Published on *Up Close* (http://www.upclose.unimelb.edu.au)

Episode 135: PTSD II: Researching and treating post-traumatic stress disorder

PTSD II: researching and treating post-traumatic stress disorder

VOICEOVER
Welcome to Up Close, the research, opinion and analysis podcast from the University of Melbourne, Australia.

JENNIFER COOK
I'm Jennifer Cook. Thanks for joining us. How do you help someone who's been pushed to the limits of their endurance? Someone who's seen and felt things that have wounded their psyche so deeply they can no longer relate to those close to them, let alone function in the normal world.
Welcome to Up Close and the second of our two part series on posttraumatic stress disorder or PTSD. In our first episode we learnt about this debilitating condition and the different ways it manifests in individuals and across cultures. Today we consider the treatment as well as some of the politics surrounding the most prevalent mental health disorder in Australia and one that affects millions worldwide. Mark Creamer is a Professor of Psychology, Department of Psychiatry, University of Melbourne and Director of the Australian Centre for Posttraumatic Mental Health. He's joined by Associate Professor Meaghan O'Donnell who is Director of Research at the Centre. And they will bring us up to date with not only the latest research findings, but also the best way to help those with this debilitating disorder.
Thank you so much for joining us again.

MARK CREAMER
It's a pleasure Jenny.

MEAGHAN O'DONNELL
Hi Jenny.

JENNIFER COOK
Now as I said in our first episode we talked about the diagnostic aspects of PTSD, how do we decide what it is? Now I'd like to talk about what we do with it? How do

we treat people with this disorder? Meaghan?

MEAGHAN O'DONNELL
Well if we think about what kind of symptoms we see in PTSD, we see intrusive memories and we see high levels of avoidance and we see high levels of arousal. So treatments tend to address each of those clusters of symptoms. So the first thing we would do with someone is really stabilise them. Make sure that they have some strategies in order to manage their high levels of anxiety and distress about these intrusive memories that they're experiencing. And then we would look at the avoidant symptoms that they're experiencing. So people with high levels of avoidance, what they're trying to do here is trying to avoid the memories of the event. And when we think about our theories of PTSD we think that one of the reasons that these symptoms don't dissipate over time, these intrusive memories don't dissipate, is because these people have very, very high - they're very good at avoiding reminders of the event. So that means these intrusive memories aren't kind of emotionally processed.

JENNIFER COOK
I see. So instead of dealing with them?

MEAGHAN O'DONNELL
That's right.

JENNIFER COOK
It's make it worse by not dealing.

MEAGHAN O'DONNELL
That's right. So they're dealing with it emotionally and so because they're so good at avoiding - and it seems to work. Because by avoiding it they don't get the memories so they think oh that's a great idea. But what we think happens is they don't emotionally process the event. And so therapy is really about emotionally processing the event. And so when I talk about emotionally processing these intrusive memories, one of the evidence based practises is prolonged exposure. And that's where we help someone to, in a very safe environment, go through the traumatic event in a very detailed, descriptive way and so they basically fill out all the details of the event. And the idea is that by going constantly over the traumatic event they habituate or they kind of get used to what their experience was. In that context they're emotionally processing it. And as a result the hyper arousal symptoms drop off and their avoidance drops off over time as well.

JENNIFER COOK
I can't help but think how incredibly confronting that would be for someone who has been coping by using avoidance. Thinking they're coping and at what stage they would have had to have got to even ask for that help in the first place.

MARK CREAMER
That's absolutely right. And I guess the point is that they're asking for help because

their avoidance is no longer working because the images are continuing to intrude. The nightmares are coming and so on. And so they recognise that the avoidance may have worked for a while but isn't working anymore. It is difficult and as therapists we need to recognise that and spend a lot of time with people explaining what's going to happen and reassuring them and making sure that they recognise that they're in control all the time. You know, we're not going to allow them to be overwhelmed and so on. We tend to call this exposure, prolonged exposure. And the analogy with someone for example, the very simple end of the spectrum is someone who's very frightened of spiders, so a spider phobic. And the way we treat that is by very gently introducing them to spiders, a small spider on the other side of the room and so on. And I talk to my clients, my patients about exactly this. Because that's what we're doing with the memory. That the memory is your spider, your frightening thing and we're going to help you confront that memory step by step and a little bit at a time.

