Relevance and validity of evidence in the psychological treatment of trauma

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Critical questions

What are the benefits of the trend towards evidence-based treatment in PTSD?

- Could help stop some people from being seriously harmed by treatment. Randomised controlled trials can challenge conventional wisdom e.g. relaxation training
- They have assisted us in recognising some of the multitude of interrelated predictor variables and complex sequelae associated with traumatisation
- Have reported some alleviation in suffering that is apparently maintained at follow-up. (Sherman, 1998)
- Help identify the common elements of successful treatments e.g. emotional and cognitive processing of the traumatising experience, gradual re-exposure to the event/s and reformulation of its meaning (Valent, 1999)

Are there limitations to the evidence base?

- Yes. Focus on select populations on people with relatively straightforward PTSD rather than more complex traumatic stress reactions that we see daily in clinical practice
- The most distressed clients generally do not volunteer or drop out of these treatment outcome studies
- Traumatic incident may precipitate consequences associated with unresolved, affectively similar but different traumatic experiences from an individual’s past. These factors can amplify symptoms of trauma exposure (e.g. arousal, emotional numbing and avoidance, intrusive dreams and flashbacks) and result in greater but generally unknown variance in the outcome data. The small numbers in most treatment outcome studies amplifies this effect and the exclusive focus in randomised controlled trials on the presenting circumscribed trauma. Longer term psychosocial functioning following treatment could also be informed by these it factors (both untreated previous trauma and post treatment traumatic experiences) (Baldwin, 2000).
- Problems with the outcome measures used (e.g. about looking at the duration of the startle response rather than the initial startle magnitude
given the possibility of permanently altered initial limbic responses, Baldwin 2000)

Dominated by the experimenter orientation model that allows the experimenter to function as a reflective knower but implicitly denies this capacity to the data contributor (Viney, 1988, `1992)

Often presumed that our findings are in some way absolute or timeless when at best they are only more or less useful approximations

What other important sources of information may be excluded from the evidence base?

Unique characteristics of the therapist and the therapeutic relationship become nothing more than irrelevant (as in pharmacological interventions) or troublesome confounding variables to be "controlled" neutered or placed in the general pool of non-specific factors. This seems ridiculous especially when we are talking about trauma that has occurred in an interpersonal context where issues of control, autonomy, use of power, integrity, honesty, respect and boundary violations are so pertinent to the nature of the traumatisation itself and so fundamental to the process of recovery.

Very constrained ways of telling multiple stories about what happened in therapy i.e. journal article with its introduction and hypotheses followed by methods, results and discussion sections

When neither interventions nor the problems under treatment correspond with the clear lines of evidence-based research in practice the format of the evidence base itself needs to adapt in the direction of practice-based evidence (Margison, 2001)

What are dangers of generalising from the evidence base?

This might suit the pecuniary interest some organisation and some treatment outcome researchers who could incur liability and be far from objective.

It is assumed that the unique clinical capacity of those providing treatment is far less important that the techniques they use. Psychotherapy becomes treatment of the mind rather than treatment by the mind (Mace and Moorey, 2001)
Risk of indulging in logical fallacies (e.g., a psychiatric drug appears to help this condition therefore the condition must be caused by biology).

Training, supervision, accreditation, research funding and treatment becomes informed only by the dominant paradigms and power brokers within the trauma field leaving less room for creativity, innovation or change in the dominant paradigm. Investigations of an intensive exploratory kind may be largely excluded resulting in a loss of the richness of information of what we can learn from traumatised people about factors that might improve treatment outcome. Do we want replications (with minor socially and academically acceptable variations) of what we already know or are we open to understandings that may challenge our pre-existing ways of making meaning of this treatment and how they work? For example, is it the therapeutic technique that works or is the individual ways traumatised people make meaning of a technique that informs its apparent efficacy? We are at risk of effectively filtering the traumatised person’s world to fit with our preconceptions, our knowledge base and the forced choices of our standardised outcome measures.

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