

Psychotherapy at the Point of a Pistol¹

by

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ABSTRACT

Although specific phobias are among the most prevalent and most treatable of the anxiety disorders, successful treatments for firearm phobias are seldom reported. The assessment and treatment of a phobia specific to firing the 9 mm service pistol is described. The case was identified during a Return to Australia Psychological Screening (RTAPS) evolution, following the operational deployment of a Royal Australian Navy warship. The screening package involved group based psycho-education and standardised self-report scales for detecting trauma experiences and sources of psychological distress. These were followed by semi-structured individual interviews. This process revealed a sailor with a phobia linked to a traumatic experience following an unauthorised discharge of a 9 mm pistol. A behavioural treatment regime was planned and conducted at sea under operational conditions. Live firing constituted the main intervention. The positive results suggest live firing is a safe and effective form of single session exposure, conditional on additional safety precautions to supplement regulated weapons handling procedures.

INTRODUCTION

SPECIFIC PHOBIAS ARE less frequently reported in the literature than agoraphobia, social phobia, panic disorder, and other anxiety disorders. Yet specific phobias may be among the most prevalent of all mental disorders in the community. In a rare study of the prevalence of a broad sample of specific phobias, Frederikson et al.¹ found 21.2% of women and 10.9% of men met criteria for any single specific phobia in a community sample of adults aged 18-70 years (n = 704). Multiple specific phobias were found in 5.4% of women and in 1.5% of men. However, no reports of the prevalence of firearm phobia in the civilian community or among serving military personnel were located.

Graduated in-vivo exposure therapy is now the preferred treatment for specific phobias^{2,3}. However, the only study located reporting the treatment of a firearm phobia⁴ revealed that, in 1973, evidence-based treatment consisted of in-vivo flooding, motor activity, modelling and social reinforcement. It is plausible that firearm phobia treatments are rarely reported through being seldom necessary in civilian settings. Becoming severely gun-shy can be an adaptive response when there are no personal safety or occupational implications. In contrast, persons in military or police service may require immediate treatment to avoid the potentially disastrous consequences of failing to use firearms rapidly, safely and effectively when required. In addition, untreated firearm phobias may have adverse career implications through the inability to maintain small arms proficiency.

There is evidence that pre-existing specific phobias may increase the subsequent risk of post-traumatic stress disorder (PTSD) following acute stress exposure. This is consistent with studies identifying the psychiatric history and the number of prior war-related traumatic experiences, as risk factors for PTSD¹¹. Furthermore, phobias can lead to depression, which subsequent to a traumatic experience may increase the risk of PTSD emergence¹².

Current theory guiding the treatment of combat stress reactions is based on a widely accepted doctrine of proximal and immediate treatment with clear recovery expectations. More recently, the evidence-base for this doctrine has been challenged. Despite this controversy, trauma-related firearm phobia appears suited to proximal and immediate treatment when there is a need to restore the capacity for safe and effective use of firearms.

This report aims to assist health professionals to treat firearm phobias in operational environments. An intervention in an operational setting is described, using a 9 mm semi-automatic pistol, a weapon in use throughout the Royal Australian Navy. Identifying personal and operational details were omitted for security reasons and to protect the person's privacy. Ethics approval for publication was obtained from the Australian Defence Human Research Ethics Committee.

METHOD

Detection via mental health screening

A routine Return to Australia Psychological Screening (RTAPS) evolution was conducted onboard an Australian warship returning from a recent operational deployment. Subsequently, one person was identified as having a probable DSM-IV¹⁵ diagnosis of a specific phobia to the 9 mm service pistol. The RTAPS procedure required each member of the Ship's company to attend a group information session (40-50 minutes), complete a screening battery, then attend an individual interview (20-60 minutes) with a member of the visiting Mental Health Team (Navy Reserve Psychologists and a Navy Reserve Mental Health specialist Nursing Officer). The screening battery covered personal details, operational experience, impressions of the deployment experience, pre- and post-deployment career intentions, and sources of stress during the deployment. The screening battery included the civilian version of the Posttraumatic Checklist (PCL-C)^{16,17} a scale of non-specific psychological distress (K10)^{18,19}, a Traumatic Stress Exposure Scale-Revised (TSES-R)²⁰ and an Australian Defence Force checklist of major deployment stressors¹¹

