Treating Trauma – Part 2

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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 fifth episode in our series on trauma and mental health. In the last episode, we looked at the three treatments for PTSD and related conditions that have the largest body of research support. And you may remember that they come under the broad heading of trauma focused psychological treatments. We talked about Prolonged Exposure, Cognitive Processing Therapy, and EMDR. In this episode, I want to move on, and look at some of the possible treatments beyond trauma-focused psychological therapy. We're going to start off by looking at the role of medication, and we'll go on to look at some alternative treatment options. To help me explore these issues, let me introduce our two guests for this episode. Neil Greenberg is Professor of Defence Mental Health at Kings College, London and for many years was a psychiatrist in the Royal Navy. Welcome, Neil. Thanks very much for joining us.

Professor Neil Greenberg (01:12):

Very welcome. Good to be here. Thanks, Mark.

Professor Mark Creamer (01:14):

Professor Meaghan O'Donnell is Head of Research at Phoenix Australia Centre for Post-traumatic Mental Health at the University of Melbourne. Welcome, Meaghan.

Professor Meaghan O'Donnell (01:22):

Hi, thank you.

Professor Mark Creamer (01:24):

If I can turn to you first, Neil, as I said, we talked in the last episode about trauma-focused psychological treatments, but presumably medication has an important part to play in PTSD and related conditions. So, can we kick off with you giving us a bit of an overview, a bit of a riff on pharmacological treatments for PTSD?

Professor Neil Greenberg (01:42):

Yeah, well I think it's probably fair to start by saying that pharmacological treatments are not the first line treatments. I think you've mentioned in your introduction, psychological talking therapies are where you're going to start in almost all cases. But, pharmacological agents do have a role, and I guess it's easy enough to split them into a couple of different ways. First, it is, there's a few out there that have claimed to be preventative agents, so preventing people from developing PTSD. There's some out there which treat, at least treat the symptoms, and then there's another group which seemed to, claim anyway, to help make psychotherapy more effective. So, in the prevention group, the strongest evidence comes from a medication called Hydrocortisone, which is a steroid, a corticosteroid. And, although the studies that I've looked at that are pretty small in number, there does seem to be some evidence that people who get given Hydrocortisone shortly after going through a traumatic event may be less likely to develop PTSD.

Professor Mark Creamer (02:45):

Can I interrupt you there? Because you're talking about prevention. We know that psychophysiological arousal at the time of the trauma is an important predictor. So, in terms of prevention, what about other things that might bring down arousal? For example, beta blockers, is there a place for them?

Professor Neil Greenberg (03:01):

Absolutely. So, beta blockers, again, are another medication that's been claimed to reduce arousal, therefore reduce the likelihood of PTSD, as indeed have opioids as well. And I have to say though, when you look at the evidence for all three agents, Hydrocortisone, beta blockers and opioids, actually it's not particularly fantastic. We're not in a state yet where the paramedic at the side of the road is going to be delivering any one of these medications with the aim of reducing psychological trauma later on. But I think there are definitely areas worthy of further research. And of course, if we could get a preventative agent, that would be fabulous. One important caveat here, just before we move on to treatment agents, is about benzodiazepines. Now benzodiazepines don't have a role for treatment, but also there is no role for them in prevention either. So, we don't have any evidence that they're useful. I think that's

important, because in the old days, the doctor would give you a strong sedative and send you off to your bed when you've been through trauma. And actually, that's probably not such a good idea.

Professor Mark Creamer (04:04):

And probably still used a bit, perhaps in primary care?

Professor Neil Greenberg (04:08):

Absolutely. So, I think both in the UK, and I know in Australia that there is a strong, I think feeling there, I say in primary care and perhaps some non-expert mental health professionals, that giving a sedative is useful for PTSD, when in fact they're actually contraindicated. It's not just not useful, it can actually do some harm. So, I think that's a real strong message is whatever you do, don't be using benzos.

Professor Mark Creamer (04:32):

Okay. So, let's talk about treatment then. Once the person's got PTSD or something similar, what might drugs do there, or what drugs might we use?

