Overcoming Trauma

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In recent years, one in every eight Poles has been involved in a road traffic accident. In the aftermath, many are affected by symptoms described by psychologists and psychiatrists as posttraumatic stress disorder (PTSD). Psychologists study the mental wellbeing of people who have been involved in such accidents, and also provide therapies helping them resume their normal activities

The World Health Organization (WHO) estimates that each year, 1.24 million people are killed and at least 20 million are injured in traffic accidents. In the coming 15 years, such events are likely to become one of the leading causes of death and the main cause of PTSD in countries not involved in armed conflict. In Poland, as motor transport continues to develop, the frequency of accidents is reaching an apocalyptic scale. Over a dozen people die on our roads every day, and over 100 are injured. Participants in accidents require medical assistance, as well as psychological support aiming to reduce or eliminate posttraumatic stress.

It's a war out there

During the 12 months following a traffic accident, almost a quarter of victims are diagnosed with some type of mental disorder. They most commonly present with symptoms of acute stress disorder (ASD); if the symptoms persist for over a month, they fall under the category of PTSD. Symptoms include reexperiencing and involuntary recurrent thoughts about the traumatic event, avoidance of memories of the event, a sense of numbness, change in mood and in beliefs about oneself and the world, negative thoughts about oneself and the world, hyperarousal and heightened emotional responses. The symptoms cause sufferers ongoing distress, poor performance at work (or, in children and students, difficulties with learning), and worsened social relationships presenting as issues such as conflict within the family. Although PTSD may last just a month, it can also persist for the rest of the sufferer's life, as has been observed in many war veterans. In around half of all patients, PTSD symptoms gradually recede over the period of around two years, although if this does not happen, the likelihood of natural remission drops radically. There is also the risk of secondary problems, such as depression, personality disorders addiction to substances (such as alcohol); related problems may hinder and complicate any future therapy.

Research conducted in Poland and around the globe indicates that chronic PTSD affects around 10% of participants in traffic accidents, with perpetrators suffering less frequently than victims. However, problems frequently go undiagnosed. Patients visiting doctors generally describe their symptoms selectively, noting anxiety problems or trouble sleeping while omitting other symptoms which might help the clinician diagnose PTSD. This forms a part oftheir general avoidance of recalling the event, which means that as well as not seeking appropriate help, there is a high likelihood of symp-

toms going undiagnosed. As a result, many victims of traffic accidents are at risk of being persistently affected by PTSD. This means that psychiatrists and psychologists should not just continue to study the underlying foundations of such disorders, but – first and foremost – they must strive to develop effective methods for treating posttraumatic disorders.

