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Implementing Cognitive Processing Therapy for Posttraumatic Stress Disorder With Active Duty U.S. Military Personnel: Special Considerations and Case Examples

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Numerous studies and reports document the prevalence of combat-related posttraumatic stress disorder (PTSD) in military personnel returning from deployments to Iraq and Afghanistan. The Department of Veterans Affairs and Department of Defense recommend cognitive processing therapy (CPT) as one of two first-line treatment options for patients with PTSD. CPT is an evidence-based, trauma-focused cognitive treatment for PTSD that has been shown to be efficacious in a wide variety of populations, but has just begun to be implemented with active duty military. The purpose of this article is to describe treatment considerations that may be pertinent to active duty populations, including stigma related to mental health treatment and minimization of symptoms, duty obligations, and special factors related to rank and occupational specialties. We provide recommendations for navigating these issues within the CPT protocol. Additionally, we discuss common themes that may be especially relevant when conducting CPT with an active duty military population, including blame/responsibility, the military ethos, erroneous blame of others, just-world beliefs, traumatic loss, fear of harming others, and moral injury. Case examples illustrating the use of CPT to address these themes are provided.

MORE than 2.6 million service members have deployed in support of combat operations in Iraq and Afghanistan since 2001 (Institute of Medicine, 2014). An estimated 10–18% of active duty military and veterans develop posttraumatic stress disorder (PTSD) after deployment to a combat zone (Hoge, Riviere, Wilk, Herrell, & Weathers, 2014; Hoge, Terhakopian, Castro, Messer, & Engel, 2007; Hoge et al., 2004; Vasterling et al., 2006). PTSD is associated with significantly impaired functioning (e.g., Kessler, 2000) and does not typically remit without treatment. Cognitive processing therapy (CPT; Resick, Monson, & Chard, 2014; Resick & Schnicke, 1992) is an evidence-based, trauma-focused cognitive treatment for PTSD and comorbid symptoms. Research has found CPT to be effective in treating a variety of populations including

rape victims (Resick, Nishith, Weaver, Astin, & Feuer, 2002), survivors of childhood sexual assault (Chard, 2005), physical assault victims (Resick et al., 2008), and military veterans (Monson et al., 2006). The Department of Veterans Affairs (VA) and Department of Defense (DOD) recommend CPT as one of two first-line treatment options for patients with PTSD (Center for Deployment Psychology, 2011; Karlin et al., 2010).

Despite the increased use of CPT in VA and DOD settings, limited research has been conducted using CPT in active duty military populations. The STRONG STAR Multidisciplinary PTSD Research Consortium is conducting the largest clinical trials to date of CPT for PTSD in active duty service members. We recently have completed a trial comparing group CPT-cognitive-only version (CPT-C) to group present-centered therapy (Resick et al., 2015), and are currently conducting a study comparing group and individual CPT-C. This experience has highlighted a variety of salient issues in which treating active duty service members may be different from treating civilians or veterans. The purpose of this article is to describe treatment considerations that may be pertinent to active duty

¹ Video patients/clients are portrayed by actors.

populations and to provide recommendations for navigating these issues within the CPT protocol. We begin with an overview of CPT treatment. Next, we highlight special considerations for group and individual mental health treatment for active duty military. Finally, we discuss common themes and case examples that may be especially relevant when conducting CPT with this population. It should be noted that this experience is specific to a largely army population and may not generalize to other branches of the military.

CPT Treatment Overview

CPT is a 12-session manualized protocol typically conducted once or twice per week in an individual or group format. After receiving psychoeducation about the development and maintenance of PTSD symptoms, patients explore their perceptions of the meaning of the traumatic event through a written impact statement in which they describe why they believe the event occurred and the impact it has had on their beliefs about themselves, others, and the world. This statement is used to help patients identify maladaptive thoughts, or “stuck points” about the trauma that contribute to the development of negative manufactured emotions such as guilt and shame. The original CPT manual also includes a written trauma account. However, the CPT-C protocol (which does not include a written trauma account) was selected for our studies in an active duty population based on findings from a dismantling study that CPT-C results in more expedient treatment gains and that the written account did not improve outcomes (Resick et al., 2008). Throughout the rest of this paper, CPT will refer to the version without written accounts.

When individuals are confronted with a traumatic event, they reconcile the conflicting information about this event with their preexisting beliefs through assimilation, overaccommodation, or accommodation of this information. Assimilated stuck points develop when information about the traumatic event is altered to match prior beliefs (e.g., “If I had been paying attention, my soldiers wouldn’t have died”) or is incorporated into matching preexisting negative cognitions (e.g., “I am completely powerless”), while overaccommodated stuck points involve altering one’s beliefs to the extreme (e.g., “The world is completely dangerous”). Accommodation is modifying one’s beliefs in order to incorporate the new information in a realistic way (e.g., “I did everything I could at the time, but I would not have been able to stop the bomb from exploding”). The goal of CPT is to identify and challenge dysfunctional assimilated and overaccommodated cognitions and to accept the reality of the event, resulting in the development of more balanced and realistic beliefs (accommodation).

In the beginning of therapy, patients write an impact statement in which their thoughts about the causes and

consequences of the worst traumatic event are described. The impact statement is used to identify dysfunctional thoughts, or stuck points about the trauma. The stuck points that are gleaned from the impact statement are put on a stuck point log that is used throughout the therapy. Patients then learn to recognize their stuck points and observe the connection between their thoughts and emotions through the use of A-B-C worksheets in which they identify a situation, related thought, and resulting emotion. They are also introduced to the idea that changing thoughts may change their emotions (and other PTSD symptoms). The therapist uses Socratic dialogue, a form of questioning that encourages patients to examine their beliefs rather than being told in a directive way, to help patients begin to challenge their stuck points, and demonstrate flexibility in their thinking.

The next phase of therapy is focused on helping patients learn to challenge their own maladaptive cognitions using several worksheets that build upon one another. The Challenging Questions Worksheet guides the patient in examining evidence for and against the stuck points, exploring the context of the situations related to the belief, and determining whether the belief is based on facts or feelings. Using the Patterns of Problematic Thinking Worksheet, patients identify habitual and often maladaptive ways in which they tend to respond to situations, such as jumping to conclusions, exaggerating or minimizing, or mind reading. Finally, the Challenging Beliefs Worksheet (CBW) combines the previous materials to help patients identify stuck points and related emotions, challenge those stuck points, and develop more balanced and realistic alternative beliefs. The last phase of treatment uses the CBW to focus on themes commonly affected by trauma, including safety, trust, power/control, esteem, and intimacy. Toward the end of treatment, there are two behavioral assignments: giving and receiving compliments, and engaging in pleasant events each day. For the final practice assignment, patients rewrite the impact statement reflecting on the meaning of the traumatic event at present, and changes in their cognitions are noted and discussed. Further details about the session-by-session content of the therapy may be found in the treatment manual (Resick et al., 2014).

Special Consideration for Mental Health Services in Military Populations

Our experiences with providing CPT-C in an active duty military setting highlighted a number of factors that are more salient for active duty soldiers than for veterans who are no longer engaged with the military—for instance, barriers to treatment that are found in civilian settings (e.g., stigma related to mental health diagnosis and treatment) may be more pronounced within the military culture. Logistical issues including working around duty obligations are also important considerations when conducting treatment with this population. Additional factors

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