Professor Neil Greenberg (04:39):

Yeah, so the strongest evidence there is on antidepressants, and particularly on the SSRIs, Serotonin Specific Reuptake Inhibitors, but also the SNRIs such as a medication called Venlafaxine. So, in the UK, our national guidelines, the NICE guidelines, did a big review, which they always do. And we published our guidelines at the end of 2018, so they're reasonably up to date. And there was a big debate amongst the guidelines group about whether we should just say Peroxetine, Fluoxetine and Venlafaxine, which are three particular drugs, or whether actually it was a class effect. And actually, although there's stronger evidence for one or the other, most of it relates to the fact that the studies haven't been done with all the other medications. So, we can't really be sure. And the overall feeling from the NICE group was that actually, SSRIs or SNRIs as a form of medication for PTSD?

(05:30):

They were all kind of okay, and probably you could use any one of them, even though there is some stronger evidence for one or the other. Again, second line. So, therefore people who don't want psychological therapies, or aren't suitable for them, or people who have got a lot of comorbid depression, then these medications can be quite useful. And in some people, with the right dose, quite often the dose has to be a bit higher, they can make a really useful impact on symptoms, but I wouldn't say they were curative, or they weren't treating the condition. It's unlikely, when you withdrew the antidepressant, that people would not have PTSD anymore.

Professor Mark Creamer (06:06):

Sure. You were saying they're for, perhaps, people who don't want or can't get psychological treatment, but am I right in saying that something like the SSRIs, this group of antidepressants, we can use at the same time as psychological treatment, whereas with the benzos we can't. People can be on an SSRI and be going through trauma focused therapy?

Professor Neil Greenberg (06:26):

Absolutely, absolutely. And I think in many cases, if someone's got significant PTSD or a significant depression, actually that may be well be a really good thing. Certainly in my experience, and I'm sure other clinicians will have their own, is that actually many people are quite anti-medication. So, trying to persuade them to take an antidepressant is sometimes more difficult. But they definitely do have a role, and as a second line treatment that they are absolutely well accepted, and that the evidence is definitely there.

Professor Mark Creamer (06:52):

Okay. So, I interrupted you. You were going to go on and talk about some other classes of drugs, I think?

Professor Neil Greenberg (06:57):

Yeah, so the two other ones that are most commonly quoted are low dose anti-psychotic medications, tranquillising medications, particularly there's evidence with Risperidone and also with Quetiapine, I think the UK guidance is that they should only be used by specialists. If you've got someone who's got psychotic symptoms and PTSD, then actually they're pretty good. But even in people who haven't got psychotic symptoms, if they're very disturbed, really aroused, then actually these medications do have a role to play to bring the arousal down. And actually, that might make them more able to engage in therapy and, particularly, to control symptoms sometimes when you can't actually get on and treat the PTSD. And the other medication that's commonly talked about in this group is also Prazosin, which is a medication for blood pressure, but can have helpful effects on nightmares. Do you know, it's a funny medication, because there's some people who absolutely advocate and say it's amazing, and they commonly prescribe it. And there's others who say it's not particularly good. When we looked at the evidence overall, we didn't in the UK find enough evidence to say we should recommend it. But certainly, especially in the hands of a specialist, where you've got someone with bad nightmares, I think Prazosin might have a role.

Professor Mark Creamer (08:15):

Yeah, exactly. So, even though I take your point that the research is equivocal, perhaps, I guess it does, when you're thinking about prescribing, so I'm going to ask this question actually, how do you decide for each patient, which to a certain extent it's going to be your clinical judgement, and perhaps even suck it and see, and if it doesn't work, maybe we try something else. Would that be right?

Professor Neil Greenberg (08:34):

Yeah, I mean I hope we wouldn't just start with suck it and see, but I take your point. It is absolutely trying to match what you have in your medication toolbox to the patient in front of you, and also what the patient's willing to accept. Because although, for instance, anti-psychotics in low dose can be really useful for arousal, they can also be quite sedating. So, there's some side effects there. And there isn't a medication out there that unfortunately has no side effects. So, it is a balancing act.

Professor Mark Creamer (09:00):

Exactly. And that particular class of the, we call them the atypical psychotic antipsychotics, but yes, people again often don't like taking them because of that sedative effect, don't they, is that right? They find they feel numb.

