

PTSD Resolution Ltd
Registered charity No 1133188

What we do and what the outcomes are. 26.11.2013

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Introduction

Resolution is a UK registered mental health charity which relieves suffering in ex-service people with post traumatic symptoms.

Resolution uses the Human Givens (HG) network of therapists. HG therapy is a development from Cognitive-Behavioural Therapy (CBT), making use of information about the structure of brain and body systems that was unavailable when the original cognitive-behavioural approach was being formulated.

As a result the HG approach acknowledges that the roots of distress generally lie in emotional systems, and it places less emphasis on the primacy of cognitive systems than in mainstream CBT practice. However, CBT is changing rapidly and there is now nothing in the HG approach that a sufficiently trained CBT therapist would not be able to do.

Cases seen by Resolution are generally complex and include elements apart from post-traumatic symptoms. Resolution takes a whole-person view of each case and attempts to resolve as many of the client's difficulties as possible, and to equip him or her to continue to manage life sustainably in the future.

HG therapy appears to suit a wide spread of mental health presentations: a recent study (Andrews et al, 2013) confirms earlier reports (Tsaroucha et al., 2012; Andrews and Miller, 2012; Yates and Atkinson, 2011), suggesting a 'moving to recovery' rate of 53.9 per cent (50.6 per cent when also taking into consideration reliable change) for a large number of cases treated by HG therapists.

This exceeds by some margin the revised IAPT target set by the UK Department of Health of 40 per cent moving to recovery (IAPT, 2012).

Using the HG approach in psychological trauma

Resolution sees therapy as a self-adjusting, self-limiting, cooperative venture rather than something conducted according to a doctrine or protocol. The ultimate aim is for the client to self-manage a life that works independently of therapeutic support. The goal of symptom reduction nonetheless determines a logical order of events in treatment for trauma, and there is a normal series of steps, followed over a number of sessions, by therapists working for Resolution:

- Rapid rapport-building to establish a therapeutic relationship;
- information-gathering in which the therapist will listen to the history as far as is necessary a) to formulate a treatment plan and b) to 'hear' the patient, while beginning to re-structure the meanings of these events;
- relaxation and breathing training to teach the patient how to regain control of his/her physiology;
- progressively re-exposing the patient to the sensory components of their traumatic memories, in a state of carefully controlled arousal and preferably without narrating,

as part of a process of changing the emotional value of those memories and re-evaluating the meaning of those events;

- mentally rehearsing taking part in previously feared activities, preparatory to behavioural experiments between sessions or with the therapist;
- building and rehearsing a framework for life after therapy that will be emotionally satisfactory as informed by the HG / self-determination framework. This may involve work on other areas of the client's life including coping strategies, relationships, work and so on. Resolution will also help other family members who have vicarious trauma and/or have been traumatised by the original sufferer.

These steps are taken progressively over a number of sessions as appropriate. The treatment is designed to address the cognitive, emotional and behavioural disturbances found in ex-service personnel including those with post-traumatic symptoms, and is delivered in a way which is entirely compatible with the guidelines on trauma-focussed CBT treatment.

It is extremely important to emphasise that Resolution takes a whole-person view and does not attempt to apply any kind of 'quick fix' to trauma symptoms; therapy takes as long as it takes, and care is taken not to work too quickly. In practice, therapists will generally prioritise trauma where it is possible to do so, as the increased cognitive capacity available after trauma has been addressed may make it easier to do such other work as is needed, but this is a matter for discussion with the client.

In this context it becomes possible, generally, to do useful work with clients who have complex PTSD presentations including co-morbid problems with alcohol and/or other substances. Resolution will, where possible, negotiate support from other agencies and develop contracts with clients that allow, for example, for therapeutic work to be done at a time and place where they can feel safe and be sober.

Why Resolution uses this approach rather than 'standard' CBT

Firstly, it is not clear that there is such a thing as 'standard' Trauma-Focussed CBT. The NICE guideline CG026 aggregated papers on all of the following treatment programmes into its category of trauma-focused CBT:

- prolonged exposure
- image habituation training
- imaginal flooding (implosive flooding) therapy
- imaginal exposure and biofeedback-assisted desensitisation treatment
- cognitive reprocessing therapy
- cognitive-behavioural treatment
- cognitive therapy for PTSD (Ehlers et al, 2005),
- cognitive restructuring plus exposure
- cognitive restructuring

- cognitive trauma therapy
- brief eclectic psychotherapy (!)

