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National Center for PTSD
Posttraumatic Stress Disorder

CTU Online

CLINICIAN'S TRAUMA UPDATE

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In This Issue:

CTU-*Online* contains summaries of clinically relevant research publications including links to the full article (Trouble accessing? See bottom of last page) and the PILOTS ID number for easy access. (What is PILOTS?)

U.S. Department of Veterans Affairs

Treatment

Cognitive therapy for PTSD

A 2007 study concluded that cognitive interventions are unnecessary given the efficacy of behavioral interventions for anxiety and depression. But the issue is far from settled. Authors of a new review examined the relative efficacy of cognitive and exposure treatment for PTSD, whether adding cognitive restructuring to exposure enhances cognitive changes, and if restructuring is better than exposure for associated symptoms. Two commentaries offer some broader perspectives on the dialog. The review was limited to RCTs involving adult trauma survivors that compared exposure to either cognitive restructuring alone or to a combination of exposure and restructuring. The incremental benefit of adding restructuring to exposure was significant for guilt symptoms and slight for some measures of cognitive change. The efficacy of restructuring alone was comparable to that of exposure or their combination in improving PTSD. Restructuring, alone or in conjunction with exposure, led to greater improvement in symptoms of detachment than exposure alone. With the caveat that small sample sizes may have contributed to the lack of differential effects between treatments, the authors suggest that clinicians can confidently utilize either cognitive therapy or exposure for patients with PTSD. The authors also note the need to identify the mechanisms of action within these treatments. Such knowledge would advance theory and assist investigations into specific patient and treatment characteristics for which one or the other therapy is most useful. Read the article … http://dx.doi.org/10.1111/j.1468-2850.2010.01201.x

Two commentaries on this review offer additional perspectives. The first commentary discusses the possibility of addressing dysregulated stress reactivity in individuals with PTSD via "present-centered" cognitive therapy that entails stress management and self-regulation skills related to daily life. The author also suggests that the ultimate value of cognitive therapy may be in modifying information processing systems that are altered in PTSD. Read the commentary … http://dx.doi.org/10.1111/j.1468-2850.2010.01202.x.

The second commentary challenges researchers to look beyond efficacy by conducting equivalence trials to examine differences between cognitive and behavioral therapy on factors such as cost, ease of delivery and training, adverse effects, and patient preference. The author also mentions issues that have been studied infrequently in PTSD treatment research but are significant for clinicians and patients. Read the commentary…http://dx.doi.org/10.1111/j.1468-2850.2010.01203.x.

Hassija, C. M., & Gray, M. J. (2010). Are cognitive techniques and interventions necessary? A case for the utility of cognitive approaches in the treatment of PTSD. *Clinical Psychology: Science and Practice, 17*, 112-127. PILOTS ID: 34746

Ford, J. D. (2010). Just think about it: How can cognitive therapy contribute to the treatment of posttraumatic stress disorder? *Clinical Psychology: Science and Practice, 17*, 128-133. PILOTS ID: 34771

Tarrier, N. (2010). The cognitive and behavioral treatment of PTSD, what is known and what is known to be unknown: How not to fall into the practice gap. *Clinical Psychology: Science and Practice, 17*, 134-143. PILOTS ID: 34772

More support for Internet-based delivery of PTSD treatment

Therapist-assisted Internet interventions offer an exciting strategy to increase service utilization by enhancing access to care among PTSD patients. One such model, DESTRESS, showed promising results in a randomized trial with US military personnel, and a modified version is being evaluated for use in military primary care patients. Now researchers have reported positive findings in an open trial of internet-based treatment in 22 Australian Veterans. The 10-week CBT (PTSD Online) led to improvements in PTSD symptoms that were comparable to findings for face-to-face treatment. Nine of the 22 patients no longer had PTSD after treatment, and 10 no longer had the diagnosis at follow-up. Therapeutic alliance ratings were high, contradicting common criticisms of treatments delivered via the Internet. Total therapist time averaged less than 20 minutes per week and delivery was 3.7 times less expensive than face-to-face delivery. However, there were no improvements in comorbid conditions or quality of life, in contrast to what is often found for face-to-face treatment. In addition, patient satisfaction ratings were modest, leading the authors to consider modifying the program to enhance its appeal. In-person treatment is still the standard of care, but Internet interventions may be beneficial for individuals who have limited access to treatment, such as those in rural areas or who avoid treatment due to stigma. Read the article… http://dx.doi.org/10.1016/j.janxdis.2010.04.005.

