Treating Trauma – Part 1

https://www.mhpn.org.au/podcasts

Release date:	Wednesday, March 24th 2021 on MHPN Presents
Presenters:	Professor Mark Creamer, Clinical and Consulting Psychologist Dr Barbara Rothbaum, Professor, Associate Vice Chair of Clinical Research (Emory School of Medicine, Department of Psychiatry) Associate Professor Christopher Lee, Certified EMDR & ISST Trainer Dr Debra Kaysen, Clinical Psychologist & Professor (Dept of Psychiatry & Behavioural Sciences, Stanford University)

Disclaimer: The following transcript has been autogenerated and may contain occasional errors or inaccuracies resulting from the automated transcription process.

Host (00:01):

Hi there. Welcome to Mental Health Professionals' Network podcast series. MHPN's aim is to promote and celebrate interdisciplinary, collaborative mental health care.

Professor Mark Creamer (00:17):

Hi, My name's Mark Creamer, and welcome to this fourth episode in our podcast series on trauma and mental health. Over the last three episodes, we've looked at the history of our understanding of the mental health effects of trauma. We've looked at different types of potentially traumatic experiences, and different reactions to those experiences. We looked at why some people seem to be affected while others are not, and then leading on from that, we looked at the concept of resilience. In the next three episodes, we're going to focus on treatment and recovery, both from the perspective of experts in mental health, who specialise in problems like PTSD or post-traumatic stress disorder, and from the perspective of experts by experience. We're going to talk to people who have been through some pretty horrific traumatic experiences and tackle the often challenging process of recovery. In this particular episode, we're going to explore the three treatments for PTSD and related conditions that have the largest body of research support.

(01:24):

They come under the broad heading of trauma-focused psychological treatments, and we're going to talk in this episode about Prolonged Exposure, Cognitive Processing Therapy, and Eye Movement Desensitisation and Reprocessing. And to help me explore these issues, it gives me great pleasure to introduce three of the world's leading experts in these three treatment approaches, all joining us via the wonders of Skype. Barbara Rothbaum is a Professor of Psychiatry and Vice Chair of Clinical Research at Emory University in Atlanta, Georgia. She has, and I really mean this Barbara, Barbara has almost legendary status for her work in the treatment of anxiety disorders going back for a very, very long time, and especially in PTSD. And Barbara specialises in various aspects of a treatment that we call Prolonged Exposure. So, welcome Barbara. Thanks very much for joining us.

Dr Barbara Rothbaum (02:18):

Thank you, Mark. I'm happy to be here. And all that just means I'm old!

Professor Mark Creamer (02:23):

Yes. I fear that we all are, but anyway, thanks, Barbara. Debra. Debra Kaysen is a Professor at the Department of Psychiatry and Behavioural Sciences at Stanford University in California. She also specialises in the treatment of PTSD, as well as in mood and substance use disorders. And her particular clinical and research specialty in terms of a treatment approach is something called Cognitive Processing Therapy. Welcome, Debra. Thanks very much indeed for joining us.

Dr Debra Kaysen (02:52):

Thank you so much. I wish I was there in person, but this is fabulous.

Professor Mark Creamer (02:56):

Yes, for what it's worth, today is a beautiful day here in Melbourne. It's wonderful. And our final guest in this episode is Chris Lee. Chris is a clinical psychologist in private practice, and an Associate Professor in the Department of Psychiatry at the University of Western Australia. He specialises in the treatment of both PTSD and personality disorders, and he has a long-standing interest as a clinician, researcher and trainer in the third approach that we're going to talk about today, Eye Movement Desensitisation and Reprocessing, or EMDR. Welcome Chris. Thanks very much for joining us.

Associate Professor Christopher Lee (03:29):

Pleasure, Mark.

Professor Mark Creamer (03:29):

So, to kick us off today, I'm going to give each of our guests something of a challenge, and that is to give us a very brief explanation of their particular therapeutic approach to give us, if you like, the kind of essence of the treatment. So, let me start with you Barbara, and a very basic question. What is Prolonged Exposure?

Dr Barbara Rothbaum (03:50):

Prolonged Exposure? Well, in Prolonged Exposure, we ask the person to go back in their mind's eye to the time of the trauma, and recount it in the present tense repeatedly, over and over in each session, and then across sessions, and then we talk about it. The idea is that PTSD is maintained by avoidance, and so we're countering that directly with exposure. So, we're helping them confront the memory of what happened, and reminders and triggers of what happened, but in a therapeutic manner so that something changes.

