



CTU-ONLINE

Clinician's Trauma Update

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Treatment

Prolonged Exposure can augment medication response in partial medication responders: Both selective serotonin reuptake inhibitors (SSRIs) and cognitive-behavioral therapy (CBT) are effective for treating PTSD. Yet many PTSD patients are treated with a combination of medication and psychotherapy. A recent study conducted at several university-based medical centers examined whether augmenting sertraline, an SSRI, with CBT, would enhance the effect of the drug. Male and female outpatients with PTSD received open-label sertraline for 10 weeks and then were randomized to 5 additional weeks of sertraline alone ($n = 31$) or sertraline plus 10 twice-weekly sessions of Prolonged Exposure (PE; $n = 34$). Sertraline led to a meaningful improvement in symptoms at 10 weeks. Augmentation with PE did not lead to further improvement among participants who had shown a good response to sertraline. However, among partial responders, PE led to further improvement, whereas continued sertraline had no additional impact. These findings are important because they demonstrate an effective strategy for helping partial medication responders have a more adequate response to treatment.

[Read the Article](#) Rothbaum, B.O., Cahill, S.P., Foa, E.B., Davidson, J.R.T., Compton, J., Connor, K.M. et al. (2006). Augmentation of sertraline with Prolonged Exposure in the treatment of posttraumatic stress disorder. *Journal of Traumatic Stress, 19*, 625-638. PILOTS ID 80288

Cognitive Processing Therapy (CPT) is effective for military veterans: Although CPT has been found effective for treating nonveteran women, no prior study had evaluated whether CPT also would benefit veterans. In a recent study, male and female veteran outpatients were randomized to 10 twice-weekly sessions of CPT ($n = 30$), which usually took 10 weeks to complete, or to a waiting list ($n = 30$) for 10

weeks. The study had broad inclusion criteria, and patients were allowed to continue any stable medication regimen and receive psychotherapy for conditions other than PTSD. Intention-to-treat analyses found that veterans treated with CPT had greater reductions than veterans assigned to waitlist in PTSD symptoms and anxiety; the effect on depression was marginally significant. The CPT group was more likely than the waitlist group to no longer meet diagnostic criteria: 40% vs. 3% at the posttreatment (10 week) assessment and 30% vs. 3% at 1-month follow-up. In the CPT group, outcomes did not differ as a function of PTSD disability status. Dropout from treatment was only 20% in CPT, which was comparable to the 13% dropout from the waiting list. This study demonstrates that CPT can substantially benefit the kind of veterans treated in VA settings, who often have multiple comorbidities and who are engaged in a variety of treatments.

[Read the Article](#) Monson, C.M., Schnurr, P.P., Resick, P.A., Friedman, M.J., Young-Xu, Y., & Stevens, S. (2006). Cognitive Processing Therapy for veterans with military-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 74, 898-907. PILOTS ID 28862.

Venlafaxine is effective for PTSD in short-term and continuation treatment: Selective serotonin reuptake inhibitors (SSRIs) are effective for treating PTSD, although many patients do not respond or have only a partial response. Whereas SSRIs block the reuptake of serotonin only, venlafaxine is an antidepressant that inhibits the reuptake of both serotonin and norepinephrine, another neurotransmitter also implicated in the pathophysiology of PTSD. Therefore, venlafaxine could be an especially effective treatment. In a large international study conducted at 56 sites, 329 patients with PTSD (12% of whom were combat veterans) were randomly assigned to receive either venlafaxine or placebo for 24 weeks. At 24 weeks, the primary endpoint, the venlafaxine group had greater reductions than the placebo group in PTSD symptoms. The effect was small ($d = .31$), and both groups experienced substantial symptom reductions. The venlafaxine group was more likely than the placebo group to achieve complete remission (51% vs. 38%) and also had greater improvements in depression, functioning, quality of life, and resilience. However, despite achieving greater benefits, the venlafaxine group did not report greater satisfaction with medication, a finding that the investigators attribute to medication side effects. Most medication studies tend to evaluate the effects of 10 or 12 weeks of treatment. Because trials of SSRIs have shown that some patients continue to improve if they remain on medication longer, this study provides a helpful perspective on longer-term treatment outcome.

[Read the Article](#) Davidson, J., Baldwin, D., Stein, D.J., Kuper, E., Benattia, I., Ahmed, S., et al. (2006). Treatment of posttraumatic stress disorder with venlafaxine extended release. *Archives of General Psychiatry*, 63, 1158-1165. PILOTS ID 28838.