In NICE's view cognitive-behavioural therapy programmes for PTSD "include one or more of the following groups of treatment techniques: exposure, cognitive therapy and stress management". There is no question that the Resolution protocol includes all of these.

The NICE guideline mentions some protocols commonly used in the NHS, but not others, but does not prescribe or proscribe any particular protocol. Nonetheless is it reasonable to ask why Resolution avoids some trauma protocols that are widely used in the UK, such as Prolonged Exposure (Foa et al., 1991) or the Ehlers-Clark protocol (Ehlers & Clark, 2000). There are many reasons, apart from a simple wish to provide an alternative:

- Many Resolution clients have already failed treatment offered by Combat Stress and the NHS, so it would likely be unhelpful to offer them the same process which has previously not worked for them;
- Verbalising the contents of traumatic memories is unlikely to be a happy experience. Anecdotally, one reason patients stay in therapy with Resolution is that they are not required to talk about appalling events repeatedly;
- Broca's area is compromised in trauma, so talking about traumatic memories may be an excessive effort (Hull 2002) and an inefficient therapeutic route;
- The highly structured nature of traditional CBT can make it unsuitable for people with complex mental health needs (NHS 2013).
- Veterans do not only suffer fear memories; there is often a complex mixture of emotion including guilt and shame, which may be more amenable to imagery-based restructuring (see, e.g. Arntz et al., 2005; Grunert et al. 2007);
- Exposing client and therapist to repeated verbalisations of trauma memories as in, for example, Prolonged Exposure will likely cause therapist burnout (e.g. Killan 2008) and may increase distress in the client and so cause dropout (Eftekhari et al. 2013), so avoiding the verbal component (as far as is possible) during re-exposure may be protective to both.
- The Resolution / HG approach also controls client and therapist arousal during re-exposure, preventing unnecessary distress and, theoretically at least, reducing the risk of symptom exacerbation in the patient and vicarious traumatisation and burnout in the therapist. It is also considered humane to reduce distress as far as is consistent with the agreed aims of therapy.

Governance and supervision.

The therapists are all members of the HGI, which monitors their insurance, CPD and supervision. Additional supervision is available to any Resolution therapist at any time. The HGI provides ethical guidance and the disciplinary process, and is in the process of becoming accredited by the Professional Standards Authority.

Resolution has its own ethics committee and insurances and is an organisational member of the BACP.

How effective is the Resolution service for veterans?.

A recent review by Bill Andrews of the International Center for Clinical Excellence (ICCE) analysed outcomes for 150 cases accepted into therapy by Resolution. The full report is reproduced below, but in summary:

- 150 cases were accepted into therapy (IAPT definition) and seen by 51 therapists
- Average CORE-10 score improved from 23 to 10.4
- 'Moving to Recovery' rate was 56%
- Average IES-E score moved from 54 to 24
- 75% of cases improved by 20 points or more
- Effect size was substantial (>1.5) on both measures

It is emphasised that these are results for the service as a whole, not just the treatment method. There are several reasons why Resolution clients tend to do well:

- the client group is self-selecting - they have chosen to start therapy with Resolution and are, presumably, primed for change;
- there is little or no waiting list, so the motivation to change which brought them to contact Resolution may be preserved at the time of the first session;
- the first session is seen as a key opportunity to reinforce that motivation, explain the source of the client's distress and instil confidence that some degree of positive change can usually be achieved;
- Resolution therapists are trained in a particular method of rapport-building, with the aim of accelerating and deepening a therapeutic relationship
- clients are not required to 'disclose' traumatic memories
- visualisation as a method of re-exposure may increase the efficiency of trauma treatment
- the whole therapeutic enterprise is conducted inside a bio-psycho-social wrapper which teaches patients how to understand and, to some degree, control their own cognitive, emotional and physical experience. It aims to teach clients how to build a life that 'works' at an emotional level, reducing overall distress.

However, the important point from the Veteran's point of view is that the real-world outcome figures are good, and veterans report that the treatment is tolerable and humane.