Professor Mark Creamer (04:31):

And this has direct analogy, doesn't it, with the way that we might treat other anxiety disorders. If we go back to something like a simple phobia, like a spider phobia, similar kind of approach we would be using, wouldn't we?

Dr Barbara Rothbaum (04:42):

Exactly. And that's where it was developed from, that we know that anxiety and especially anxiety disorders that are characterised by avoidance, a wonderful effective treatment for them, and pretty efficient is exposure, but therapeutic exposure. So, again, asking people to confront what they're scared of but in a therapeutic manner so that it changes. They learn that what they are scared of won't happen, and that their anxiety and distress will come down while they're still confronting it. They don't need to avoid or escape.

Professor Mark Creamer (05:17):

Yeah, because avoiding, I suppose, when we avoid, the anxiety does come down and that reinforces the avoidance. It makes it more likely we'll avoid next time.

Dr Barbara Rothbaum (05:27):

Exactly. It teaches our body and our brains that the only way to control this anxiety is to get away from it, to get away from what's causing it. And when we stay with it, we learn something different. We learn that we can handle it, we learn that nothing bad happens, and that our distress goes down and we get used to it.

Professor Mark Creamer (05:45):

Can I just talk about, briefly, how it might be implemented? You talked there about talking through the event, and we might call that imaginal kind of exposure, but presumably we'll also do live, or what we sometimes call in vivo exposure, would we? Is that going to be an important part of treatment?

Dr Barbara Rothbaum (06:02):

Yes. We want people to be able to confront the memory in their imagination, and then all triggers of it in the real world, in vivo exposure. And that's where we will construct what we call a hierarchy, an in vivo exposure hierarchy. And that's just a list of situations that the person either avoids, or they endure with great anxiety, or they use safety behaviours to endure. So, for example, walking to the car from the

front door outside at night, and maybe having the keys between their fingers just in case they're assaulted, when they live in a relatively safe neighbourhood. So, it's not necessary. So, we will teach them how to do these things without the safety behaviours, and doing them over and over again and long enough for their anxiety to come down, to realise the situation is not as dangerous as their body is making them think it is.

Professor Mark Creamer (06:55):

And with your hierarchy of different situations, we're generally, I suppose, going to start with the easier ones, and we're going to gradually build up to those that are more difficult.

Dr Barbara Rothbaum (07:04):

We use what's called a SUDS, and it's basically an emotion thermometer, Subjective Units of Discomfort or Distress, where zero is no anxiety, no distress, and 100 is panic-level distress. And we'll usually start with items at about a 50. So, it causes some anxiety, but it's manageable.

Professor Mark Creamer (07:22):

Well, thanks very much, Barbara. I think you did a fantastic effort there at summarising a life's work in four minutes, so that's pretty good going. And of course, there'll be lots of opportunity to say more. Let me move on to you Debra, and perhaps ask you the same question. What is Cognitive Processing Therapy?

Dr Debra Kaysen (07:38):

So, the concept behind Cognitive Processing Therapy is that when people go through a traumatic event, it changes the way they make meaning, both about why the event happened, and the way they see themselves and the world. So, how they think about their present and their future. And so, part of what we do in Cognitive Processing Therapy is we look at the stories that they tell themselves about the event itself. Why it happened, how it could have been prevented in their mind, who's to blame? As well as the implications of the traumatic event. So, what it means for them now. Beliefs like, because this happened to me in the past, I'll never be safe. The world is dangerous, no one is trustworthy.

Professor Mark Creamer (08:19):

And then I mean, those kinds of beliefs of course are not helpful. They're going to get in the way of recovery presumably, aren't they? If we keep believing that?

Dr Debra Kaysen (08:29):

Absolutely. So, about the event itself, the problem with those beliefs is they're extremely painful, and they usually are not accurate about the event. So, if the event could have been prevented, the person probably would've done something differently. It's not helpful to say that something is your fault when it really isn't. And so having the person look at those stories that they're telling themselves, and the way that those beliefs are not accurate and are not helpful. And again, with the beliefs about present and future, it really restricts your life and it increases your suffering if those are the things that you're telling yourself.

Professor Mark Creamer (09:03):

And you would do that kind of, I guess, challenging those beliefs using, I guess, a series of, well, I guess challenging questions that people might ask themselves about, is it really true or is there evidence for it?