Professor Neil Greenberg (09:15):

But there's other people, again, perhaps people who've got more complex, or more chronic PTSD that hasn't responded well to talking therapy, where if you're looking about living with some of the symptoms, they can make a really useful part of a comprehensive care plan. And just saying, there's one last group of ones which are, again, said to potentially help make psychotherapy more effective. And there's kind of two contenders in this group. The one that I think has probably got the strongest evidence is MDMA, which as we know is a medication used by people outside of the doctor's surgery quite regularly.

Professor Mark Creamer (09:54):

Just to be clear, we're talking effectively ecstasy here.

Professor Neil Greenberg (09:58):

Ecstasy, absolutely, to use its more street name. And that medication, there is actually reasonable evidence, and there's also a number of good trials going on in different places around the world, certainly in Cardiff and Wales, I know the Netherlands, I'm not sure about Australia, lots done in America, looking to see whether MDMA-assisted psychotherapy is more effective.

Professor Mark Creamer (10:20):

That's right. And in fact, sorry to interrupt, but Barbara, Barbara Rothbaum was talking about this briefly in the last episode, and I guess I just make the point, or emphasise the point that we are talking here, are we not, about using, in this case, ecstasy to assist psychotherapy, not as a standalone just take ecstasy and your PTSD will be cured?

Professor Neil Greenberg (10:39):

Absolutely. It's a really important point, which I try and tell the media professionals who talk to me quite a lot, MDMA does not treat PTSD. MDMA may make psychotherapy for more difficult-to-treat PTSD more effective. And on that same piece, and again you've spoken to Barbara, D-Cycloserine is the other medication which is meant to facilitate learning. And again, there are some suggestions that if you do psychotherapy whilst giving D-Cycloserine, it can make things more effective. I think the evidence there again, is really quite equivocal, and we're not yet at a point where we can say either one of these two medications are going to make psychotherapy more effective, but there's certainly good targets for more research.

Professor Mark Creamer (11:18):

Sure, absolutely. Maybe the way of the future. The other thing I'm thinking about the way of the future that, as you say, our SSRIs, our SNRIs, were developed for depression, first and foremost they're antidepressants, and then our atypical antipsychotics, for psychosis and so on. The reality is, we don't have a PTSD specific drug at this point, do we?

Professor Neil Greenberg (11:38):

No, we don't. And actually, I've been involved in a couple, with a couple of groups who have come up with some really interesting drugs based upon GABA and other neurotransmitters, and also some based upon the immune response as well, because there is theory about the links between immune system and developing PTSD, which appear to be more specific. But again, we're a long way from many of those medications coming to the market in a way that we can, I think trial them well, or certainly prescribe them to complex cases.

Professor Mark Creamer (12:09):

Yeah, great. Okay, so let's talk a bit more about alternative treatments then. And if I could turn to you, Meaghan, I guess I'm thinking that there's increasing evidence around some alternative approaches in PTSD and related conditions. I'm thinking of things, perhaps, like mindfulness or ACT, Acceptance Commitment Therapy. I'm even thinking of more physical approaches like yoga and acupuncture. So, again, I wonder if you could just give us a bit of a riff, or talk briefly about whether we've got evidence for these kinds of approaches.

Professor Meaghan O'Donnell (12:42):

Yeah, look, I think I might start where Neil started. And that's in saying that first line treatments are our talking treatments, which Mark you've discussed in other podcasts. And so, we'd always start with those treatments. But there are some emerging treatments that I think are worth talking about. The best place to find out what treatments have an emerging evidence base is using treatment guidelines, and the Australian PTSD treatment guidelines have just been updated, and you can find those on the Phoenix Australia website. And I think that's a really useful place to start if anyone has any questions about evidence for particular treatments.

Professor Mark Creamer (13:27):

I agree, I think it's an excellent idea. And I'd also refer back to what Neil was saying about the UK NICE guidelines, the National Institute for Clinical Excellence, also another set of great guidelines. But yeah, I quite agree the Australian guidelines, and we'll put links to all three of those guidelines on the MHPN website next to this podcast episode. They're all free to download, so I'd encourage you to have a look at them.