DIFFERENTIAL DIAGNOSIS

Clear signs of a specific phobia emerged in the screening measures and were explored further during the individual interview. From a clinical perspective, the most useful scales for detecting this case included the purpose-designed checklist of 36 typical major stressors¹⁵, the PCL-C^{16,17}, the TSES-R²⁰, and a general question about negative experiences during the deployment. Candidate major stressors were rated on a five-point scale from 'No stress' to 'Extreme stress'. The sailor rated two items as causing extreme stress ('unauthorised discharge of firearms', and 'other experiences'). Both items referred to the same incident. The traumatic origins of the phobia were reflected in a PCL-C total score of 26 (below the recommended threshold of 50 for clinical follow up) with elevated scores on items 5-7 (quite a bit, level 4 of a 5 point scale); and items 1, 2 and 8 (moderately, level 3 of a 5 point scale).

The TSES-R indicated that no other trauma exposure had occurred during the deployment. Feelings of fear or horror in relation to the unauthorised discharge were described as moderate (level 3 of a 4-point scale) immediately following the incident. Although the unauthorised discharge occurred two months earlier, feelings of fear or horror had not subsided, and the sailor had been taken off-boarding party duties due to a self-reported inability to carry and discharge a firearm. Other stressful experiences reported during the deployment included: the threat of danger, separation from a partner, lack of contact with family and friends, and worry about leave arrangements on return (all were rated level 4 of 5, 'A lot of stress'). The sailor's concern about leave was resolved via the Divisional system in the two days between completing the screening battery and the individual interview.

The K10 scale measures non-specific psychological distress and showed elevated scores on items 3, 9 and 10 in particular. At interview, it was determined that these items projected increased worry, anxiety and depressive symptoms associated with deployment fatigue and the career implications of no longer being able to perform an essential duty. At interview, the sailor doubted any treatment for this disorder was feasible and expected certain discharge from military service. The separation from a partner during the deployment also contributed to elevated K10 scores, but the sailor regarded this as less severe and more manageable than the firearm phobia.

A probable diagnosis of Specific Phobia (300.29, Other Type) was made in accordance with DSM-IV¹⁵ by identifying the source of fear as a specific object (the 9 mm pistol) and a specific situation (being required to carry and possibly discharge the pistol), as distinct from the more general fear of a panic attack (as in panic disorder) or of humiliation or embarrassment in certain social situations (as in social phobia). There was no evidence of a delusional basis to the fear as the time and place of the unauthorised discharge was verified. The traumatic

symptoms resulting from the unauthorised discharge were below the threshold required for Acute Stress Disorder and were best explained by a Specific Phobia (Other type) with a traumatic origin.

TREATMENT PLANNING

The preliminary steps of exposing the sailor to the pistol were unnecessary as, over the two weeks prior to the arrival of the Mental Health Team, the sailor had attended the armoury several times per week to handle one or more firearms for a few minutes. It was ascertained that the sailor was ready for 9 mm to live firing under close supervision and that there was sufficient time and ammunition (one half-day and over 700 rounds were available) to achieve a satisfactory single session treatment outcome. The sailor preferred immediate treatment over deferred arrangements once ashore and, although nervous about live firing, assured the treatment team sufficiently that high initial levels of anxiety could be tolerated. Brief counselling was provided to ensure the sailor understood and accepted that, even under extreme sensations of anxiety, it was possible to follow orders as usual. The need for a special live firing activity was discussed with the Buffer (the Chief Bosun's Mate), the Executive Officer, and cleared with the Commanding Officer. Subsequently, the live firing was scheduled for the next forenoon in accordance with Ship's standing orders.

An exposure treatment plan was formulated from first principles. These principles suggest that each exposure activity be perceived as challenging but not impossible, with expected subjective units of distress (SUD) at commencement ideally in the range of 6-8 out of a maximum 10, where 10 represents the highest distress ever experienced and 0 represents no discomfort or concern. The second principle requires an exposure repetition to continue until SUD ratings decrease by a substantial amount (usually 30-50%). Once a sufficient SUD reduction is achieved, the exposure repetition should cease, to reward the person with a short break. The third principle requires multiple repetitions at each exposure level, until recommencing the exposure activity at that level of challenge no longer triggers substantial SUD ratings. The sailor's SUD was expected to begin high at 7-9 and drop to 2-3 out of 10 on completion of five or more details of live firing.