Dr Debra Kaysen (09:17):

Absolutely. I've had people who think that we're telling people what to think, and if you're doing the therapy properly, that's not actually what you're doing. The entire dance is through using questions to help the person create their own meaning, to have the person look at what is really true in their life. And what is elegant for me about CPT is that it has very little to do with what I know, or what I believe, and has everything to do with the client's worldview.

Professor Mark Creamer (09:47):

Absolutely. Barbara was talking there about exposure, about confronting the painful memories. Is there a place for, perhaps, writing it? I know that CPT sometimes has used writing as part of treatment. Is that an important component, do you think, to write out what happened?

Dr Debra Kaysen (10:04):

I think for some people it is, and for some people it isn't. So, there have been research studies looking at the use of a written account, writing out what happens, and at least based on the data that we have, for people who are really emotionally shut down, who are having trouble getting to the feelings about the event, for people who might be dissociating more, that writing the account can be extremely helpful, and an extremely powerful part of therapy. But it also doesn't appear to be necessary for everyone. And if you think about it, if I'm asking you curious questions to walk me through what happened, you're having to take the memory out and look at it to answer those questions. You're just doing it in smaller pieces.

Professor Mark Creamer (10:47):

Yeah, absolutely. And I hope that that's a theme we'll be able to come back to. But anyway, thank you so much, Debra. Again, a beautifully concise and understandable description there. So, thanks so much. Finally, let me transfer the pressure to you, Chris, and ask you the same question. What is EMDR?

Associate Professor Christopher Lee (11:05):

Well, let's hope I can do it as beautifully and as concise as the two previous speakers. So, in essence, EMDR involves the person focusing on the key aspects of their trauma experience, while simultaneously involved in another task. Mostly, this other task is the therapist moving their fingers from side to side, creating an eye movement process for the client. What we find in EMDR is that this process results in both a desensitisation and a reprocessing effect. In terms of desensitisation, the memory becomes less vivid and less emotional. And in terms of reprocessing, prior to therapy if the trauma memory is associated with a sense of I'm not safe, or people can't be trusted, then during the EMDR instead, the person starts to access other experiences from their life where in fact they were able to trust people, or situations where in fact they were able to be safe.

Professor Mark Creamer (12:08):

Yeah, absolutely. And I'm interested that you talk about accessing the memory while doing something else, in this case, bilateral eye movements. Do you think it could be other things other than eye movements to get the same kind of effect?

Associate Professor Christopher Lee (12:21):

Well, the research does support that certain types of tasks are going to do better on this. So, one of the theories to account for the effects is known as working memory, and trauma experiences take up a lot of capacity from our working memory, particularly a form of working memory which is our visual spatial sketch pad. So, an eye movement task or other spatial task will compete for attention with that memory that's been triggered. And it's basically extremely hard, impossible to keep thinking of your trauma experience and doing a complex visual task. So, you degrade how the trauma memory is stored.

Professor Mark Creamer (12:59):

It's very interesting, and I don't really know anything about it, but I know that people are also playing with other tasks like, I think Tetris, is that right? And seeing whether those kinds of tasks that take up a lot of this kind of working memory are also going to achieve the same effect? Would that be right?

Associate Professor Christopher Lee (13:15):

Yes, there's an explosion of interest in what types of working memory tasks might produce some, and even outside of the clinical domain. So, women who've had to have an emergency caesarian birth, it looks like if you can get them to play Tetris within six hours of their emergency caesarian, they actually are less likely to have intrusive recollections of that event in the next week.

Professor Mark Creamer (13:41):

It's extraordinary stuff, isn't it? And I would just remind the listener to be a little cautious. This is very, very early stage. We're not going to prescribe Tetris as the treatment for PTSD across the board or anything like that. But wonderful, Chris, thank you. I think that EMDR is perhaps not immediately as intuitive as the other two, but I think you explained it beautifully there, and in fact, listening to the three of you, well it's going to lead me into my next question. But before I do, I just do want to emphasise to the listener that there is a large body of rigorous outcome data that supports these three approaches. And the best place to look, I think, if you're interested in that, is the international PTSD treatment guidelines, like the Australian guidelines produced by Phoenix Australia, the UK guidelines produced by the National Institute of Clinical Excellence or NICE, and the ISTSS, the International Society for Traumatic Stress Studies Guidelines. All of those are available to download for free, we will put links to each of those guidelines on the website, on the MHPN website, next to today's podcast.