Klein, B., Mitchell, J., Abbott, J., Shandley, K., Austin, D., Gilson, K., Kiropoulos, L., Cannard, G., & Redman, T. (2010). A therapist-assisted cognitive behavior therapy internet intervention for posttraumatic stress disorder: Pre-, post- and 3-month follow-up results from an open trial. *Journal of Anxiety Disorders, 24*, 635-644. PILOTS ID: 34309

Prazosin leads to better long-term outcomes than quetiapine for disturbed sleep

The comparative effectiveness of medications for sleep problems in PTSD has not been studied—until recently, that is, when VA investigators conducted retrospective chart reviews to examine the outcomes of male Veterans with PTSD who had received either quetiapine or prazosin. Studies like this serve an important function—to offer preliminary evidence about possible differences between treatments—even though they are less conclusive than randomized controlled trials. Quetiapine is an atypical antipsychotic and prazosin is an alpha 1-adrenergic receptor antagonist. SSRIs, benzodiazipines, and other sleep agents (e.g., diphenhydramine, trazadone) were also common medications used by the Veterans. The majority of Veterans (61-62%) in both groups showed improvement in nighttime symptoms after 6 months. Yet Veterans who received prazosin were 3 times more likely than those who received quetiapine to continue the medication 3 to 6 years later, which the authors interpret as an indicator of long-term effectiveness. More Veterans discontinued quetiapine due to side effects (e.g., sedation and metabolic effects) and ineffectiveness, whereas prazosin had higher rates of discontinuation due to resolution of symptoms. Despite the better outcomes of prazosin, quetiapine initially was prescribed more than twice as often. Given the results, the authors encourage prescribers to consider prazosin as their first choice in targeting disturbed sleep in patients with PTSD. Read the article…http://dx.doi.org/10.1097/JCP.0b013e3181dac52f.

Byers, M. G., Allison, K. M., Wendel, C. S., & Lee, J. K. (2010). Prazosin versus quetiapine for nighttime posttraumatic stress disorder symptoms in veterans: An assessment of long-term comparative effectiveness and safety. *Journal of Clinical Psychopharmacology, 30*, 225-229. PILOTS ID: 34287

OEF/OIF Veterans

Screening for PTSD in OEF/OIF Veterans

The VA mandates PTSD screening using the 4-item Primary Care PTSD Screen. The DoD has incorporated the screen into the post-deployment health assessment program as well. However, the screen had been validated on older Veteran cohorts only, despite its widespread use in OEF/OIF Veterans. A new study by investigators at the mid-Atlantic MIRECC validated the PC-PTSD in OEF/OIF Veterans. The investigators also examined the 17-item Davidson Trauma Scale and the SPAN, a brief screening measure derived from 4 items of the larger scale. The sample consisted of 220 male and female OEF/OIF Veterans, 25% of whom had PTSD according to the Clinician-Administered PTSD Scale. At the recommended cutpoint of 3 items, the PC-PTSD had excellent sensitivity (.83), specificity (.85), and efficiency (.85). The SPAN also had excellent sensitivity (.87), specificity (.83), and efficiency (.88). Despite the comparable values, the SPAN performed even better than the PC-PTSD according to another measure. The AUC (area under the curve), for which .50 indicates no discriminability and 1.0 indicates perfect performance, was .88 for the PC-PTSD and .93 for the SPAN. When interpreting these results, it is important to remember that the SPAN was embedded in a larger scale, which may have enhanced how participants responded to the SPAN items. However, the more important message is that both screens performed very well, lending confidence to the use of these brief measures for screening OEF/OIF Veterans. Read the article… http://dx.doi.org/10.1016/j.psychres.2009.11.009.

