Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 1, Module 2, Article 3, pp. 1-6, 07-27-2005 [copyright by authors]

Commentary on Three American Troops in Iraq: Evaluation of a Brief Exposure Therapy Treatment for the Secondary Prevention of Combat-Related PTSD

Towards Formalizing a Very Promising Treatment

MICHAEL R. PETRONKO[a,b]

[a] The PTSD Clinic, Rutgers—The State University of New Jersey
[b] Correspondence concerning this article should be addressed to Michael R. Petronko, PTSD Clinic, Rutgers University, Graduate School of Applied and Professional Psychology, 797 Hoes Lane West, Piscataway, NJ 08854-8022. Email: mpetronk@rci.rutgers.edu

ABSTRACT

Cigrang, Peterson, and Schobitz (2005) present three case studies of a cognitive-behaviorally based approach to treat early symptoms of PTSD in American soldiers fighting in Iraq. Their clinical model is very promising in its capacity not only to address the needs of these soldiers in the combat theater, but also to proactively mitigate more pernicious symptom development subsequent to their return home. As one direction for extending their work, I suggest that they consider further formalizing and standardizing it so as to (a) facilitate group-based research using a model that complements the case studies; (b) enhance its use in training; and (c) increase its capacity for dissemination. I further discuss the role of case studies in developing manualized therapy, together with the issue of degree of structure in manualization.

Key words: Post Traumatic Stress Disorder (PTSD); cognitive behavior therapy; exposure treatment; evidence-based treatment.

For more then 25 years I have directed a Federally funded Post Traumatic Stress Disorder (PTSD) clinic that has been providing cognitive-behavior therapy (CBT) to veterans suffering from PTSD. Initially, most of the patients with whom we worked were Vietnam War veterans with classic PTSD. More recently, veterans from Iraq have began to appear, not surprisingly evidencing similar symptoms. I was particularly interested therefore to learn how Cigrang, Peterson, and Schobitz (2005) applied CBT principles to address the early symptoms of PTSD in the contemporary Iraqi war theater to serve as a secondary prevention of this disorder.

Cigrang et al. provide a rich, unique framework from which to understand trauma in the context of the present-day Iraqi war. Their vivid descriptions of veterans' experiences, which served to meet criteria as traumatic events, evoke a visceral response in the reader. In addition, their study eloquently chronicles the demands on professionals who attempt to provide proactive strategies with which to prevent contemporary stress reactions developing into entrenched PTSD. More specifically, their article provides a very promising alternative to the military's approach of

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 1, Module 2, Article 3, pp. 1-6, 07-27-2005 [copyright by authors]

automatically employing the Critical Incident Stress Management (CISM) program for use in combat situations. As an example of an application of an evidenced-based strategy, the Cigrang et al. cases are very impressive in their creative adaptation of CBT principles to the particular needs and contexts of American soldiers exposed to highly stressful combat conditions in Iraq.

Overall, the Cigrang et al. cases were conducted in a clinically flexible manner, adapting the procedures to the therapist's perception of the needs of each case. Such an approach can be ideal for developing a new model. However, I propose that the authors now direct their work to formalizing and standardizing – usually called "manualizing"-- the approach so as to (a) facilitate group-based, empirical research using the model; (b) enhance the model's use in training; and (c) increase its capacity for dissemination. In all three contexts standardization helps to create a method for maintaining consistency and fidelity to the model, so that its practice does not drift in type and quality from the original design (Chambless & Hollon, 1998; Nathan & Gorman, 2002; Seligman, 1995).

In a related way, having a manual provides an objective criterion with which to assess a therapist's competence in employing the model. On the other hand, as described below, while manualization is typically identified with group outcome studies, I want to emphasize that my call for manualizing the Cigrang et al. model does not reduce the need for continuing case studies that document how the more manualized model works in individual cases. Moreover, as also described below, the degree of manualization that leads to optimal outcome effectiveness is itself an empirical question.

