



# CTU-ONLINE

## *Clinician's Trauma Update*

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*CTU-Online, 1(3), June 2007*

### **CLINICIAN'S TRAUMA UPDATE, 1(3), JUNE 2007**

#### *Treatment*

*A note from the editor:* Investigators in three recent studies have reported discouraging news about the efficacy of medications for treating PTSD. The findings of two studies suggest that selective serotonin reuptake inhibitors (SSRIs)—the recommended pharmacologic method for treating PTSD—are ineffective: one flexible-dose study in a VA outpatient sample composed primarily of middle-aged men who had experienced combat trauma, and one fixed-dose study in a civilian sample composed primarily of middle-aged women who had experienced civilian trauma. The findings of the third study also suggest that prazosin, an anti-hypertensive medication, is ineffective for treating overall PTSD symptom severity in VA outpatients. However, there is cause for some optimism. Prazosin was highly effective for reducing nightmares and sleep disturbance, the problems targeted by the investigators. Furthermore, a recently-published meta-analysis found that trauma-focused cognitive behavioral therapy and EMDR are more effective than stress management and other treatments for PTSD. (*For details, please read on.*)

**Sertraline reported to be ineffective for treating PTSD in VA patients:** The Food and Drug Administration has approved two SSRIs, sertraline and paroxetine, for treating PTSD. Although several studies have shown that SSRIs are effective in veteran populations, a question exists as to whether these drugs are also effective among veterans who seek VA care. Investigators addressed this question in a randomized clinical trial that enrolled 169 outpatients from 10 VA Medical Centers during 1994-1996. Most (80%) of the patients were male, and 71% had experienced combat. On average, the patients were 45 year olds and had experienced their index trauma 23 years prior. Patients received either sertraline or placebo for 12 weeks according to a flexible-dosing schedule; the average final dose was 135 mg/day for sertraline and the equivalent of 172 mg/day for placebo. There were no differences in PTSD severity, the primary outcome, or in any secondary outcomes at the end of treatment. The average decrease on the Clinician-Administered PTSD Scale was -13.1 in the sertraline group and -15.4 in the placebo group. Results did not consistently differ as a function of gender, illness duration, illness severity, type of trauma, or comorbid substance abuse. These findings do not indicate that sertraline and other SSRIs are ineffective for treating veterans or combat trauma. However, these medications may require augmentation with other treatments among VA patients who have chronic, long-term PTSD.

[Read the article](#) Friedman, M.J., Marmar, C.R., Baker, D.G., Sikes, C.R., & Farfel, G.M. (2007). Randomized, double-blind comparison of sertraline and placebo for posttraumatic stress disorder in a Department of Veterans Affairs setting. *Journal of Clinical Psychiatry*, 68, 711-720. PILOTS ID 29522.

**Fixed-dose fluoxetine reported to be ineffective for treating PTSD:** Medication studies may be conducted using a fixed or flexible dosing schedule, depending on the intent of the investigators. Flexible dosing attempts to optimize the benefit to a patient by providing as much (or as little) medication as the patient needs to achieve symptom reduction. Fixed dosing permits more systematic evaluation of the general benefits associated with standardized doses, which is useful for making recommendations about dosing in practice. A group of investigators recently reported the results of a randomized clinical trial conducted to determine whether fluoxetine is also effective when administered in fixed doses. The same group had previously found that the SSRI fluoxetine administered according to flexible dosing was effective for treating PTSD. The 411 patients, who were recruited from 43 sites across the US, were randomized to receive either 20 mg or 40 mg per day of fluoxetine, or placebo. On average, patients were 41 years old. Over 70% were women, and sexual trauma was the most common type of trauma experienced. At the end of treatment, there were no differences between groups in change on any outcomes. Roughly 40% of patients in all groups were considered to have responded to treatment. The investigators suggest that the 40 mg dose was insufficient, citing their prior flexible-dose study, in which selection criteria were identical to the fixed-dose study but the average dose was 57 mg/day. These results suggest that fluoxetine treatment should be titrated depending on a patient's response and that doses may need to be relatively high in order to effectively reduce PTSD symptoms.

[Read the article](#) Martenyi, F., Brown, E.B., & Caldwell, C.D. (2007). Failed efficacy of fluoxetine in the treatment of posttraumatic stress disorder: Results of a fixed-dose, placebo-controlled study. *Journal of Clinical Psychopharmacology*, 27, 166-170. PILOTS ID 29532.

**Prazosin reduces trauma-related nightmares and sleep disturbance:** Sleep problems are a common and clinically challenging symptom of PTSD. Most pharmacologic interventions tested have not been very effective for improving sleep. One exception is prazosin, an alpha-1 adrenergic receptor antagonist that has been used in general medicine to treat hypertension and problems related to benign prostatic hypertrophy. A small study of 10 patients had shown that prazosin was effective for reducing nightmares and sleep disturbance. But would it work when administered in a larger sample? Investigators at the VA Puget Sound Healthcare System addressed this question in a randomized clinical trial involving 38 male and 2 female veterans with chronic PTSD and significant sleep problems. On average, the veterans were 56 years old, and 80% had served in the Vietnam War. Patients were randomized to receive either prazosin (mean dose =13.3 mg/day) or placebo every night for 8 weeks. At the end of treatment, the prazosin group had fewer trauma-related nightmares, higher sleep quality, and better clinical global impression scores relative to the placebo group. However, groups did not differ in total PTSD symptom severity or depression. The prazosin was well-tolerated and did not lead to significant changes in blood pressure. This study suggests that prazosin is a safe and effective method for promoting improved sleep in PTSD. A large multi-site VA Cooperative Study is underway to provide more information about the efficacy of prazosin in VA patients.

[Read the article](#) Raskind, M.A., Peskind, E.R., Hoff, D.J., Hart, K.L., Holmes, H.A., Warren, D., Shofer, J., O'Connell, J., Taylor, F., Gross, C., Rohde, K., & McFall, M.E. (2007). A parallel group placebo controlled study of prazosin for trauma nightmares and sleep disturbance in combat veterans with post-traumatic stress disorder. *Biological Psychiatry*, 61, 928-934. PILOTS ID 29403.

**Should front-line treatment for PTSD be trauma focused?** Recent practice guidelines recommend exposure therapies as front-line interventions for the treatment of PTSD. Some clinicians still hesitate to use exposure therapies for a number of reasons. A recent meta-analytic review of 38 randomized clinical trials of PTSD treatment lends further support to the practice guideline recommendations. Trauma focused cognitive-behavioral therapy (TFCBT) and Eye-Movement Desensitization and Reprocessing (EMDR), both trauma-focused, were the most effective treatments compared with stress management, cognitive-behavioral group therapy, and other treatments. TFCBT and EMDR did not differ in their effectiveness. The investigators reported that the two studies of individual TFCBT for Vietnam veterans had smaller effect sizes relative to effects from other samples. However, this does not mean that trauma-focused treatments have limited utility for treating Vietnam veterans. The studies demonstrated that TFCBT was effective in these patients, even if the effects were smaller than the effects in other patients. Furthermore, a recent study not included in the meta-analysis found excellent results for Cognitive Processing Therapy, another trauma-focused approach, with a sample comprised almost entirely of Vietnam veterans. Treatment benefits may be limited in any patients who have severe and chronic PTSD as is often seen in Vietnam veterans and other VA patients. The message for clinicians is that trauma-focused treatments appear to be more effective than other approaches for treating PTSD in a range of patients.

[Read the article](#) Bisson, J.I., Ehlers, A., Matthews, R., Pilling, S., Richards, D., & Turner, S. (2007). Psychological treatments for chronic posttraumatic stress disorder. Systemic review and meta-analysis. (2007). *British Journal of Psychiatry*, 190, 97-104. PILOTS ID 29447.

**Flexible use of manualized therapy is effective for treating PTSD symptoms and functional impairment.** Manualized treatments are often thought of as rigid and inapplicable to real world settings, in which patients may need more or fewer sessions than specified in a treatment manual. Yet there has been a push to make evidence-based treatments, and the manuals that often accompany them, more accessible to community mental health providers. With that goal in mind, a recent study evaluated the flexible use of manualized cognitive-behavioral therapy (CBT) for treating PTSD in survivors of the 9/11 terrorist attacks. Conducted in a clinical services program that offered free treatment for individuals negatively affected by 9/11, the study enrolled 59 participants with at least one re-experiencing symptom. Therapists, who varied in their level of expertise using CBT, were given the freedom to deviate from the manual, omitting or adding sessions as dictated by clinical judgment. The treatment resulted in an overall reduction in PTSD and depression symptoms, and improvement in participants' social and emotional functioning. Although therapists in this study received more training and supervision than might occur naturally in community mental health settings, the results are important because they illustrate the potential for manualized treatments to be applied flexibly and successfully outside of research protocols.