Professor Meaghan O'Donnell (13:49):

Yes. So, look, I think let's start with mindfulness and meditation. We know this has a reasonably good evidence-base for depression and anxiety disorders. In PTSD, there's probably not enough studies for us to say it's a leading treatment intervention. There's emerging evidence to say that it's quite useful. Often

the studies in these areas are not very high quality, and I think that's where we are lacking a good evidence base. But we would say there's probably an emerging evidence base around mindfulness and meditation. There was a particularly good randomised control study looking at Chia meditation with PTSD, and that showed an equivalence with one of our first line treatments, Prolonged Exposure. So, we would say that once we start seeing really well controlled studies, we probably will get more of an evidence base in this area. Along with meditation, I think yoga is getting an emerging evidence base. Still not first line treatment, but we certainly need to do more research in that area, but it's a promising area. And acupuncture is another one where there is an emerging evidence base. And so, we do need better controlled studies, but it's looking quite promising.

Professor Mark Creamer (15:13):

And we won't go into it now, but it does raise questions about the mechanisms involved, doesn't it? And how come we've got all these quite diverse approaches that seem to be doing something.

Professor Meaghan O'Donnell (15:21):

Yeah. Well, one of the ones I really like to talk about is exercise. And I think here we've got a really lovely mechanism of why exercise might be useful, and that is that BDNF, Brain-Derived Neurotrophic Factor, which is a neurotransmitter. That actually increases when you exercise, and we know that BDNF is really useful for fear extinction learning. And at the moment, our trauma-focused treatments all use fear extinction learning as a mechanism for treating PTSD. So, there's a couple of trials happening. There's one happening that Kim Felmingham is leading in Australia, and we're involved with that too, where we are looking at whether, if you put exercise in front of Prolonged Exposure, whether you get a better treatment effect because you're prepping the body to actually extinguish the memory around the trauma. So, that's a really useful area.

Professor Mark Creamer (16:23):

Absolutely. And I guess probably, there's more and more evidence that exercise is good for mental health across the board, isn't it? That we know it helps in depression. We know it helps really for all sorts of things. So, everybody get out there and get your aerobic exercise.

Professor Meaghan O'Donnell (16:37):

Yeah, that's right. Neuro feedback's another one that's got an emerging evidence base. Again, the studies are not very strong in this area, but certainly probably worth looking at. And this is where you use EEG, or some kind of brain imaging processes, to help the individual learn to regulate their brain activity, and that kind of biofeedback can be useful. But again, there's some recent systematic reviews showing that there's an emerging evidence base around it, and we definitely need some more studies.

Professor Mark Creamer (17:14):

Yeah, sure. So, all sorts of interesting things happening, and I know that you are involved in looking at a couple of innovative treatments yourself. Can you just take us briefly through perhaps one of those?

Professor Meaghan O'Donnell (17:26):

Yeah. So, I'm really interested in, at the moment all of our leading first line treatments for PTSD, you focus on the trauma, so they're called trauma focused treatments, and you would hear about those in the other podcasts that Mark has done. I'm really interested in whether we can treat PTSD by not focusing in on the trauma specifically. So, are there other ways of accessing and improving PTSD symptoms without focusing on that trauma memory? And the reason that I'm interested in that is, that often people are very anxious and don't want to focus on the trauma memory. They find it quite aversive. And so, that often prevents people from actually engaging in the treatment. So, if we can have some other treatments that are a bit more acceptable, then maybe we can improve, decrease some of the barriers to treatment. So, I'm really interested in transdiagnostic interventions.

(18:28):

So, these are targeting, often emotion regulation processes, so helping people when they feel these strong emotions associated with PTSD, are there ways that they can down-regulate those emotions? And so, teaching emotion regulation skills, in teaching, you can teach those in a number of different ways. One of the treatments that I'm particularly interested in is one called the United Protocol, and this is one where we look at emotional learning, emotion regulation, training, increasing skills. And what we found, we've just published a very small trial looking at, specifically at PTSD, and you can see that the PTSD symptoms drop as a result of just increasing someone's emotion regulation skills. The thing I really like about this is, that the intrusive memories also drop. And so, it seems to be that even though we are targeting emotion regulations, we're not necessarily targeting the trauma memory, we get a reduction in these symptoms. So, that's really, really promising.

Professor Mark Creamer (19:42):

Quite agree. I think it is very promising, it's really interesting stuff. Although, I should say that, for the benefit of the listener, it's almost blasphemous to say that we can treat PTSD without focusing on the trauma. We've been hammering that message for so long. But it's very interesting, your point, that even if you're not focusing on it, actually the memories may be modified.

