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Prolonged Exposure for PTSD in a Veteran group: A pilot effectiveness study

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ABSTRACT

Previous research has consistently demonstrated that Prolonged Exposure (PE) therapy is an effective treatment for posttraumatic stress disorder (PTSD). Traditionally, PE has been studied and delivered on an individual basis. However, the growing number of Veterans in need of PTSD treatment has led to increased interest in group therapies as an efficient way to provide access to care. The current study examined a group and individual hybrid treatment that was developed based on PE principles. Treatment was 12 weeks in length and consisted of 12 one-hour group sessions focused on in vivo exposures, and an average of approximately five-hour long individual imaginal exposure sessions. Data for this study were derived from 67 veterans who participated in 12 cohorts of the Group PE. Significant reductions in PTSD and depression symptoms were found in both completers and intent-to-treat sample analyses. The clinical implications of these findings are discussed.

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1. Introduction

PTSD treatment guidelines support exposure therapy as a first line intervention (e.g., Friedman, 2006; IOM, 2007; VA/DoD Clinical Practice Guideline, 2010). Prolonged Exposure (PE) therapy, the most utilized exposure treatment program for PTSD, has consistently demonstrated efficacy in reducing the symptoms of PTSD and related psychopathology, such as depression, anger, and guilt for both veterans and non-veterans (Cahill, Rauch, Hembree, & Foa, 2003; Foa et al., 1999, 2005; Paunovic & Ost, 2001; Rauch et al., 2009; Resick, Nishith, Weaver, Astin, & Feuer, 2002; Rothbaum, Astin, & Marsteller, 2005; Schnurr et al., 2007; Tuerk et al., 2011). The Veterans Health Administration has conducted an ongoing nationwide PE training initiative in the interest of making evidence-based treatment widely available for Veterans diagnosed with PTSD. To date over 1300 VA mental health professionals have attended training in the provision of individual PE as part of this formal implementation program (Rauch, Eftekhari, & Ruzek, 2012) and several additional hundreds were trained in delivering PE in other VA training programs. Examination of the effectiveness of these VA PE Roll Out trained clinicians using data from their training cases only, showed large effects on PTSD ($d = 0.86$; Eftekhari et al., 2013). The widespread training and dissemination of evidence-based psychotherapies for the treatment of PTSD within the VA system has been an important advance in providing the nation's Veteran population with a pathway to improved mental health and well-being. However, the growing number of Veterans in need of PTSD treatment has placed emphasis on the need to facilitate access to these gold standard treatments.

Empirical support for group interventions for PTSD is less established than for individual interventions. Recently, however, interest in group therapies for PTSD has increased in order to help meet the demand for treatment of PTSD among Veterans. The need for both effective and efficient treatments has led to the development

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of several new group protocols, as well as reviews of the existing group literature. For instance, in a recent meta-analysis of studies of cognitive behavioral groups for PTSD, the authors concluded that group CBT is an effective intervention for individuals with PTSD (Barrera, Mott, Hofstein, & Teng, 2013). Further, they reported no significant differences in the effect sizes between group CBT that included in-session exposure and those that did not include disclosure in groups. However, protocols that included exposure had large effects sizes (sizes (ES = 1.32; 95% CI: 0.89–1.75) while those without had small to moderate effects (ES = 0.49; 95% CI: −0.19 to 1.18) suggesting that the small number of trials for this comparison and significant heterogeneity in protocol effect may override the group versus individual difference. In addition, group CBT that included in-session exposure had slightly higher rates of attrition (26.4%) than groups without disclosure.

Group interventions for PTSD may offer potential benefits over individual therapy. One potential benefit of group is the opportunity for positive social interaction and bonding. For patients with PTSD this can be an especially therapeutic feature due to the isolation and mistrust that often cluster with PTSD. Specifically, psychoeducation about PTSD symptoms within a group format may allow group members to interact with others while normalizing symptoms and challenging the assumption that individuals are alone in their experience of their symptoms. Additionally, when exposure protocols are used, group members can encourage each other to engage in the work of therapy, such as in vivo exposure exercises, in a manner that group leaders cannot because of the members' shared symptoms and experiences of PTSD. Further, when provided with appropriate group size, group interventions can be an effective use of specialty trained staff resources (Sloan, Bovin, & Schnurr, 2012).

