Treating Trauma: How to Improve Client Engagement, Retention, and Outcomes

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Accuracy, Utility, and Risks Statement

This presentation discusses strategies for engaging clients in trauma treatment, in a way that aims to increases retention, maximize value-based outcomes, use shared decision making, improve therapist conceptualization, and that uses routine outcome monitoring.

This presentation is not a training for how to use specific evidence based modalities for treating PTSD/trauma such as EMDR, PE, or CPT, but rather a supplement to increase the effectiveness of these modalities. Misapplication of these materials by individuals not trained in the delivery of evidence based therapy for trauma could be a risk to the wellbeing of the client.

In order to benefit clients who have trauma, a therapist is ethically obligated to understand how trauma impacts someone’s biology, behavior, and psychology, how to relationally align with the client, and know how to competently deliver trauma informed and evidence based therapies.

Program Notices

Conflicts of Interest:

None.

Commercial Support:

None.

Agenda

- Introduction: Shared decision-making, building commitment, and conceptualization matter
- Using psychoeducation as part of pretreatment shared decision-making
- Mapping neurobiology model to different EBT's
- Case vignettes and practical conceptualization
- Q&A

Shared decision-making and psychoeducation: Why is this necessary?

Initiation is low and dropout is high

- 66% received treatment,
- 25% received an adequate dose
  - (Spoont, Murdoch, Hodges, & Nugent, 2010).
- When offered CPT or PE, 82% initiated
- 38.5% dropped out
- 25% did so before session 3
  - (Kehle-Forbes, Shannon, et. al., 2016).

Treatment Dropout Rate Data (controlled trials)

- American: 18.2% aggregate (Imel, et. al., 2013)
- Australian: 20.9 % (Varker, Tracey, et. al., 2018)
- American Veterans: 24.2% aggregate (Edwards-Stewart, et. al., 2021)
  - 27.1% when trauma-focused

Nuances in 2013 study:

- No differences between types of treatment when Trauma focused
- Present Centered Therapy has slightly lower dropout rates
- Imel, et. al., 2013)

Interpret with caution!

- PCT is not the most practical
- Designed for experimental research
- Focuses on common therapeutic factors
- "PCT, like all forms of therapy, is designed to enhance a sense of mastery. This is facilitated by psychoeducation about PTSD symptoms and an emphasis on identifying how these symptoms may influence and/or interact with current emotions and difficulties" (Shea, 2023)

What about real-life? (non-controlled settings)

- A higher range:
    - 38.5% (Kehle-Forbes, Shannon M, et. al., 2016)
    - 44% (Wang, etl. al., 2005)

Why is initiation so difficult and dropout so common?

What motivates higher initiation and completion rates?

Here's what the data says:

Treatment Initiation: What Helps

- Correlations to improved initiation (Larsen, et. al., 2024):
  - Detailed Information
  - Metaphor & Visual Aids
  - Patient perception of clinician
- Self-reported reasons (Watts, et. al., 2016):
  - More/better information

Treatment Initiation: What Hinders

- Negative Beliefs
- Misconceptions
  - Hessinger, London, & Baer, 2018

The Need for Shared Decision-Making

- Aid developed by VA
- Focused on individualized psychoeducation, treatment options, goal-setting, and informed consent
- Significantly increased rate of initiation
- Significantly increased speed of initiation

- Hessinger, London, & Baer, 2018

Treatment Completion: What Helps

- Correlations (Alpert, Hayes, Barnes, Sloan, 2020):
  - More expressed emotion

Treatment Completion: What Hinders

- Correlations (Alpert, Hayes, Barnes, Sloan, 2020):
  - Higher physiological impact/arousal
  - More overgeneralized beliefs
- Self-reported reasons (Browne, Kendall C, et. al., 2021):
  - Concerns about treatment efficacy

Conclusion/TLDR about the data:

- Many different evidence-based modalities work
- Despite lower drop-out rates of PCT in controlled settings, trauma-focused therapies are more practical in non-controlled clinical settings
- Trauma-focused therapies are exceptionally uncomfortable and difficult to complete for patients
- Shared decision-making is a key to improved initiation and completion