Appendix

Outcomes in the PTSD Resolution Trauma Service for UK Veterans

**Bill Andrews, independent researcher and Senior Associate of the
International Centre for Clinical Excellence.**

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Background

Originally, PTSD Resolution used just the Impact of Events Scale - Extended (IES-E) to reduce the data collection burden on therapists and clients. However in late 2010 Resolution started collecting CORE10 data as well as IES-E scores, in order to acquire a broader picture of therapeutic outcomes.

This report considers data collected since CORE10 collection began. Data was gathered by PTSD Resolution therapists through a practice research network and has been independently analysed. The analysis includes every case accepted into therapy (according to the IAPT definition) since CORE10 outcomes became available.

Data collection rates in Resolution are very high, but for one reason or another there are some cases where either or both of the measures are unavailable.

In this group of 150 cases assessed with both CORE10 and IES-E measures, there were 4 females and 146 males. The mean age was 43, age range 23 to 85.

Number of sessions

A small number of cases received in excess of 8 treatment sessions, but the vast majority were treated in 6 sessions or fewer. The mean number of treatment sessions was between 5 and 6.

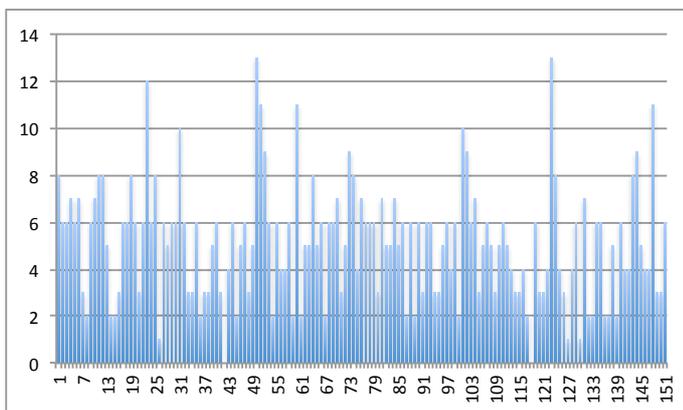


Fig. 1: Number of sessions by case.

Number of therapists involved

The 150 cases were treated by 51 different therapists, and treatment was largely successful regardless of which therapist saw the client.

The vast majority of therapists saw 4 clients or fewer. Only 6 therapists saw 6 or more cases, and 17 therapists saw only 1 case. The treatment seems to be relatively immune to therapist effects.

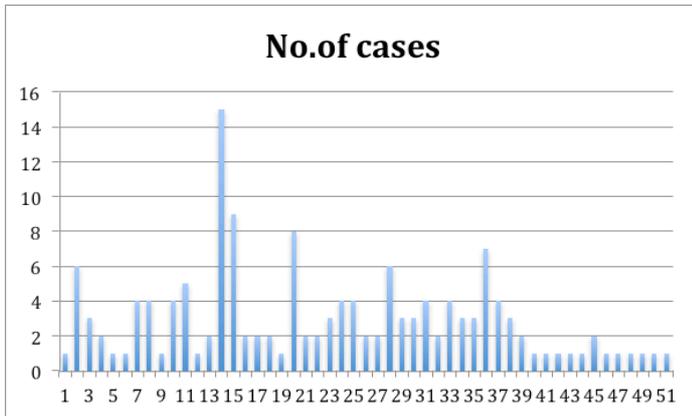


Fig 2: Number of cases treated by therapist

Outcomes

On both IES-E and CORE10 outcome measures the magnitude of change was substantial.

CORE10

Average CORE10 score moved from 23 pre-treatment to 10.4 post-treatment.

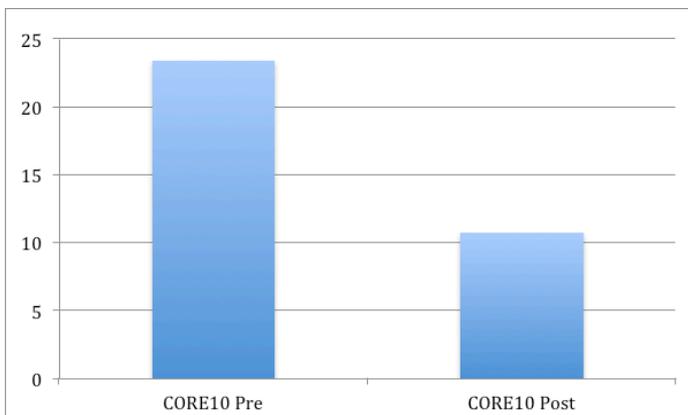


Fig. 3: Average CORE10 scores pre- and post-tx

IES-E

As might be expected, the disorder-specific IES-E shows a more substantial change than the more generic CORE10 measure. The average IES-E score was reduced from 54 to 24.

