

Trauma Informed Guilt Reduction Therapy With Combat Veterans

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Guilt related to combat trauma is highly prevalent among veterans returning from Iraq and Afghanistan. Trauma-related guilt has been associated with increased risk for posttraumatic psychopathology and poorer response to treatment. Trauma Informed Guilt Reduction (TriGR) therapy is a 4-module cognitive-behavioral psychotherapy designed to reduce guilt related to combat trauma. The goals of this study were to describe the key elements of TriGR and report results of a pilot study with 10 recently deployed combat veterans. Ten combat veterans referred from a VA Posttraumatic Stress Disorder (PTSD) or mental health clinic completed TriGR over 4 to 7 sessions. Nine veterans completed the posttreatment assessment.

This initial pilot suggests that TriGR may help to reduce trauma-related guilt severity and associated distress. Changes in trauma-related guilt were highly correlated with reductions in PTSD and depression symptoms over the course of treatment, suggesting a possible mechanistic link with severity of posttraumatic psychopathology.

TriGR warrants further evaluation as an intervention for reducing guilt related to traumatic experiences in combat.

COMBAT veterans often report perpetrating, failing to prevent, or witnessing acts during combat that violate the values they live by in their civilian lives (Litz et al., 2009; Maguen et al., 2010; Nash, 2007; Stein et al., 2012). Trauma survivors who negatively appraise their action or inaction during combat may experience guilt, a distressing emotion arising from complex cognitive appraisals, including negative self-evaluation of one's behavior in comparison to valued standards (Kubany & Watson, 2003; Lewis, 1971; Litz et al., 2009; Tangney & Dearing, 2002; Watson, Juba, Manifold, Kucala, & Anderson, 1991). Guilt related to traumatic events has been shown to partially mediate the relationship between combat exposure and symptoms of both posttraumatic stress disorder (PTSD) and depression in veterans (Browne, Evangeli, & Greenberg, 2012; Marx et al., 2010; Watson et al., 1991) and has been implicated as a risk factor for the development of multiple forms of posttraumatic psychopathology, including PTSD, depression, and substance use disorders (Andrews, Brewin, Rose, & Kirk, 2000; Kim, Thibodeau, & Jorgensen, 2011; Leskela, Dieperink, & Thuras, 2002; Marlatt & Gordon, 1985;

Meehan, O'Connor, Berry, Weiss, & Acampora, 1996). Traumatic guilt has also been shown to have a strong correlation with reexperiencing symptoms of PTSD (Stein et al.) and may contribute to suicidal ideation (Hendin & Haas, 1991; Hyer, McCranie, Woods, & Boudewyns, 1990; Kubany et al., 1996).

Trauma-related guilt can persist without appropriate treatment (Kubany & Manke, 1995). Kubany and colleagues (1995) found Vietnam veterans continued to experience high levels of posttraumatic guilt and associated distress nearly four decades after combat exposure. In a later study, Kubany and colleagues (2003) found guilt was significantly reduced in female interpersonal violence survivors who received cognitive therapy for battered women, a treatment that targets guilt cognitions in addition to PTSD, whereas guilt scores did not change significantly in a comparison condition that did not receive treatment.

Because posttraumatic guilt has been identified as having a role in the development and maintenance of several forms of posttraumatic psychopathology, it may be an ideal target for intervention. Among combat veterans, having comorbid problems appears to be the norm, not the exception (Goldsmith, Wilkins, & Norman, 2012). For example, of all new Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans enrolled in a VA hospital from October 2001 to January 2008 diagnosed with mental health disorder, 29% were diagnosed with two disorders, and 33% were diagnosed with three or more disorders (Seal et al.,

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2009). These findings suggest the need for consideration of how to most effectively and efficiently address comorbidity and the complex array of problems with which veterans present to treatment. One possible pathway is to develop interventions that target a mechanism thought to underlie multiple highly prevalent disorders, such as guilt. However, as of yet, there are no empirically supported treatments that take a transdiagnostic approach to targeting guilt among combat veterans. To date, treatments for posttraumatic psychological health issues have been disorder specific (Lang et al., 2012).