So, now I'd like to open things up a bit and see if we can move into a bit more of a discussion format. That's not easy in online panels like this, but we'll see what we can do, see how it works. So, my first question to all of you, which I've kind of hinted at already, is that these three approaches seem quite different at first sight, and yet they all seem to work. And so, I guess, I wonder if we can extract any common elements or mechanisms from these three effective treatments. Is there perhaps something

similar happening in each? And I might turn to you first, Barbara, but I'll ask Debra and Chris to just jump in whenever they like. But Barbara, any thoughts on common mechanisms across these approaches?

Dr Barbara Rothbaum (15:28):

I absolutely agree that we are trying to get people to the same place, and in some ways they're more similar than different. We just emphasise different aspects. We want people not to be avoiding. We want people to be more comfortable with reminders. We want people to have a different relationship to the trauma memory, and trauma reminders. And that's going to involve thinking about it differently, thinking about themselves differently, thinking about their world differently, thinking about the traumatic experience differently. For example, we believe our stories rather than the facts. So, I work a lot with veterans lately, and a typical story might be driving back to base, hit by an IED. Everything, Humvee fills with smoke, and Smith dies, and it was my fault because I was driving. So, if you can't even go there, then you can't possibly think about it differently. And once you go there, I mean, and I think that's all of our goals, is to have people think about it differently and it's just what we emphasise. So, we have found that by going there and asking them to go through the memory over and over, very often spontaneously after doing this, they come back and they say, it sucks that Smith died, but I don't know what I could have done differently. There were eight eyes on the road, it was the insurgents' fault. So, I do think that in some ways, there more commonalities than differences between what we're doing.

Professor Mark Creamer (17:02):

So that, what we might call, for want of a better term, cognitive change or change in the way of thinking that you just talked about at the end there, Barbara, is exactly what you are aiming for, Debra, with CPT?

Dr Debra Kaysen (17:13):

Absolutely. And, the reverse is also true. So, when people's stories change about the world, they change their behaviour, and you don't always have to assign them to go out in the world to see that kind of behaviour change. In fact, if somebody isn't changing their behaviour, I would say that I didn't do a good job for them. And so, all of a sudden, you see the person who's like, oh, well maybe the world isn't so dangerous. I'm going to go out to the grocery store when it's crowded, even though that was kind of scary for me. And so, it's what I think is so beautiful and elegant, is that we have these different pathways that help people. I think the other thing that these therapies all do is they increase affect tolerance, and that you don't necessarily have to overtly teach people to be able to sit with negative emotions in order to get them to learn that skill.

Professor Mark Creamer (18:03):

Yeah, quite. Chris?

Associate Professor Christopher Lee (18:06):

Yeah, I agree there are similarities. All involve having the person focus on the memory, and all involve having the person focus on a hotspot in the memory, the part that is like most vivid or most disturbing. That all involve having a think about, what does this memory kind of mean to you? How is it affecting your behaviours now? What does that imply about underlying thought processes, and to a certain extent all involve a stimulation of somatic experiences. So, focusing on where in the body feels

distressing. And treatments, in EMDR anyway, it generalises best when the clinician can get, those aspects are right, then the desensitisation has its best chance of working. With Debra's point about behaviour change, that also would echo my experience as well, is that often when you get these fundamental shifts in the self or the world, behaviour changes, but I think an experienced EMDR clinician would target the behaviour change if it hasn't been happening, because it should, and see what else that tells us about what needs to be desensitised or what meanings need to shift.

Professor Mark Creamer (19:15):

Sure.

Dr Barbara Rothbaum (19:16):

I'm going to add, if I may, because Mark, you said that what we're all looking for are cognitive changes, I'm going to add that we are looking for changes in our bodies as well, because those are very prominent symptoms in PTSD. And I think it's part of what makes people with PTSD feel crazy, for example, our veterans, they can know they're not in a war zone, yet their bodies are responding as if there's the same level of threat. And so what we've seen, we will conduct psychophysiological studies pre and post-treatment, and we'll see that their psychophysiological reactions to trauma reminders are decreasing as well. So, I think it all goes together, but we're aiming for a number of shifts.

