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CLINICIAN'S TRAUMA UPDATE 3(1), FEBRUARY 2009

Treatment

Prolonged Exposure in a real-world VA setting: Research has shown that Prolonged Exposure, or PE, is effective for many types of PTSD patients, including Veterans. VA has been conducting a national rollout of PE (and a rollout of Cognitive Processing Therapy) to disseminate effective treatment broadly throughout the system. Now a new study conducted at the Ann Arbor VA demonstrates the benefits of PE when applied in routine clinical practice. Eight male and 2 female Veterans with chronic PTSD were treated with PE. Clinicians using PE for the first time treated 5 of the 10 patients, and an experienced PE clinician treated the rest. Eighty percent of the Veterans had clinically significant reductions in their PTSD symptoms, and the outcomes of trainees and the experienced therapist did not differ. Fifty percent of the patients no longer met criteria for PTSD. The effect size of pre-post change was extremely large ($d = 2.19$), which the investigators noted was comparable to a high of 2.3 that had been observed in a prior study of female sexual assault survivors. Readers should keep in mind that this is a very small study. Its strength is that it provides information about the feasibility and effectiveness of PE in practice.

Read the article... <http://dx.doi.org/10.1002/jts.20380>

Rauch, S.A.M., Defever, E., Favorite, T., Duroe, A., Garrity, C., Martis, B., & Liberzon, I. (2009). Prolonged Exposure for PTSD in a Veterans Health Administration PTSD clinic. *Journal of Traumatic Stress*, 22, 1, 28-35. PILOTS ID 82585.

Prevention

Is psychoeducation successful in preventing PTSD development? Militaries around the world use psychoeducational debriefing pre- or post-deployment. In the US, the Battlemind program was initiated for OEF/OIF returning Vets; in the UK, pre-deployment psychoeducation is standard policy. But is psychoeducation effective? Recently, British authors reviewed the literature on psychoeducation, which they define as "provision of information ... about what might happen should [individuals] be exposed to a trauma or, having been exposed, should they develop symptoms." Few studies have specifically examined the role of psychoeducation for preventing PTSD. One trial found that civilians who received self-help materials after trauma did not do better than those who did not receive such materials. Moreover, there was a trend for those individuals who met criteria for PTSD to do less well if they had received psychoeducation than if they had not. Based on this study and an

overview of related research psychoeducation, appears, at best, ineffective, and worst deleterious. For example, clinical trials that have used psychoeducation as a control for evaluating an active (usually CBT) treatment for PTSD have found the active treatment superior to psychoeducation. Studies of post-trauma debriefing also offer insight into the utility of psychoeducation. In a study that assigned trauma civilians to one of three groups—emotional ventilation, educational debriefing, or no debriefing—the groups did not differ in symptoms at follow-up. In fact, participants with high baseline hyperarousal scores assigned to the emotional debriefing group had significantly more PTSD symptoms at 6 weeks than survivors who received no intervention. Outside of mental health, e.g., in treatment of occupational stress and back pain, there are examples of psychoeducation sensitizing individuals to develop the particular difficulty or disorder. The authors concluded that more research is needed but that the limited research suggests psychoeducation is ineffective at best, and harmful at worst.

But is this dismissal of psychoeducation hasty? Most commentators on the literature review think so. They agreed with the takeaway point that psychoeducation should be rigorously evaluated, but critiqued the methodology of the review. One criticism is that “psychoeducation” was not well defined in the initial paper, making it difficult to understand exactly what is ineffective, useful, or harmful. Furthermore, they argued, psychoeducation was equated with concepts related to, but distinct, from what appears to be the psychoeducation in which the authors are most interested—psychoeducation as prevention for PTSD development. For example, psychoeducation is not equivalent to debriefing, the goal of which is for individuals to process overwhelming events. Psychoeducation as a component of treatment for individuals who already have PTSD also appears distinct from psychoeducation as a sole preventative measure. In addition, the commentators noted that there are no data suggesting that education about PTSD symptoms is likely to produce these symptoms in individuals. Further, they noted that psychoeducation can inform individuals of potential symptoms and normal recovery.

According to the commentators, another problem with the review is that the authors omitted a study showing that psychoeducation can help to prevent PTSD and other problems. The study tested a brief psychoeducational video developed for female rape victims presenting for a forensic medical exam soon after a rape. At a 6-week assessment, women in the video condition who had a prior history of rape reported lower frequency of PTSD and depression, compared to women with a history of rape in the no-video condition, whereas those in the video condition without a history of prior rape reported higher frequency of PTSD and general anxiety symptoms than women without a history of prior rape in the no-video condition. There were no differences in psychopathology between the groups 6 months after the rape.

The commentators also pointed out that educational interventions depend on a number of key factors, such as dosage, intervention schedule, audience characteristics, and educational goals. These goals may be prevention, fostering resilience, facilitation of treatment, and relapse prevention. The commentators suggested that it may be helpful to interpret psychoeducation within a model which would take into account the needs of the target population, timing of the trauma and treatment, and the cultural context.

The review and commentaries offer a provocative discussion of an important topic. One’s perspective is likely to affect the interpretation of the arguments—meaning that if you think psychoeducation is not effective, or if you think it is, the discussion probably won’t change your mind. One thing most readers will agree on, however, is that more evidence is needed. It seems premature to draw firm conclusions either way. Read the abstracts by accessing the PILOTS database numbers (as indicated with each reference below).

Wessely, S., Bryant, R.A., Greenberg, N., Earnshaw, M., Sharpley, J., & Hughes, J.H. (2008). Does psychoeducation help prevent posttraumatic psychological distress? *Psychiatry, 71*, 287-302. PILOTS ID 31778.

