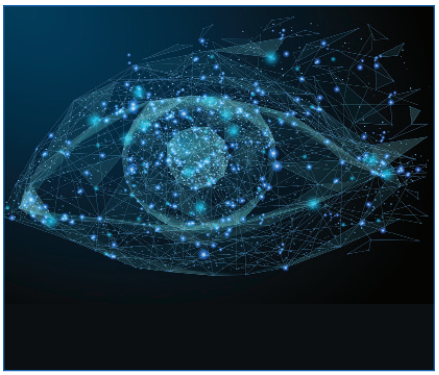

COMMENTARY

Ethical Reflections on Offering Patients Accelerated Resolution Therapy (ART)

ABSTRACT

ABSTRACT: Accelerated resolution therapy (ART) is a new therapy for post-traumatic stress disorder (PTSD) that has shown exceptional promise. Compared with other standard, more evidence-based treatments, initial research has shown ART to be as effective, quicker, easier to learn, and more cost-efficient. There are ethical issues clinicians should consider before recommending ART to their patients, including the need for additional research to fully establish ART's net benefits and the difficulty patients might encounter accessing therapists trained to perform ART-based therapy. However, the authors argue that based on the moral principle of beneficence—helping their patients—and respecting patient autonomy, clinicians should consider informing their patients with PTSD of this emerging therapy to allow patients to make fully informed decisions regarding their treatment.

KEYWORDS: Accelerated resolution therapy, ART, cognitive processing therapy, CPT, posttraumatic stress disorder, PTSD, ethical principles, patient autonomy, informed consent

by EDMUND G. HOWE, MD, JD; LANEY ROSENZWEIG, MS, LMFT; and AMY SHUMAN, MSW, LICSW, DCSW

Dr. Howe is Professor of Psychiatry and Medicine, Uniformed Services University of the Health Sciences, in Bethesda, Maryland. Ms. Rosenzweig is with the Rosenzweig Center for Rapid Recovery in Orlando, Florida. Ms. Shuman is a sychological counselor at the Counseling Center of Western New England University in Springfield, Massachussetts.

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Accelerated resolution therapy (ART) is a relatively new treatment for posttraumatic stress disorder (PTSD) that was developed by Laney Rosenzweig over a decade ago.[1] It is derived from Eye-Movement Desensitization and Reprocessing (EMDR) therapy, but according to its creator, it is more directive, can be administered in a shorter amount of time, and is easier to learn.[1] ART-based therapy assists patients in creating new images of past trauma they have experienced, using eye movements to enhance this process and increase relaxation. The therapy usually takes 1 to 5 one-hour sessions, with an average of 3.7 sessions. Although ART is evidence-based,[1,2] it is still a relatively new treatment option, and there are several ethical issues clinicians should consider before recommending ART to their patients with PTSD. This commentary attempts to address some of these ethical issues.

BACKGROUND

ART is relatively easy to learn and does not require years of experience to implement. It involves a systematic approach in which practitioners follow a series of steps to administer ART to patients with PTSD. The authors of this article have found that some patients are able to resume activities they were unable to perform due to trauma after having had just one ART session. Clinicians might also find that ART offers some relief from "compassion fatigue" because patients are not required to recount their traumatic story aloud. The lack of a need to verbalize the trauma might help make the therapy easier on the patient and the therapist.

The first published study involving ART included 80 participants with PTSD.[1] They were predominately female civilians. Most of the cohort had experienced past violence or the loss of a loved one. In this study, almost 80 percent of the participants responded positively after an average of less than four treatment sessions. The symptoms remained alleviated after two months.[1]

In a randomized, controlled trial by Kip et al,[2] 57 U.S. service members/veterans with combat-related PTSD were treated with either the ART-based psychotherapy or an attention control (AC) regimen. The ART was delivered in 3.7±1.1 sessions with a 94-percent completion rate. The investigators reported that mean reductions in symptoms of PTSD, depression, anxiety, and trauma-related guilt were significantly greater ($p<0.001$) among the ART group compared to AC, and that these results persisted at three months, including reduction in aggression ($p<0.0001$). The investigators also reported that adverse treatment-related events were rare and not serious.[1]

Currently, a three-year randomized, controlled study by Chard et al[3] is being conducted comparing the effectiveness of ART with cognitive processing therapy (CPT), using no therapy wait-list as the control, for treatment of PTSD among civilians, United States military veterans, and active service members. The primary outcome

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CORRESPONDENCE: Edmund Howe, MD, JD; Email: Edmund.howe@usuhs.edu.

measure will be PTSD symptom severity, and the secondary outcome measure will be depression symptom severity.