TOWARDS MANUALIZING THE CIGRANG ET AL. MODEL

Length of sessions. One way in which the model could be standardized is in the proposed systematic construction of the exposure sessions in both length and content, and in how emotions are measured throughout. These issues were not adequately addressed in the Cigrang et al. cases. Some sessions lasted almost an hour and a half, and others, only a half of an hour. Also, during sessions, it appears that the authors only used their own subjective experience of observing distress to determine when a session should be completed. Following the usual approach employed in cognitive-behavior therapy, I would suggest adding a "Subjective Units of Distress" (SUDS) procedure, which consists of a scale with which clients rate their experienced distress, typically ranging from 0 to 100. Having SUDS ratings is even more important when more than one therapist is employed in a particular study, as was the situation in the Cigrang et al. cases. Lastly, SUDS could be used to reflect when a person has habituated to the traumatic stimuli.

Additional assessment instruments. A strategy by which to connect the Cigrang et al. model to the large CBT literature on PTSD and also to help document clients' overall psychological conditions would be to expand the number of objective assessment instruments used. I would recommend doing this both (a) to more adequately describe the patients prior to treatment (allowing for future comparisons of efficacy with others in different settings), as well as (b) to facilitate systematic case formulation, which will be discussed subsequently. I would suggest prescreening instruments like the Anxiety Disorders Interview Scale-Revised (ADIS-R,

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 1, Module 2, Article 3, pp. 1-6, 07-27-2005 [copyright by authors]

DiNardo and Barlow, 1988); the Beck Depression Inventory ("BDI-II," Beck, Steer, & Brown, 1996); the Beck Anxiety Inventory ("BAI," Beck, & Steer, 1990); and a screen for general mental/physical health, such as the Symptom Checklist 90-Revised ("SCL-90," Derogatis, 1994), the Treatment, Evaluation, and Management instrument ("TEaM," Grissom, Lyons, & Lutz, 2002), and the Outcome Questionnaire 45 ("OQ-45," Lambert, Burlingame, Umphress, Hansen, Vermeersch, Clouse, & Yanchar, 1996). Kean, Weathers, & Foa (2000) present an excellent description of the various assessment instruments employed in work with PTSD, which should also be consulted.

Cigrang et al. also endorse the need for a variety of assessment instruments beyond a focus on PTSD symptoms per se. They write: "Use of single-session psychological debriefing or exposure therapy as preventive interventions for all individuals exposed is inappropriate. Service members who seek help or are referred for psychological assistance following IED exposure should receive *a comprehensive clinical evaluation*" (2005, p. 12, italics added).

Longterm follow-up. Another important scientific addition to the Cigrang et al. case model would be the addition of longterm follow-up data. These data could assess whether the intervention is truly preventive in the long term regarding the development of PTSD. These data could also be employed to perform cost-effectiveness analyses to assess the degree to which the early intervention saves resources over time. Longterm follow-up should include data obtained when the person returns home.

Developing the use of non-exposure-based CBT techniques. It is clear from the clinical description of their cases that Cigrang et al. went beyond exposure-only techniques to employ cognitive procedures. For example, they tell us that "Airman A. found it helpful in understanding his emotional reaction to the IED attack on his patrol to consider the event in the context of his family background" (p. 16); and "Following the imaginal exposure, the psychologist engaged Soldier B. in a Socratic dialogue on a belief he had expressed" (p. 17).

To further formalize their model, Cigrang et al. should be more explicit and operational in how these cognitive procedures are to be employed and integrated into the therapy in terms of clinical decision-making in adapting to the variability among clinical cases. As an example of this variability, in the third case, Airman C. not only received injuries and/or witnessed death as in the other two cases, but also left a boy untreated. Veterans and others often report the resulting guilt Airman C. describes, but the usually recommended treatment is not exposure. Rather, a purely cognitive method is typically employed for trauma-related guilt (see Kubany, 1998). To develop more explicit procedures for creating individualized treatment plans, I would suggest approaches like the "case formulation" model of Persons (1993) or the "problem-solving" model of Nezu, Nezu, and Lombardo (2004).

