



CTU-ONLINE

Clinician's Trauma Update

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Assessment and Treatment

Explicitly defining delayed-onset PTSD could help resolve controversies about the diagnosis: The criteria for diagnosing delayed-onset PTSD have important implications for decisions regarding benefits in the VA system. Veterans often seek compensation years after their initial traumatic experiences, thus confusing traditional notions of immediate dysfunction post-trauma. Empirical evidence has not helped to settle the debate because studies report conflicting results on the prevalence—and even the existence—of delayed-onset PTSD. In order to make sense of the evidence, the authors of a recent paper conducted a systemic literature review. After rigorous selection of 74 potential studies, they included 29 studies in the analysis. Overall, the review revealed that differing interpretations of the DSM criteria contributed to the varying prevalence of delayed-onset PTSD in the literature. For instance, cases diagnosed on the basis of having *no* symptoms until 6 months after an event were rarer than cases who were given the diagnosis based on having had some prior symptoms before delayed onset. By highlighting the inconsistent definitions used for delayed-onset PTSD and how definitions affect prevalence, this study explains some of discrepancies that have been reported. Although there are other

reasons for diagnostic confusion not discussed in the paper, it is important for suggesting that the use of a consistent term could increase clarity and knowledge about the diagnosis.

Read the article... <http://dx.doi.org/10.1176/appi.ajp.2007.06091491>

Andrews, B., Brewin, C.R., Philpott, R., & Stewart, L. (2007). Delayed-onset posttraumatic stress disorder: A systematic review of the evidence. *American Journal of Psychiatry*, 164, 1319-1326. **PILOTS ID 29902.**

Reasons for substance use relapse differ in PTSD: Among patients treated for substance abuse, those with comorbid PTSD are at risk for poor outcomes. And it's not just the outcomes that differ. Reasons for relapse may differ as well. For example, patients with PTSD are more likely than other patients to cite negative emotions, physical discomfort, and interpersonal conflict as precipitants. However, there has been little investigation of whether the relapse process in PTSD differs from the process in other substance-abusing patients. A new study of 65 patients discharged from a private inpatient substance use treatment program provides more information about the nature of these differences. Investigators interviewed 37 women and 28 men who used any alcohol or drugs during the 6 months following discharge. Half (49%) had PTSD. The patients with PTSD were more likely to report using to cope with depression, whereas the patients without PTSD were more likely to report using in response to a substance-related cue. The PTSD patients also were more likely to expend greater effort to get a substance and to use it to get intoxicated. Differences were most pronounced among patients with unremitted PTSD, who differed from all other patients in reasons for use and in factors indicating higher risk of poor outcomes. These findings indicate the importance of addressing PTSD in substance treatment programs. Anticipating that reasons for relapse may be different in PTSD could lead to better outcomes for patients with comorbid PTSD. Furthermore, specifically focusing on treating PTSD along with substance use problems could decrease the risk of relapse as well.

Read the article... <http://dx.doi.org/10.1016/j.addbeh.2006.11.020>

Ouimette, P., Coolhart, D., Funderburk, J.S., Wade, M., & Brown, P.J. (2007). Precipitants of first substance use in recently abstinent substance use disorder patients with PTSD. *Addictive Behaviors*, 32, 1719-1727. **PILOTS ID 29587.**

OIF/OEF Veterans

PTSD prevalence immediately post-deployment may underestimate future problems:

Military personnel serving in Iraq receive a physical and mental health exam known as the Post-Deployment Health Assessment, or PDHA, in the immediate post-deployment period, sometimes in theater before reintegration or within the first two weeks of reintegration. Investigators at the Walter Reed Army Institute of Research compared these initial PDHA reports with reports made a few months later by conducting a follow-up examination of 509 US Army soldiers—495 men and 13 women—who had been assessed immediately upon return from a 12-month deployment in Iraq. The soldiers, who were randomly sampled from 1,578 who participated in the original assessment, were assessed 120 days later. Readjustment problems were substantially higher at 120 days (22.7%) than at reintegration (10.6%). For example, PTSD according to a strict definition increased from 1.4% to 4.8%; estimates for a broad definition rose from 3.0% to 8.4%. Whereas 15.4% of the sample had delayed onset of problems, only 3.3% recovered. This study

underscores the need for continued surveillance of veterans during the postdeployment period. The study also underscores the need for strategies to engage returning veterans in treatment. Although there was an increase in the number of soldiers wanting to see a counselor, from 1.9% to 4.9%, these numbers are low relative to the need.