Professor Meaghan O'Donnell (20:02):

And there's different ways to skin a cat. Are we allowed to say that scientifically? I think there's different mechanisms that we can target that lead to the same end. And so, I think when we think about these emerging evidences, these emerging interventions, they are targeting different mechanisms. And so, I think that's really useful to be able to give people a range of different types of interventions to improve PTSD outcomes.

Professor Mark Creamer (20:29):

I was talking to Neil, well, Neil and I were talking a minute ago, about combining perhaps drugs with psychological treatments. Can we kind of load these psychological treatments up on top of each other? Can we do Prolonged Exposure plus mindfulness plus whatever?

Professor Meaghan O'Donnell (20:45):

Yeah. So, this is known as augmentation, isn't it? So, where you add one intervention to another to see if you get more improvements than just a standalone intervention. Look, it seems to be, we've just done a systematic review in this, and it seems to be that if you add one first line intervention to another, you don't get an additive effect. Or, if you add an intervention that's targeting the same mechanism, so, one fear extinction learning intervention with another fear extinction learning, you don't get an effect. It seems to be there's a ceiling effect. But what we have seen is if you target another mechanism, that looks promising. So, a really nice one is, it seemed to be that if you target an individual's ability to increase capacity to absorb information, so we know that PTSD is associated with poor concentration, poor memory, and if you target those areas, you do get an additive effect. So, this is why we think that Transcranial Magnetic Stimulation might be a useful mechanism here, because you are kind of increasing someone's ability to absorb information, which preps them for actually going into a talking treatment. And we are seeing emerging evidence to suggest that this could be useful.

Professor Mark Creamer (22:11):

So, people may have heard of TMS, and so yeah, we've got some studies haven't we, of TMS with CPT, which we were talking about last time, Cognitive Processing Therapy. Okay, good, good, good. Let me go on there, and take it one step further, as it were. And I'd really like you both to comment on this, but I'll start with you Neil. There's another level of strategies that I think would be hard to conceptualise as treatment in any kind of formal way, but they're still quite widely endorsed. And I'm thinking of things like pets, service dogs, or therapy dogs kind of thing. I'm thinking of things like outward bound courses, and long treks through the bush and things like that. So, what do you think? Have they got a place at all in the treatment of post-traumatic stress and so on?

Professor Neil Greenberg (22:58):

So, I think we're going to start off by saying these are not a place where we would recommend them as a first-line treatment. That's the first thing to say. But, there are a number of people who don't respond well to first-line treatments. So, they have their trauma-focused therapy, they maybe have another therapy, they have some medication, and they're still left with some pretty reasonable impairment. So, I think once you get to the position of saying, okay, I'm not thinking that in the next three months we are going to get to remission of your symptoms, and you tried lots of the more standard approaches, some of these perhaps more esoteric activities, I think, do have a place. And certainly, in terms of symptom reduction and living with your difficulties, they're quite important. We also know, don't we, that a number of who have PTSD over time improve anyway. And they improve and we're not yet clear what it is that gets people better without any intervention.

(23:55):

But actually, some of these activities may well be things that people are doing where they're finding new directions, and new meaning in their lives, and I think pets, and animals, and the outdoors may be part of that. Another way of thinking about it also, and this is to use my career in the Navy, is to think about platform and ordinance. So, a warship is not a weapon system, but it's a great place to put lots of weapons systems on. Also, if you've got an outdoor activity, or pets, or those sort of things, and you get people into a good state where people are more receptive, it may well be that actually, at that point, actually the standard therapies might be more effective. So, certainly in the UK, there's a number of,

particularly, veterans charities, who are very keen to use things like surfing and horse riding as treatments of PTSD.

(24:46):

And, I think, what we found is actually that's not really going to help. But actually when people have been horse riding or surfing or what have you, and then they have their therapy afterwards, at least anecdotally, which is a terribly unscientific way of looking at anything, I know, people seem more receptive to engage with more standard treatments. So, yeah, I think that's a useful way of seeing these things. And we shouldn't, as we sometimes do, get into a battle of saying, well, unfortunately swimming with dolphins is very nice, but it's not going to get you better, because people like swimming with dolphins.

