A review on the study's results on treating acute stress disorder with cognitive ...

Health & Medicine

The title of this article is “ Cognitive Processing Therapy for the Treatment of Acute Stress Disorder Following Sexual Assault: A Randomized Effectiveness Study.” This title is clear and accurate; it is an adequate representation of the study because it informs readers of the population, setting of the study, intervention, and possible outcomes of the study while communicating the key variables of the study. The authors of this study are Reginald D. V. Nixon, Talitha Best, Sarah R. Wilksch, Samantha Angelakis, Lisa J. Beatty and Nathan Weber; they are all affiliated with the School of Psychology of Flinders University in Adelaide, Australia. The only credentials that was provided is that Reginald D. V. Nixon has a Ph. D. in Psychology. Even though the credentials were not all written, the main author, Reginald D. V. Nixon, has the appropriate credentials and is qualified to conduct this study. The authors also provided contact information to allow readers to be able to ask any questions on the study, and the keywords included are relevant to be able to find the article (Nixon et al., 2016).

Type of Study

This is a qualitative randomized repeated measures design, with post treatment assessments. This kind of study uses the same subjects throughout the research in both experimental and control groups. It is a longitudinal study that collects data overtime. In this study, there is more statistical power because they can control factors between the subjects. Because there is more statistical power, they can have less subjects and assess the results over time (Nixon et al., 2016).

Purpose of Study

The purpose of this study was to analyze the effectiveness of cognitive processing therapy in patients who have acute stress disorder due to sexual assault. No research questions were stated, but according to the literature, there have been no trials that showed that cognitive processing therapy has been effective in the treatment of acute stress disorder. Most studies have been done with other forms of trauma, but trauma related to sexual assault usually affects patients with higher levels of symptoms. About 30% of patients have shown to have recovered 4 months after the trauma; therefore, there is a reason to continue studying this topic to test and analyze cognitive processing therapy in sexual assault survivors in the mental health community (Nixon et al., 2016).

There are also two gaps in the medical field’s knowledge on how to treat acute stress disorder. The first gap is how effective treatment is for acute stress disorder in the mental health community setting. The second gap is that some doctors are concerned that this kind of therapy would make the symptoms worse because of the repeating idea of the trauma they experienced. The researchers had three main goals for this experiment. The first goal is to evaluate how effective the 6 week cognitive processing therapy is in a trauma focused approach. The second goal is to see how effective this therapy is in a sample with patients who have all been sexually assaulted. The third goal is to determine if this therapy can or should be used as an effective therapy in routine clients (Nixon et al., 2016).

Hypotheses

The researchers predicted that cognitive processing therapy and the usual treatment would reduce the severity of acute stress disorder and depression after their trauma, but there would be better results after cognitive processing therapy compared to conventional therapy (Nixon et al., 2016).

Research Design

The sample size consisted of 46 participants. The criteria to be included to the study was that the participant had to be 18 years of age or older, experienced sexual assault or rape within the past month, were able to participate in counseling that was face to face, and sought treatment at Sexual Assault Crisis Centre in Adelaide and Yarrow Place Rape anytime between June 2008 and April 2011. They also had to meet the criteria for being diagnosed with acute stress disorder and had to be stable for 4 weeks before beginning the intervention. There were some exclusions to increase the validity of the study. Participants who had psychosis that was uncontrolled, were dependent on substances, did not speak English sufficiently, had cognitive disabilities or impairments, were at increased risk for suicide or were suicidal, or had ongoing traumatization were all excluded from the study. Written consent was received from all of the participants, and the ethics committee of the hospital approved the study. All participants had to be assessed for 4 weeks; those who could not be were excluded as well. The majority of the sample size were females with an average age of late twenties to early thirties and Caucasian ethnicity. The subjects were then allocated randomly to either the cognitive processing therapy group or

the control group. This randomization helped decrease biases and strengthen the results of the study (Nixon et al., 2016).

The design was a randomized repeated measures design with post treatment assessments 1 week after the completion of the intervention. There were also assessments to follow up 3, 6, and 12 months after the original therapy. The subjects were assessed by researchers who were blinded as to what the treatment was and what the extent of the treatment was. Their sole purpose was to assess the subjects; this was done to decrease bias. The subjects were then randomized into groups. To ensure the subjects of the study were assessed appropriately and equally throughout the study, the researchers used the Clincian-Administered PTSD scale(Nixon et al., 2016). Researchers assessed their diagnosis and how severe their symptoms were. Clincian-Administered PTSD scale assesses 17 symptoms of PTSD. This scale also measures the severity of each symptoms on a scale of five points. The overall score measured the severity of their diagnosis (Weathers et al., 2015). The researchers used this to be able to examine the outcomes of the intervention throughout all severities(Nixon et al., 2016). Researchers also used the MINI International Neuropsychiatric Interview to assess any other anxiety, mood, or substance abuse disorders (Sheehan et al., 1997). Researchers used a interview to collect information on demographics, history of trauma, and the use of medications; they also used the Credibility and Expectancy Questionnaire to assess what the participants expected regarding the treatment they would be given (Nixon et al., 2016).