Read the article... <http://dx.doi.org/10.1037/1541-1559.4.3.141>

Bliese, P.D., Wright, K.M., Adler, A.B., Thomas, J.L., & Hoge, C.W. (2007). Timing of postcombat mental health assessments. *Psychological Services, 4*, 141-148.

PILOTS ID 29909.

Childhood trauma can increase the risk of mental health problems in military personnel:

For some military personnel, the trauma encountered in a warzone is not the first trauma they have experienced. They may have been exposed to significant stressors in childhood, before joining the military. A new study by Army investigators reported on how these kind of experiences affected mental health in two samples of soldiers: 4,529 who were studied before deployment to Iraq and 2,392 studied 3 months after returning from Iraq. The investigators assessed childhood experiences broadly, including traumatic stressors such as physical abuse and other serious stressors such as having an alcoholic parent. Just over half of the soldiers reported at least one adverse childhood experience. The prevalence of PTSD and depression was elevated among soldiers who experienced 2 or more events, regardless of whether they had been deployed. Prevalence was especially high among soldiers who had experienced 4 or more childhood events, e.g., for PTSD, the odds of PTSD in this group was approximately 5 times higher than the odds in soldiers who had experienced no events. The effects of childhood events were independent of the effect of combat exposure, a finding that has particular relevance for clinicians in VA and DoD settings. It may be necessary to directly address childhood trauma as a focus of treatment in order to obtain optimal reductions in symptoms and improvements in functioning.

Read the article... <http://dx.doi.org/10.1016/j.amepre.2007.03.019>

Cabrera, O.A., Hoge, C.W., Bliese, P.D., Castro, C.W., & Messer, S. (2007). Childhood adversity and combat as predictors of depression and posttraumatic stress in deployed troops. *American Journal of Preventive Medicine, 33*, 77-82. **PILOTS ID 29869.**

PTSD in Primary Care

Elderly veterans who use VA health services have lower rates of PTSD than younger

veterans: Veterans age 65 and older make up 45% of VA healthcare users. They constitute a population at risk for PTSD and other mental health problems. Yet the prevalence of PTSD in older veterans who use the VA is unknown. A group of investigators at 4 VA Medical Centers recently examined the rates of PTSD among 745 veterans receiving health care services. The investigators used a combination of retrospective chart reviews, self-reports and semi-structured interviews (CAPS) for analysis. In the older veteran group there were 1/3 fewer cases of PTSD than in the younger group of veterans, despite a higher reported prevalence of combat exposure for the older group. The older group also had lower rates of other psychiatric disorders, their physical health was not worse, and they did not use VA health services more than veterans who were under 65. Although this study suggests that older veterans are more resilient than younger veterans, the results could be explained by a difference between age groups in willingness to

report problems as well as selective mortality in older veterans. Nevertheless, the study highlights the needs of older veterans with PTSD and serves as a reminder to consider these needs in our effort to treat this population.

Read the article... <http://dx.doi.org/10.1097/JGP.0b013e3180487cc2>

Frueh, B.C., Grubaugh, A.L., Acierno, R., Elhai, J., Cain, G., & Magruder, K.M. (2007). Age differences in PTSD, psychiatric disorders, and healthcare service use among veterans in VA primary care clinics. *American Journal of Geriatric Psychiatry*, 15, 660-672. **PILOTS ID 29870.**

