Discussion: Treatment of Prolonged Posttraumatic Stress Disorder—Learning from Experience

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Reports of limited treatment effect in Vietnam veterans with PTSD are discussed. Survivors of multiple traumata who suffer from complex PTSD and who live in poverty and distress may not properly represent the general case of PTSD. Yet the lessons learned suggest that attempts to treat prolonged PTSD by redressing causation are ineffective. The appropriateness of targeting symptoms is also challenged. Previously heralded rhetorics of healing trauma should be replaced by careful assessment of residual disability in a social context. Recognizing treatment-resistance in PTSD could lead to favorably investigating interventions of modest effect, to shifting from exploration to rehabilitation, and to redefining outcome measures such that changes in a variety of domains are appreciated.

KEY WORDS: posttraumatic stress disorder; treatment interventions; treatment-resistance; rehabilitation.

David Read Johnson and colleagues’ sobering papers (Johnson et al., this volume; Johnson et al., 1996) conclude 20 years of specialized inpatient treatment programs for posttraumatic stress disorder (PTSD). Complementing previous reports of limited success in the treatment of PTSD, these excellent studies are likely to have a major effect on the field: Therapists, theoreticians, policy makers, and, most importantly, PTSD patients are likely to ask themselves where, after all, twenty years of passionate rhetoric regarding trauma, the illness that follows trauma, and the “healing of

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trauma” (e.g., Haley, 1974; Horowitz, 1974, for salient early “milestones”) have led them.

One, therefore, must be very cautious in reading these reports and generalizing from their findings: Inappropriate generalizations can be as harmful as further ignoring the problem of treatment effectiveness in PTSD, or eluding it by proposing yet another revolutionary technique. It is, seemingly, true that we can better identify, evaluate and even predict PTSD than effectively treat this disorder, at least at its chronic form. Hence, it is time to start learning from experience, or, as Johnson et al. suggest, start unlearning.

Generalizing from the VA Experience

Yet, before going so far, one must evaluate the extent to which the clinical samples in Johnson et al.’s reports are truly representative of the larger population of PTSD patients. Previous reviewers suggested that controlled treatment trials in PTSD, most of which included Vietnam veterans, must be supplemented by studies of other samples (e.g., Friedman, 1988; Shalev, Bonne, & Eth, 1996; Solomon, Gerrity, & Muff, 1992). Yet, such statements have not been followed by specific inquiry into what makes it harder, indeed hazardous, to generalize from the Vietnam veterans/VA experience.

The current and detailed descriptions (particularly Johnson et al., 1996) allow such inquiry to be made, following which some particularities do emerge. First, for many of these inpatients the Vietnam experience was only one of several lifetime traumatizations (averaging 11 traumatic events per patient). For 45% of that sample the first trauma had occurred at an average age of 7. Importantly, more traumatic events have occurred after the Vietnam war than before the war. The degree to which such repeated traumatization is typical of PTSD is debatable, and each practitioner may compare this sample with his or her own patients. Moreover one may wonder if the treatment of such repeatedly traumatized individuals should focus on any specific trauma or, conversely, address the effects of multiple traumatization, past, present and possibly future.

Second, the fact of comorbid disorders must be considered. When, as described here, 76% of the patients suffer from concurrent major depression, the alleviation of depression may become of central significance (e.g., by pharmacotherapy, including pharmacological enhancement, as in resistant depression, or by cognitive-behavioral therapy dedicated to depression). Not only has it been argued that effective pharmacotherapy of comorbid depression can facilitate successful psychotherapy in PTSD (e.g.,