In addition to the review outlined above, several recent articles have examined new group exposure protocols (e.g., Castillo, C'de Baca, Qualls, & Bornovalova, 2012; Mott et al., 2013; Ready et al., 2008; Ready, Sylvers et al., 2012a; Sutherland et al., 2012). The majority of these studies (Mott et al., 2013; Ready et al., 2008; Ready, Sylvers et al., 2012a; Sutherland et al., 2012) have relied on a similar manual (originally developed by Lorenz et al., 2006). In each of these studies, significant reductions in PTSD symptoms were noted, and in the case of Ready, Sylvers et al. (2012a) the effect size for this change was shown to be large ($d = 0.89$). However, the groups were very time intensive, meeting twice weekly for 3 hours per group, for between 12 and 18 weeks.

Castillo et al. (2012) proposed an alternative to the aforementioned protocol. This protocol was much shorter, consisting of only 6 weekly 90-min sessions, and it included approximately 3 people in each group. Sessions focused on imaginal exposures and included time for processing. Results demonstrated that there was significant symptom reduction. However, the pre to post effect size on the PTSD checklist was small ($d = 0.26$). Indeed, both the Ready, Sylvers et al. (2012a), Ready, Vega, Worley, and Bradley (2012b), and Castillo et al. (2012) studies show effect sizes smaller than most trials with a full PE protocol. As such, concerns over whether these treatments are providing a full "dose" of exposure have been raised.

Finally, Ready, Vega et al. (2012b), published a report on a mixed group and individual exposure treatment. Their version of the treatment was largely based on the 12-week group described previously. During the first and last 2 weeks of the treatment, the participants attended twice weekly group sessions, each lasting 4 hours in length. During the middle 8 weeks, there was 1 weekly group meeting and 6 individual sessions for a total of more than 50 hours of session time. As with the previous groups, significant reductions were noted across measures, and effect sizes were large (e.g., $d = 1.63$ on PCL from pre to post).

In sum, the results of these studies suggest that group therapy for PTSD that included an exposure component can be effective, but the models used tend to require more session time per Veteran. For instance, the studies by Ready and colleagues are extremely time intensive, requiring participants to commit to between 72 (in the standard 12-week protocol) and 96 hours (in the 16-week version). This time burden is considerably higher than the 18 hours of in-session work traditionally required in individual PE and would require that at least 8 participants complete each group in order to even match the efficiency of individual treatment delivery, as groups required two leaders. On the other hand, the protocol proposed by Castillo et al. (2012), was briefer, but produced a much smaller effect size and was only able to accommodate small number of patients per group. Overall, however, previous group studies reported positive findings both in terms of outcome, as well as retention, with reported rates of completion ranging between 87.5% and 100% (Castillo et al., 2012; Ready, Vega et al., 2012b; Sutherland et al., 2012).

The purpose of this study was to develop and test a hybrid group and individual intervention protocol that would be both effective and efficient and would allow providers to make exposure based treatment more readily available to patients. The protocol that we developed aimed to minimally modify the traditional PE protocol, to ensure that clinicians trained in PE could implement the protocol easily and effectively. Indeed, we intended that the manual for this protocol be written as an addendum to the established PE manual (Foa et al., 2007). As such, this intervention includes all three primary components of PE: psychoeducation, in vivo exposure, and imaginal exposure followed by processing. No additional components were included. See below for additional details of the protocol.

2. Method

2.1. Participants and procedures

The current study is based on a clinical sample of Veterans who presented for an evaluation and were enrolled for treatment at a PTSD Clinic within a midwestern VA Hospital. Based on the results of the initial clinical evaluation, individual providers collaboratively developed a treatment plan with the patient. Participants included in this sample were patients whose treatment plan recommended therapy for PTSD and had indicated interest in group. Specifically, data for this study were derived from 67 veterans who participated in 12 cohorts of the Group PE. The average age of the sample was 54.5 years of age (SD = 13.3), and was predominantly male (98.5%). The majority of participants were either Vietnam Veterans (67.2%) or OEF/OIF/OND Veterans (23.9%). Most participants were diagnosed with a co-morbid mental health disorder in addition to PTSD (88.0%) and were engaged in medication management in addition to this intervention (82.1%). Finally, the greatest number of patients identified a combat trauma as the index event (77.6%), although the groups included participants that had experienced various traumas (e.g., military accidents, military sexual assault, and civilian traumas). See Table 1 for full descriptive statistics.

Prior to beginning the group, participants typically met with one of the group leaders individually to discuss the group. The Clinician-Administered PTSD Scale, which was administered as part of the standard clinical intake, was readministered during this individual appointment in instances where the initial intake assessment took place more than 1 month before this pre-group appointment.

2.2. Exclusionary criteria

Since Veterans were selected for the group in standard clinical care, enrollment in the group was determined based on clinic