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Comorbidity in the prediction of Cognitive Processing Therapy treatment outcomes for combat-related posttraumatic stress disorder☆

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ABSTRACT

This paper examines clinical predictors of posttraumatic stress disorder (PTSD) treatment outcomes following Cognitive Processing Therapy (CPT) in Australian military veterans. Fifty nine treatment seeking veterans were enrolled in a randomized controlled trial comparing 12 sessions of CPT ($n = 30$) with usual treatment ($n = 29$) at three community-based veterans counseling centers. PTSD and key co-morbidities (depression, anxiety, anger and alcohol use) were measured. Growth curve modeling was used to examine factors which influenced PTSD severity post-treatment. For the CPT condition, baseline anger was the only co-morbidity predictive of change in PTSD severity over time. Participants with higher anger scores showed less of a decrease in PTSD severity over time. Higher anxiety in participants in treatment as usual was significantly associated with better treatment gains. This research suggests that veterans experiencing high levels of anger might benefit from targeted anger reduction strategies to increase the effectiveness of CPT treatment for PTSD.

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1. Introduction

Posttraumatic stress disorder (PTSD) is a common psychiatric sequel of exposure to a traumatic event. Reported rates of PTSD are as high as 10–30% among returnees from recent military conflicts (Thomas et al., 2010). Fortunately we have effective treatments for PTSD. The two most established trauma focused cognitive-behavioral (TFCBT) treatments indicated in international treatment guidelines are prolonged exposure (PE) (Foa & Rothbaum, 1998) and Cognitive Processing Therapy (CPT) (Resick, Monson, & Chard, 2007). Despite the increasing evidence base surrounding these treatments, they are not equally effective for all sufferers. Between 40 and 60% of participants in research trials of effective treatments retain PTSD diagnosis at follow-up e.g. Forbes et al. (2012) and Monson et al. (2006). Understanding the factors that moderate and mediate PTSD treatment effects will enable more informed treatment planning, targeting of treatments to maximize improvement for responders, and improved approaches for those who are otherwise not responding. One of these factors is comorbidity, which is present in approximately 80% of PTSD cases. The most common comorbidities are depression, other anxiety problems, anger and substance abuse (Toole, Catts, Outram, Pierse, & Cockburn, 2009). Cognitively oriented trauma focused treatments such as PE and CPT require emotional engagement with traumatic memories. Leading theories suggest that comorbidities influence treatment outcomes by disrupting or inhibiting emotional engagement with the traumatic material which is required in treatments such as PE and CPT.

Only a small number of studies have examined this issue to date, even fewer using data drawn from randomized controlled trials (RCTs). Analyses drawn from RCT data allows for more intervention specific interpretation of the findings. As yet no studies have examined comorbid factors influencing outcomes for veterans with PTSD using RCT generated data. Less rigorous studies using cohort study design in veterans have found that anger (Forbes, Creamer, Hawthorne, Allen, & McHugh, 2003; Forbes et al., 2005), anger and guilt (Stapleton, Taylor, & Asmundson, 2006) and alcohol (Seidel,

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Gusman, & Abueg, 1994), as well as the interaction between them (Forbes et al., 2008), negatively impacted on recovery following treatment.

This research examined the influence of comorbidity on treatment outcome in a RCT of CPT in veterans with military related PTSD. As CPT gains momentum it is increasingly important to better understand factors associated with variability in treatment response, particularly in the context of comorbidity, to aid the tailoring and refinement of treatment delivery. This investigation needs to also understand the specificity of treatment predictors to frontline treatments as distinct from being predictors of treatment response generally.

2. Methods

A detailed description of the methods is provided in Forbes et al. (2012).

2.1. Participants

Fifty nine veterans presenting for treatment at three community based Veterans and Veterans' Families Counseling Services (VVCS) offices in Australia were recruited. Vietnam era veterans comprised 66% ($n = 39$) of the sample, Timor 14% ($n = 8$), Iraq or Afghanistan 5% ($n = 3$) and 15% ($n = 9$) other conflicts. Exclusion criterion included current uncontrolled psychosis, current suicidal ideation or significant cognitive impairment. Stable use of psychotropic medications was permitted.