Professor Mark Creamer (25:17):

Absolutely. And these are really complex disorders, often we're looking at, and we may well have to have complex kind of pathways to treatment. Just for the benefit of people, it was ironic talking about dogs there, you may have heard that Meaghan's dog was barking in the background there. It's all part of recording live.

Professor Meaghan O'Donnell (25:36):

And she's making a claim for dogs being good for your mental health, I think that was her point. Look, I totally agree with Neil, that focusing in on someone's wellbeing is useful for their mental health. And so dogs, I think exercise, diet, all these things are good for your wellbeing. That helps your mental health, and that ultimately is useful for PTSD symptoms. It doesn't mean that that's the only treatment that you do, and we always recommend first line treatments, but for those, especially people with resistance, treatment resistance, alternate approaches can be very useful.

Professor Mark Creamer (26:15):

I used to have one of my clinical mentors way, way back in the distant past, he used to say that it's very easy to make someone feel better, it's very difficult to make someone get better. And I think sometimes we're a bit dismissive about this idea of helping someone feel better. Actually, that's pretty important.

Professor Meaghan O'Donnell (26:31):

And, I think those maintenance models are really useful. So, it might be that someone's going to have persistent symptoms for the rest of their life and can we actually, like a service dog might be very useful in these situations, if it helps them engage in life, they can get to the shopping centre, they can actually do things they couldn't actually do before. I think that's really, really useful. So, there's a role.

Professor Mark Creamer (26:56):

Absolutely.

Professor Neil Greenberg (26:56):

Can I just jump in there? The thing, and I completely agree, we're singing off the same song sheet, the danger of these therapies I think isn't that the therapy themselves is likely to necessarily cause harm, but certainly in the UK there is, a lot of these therapeutic providers who provide these esoteric therapies will do it tomorrow. Whereas, if you're going for a mainline standard treatment, that's going to take two, three months before you get there, and you've got someone who's desperate for some intervention, and what happens is they're going to treat the thing tomorrow over the thing they have to wait a few months, and then if the thing tomorrow doesn't work, because the dogs were nice but I didn't get better, you then get to this state of sort of therapeutic nihilism, that I can't be helped. And so then you get into this really unhelpful situation, where people can have a chronic condition that could have been treated. So, I think, like Meaghan says, we have to work together with these different groups, and not trying to say you are wrong and we are right, otherwise we're not going to help the people with the problems.

Professor Mark Creamer (27:49):

Absolutely. But we also, perhaps, need to gently modify some of the expectations that some of the proponents might put on it, that this is a fantastic cure of PTSD when you say, well no, the data don't say that. That's not, yeah.

Professor Meaghan O'Donnell (28:02):

Yeah, but also I think we need research. So, there's a particularly nice study that was published in a high impact journal looking at service dogs, and it did show that, relative to usual care, service dogs improve PTSD symptoms. I think that we just need better research too, to work out when it's useful to have these alternate treatments. So, I think it's not just about making people feel better, we also need to make sure we have research to support this.

Professor Mark Creamer (28:39):

Yeah, no, I agree entirely. I agree entirely. Which leads me nicely on to the next thing I wanted to ask you, is actually the final part of our discussion today, which is about people like us in inverted commas, are often asked to provide advice about which treatments should or shouldn't be funded, for example, by government or by third party insurers or whatever. So, I'm wondering, what kinds of criteria you would be looking for when you make that decision, when you provide that advice, and either of you want to jump in first, then?

Professor Meaghan O'Donnell (29:08):

The first thing is, has the person tried evidence-based treatments? And if there's evidence of treatment resistance, I would be asking, is there harm associated with this alternate intervention, or this new intervention? If it looks like there's no harm, and it looks like we might be able to improve someone's wellbeing, and we feel that focusing on their wellbeing is useful, then I think that we could think about funding a particular intervention. But it has to be a sequence that you go through. You really want to know that this person has tried at least one or two evidence-based treatments.

Professor Mark Creamer (29:52):

Yeah, that's an important point. Anything you'd add, Neil?