JENNIFER COOK
Now of course human beings are complex creatures. We will find lots of ways of coping and dealing and avoiding as you've just said. And we know that PTSD doesn't happen in isolation and people can tend to cope by self medicating can't they? Could you explain to us a bit more about that Meaghan?

MEAGHAN O'DONNELL
Well we do see a lot of comorbidity with PTSD. So it does occur in the context of lots of other disorders. So substance use disorder is a typical one. Often you find this with men who develop posttraumatic stress disorder is that one of the ways they cope with these very intrusive distressing memories is by self medicating, so using alcohol or other substances. And so in terms of therapy or intervention, we need to address the substance use disorder in addition to the posttraumatic stress disorder.

MARK CREAMER
And of course, you know, substance use often has a kind of cultural, sub-cultural context as well. That in many sub-cultures again, some of the more male dominated professions, the idea of going down the pub and having a few beers is kind of part of the culture and that's the accepted way of dealing with these things. And so that behaviour can then start to become entrenched and become quite destructive in the longer term as people use it to manage symptoms and to mask the symptoms of depression or PTSD. And of course the dilemma is that the alcohol is serving a purpose in the sense of helping them manage the symptoms. So you can't take away that crutch and leave them with nothing. And so the idea of working with substance abuse and PTSD is very much to do it concurrently, to work with the two together. Because when you get on to the aspect of confronting the memories and doing the painful work of treatment, it's really important that they're not using alcohol as a way of coping with that. So we do a lot of the symptom management stuff. Helping them to manage anxiety, manage the painful feeling first while we reduce the alcohol use and we get the alcohol under control. And then we can move on to do the memory work which is the main therapeutic ingredient.

MEAGHAN O'DONNELL
You know, as I said before, PTSD is comorbid with a whole pile of other disorders. So depression is one - you know up to 70 per cent of people with PTSD will have depression as well. So again it makes a very complex picture in terms of teasing out some of these issues for therapy or for psychological interventions.

MARK CREAMER
If I could just go tangentially a minute because it's kind of interesting. The area that gets a lot of interest at the moment is something called chemoprophylaxis. In other words can we prevent PTSD by using drugs? And there's some interesting research, albeit opportunistic kind of research, that suggests that people who've had a few drinks at the time of the trauma do better. Because their level of arousal is lower, they're not so frightened at the time and they end up doing better. And of course when you think about it, that's got a long, historical perspective hasn't it? Because before people went into battle they'd have a tot of rum or whatever. My grandmother used to say if you had a shock you have a brandy, you know. So it's kind of got a long history during or immediately after the trauma, that alcohol might help a little bit. But of course, then as time goes on it becomes more and more unhelpful and more and more destructive.

JENNIFER COOK
Insidious.

MARK CREAMER
Insidious indeed, yes.

JENNIFER COOK
This is Up Close and we're coming to you from the University of Melbourne, Australia. I'm Jennifer Cook. And our guests today are Meaghan O'Donnell and Mark Creamer and we're talking about posttraumatic stress disorder.
So Meaghan what are some of these evidence based treatments?

MEAGHAN O'DONNELL
So I mentioned prolonged exposure and that's very good at addressing these intrusive memories. Cognitive Behavioural Therapy is also very useful, especially if it does have this trauma component. Cognitive Processing Therapy is another form of Cognitive Behavioural Therapy that's particularly useful for PTSD as well. And then the third treatment modality is EMDR, that's eye movement, desensitisation and reprocessing. And this is a series of techniques where people move their eyes and it seems to facilitate reprocessing the traumatic memory. Though the Australia PTSD treatment guidelines suggest that it's best paired with some prolonged exposure as well to make it most effective.