2.2. Measures

PTSD symptoms and diagnosis were assessed using the Clinician Administered PTSD Scale (CAPS; Blake et al., 1995). Comorbidity was measured using the Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996), the State Trait Anxiety Inventory (state scale) (STAI; Spielberger, Gorsuch, & Lushene, 1970), the Dimensions of Anger Reactions Scale (DAR7; Forbes et al., 2004) and the Alcohol Use Disorders Identification Test (AUDIT; Babor, de la Fuente, Saunders, & Grant, 1989).

2.3. Procedure

After complete description of the study to the participants, written informed consent was obtained (approved by Department of Veterans' Affairs Human Research Ethics Committee, 2007). Eligible participants ($n = 59$) were randomized to CPT ($n = 30$) or treatment as usual (TAU) ($n = 29$). Follow-up assessments were independently conducted at treatment completion and at 3-months post-treatment.

2.4. Therapists

Treatment was delivered in the community-based mental health services of the Veterans and Veterans Families Counseling Service (VVCS) by staff who were ongoing employees of the service, randomized to provide either CPT ($n = 9$) or TAU ($n = 9$). They received a 2-day CPT workshop followed by weekly 1-h group consultations by teleconference with the CPT expert trainer (R.N). Therapists providing TAU received a trial briefing but no training or supervision.

2.5. Treatments

CPT is a 12-session manualized treatment for PTSD. It comprises cognitive restructuring and written exposure elements and aims to address key posttraumatic themes such as safety, trust, power and control. Individual 60-min therapy sessions were delivered twice a week according to the Military Version Manual (Resick et al., 2007). Adherence to the manual was checked by rating audio recordings and found to be comparable to other studies in achieving adherence to protocol of 92%.

For the TAU condition, the content of each session was recorded in written form but not prescribed to ensure the delivery of representative 'usual treatment'. The TAU intervention depended on the orientation of the therapist and included elements of psychoeducation, supportive counseling, non-trauma focused symptom management interventions, some CBT and elements of exposure. Drop-out and attendance rates were equivalent for both groups.

2.6. Data analysis

An analysis of treatment outcomes was reported in a previous paper (Forbes et al., 2012), which employed growth curve modeling (GCM) to investigate the trajectory of change over time in CAPS severity scores, and the relationship with group membership (CPT versus TAU). In this paper, a regression analysis was undertaken to identify comorbidity predictors of the PTSD treatment outcomes. Growth curve modeling against a square root trajectory was used (see Forbes et al. for a full description). The intercept and slope terms derived for the CPT and TAU groups, respectively, were regressed on to the clinical predictor variables. The significance of the coefficients indicates the strength of relationship between the trajectory parameters and these measures.

3. Results

Initial intent-to-treat analyses as reported in Forbes et al. (2012) found significantly greater improvement for participants receiving CPT over TAU at post-treatment and 3-month follow-up. CPT also produced greater improvements in anxiety and depression than usual treatment. Here, the predictors of treatment outcomes are examined. Table 1 reports the mean CAPS severity and comorbidity scores for the whole sample, the CPT group and the TAU group at intake. At baseline the two groups did not differ on any comorbidity variables. The standardized coefficients and p-values resulting from regressing the intercept and slope on the clinical comorbidity predictors are presented in Table 2. For the CPT group, only anger was significantly predictive of change in CAPS scores over time following treatment ($p < .001$), with higher anger associated with poorer treatment response ($p < .05$). For the TAU group only anxiety was predictive of changes in CAPS severity over time, with higher anxiety associated with better treatment response.

4. Discussion

This is the first study to examine comorbidity as a predictor of treatment outcome in veterans receiving CPT treatment. The analysis found that of depression, anxiety, alcohol and anger, only anger predicted response to CPT treatment, with more severe anger being associated with reduced treatment gains. This finding is consistent with findings from cohort studies examining male veterans with PTSD (Forbes et al., 2008).

It has been suggested that anger may serve to inhibit anxiety following a trauma, especially when effortful avoidance is unsuccessful (Riggs, Dancu, Gershuny, & Greenberg, 1992). This raises the possibility that CPT may not have been as successful with the veterans with elevated anger because they were not able to engage in anxiety-related concerns because the anger inhibited emotional engagement. A related interpretation is that veterans' fear of anger expression (rather than anger itself) may have attenuated responsivity to PTSD treatment (see Forbes et al., 2008). That

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