Journal of Anxiety Disorders 24 (2010) 909–917

Contents lists available at ScienceDirect

Journal of Anxiety Disorders

Effects of additional prolonged exposure to psychoeducation and relaxation in acute stress disorder

Claudia Freyth, Karin Elsesser*, Thomas Lohrmann, Gudrun Sartory

Department of Clinical Psychology, University of Wuppertal, Wuppertal, Germany

ARTICLE INFO

Article history:
Received 9 February 2010
Received in revised form 17 June 2010
Accepted 17 June 2010

Keywords:
Acute stress disorder
Prolonged exposure
Heart rate
Trauma-related pictures

ABSTRACT

We investigated the effect of prolonged exposure (PE) on the heart rate (HR) and skin conductance response to trauma-related stimuli in acute stress disorder (ASD). Forty recent trauma victims with ASD were randomly assigned to three sessions of either PE or supportive counseling (SC) with both groups also receiving psychoeducation and progressive relaxation. Assessments were carried out before and after treatment and again after 3 months. Four years later, patients were asked by telephone whether they had received further treatment. There were no significant group differences with regard to symptomatic improvement at the end of treatment. Both groups showed initial cardiac acceleration to trauma-related pictures. After treatment the PE group showed attenuation of the HR response and a reduction in spontaneous fluctuations (SF) whereas the SC group showed a decelerative (orienting) response and a marginal increase in SF. Following SC, 43% received further treatment compared to 9% after PE.

© 2010 Elsevier Ltd. All rights reserved.

1. Introduction

Exposure to traumatic stress can result in post-traumatic stress disorder (PTSD) which combines the symptoms re-experiencing (criterion B), avoidance (C), and arousal (D) (DSM-IV-TR; American Psychiatric Association, 2000). Occurrence of these and dissociative symptoms during the initial month after the traumatic experience is termed acute stress disorder (ASD). Whereas, the majority of victims of civil trauma such as road traffic accidents or assault show improvement over time (Scholes, Turpin, & Mason, 2007), those suffering from ASD have been reported to carry a high risk of also developing PTSD (Harvey & Bryant, 1998). This stress disorder can, in turn, promote the development of a number of other disorders. Creamer, Burgess, and McFarlane, (2001) found sequelae in over 80% of PTSD patients. Most frequently reported was depression in 58%, substance-related disorder in 43% and phobias and generalized anxiety in a third of the patients. Given the disabling nature of PTSD and its potential to trigger further psychological disorders, it seems of paramount importance to provide early intervention to individuals who are likely to develop PTSD.

Cognitive behavior therapy (CBT) for ASD is usually employed 2–5 weeks following the trauma and combines approaches such as prolonged exposure with cognitive restructuring and anxiety management techniques. This treatment was found to be effective compared to a wait-list control condition (Bisson, Shepherd, Joy, Probert, & Newcombe, 2004; Foa, Hearst-Ikeda, & Perry, 1995), a self-help booklet (Ehlers et al., 2003), supportive counseling (Bryant, Harvey, Dang, Sackville, & Basten 1998; Bryant, Moulds, Guthrie, & Nixon, 2005; Bryant, Moulds, & Nixon, 2003; Bryant, Sackville, Dang, Moulds, & Guthrie, 1999) and cognitive restructuring (Bryant et al., 2008) although there are also discrepant reports showing no significant differences between treatment conditions (Echeburúa, de Corral, Sarasua, & Zubizarreta, 1996; van Emmerik, Kamphuis, & Emmelkamp, 2008). Additional anxiety management training (Bryant et al., 1999) or hypnotherapy (Bryant et al., 2005) failed to be more efficacious than CBT on its own. Long-term follow-ups tended to confirm the short-term results (Bryant et al., 2006) although there are also reports of a long-term convergence of groups (Foa, Zoellner, & Feeny, 2006) suggesting that treatment merely accelerates recovery. In the majority of these studies, the control group received psychoeducation and general problem-solving training which does not permit conclusions as to the differential efficacy of the various CBT components. In order to evaluate the unique contribution of trauma-related exposure, relaxation was included in both treatment conditions. It was expected to address arousal symptoms but not specifically trauma-related stress symptoms.

Throughout the previous studies, outcome measures were those of self-report, be it in the form of standardized interviews or of questionnaires, the tacit assumption being that all other components of the stress response show similar recovery. There is ample evidence that PTSD is associated with physiological reactivity, in

* Corresponding author at: Department Psychology, University of Wuppertal, Max-Horkheimer-Strasse 20, D-42119 Wuppertal, Germany. Tel.: +49 202 439 3947; fax: +49 202 439 3031.
E-mail address: elsesser@uni-wuppertal.de (K. Elsesser).