MARK CREAMER
The reason that Meaghan is able to talk like that is because we now have a substantial body of research evidence and we have in a couple of countries what we

call systematic reviews of the literature that allow us to combine many studies together and to determine on the basis of those many studies what the treatments of choice are. And the two big ones I think if people are interested are the National Institute of Clinical Excellence in the UK that were called the nice guidelines and also the NHMRC guidelines here in Australia that are available from our website. So these outline, as Meaghan said, the first line treatments of choice which are the trauma focus psychological treatments and also the second line treatments which are the pharmacological treatments. And here we're looking at - people won't be surprised to know, the new generation antidepressants, the SSRIs, the selective serotonin reuptake inhibitors, which are called antidepressants. But really they're kind of brain drugs because they work for so many different disorders. But they are the treatment of choice from a drug perspective. And very often of course we see a combination of someone perhaps getting both psychological treatment and pharmacotherapy. Or in situations where psychological treatment is not available, perhaps there aren't trained practitioners and so on, and then medication can be very useful. So both are important components of treatment.

JENNIFER COOK
Mark could you just explain to us a bit more about the drugs. You said they're not strictly antidepressants, more brain drugs.

MARK CREAMER
Well of course there's a lot of debate about why these drugs actually work. But they are working on something called neurotransmitters which are chemicals in the brain that take messages around. And the assumption has always been that several disorders, but particularly depression, are a function of the fact that there is a shortage if you like of these neurotransmitters. And so the SSRIs are one approach of trying to increase the amount of these chemicals in the brain. But what's interesting is that although they were designed for depression, the more they're used the more it's clear that they're actually having affects on other conditions, certain anxiety disorders, even certain addictive behaviours, but also PTSD. And there are a number of advantages to them in terms of their ease of use and in terms of the broad spectrum of their influence. So all the three clusters that Meaghan talked about, the intrusive memories and the avoidance and the arousal, all seem to benefit from this drug. But I would emphasise, I would like to come back to where we started, and that is that these drugs are still a second line treatment. The treatment of choice is unquestionably a trauma focused psychological therapy. And that makes sense because it is about whatever terms you want to use. It's about coming to terms with what happened. It's about confronting what happened. It's about working through what happened. It makes sense that this is a psychological process that survivors have to go through.

JENNIFER COOK
We've spoken about the person suffering from PTSD and what they go through and how it may best be treated. I'd like to talk now a little bit now about the impact on the people around them, on family and friends. How does it affect them and what kind of support do they need?

MARK CREAMER
Well this is a disorder that can have enormous impacts on loved ones, on family and friends and so on. Again if we think about the symptom profile that Meaghan was talking about, part of it at least is characterised by social withdrawal, by shutting down the system, by becoming emotionally numb and withdrawn and so on. But also combined with being very volatile, angry and aggressive and irritable and so on and jumpy. And so for family members to have to live with this change in their loved on can be very, very difficult indeed. And unfortunately we do see a large amount of relationship breakups and family dysfunction in families of people who have PTSD.

JENNIFER COOK
And there has been some evidence, hasn't there, of children of sufferers from PTSD and the effects it has had on them. Meaghan.

MEAGHAN O'DONNELL
Well we don't know if it's necessarily about the PTSD itself that makes the children of sufferers particularly vulnerable, but we do see evidence of mental health problems in the children of people who have PTSD. But this could be a function of having a mental health disorder. So it could be that people who have depression, that impacts on their children as well. We need to do a lot more research around teasing out whether there is something specifically toxic to children if a parent has PTSD. Or whether it's you see these kinds of problems across the whole spectrum of mental health disorders.