Employing process measures for daily charting. A necessary addition to the procedures that Cigrang et al. employ would be to include process measures. Among the areas to be monitored are: depression, anxiety, and worries; sleep problems; and behavioral avoidance of traumatic stimuli. Such measures quantitatively monitor the ongoing impact of the therapy and

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 1, Module 2, Article 3, pp. 1-6, 07-27-2005 [copyright by authors]

have been found useful in complementing qualitative analyses as a way of understanding and managing clinical process (e.g., Barlow, & Craske, 2000; Lambert, Harmon, Slade, Whipple, & Hawkins, 2005).

Experimental controls. In future applications of the Cigrang et al. model, case studies should be complemented with experimental group studies, to enhance the grounds for drawing causal inferences about the effectiveness of the model. This will require the use of control groups. For example, if the authors wish to demonstrate the relative efficacy of exposure-based therapies against the military's approved protocol of employing Critical Incident Stress Bebriefings (CISD) as the last stage of their Critical Incident Stress Management (CISM) model protocol, then why not randomly assign intakes to one of the following conditions: exposure alone, exposure with cognitive-behavior therapy, CISD, placebo/no treatment control (e.g., come in to the clinic and talk about sports). The placebo/no treatment control condition seems necessary in a combat setting because of the potential effects that removal from a traumatic setting alone might provide regardless of what occurs during these occasions.

THE ROLE OF CASE STUDIES IN MANUALIZED THERAPY

As mentioned above, while manualization is typically identified with group outcome studies, there is an important role for case studies of manualized therapies, for a variety of reasons (Edwards, Dattilio, & Bromley, 2004; Fishman, 2005). First, manualized approaches frequently develop from the less standardized and more individualized environment of practice in clinically focused settings -- as in the Cigrang et al. studies -- and it is important to compare systematically the original clinical case procedures with those employing a more formal manual. Second, as illustrated in the extensive variation among the three cases in the Cigrang et al. study, any manual has to be adapted to the particular circumstances of the individual client, and it therefore becomes important to see how a specific manual plays out with a variety of patients with the same type of problem. For this reason, manualizing an approach like the Cigrang et al. model calls for conducting additional case studies to document the detailed processes by which the manualized model works with specific individuals.

A related question is the degree to which a manual should be standardized and structured so as to obtain an optimal level of effectiveness. Wilson (1996, 1997), a strong advocate of manualized CBT approaches, points out that all manuals have flexibility with regard to the manner in which the therapist develops a positive working relationship with the client:

> The importance of developing rapport and building a positive therapeutic alliance is no less important in manual-based therapy than conventional therapy. The quality of the therapeutic relationship will help determine the extent to which patients comply with treatment interventions. Therapists have a critical role to play in overcoming ambivalence about behavior change, and in nurturing commitment to change despite psychological setbacks. (1996, p. 305)

In addition, Wilson (1997) points out that CBT manuals are typically designed to allow for some degree of individualization because of the availability of multiple techniques and

ongoing assessment of patients' response to treatment in CBT. This point is very nicely summed up in a quote Wilson (1997) cites from Jacobson and Hollon (1996), who have elaborated on the issue of individualization in regard to the nature of CBT in the treatment of depression:

> CBT consists of a number of interrelated strategies that typically unfold in sequential fashion over time and that are modified on an ongoing basis to fit the needs of the patient. What is appropriate to do at any point in time depends on the idiosyncratic characteristics of the patient, where the patient is in the course of therapy, and what issues have already been discussed . . . . . competence is linked to context. (p. 106)

In sum, there is an intrinsic need for therapy manuals to have some degree of flexibility. At the same time, CBT clinical models like Cigrang et al.'s need to have a fair amount of structure. For example, all three of the patients in their study went through a similar exposure procedure. Thus, the question might be viewed not as whether to create a manual for CBT treatments, but rather how much flexibility to build into the manual for optimal results. For example, should all the exposure sessions be of equal length, or should length be determined by other factors which could also be operationalized and thus made consistent across people? What should be added to the Cigrang et al. model are explicit guidelines for making the decision about exposure session length. In any event, fortunately the question of how much variability leads to optimal results is an empirical one; and once a model like Cigrang et al.'s becomes more manualized, it will be possible to assess whether this change leads to any decline in outcome effectiveness, both from the perspective of case studies and group studies.

REFERENCES

Barlow, D.H., & Craske, M.G. (2000) *Mastery of your anxiety and panic (MAP-3): Client Workbook for anxiety and panic.* San Antonio, TX: Graywind Psychological Corporation.