Professor Neil Greenberg (29:55):

Well, I'd agree with that. So, in the UK, we have so many of these veteran charities. We came up with what we called safe and ethical practice guidelines, which is very different to evidence-based treatment guidelines. But what we want is, that the organisation providing these kind of esoteric therapies to at least not try and say, oh, you mustn't go and get anything else, because we've got it right. They must do risk assessment, they must have basic clinical skills. They must keep the family doctor, the general practitioner informed of what's going on. And so, if they play nicely, so to speak, and as Meaghan said, we've tried all our standard treatments, I think absolutely, let's support that on an individual case basis. But, I do think that if people do make a gradual recovery, I don't think we should ever get away from the fact is that a, three or four years later, another course of evidence-based therapy, when they're in a better place to be receptive to it, perhaps may make a difference when it didn't before.

(30:50):

And the other thing to add into it is also this idea about work. And I don't think we speak about work enough, because what often happens is, if you've got your PTSD in an occupational setting, you then get pensioned off for, until you're 67 or what have you. And I don't think that's very useful, even though it's nice to have the money. So, I think that the key point of the care coordinator is obviously to make sure the dog's there, but is to make sure that actually, people's holistic care is looked at, not just they enjoy going surfing, swimming, or whatever else they're doing with dogs or animals.

Professor Mark Creamer (31:26):

I think that point that you made at the end there, Neil, about work is really important. I agree entirely that we don't spend nearly enough time talking about work, and the importance of work, or the importance of having meaningful activities in your day, and so on, and how important that is just for mental health and recovery.

Professor Neil Greenberg (31:43):

Yeah. Well, perhaps one piece I would say on that is, we've got a few studies looking, again, this is in veterans who have had treatment for various mental health problems including PTSD. And actually, what we often see is, before their PTSD symptoms get a lot better, actually their functionality improves. So, we use the work on social adjustment scale as one measure, and actually they become more functional. Once they become more functional, and then their self-esteem improves, actually, they're much more able to engage with their therapy. So, I think these nice-to-have esoteric bits, which work, I would say, is a key part of, I think we shouldn't just see, we need to treat just your symptoms, we need to treat the whole person, which as you say, includes meaningful activities, ideally including work.

Professor Mark Creamer (32:23):

Yeah, absolutely. Perhaps, giving more thought to whether someone is at the best place to start evidence-based treatment, whether there's some pre stuff that we should be doing to stabilise them, to

improve functioning, to improve their emotion regulation, whatever. Yeah. Alright, it's clear that, for some people at least, medication is an important addition to trauma-focused treatment for PTSD, and in some cases may be used instead of a psychological kind of treatment. We know that there are several other approaches that seem to be helpful to some people some of the time, and I think that this highlights the point that both Meaghan and Neil have made, I think, the importance of tailoring treatment to the individual. We really don't have treatments that we think, that we know, are going to work for everybody. So, if the first line treatment doesn't seem to be very effective, we need to be comfortable branching out a little bit.

(33:17):

Equally, I think that both Meaghan and Neil made the very important point that we have a responsibility to ensure that people with PTSD and related conditions are offered a therapeutic dose of a first-line evidence-based treatment, with medication of course, if that's appropriate. So, we really do have an ethical obligation, I think, to ensure that people have access to these treatments, but that does not mean that they can't be offered other interventions and support, maybe concurrently with the main treatment, or as an adjunct, or perhaps even subsequently, especially if, as we were saying, if there are residual symptoms, they perhaps haven't responded especially well to treatment. In our next episode, which is the final one in this series, we're going to be talking to more experts, but this time we're going to be talking to experts by experience. We're talking to three people who've experienced very different types of traumatic event, and they'll be talking to us about their recovery. I'm looking forward to that one enormously. But for now, thank you very much again to Neil Greenberg and Meaghan O'Donnell.

Professor Meaghan O'Donnell (34:25):

Thank you. It was a pleasure.

Professor Neil Greenberg (34:26):

Pleasure's mine too.

Professor Mark Creamer (34:28):

And don't forget that wherever you got your podcast, you should find a link to a survey which will enable you to give us some feedback, not only about these episodes that you've been listening to, but also ideas for what you'd like to hear, in terms of future podcasts around mental health. I'm Mark Creamer, and I hope that you'll join me for the next episode in our podcast series on trauma and mental health.

Host (34:52):

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