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## CLINICIAN'S TRAUMA UPDATE 2(6), DECEMBER 2008

### Treatment

**Older veterans receiving less medication for PTSD:** In 2001, projections suggested that by 2020 nearly half of all male veterans in the US would be 65 years of age or older. Though the demographic characteristics of our veterans have changed in the past 7 years, older adults remain a growing population in the VA. Recent concern about polypharmacy in the treatment of PTSD may be particularly relevant to older veterans, who are at high risk of adverse events. Investigators at West Haven VA examined the medical records of all veterans over 45 years old with a diagnosis of PTSD who were seen at a VAMC in FY 2004 ( $N = 244,947$ ). Over eighty percent (81%) of patients had received at least one prescription for a psychotropic medication. Among those taking medication, 88% received at least one prescription for an antidepressant, 61% at least one prescription for an anxiolytic/sedative hypnotic, and 33% at least one prescription for an antipsychotic. Higher age and being seen in primary care versus mental health were related to lower prescription rates. Eighty-seven percent of patients 45-54 years seen in a mental health clinic had at least one prescription for a psychotropic medication, as compared with 67% of patients over 84 years old. The investigators suggest that these results may reflect multiple possibilities: age-related reduction in PTSD symptom severity, a diagnostic status no longer reflective of current functioning, comorbid medical conditions requiring cautious use of psychotropic medications, greater reluctance of the elderly to agree to take medications, and the increased likelihood of elderly patients to present with, and be treated for, somatic versus emotional symptoms. Clinicians working with any patients of any age should be aware of their patients' medication regimens; clinicians working with the elderly may want to be especially informed about their patients' medication needs. Read the article...

[http://journals.lww.com/ajgponline/Abstract/2008/10000/Pharmacotherapy\\_for\\_Older\\_Veterans\\_Diagnosed\\_With.3.aspx](http://journals.lww.com/ajgponline/Abstract/2008/10000/Pharmacotherapy_for_Older_Veterans_Diagnosed_With.3.aspx)

Mohamed, S., & Rosenheck, R. (2008). Pharmacotherapy for older veterans diagnosed with posttraumatic stress disorder in Veterans Administration. *American Journal of Geriatric Psychiatry*, 16, 804-812. PILOTS ID 31388.

**Treatment matching key for group-based PTSD treatments:** Group-based programs are widely used to treat veterans' PTSD in VA hospitals across the country. It has been difficult to compare the formats and determine the best design for group-based programs due to the differences in intensity (length of treatment), content, and setting (inpatient, outpatient). Researchers in Australia, facing a similar array of group-based treatment models, compared the outcomes of 4,339 veterans who participated in one of 5 different group-based cognitive-behavioral programs. The researchers assessed the veterans' PTSD, depression, anxiety, and alcohol misuse at baseline, and at 3-month and 9-month follow-up. On average, all groups experienced the same amount of

improvement. However, looking within program types, the researchers found that treatment response was greater when the severity of a veteran's PTSD matched the intensity of the program. Specifically, veterans with mild PTSD fared better when they participated in low-intensity programs, and veterans with more severe PTSD did better when enrolled in higher intensity programs. Because it is unclear what is the best type of program overall, referring a patient to a program in which the intensity matches the patient's level of symptoms might be a way to address some of the uncertainty about program effectiveness. These data also suggest that programs designed with flexible intensities could be an alternative strategy for responding to patients with differing levels of PTSD symptoms. Read the article...

<http://www.informaworld.com/smpp/content~content=a905607113~db=all~order=page>

Forbes, D., Lewis, V., Parslow, R., Hawthorne, G., & Creamer, M. (2008). Naturalistic comparison of models of programmatic interventions for combat-related post-traumatic stress disorder. *Australian and New Zealand Journal of Psychiatry*, 42, 1051-1059. PILOTS ID 31462.

**Speculation about why EMDR is not widely accepted:** Eye movement desensitization and reprocessing (EMDR) remains controversial despite evidence that it is an effective treatment for PTSD. The author of a recent paper uses a theory of scientific resistance as an explanation for the status of EMDR in the US military and VA healthcare systems. By situating EMDR within a broader theory of how scientific thought unfolds, the author is able to outline how the questions about and objections to EMDR are part of an inevitable process of cultural resistance to new ideas. He suggests that negative attitudes toward EMDR make sense in the context of how predominant paradigms, in this case, cognitive behavioral therapies, are maintained by resisting different and/or opposing ideas. In depicting the resistance to EMDR within this larger process, rather than as resistance to the therapy itself, the author urges researchers and clinicians to utilize EMDR as a treatment of PTSD for combat veterans. Even if the argument proposed in this paper is not true, the paper provides clinicians and researchers an opportunity to recognize how clinical practice and beliefs can be influenced by social and cultural environments. Read the article... <http://dx.doi.org/10.1016/j.socscimed.2008.09.025>

Russell, M.C. (2008). Scientific resistance to research, training and utilization of eye movement desensitization and reprocessing (EMDR) therapy in treating post-war disorders. *Social Science & Medicine*, 67, 1737-1746. PILOTS ID 31479.

## OIF/OEF Veterans

**Numbing and avoidance symptoms greatest predictors of functional impairment:** Although criteria for PTSD diagnosis include some form of impairment, it is unclear whether functional impairment results from meeting PTSD symptom criteria. Alternatively, impairment may be related to specific symptoms of the PTSD symptom profile or it may represent a compounding effect, with greater symptomatology directly relating to greater impairment. Investigators surveyed a random stratified sample of UK military personnel serving in Iraq ( $n = 4,722$ ) and a reservist comparison sample ( $n = 5,550$ ) and administered measures of PTSD, functional impairment, general health, and alcohol use. Higher PTSD scores were related to greater impairment, regardless of whether PTSD diagnosis was met. Endorsement of avoidance and numbing symptoms increased the risk of greater functional impairment more than the other two symptom clusters. Additionally, avoidance and numbing symptoms, as well as hyperarousal symptoms, were associated with impairment even when adjusting for the other two symptom clusters. Many studies have shown that PTSD is related to greater impairment, and some studies have even examined the specific relationship between impairment and PTSD symptom clusters. What's most important is the finding that PTSD symptoms are related to impairment even among individuals who do not meet diagnostic criteria. Clinicians should remember that cases of partial PTSD may be in need of interventions to improve functioning and quality of life. Read the article...

<http://dx.doi.org/10.1016/j.jpsychires.2008.09.006>

Rona, R.J., Jones, M., Iverson, A., Hull, L., Greenberg, N., Fear, N.T., Hotopf, M., & Wessely, S. (2008). The impact of posttraumatic stress disorder on impairment in the UK military at the time of the Iraq war. *Journal of Psychiatric Research*. Retrieved online October 22, 2008. PILOTS ID 31476.

**DRRI validated for use with new veterans:** The wars in Iraq and Afghanistan are unique both in terms of the nature of the wars and the faces of the warriors. About 20% of OIF/OEF veterans utilizing VA services have a diagnosis of PTSD, nearly twice as many as Gulf War veterans. Investigators at the National Center for PTSD and VA Boston Healthcare System examined whether the Deployment Risk and Resilience Inventory (DRRI), originally developed in the context of the Gulf War, would be valid for use with this new line of veterans. Six hundred and forty Iraq-deployed soldiers were given the DRRI along with PTSD, depression, health, and other measures at Ft. Lewis, WA and Ft. Hood, TX shortly before and after deployment. Investigators found that the items in each scale appeared to measure the same construct and that the scales appeared to have the expected relationships with mental and physical health measures, with risks positively relating to symptoms and resiliency factors negatively relating to symptoms. Clinicians and researchers can use the DRRI with confidence when assessing OIF/OEF veterans. Read the article... <http://dx.doi.org/10.1177/1073191108316030>

Vogt, D.S., Proctor, S.P., King, D.W., King, L.A., & Vasterling, J.J. (2008). Validation of scales from the Deployment Risk and Resilience Inventory in a sample of Operation Iraqi Freedom veterans. *Assessment*, 15, 391-403. PILOTS ID 31486.

## Comorbidity

**Risk factor subtypes suggest differential needs for primary care:** Both research projects and healthcare programs typically target specific risk factors such as smoking, hypertension, and psychiatric comorbidity. But risk factors rarely occur in isolation. Consider two hypertensive patients: one an obese smoker, and the other a normal weight alcohol abuser who has severe PTSD. Now researchers at the Syracuse VA have demonstrated that such co-occurrences reflect patient subtypes with distinct treatment needs. Using data from over 10,000 veterans seen at a VA primary care clinic between January 1 and June 30 in 2005, the researchers performed latent class analysis—a sophisticated analytic procedure that permits observations to be sorted into “classes,” or types, based on multiple characteristics. Almost 89% of the veterans were characterized as a relatively healthy type with only moderately elevated likelihood of hypertension. The second type, 5% of the sample, had a high likelihood of alcohol use, depression, and smoking, and included all of the veterans with PTSD. These veterans had more disease burden. In fact, they were 4.6 times more likely than the relatively healthy type to have 4 or more chronic diseases. The third type, 7% of the sample, had a high likelihood of alcohol abuse, smoking, and hypertension, without PTSD or depression. The investigators suggest that integrating interventions for patient types could facilitate treatment. For example, both primary care and behavioral health providers might be needed to address the comorbidities in the distressed/PTSD type. The good news for these patients is that VA has been promoting the use of collaborative care. Read the article... <http://dx.doi.org/10.1007/s10865-008-9176-1>

Funderburk, J.S., Maisto, S.A., Sugarman, D.E., & Wade, M. (2008). The covariation of multiple risk factors in primary care: A latent class analysis. *Journal of Behavioral Medicine*, 31, 525-535. PILOTS ID 31463.

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