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Hypnotherapy and cognitive behaviour therapy of acute stress disorder: A 3-year follow-up

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Abstract

The long-term benefits of cognitive behaviour therapy (CBT) for trauma survivors with acute stress disorder were investigated by assessing patients 3 years after treatment. Civilian trauma survivors ($n = 87$) were randomly allocated to six sessions of CBT, CBT combined with hypnosis, or supportive counselling (SC), 69 completed treatment, and 53 were assessed 2 years post-treatment for post-traumatic stress disorder (PTSD) with the Clinician-Administered PTSD Scale. In terms of treatment completers, 2 CBT patients (10%), 4 CBT/hypnosis patients (22%), and 10 SC patients (63%) met PTSD criteria at 2-years follow-up. Intent-to-treat analyses indicated that 12 CBT patients (36%), 14 CBT/hypnosis patients (46%), and 16 SC patients (67%) met PTSD criteria at 2-year follow-up. Patients who received CBT and CBT/hypnosis reported less re-experiencing and less avoidance symptoms than patients who received SC. These findings point to the long-term benefits of early provision of CBT in the initial month after trauma.

Keywords: Acute stress disorder; Posttraumatic stress disorder; Cognitive behaviour therapy; Treatment

Introduction

Most prospective studies indicate that approximately three-quarters of people who meet criteria for acute stress disorder (ASD) in the initial month after trauma exposure subsequently develop chronic post-traumatic stress disorder (PTSD; for a review, see Bryant, 2003). The capacity to identify a group of high-risk trauma survivors in the initial phase after trauma exposure has led to early intervention programs that attempt to prevent PTSD in those who are most likely to suffer this condition. In an initial treatment study of ASD, five sessions of either cognitive behaviour therapy (CBT) or supportive counselling (SC) were provided to civilian trauma survivors who met criteria for ASD (Bryant, Harvey, Sackville, Dang, & Basten, 1998). CBT involved prolonged imaginal exposure, cognitive therapy (CT), and anxiety management. This study found that 17% and 67% of the CBT and SC groups, respectively, met criteria for PTSD 6-months post-trauma. A subsequent study that attempted to dismantle the effective components of CBT randomly allocated 45 participants with

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ASD to either (a) a combination of prolonged exposure (PE), CT, and anxiety management (CBT), (b) combined PE + CT, and (c) SC (Bryant, Sackville, Dang, Moulds, & Guthrie, 1999). At 6-months follow-up, there were fewer patients in the PE + CT (15%) and CBT (23%) than SC (67%) conditions. A 4-year follow-up of participants who completed these two treatment studies indicated that those who received CBT reported less intense PTSD symptoms 4 years after treatment than participants who received SC (Bryant, Moulds, & Nixon, 2003).

We subsequently conducted another treatment study that tested the proposition that adding hypnosis to CBT may facilitate treatment gains. This proposal was based on theory that hypnotic techniques may breach dissociative symptoms that characterize ASD (Spiegel, 1996), evidence that ASD participants are more hypnotizable than trauma survivors who do not develop ASD (Bryant, Moulds, & Guthrie, 2001), and convergent evidence that CBT supplemented by hypnosis leads to more clinical gains than CBT alone (Kirsch, Montgomery, & Sapirstein, 1995). Accordingly, this study compared CBT, CBT combined with hypnosis, and SC. Specifically, CBT comprised 5×90-min sessions that included education, anxiety management, CT, and imaginal and in vivo exposure. CBT/hypnosis was identical to CBT with the addition that each imaginal exposure session was preceded by an audiotape describing a hypnotic induction. The 15-min induction involved suggestions for focused attention, muscle relaxation, and deepening suggestions. The induction was modelled on the hypnotic induction described in the Stanford Hypnotic Clinical Scale (SHCS) for Adults (Morgan & Hilgard, 1978–1979). This was followed by 2 min of suggestions for full engagement in the exposure exercise and experiencing all the affective and sensory detail as possible. The SC program comprised education about trauma, general problem-solving skills, and provided an unconditionally supportive role. SC specifically avoided hypnosis, cognitive restructuring and exposure techniques. This study found that in terms of treatment completers, fewer participants in the CBT and CBT/hypnosis conditions met criteria for PTSD than those in SC at post-treatment and 6-month follow-up. Although CBT/hypnosis resulted in greater reduction in re-experiencing symptoms at post-treatment than CBT, there was no difference between these active treatments at the follow-up assessment.

The current study reports on a 3-year follow-up assessment of participants in this treatment study. It is commonly thought that CBT is an effective treatment of post-traumatic stress because it facilitates emotional processing, promotes mastery of distressing memories, and integrates corrective information that leads to less catastrophic appraisals of the traumatic experience (Rothbaum & Schwartz, 2002). We predict that CBT will lead to long-term gains for people who initially display ASD because the extinction of fear reactions in the initial month and the integration of corrective information should have long-term benefits in reducing PTSD. Although there were no outcome differences between CBT and CBT/hypnosis at the 6-month follow-up, we tested the proposition that CBT/hypnosis may have resulted in greater symptom reduction at longer-term follow-up because hypnosis may promote emotional processing of aversive experiences, and this factor may promote better adaptation over the 3 years after treatment.

Method

Participants

There were 109 participants who were assessed and 22 were excluded because they declined therapy ($n = 6$), were markedly suicidal ($n = 8$), or had a history of substance dependence ($n = 8$). The 87 participants who entered therapy comprised nonsexual assault ($n = 48$) and motor vehicle accident ($n = 39$) survivors who attended the PTSD Unit at Westmead Hospital and met criteria for ASD. Table 1 presents the number of participants who participated in each stage of the study. Inclusion criteria included (a) having been involved in either an MVA or nonsexual assault within the past 2 weeks, (b) satisfying criteria for ASD, (c) proficiency in English, and (d) aged between 18 and 60 years. Exclusion criteria included (a) current suicidal ideation, (b) diagnosis of psychosis, organic mental disorder, or substance abuse, and (c) evidence of brain injury sustained in the trauma. Full recruitment details are available in the initial treatment study report (Bryant, Moulds, Guthrie, & Nixon, 2005). There were 53 eligible patients available at follow-up (77% of treatment completers). Table 1 presents a summary of participation rates at each stage of the treatment study and follow-up assessments.