【Articles】

Prolonged Exposure Therapy for Patients with PTSD in an Outpatient Clinic

Naoyasu Motomura, Akiko Wakabayashi**, Yasuo Kawabata**

* Department of Psychiatry, Faculty of Nursing, Osaka Medical College
**Department of Neuropsychiatry, Osaka Medical College

(Received December 25, 2016)

We conducted prolonged exposure therapy (PE therapy) for Japanese PTSD patients and examined the effect. The results suggest that PE therapy is effective both PTSD symptoms and depressive state and PE therapy is also effective for Japanese PTSD patients. As the number of subjects is limited in the present study, further examinations are critical in the near future.

Key words: PTSD, depression, PE therapy, outpatients clinic

I. Purpose

Trauma focused cognitive behavioral treatment (CBT) is recommended with substantial clinical confidence in treatment guidelines for post traumatic stress disorder (PTSD). And this treatment is considered a first-line treatment for PTSD (1). Among trauma-focused CBT, exposure therapy has the largest number of randomized clinical trials demonstrating its efficacy across various trauma populations(2,3). Prolonged exposure therapy(PE) is especially efficacious for chronic PTSD(4,5). However, there are only several studies for investigating the efficacy of PE therapy for Japanese PTSD patients(7,8). The aim of this study was to investigate the feasibility of PE for Japanese PTSD patients, which has different culture from Western countries.

II. Participants

We opened outpatients clinic for PTSD in 2006 April. For three years we had 43 patients suspected for PTSD. Out of these patients, 28 were screened for inclusion according to the DSM-IV criteria for PTSD. In total, 9 women and 4 men participated in this study. Their mean age was 32.4 years. All were Japanese nationals who had been
born and had grown up in Japan. Their primary traumas included motor vehicle accidents with serious injury (4), physical assault with serious injury (3), witness to the fatal accident of a friend (4) and sexual assaults(2). No participants had a history of childhood trauma. Index trauma had occurred after age 18 and mean length of time since index trauma was 11.8 months. No participant had ever experienced trauma-focused CBT or eye movement desensitization and reprocessing (EMDR) prior to joining this study although 9 had received prior supportive counseling after the traumatic event. Five participants had undergone drug treatment using a SSRI.

III. Measures

The therapists performed assessments before and after treatment and 6-month follow-up appointments using IES-R and BDI-II. The Impact of Event Scale-Revised was used as a self-report measurement for PTSD symptom severity. The Japanese version of the IES-R has also been well validated with good reliability and validity(9). In addition, we assessed depressive symptoms using BDI-II(10).

IV. Procedure

Three therapists conducted PE therapy for PTSD patients. The author had attended a 4-day PE training workshop in Tokyo. All sessions were videotaped and reviewed weekly. The PE treatment was delivered in 10 to 15 weekly 90-minutes sessions(5, 6). The content and structure of each session was specified in a Japanese version of the PE manual. This PE treatment consisted of psychoeducation about common reactions to trauma, breathing retraining, in vivo exposure (approaching safe situations that patients avoid due to trauma-related fears), imaginal exposure (repeated recounting of trauma memories during sessions and listening to a recording of the recounting made during therapy sessions), and processing(discussion of thoughts and feelings related to exposure exercises).Session 1 and 2 were introductory, providing treatment rationale and psychoeducation on PTSD. Imaginal exposure and processing were then conducted in the remaining sessions. This study was approved by the ethical commettie of Osaka medical college.

V. Results

Out of 13 patients 3 subject dropouted. These 10 patients completed between 10 and 15 sessions, posttreatment assessment, and follow-up assessments at 6 months after the treatment. The completers well understood the treatment rationale. They were
not reluctant to express overwhelming emotion during recounting of trauma memories in imaginal exposure. They also complied well with their assigned homework on in vivo exposure.

The IES-R scores of 10 completers at the pretreatment assessment ranged from 25 to 80. In completer analysis, data of IES-R were analysed each time with repeated ANOVA and Tukey’s studentized range test for marginal means. There were significant reductions over time on the IES-R (Figure 1).

Fig 1: Changes of IES-R score

The mean score of BDI-II was 24.1+/-8.7 before treatment and 8.4+/-3.8 after treatment. Statistical analysis between BDI-II score before and after the treatment showed significant (Figure2). Pairwise comparisons showed that symptom levels remained low from posttreatment assessment and all 10 participants on 6-months follow-up assessment no longer met PTSD criteria.
Our results showed significant ameliorations of PTSD symptoms in Japanese patients after PE treatment, in terms of self-rated measurements. Symptom levels remained low at 3 and 6 months after treatment. In addition, we found significant amelioration of depressive symptoms after treatment. Our results are generally in accordance with previous studies establishing the efficacy of PE on PTSD and depression related to PTSD. Considering that previous research has found an approximate 20% dropout rate for PE treatment across studies, dropout in our study (3 out of 13) was not higher than that in western countries. This strongly suggests that Japanese patients can at least tolerate exposure-based therapy as well as patients in western countries. Although evidence-based treatment has been strongly recommended, there is only few study in the field of PTSD treatment in non-western countries. Therefore, it is still not completely clear whether treatment established for PTSD patients in the West can be recommended as a feasible treatment for PTSD patients despite cross-cultural differences. Unfortunately, there are a number of limitations to this study.

First, it was an uncontrolled trial and we only analyzed completer data.
Therefore, our findings, though significant, are not conclusive. Second, we did not exclude concurrent pharmacotherapy. To control the effect of pharmacotherapy, however, subjects (5 out of 10) who were undergoing SSRI treatment. In conclusion, our findings for this study suggest the feasibility of PE for PTSD due to various kinds of traumatic events in Japan. Subsequent research should include randomized controlled trials to examined the efficacy of PE for PTSD patients more accurately as an evidence-based treatment in Japan.

References