

Implementing Prolonged Exposure for Veterans With Comorbid PTSD and Traumatic Brain Injury: Two Case Studies

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Initial studies suggest that prolonged exposure (PE) can be successfully implemented with veterans with comorbid posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI). However, due to persistent TBI-related cognitive deficits associated with moderate to severe TBI, clinicians may have significant concerns about implementing these treatments and may have questions about how to adapt procedures to facilitate successful outcomes. The present article demonstrates the successful implementation of PE in instances where the presence of TBI-related neurobehavioral symptoms interfered with standard treatment implementation. Procedural modifications such as the inclusion of partners or multidisciplinary staff, incorporation of compensatory strategies, and titration of exposure exercises are demonstrated. Finally, clinical recommendations are provided to assist mental health practitioners with assessment and treatment planning.

NEARLY 2 million troops have been deployed to Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) since 2001 (Fischer, 2014). Due to high rates of combat and blast exposure, health care providers within the Departments of Veterans Affairs (VA) and Defense (DoD) are providing health care to increasing numbers of veterans and active-duty service members returning with complex mental and physical health problems (Hoge et al., 2004; Hoge et al., 2008). Traumatic brain injury (TBI) is often referred to as the “signature injury” of OEF/OIF/OND conflicts (Taylor et al., 2012). While estimates of TBI are difficult to establish due to varying screening strategies, recent estimates suggest nearly 20% of OEF/OIF veterans have sustained a TBI during deployment (Tanielian & Jaycox, 2008).

Significant concerns have also been raised about the high prevalence of combat-related posttraumatic stress disorder (PTSD) within this cohort. However, it is important to note, estimates of PTSD in returning service members vary

significantly based on the methodology of assessments. Studies utilizing screening measures with greater sensitivity have yielded a range of 10% to 20% of service members suffering from PTSD (Sundin, Fear, Iversen, Rona, & Wessely, 2010), while structured clinical interviews have demonstrated a lower rate of 7% to 10% (Erbes, Polusny, Arbisi, & Koffel, 2012). Despite these complexities in assessment practices, active-duty personnel and veterans with histories of TBI appear to be at a greater risk for developing PTSD, with estimates ranging between 33% to 39% (Carlson et al., 2011).

When considering implementation of evidence-based mental health treatments in the context of TBI, it is essential to consider TBI severity. TBI severity is largely determined by duration of loss of consciousness (LOC), length of posttraumatic amnesia (PTA), and Glasgow Coma Scale (GCS) scores (Management of Concussion mTBI Workgroup, 2009). Individuals who sustain a mild TBI (mTBI), characterized by minimal LOC and PTA, typically recover to baseline functioning within 1 week to 3 months after injury, and neurocognitive deficits that persist are often associated with underlying mental health processes, such as PTSD (Carroll et al., 2004; Polusny et al., 2011; Vanderploeg, Belanger, & Curtiss, 2009). When the severity of TBI is moderate to severe, individuals are likely to have persistent behavioral and neurocognitive deficits (e.g., impaired memory, slowed processing speed, impulsivity,

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and lability; Brown et al., 2005). For these individuals, persistent cognitive and behavioral impairments may undermine the effectiveness of mental health treatment.

Although evidence for the effectiveness of EBPs in PTSD/TBI veterans is building (Sripada et al., 2013; Walter, Kiefer, & Chard, 2012; Wolf, Strom, Kehle, & Eftekhari, 2012), several important questions remain, including the timing of mental health interventions (e.g., concurrent versus stages of care) or whether modifications to treatment protocols are necessary to achieve successful outcomes with this population (Carlson et al., 2011; Soo & Tate, 2007). Although it is important to incorporate a holistic approach, current treatment guidelines strongly encourage clinicians to identify and address symptoms in a stepwise fashion with an emphasis on first targeting psychiatric symptoms (Brenner, Vanderploeg, & Terrio, 2009; *Management of Concussion/mTBI Workgroup*, 2009). However, in the absence of randomized controlled trials, or large-scale effectiveness studies, providers may have concerns that current evidence-based practices for PTSD may be less effective with patients who have sustained a brain injury, especially when the severity of a TBI increases (Carlson et al., 2011). Further, the presence of cognitive and behavioral deficits may arouse apprehension about the safety of using exposure therapies with this population.