Evidence-based treatments for PTSD such as Prolonged Exposure Therapy (PE) and Cognitive Processing Therapy (CPT) can help individuals successfully process traumatic guilt (Smith, Duax, & Rauch, 2013), but not all who have posttraumatic distress have PTSD. Clinicians who treat combat veterans report that the diagnosis of PTSD does not fully account for the presentations of trauma-related guilt and other forms of posttraumatic distress that they frequently see in their patients (Becker, Zayfert, & Anderson, 2004; Drescher et al., 2011). These clinicians further report that they would like additional guidance on how to help their patients resolve complex issues such as trauma-related guilt (Nash, 2007). Indeed, research suggests that trauma-related guilt appears to be less amenable to change by exposure-based treatments such as PE (Foa & Meadows, 1998; Nishith, Nixon, & Resick, 2005; Owens, Chard, & Cox, 2008; Pitman, Altman, Greenwald, & Longpre, 1991; Resick & Schnicke, 1992) and has been found to impede the processing of fear and other emotions related to traumatic events (Arntz, Tiesema, & Kindt, 2007; Brewin, Dalgleish, & Joseph, 1996; Foa & Meadows, 1997; Joseph, Williams, & Yule, 1997; Monson et al., 2006; Riggs, Dancu, Gershuny, Greenberg, & Foa, 1992). It has been suggested that cognitive-focused treatments, such as CPT, may be more effective in reducing posttraumatic guilt (Resick, Nishith, Weaver, Astin, & Feuer, 2002). While one investigation suggests that CPT may reduce some but not all types of trauma-related guilt cognitions in female rape victims (Resick et al., 2002), a later study failed to find significant pre-to-post differences in posttraumatic guilt in Vietnam veterans receiving CPT (Owens et al., 2008). After evaluating the effects of CPT and PE on trauma-related guilt, Resick and colleagues (2002) suggested that certain types of guilt cognitions might require more formal cognitive intervention. It has also been suggested that for those with posttraumatic guilt, increased therapeutic focus on cognitive techniques to reduce cognitions related to guilt may lead to reduced avoidance and may help to reduce PTSD symptom severity (Owens, Walter, Chard, & Davis, 2012; Stein et al., 2012). In summary, evidence-based treatments for PTSD have been shown to reduce guilt; however, the extent to which they reduce

guilt has not yet been sufficiently examined in randomized controlled trials and, based on available research, additional treatment options are warranted.

Moreover, approximately 20% to 36% of individuals who begin best practice treatments, including CPT and PE, drop out before receiving what is considered to be a therapeutic dose (Bradley, Greene, Russ, Dutra, & Westen, 2005; Imel, Laska, Jakupcak, & Simpson, 2013). Among those with PTSD who complete these interventions, close to one half of individuals continue to meet diagnostic criteria for PTSD (Resick et al., 2002; Schnurr et al., 2007). In addition, data indicate that patients have better compliance to psychotherapy when they receive a preferred treatment approach (Kwan, Dimidjian, & Rizvi, 2010). Taken together, these findings support the need for evaluation of additional treatment options that target a mechanism that is highly distressing, challenging to treat, and associated with the development and maintenance of multiple disorders (Goldsmith et al., 2012; Lang et al., 2012).

Based on the above rationale, we developed Trauma Informed Guilt Reduction (TrIGR; Allard, Wilkins, & Norman, 2010; Norman, Wilkins, & Allard, 2010), a brief (4-module) manualized intervention designed to reduce trauma-related guilt and distress in combat veterans. The intervention is based on a model that proposes that guilt has the potential to serve a prosocial function in that it may encourage someone to apologize, take reparative action, or make a commitment to change behavior (Tangney, Stuewig, & Mashek, 2007). For example, a sense of guilt due to offending someone may lead to a commitment to behave differently in similar situations in the future. However, individuals who experience PTSD and other forms of posttraumatic distress (e.g., substance use, depression) often avoid trauma memories and associated negative thoughts and feelings (Foa, Steketee, & Rothbaum, 1989; Held, Owens, Schumm, Chard, & Hansel, 2011), therefore stunting the potential for evaluating and processing feelings of guilt adaptively (Henning & Frueh, 1998; Joseph et al., 1997; Kubany & Ralston, 1998; Lee, Scragg, & Turner, 2001). Unexamined guilt over a specific event can turn to more global shame attributions, such that conclusions about guilt related to a single event generalize to the entire self and become the focus of the emotional experience (e.g., "I am evil," "I am a monster," "I deserve to suffer"; Kubany & Watson, 2003). Global attributions of shame are also associated with high risk of psychopathology (Kim et al., 2011; Robinaugh & McNally, 2010; Tangney & Dearing, 2002). The avoidance involved in posttraumatic stress reactions also interferes with individuals living according to their values, which further contributes to posttraumatic distress (Kubany & Watson, 2003).

The goals of this study are to describe the key elements of TrIGR and present pilot data from a sample of 10 recently deployed combat veterans who served in OEF/

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