Professor Mark Creamer (20:00):

Yeah, exactly. Exactly. And that process, perhaps, we used to call, perhaps we still do, habituation, but the idea, as I think Debra was saying really, about affect tolerance or about being able to tolerate anxiety, being able to tolerate bad feelings and hanging in there, and they will come down, and this idea they come down, of course. Absolutely. Okay. So, taking away from that, it seems to me that we're all agreed that confronting what happened is fundamental, and that's why I guess we call these approaches, trauma-focused psychological approaches, pretending it didn't happen is probably not going to be very helpful, and that they're all about changing the memory in this traumatic memory network in some way or form. Along with, linked to that I guess, is the idea of habituation. I'd like to move on, and I guess what I'd say is that we need to acknowledge that it's not always possible to provide treatment of the quality that we might see in the big, randomised controlled trials, that specialised treatment is not available to everyone, that it may be, even if it is available, difficult to engage people for a full dose or even at all.

(21:09):

And very often, it's going to be left to non-specialists to assist survivors of trauma. So, I wonder if any of you could have a riff on if and how much you think that we might be able to simplify, or degrade our treatments away from the rigorous formal protocols to something that non-specialists, maybe people in primary care, which is going to be much more accessible for survivors of trauma, can use. Debra, let's kick off with you. Any ideas? Can we degrade CPT, or simplify?

Dr Debra Kaysen (21:40):

I have a twinkle in my eye, because I like breaking therapies. Yes, we absolutely can. I mean, we've done work in Iraq and in Congo with teaching community health workers how to deliver CPT, and it didn't

degrade the therapy. There were some elements that we left out. We simplified things in Congo, the community we were working with had about a year and a half of education formally, so the women couldn't read or write. And so we changed the therapy so it could be memorised. And what we found, is that the therapy was still highly effective, but you have to support the clinicians. You have to support the community health workers, and that is not inexpensive. You have to provide regular supervision and guidance in that process.

Professor Mark Creamer (22:24):

But I think that's really good to know, because I do find one of the uninformed criticisms sometimes of CPT is it only works with intelligent people. And if you're not intelligent, if you haven't got good literacy skills and so on, you're never going to get anywhere. But, I'm not saying that the clients in the Congo or wherever weren't intelligent, but nevertheless, they weren't well-educated in a traditional sense. So, that's really encouraging.

Dr Debra Kaysen (22:46):

And our therapists had about a high school education.

Professor Mark Creamer (22:48):

Yeah, yeah, exactly. Exactly. That's right.

Associate Professor Christopher Lee (22:51):

Yeah, I'd like to jump in now. I mean that's amazing, Debra, because it really echoes the findings from, EMDR International Association has a humanitarian relief program that's very active in providing therapy to a large number of people delivered through local healthcare workers, and it's the same takeaway message. You can create a package that's possible for them to deliver the treatment. It appears to be effective, but support is a key. Maintaining the enthusiasm and the commitment to help in this particular way is sometimes a challenge.

Professor Mark Creamer (23:31):

Absolutely. And I think it raises questions for us, doesn't it? Even in developed, rich countries, that if we're going to ask our GPs, our general practitioners, family doctors, or community nurses, or whatever to do this stuff, you can't just give them a one-day training and walk away, that you're going to need to support them through it. Barbara, it seems to me that perhaps Prolonged Exposure is, perhaps, the easiest to understand in a simplified form because I think it's something that a lot of people do automatically. But would you say that that's right, that we can teach people to do Prolonged Exposure without having to have full-blown therapists?

Dr Barbara Rothbaum (24:02):

Absolutely. I mean, that's how most of us, so about 70% of us will be exposed to a traumatic event in our lifetime, but not 70% of us end up with PTSD, because most of us are doing therapeutic things. We're crying, we're thinking about it, we're talking about it. We're processing that emotion and

confronting the memory. It's when people avoid it that they get into trouble. I love this quote. In Australia, do you know who Mr. Rogers is? Fred Rogers?

Professor Mark Creamer (24:34):

I don't think we do actually. But enlighten us.

Dr Barbara Rothbaum (24:37):

You don't. Well, he was a wonderful man who had a children's show, and he would teach them how to deal with their emotions. I love his quote, "Anything that's human is mentionable, and anything that is mentionable can be more manageable. When we can talk about our feelings, they become less overwhelming, less upsetting, and less scary". And that's basically exactly what we do in exposure therapy. I think that smart people who are around folks who are exposed to trauma know that they need to talk about it. Smart First Sergeants will look and see somebody, after something's happened, and just check in. How you doing? That was rough out there. Tell me what's going on? The clergy is good at that. Good friends are good at that. I mean, there are a lot of people who understand at a very basic level, when important things happen to us, we need to talk about them. And it's like the grief process. I mean, the only way to the other side of the pain is through it.