Prolonged exposure (PE) is an evidence-based psychotherapy that has been shown to be a highly effective treatment for PTSD and is strongly supported by the Institute of Medicine (2008) and VA/DoD guidelines as a first-line treatment. Research has illustrated that PE is effective with a variety of traumatic events, including sexual abuse (Foa et al., 1991) and physical assault (Foa et al., 1999), and with veterans and military service members (Goodson, Lefkowitz, Helstrom, & Gawrysiak, 2013; Rauch, Defever, Favorite, Duroe, Garrity, Martis and Liberzon, 2009; Rauch, Grunfield, Yadin, Cahill, Hembree and Foa, 2009; Schnurr et al., 2007; Tuerk et al., 2011) and with individuals who experience significant psychiatric comorbidity including anger and personality disorders (Cahill, Rauch, Hembree, & Foa, 2003; Hembree, Cahill, & Foa, 2004). While there are no large, randomized controlled trials examining PE with veterans diagnosed with PTSD/TBI, initial results from effectiveness studies are encouraging and demonstrated clinically significant and reliable reductions in PTSD and depressive symptoms (Sripada et al., 2013; Wolf et al., 2012). However, the samples within these studies have been small and primarily comprised of veterans who sustained a mild TBI. Therefore, it is important to further examine the clinical application of PE with a broader population and to answer the question of how to best implement PE with veterans with more significant TBI.

Although it is important to adapt treatments to meet the diverse needs of a patient, it is equally important to ensure fidelity to the treatment protocol when utilizing

evidence-based treatments. Significant deviations from standard implementation can result in poor treatment outcomes. However, in cases where comorbid symptomatology (e.g., TBI-related deficits) complicates standard implementation, therapists may need to modify treatment procedures in a manner consistent with the underlying theory to attain optimal outcome. Within the PE literature, prior manuscripts have expanded upon the standard manual, to include strategies for enhancing implementation (Hembree, Rauch, & Foa, 2003). Given the complicated array of neurobehavioral deficits often present in cases with PTSD/TBI, further examination of treatment augmentation with this population is needed.

The purpose of the present article is to demonstrate successful implementation of PE in instances where the presence of TBI-related cognitive and behavioral deficits (e.g., poor memory, inattention, sensory deficits, and impulsivity) interfered with standard treatment implementation. Therefore, we present two OEF/OIF veterans who received PE at VA medical centers. Cases were selected to highlight protocol-consistent modifications to enhance treatment outcomes with this population, and common challenges to effective implementation of PE in intensive outpatient, residential, and rehabilitation settings.

Case Presentations

Assessment and Treatment Outcomes

Both cases utilized a structured PTSD interview to confirm the DSM-IV-TR (American Psychiatric Association, 2000) diagnosis at baseline. Both cases monitored PTSD and negative mood symptom severity using self-report measures throughout treatment.

Diagnosis and Severity of PTSD Symptoms

Case 1 utilized the Clinician-Administered PTSD Scale (CAPS; Blake et al., 1995), a structured interview which examines the frequency and intensity of PTSD symptoms. The CAPS has excellent reliability, convergent and discriminant validity, and diagnostic utility (Weathers, Keane, & Davidson, 2001). Case 2 utilized the PTSD Symptom Scale-Interview (PSSI; Foa, Riggs, Dancu, & Rothbaum, 1993), a structured interview that rates the severity of PTSD symptoms on a 4-point Likert scale from 0 (*not at all*) to 3 (*very much*). The PSSI has demonstrated excellent internal consistency, concurrent validity, and test-retest reliability (Foa & Tolin, 2000).

Within both cases, the PTSD Checklist (PCL) was used to track PTSD symptom severity across the course of treatment. The PCL is a 17-item scale corresponding to the DSM-IV-TR criteria for PTSD. Respondents rate how much they have been bothered by each symptom during the past week on a 5-point Likert scale. The 17 items can be summed to create a total score representing a measure of PTSD symptom severity (range 17–85). The PCL has

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