[Read the article](#) Levitt, J.T., Malta, L.S., Martin, A., Davis, L., & Cloitre, M. (2007). The flexible application of a manualized treatment for PTSD symptoms and functional impairment related to the 9/11 World Trade Center attack. *Behaviour Research and Therapy*, 45, 1419-1433. PILOTS ID 29528.

### *Comorbidity*

**Recent study lends support to intensified treatment for dually diagnosed patients:**

Substance abusers who are dually diagnosed with another disorder such as PTSD often receive treatment focused on their substance abuse only, despite recommendations calling for increased PTSD intervention and simultaneous treatment of the dual diagnoses. The need for intensified treatment was recently demonstrated in a randomized clinical trial of substance abuse treatment involving 428 cocaine-dependent outpatients. The patients were randomly assigned to receive 1 of 4 psychosocial treatments: individual cognitive therapy, supportive expressive therapy, psychodynamic therapy, and individual and group 12-step counseling. (Differences among the treatments were reported in a separate paper.) Regardless of the treatment received, patients with comorbid PTSD had greater interpersonal and psychological difficulties and remained more symptomatic than patients without PTSD even after treatment. Although formal tests of statistical interaction indicated that patients with comorbid PTSD responded to treatment similarly to patients without PTSD, specific tests within each group showed fewer improvements in the comorbid group, including change in alcohol problems. These findings indicate a need for more focused and intense intervention among substance abusers who have comorbid PTSD.

[Read the article](#) Najavits, L.M., Harned, M.S., Gallop, R.J., Butler, S.F., Berber, J.P., Thase, M.E., & Crits-Christoph, P. (2007). Six-month treatment outcomes of cocaine-dependent patients

with and without PTSD in a multisite trial. *Journal of Studies on Alcohol and Drugs*, 68, 353-361. PILOTS ID 29539.

**Psychiatric outpatients with both PTSD and chronic severe pain (CSP) have more physical and psychosocial stressors than patients without either disorder.** PTSD and chronic pain frequently co-occur. Previous studies of veterans and other selected samples have shown that the combined condition produces more physical and psychosocial stressors than either disorder alone. However, no studies have looked at the prevalence of PTSD and CSP in a general psychiatric population, or at the unique features resulting from the combined condition. A recent study examined the general occurrence of PTSD and CSP in 295 psychiatric outpatients. Twenty-four percent of the patients met criteria for both PTSD and CSP. As in prior studies of veterans, these patients reported more chronic medical conditions and more stressful life events than patients without either disorder. Psychiatric outpatients with both conditions also had decreased confidence in coping with a mental illness. This study suggests the need for interventions to assist patients with PTSD and CSP manage physical and psychosocial stressors. The study also suggests the need for clinical strategies to help these patients cope with PTSD and other comorbid psychiatric conditions.

[Read the article](#) Villano, C.L., Rosenblum, A., Magura, S., Fong, C., Cleland, C., & Betzler, T.F. (2007). Prevalence and correlates of posttraumatic stress disorder and chronic severe pain in psychiatric outpatients. *Journal of Rehabilitation Research & Development*, 44, 167-178. PILOTS ID 29553.

**PTSD may be undertreated in patients with comorbid PTSD and bipolar disorder:** PTSD is a common comorbid condition among patients with bipolar disorder, and yet the impact and treatment implications for PTSD in these patients have not been closely examined. In a recent VA study, the charts of 139 veterans with either PTSD only, bipolar disorder only, or comorbid PTSD and bipolar disorder were examined to extract information about service utilization and clinical features. The 41 patients with comorbid bipolar disorder and PTSD had a more severe course of illness than those patients with either disorder alone. The group with comorbid bipolar disorder and PTSD also received fewer psychotherapy sessions and less antidepressant medications than the other groups. In an interesting difference from the findings of earlier studies, substance use (although more frequent in the comorbid group) was not the prime mediator of illness intensity. Instead, untreated PTSD also contributed to the severity of bipolar disorder. Although this study is confined by the limitations inherent in chart reviews, and results are based on only male veterans with combat-related PTSD, the study is important: it highlights the need to assess the unique interaction between comorbid PTSD and bipolar disorder, and the need to carefully treat both disorders.

[Read the article](#) Thatcher, J.W., Marchand, W.R., Thatcher, G.W., Jacobs, A., & Jensen, C. (2007). Clinical characteristics and health service use of veterans with comorbid bipolar disorder and PTSD. *Psychiatric Services*, 58, 703-707. PILOTS ID 29554.

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