Professor Mark Creamer (25:45):

Absolutely. Absolutely. I agree entirely. And that, the point you make about the military analogy there, but whether it's military or emergency services or whatever, the culture of the work environment that someone's been injured in is so important. Is it supportive? Is it cohesive? And so on. And I do think that the point all of you have mentioned really, is that the link to the normal recovery process, this really important point that we've emphasised a number of times through our series, that most people don't go on to develop long-term mental health problems. Why don't they? They don't because they're doing the things that we've just been talking about today. Wonderful. I've got to move on unfortunately, because the final thing I would like to talk about today, is the fact that these are the best treatments we've got, but the fact is that they still don't help everybody with PTSD. They certainly don't cure everybody completely. And I'm wondering what you might think about whether there's scope to adapt, or improve, or augment if you like, these approaches to make them more effective and to help them assist more people. And maybe I'll start with you this time, Chris. Do you think EMDR, is there scope to improve the way we do EMDR?

Associate Professor Christopher Lee (26:48):

I think there's some fantastic opportunities and research underway to do that. So, at the moment, we're getting about 80% of people with say, PTSD from the childhood experience and no longer have those symptoms after a course of treatment when you look at them one year later. But that's 20% who haven't, in fact, recovered. And also, with the people that have recovered, they're not necessarily symptom-free in other aspects of their lives. So, they still have relationship issues perhaps, and other things, even though they don't make PTSD criteria. So, we definitely think that we can improve it. There's three major areas of research at the moment. The first is, what is the best type of dual-attention task to do with the trauma memory? So, is finger waving and eye movement the most important, or should it be more complex and involve tapping and other spatial tasks?

(27:49):

So, working out what is optimal is certainly an area of research. The second area of research is the intensity. So, at the moment, there are studies underway comparing twice a week versus once a week. I think most people working in trauma have found that more frequent is better. A lot of the outcome studies are twice a week instead of once a week, although it's rarely been tested. There's also idea of mass therapy. So, therapy delivered within eight days over twelve seems to give the same treatment effect, and you don't get dropouts. And then the third area is, trying to individualise it a little bit more. So, what factors determine non-response to EMDR treatment? And we've got twelve likely suspects at the moment, and we're trying to, in a trial, work out which one of those best predicts, or which combination of those best predict people who don't respond.

Professor Mark Creamer (28:42):

There's a lot of exciting work going on around the place, isn't there? I'm really very impressed. Barbara, any thoughts?

Dr Barbara Rothbaum (28:48):

Yeah, the way we're modifying exposure is, one, in the timing of it. So, for example, we're doing some studies in the emergency room. The best way to treat PTSD is to prevent it if we can. And it's basically an exposure, modified exposure paradigm. The other is, one of the reasons some people don't get better from PTSD is they drop out of treatment, because it's a disorder of avoidance. So, we're also experimenting, and it's not experimenting at this point, with an intensive outpatient program model. So, we bring people in from all around the country in the US, and we treat them every day for two weeks, and we have a 90% completion rate. So, that's wonderful. I've also been experimenting with different kinds of medication that can facilitate or augment exposure. So, early on we did D-cycloserine, which is an NMDA partial agonist. I just spent a ten-day training in MDMA psychotherapy, and some of your colleagues from Melbourne, and other places in Australia were there. And it's all about...

Professor Mark Creamer (29:56):

And, MDMA. We're talking about ecstasy, in street terms?

Dr Barbara Rothbaum (30:00):

Right. And also to make the point, ecstasy is, hopefully includes, MDMA, but you don't know what it is because you get it on the street. When we're doing clinical trials, this is pharmaceutical-grade MDMA, and there have been no serious adverse events in any of the clinical trials using it. And, we think that that might facilitate people who haven't been able to achieve the level of recovery that we know is possible from standard treatment, so in a treatment-resistant population. Also, Kim Felmingham's study trying exercise to increase BDNF prior to exposure therapy. So, we think that there are a number of things that we can do, and especially based on the mechanisms, and the brain mechanisms of PTSD, and fear conditioning, and the extinction of fear.

Professor Mark Creamer (30:52):

Good. So, lots of exciting stuff happening there. Debra, what about CPT? Are there things that we might do to enhance it?

