

Efficacy of interoceptive exposure therapy combined with trauma-related exposure therapy for posttraumatic stress disorder: A pilot study

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Abstract

The aim of this case series was to examine efficacy of interoceptive exposure (IE) combined with trauma-related exposure therapy (TRE) for posttraumatic stress disorder (PTSD). Seven participants completed treatment consisting of four weekly sessions of IE followed by eight weekly sessions of TRE (four sessions of imaginal exposure and four sessions of in vivo exposure). Assessments were conducted at pretreatment, posttreatment, 1- and 3-month follow-up. Outcome measures included PTSD symptoms, anxiety sensitivity, posttraumatic cognitions, anxiety, and depression. Five of the seven participants showed pre- to posttreatment improvements on these measures, and two participants showed less symptom reduction. Results at the 1-month follow-up showed that treatment gains were generally maintained in five (of the seven) participants and four of these individuals no longer met PTSD diagnostic criteria. Four individuals completed the 3-month follow-up and their symptoms and diagnostic status remained unchanged. These preliminary findings are promising. The next step in this line of research is to conduct a randomized, controlled trial to further to examine the efficacy, tolerability, and mechanisms of using IE in the treatment of PTSD.

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Trauma-related exposure therapy (TRE) is among the most effective treatments for posttraumatic stress disorder (PTSD) (Taylor, 2006). TRE entails a combination of (a) imaginal exposure to traumatic memories (e.g., writing out and re-reading a description of the traumatic event or verbally recounting memories of the traumatic event several times in a session), and (b)

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in vivo exposure to distressing but harmless reminders of the trauma (e.g., returning to the scene of a traumatic traffic accident). Despite the fact that many people benefit from TRE, several limitations of this treatment have been identified. First, not all individuals respond to TRE and many individuals continue to be symptomatic after treatment. For patients treated with TRE, up to 45 percent still meet criteria for PTSD by the end of a typical (e.g., 8–12 weeks) course of treatment (van Minnen, Arntz, & Keijsers, 2002). A further problem is that some individuals are unable to tolerate the side-effects of TRE (e.g., the transient worsening of symptoms during the initial phase of treatment; Taylor, 2006). Thus, recent research efforts have focused on how TRE can be effectively combined with other psychosocial interventions to further improve outcome. So far the results have been disappointing, as they suggest that TRE combined with many other interventions (e.g., cognitive restructuring) is generally no more effective than TRE alone (Taylor, 2006). Further research is needed to develop and evaluate novel methods that can further improve both treatment tolerability and treatment efficacy.

There is growing evidence that elevated anxiety sensitivity (AS) may play an important role in PTSD, and methods for reducing AS – particularly interoceptive exposure (IE) – may be an effective intervention for PTSD. AS is the fear of anxiety-related sensations, which arises from beliefs that the sensations will have harmful physical, cognitive, or social consequences (e.g., believing that heart palpitations will lead to cardiac arrest). IE involves exposure to feared bodily sensations through harmless brief exercises (e.g., repeatedly hyperventilating for 1 min, spinning for 1 min, or breathing through a narrow straw for 30 s). Through repeated exposure to these sensations, patients learn that the sensations do not lead to catastrophic consequences, and thus their AS is reduced.

Reduction in AS through use of IE may not only reduce PTSD symptoms, but also may facilitate conventional TRE for PTSD. That is, by first reducing the fear of arousal-related sensations through IE, patients may also be better able to tolerate the arousal symptoms generated during TRE. In turn, by reducing their fear of anxiety reactions, patients may become more engaged in the TRE during exposure, and thus be more likely to complete TRE exercises, and be less likely to withdraw from treatment prematurely (e.g., due to the side effects or other forms of symptom worsening that can occur in the initial weeks of TRE).

Although the exact nature of the relationship between AS and PTSD remains unclear, there is considerable empirical and theoretical support for investigating the merits of targeting AS in the treatment of PTSD. Evidence suggests that AS contributes to, or amplifies, the intensity of anxiety and other emotional reactions, and that it has a key role in the etiology and maintenance of panic attacks and panic disorder (e.g., McNally, 2002). It has also been linked to development of other anxiety disorders, including PTSD (e.g., Bernstein et al., 2005; Feldner, Lewis, Leen-Feldner, Schnurr, & Zvolensky, 2006; Taylor, 1999, 2000). Research shows that AS is elevated in PTSD, compared to control groups, and is correlated with PTSD symptom severity (Fedoroff, Taylor, Asmundson, & Koch, 2000; Lang, Kennedy, & Stein, 2002; Taylor, Koch, & McNally, 1992), and decreases in AS are correlated with treatment-related reductions in PTSD symptoms (Fedoroff et al., 2000). Recent studies have also shown an interaction between AS and the frequency of traumatic events predicts PTSD symptom severity (Bernstein et al., 2005; Feldner et al., 2006).

This line of research subsequently led to its clinical applications, in which we reported a case study in which PTSD (in a patient without comorbid psychopathology such as panic attacks) was successfully treated with IE followed by TRE (Wald & Taylor, 2005). The next step in evaluating this treatment package was to conduct a series of case studies, which would be used as a pilot study before conducting a randomized, controlled trial. The purpose of the present study was to

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