Use of ART has expanded beyond the United States to other countries, including Italy, England, Scotland, Ireland, Korea, Kuwait, and Canada.[4] In November 2015, the Substance Abuse and Mental Health Services Administration (SAMHSA) made the determination that ART was an evidence-based treatment for trauma-related disorders, depression, and resilience.[5] ART appears to be a safe and effective treatment for PTSD, which could be especially important for military service members who are particularly prone to acquiring PTSD.[5–10] Additionally, research suggests that ART-based therapy is cost effective. Patients treated with ART often make significant gains in a shorter period of time, compared with other treatments, and thus would likely require fewer paid sessions with the therapist.[1,2]

Currently, the first-line treatments for PTSD are CPT, prolonged exposure (PE) therapy, and eye movement desensitization and reprocessing (EMDR), with efficacies approaching 70 percent.[11] CPT can require 12 treatment sessions, PE can require 8 to 15 sessions, and EMDR 5 to 15 sessions or more. Some patients require a year or more of therapy using the EMDR approach.[2] In comparison, the treatment period using ART is typically much shorter (1–5 one-hour sessions) and appears, based on the limited data available, to be more effective.[12]

THE DECISION TO RECOMMEND ART

First-line therapies and ART. Clinicians might ethically struggle with the decision of whether to recommend ART, along with the other therapy options, to their patients with PTSD at the beginning of the treatment plan or only offer ART after the patients have failed a first-line therapy. Consider the following: For PTSD, there are several well-tested and effective treatments (e.g., CPT, PE, EMDR); thus, patients with PTSD have a chance of doing well using one of these other treatments, without ART. While ART compares favorably to these other treatments, there are not yet any long-term follow-up studies on ART, and history has shown us that medical errors can occur when a treatment is prescribed before adequate long-term studies have been performed. For example, the use of thalidomide, years ago, is still a paradigmatic example. Thalidomide was first marketed in 1957 as a mild sleeping pill safe even for pregnant women, but animal tests during the developmental stage of the drug did not look into the effects of the drug during pregnancy. By 1960, thalidomide was marketed in 46 countries, with sales nearly matching those of aspirin. In the 1960s, many children who were exposed to thalifomide *in utero* were born with phocomelia as a side effect of the drug, resulting in the shortening or absence of limbs.[13] Some treatments for emotional illness have also been shown to be harmful, thus warranting our present skepticism regarding new therapies. The practices of creating false memories of incest in patients in an attempt to unearth childhood memories of sexual abuse; attempting to convert patients who were gay; and the Double-bind Theory—a theory that schizophrenia was caused by irresolvable communication failures between a child and his parents are historical examples of emotional harm caused by certain methods of psychotherapy.[14-16]

There are good reasons to recommend first-line treatments to protect patients with PTSD rather than opting for emerging treatments that appear to work more quickly. Seemingly beneficial new treatments could have harmful side effects that are not yet evident. Patients with PTSD and depression can feel hopeless and therefore more vulnerable, which means they might readily accept any potentially promising treatment without careful consideration if it meant they could get relief from their symptoms. Thus, some clinicians might feel it prudent to only offer ART if first-line treatments have failed. When patients are suffering, however, compassion dictates that providers give them relief. For example, even when certain drugs for treating cancer are still not fully tested, if the standard medications are not working for a patient, the provider might consider offering the patient access to experimental drugs. Relevant to PTSD treatment, however, it might serve the patient better to offer ART along with the other therapies right from the start and allow the patient to make a fully informed decision regarding which therapy he or she would prefer.