Dr Debra Kaysen (31:02):

Enhance it? Yeah, and I think the same types of directions that Barbara is talking about are some of the exciting directions in CPT as well. There's a group at Rush that's been doing mass dosing of CPT. Also, some folks at the national centres where you do therapy over a week or two weeks. Again, really impressive results and very, very little dropout. To me, I think that's one of the most exciting directions that I've seen in the field. In terms of other pieces, again, you've got that access issue and dropout issue. So, are there ways that we can make the therapy shorter? A colleague of mine just finished a pilot study where she has a one session with four booster call intervention for sexual assault survivors, where it's something that could be used very soon after a sexual assault to prevent the development of PTSD, and prevent problem drinking as well, which can be an issue. So, I think that's exciting. We'll see if it pans out over time. And then for me, it's around those issues around access to care. That's where a lot of my personal passion is. So, telehealth delivery isn't that novel anymore, but it is a way to get care to people who otherwise will never get to an academic medical centre, or to a specialist in private practice. So, can we leverage really trained providers in ways that will get more people care and also reduce dropout?

Professor Mark Creamer (32:31):

Yeah, sure. And in just a few seconds, we really don't have long, TMS Transcranial magnetic stimulation?

Dr Debra Kaysen (32:37):

There is some very exciting work with TMS combined with CPT. Absolutely. Yeah.

Dr Barbara Rothbaum (32:43):

And I'll add, combined with PE, and actually we're doing it for our veterans, we've seen enough veterans now that we know the trajectory. If people look like they're not going to achieve the full response in their second week, then we're adding TMS prior to the exposure. And the idea is it makes the brain a little bit more plastic.

Professor Mark Creamer (33:01):

All sorts of interesting stuff happening. I also like the reference that most of you make to the idea of prevention. I mean, obviously, if we can intervene early, an ounce of prevention is better than a pound of cure, especially when we don't have particularly good cures. So, that's not actually true. We've got great cures, but they're just not perfect.

Dr Debra Kaysen (33:18):

Well, you can't get the years back.

Professor Mark Creamer (33:20):

That's true. Exactly. Exactly. That's right.

Dr Debra Kaysen (33:22):

You can't turn back the clock when somebody comes to see you 20 years post-trauma. You can treat the PTSD, but you can't get them the time.

Professor Mark Creamer (33:28):

Exactly, exactly. And the longer people have it, the more it impacts on social relationships, and work, and so on. Okay, look, I would just love to keep this discussion going, and talk some more about these, they're fascinating issues, but unfortunately time has run out. We've got to draw the episode to a close. So, the important take-home message, I think, is that these three trauma-focused psychological treatments, Prolonged Exposure, Cognitive Processing Therapy, and EMDR, are currently the first-line treatments of choice for PTSD and related conditions. Now, of course, it might be that as more research is done over the coming years, maybe other effective treatments will emerge, but at this point, I think we need to be quite clear that we should do all we can to ensure that someone with a diagnosis of PTSD is offered a therapeutic dose of at least one of these three treatments.

(34:24):

But, the person of course may be offered something else alongside that trauma-focused approach. Or perhaps after that treatment has finished, if there are still some residual problems. And that's going to be the focus of our discussions in the next episode. We're going to look at medication, and the role of medication in PTSD, but also other alternative treatment approaches for PTSD and related conditions. So, I really hope that you'll join me for that episode. For now, I would like to really warmly and fulsomely thank my three guests for today, Barbara Rothbaum, Debra Kaysen, and Chris Lee, who I must say I thought were all brilliant. So, thank you very much to you all.

Dr Debra Kaysen (35:02):

Pleasure, Mark, thank you. It was so fun.

Dr Barbara Rothbaum (35:04):

It was very fun.

Professor Mark Creamer (35:06):

And there's going to be a survey link, I think, wherever you download your podcast. So, do please, if you've got the time, click on the link, fill in the survey. And not only can you tell us how much you've enjoyed, or didn't enjoy, these episodes, but you can also give us some ideas about what you'd like to hear in terms of future podcasts around mental health. Okay. I'm Mark Creamer. I hope you'll join me again for the next episode in our podcast series on trauma and mental health.

Host (35:36):

Visit mhpn.org.au to find out more about our online professional program, including podcasts, webinars, as well as our face-to-face, interdisciplinary mental health networks across Australia.