MARK CREAMER
It's an interesting thing. A lot has been written about this concept of transgenerational impact of trauma. And of course, holocaust survivors are one obvious group. Veterans are another obvious group where a lot of this work has been done and it's very complicated. There's no clear answer at the moment.

JENNIFER COOK
It seems at the very heart of this PTSD is the issue of vulnerability. And Meaghan you've got some really interesting statistics about those who develop PTSD after a car accident.

MEAGHAN O'DONNELL
That's right. So a lot of my research looks at injury survivors. You know this is a particularly interesting group because injury occurs so frequently. Severe injury is one of the biggest causes of PTSD because it happens so frequently. So even though someone is more likely to develop PTSD after a rape, severe injury is one of the biggest causes of PTSD. So in terms of the kind of things that contribute to someone developing PTSD after a severe injury such as a motor vehicle accident, you know there are characteristics that the person brings in to the trauma itself. So Mark talked about this in our last episode about those kinds of premorbid vulnerabilities. But then there's the issue of the event itself. That contributes to their vulnerability. And then there are aspects about what happens after the event and I think we could just tease that out a little bit more. In terms of what keeps someone

safe or what increases someone's resilience against developing, say PTSD?

MARK CREAMER
And certainly this feeling of safety in the aftermath. I mean we are recording this program just a matter of weeks really after a massive earthquake in New Zealand in Christchurch and one of the things we're hearing is the extent of the aftershocks. That frequently, they're experiencing aftershocks. And one can't help but wonder what that does for people's feeling of vulnerability and fear of a recurrence and so on. And that's a very clear example from the natural disaster area. Of course we know the same thing happens in areas like assault, where people are in dangerous situations, fear of being assaulted again, or in military deployments. And so that sense of safety and that sense of being able to actually start the recovery process is crucial in terms of predicting adjustment.

MEAGHAN O'DONNELL
And we know that social support is a very, very protective factor. So people with good levels of social support are very, very protected. Now in situations as you say Mark, where the whole community has been affected, then people's social support aren't necessarily available to help someone through the event because those people are suffering as well. So this is when we start getting all those community impacts of surviving a natural disaster which makes it particularly difficult.

JENNIFER COOK
We saw that here very vividly in Victoria with the bushfires in 2009 where we had whole communities affected by fire.

MARK CREAMER
Exactly right. Exactly right. And so the recovery operation following those bushfires and indeed we've had some bad floods in Queensland not long ago and so on, the recovery operation needs to address a number of different levels. But the community level, the broad whole population that's affected, it needs to address the people with low level problems who might be going to see their GPs and so on and it needs to address those with more severe problems, the minority who will need specialist mental health care. And so we've developed a framework and a way of responding to these kinds of disasters that takes those three levels into account.

JENNIFER COOK
This is Up Close coming to you from the University of Melbourne, Australia. I'm Jennifer Cook. And our guests today are Meaghan O'Donnell and Mark Creamer and we're discussing posttraumatic stress disorder.
Now can you tell us about the particular challenges that soldiers face in the military. So namely it's this prolonged exposure to trauma.

MARK CREAMER
There are a range of factors associated with military service and particularly deployment to a dangerous area, a combat zone or whatever that are very, very high risk. And one of them as you mentioned is the very long duration during which time

often the person can't afford to relax. So maybe six, 12, even the American deployments sometimes even longer than that, of constantly being on alert. Constantly being on the look out for signs of danger. And you know there is some evidence to suggest that this lengthy exposure actually results in a kind of recalibration if you like of the nervous system that is very difficult to reverse sometimes when people return. So it can have quite long lasting affects. And of course the complexities of war and combat and the horrible, horrible things that happen, a lot of factors can make it very difficult. This is something that our armed forces around the world need to take account of and I have to say that in recent years they've come a long way in recognising and trying to do something about the potential mental health effects of these deployments.

JENNIFER COOK
You used that expression recalibration of the nervous system. Could you just explain that a bit more? What are you talking about?