Southwick, S., Friedman, M., & Krystal, J. (2008). Does psychoeducation help prevent post traumatic psychological stress disorder? In reply. *Psychiatry, 71*, 303-307. PILOTS ID 31779.

Hobfoll, S.E., Walter, K.H., & Horsey, K.J. (2008). Dose and fit are vital to intervention success. *Psychiatry, 71*, 308-318. PILOTS ID 31780.

Creamer, M. & O'Donnell, M. (2008). The pros and cons of psychoeducation following trauma: Too early to judge? *Psychiatry, 71*, 319-321. PILOTS ID 31781.

Kilpatrick, D.G., Cogle, J.R., & Resnick, H.S. (2008). Reports of the death of psychoeducation as a preventative treatment for posttraumatic psychological distress are exaggerated. *Psychiatry, 71*, 322-328. PILOTS ID 31782.

Krupnick, J.L., & Green, B.L. (2008). Psychoeducation to prevent PTSD: A paucity of evidence. *Psychiatry, 71*, 329-331. PILOTS ID 31783.

Ruzek, J.I. (2008). Wanted: A theory of post-trauma information delivery. *Psychiatry, 71*, 332-338. PILOTS ID 31784.

Writing as self-help tool does not help prevent PTSD: Despite evidence that writing about a stressful event can have positive effects on mental and physical health, there is no conclusive evidence that writing can reduce the symptoms of PTSD. However, writing had not been tested as a strategy for preventing PTSD, prompting researchers in England to use writing as an early intervention technique for patients who had a traumatic injury and were at risk of developing PTSD. Sixty-seven patients were randomly assigned to a writing intervention group or waitlist control group. Both sets of patients were asked to read a self-help booklet about acute stress symptoms, and 5-6 weeks post injury, the 31 patients in the intervention group were asked to write about their injuries in three consecutive 20-minute sessions (one in the office, two at home). The two groups of patients did not differ in PTSD, anxiety, or depression when assessed 3- and 6-months later. However, the majority of patients (71%) said that the writing exercises were helpful. This pattern—perceived benefit without clinical benefit—replicates findings from prior studies. Does this mean that writing has no place in the prevention or treatment of PTSD? As a primary strategy, probably not—but if patients find them to be helpful, writing assignments may be useful when combined with more effective treatments. Read the article... <http://dx.doi.org/10.1016/j.brat.2008.10.006>

Bugg, A., Turpin, G., Mason, S., & Scholes, C. (2009). A randomized controlled trial of the effectiveness of writing as a self-help intervention for traumatic injury patients at risk of developing posttraumatic stress disorder. *Behaviour Research & Therapy, 47*, 6-12. PILOTS ID 31738

Military Sexual Trauma

Effects of military sexual trauma differ between men and women: Both men and women may develop posttraumatic symptoms after military sexual trauma (MST). Prior VA research has shown that men and women who experienced MST had increased comorbid psychiatric and physical problems as well. New findings from a team of researchers at the VA Boston Healthcare System provide further evidence about the negative effects of MST on men and women. The 1,847 Marines in this longitudinal study had originally been assessed in their first week of boot camp at Parris Island in

1997. Twenty-one months later, the investigators re-assessed the 317 Marines who had reported MST during boot camp. The 226 women and 91 men were asked about the symptoms of posttraumatic stress, depression, and physical health functioning they had experienced in the 6 months following the MST. Although women were much more likely than men to experience MST, the effects of MST on health functioning were opposite in men and women. Among men, higher levels of MST were related to decreased health, as expected. Among women, however, higher levels of MST were related to improved health. The question is why? The investigators speculated that female Marines who experience MST may attempt to increase their sense of control by increasing their physical fitness and trying to protect themselves from future assault.

Read the article... <http://dx.doi.org/10.1002/jts.20386>

Shipherd, J.C., Pineles, S.L., Gradus, J.L., & Resick, P.A. (2009). Sexual harassment in the Marines, posttraumatic stress symptoms, and perceived health: Evidence for sex differences. *Journal of Traumatic Stress, 22*, 1, 3-10. PILOTS ID 82582.

Comorbidity

Elevated risk of metabolic syndrome in Veterans with PTSD: As evidence grows about the increased risk of physical health problems in individuals who have PTSD, it is important to examine factors that explain this risk. New findings from a study of Veterans suggest that metabolic syndrome constitutes one potential explanation. Metabolic syndrome refers to a combination of risk factors that include hypertension, abdominal obesity, insulin resistance, and elevated lipids. It is associated with serious chronic health problems, including cardiovascular disease and diabetes, and even mortality. The investigators conducted physical and psychological exams with 253 Veterans who sought treatment at the PTSD and Gulf War Screening Programs at the Cincinnati VA Medical Center. Metabolic syndrome was prevalent in the Veterans with PTSD as well as Veterans with major depression. Prevalence was 34% in PTSD, 28% in major depression, and 46% in combined PTSD and depression. But PTSD had effects that were independent of depression. When the investigators statistically controlled for the effects of depression, smoking, substance abuse, and demographic characteristics, the risk of metabolic syndrome increased 10% for every 10-point increase on the Clinician-Administered PTSD scale. These findings are important for two reasons: first, they provide evidence of a plausible biological explanation for the increased risk of physical disease observed in Veterans with PTSD, and second, they suggest possible targets for intervention to reduce this risk through diet, exercise, and medication.

Read the article... <http://dx.doi.org/10.1186/1741-7015-7-1>

Heppner, P.S., Crawford, E.F., Haji, U.A., Afari, N., Hauger, R.L., Dashevsky, B.A., Horn, P.S., Nunnink, S.E., & Baker, D.G. (2009). The association of posttraumatic stress disorder and metabolic syndrome: A study of increased health risk in Veterans. *BMC Medicine, 7*, 1-27. PILOTS ID 31752.

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