

Perceived Perpetration During Traumatic Events: Clinical Suggestions From Experts in Prolonged Exposure Therapy

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Prolonged exposure therapy (PE) is a treatment that has proven effectiveness in reducing the symptoms of posttraumatic stress disorder (PTSD) and related psychopathology. Providing PE to trauma survivors with PTSD, particularly related to combat trauma, often involves addressing guilt or shame related to their contextually appropriate use of violence and lethal force. In this paper, we present 4 clinical case vignettes in order to define the concept of perceived perpetration, and offer clinical suggestions for assessment and treatment with PE. Specifically, we examined issues such as identifying what type of traumatic events are appropriate for the use of PE, how to approach issues surrounding actions that could be perceived as perpetration, and attending to trauma-related guilt or shame.

PROLONGED exposure therapy (PE), a type of exposure therapy, is an empirically supported treatment for PTSD and related psychopathology, such as depression, anger, and guilt (Cahill, Rauch, Hembree, & Foa, 2003; Foa et al., 1999; Foa et al., 2005; Hembree et al., 2005; Paunovic & Öst, 2001; Rauch, et al., 2009; Resick, Nishith, Weaver, Astin, & Feuer, 2002; Rothbaum, Astin, & Marsteller, 2005; Schnurr et al., 2007; Tuerk et al., 2011). In response to the need to provide effective treatments to men and women who have served in the Armed Forces, the most recent U.S. Department of Veterans Affairs and Department of Defense (VA/DoD) treatment guidelines recommended exposure therapy as a first-line intervention for PTSD (Freidman, 2006; Institute of Medicine, 2007; VA DoD, 2010). In addition, the Veterans Health Administration is conducting a nationwide rollout to train clinicians to be providers of PE (Rauch, Eftekhari, & Ruzek, 2012).

Military personnel are at a high risk for using lethal force and perpetrating harm (both intentional and unintentional) while serving in a combat zone. A recent analysis of data collected as part of Operation Iraqi Freedom postdeployment screening program found that

40% of soldiers reported killing or being responsible for killing during their deployment (Maguen et al., 2010). In addition, after controlling for combat exposure, killing emerged as a significant predictor of PTSD symptoms, alcohol abuse, anger, and relationship problems. Higher rates of PTSD among Vietnam veterans have also been reported among those directly involved in atrocities (MacNair, 2002).

In response to the complex moral and ethical challenges that modern warfare poses for service members, Litz et al. (2009) have introduced the concept of “moral injury.” They conceptualize potentially morally injurious events as those that involve “perpetrating, failing to prevent, or bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations” (p. 700). Given that events such as these may unfortunately be commonplace for veterans, Litz et al. suggest that it is important for clinicians to expand their repertoire in order to fully address the psychological sequelae stemming from morally injurious events. Accordingly, they propose a modified CBT intervention that addresses moral injury (see Steenkamp et al., 2011, for intervention). Although they include an abbreviated exposure component in this treatment, they argue that traditional exposure-based treatment focusing on fear and anxiety-based PTSD symptoms may not adequately address the guilt and shame that may follow from morally injurious events. This assertion, however, is not consistent with research showing that PE results in significant reductions in guilt as well as PTSD symptoms (Foa & Rauch, 2004; Resick et al., 2002).

Keywords: prolonged exposure; perceived perpetration; PTSD; trauma

1077-7229/12/461–470\$1.00/0

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 **Continuing Education Quiz located on p. 556–557.**