- **Most important factors in shared decision-making**:
  - Individually conceptualized psychoeducation about PTSD
  - Strong rationale and understanding of treatment options
  - Informed consent
  - Strong working alliance

Ethical and Practical Implications:

- Ethical obligations:
  - Informed consent
  - Do no harm (don't accidentally make things worse)!
  - Competency
- Practical:
  - Pretreatment can't be skipped
  - Quality psychoeducation and conceptualization helps patients and help therapists

Using psychoeducation as part of pretreatment shared decision-making

Kara Harmon, PhD

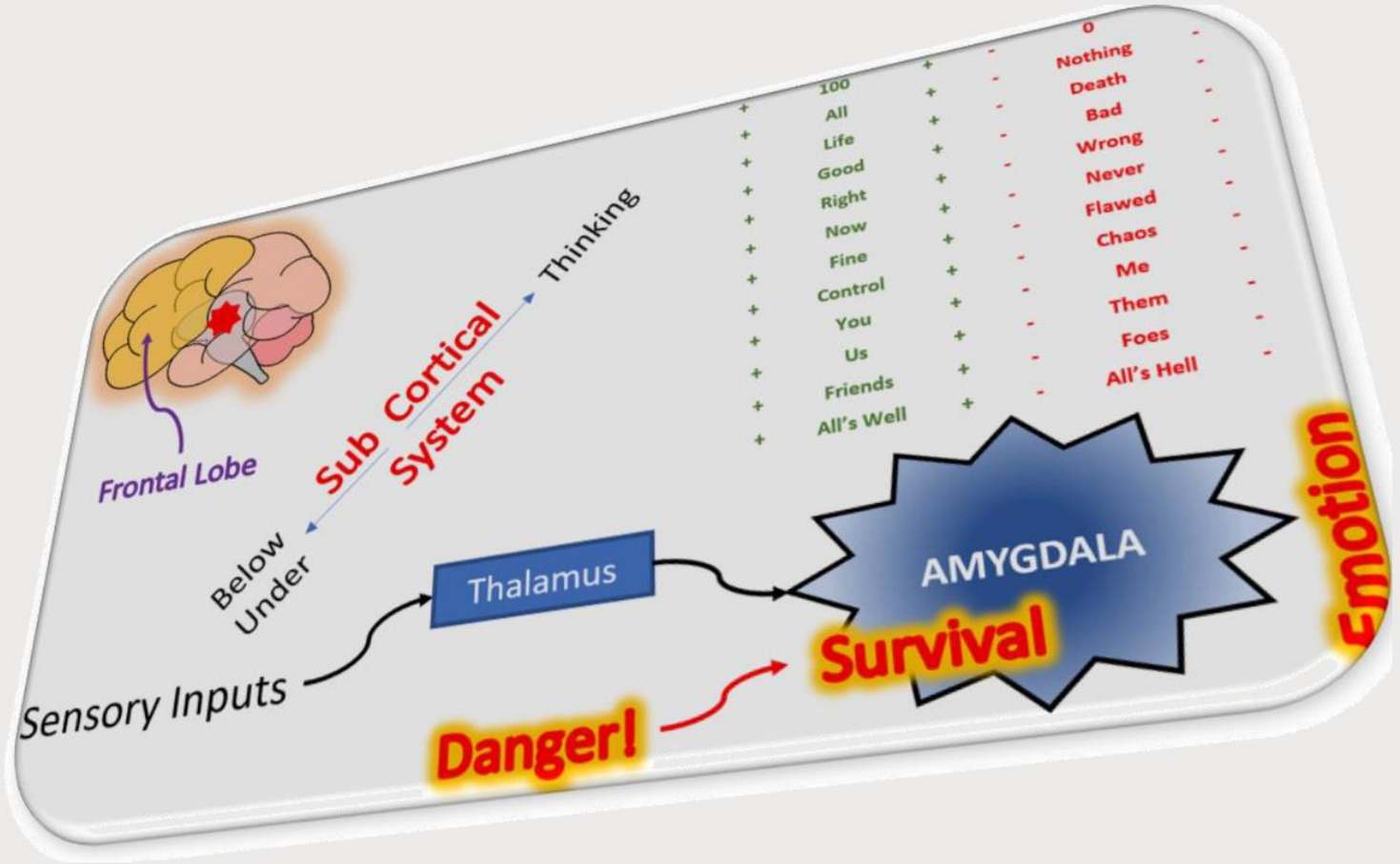
My primary aim is to train clinicians to more effectively deliver EBTs for PTSD/trauma

- Increase retention
- Maximize value-based outcomes
- Use shared decision making
- Improve conceptualization and
- Use routine outcome monitoring

so clients can engage, complete, *and* benefit from evidence-based interventions for PTSD/trauma!