Calhoun, P. S., McDonald, S. D., Guerra, V. S., Eggleston, A. M., Beckham, J. C., Straits-Tröster, K. A., & Department of Veterans Affairs Mid-Atlantic MIRECC OEF/OIF Registry Workgroup (2010). Clinical utility of the primary care - PTSD screen among U.S. veterans who served since September 11, 2001. *Psychiatry Research, 178*, 330-335. PILOTS ID: 34427

Military sexual trauma in OEF/OIF Veterans

In 2002, VA mandated universal screening for military sexual trauma, defined as sexual assault or repeated, threatening acts

of sexual harassment. In 2003, investigators from the Palo Alto VA Healthcare System found that 21.8% of women and 1.1% of men in a national sample of VA outpatients screened positive for MST. Now a new study by the same team reports specifically on OEF/OIF Veterans. The authors examined medical records of all OEF/OIF Veterans separated from military service by September, 2006, who used VA mental health or primary care services between October 2001 and the end of September 2007. Of the 17,580 women and 108,149 men who were screened, 15.1% and 0.7%, respectively, reported MST. Men and women with MST were more likely than those who did not report MST to be diagnosed with PTSD, other anxiety disorders, depression, and substance use disorders. The association between MST and PTSD was stronger in women than men. Due to the cross-sectional nature of both studies, the investigators could not rule out the possibility that some percentage of the problems predated the experience of MST. What is definite is the need for mental health care for MST and associated conditions for both women and men. Read the article…http://dx.doi.org/10.2105/AJPH.2009.171793.

Kimmerling, R., Street, A. E., Pavao, J., Smith, M. W., Cronkite, R. C., Holmes, T. H., & Frayne, S. M. (2010). Military-related sexual trauma among Veterans Health Administration patients returning from Afghanistan and Iraq. *American Journal of Public Health, 100*, 1409-1412. PILOTS ID: 34769

Is mental health worse in active duty or National Guard personnel?

It depends, say the authors of new study of OIF soldiers. They found that at 3 months postdeployment, 45% of the active duty and 33% of the National Guard soldiers met screening criteria for at last one mental health problem. These estimates are higher than those reported in a prior study and counter to observations that active duty soldiers report lower rates of problems than National Guard soldiers. The prior study found 20% of active duty and 42% of National Guard soldiers had a mental health problem. The authors suggest that the discrepancies may relate to methodological differences between the studies. Their study used an anonymous survey; the prior study was based on the non-anonymous PDHA and PDHRA health surveillance program. This anonymity may have alleviated mental health stigma felt by both contingents but may have had a particularly strong affect on active duty soldiers, who reported greater stigma. The overall higher prevalence of mental health problems was due primarily to a higher rate of problems with aggression reported in the current versus the prior study, which suggests that aggression may be significantly underreported if anonymity is not assured. This has important clinical implications for assessment and serves as a reminder that aggression warrants as much attention as PTSD. Read the article… http://dx.doi.org/10.1176/appi.ps.61.6.582.

Kim, P. Y., Thomas, J. L., Wilk, J. E., Castro, C. A., & Hoge, C. W. (2010). Stigma, barriers to care, and use of mental health services among active duty and National Guard soldiers after combat. *Psychiatric Services, 61*, 582-588. PILOTS ID: 34447

Comorbidity

Effects of comorbid PTSD on treatment for other disorders

Investigators at the San Diego VAMC recently reported how comorbid PTSD affected the outcomes of Veterans who received treatment for concurrent depression and substance dependence. Growing evidence shows that the presence of PTSD among patients with other disorders is associated with greater complexity and impairment, and sometimes, with poorer treatment response. The 178 Veterans, 38% of whom had PTSD received 36 inpatient group sessions of either Integrated Cognitive-Behavioral Therapy or 12-Step Facilitation Therapy. Veterans with PTSD had higher depression than those without PTSD not only at baseline, but also at posttreatment and 18-month follow-up. Still, Veterans with and without PTSD showed improvements in depression following both treatments. Results for substance use differed over time between the two treatments. Initial response to treatment was comparable for PTSD and no PTSD patients regardless of which treatment they received. By the 18-month follow-up, Veterans without PTSD reported a higher percentage of days abstinent (91%) than those with PTSD (77%) in the Integrated CBT group. However, there were no differences between the PTSD and no PTSD groups among Veterans who received the 12-Step Facilitation Therapy (75% vs. 76%). The authors suggest the possible need for booster sessions to maintain gains or for PTSD-specific treatment, particularly if depression symptoms are due to PTSD. Read the article…http://dx.doi.org/doi:10.1016/j.jsat.2010.01.013.

Norman, S. B., Tate, S. R., Wilkins, K. C., Cummins, K., & Brown, S. A. (2010). Posttraumatic stress disorder's role in integrated substance dependence and depression treatment outcomes. *Journal of Substance Abuse Treatment, 38*, 346-355. PILOTS ID: 34718.

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