Standard safety precautions were strengthened by providing two supervisors: the Buffer, for safety procedures and coaching, and a Mental Health Team member to monitor the sailor's physical signs and capacity for safe conduct. Immediate action drills were not to be practiced unless stoppages actually occurred. Service ear protection was worn at the firing point. Lanyards secured pistols to holsters to prevent loss of weapons overboard.

The first detail consisted of the sailor only. Four other shooters were readied in two additional details. Each shooter was provided with three or four 13-round magazines per detail. While not shooting, the sailor was required to remain a safe distance from the firing point and assist by mustering and reloading magazines and by launching targets overboard. This provided short breaks while keeping the sailor continuously occupied. At the target delivery point, ear protection was removed to hear calls for new targets. This enabled continuing exposure to the sight, smell and sound of 9 mm pistols discharging.

The first discharge was to be initiated by replacing the usual firing order 'watch and shoot' with the command 'fire' to remove the decision burden from the sailor. The Buffer proposed an additional drill in which the sailor was required to target his fall of shot. This drill was included because it requires constant visual scanning of the target zone and fast aiming and squeezing responses as in snap shooting. This drill was expected to help by reducing the time available for the sailor to dwell on internal sensations.

RESULTS

The sailor did not fire as expected on the first order. Aim was maintained without firing until a second fire order produced the appropriate response, the sailor firing the first round. The first magazine was expended slowly as targets became visible in the wake. The second and third magazines were used for the drill 'follow my fall of shot', with the Buffer leading. The sailor seemed to increase rate of fire as comfort increased, and reported later that slow-firing was more difficult than more rapid firing. Individual target selection was used for the fourth magazine. After four magazines, the sailor was stood down and the next detail brought forward. The sailor reported a SUD of 9.5 out of 10 before firing the first round, which reduced to 7/10 after the fourth magazine. In

the three subsequent details, the sailor followed similar procedures and reported similarly decreasing SUD ratings as per Table 1.

Firing Detail	Rounds expended	SUD rating at commencement (range 0-10)	SUDS rating on completion (range 0-10)
1	52 (4 mag.)	9.5	7.0
3	52 (4 mag.)	7.0	5.0
5	52 (4 mag.)	5.0	3.0
7	39 (3 mag.)	3.0	1.0

Table 1: Subjective units of distress (SU D) during live firing. *magazines

DISCUSSION

A sailor with a firearm phobia was identified through routine mental health screening. It is unlikely that this person problem would have been identified and treated if psychological screening had not been a post-operational requirement. Even the internal inquiry into the unauthorised discharge (whose findings are restricted), which precipitated the condition, was unlikely to identify the need for treatment of a specific phobia. A potentially disastrous situation was averted by treating an incapacity for safe use of firearms by a sailor expected to have a high degree of firearm competence. In addition, mental health status, employability and career prospects were at risk had this condition remained untreated. Further details on the sailor's progress were unavailable at the time of writing 14 weeks later, however, it was confirmed that employment had continued in the same category of service.

Interestingly, the sailor's mental health status was also compromised by leave difficulties and recent separation from a partner, yet the sailor felt these issues were more manageable than the phobia and its consequences. The sailor's own judgment was accepted, although it is acknowledged that in many cases these issues require attention before attempting an exposure intervention.

Once the proposed intervention was explained and expectations of recovery were clearly articulated, the sailor willingly cooperated and accepted the treatment plan advocated by the Mental Health Team, even though personal expectations of success were low. The sailor later recalled that, just prior to commencement of the exposure session, peers were told: "...those guys are nuts". This recollection was taken by the Mental Health Team as possibly reflecting the sailor's high anticipation anxiety and low confidence in the efficacy of the proposed treatment. Such dissonance is not unusual in the military, as members are trained to trust and obey the judgment of higher ranks even when the quality of that judgment is unknown. In military settings, this, and a capacity to follow orders under duress, appears to facilitate the proximal and immediate treatment of firearm phobia in accord with the current theory for the treatment of combat stress reactions.^{13,14}

In a civilian context, however, greater caution is indicated. Clinicians could consider additional exposure grades, such as extensive dry handling and cleaning drills, virtual reality firearm drills, air pistols, and 22 calibre firearms with subsonic ammunition. The positive outcome achieved in this case supports the use of live firing, with strengthened safety precautions, as an effective single session exposure treatment for firearm phobia, suitable for proximal use in operational environments.

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