Tools to Enhance Conceptualization:

Psychoeducation of the Impact of Trauma on the Brain and Body



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Mapping neurobiology model onto Evidence Based Treatments

A note on diversity:

- Most research on American Veterans (limiting)
- What causes PTSD is different for everyone
- Discrimination can be traumatic and more complex than discreet events
- Really knowing and accurately conceptualizing your patient and tailoring treatment to the individual is key

PROLONGED EXPOSURE (PE)

- Recovery happens by approaching feared, yet objectively safe, stimuli through a process of exposure and habituation. By activating emotional responses during exposure, clients can learn that:
  - Memories and reminders of the trauma, while distressing, are not inherently dangerous.
  - Feelings of distress are temporary and naturally subside over time.
  - Physiological reactions, like a racing heart, are not harmful or life-threatening.
  - They possess the capacity to tolerate and manage negative emotions effectively.

COGNITIVE PROCESSING THERAPY (CPT)

- Clients are asked to provide a written narrative account of the trauma they experienced and then identify a list of "stuck points," or unhelpful beliefs about themselves, others, or the world, that they developed from the trauma.
- Stuck points are related to safety, trust, power/control, intimacy, and esteem. They influence avoidance-based "safety behaviors," which in turn reinforce the unhelpful beliefs, keeping the client "stuck" in trauma-based living.
- The main intervention is through written worksheets, which are meant to restructure beliefs in hopes of increasing approach-based behaviors.

EYE MOVEMENT DESENSITIZATION AND REPROCSESING (EMDR)

- During an EMDR protocol, clients are asked to recall the traumatic memory and described associated cognitions, emotions, and bodily sensations
- Once the memory network of the trauma is activated, bilateral stimulation (BLS) is applied
  - Debate in the field on the mechanism of action. Adaptive Information Processing (AIP) model originally suggested that EMDR removes obstacles that keep brain from effectively "processing" stimuli (e.g., shifting it from "present" to "past" experience).

Case vignettes and practical conceptualization

PRACTICAL APPLICATION

- The following two vignettes represent some common presentations of clients with PTSD.
- We will explore how the model described today would apply to each of these individuals in treatment
- Remember: The most important factors in shared decision-making are:
  - Individually conceptualized psychoeducation about PTSD
  - Strong rationale and understanding of treatment options
  - Informed consent

VIGNETTE #1

Clara is a 27-year-old white cisgender bisexual woman who was assaulted by a male acquaintance at party three years ago. Since the incident, she describes her life as being in a constant state of vigilance. “I feel like I can never relax,” she says during therapy. At work, her performance suffers because she is hyper-focused on the exact whereabouts of her male coworkers to the point where she cannot sustain attention on her own tasks.

Her nights are restless. She wakes up drenched in sweat, with nightmares whose content represent aspects of the assault. As a result, she avoids sleeping altogether some nights, leaving her exhausted and irritable during the day. Clara avoids social events, particularly those where alcohol might be present, fearing a loss of control or "letting my guard down." She also feels a deep sense of shame and often isolates herself, convinced that others can sense her “brokenness.”

Clara often experiences panic, triggered by seemingly benign things like certain music or the sound of men's voices. Clara says her body betrays her; her heart races, her hands shake, and her stomach churns without warning throughout her week. "Sometimes I feel like I'm going crazy," she admits. She also experiences feelings of numbness and detachment, describing days where she feels like she's "just going through the motions" and unable to connect emotionally with loved ones.

