Evaluating an evidence-based, theory driven resilience intervention for the primary prevention of PTSD

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Special thanks for Department of Fire & Emergency Services WA

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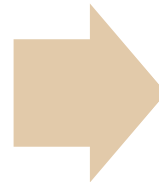
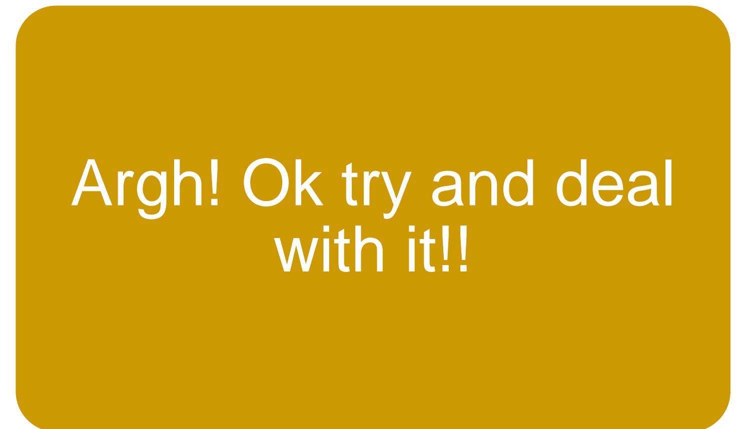
Current Practice





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Where are the gaps?

- Current process= screen and treat.
- Resilience research appears broad and is not targeted at preventing pathology.
- There is a political call for primary prevention efforts.
- PTSD primary prevention research is limited and in early stages.

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Primary prevention

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Systematic Review Skeffington, Rees & Kane (2013)

- Length and content of interventions varies, but common factors support a cognitive model.
- No thorough, randomised controlled trials.
- Skills building is more effective than psychoeducation alone.

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What next?

It is clear that controlled trials guided by relevant psychological theory are needed in this area.

I used the current evidence and a cognitive model of PTSD to develop a program aimed at the primary prevention of PTSD.

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Mental Agility & Psychological Strength Program (MAPS)

Following the evidence-based and a cognitive model of the aetiology of PTSD, aim to reduce maladaptive appraisals/ and promote adaptive coping

- Psychoeducation
- Self Care
- Social Support
- Coping Strategies

- Nested within a framework of normalisation

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Implementation & Evaluation

Design

N = 75 fire-fighter recruits (31 intervention, 46 TAU)

A pre-intervention/ 6 month follow up/ 12 month follow up control group design with clustered random allocation of participants.

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Hypotheses

H1: The intervention group will show a greater pre-post increase in trauma knowledge (as measured by a trauma knowledge test).

H2: The intervention group will report a greater pre-post increase in levels of perceived social support & satisfaction (as measured by the SSQSR).

H3: The intervention group will report a greater pre-post increase in levels of adaptive coping (as measured by the COPE total score).

H4: The intervention group will show less increase, or decrease in pathology (as measured by the PCL-C and DASS-21).

H5: Any changes in the intervention group will be maintained at 6-month follow-up.

H6: Any changes in the intervention group will be maintained at 12-month follow-up.

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Results

Look out for Skeffington, Rees, Mazzucchelli & Kane (under review)

- The only significant difference: trauma & resilience knowledge
- $F(2,182) = 8.75$, $p < .001$, $\eta_p^2 = .09$

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Why?

- The obvious…..

This intervention simply did not work

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Why else?

- Insufficient power
- Ineffective dose
- Inappropriate program components
- Issues with measurement
- **Issues with time-span**
- Perhaps removing barriers to treatment seeking reduced masking of symptoms

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Future directions

- Changes to the program
- **Longer follow up**
- Different measures
- Address practical barriers

- Consider that this kind of primary prevention strategy is not appropriate.

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Thankyou

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