The TRAKT program

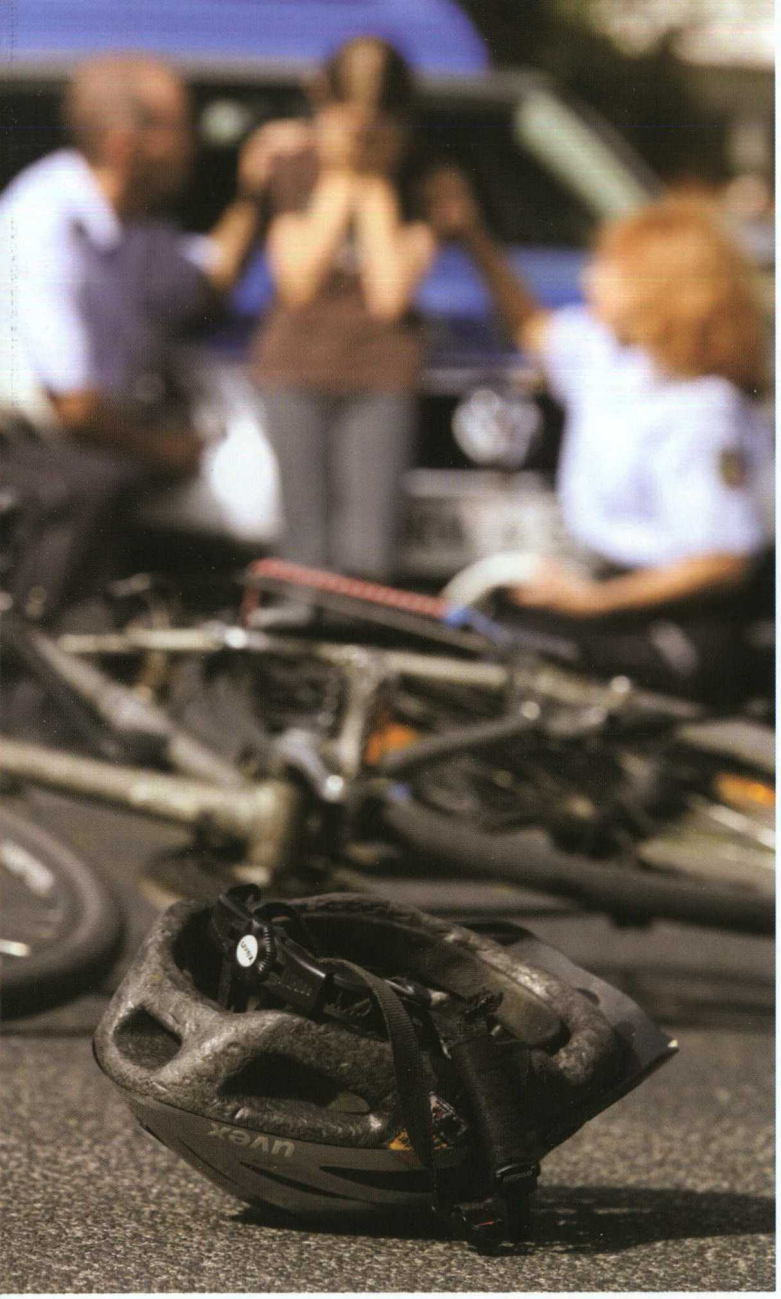
Our team at the University of Warsaw has created a research and treatment program, named "TRAKT," providing support to victims of traffic accidents. The treatment strives to improve the patient's quality of life by reducing PTSD symptoms and the distress that goes with them. The indirect aim of the program is to prevent long-term personal, social, and economic effects of symptoms associated with chronic PTSD. Contemporary treatments can be divided into psychosocial methods including various forms of psychotherapy, in particular cognitive-behavioral therapy, and pharmacological treatments, mainly selective serotonin re-uptake inhibitors (SSRIs). Around 70% of people who complete a course of standard therapy go into remission. Reports on the standards of PTSD treatments indicate the need for continuing studies into the efficacy, effectiveness, and cost-efficacy of different types of treatment. As such, the TRAKT program had a research dimension, aiming to compare the efficacy of various therapies, alongside the practical side of providing treatments whose effectiveness had been confirmed in studies conducted in other countries.

The TRAKT program was financed by the Financial Mechanism Committee established by Iceland, Liechtenstein and Norway through the EEA Mechanism and the Polish Ministry of Science and Higher Education (PL0088), and aimed to test and compare the efficacy of pharmacological therapy, psychotherapy, and treatment combining both these methods. In the "psychotherapy arm" therapists used prolonged exposure (PE) cognitive behavioral therapy devised by Prof. Edna Foa, a leading specialist in the treatment of PTSD. The method eliminates stress responses by means of interventions derived from knowledge about instrumental conditioning processes and cognitive and emotional processing of memories of the traumatic event. The standard course of treatment includes eight to twelve weekly sessions lasting an hour and a half, held over a period of around three months. In the study we used paroxetine (an SSRI routinely used to treat depression and anxiety disorders), also administered over a course of three months. This is a sufficient time to reach the desired therapeutic effect, and makes the patient group directly comparable with that receiving PE. Finally, combined therapy involved the concurrent use of medication and psychotherapy.