Recommending ART when it is not easily accessible. There might be instances when a provider believes a patient with PTSD would benefit from ART, but knows there are no clinicians in the area who are trained to administer ART. The clinician might then ethcially question whether he or she should still recommend the treatment to the patient. A common example of this is telling a patient that kidney dialysis would sustain the patient's life even when the clinician knows the patient cannot afford the treatment. The ethically preferable option in this case would be to give the patient this information, even though it might make the patient's emotional pain worse. The theory behind this decision, first, is that, with this knowledge, the patient might feel empowered to find a way to pay for the dialysis. Second, even if the patient is not able to find a way to pay for the treatment, the clinican is respecting the patient's autonomy by giving the patient the option to at least try. Using similar reasoning, providers might consider telling patients about ART even when it isn't easily accessible in their area, because this might empower patients to find a way to access ART if they so choose. There are several published articles describing ART in adequate detail, as well as information on ART available on the internet, that clinicians can provide to their patients that will allow patients to make fully informed decisions as to whether to pursue ART or undergo a different type of therapy.[1,4,17,18]

Patient autonomy. At times, clinicians might ethically struggle with whether to make a treatment decision for a patient that the clinician thinks is for the best or whether to allow the patient to make his or her own treatment decisions. Many ethicists might view making decisions *for* patients, instead of *with* patients, to be unethical and unacceptably paternalistic. Currently, even law dictates the use of the patient-autonomous approaches (short of instances where the patient is in danger of harming others or self). The available evidence thus far has shown ART to be at least as effective as current first-line treatments.[2] Additionally, ART has been shown to require a relatively short amount of treatment time with no significant negative side effects;[2] thus, allowing the patient to decide for him- or herself whether to undergo ART versus another form of treatment might be a reasonable and ethical approach when planning a patient's treatment path.

There is a subtlety regarding what clinicians should mention when informing patients about ART. For example, when undergoing ART, patients are in control and can choose what trauma they want to overcome without needing to tell the therapist about it. ART has been shown to offer resolution and relief of symptoms without the need to share the nature of the patient's trauma.[2] During ART therapy, the patient can imagine an experience of past trauma and, with cues from the therapist, create in its place a new image of this memory without needing to inform the

therapist of the actual nature of the trauma. Rosenzweig believes the best clinical practice is to empower the patient, not the therapist, to make the decision whether to share details regarding the trauma. This is especially true when considering the timing of addressing grief associated with trauma.

When discussing treatment options with patients, it is important for clinicians to keep in mind that they should not merely state what they know about ART and the other first-line treatments for PTSD and then leave it to their patients to make the treatment decision wholly on their own. Rather, clinicians should discuss each treatment option in depth with their patients, paying careful attention to each patient's individual needs. For example, how much time the patient has for treatment is an important consideration. Additionally, how the patient might feel undergoing a new therapy that takes less time, but has fewer studies, compared to older therapies that take more time but have more studies is an issue that should be discussed with the patient before deciding on the optimal treatment path. It is the therapist's role to explain that a new therapy is available and how it works and then allow the patient to choose whether to undergo the new therapy or one of the other therapies.

CLOSING COMMENTS

The Institute of Medicine (IOM) issued a special panel report in June 2014 in regard to the efficacy of PTSD identification and treatment within the Department of Defense (DOD) and Veterans Affairs (VA). The panel recommended that "Both departments should use evidence-based treatments as the treatment of choice for PTSD, and these treatments should be delivered with fidelity to their established protocols. Any new programs and services should be piloted and include an evaluation process to establish the evidence based on their efficacy and effectiveness."[19] It is the authors' belief that institutions should support patients by providing ART training to their therapists to maximize the choices patients have regarding their treatment. There might be institutional resistance to giving this support because of the comparatively smaller set of evidence-based studies on ART. Ethically, however, this resistance might be short-sighted. PTSD is a crippling disorder that affects all populations in the world.[20] We believe any new treatment that shows promise, such as ART, should be rigorously studied as soon as possible. Let us hope that this is the case in the future.

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