0887-6185/$ – see front matter © 2010 Elsevier Ltd. All rights reserved.
doi:10.1016/j.janxdis.2010.06.016

particular, heart rate (HR) acceleration on exposure to trauma-related stimuli (for a review see Orr, Metzger, & Pitman, 2002) and PTSD patients without physiological reactions were reported to be less severely affected by re-experiencing symptoms and depression (Keane et al., 1998). Trauma victims with ASD were also found to exhibit HR-acceleration to pictures, which they judged to be trauma-relevant, compared to trauma victims without ASD and control subjects not exposed to a traumatic event (Elsesser, Freyth, Lohrmann, & Sartory, 2008; Elsesser, Sartory, & Tackenberg, 2004; Rabe, Dörfel, Zöllner, Maercker, & Karl, 2006). Compared to neutral pictures, generally aversive ones elicited brief cardiac deceleration in all groups. This attentional, so-called "orienting" response is usually found in response to interesting stimuli (Jennings, 1986) and is considered to lower the perceptual threshold thereby enhancing stimulus input and processing (Graham, 1979). Amplitude of the accelerative cardiac response to trauma-relevant pictures was positively correlated with the number of re-experiencing symptoms and both were predictive of the development of PTSD symptoms after 3 months (Elsesser, Sartory, & Tackenberg, 2005). It is well established in other anxiety disorders that the HR response to fear-relevant contents subsides with successful treatment, in particular, with exposure methods (e.g., Sartory, Eves, & Foa, 1987). PTSD patients also evidenced attenuation of the HR response to trauma-related stimuli after CBT (Blanchard et al., 2002; Rabe et al., 2006). So far it has not been investigated whether the HR response is attenuated together with the symptomatic relief in the treatment of ASD nor, indeed, whether the initial HR response is predictive of treatment outcome.

In the present study, trauma victims with ASD were treated either with prolonged exposure or supportive counseling in addition to psychoeducation and progressive relaxation which was given to both groups. Assessments took place before and after treatment and after another 3 months and included the measurement of the HR response to trauma-related pictures. Additionally, patients were contacted by telephone approximately four and a half years later and asked whether they had received further treatment. We expected prolonged exposure to be more effective than supportive counseling in terms of long-lasting symptomatic relief and to have a more attenuating effect on the accelerative HR response. The latter was also thought to be predictive of treatment outcome in the prolonged exposure group.

2. Methods

2.1. Participants

Forty consecutive referrals of trauma victims to the outpatient treatment center of the Psychology Department of the University of Wuppertal took part in the study. They were referred by the local police and victim support departments as well as accident and emergency departments of hospitals. Among the exclusion criteria were psychotic, substance-related and organic mental disorder, current suicidal ideation, chronic PTSD, age younger than 18 years, and ongoing traumatic stressors (such as an abusive partner). None of the participants were involved in a current litigation procedure. Thirty-two additional referrals were excluded (14 met PTSD criteria, 8 did not meet ASD criteria of 2 or more of the symptom categories B–D and 10 did not attend further appointments after the first diagnostic session). Another 6 patients (3 in each treatment group) terminated the intervention prematurely. Twenty-four of the participating trauma victims met criteria of an acute stress disorder (ASD) and the other 16 met all criteria apart from reporting less than three dissociative symptoms. The traumatic event occurred an average of 20.5 days (SD = 9.4; range: 3–38 days) before the first assessment. The study was approved by the Ethics Committee of the University of Wuppertal. All participants provided written informed consent and received a small remuneration to cover travel expenses.

2.2. Design

Patients were randomly allocated to one of two treatment groups, i.e., prolonged exposure (PE: $n = 19$) or supportive counseling (SC: $n = 21$) by assigning consecutive referrals alternately to the two treatment conditions. Treatment consisted of 3 weekly, individually administered sessions lasting 90 min in the case of the first treatment session and 60 min of the second and third treatment session. Assessments were carried out before treatment (pre-treatment), 1 week after treatment (post-treatment) and after another 3 months (follow-up; FU). In November 2009 all patients were again contacted by telephone and asked as to their well-being and whether they had received further treatment for the stress disorder. As the treatment trial had stretched out over two and a half years, the follow-up varied considerably between patients. The median time was 52 months (ranging from 29 to 66 months in case of the SC group and from 24 to 60 months in case of the PE group).

2.3. Treatment methods

All treatments were carried out by qualified clinical psychologists trained in CBT.

2.3.1. PE (prolonged exposure)

The first session was devoted to psychoeducation, training in progressive muscle relaxation and elicitation of the trauma script by exploring the sequence of events with the participant's emotional and cognitive reactions. At the end of the session patients were given written information about stress disorders and a CD with instructions to carry out progressive muscle relaxation to be practiced at home. They were also asked to think about the traumatic event in case they could remember more details by the following session. During the second session, progressive muscle relaxation was carried out again after which participants were given extensive imaginal exposure to the trauma script. Beyond being asked to carry out relaxation, patients were not given explicit homework instructions although the maintaining role of avoidance was pointed out to them. During the final session, the patient and therapist went to the site of the traumatic incident for in vivo exposure. Participants were asked to relive the traumatic event again and both therapist and trauma victim remained there until the fear of the patient abated. Afterwards the patient stayed at the site on his/her own and reported back to the therapist after the remission of fear.

2.3.2. SC (supportive counseling)

The first session was also devoted to psychoeducation followed by training in progressive muscle relaxation and participants were also given written information about PTSD and a CD with relaxation instructions to practice at home. Afterwards, patients were asked about everyday problems which had resulted from the trauma experience. At the beginning of the second session, relaxation exercises were repeated. For the remaining time and the third session problem-solving skills and general counseling were applied in the discussion of problems at work and in family life while mention of the traumatic incident was avoided.

Twenty-seven (19%) randomly chosen treatment sessions were taped and given to an independent assessor. All of the sessions were attributed correctly to the respective treatment condition.

دریافت فوری ← متن کامل مقاله

ISIArticles
مرجع مقالات تخصصی ایران

✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
✓ امکان دانلود نسخه ترجمه شده مقالات
✓ پذیرش سفارش ترجمه تخصصی
✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
✓ دانلود فوری مقاله پس از پرداخت آنلاین
✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات