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CLINICIAN'S TRAUMA UPDATE 2(3), JUNE 2008

Treatment

CISD has limited benefit for military peacekeepers. Critical Incident Stress Debriefing (CISD) is often used in military and other organizational settings in an attempt to prevent or minimize adverse outcomes of traumatic exposure. The intervention has generated controversy, perhaps in part due to its widespread use in the absence of solid empirical evidence from randomized clinical trials to demonstrate its effectiveness. Now a new study by VA and DoD investigators provides the first such evidence—and the results are disappointing. The investigators randomly assigned 952 military personnel who were serving on a 6-month peacekeeping mission in Kosovo to one of 3 group conditions: a CISD session, a stress management class, or assessment only. Study participants completed assessments of PTSD, depression, aggressive behavior, and other symptoms before and after the intervention, and then 3-4 and 8-9 months later. There were no differences among groups on any of the outcomes. Among individuals who experienced greater exposure to traumatic events, there were small but clinically insignificant improvements in PTSD and aggressive behavior in the CISD group, but there also were small (and again, clinically insignificant) increases in problem drinking among more highly exposed participants. The investigators noted that despite the absence of meaningful effects, CISD was rated favorably and was not harmful. They suggest that despite the lack of efficacy of CISD, “human, social, and informational needs” may be a reason to continue its use in military personnel and other workers exposed to traumatic events.

Read the article...

Adler, A.B., Litz, B.T., Castro, C.A., Suvak, M., Thomas, J.L., Burrell, L., McGurk, D., Wright, K.M., & Bliese, P.D. (2008). A group randomized trial of Critical Stress Debriefing provided to US Peacekeepers. *Journal of Traumatic Stress*, 21, 253-263.

PILOTS ID 81971.

<http://dx.doi.org/10.1002/jts.20342>

Exposure versus cognitive restructuring for acute stress disorder: Several studies have demonstrated that brief cognitive-behavioral therapy is effective for preventing the development of PTSD in patients who have acute stress disorder. However, there is ongoing debate about the optimal type of cognitive-behavioral therapy to use; specifically, whether the approach should employ exposure or cognitive techniques. Until recently, there were no solid data to help clinicians choose which strategy to adopt. Now a new study from Australia sheds light on the topic—and is bound to generate some heat as well. The investigators randomized 90 male and female patients with acute stress disorder resulting from a motor vehicle accident or nonsexual assault to receive 5 weekly 90-

minute sessions of Prolonged Exposure (PE) or cognitive restructuring (CR), or to a waiting list. Dropout was approximately 20% in each group, and the PE group had lower distress (rated at the beginning of each session) than the CR group from session 3 on. At the end of treatment, fewer PE patients than CR patients had PTSD: 12% vs. 54%. PE patients had greater reductions than waitlisted patients in PTSD and other symptoms. The CR group did not differ from the waitlisted group on any outcome. At 6-month follow-up (which did not involve the waitlist group), PE patients were less likely than CR patients to have PTSD (14% vs. 47%). One caveat about this study is that the investigators used the last-observation-carried-forward method of handling missing data, which can distort findings. Another caveat is that the findings may not generalize to other traumatized populations. Nevertheless, the results of this study should encourage clinicians to use exposure therapy with patients suffering from acute stress disorder.

Read the article...

Bryant, R.A., Mastrodomenico, J., Felmingham, K.L., Hopwood, S., Kenny, L., Kandris, E., Cahill, C., & Creamer, M. (2008). Treatment of acute stress disorder: A randomized controlled trial. *Archives of General Psychiatry*, 65: 659-667. PILOTS ID: 30881.

<http://archpsyc.ama-assn.org/cgi/content/short/65/6/659>

Group-based exposure therapy for PTSD. Group therapy is an efficient strategy for providing care and is well-received by patients. Yet despite its widespread use throughout the VA system, there is only modest evidence that group therapy is effective for treating PTSD, in veterans or civilians. In fact, there has been only one randomized clinical trial in veterans (showing that trauma-focused cognitive behavioral treatment was no better than present-centered treatment). Given this limited evidence base, the results of a study conducted at the Atlanta VA are particularly relevant. Investigators enrolled 102 veterans in an open trial of a group treatment that included exposure therapy, one of the most effective individual treatments for PTSD. Over 90% were Vietnam veterans and all but one were male. The treatment was intensive, with 16 to 18 twice-weekly 3-hour sessions. Patients received at least 60 hours of exposure through 3 or more hours of in-group exposure to their own trauma, 27 or more hours of exposure to others' war-trauma, and 10 homework assignments to listen to recordings of their trauma presentations. There were large pre-post effect sizes for improvement in clinician-rated PTSD symptoms: $d = 1.20$ after treatment and $d = 1.22$ at follow-up. These findings suggest that meaningful gains can be made in group therapy if there is a substantial amount of both exposure and overall treatment. Of course, the treatment needs to be evaluated in a randomized clinical trial. It would be useful to know how it compares with individual treatment, and what the costs and benefits are in terms of patient outcomes and clinician workload.

Read the article...

Ready, D.J., Thomas, K.R., Worley, V., Bakscheider, A.G., Harvey, L.A.C., Baltzell, D., & Rothbaum, B.A. (2008). A field test of group based exposure therapy with 102 veterans with war-related posttraumatic stress disorder. *Journal of Traumatic Stress*, 21, 150-157.

PILOTS ID 81782.

<http://dx.doi.org/10.1002/jts.20326>

Anger and treatment outcome in veterans with PTSD. A recent Australian study explored potential mediators of anger on treatment outcome among 103 male Vietnam veterans who underwent treatment for PTSD. Evidence suggests that anger negatively influences the outcome of treatment, but it is not clear how anger has such an effect. For example, anger might interfere with therapeutic alliance or obstruct the access to vulnerable emotions, thus preventing emotional processing. Anger also might sabotage interpersonal relationships and reduce social support. Veterans in the study completed self-reports of PTSD, alcohol use, anger, social support, fear of emotion, and therapeutic alliance at intake and then 9 months following treatment. Higher levels of anger at intake predicted higher PTSD severity at follow-up. The investigators then tried to determine factors that might explain this relationship. Of all potential mediating variables, only greater fear of anger and alcohol problems predicted poorer treatment outcome. In other words, the effect of anger was not due to its severity alone, but rather, the fact that higher severity was associated with fear of anger (and losing control) and alcohol comorbidity. The investigators suggest that these factors may impede willingness to access trauma memories—a possibility they didn't assess but that sounds

plausible. The implication of the study's findings for clinicians who work with traumatized veterans is that exploring fear of anger, and addressing this fear, can have real therapeutic benefit.

Read the article...

Forbes, D., Parslow, R., Creamer, M., Allen, N., McHugh, T., & Hopwood, M. (2008). Mechanisms of anger and treatment outcome in combat veterans with posttraumatic stress disorder. *Journal of Traumatic Stress, 21*, 142-149. PILOTS ID 81781.

<http://dx.doi.org/10.1002/jts.20315>

Women with borderline personality characteristics can benefit from cognitive-behavioral therapy for PTSD.

Previous research suggests that borderline personality disorder (BPD) can hinder the successful treatment of co-morbid conditions, including substance abuse, major depression, and obsessive-compulsive disorder. In the case of PTSD, the findings are inconclusive. However, clinical lore asserts that symptoms of BPD, such as anger, aggression, and self-harm, could interfere with intensive exposure and cognitive restructuring therapies. Given the high numbers of patients who have both disorders, it makes sense to understand more fully how BPD might affect the outcome of PTSD treatment. A recent study did just that, using data from a larger study that compared Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) for the treatment of PTSD in female rape victims. The investigators assessed symptoms of BPD in the 131 participants prior to treatment and assessed PTSD and other symptoms at pretreatment and 3- and 9-month follow-up. Even though women who had higher BPD symptoms also had more severe PTSD before treatment, they were just as likely as women who had lower BPD symptoms to complete treatment and to improve on measures of PTSD and other symptoms. It is important to remember that these findings do not generalize to patients with BPD who are not stable enough to enter treatment. However, the results deserve attention because they provide evidence that contradicts beliefs held by many clinicians about the inability of patients with borderline personality symptoms to tolerate and benefit from trauma-focused cognitive behavioral treatment for PTSD.

Read the article...

Clarke, S.B., Rizvi, S.L., & Resick, P.A. (2008). Borderline personality characteristics and treatment outcome in CBT treatments for PTSD in female rape victims. *Behavior Therapy, 39*, 72-78. PILOTS ID 30601.

<http://dx.doi.org/10.1016/j.beth.2007.05.002>

What drives treatment preference among trauma survivors? Considering the number of people who do not seek or receive effective treatment for trauma-related symptoms, it is important to understand what motivates treatment preference. With the aim of illuminating the thought processes behind patients' choices, a recent qualitative study examined the treatment preferences of women who had been traumatized. The investigators recruited 74 women with trauma histories to watch videotaped descriptions of two modes of treatment for PTSD: psychotherapy (Prolonged Exposure) and medication (sertraline). Participants then chose either treatment or no treatment, and were interviewed about the reasons for their choice. Echoing previous studies that show patients generally prefer psychotherapy to medication, 58 of the women chose psychotherapy. Almost half of the women (49%) cited a treatment's mechanism as the reason for choosing a particular treatment. Among women who chose PE, 77% believed that it was necessary to talk about trauma, e.g., "Confronting trauma is important for healing." Medications were perceived by many women as "only a temporary solution" that "couldn't give you a chance to learn to cope with symptoms." This study is limited by its focus on a theoretical choice for women who were not seeking treatment, but it should prompt mental health providers to think about the reasons why patients choose to enter treatment and why patients might also avoid effective treatments such as medications.

Read the article...

Angelo, F.N., Miller, H.E., Zoellner, L.A., & Feent, N.C. (2008). "I need to talk about it": A qualitative analysis of trauma-exposed women's reasons for treatment choice. *Behavior Therapy, 39*, 13-21. PILOTS ID 30686.

<http://dx.doi.org/10.1016/j.beth.2007.02.002>

Assessment

New findings on the validity of PTSD assessment in OIF/OEF veterans. The 17-item PTSD Checklist (PCL) and 4-item Primary Care PTSD Screen (PC-PTSD) are two of the most commonly used measures of PTSD in VA and DoD settings. For example, the PC-PTSD serves as the basis of mandatory PTSD screening in VA and is included in the Post-Deployment Health Assessment and Reassessment surveys. Evidence about the reliability and validity of the PCL and PC-PTSD has come from studies of veterans and civilians. A recent study of 352 Army soldiers is the first to evaluate these measures in active duty personnel—and the results are good. The investigators compared scores on the PC-PTSD and PCL with a PTSD diagnosis-based clinical interview, the MINI (Mini International Neuropsychiatric Interview). Both instruments performed well and were comparable in terms of diagnostic accuracy. The optimal cutoff on the PC-PTSD was 2 or 3, with 3 better for ruling out individuals who did not have PTSD. The optimal cutoff on the PCL was 30-34, lower than the 50 often used in research and clinical practice but comparable to the optimal score identified in prior studies of primary care patients. The 2 avoidance items on the PCL were particularly useful for diagnosis. The investigators pointed out that the results may not generalize to women because most study participants were men. Nevertheless, these findings demonstrate the value of brief screening and add validity to the continued use of the PCL and PC-PTSD in research and clinical settings with military personnel.

Read the article...