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VIGNETTE #1 Individualized Treatment Options

- CPT
- PE
- EMDR

VIGNETTE #2

James is a 38-year-old cisgender heterosexual Asian American Army veteran who served multiple tours in a war zone. Since returning home, he finds it nearly impossible to re-integrate into civilian life. "It feels like the war never left me," James confesses during a support group meeting. He experiences intense nightmares of combat, often waking up shouting or swinging his fists, convinced he’s still on the battlefield.

Crowded places, like grocery stores or sporting events, make him feel trapped and on edge. He avoids them altogether, explaining, "I can’t help scanning every face, every corner, looking for a threat." Unexpected noises, like a car backfiring, send him into a state of panic. He freezes or looks for cover, even though he knows logically he’s no longer in danger.

James also struggles with a pervasive sense of guilt. He blames himself for the loss of fellow soldiers, saying, "I should’ve done more to protect them." This guilt contributes to bouts of depression and angry outbursts, which have strained his marriage and friendships.

He describes feeling emotionally numb, like a “shell” of who he used to be. "I can’t connect with my kids or my wife anymore," he shares. "They don’t understand why I can’t just move on." This disconnection leaves him feeling isolated and hopeless, unsure if he’ll ever reclaim a sense of normalcy.

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VIGNETTE #2 Individualized Treatment Options

- CPT
- PE
- EMDR

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- REFERENCES

Alpert, Elizabeth et al. “Predictors of Dropout in Cognitive Processing Therapy for PTSD: An Examination of Trauma Narrative Content.” *Behavior therapy* 51.5 (2020): 774–788. Web.

Browne, Kendall C et al. “Veterans Self-Reported Reasons for Non-Attendance in Psychotherapy for Posttraumatic Stress Disorder.” *Psychological services* 18.2 (2021): 173–185. Web.

Edwards-Stewart, A., Smolenski, D.J., Bush, N.E., Cyr, B.-A., Beech, E.H., Skopp, N.A. and Belsher, B.E. (2021), Posttraumatic Stress Disorder Treatment Dropout Among Military and Veteran Populations: A Systematic Review and Meta-Analysis. *JOURNAL OF TRAUMATIC STRESS, 34*: 808 -818. https://doi.org/10.1002/jts.22653

Hill M. D. (2020). Adaptive Information Processing Theory: Origins, Principles, Applications, and Evidence. *Journal of evidence-based social work (2019)*, *17*(3), 317–331. https://doi.org/10.1080/26408066.2020.1748155

Imel, Zac E et al. “Meta-Analysis of Dropout in Treatments for Posttraumatic Stress Disorder.” *Journal of consulting and clinical psychology* 81.3 (2013): 394–404. Web.

Kehle-Forbes, Shannon M et al. “Treatment Initiation and Dropout From Prolonged Exposure and Cognitive Processing Therapy in a VA Outpatient Clinic.” *Psychological trauma* 8.1 (2016): 107–114. Web.

Landin-Romero, R., Moreno-Alcazar, A., Pagani, M., & Amann, B. L. (2018). How Does Eye Movement Desensitization and Reprocessing Therapy Work? A Systematic Review on Suggested Mechanisms of Action. *Frontiers in psychology*, *9*, 1395. https://doi.org/10.3389/fpsyg.2018.01395

Larsen, Sadie E et al. “Patient Experiences in Making PTSD Treatment Decisions.” *Psychological services* 21.3 (2024): 529–537. Web.

Shea, T. (2023). *Present-Centered Therapy for PTSD - PTSD: National Center for PTSD*. Www.ptsd.va.gov. https://www.ptsd.va.gov/professional/treat/txessentials/present_centered_therapy.asp

Spoont, M. R., Murdoch, M., Hodges, J., & Nugent, S. (2010). Treatment receipt by veterans after a PTSD diagnosis in PTSD, mental health, or general medical clinics. *Psychiatric Services, 61*, 58–63. http://dx.doi.org/10.1176/ps.2010.61.1.58

Varker, Tracey et al. “Dropout from Guideline-Recommended Psychological Treatments for Posttraumatic Stress Disorder: A Systematic Review and Meta-Analysis.” *Journal of affective disorders reports* 4 (2021): 100093-. Web.

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States:

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