MARK CREAMER
The research evidence is still equivocal but the theory would be that if someone spends so long with their threat detection and response system on high alert for a very long period of time, then it becomes difficult to switch it off. And so they come back to the hopefully relatively safe cities and towns that they live in with their families, and yet they're still on that state of hypervigilance and it just can't turn off. One of the things we see in many people is the sort of adrenaline junky. The idea that they constantly have to find things that are frightening. Drive fast, do dangerous activities, you know, thrilling sports and so on which may be a way of dealing with this constant hyped up, hyped up state. So we need to spend a lot of time teaching people to readjust back into society, back in Australia after the deployment. And a lot of that is about reducing arousal. It's about being able to bring the nervous system back down to a level that's appropriate for the level of threat here in Australia or in Europe or wherever it is.

JENNIFER COOK
And there are some people, and there have been studies done on people who seem to cope very well with prolonged periods of high stress say in a military situation. Tell us a little bit about that.

MARK CREAMER
Well I think the point you're making really is that there are enormous individual differences.

JENNIFER COOK
Yes.

MARK CREAMER
And what's good stress for some people is bad stress for other people. And really what that highlights is the challenge that certainly the military around the world is facing in terms of trying to select people. Trying to determine before people join

who's going to be able to tolerate high levels of stress for long periods of time. But I have to say it's a bit of a challenge, you know, we've got a long way to go before we can reliably do that.

JENNIFER COOK
And also I can imagine a scenario where you have someone who appears to cope with stress very, very well so you keep putting them in that situation with the stress. How good is that long term for that person? Do they just have a longer lead time or they eventually break down? Are we just putting too much on them?

MARK CREAMER
Well I think that's the question everybody is asking. Does everybody have their breaking point?

JENNIFER COOK
Yes.

MARK CREAMER
And I suspect they probably do. Certainly in military defence forces around the world, there are certain roles that are very much in high demand. And so there are certain elements of the defence force that keep getting deployed because they need to be deployed all the time. And we need to be asking the question, ?Yes, okay, these guys are pretty resilient but is there going to come a point at which this gets too much even for them??
So I think it's incumbent upon the defence forces to be really closely monitoring the mental health and wellbeing of these forces that are deploying regularly to make sure that we can identify the problems very early on and intervene before major damage is done.

JENNIFER COOK
Now PTSD is a very politically charged issue, isn't it Mark?

MARK CREAMER
Because it has massive implications often for governments and for big institutions like our defence forces and our emergency services and so on, and how government should respond, it is very politically charged. It can be a very kind of emotive issue about which people have very strong views. And of course I think we talked about this last week. That it's inextricably tied up with sometimes with issues of compensation and what that might mean. And I might get Meaghan to chat about this because it's more her area than mine. But there's a lot of interest now, isn't there, in compensation and recovery for trauma.

JENNIFER COOK
And indeed in our first episode we talked about how it was actually called compensation neurosis.

MARK CREAMER

A compensation neurosis, that's right, yes.

MEAGHAN O'DONNELL
Yes. And the issue with PTSD that's particularly interesting is that it's one of the only psychiatric disorders that the aetiology is built in to the diagnosis. That is, that someone has to have a traumatic event. And it's one of the reasons that lawyers like it because if someone develops depression after a traumatic event, you can't say well this person developed depression because of a traumatic event because that's not in the diagnosis. But PTSD you have to have the traumatic event to get the diagnosis in the first place. So it's because it's linked to the trauma then lawyers find it very easy to then say well therefore we can get compensation because this person has this psychiatric disorder because of the traumatic event. It's kind of neat and tidy whereas depression or - you know, it's a phobic disorder, cannot be necessarily intrinsically linked to the traumatic event.

MARK CREAMER
The big fear of course is that compensation will make people stay sick. And that's the big question. Are people staying sick because they have to hang on to their illness in order to get compensation?