Naltrexone and disulfiram can benefit veterans with comorbid PTSD and alcohol dependence: Alcohol problems are common in PTSD, particularly among veterans treated in the VA system. Although naltrexone and disulfiram are FDA-approved medications for treating alcohol dependence, there has been little investigation of whether these medications are safe and effective for patients with comorbid psychiatric disorder. It was not clear that patients with PTSD would benefit from such treatment, or whether they might respond differently than patients with other psychiatric disorders. In this study, 254 veterans with alcohol dependence and at least 1 current Axis I disorder were randomized to naltrexone, disulfiram, their combination, or placebo for 12 weeks. Veterans with PTSD ($n = 93$) differed from other veterans in the effects of medication on alcohol outcomes and cravings. The effect of medication was more pronounced among veterans with PTSD, who had better outcomes when on any medication (vs. placebo). Visual inspection of the data suggests that the basis of these differences was a stronger placebo response among veterans without PTSD. PTSD patients were more likely than other patients to report side effects. PTSD patients also had modest but significant improvements in PTSD symptoms; however, symptom severity was much lower than is typical in PTSD treatment studies, which limits the generalizability of findings. Despite this caveat, the study is encouraging because it shows that

medications can be used to treat alcohol problems in veterans with PTSD without worsening their PTSD symptoms.

[Read the Article](#) Petrakis, I.L., Poling, J., Levinson, C., Nich, C., Carroll, K., Ravelski, E., et al. (2006). Naltrexone and disulfiram in patients with alcohol dependence and comorbid posttraumatic stress disorder. *Biological Psychiatry*, 60, 777-783. PILOTS ID 28869.

Physical Health

PTSD is linked to increased risk of coronary heart disease in older veterans: There is increasing evidence that PTSD is associated with poor health. Correlates of PTSD, such as dysregulation of the stress response system along with smoking and other poor health habits, might increase the risk of cardiovascular problems in PTSD patients. In this study, investigators examined the incidence of coronary heart disease in 1002 older veterans who had been participating in a longitudinal research project since the 1960s. A prior study of combat veterans in this cohort had found that PTSD was associated with increased risk of other disorders, but not coronary heart disease specifically. Using somewhat different methods and including veterans without combat exposure, the investigators found that PTSD was associated with increased risk of nonfatal MI and fatal coronary heart disease combined, and of these categories plus angina. This study deepens our understanding of the multidimensional nature of posttraumatic reactions. It raises important questions about treatment: can we prevent disease from occurring by treating PTSD early? Even if we treat PTSD long after physical disease has developed, can we improve the symptoms of that disease?

[Read the Article](#) Kubanzansky, L.D., Koenen, K.C., Spiro, A., Vokonas, P.S., & Sparrow, D. (2006). Prospective study of posttraumatic stress disorder symptoms and coronary heart disease in the Normative Aging Study. *Archives of General Psychiatry*, 64, 109-116. PILOTS ID 28961.

PTSD and depression worsen over time in severely injured soldiers: Being injured during a traumatic event increases the risk of developing PTSD. Due to enhanced protective equipment and medical care for military personnel serving in Iraq, many personnel are surviving injuries that would have been fatal in prior wars. Therefore, the war in Iraq provides a unique opportunity to understand the psychological effects of such severe injuries. A recently-published study did just that, following 613 US soldiers at 1, 4, and 7 months after being hospitalized at Walter Reed Army Medical Center for injuries sustained in Iraq; 243 completed all assessments. The prevalence of PTSD (4%) and depression (4%) at 1 month was low but increased over time so that prevalence at 7 months was 12% and 9%, respectively. Although some initial cases remitted, there were more new cases emerging at the later follow-ups: 79% of soldiers with either PTSD or depression at 7 months had neither diagnosis at 1 month. Higher severity of physical symptoms at 1 month increased the likelihood of disorder at 7 months; for PTSD, the odds ratio was 9.1 and for depression it was 5.7. By showing that the early psychological response to trauma among patients with severe injuries may not provide an accurate estimate of long-term adjustment, this study emphasizes the need for careful long-term follow-up to ensure that patients receive the treatments they need.

[Read the Article](#) Grieger, T.A., Cozza, S.J., Ursano, R.J., Hoge, C., Martinez, P.E., Engel, C.C., et al. (2006). Posttraumatic stress disorder and depression in battle-injured soldiers. *American Journal of Psychiatry*, 163, 1777-1783. PILOTS ID 28850.