The intervention of cognitive processing therapy consisted of 6 sessions for 90 minutes each (Nixon et al., 2016). In the beginning, participants were taught cognitive restructuring techniques, and towards the end, participants were given advanced worksheets and alternative ways of thinking. Then they were required to write about their traumatic event through the 6 weeks. The intervention group was established as a systematic plan. The control treatment group was not a systematic plan. It involved counseling, psychoeducation, interpersonal therapy, problem solving and acceptance techniques, and talking about their feelings and thoughts (Cognitive Processing Therapy for PTSD, 2016). To ensure that therapy was equivalent, all sessions were videotaped, and therapists had to adhere to cognitive processing therapy components with competency. They were also rated by therapeutic factors to have equal sessions throughout the study (Nixon et al., 2016).

The researchers used the intent-to-treat sample to conduct statistical analyses. The researchers used this to see how effective the study was, to reflect on the content of the trial, and to analyze that participants vary in the amount of treatment that was needed. To analyze the sample size, the researchers used a priori power analysis, which figured that 60 subjects would allow researchers to be able to have effective results. Because this sample size was not met, the researchers used an interpretative approach and analysis that focused in on the confidence intervals and effect sizes. The continuous measures, like Clinical Administered PTSD Scale, Posttraumatic Stress Disorder Check List, Beck Depression Inventory, Posttraumatic Cognitions Inventory used ANOVA. The categorical outcomes, like the status

of PTSD, the patient’s response to treatment, and appropriate end functioning, were analyzed by a generalized linear model with binomial distribution and multivariate imputation by chained equations. To analyze the outcome of the treatment, researchers defined a positive change of 12 points or more on the Clinical Administered PTSD Scale with a total score below 45 points; a positive outcome was defined as having a Clinical Administered PTSD Scale score under 20 points. To interpret data, the researchers based it on the magnitude of the effects and the confidence intervals. The instruments valid and reliable, and the statistics used were appropriate(Nixon et al., 2016).

Findings

The findings of this study indicates that cognitive processing therapy led to better outcomes in patients who have acute stress disorder after being sexually assaulted (Nixon et al., 2016). It has been deemed beneficial because it teaches patients how to handle upsetting thoughts about the trauma they have experienced and teach patients new skills on how to cope and think about the traumatic experiences they have been though(Cognitive Processing Therapy for PTSD, 2016). It also indicates that this form of therapy can be used as an early intervention in mental health settings. Both interventions did help reduce the symptoms of acute stress disorder, depression, and post traumatic stress disorder. The results showed that there was a greater decrease in the Clinician-Administered PTSD scale scores, the Posttraumatic Stress Disorder Check List, the Posttraumatic Cognitions Inventory, and the Beck Depression Inventory of the treatment group, which indicate positive changes (Nixon et al., 2016).

There were many limitations discussed. The sample size, even though adequate, was not as large as it could have been. There was also a lack of a complete control group. Even though this group was not included for ethical reasons, the lack of this group could not determine whether or not this intervention was more effective than recovering naturally without treatment. Another limitation is that the participants were in different ranges of the severity of their symptoms, and there were different therapists throughout the interventions. The control group also allowed therapists to conduct their therapy sessions without a framework (Nixon et al., 2016).

Although this is the first study of its kind, there has been other studies that analyzed the benefit of cognitive processing therapy, and the results correlate with this study. A similar study was done, but it did not compare cognitive processing therapy to conventional therapy. In this study, researchers analyzed the effect of cognitive processing therapy for acute stress disorder following a homophobic assault. The results showed that this kind of therapy was beneficial in lowering the symptoms of acute stress disorder, depression, and post traumatic stress disorder in victims of homophobic assaults (Kaysen, Lostutter, & Goines, 2005). Another study was done to analyzed how cognitive processing therapy would affect participants how have been sexually assaulted. This study did not use this therapy as a form of treatment for after the event had occurred, but the results showed that there was a significant improvement in symptoms of depression and PTSD even after the trauma had occurred months or years prior. The participants of this study reported a better quality of life and a feeling of hope after this therapy. Even though the duration of time since the trauma

was much longer, it still showed benefits in the participants (Resick & Schnicke, 2016). Another study was done to analyze how cognitive processing therapy affected PTSD in veterans. Although it is not the same trauma, there is still a similarity in the symptoms that can occur. This study showed that the benefits of this therapy went beyond just the symptoms of PTSD; it also improved recurring symptoms of general anxiety disorder, depression, distress, and social adjustment (Monson et al., 2006). This outside literature correlates with the results of this research and strengthens the results of the study.

Recommendations

Based on their experience conducting this study, if the researchers reproduced the study with a larger population and participants, they would produce stronger and more sensitive findings in the future. The study should include more male participants to generalize the findings. The conclusions of this finding hold some value and clinical importance, but more research needs to be done to solidify the benefits of cognitive processing therapy on acute stress disorder after sexual assault. Another recommendation would be to have the treatment as usual group follow a more strict therapeutic approach because this group had no restrictions on how the therapy was delivered or the overall content of the therapy. The therapists in this group also strived to deliver the best therapy they could, and this was evidenced in the videos sessions. Lastly, the therapists of the cognitive processing therapy group had to learn a therapeutic approach that was different than their normal approach, which could rely in therapy that was not as effective as it could have been. Making all of these changes and recommendations

would help solidify the strength of cognitive processing therapy (Nixon et al., 2016).

Significance

The significance for nursing for this study is that it is an alternative therapy to help patients who have acute stress disorder related to sexual assault. Nurses can educate patients on this kind of therapy as an alternative. The results of the study indicate that patients had better results in their healing process with this therapy as opposed to the usual treatment. These findings can help patients with this kind of acute stress disorder by giving them the best possible therapy that is used with the most effective outcomes (Nixon et al., 2016).