Traumatic events that involve morally injurious events are likely to elicit debilitating guilt and shame. Accordingly, clinicians utilizing PE to treat symptoms of PTSD must also attend to these negative moral emotions. In a review of the literature on guilt, [Tilghman-Osborne, Cole, and Felton \(2010\)](#) found discrepancies regarding the relationship of guilt to psychopathology and proposed that these resulted from variable definitions and measurements of the construct of guilt. The reviewers concluded that guilt is a complex construct involving both affective and cognitive components, real or imagined moral transgression, and behavioral self-blame. For the purposes of this paper, we will conceptualize guilt similarly to [Tilghman-Osborne et al. \(2010\)](#) as thoughts and feelings resulting from a perceived moral transgression with behavioral but not characterological self-blame. Feelings of responsibility and remorse may be part of guilt along with a desire to make reparations. [Litz et al. \(2009\)](#) concluded that guilt is associated with a decrease in committing similar offenses in the future, and it often facilitates making amends. [Tangney, Stuewig, and Mashek \(2007\)](#) argue that guilt is adaptive when individuals acknowledge their moral transgression and take appropriate responsibility. They argue that guilt is maladaptive when it is fused with shame and produces feelings of contempt and disgust for a defective self.

In contrast to guilt, which involves a negative evaluation of a specific behavior in a situation (I did something bad/wrong that I regret), the moral emotion of shame entails a negative evaluation of the global self (I am a bad person; [Tangney et al., 2007](#)). In their review of the existing literature on shame and guilt, [Tangney et al.](#) concluded that shame is a more painful and damaging emotion to one's mental health because the core of the self is the object of the condemnation rather than a specific behavior. Shame often results in one feeling exposed and expectant of others' disapproval or negative judgment. While guilt can lead to a desire to make amends, shame is linked to disruption of empathic connection and the tendency to withdraw interpersonally and focus on internal distress. Feelings of shame are also positively correlated with anger, hostility, expressions of anger in destructive ways, and externalization of blame. The distressing emotion of shame is difficult to resolve as it reinforces defective self-views. Clinicians providing treatment for PTSD that has resulted from traumatic events that elicit feelings of shame and maladaptive shame-infused guilt, such as potentially morally injurious traumas, must be intentional in addressing patients' distress related to these emotions. It follows that a goal for treatment would be to "unfuse" the shame from the guilt and assist the trauma survivor in acknowledging appropriate levels of responsibility for their action or inaction. Specific recommendations for how to utilize PE for this purpose will follow.

In order to address the concern that exposure-based treatments for PTSD may not sufficiently address symptoms of guilt and shame stemming from morally injurious traumas, we present clinical suggestions for how to address these issues when providing PE. In particular, we will focus on morally injurious traumas that involve acts of perceived perpetration and discuss how PE can address resultant PTSD and associated guilt and shame. For the purpose of this paper, we define perceived perpetration as occurring when a trauma survivor, in the context of his/her trauma, (a) acted with potentially violent and/or lethal force or failed to act when violence was occurring to others, and (b) interprets his/her behavior as perpetration or as violating his/her moral code and, (c) acted as a consequence of the trauma context and not as a premeditated act or with instrumental intent to victimize. After presenting four clinical vignettes of trauma survivors struggling to recover from traumas involving perceived perpetration, we provide guidance on how to approach assessment and provision of PE in cases involving perceived perpetration.

Clinical Vignettes

The following clinical vignettes will be used to examine key issues in the use of PE with trauma that includes perceived perpetration. These vignettes are based on the authors' collective clinical experiences treating, supervising and consulting on a number of PE cases in the VA Healthcare system that involved combat veterans. Aspects of these vignettes have been altered to protect patients' privacy.

Clinical Vignette 1: Army Reservist in Iraq

An army reservist describes her primary reexperiencing symptoms related to an incident that occurred during her deployment to Iraq. She served in an area where insurgents commonly equipped children with explosives and instructed them to approach American service members prior to detonation. The reservist had orders to fire upon people who did not follow her orders to cease in their approach, regardless of their age and gender. While she was pulling guard duty at the check point, she saw a child approaching with his hands behind his back. In the child's local language, the reservist yelled to the child to stop and show his hands. When the child continued to approach, she shouted again and fired a warning shot. The child began to run toward the reservist who then fired at and killed the child. The child did not have a bomb. The patient reported feeling numb during and after the event and now calls herself a murderer. In the week prior to this incident, several of the reservist's friends were killed when explosives on a teenage boy were detonated at a check point.

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