Clinical Psychology Review 33 (2013) 45–53

Contents lists available at SciVerse ScienceDirect

Clinical Psychology Review

Psychotherapy for military-related posttraumatic stress disorder: Review of the evidence☆

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HIGHLIGHTS

- We review outcome studies of military-related PTSD.
- We describe real-world use of evidence-based PTSD therapies in VA.
- We conclude with directions for future research.

ARTICLE INFO

Article history:
Received 16 May 2012
Received in revised form 31 August 2012
Accepted 7 October 2012
Available online 13 October 2012

Keywords:
PTSD
Combat
Military
War
Psychotherapy
Treatment

ABSTRACT

Approximately 20% of the two million troops who have deployed to Iraq and Afghanistan may require treatment for posttraumatic stress disorder (PTSD). We review treatment outcome studies on individual outpatient therapy for military-related PTSD, and consider the extent to which veterans initiate and complete available PTSD treatments. We conclude with considerations for future research.

Published by Elsevier Ltd.

Contents

☆ The authors wish to thank Nathan Stein, Yonit Schorr, and Jonathan Larson for their assistance with earlier drafts of this article.
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0272-7358/$ – see front matter. Published by Elsevier Ltd.
http://dx.doi.org/10.1016/j.cpr.2012.10.002

Deployment to war can be a profoundly stressful and life altering event that leads to lasting mental health problems in a substantial minority of service members (Rintamaki, Weaver, Elbaum, Klama, & Miskevics, 2009; Schnurr, Lunney, Sengupta, & Waelde, 2003). Posttraumatic stress disorder (PTSD) is one of the most common post-deployment mental disorders, and is associated with a host of comorbid mental and physical health problems, functional incapacities (e.g., relationship and occupational problems), and reduced quality of life (e.g., Erbes, Meis, Polusny, & Compton, 2011; Magruder et al., 2004; Shea, Vujanovic, Mansfield, Sevin, & Liu, 2010). Between 5 and 20% of Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF) veterans meet criteria for PTSD (see Ramchand et al., 2010), equating to hundreds of thousands of individuals potentially in need of formal mental health care. If left untreated, military-related PTSD has been shown to follow a chronic course, resulting in lifelong dysfunction (e.g., Prigerson, Maciejewski, & Rosenheck, 2002). The mental health interventions available to treat service members and veterans with PTSD have evolved significantly in recent decades and, since the start of the current wars, the clinical landscape of the U.S. Departments of Defense (DoD) and Veterans Affairs (VA) have undergone considerable transformation in an attempt to make evidence-based care available to all patients with PTSD (see Karlin et al., 2010).

Although there are a variety of disciplines involved in the mental health care of veterans and service members, in this paper, we review psychotherapy for military-related PTSD. We first review clinical outcome studies that target PTSD in veterans and active duty personnel, then review the real-world clinical implementation of these treatments within the DoD and VA, and end with considerations for future research. The scope of this paper is limited to individual outpatient psychotherapy, although couples (e.g., Fredman, Monson, & Adair, 2011), family (e.g., Glynn et al., 1999), group (e.g., Norman, Wilkins, Tapert, Lang, & Najavits, 2010), inpatient/residential (e.g., Alvarez et al., 2011), and web-based (e.g., Litz, Engel, Bryant, & Papa, 2007) psychotherapies for military-related PTSD are also available and represent important additional sources of patient care.

1. Extant PTSD treatments for service members and veterans

Treatment of military-related PTSD in the U.S. falls chiefly under the purview of the DoD (caring for active duty *service members*) and VA (treating *veterans* who have reentered civilian life as well as, to a lesser extent, some active duty service members). The recommended best practice for PTSD in VA and the DoD is cognitive-behavioral therapy (CBT). Specifically, the Joint VA/DoD Evidence-Based Practice Workgroup (Department of Veterans Affairs and Department of Defense, 2004) recommends four front-line therapies for treating veterans and service members with PTSD: exposure-based therapy (particularly prolonged exposure; PE); cognitive therapy (particularly cognitive processing therapy; CPT); stress inoculation training (SIT); and eye-movement desensitization and reprocessing (EMDR) therapy. In 2008, VA mandated that PE and CPT be made available to all veterans with PTSD (U.S. Department of Veterans Affairs, 2008) and, following extensive dissemination efforts, by 2010 all VA medical centers reported offering either PE or CPT, with 98% offering both (Ruzek, Karlin, & Zeiss, 2012).

Briefly, PE involves assisting patients to re-live and confront avoided trauma-related stimuli through repeated and prolonged emotional engagement (in imagination and *in vivo*) to extinguish conditioned fear responses and organize traumatic memories (see Foa, Rothbaum, & Hembree, 2007). CPT targets putatively maladaptive ways of thinking about trauma that are posited to maintain PTSD symptoms and includes an optional written exposure element (see Resick & Schnicke, 1996). Both therapies are manualized and time-limited; PE typically consists of 10–12 sessions of 90 min each and CPT consists of 12 one-hour sessions. Homework activities occurring outside of session form a substantial part of both treatments. SIT focuses on expanding patients' coping skills and emphasizes applied in-vivo relaxation strategies but also includes cognitive techniques and, in some cases, exposure strategies (Meichenbaum & Novaco, 1985). To our knowledge, no study has examined SIT in the *treatment* of military-related PTSD, nor is this intervention used frequently in VA or DoD, and it is thus not discussed below. EMDR is a multi-component treatment that primarily involves recalling the trauma while simultaneously focusing on an external stimulus, typically the therapist's finger being moved back and forth in front of the patient (Shapiro, 1989). We do not include EMDR in this review since its use in the treatment of military-related PTSD has recently been reviewed in detail elsewhere (see Albright & Thyer, 2010). Notably, the authors concluded that there is sparse and equivocal support for it use in the treatment of military-related PTSD.

We next review two related bodies of research: outcome studies of PTSD treatment in veterans and active duty military personnel (i.e., the current state of the science), and studies examining the real-world implementation of these interventions within VA (i.e., the current state of practice). Table 1 provides a summary of extant outcome studies.

2. Treatment outcome studies of military-related PTSD

Although the U.S. has been engaged in a war at every generation over the past century, few treatment outcome studies of military-related PTSD exist. PE and CPT were designated as treatments of choice within the DoD and VA based on numerous studies demonstrating their efficacy in improving PTSD among civilians (for a review see Bisson et al., 2007; Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). Both PE and CPT were originally developed for civilian female sexual assault survivors and, consequently, most data that attest to PE and CPT's efficacy comes from trials with female sexual assault survivors.

2.1. Intervention studies in veterans

2.1.1. Prolonged exposure

Four RCTs have been conducted on PE in veterans. The first was a large multi-site trial (N = 284) comparing PE to present-centered therapy in female veterans (N = 277) and active duty personnel (N = 7; Schnurr et al., 2007 — for an earlier trial of trauma-focused *group* therapy among male Vietnam veterans, see Schnurr et al., 2003.) The majority of patients (68%) endorsed sexual assault as their index trauma, meaning that the study more closely approximated civilian trials of PE that have been shown to be efficacious; it is unclear whether the trial can be used to support the use of PE for combat trauma (only 6% endorsed war exposure as their index event). Both treatment conditions effectively reduced PTSD symptoms from pre- to post-treatment, and at post-treatment those receiving PE were more likely to no longer meet criteria for PTSD (41% compared to 28% in the control condition). Of note, this study employed more of an effectiveness framework than is typical for RCTs, for example, many of the study therapists had little prior CBT experience and inclusion criteria were relatively broad.

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