Assessment

The 4-item PTSD screen works well for detecting PTSD in veterans with substance-abuse problems: VA currently mandates the use of the 4-item Primary Care PTSD screen (PC-PTSD). Answering “yes” to 3 of the 4 items indicates probable PTSD. The scale had been validated in primary

care patients (sensitivity = .78, specificity = .87), but not in patients presenting for substance abuse treatment, in whom symptoms of PTSD may be masked by the substance abuse. The PC-PTSD was recently validated in a convenience sample of 97 veterans. Most (98%) were male and 79% were in residential treatment at the time of the interview. A cutpoint of 3 turned out to be optimally efficient, as had been found for primary care patients. The score worked extremely well. Sensitivity was .91 and specificity was .80; the positive and negative predictive values were .69 and .95, respectively. The need for screening was evident. Although 32% of patients had PTSD according to the Clinician-Administered PTSD Scale, the diagnosis had been missed in 75% of these patients. The findings show that the PC-PTSD, which is quick and easy to administer, can be used to meet the need for screening and help these patients receive the treatments that they need.

[Read the Article](#) Kimerling, R., Tafton, J.A., & Nguyen, B. (2006) Validation of a brief screen for posttraumatic stress disorder with substance use disorder patients. *Addictive Behaviors*, 31, 2074-2079. PILOTS ID 28974.

Women Veterans and Gender Issues

Meta-analysis fails to determine the reason for the increased risk of PTSD in women: Epidemiological studies have consistently found female gender to be a risk factor for PTSD. Attempts to explain this finding in terms of sex differences in trauma characteristics, such as age at traumatization and type of trauma, have been only partially successful. A meta-analysis published in November examined 290 articles to determine the extent to which event type could examine sex differences in PTSD. The investigators found that women had higher risk of PTSD (odds ratio = 2.0). Overall, women had lower risk of exposure (odds ratio = 0.8) but the risk varied with type of event. Women were more likely than men to experience adult sexual assault and child sexual abuse, and less likely to experience accidents, nonsexual assault, combat, disasters, witnessing death or injury, and illness. There were no sex differences in PTSD prevalence for survivors of adult sexual assault, child sexual abuse, and nonsexual child abuse. However, women were more likely than men to develop PTSD following exposure to all other types of events. This result confirms prior findings from individual studies that had failed to explain the sex difference in PTSD as a result of differences in event exposure. This study is important because, as a meta-analysis, it underscores the robustness of the finding that women are at increased risk of PTSD.

[Read the Article](#) Tolin, D.F., & Tolin, E.B. (2006). Sex differences in trauma and posttraumatic stress disorder: A quantitative review of 25 years of research. *Psychological Bulletin*, 132, 959-992. PILOTS ID 28970.

Risk of PTSD due to military sexual trauma (MST) is greater than risk associated with premilitary or postmilitary trauma: A number of women experience sexual trauma while serving in the military (MST). A recent study explored the connection between sexual trauma and PTSD, contrasting the effects of MST with the effects of civilian sexual trauma, in a sample of 196 female veterans who sought mental or physical healthcare at a large VA hospital. Sexual trauma was reported by 72% of the veterans: 36% had childhood sexual abuse, 19% had premilitary (adult) sexual assault, 41% had MST, and 24% had postmilitary sexual assault. Because the majority of women had experienced sexual assault during more than one time period, the investigators used multivariate analysis to examine the unique effects of each period. Only MST was uniquely associated with increased the risk of PTSD (odds ratio = 4.3); when premilitary sexual trauma was excluded from the analysis, both MST and postmilitary sexual trauma were associated with increased risk, but the effect was larger in MST (odds ratio = 4.3) than in postmilitary sexual trauma (odds ratio = 2.1). Because the investigators did not have a nonveteran comparison sample, this study does not indicate that military service is associated with increased likelihood of sexual assault or PTSD due to sexual assault. However, the high prevalence of MST and its unique effects on the

development of PTSD underscore the importance of MST screening and PTSD treatment for female veterans.

[Read the Article](#) Himmelfarb, N., Yaeger, D., & Mintoz, J. (2006). Posttraumatic stress disorder in female veterans with military and civilian sexual trauma. *Journal of Traumatic Stress, 19*, 837-846. PILOTS ID 80410.

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