MEAGHAN O'DONNELL
There is an aspect of that and also the other fear is are there processes that, in order to get compensation you have to go through that make it difficult for someone, especially someone with a psychiatric illness. And therefore that contributes to their stress and therefore that's why it's problematic. It's probably more consistent in the Worker's Compensation literature that it does seem that the compensation process leads to worse outcomes. But in terms of other compensation schemes, so across all compensation schemes, I think the question is still out there. And we need to get much better at teasing out some of the issues where compensation may or may not impact on someone's recovery.
Genuinely compensation agencies are very keen to identify what is about their processes that might make it difficult for someone and therefore, you know, can we change those processes in order to facilitate someone's recovery.

MARK CREAMER
Because we do have some preliminary data as you'd expect that the more adversarial it is, the more people have to fight, the worse the outcomes. It's kind of what you'd expect. So maybe third party insurers and so on can learn from that process and reduce the adversarial nature without necessarily feeling that they're giving away the safeguards that they need to keep in terms of making sure they're compensating people who genuinely need it.

JENNIFER COOK
I'm trying to imagine how someone who's suffering from PTSD and all the raft of nightmare symptoms that they're going through to be then faced with a bureaucratic mountain of paperwork or mine field to get through.

MEAGHAN O'DONNELL
That's right. And numerous medical assessments where they have to repeat the traumatic event over and over again to someone that they don't know and it's not a safe environment. So PTSD is one of these particular disorders where those kinds of processes are not very - you know are very detrimental to someone.

JENNIFER COOK
I'd like to ask both of you, based on your research, if you could summarise for us. Tell us, what are some of the risk and the protective factors for PTSD? What leaves us open to it and what can we do to protect ourselves from it or recover from it?

MEAGHAN O'DONNELL
Well one of the protective things we haven?t talked about is what we see in occupations that are exposed to trauma. So our emergency services, we've spoken about the military. And we also see this with media personnel who often are at least witnessing traumatic events. And what the research is showing us is that group or unit cohesion is very, very protective. And what that means is if people are getting support from their work environment - so let's say there's good support in an ambulance unit or the fireies (fire fighters) have a really good unit that's very emotionally supportive, then that is protective as well. So there are things that especially for high risk occupations, that can be very protective and that the organisations can do in order to look after their work employees.

MARK CREAMER
To take that one step further. Because social support is so important we often have to teach people how to use it which is kind of a tragedy really. But we talk about looking after mates. You look after your mate if they get shot or if they get injured or whatever, you don't think twice about it. You've got to look after your mate if he's suffering a psychological injury, or he or she is. So teaching people how to do social support is very important. I think also that we know we've talked a number of times about this issue of arousal, being very hyped up and on edge. So teaching people arousal management, how to keep their own level of uptightness low can be an important factor we hope, we think, in terms of protecting them when they go into very difficult situations.

JENNIFER COOK
Thank you both so much for talking us through this complicated disorder. But also the implications of that, what it's like to suffer from PTSD and try and move through day to day life. Thank you Meaghan and thank you Mark.

MEAGHAN O'DONNELL
Pleasure.

MARK CREAMER
Thank you Jen.

JENNIFER COOK

We've been speaking with Professor Mark Creamer and Associate Professor Meaghan O'Donnell from the Australian Centre for Posttraumatic Mental Health about the issue of posttraumatic stress disorder.
Relevant links, a full transcript and more info on this episode can be found at our website at upclose.unimelb.edu.au. Up Close is a production of the University of Melbourne, Australia. This episode was recorded on March 10, 2011 and our producers were Eric van Bemmel and Kelvin Param. Audio engineering by Gavin Nebauer. Up Close is created by Kelvin Param and Eric van Bemmel. I'm Jennifer Cook. Until next time goodbye.

VOICEOVER
You've been listening to Up Close. For more information visit upclose.unimelb.edu.au. Copyright 2011, The University of Melbourne.
