Available online at www.sciencedirect.com

ScienceDirect

Behavior Therapy 43 (2012) 407–415

Behavior Therapy

www.elsevier.com/locate/bt

Adaptive Disclosure: An Open Trial of a Novel Exposure-Based Intervention for Service Members With Combat-Related Psychological Stress Injuries

Matt J. Gray
University of Wyoming

Yonit Schorr
VA Boston Healthcare System

William Nash
Defense Centers of Excellence

Leslie Lebowitz
Private Practice, Newton, MA

Amy Amidon
Amy Lansing
Melissa Maglione
Ariel J. Lang
University of California, San Diego, and VA San Diego Healthcare System

Brett T. Litz
National Center for PTSD, Massachusetts Veterans Epidemiological Research and Information Center, VA Boston Healthcare System, and Boston University

We evaluated the preliminary effectiveness of a novel intervention that was developed to address combat stress injuries in active-duty military personnel. Adaptive disclosure (AD) is relatively brief to accommodate the busy schedules of active-duty service members while training for future deployments. Further, AD takes into account unique aspects of the phenomenology of military service in war in order to address difficulties such as moral injury and traumatic loss that may not receive adequate and explicit attention by conventional treatments that primarily address fear-inducing life-threatening experiences and sequelae. In this program development and evaluation open trial, 44 marines received AD while in garrison. It was well tolerated and, despite the brief treatment duration, promoted significant reductions in PTSD, depression, negative posttraumatic appraisals, and was also associated with increases in posttraumatic growth.

Keywords: Combat; trauma; psychotherapy; moral injury; PTSD

The authors would also like to acknowledge the staff of the NHCP Mental Health Clinic for their invaluable efforts and contributions to this project.

Address correspondence to Matt J. Gray, Psychology Department, 1000 E University Ave., Dept. 3415, University of Wyoming, Laramie, WY 82070; e-mail: gray@uwyo.edu.

0005-7894/43/407-415/$1.00/0

© 2011 Association for Behavioral and Cognitive Therapies. Published by Elsevier Ltd. All rights reserved.

Approximately 10–20% of the 2 million U.S. troops who have served in the wars in Afghanistan and Iraq experience significant mental health

difficulties including PTSD, depression, and anxiety (e.g., Hoge, Auchterlonie, & Milliken, 2006; Hoge et al., 2004). Because PTSD and other mental health problems among veterans of war are pernicious and disabling (e.g., Dohrenwend et al., 2006), a major public health challenge is to identify ways to intervene as soon as feasible to prevent spiraling dysfunction, premature discharge, and chronic problems (Litz & Bryant, 2009).

While limited, evidence-based mental health treatment (cognitive-behavioral therapy; CBT) may be available to some service members while deployed (see Cigrang, Peterson, & Schobitz, 2005), for most service members the most viable and prudent time to provide early treatment is postdeployment, while individuals are in garrison (i.e., at their home base). During this time, however, service members continue to be busy with demanding training regimens and preparations for subsequent deployments that absorb a good deal of attention and mental effort. Consequently, service members' needs and availability may differ from that of patients receiving trauma-focused CBT in civilian and veteran outpatient settings. Service members' time is limited and their inclination to focus on emotional and psychological matters is constrained by the understandable need (and social and occupational pressures) to "carry on."

Although there is ample evidence that CBT strategies such as prolonged exposure (PE) and cognitive-processing therapy (CPT) are effective PTSD treatments (see Foa, Keane, Friedman, & Cohen, 2009), these approaches do not explicitly consider the unique cultural and contextual elements of military trauma, the phenomenology of combatants or the clinical issues that arise from combat and operational stressors, losses, traumas, and experiences that are morally compromising. Although there have been no controlled clinical trials of CBT among active-duty service members, the effect sizes in PTSD treatment trials targeting veterans with chronic PTSD are consistently smaller relative to civilian trials (e.g., Monson et al., 2006; Ready et al., 2008; Schnurr et al., 2007). In our opinion, this may, at least in part, be attributed to the fact that there are significant missing elements in the current CBT care models with respect to treating war-related traumatic stress responses.

When considering possible limitations in the application of current CBT treatment models, several factors become apparent. First, we posit that clinical trials of CBT for complex war-related PTSD may be disappointing, in part, because these models of treatment are primarily based on the fear conditioning model, which conceptualizes trauma as a high fear-inducing, life-threatening event (e.g., Friedman, 2006). We argue that existing CBT may not sufficiently address the needs of war veterans because the fear conditioning and learning model does not sufficiently explain, predict, or address the diverse psychic injuries of war (e.g., Maguen et al., 2010; Nash, 2007). Service members not only face life-threatening, high fear-based trauma; they are also exposed to horrific losses and morally injurious experiences (Nash, 2007).

Loss as a result of violence has phenomenology, course, and maintaining factors that are distinct from life-threat-related traumas (Prigerson et al., 2009). Complicated or prolonged grief reactions stemming from traumatic losses share some symptomatic and etiological features with PTSD, but have been shown to be distinct in a number of ways that have important implications for treatment. Specifically, although avoidance is prominent in PTSD and is central to exposure-based treatment approaches, complicated grief reactions are often characterized by seeking out reminders of the deceased and ruminative tendencies (Prigerson & Jacobs, 2001). In fact, avoidance symptoms have been found to be only modestly predictive of traumatic loss-related distress (see Lichtenthal, Cruess, & Prigerson, 2004, for an excellent review of these issues). If, as preliminary studies suggest, individuals suffering primarily from complicated grief and loss reactions are not especially avoidant, a treatment utilizing an unadulterated, conventional exposure approach may not be optimal for such individuals. Conventional exposure therapy is the treatment of choice for service members who experience life-threat-related fear and anxiety-based symptoms. We argue that for service members suffering from traumatic loss (in addition to or instead of PTSD), exposure-based techniques need to be augmented with techniques designed explicitly to target other variants of posttraumatic and loss-related distress.

Combat also poses unique moral and ethical challenges, some of which have been hypothesized to create lasting psychological harm (Litz et al., 2009). "Moral injury" is a term used to describe a syndrome of shame, self-handicapping, anger, and demoralization that occurs when deeply held beliefs and expectations about moral and ethical conduct are transgressed. It is distinct from PTSD insofar as it is also not inherently fear based; rather, during war, moral injury can arise from killing, perpetration of violence, betrayals of trust in leaders, witnessing depraved behavior, or failing to prevent serious unethical acts (Nash, 2007). Separable from life-threat trauma and complicated grief reactions, moral injury also requires a shift in thinking about care.

Download English Version:

https://daneshyari.com/en/article/901451

Download Persian Version:

https://daneshyari.com/article/901451

Daneshyari.com