Beck, A.T., Steer, R.A., & Brown, G.K. (1996) *BDI-II: Manual.* San Antonio, TX: The Psychological Corporation.

Beck, A.T. & Steer, R.A. (1990). *Manual for the Beck Anxiety Inventory.* San Antonio, TX: The Psychological Corporation.

Chambless, D.L., & Hollon, S.D. (1988). Defining empirically supported therapies. *Journal of Consulting & Clinical Psychology, 66,* 7-18.

Cigrang, J.A., Peterson, A.L. & Schobitz, R.P. (2005). Evaluation of a brief exposure therapy treatment for the secondary prevention of combat-related PTSD. *Pragmatic Case Studies in Psychotherapy* [Online], Vol. 1(2), Article 1. Available: http://hdl.rutgers.edu/1782.1/pcsp_journal

Derogatis, L. R. (1994). *SCL-90-R: Administration, scoring and procedures manual* (3rd ed.). Towson, MD: Clinical Psychometric Research.

DiNardo, P.A., & Barlow, D.H. (1988). *Anxiety Disorders Interview Schedule-Revised (ADIS-R).* Albany NY: Graywind Publications/Psychological Corporation.

Edwards, D,J.A., Dattilio, F.M., Bromley, D. (2004). Developing evidence-based practice: The role of case-based research. *Professional Psychology: Research and Practice, 35*, 589-597.

Fishman, D. B. (2005). Editor's Introduction to PCSP - From Single Case to Database: A New Method for Enhancing Psychotherapy Practice. *Pragmatic Case Studies in Psychotherapy* [Online], Vol. 1(1), Article 2. Available: http://hdl.rutgers.edu/1782.1/pcsp1.1.47

Grissom, G.R., Lyons, J.S. & Lutz, W. (2002). Standing on the shoulders of a giant: Development of an outcome management system based on the dose model and phase model of psychotherapy. *Psychotherapy Research, 12*, 397–412.

Jacobson, N.S. and Hollon, S.D. (1996). Prospects for future comparisons between drugs and psychotherapy: Lessons from the CBT-versus-pharmacotherapy exchange. *Journal of Consulting and Clinical Psychology, 64*, 104–108.

Kean, T. M., Weathers, F.W., & Foa, E.B. (2000). Diagnosis and Treatment. In E. Foa, T. Kean, & M. Friedman (Eds.), *Effective Treatments for PTSD* (pp.18-36). New York, NY: Guildford Press.

Lambert, M.J., Harmon, C., Slade, K., Whipple, J.L., Hawkins, E.J. (2005). Providing feedback to psychotherapists on their patients' progress: Clinical results and practice suggestions. *Journal of Clinical Psychology, 61*, 165-174.

Lambert, M.J., Burlingame, G.M., Umphress, V., Hansen, N.B., Vermeersch, D.A., Clouse, G.C., & Yanchar, S.C. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology and Psychotherapy, 3*, 249-258

Lambert, M.J., Harmon, C., Slade, K., Whipple, J.L., Hawkins, E.J. (2005). Providing feedback to psychotherapists on their patients' progress: Clinical results and practice suggestions. *Journal of Clinical Psychology, 61*, 165-174.

Nathan, P.E., & Gorman, J.M. (2002). *A guide to treatments that work, 2nd Ed.* New York: Oxford University Press.

Nezu, A.M., Nezu, C.M., Lombardo, E. (2004). *Cognitive-behavioral case* formulation and treatment design: A problem-solving approach. New *York: Springer Publishing.*

Persons, J. (1989). *Cognitive therapy in practice: A case formulation approach.* New York: W.W. Norton.

Seligman, M.E.P. (1995). The effectiveness of psychotherapy: The *Consumer Reports* study. *American Psychologist, 50*, 965- 974.

Wilson, G.T. (1996). Manual-based treatments: The clinical application of research findings. *Behaviour Research and Therapy, 34*, 295-315.

Wilson, G.T. (1997). Treatment manuals in clinical practice. *Behaviour Research and Therapy, 35*, 205-210.