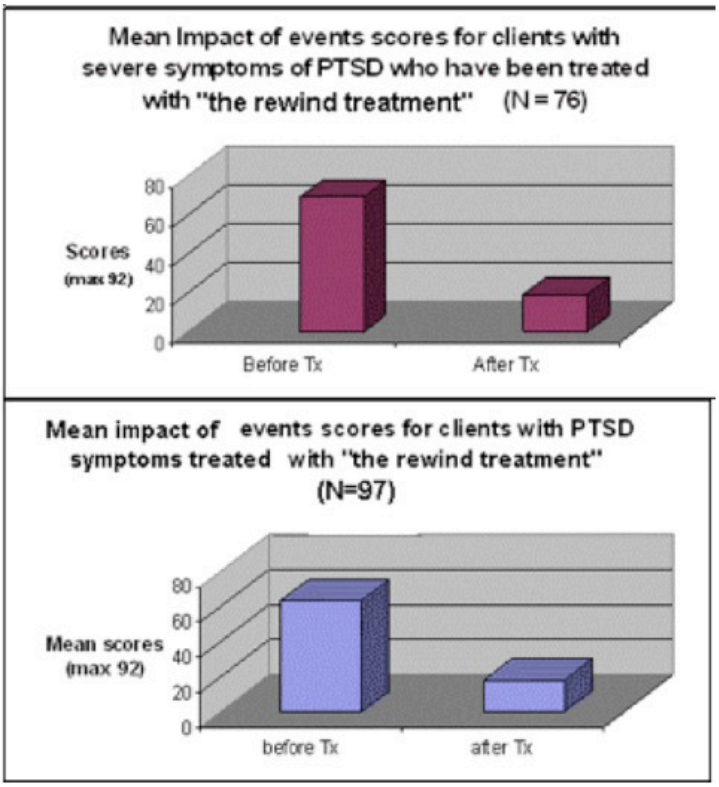
<u>Effectiveness of HG Therapy For War Veterans (Bishop & O'Callaghan 2010).</u>
This retrospective study looked at all the clients treated by the veteran counselling service, Resolution. All clients seen by Resolution who were seen for more than one session were included in this study. Demographic data was collected and the Impact of Events Scale Extended Version (IES-E) (Tehrani, 2000) was used at the beginning and end of treatment. 34 clients were included. ANOVAs indicated that demographic information was not significant to treatment results. All the clients were seen for 8 sessions or less, with an average of 3.11 sessions. IES-E scores reduced from an average of 67.24 pre-treatment to 29.29 post-treatment. The effect size using post-treatment SD was 2.54. The study concluded that HG therapy is effective in treating trauma in war veterans. It is also effective in treating multiple traumas and chronic PTSD (94% had trauma(s) over 5 years before). The positive treatment effects were achieved in 4 sessions or less, suggesting the cost-effectiveness of this treatment. Difficulty collecting demographic data with this population was also discussed. RCTs are now needed to confirm these results.



B: Other studies on the HG (a.k.a. Rewind or Resolution) approach.

The Resolution framework is as used in the Human Givens model of therapy where trauma is involved, and typically has a significant impact on post-traumatic symptoms, regardless of symptom severity and diagnostic status.

Guy and Guy (2009) recently reported on a study with Coventry City Council employees. A total of 97 clients were eligible for inclusion, with N=76 severe cases and N=21 mild cases, with a score of 50 and above on the IES-E (Tehrani 2004) indicating a severe case. The average score on the IES-E reduced from 68 to 18 for all cases, with it reducing from 69 to 18 for severe cases and from 42 to 11 for mild cases.



Andrews et al. (2011) report on a further study at a GP surgery in Luton, a total of 124 clients were included and 100% response rates were obtained. An IAPT methodology was used, using CORE, ORS and SRS measures for every client in every session. This included the usual 'planned endings' reported in most studies, as well as unplanned endings' or dropouts. CORE's Reliable Change Index (RCI) and effect sizes were calculated for 'all' endings and planned endings above cut-off. Data was compared to published results from IAPT demonstration sites and planned endings to CORE National Research Database (NRD) benchmarks. The HG approach was shown to be effective for 76% of clients above cut-off who were accepted for treatment.

Other studies (cont.)

Murphy (2007) conducted a study in Northern Ireland in conjunction with Barnados Charity and the University of Ulster. All trauma clients (N=47) who were treated using HG rewind in a Barnados trauma counselling service in Northern Ireland were included. This was a qualitative study using an interpretive phenomenological analysis (IPA) approach. The results suggest this intervention was effective in reducing posttraumatic stress reactions for all of those cases, regardless of age or gender. The reduction of symptoms was consistent whether the individual had experienced a single trauma or multiple traumas, with no significant difference in terms of time elapsed between traumatic experience and treatment. HG Rewind reduced the full range of PTSD. The results suggest HG Rewind can be used effectively as a single intervention or as part of a wider treatment programme with other treatment approaches like CBT.

A RCT comparing a single Rewind treatment session with a control session with information about anxiety and PTSD is currently being conducted in conjunction with Oxford University. The results are expected in 2013.

A qualitative study is being currently being done on a Rewind Clinic in Milton Keynes NHS in conjunction with Leicester University.

In another current study with Leicester University a within subject design is looking at the effectiveness of Rewind and HG therapy for PTSD and sub-threshold trauma using standardised questionnaires, as well as looking qualitatively at how the meaning of the trauma changes with out discussing details of the trauma as a result of the Rewind technique.

10: The Psychological Theory on which PTSD Resolution's work Is based.

The psychological theory on which PTSD Resolution's work is based is a mixed cognitive model (e.g. Ehlers, Clark 2000) with input from a neurobiological conceptualisation (e.g. Brewin 2008, LeDoux 2009): fears associated with PTSD develop through classical conditioning, and are maintained through operant conditioning as avoidance behaviours, reinforced by their anxiety-relieving effects.

Symptoms generalise as increasing numbers and types of stimuli become associated with the conditioning, and symptoms of PTSD are maintained. The aim of treatment is to recondition the memories so that they are associated with calm feelings rather than strong emotion, and the normalizing, relaxation, graduated exposure and development of coping strategies are all aimed at achieving this.

Re-conditioning is facilitated if the patient has access to their intelligence in order to participate in the process, so relaxation is used before the re-exposure and discussion of coping strategies.

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