Screening for PTSD may be important in treating depression: VA has attempted to enhance detection of PTSD in primary care settings by requiring screening with the 4-item Primary Care PTSD Screen, the PC-PTSD. However, PTSD is often comorbid with depression, a combination that may complicate the diagnostic picture as well as the prognosis. Investigators at the Portland VA Medical Center evaluated how well screening for PTSD works in a depressed population by administering a 4-item screen that is similar to the PC-PTSD to 398 depressed primary care patients. Thirty-seven percent of the sample had PTSD defined according to a cutpoint of 50 on the PTSD Checklist. Merely reporting a trauma history on the screen was inadequate for detecting PTSD. (The screen asks about trauma exposure and 3 types of symptoms). The additional endorsement of any two symptoms resulted in the optimal balance between sensitivity—correctly identifying PTSD cases—and specificity—correctly identifying non-cases. Although prior research on the PC-PTSD has included depressed patients, this new study is helpful in specifically showing that PTSD can be detected through brief screening even among individuals whose symptoms of depression may overlap with symptoms of PTSD.

Read the article... <http://dx.doi.org/10.1007/s11606-007-0290-5>

Gerrity, M.S., Corson, K., & Dobscha, S.K. (2007). Screening for PTSD in VA primary care patients with depression symptoms. *Journal of General Internal Medicine*, 22, 1321-1324. **PILOTS ID 29871.**

Other Topics

Quality of life, the *other* important patient outcome in the treatment of anxiety disorders: Symptom reduction has long been the gold standard for evaluating patient outcomes following therapy. Although this is certainly an essential part of treatment, quality of life (QOL) is also a key area to target for intervention. A recent meta-analytic review of 23 studies examined quality of life in anxiety disordered patients. A total of 2,892 participants had been included in the studies. The disorders assessed included social phobia, panic disorders, PTSD, generalized anxiety, and OCD. Overall, QOL was significantly poorer among anxiety patients than in controls ($d = 1.31$, a large effect). The investigators also examined how anxiety disorders were related to physical health, mental health, work, social, and home and family domains. Although the impairment associated with anxiety disorders was greater across all categories, the effect was larger for mental health and social functioning relative to physical health. Individual categories of QOL were most compromised in patients with panic disorder and PTSD. Measures of symptoms as indicators of positive treatment outcomes may not give the full picture of good functioning in patients. Given these findings, attempting to improve QOL rather than just focusing on symptom reduction may bring much needed vitality to a patient's life.

Read the article... <http://dx.doi.org/10.1016/j.cpr.2007.01.015>

Olatunji, B.O., Cisler, J.M., & Tolin, D.F. (2007). Quality of life in the anxiety disorders: A meta-analytic review. *Clinical Psychology Review*, 27, 572-581.

PILOTS ID 29624.

Does prior disaster training protect against PTSD? In large-scale disasters like the 9/11 attack on the World Trade Center, responders come from a diverse range of occupations: those who chose to work in dangerous situations and are trained for emergency response, such as police, paramedics, firefighters, and those who are not trained but whose help may be crucial to the recovery effort, such as construction and sanitation workers. This diversity raises the question of how training and experience influence the development of PTSD. A group of investigators addressed this question by using the World Trade Center Health Registry to examine the responses of 28,692 rescue and recovery workers. The prevalence of current PTSD, assessed 2-3 years after the attack, was lowest in police (6.2%) and highest in unaffiliated volunteers (21.2%). When demographic factors, experiences at the site, and work experiences were taken into account, PTSD prevalence was highest among construction workers, sanitation workers, and unaffiliated volunteers. Workers who engaged in tasks atypical for their occupation had increased risk of developing PTSD. For instance, construction and sanitation workers were at more risk if they had engaged in tasks outside their traditional training, such as search and rescue tasks. This study has potential implications for personnel serving in Iraq who are in noncombat roles. These individuals may especially benefit from preparatory training to help them deal with potential exposures to warzone stressors outside of what might be expected for their particular duties.

Read the article... <http://dx.doi.org/10.1176/appi.ajp.2007.06101645>

Perrin, M.A., Digraude, L., Wheeler, K., Thorpe, L., Farfel, M., & Brackbill, R. (2007). Differences in PTSD prevalence and associated risk factors among World Trade Center disaster rescue and recovery workers. *American Journal of Psychiatry*, 164, 1385-1394. **PILOTS ID 29922.**

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