As in classic experimental studies, victims of road traffic accidents diagnosed with PTSD were randomly selected to one of three treatment groups. This process, different to that generally used in clinical studies, revealed a hidden side of pharmacological treatment: almost 50% of patients assigned to the pharmacotherapy group refused to take the drugs and participate in further studies (in comparison, in the psychotherapy group the figure was below 5%). We found that the main reason given by the patients for refusing to take medication was a belief that this form of treatment is not effective. Our findings correspond to a fairly common phenomenon of patients stopping their pharmacotherapy in spite of their doctors' recommendations; however, it is difficult to say whether this occurs more frequently in Poland than other countries. Of the patients who completed the course of psychotherapy, over 80% ended treatment in remission of their PTSD symptoms; in the patients treated with pharmacotherapy, the figure was just slightly over 55%. We also found no advantages of combined therapy over psychotherapy alone.

Who benefits?

The main factors that had a negative impact on the efficacity of all the therapies we tested were interrelated variables including severe intensity of PTSD symptoms (especially avoidance), age (middle age and above), severity of symptoms characterizing personality disorders, low briskness (a temperamental trait reflecting behavioral plasticity), and time elapsed between the accident and commencing therapy (key period – longer than a year). Age, elapsed time, and severity of symptoms are typical clinical variables; remission of symptoms is less likely in older patients (lowered behavioral plasticity), those in a worse mental condition, and those who delay the start of treatment (which increases the risk of developing personality disorders).



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Patients whose PTSD symptoms persisted in spite of completing the course of therapy were offered an opportunity to continue treatment using a method they were not previously assigned to but one that is potentially effective (such as psychotherapy instead of pharmacotherapy). In this group, almost two thirds of patients completed the program in remission, raising the overall effectiveness index to close to 90%. The patients who did not recover were characterized by the same variables responsible for the ineffectiveness of the first round of therapy.

The results seem to support the use of psychotherapy to treat PTSD, although the therapy should be adapted to the specific mechanisms responsible for the persistence of the symptoms rather than following "general" methods still commonly used by therapists.

Shifting the boundaries

Data on ongoing treatment suggests that it is possible to achieve remission in patients who still met the diagnostic criteria of PTSD following the first round of therapy. More research is needed, including into the significance of the duration and modification of therapy methods beyond standard procedures. One of the key ways of boosting effectiveness may be devising personalized treatments by selecting methods and durations specific to the patient's symptoms, traits, and preferences. One of our first goals is to devise a program of cognitive (mono)therapy for the treatment of PTSD, equivalent to prolonged exposure, that might allow therapists to select the most appropriate methods for their patients. The prevalence of traumatic events, in particular traffic accidents, means that victims should be offered therapies with an empirically proven efficacy and effectiveness. This requires research yielding results that can be used in everyday therapeutic practice, resulting in an ever broader understanding, the development of improved treatment methods, and therapists providing direct benefits to patients.

Over 300 patients received such treatment as part of the TRAKT program. We have also trained almost 200 specialists in the PE method (verified to be effective under Poland's conditions) who are now able to offer it to PTSD patients. It should be stressed that the method is not restricted to any specific type of trauma experienced by the patient; although we focused on victims of traffic accidents, research conducted elsewhere has concerned treating PTSD in war veterans and survivors of rape and domestic violence. Given our awareness of the immense consequences of traumatic events for the mental wellbeing of trauma survivors, the advancement of such research is vital. As such, ongoing studies are of fundamental importance, since they will serve to help the broader public through the dissemination of results and the implementation of improved therapeutic methods in clinical practice. ■

Further reading:

Strelau J., Zawadzki B., Kaczmarek M. (2009) (eds.). *Konsekwencje psychiczne traumy: uwarunkowania i terapia* [Psychological Consequences of Trauma: Factors and Therapy]. Warsaw: Scholar.

National Institute of Clinical Excellence (2005). *Posttraumatic Stress Disorder: The Management ofPTSD in Adults and Children in Primary and Secondary Care.* London: National Collaborating Centre for Mental Health (http: //guidance.nice.org/CG26).