Bliese, P.D., Wright, K.M., Adler, A.B., Cabrera, O., Castro, C.A., & Hoge, C.W. (2008). Validating the Primary Care Posttraumatic Stress Disorder Screen and the Posttraumatic Stress Disorder Checklist with soldiers returning from combat. *Journal of Consulting and Clinical Psychology*, 76, 272-281. PILOTS ID 30778.
<http://dx.doi.org/10.1037/0022-006X.76.2.272>

OIF/OEF Veterans

Prior assault increases the vulnerability to PTSD in OIF/OEF veterans. The likelihood of developing PTSD following combat or any traumatic event depends on numerous factors, including a person's experiences before and after the event, and not just the event itself. In an effort to understand how prior assault affects risk of PTSD in OIF/OEF veterans, DoD investigators recently took advantage of data available from a unique project underway in the Department of Defense, the Millennium Cohort Study. This is a longitudinal survey of a large sample of active-duty and Reserve/Guard personnel who were enrolled between 2001-2003 and will be followed for the next 21 years. The new study focused on 890 women and 4469 men who deployed to Iraq or Afghanistan sometime after entering the Millennium Cohort Study but before completing an initial follow-up between 2004-2006. Only personnel who did not have PTSD prior to deployment were included, which enabled the investigators to test how prior sexual or physical assault affects the risk of post-deployment PTSD. Nine percent of the men and 28% of the women reported prior assault. The odds of developing PTSD during deployment were 2.3 times higher in women and 2.0 times higher in men who had experienced prior assault, in comparison with men and women who had not. These findings confirm the results of retrospective studies that yielded similar findings. However, the prospective design of the Millennium Cohort Study provides more conclusive evidence and raises an important question that needs further consideration: how to use this new information in future screening and prevention efforts.

Read the article...

Smith, T.C., Wingard, D.L., Ryan, M.A., Kritz-Silverstein, D., Slymen, D.J., & Sallis, J.F., for the Millennium Cohort Study Team. (2008). Prior assault and posttraumatic stress disorder after combat deployment. *Epidemiology*, 19, 505-512. PILOTS ID 30879.
<http://dx.doi.org/10.1097/EDE.0b013e31816a9dff>

More evidence linking mild traumatic brain injury and PTSD: There is intense interest in understanding the relationship between mild traumatic brain injury and PTSD. It makes sense that the two conditions would co-occur because the kind of event that could cause a head injury is likely to be psychologically traumatizing as well. However, some evidence suggests that there may be substantial overlap in symptoms, and in particular, that persistent PTSD may account for many of the symptoms of mild TBI after the acute recovery phase. A survey of 2,235 OIF/OEF veterans in the mid-Atlantic Coast region does not resolve this controversy but once again demonstrates that symptoms associated with mild TBI are elevated among veterans with PTSD. Approximately 11% of participants had PTSD. The prevalence of mild TBI ranged from 8-13% depending on participants' gender and theater of service. Approximately 35% of the veterans with mild TBI reported persistent postconcussive symptoms. The prevalence of postconcussive symptoms was almost 4 times higher in veterans with PTSD than in veterans who did not have PTSD, a finding that did not change substantially when the investigators controlled for symptom overlap between the two conditions. In fact, PTSD had the strongest association with persistent symptoms of all predictors, including number and type of blast exposures. The implication of these findings is that clinicians need to evaluate PTSD, head injury, and persistent postconcussive symptoms in patients who present with any of these conditions in order to provide optimal treatment.

Read the article...

Schneiderman, A.I., Braver, E.R., & Kang, H.K. (2008). Understanding sequelae of injury mechanisms and mild traumatic brain injury incurred during the conflicts in Iraq and Afghanistan: Persistent postconcussive symptoms and posttraumatic stress disorder. *American Journal of Epidemiology*, 16, 1446-1452. PILOTS ID 30880.
<http://dx.doi.org/10.1093/aje/kwn068>

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