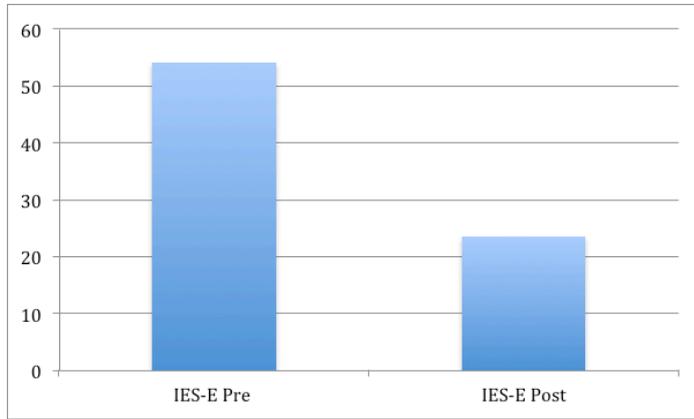


Fig. 4: Average IES-E scores pre- and post-tx

Effect size

The effect size was substantial on both measures: 1.81 on the IES-E and 1.51 on CORE10.

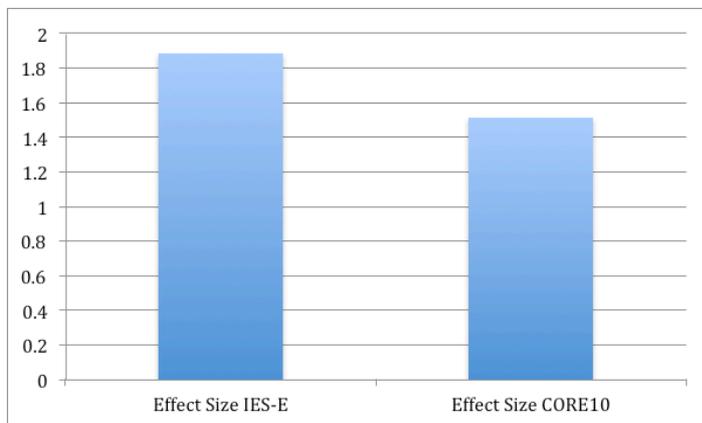


Fig. 5: Effect size

Levels of distress at start of treatment.

This client population was very distressed pre-treatment. Of the 131 cases with a pre-treatment IES-E score available, the average score was 54, a figure regarded as indicative of PTSD. 86 of those clients (66%) scored above 50, and 108 (82%) were above 40.

The average CORE10 score was 23, again a relatively high figure against the typical primary care score of between 18 and 19.

Effect of treatment: CORE10

107 of 111 cases with a pre-treatment CORE10 score were above the clinical cutoff of 11. 105 of those cases had a post-treatment measure, a data capture rate of 98%. 87 of those 105 cases had an improvement in CORE10 score of 6 points or more and so can be said to have improved reliably. 60 of those 105 cases were below cutoff post-treatment. This represents a “moving to recovery” rate of 56%, against the new IAPT target of 40% (using GAD7 and PHQ9). On CORE10 measure 83% of cases have undergone ‘reliable’ improvement, i.e. it is likely to be due to treatment and not just random improvement. This is a remarkable figure, but it is possible to have confidence in it as the data capture rate is 98%.

Effect of treatment: IES-E

131 cases had a valid pre-treatment score, and 122 had a valid post-treatment score, so again the data capture rate is high at 93%. In those 122 cases the average pre-treatment score was 54, and 79 of these 122 cases were above 50 pre-treatment. The average post-treatment score was 24, and 66 of these 79 (83%) were below 50 post-treatment. 59 of these 79 cases (75%) had improved by 20 points or more on the IES-E.

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Appendix 2:

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