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CLINICIAN'S TRAUMA UPDATE 3(2), APRIL 2009

Assessment

More debate about mild TBI: A new commentary sharply criticizes the VA and DoD screening programs for mild TBI. While acknowledging that these programs have been developed with good intentions, the authors, both DoD investigators, argue that the programs cannot achieve the intended goals because of fundamental problems in diagnostic and assessment procedures. The authors take issue with the case definition for mild TBI because it lacks information about symptoms, time course, and impairment. The authors also take issue with the instrument used for assessment because it has not been validated for use months after an injury, when routine screening typically occurs. They call for the use of validated measures that are collected closer in time to the actual injury. They also suggest that the term "concussion" should be used to more accurately reflect the acute injury and to communicate a more optimistic prognosis. Other recommendations concern the need to incorporate knowledge into the program design about the relationship between persistent postconcussive symptoms and disability compensation, and to organize treatment within a comprehensive primary-care-based framework that broadly addresses deployment-related health concerns. This article is highly relevant to anyone involved in VA or DoD healthcare. Even readers who disagree with the authors' criticisms are likely to agree with the conclusion that the goal of VA and DoD screening programs should be to promote recovery, prevent disability, and provide quality care for returning Veterans. Read the article... <http://content.nejm.org/cgi/content/full/360/16/1588>

Hoge, C.W., Goldberg, H.M., & Castro, C.A. (2009). Care of war veterans with mild traumatic brain injury – Flawed perspectives. *New England Journal of Medicine*, 360, 1588-1591.

PILOTS ID 32129.

Helpful recommendations for differential diagnosis in PTSD patients: Diagnosing PTSD can be challenging because it is frequently comorbid with and shares symptoms of other psychiatric disorders. Trainees may find it difficult to determine the answer to such questions as whether a patient's numbing is due to PTSD or comorbid depression. Even seasoned clinicians can struggle with questions like this. A recent paper offers help in the form of guidelines for some frequently-encountered diagnostic dilemmas in PTSD. The authors based their recommendations on data from 115 Veterans with PTSD and comorbid depression who were enrolled in a randomized clinical trial of group therapy. The data illustrate how difficult diagnosis can be: kappas for interrater agreement on PTSD and depression were only .64 and .48, respectively, below the recommended minimum of .70-.80 for adequate reliability. What's particularly useful about this paper is that it includes discussion

and illustrates how to determine whether a symptom should be attributed to PTSD or a comorbid disorder. For example, in the case of specific phobias, a fear of being on a telephone was attributed to PTSD in one Veteran because it was related to a traumatic incident—having a handset shot out of his hand—whereas a fear of snakes was attributed to phobia in another Veteran because the fear was unrelated to prior trauma. The authors also discuss differential diagnosis for depressive symptoms, agoraphobia, hallucinations, and personality disorder. The paper is a good teaching tool but is likely to be of interest to more experienced clinicians as well. Read the article...

<http://dx.doi.org/10.1037/a0013910>

Schillaci, J., Yanasak, E., Harned Adams, J., Dunn, M.J., Rehm, L.P., & Hamilton, J.D. (2009). Guidelines for differential diagnoses in a population with posttraumatic stress disorder. *Professional Psychology: Research and Practice*, 40, 39-45.

PILOTS ID 31852.

Treatment

Where you are can influence how you practice: Along with VA's commitment to promoting the use of evidence-based practice has come a growing interest in understanding the factors that influence clinicians' adoption of new and better treatments. Changing clinician behavior is not a simple matter. Merely informing clinicians that a new treatment is more effective than a treatment they currently use is only one of many ways to influence adoption. Now a study conducted at the Northeast Program Evaluation Center suggests that geographic location is an important factor in determining the kind of drugs prescribed for PTSD. Prazosin is an alpha-adrenergic blocker that has been used for treating hypertension and problems related to enlarged prostate. In 2002 investigators at VA Puget Sound reported the first of a series of studies showing that prazosin also is effective for reducing nightmares and sleep problems in PTSD patients. Use of the drug increased rapidly there. By 2004 it was prescribed for 38.1% of Veterans with PTSD who were treated in mental health settings and 32.5% of Veterans treated in primary care. But the likelihood of receiving prazosin fell sharply among PTSD patients the further they were from the Seattle area. For example, in 2006, 35.6% of PTSD patients treated in mental health at Puget Sound received prazosin, compared with 19.7% of patients treated less than 500 miles away and only 4.6% of patients between 1000-2499 miles away. The investigators speculate that contacts between local providers are a key mechanism through which new treatments such as prazosin are passively disseminated. Read the article...

<http://archpsyc.ama-assn.org/cgi/content/abstract/66/4/417>

Herpaz-Rotem, I., & Rosenheck, R.A. (2009). Tracing the flow of knowledge: Geographic variability in the diffusion of prazosin use for the treatment of posttraumatic stress disorder nationally in the Department of Veterans Affairs. *Archives of General Psychiatry*, 66, 417-421.

PILOTS ID 32123.

The latest news on group treatment for PTSD: There is no conclusive evidence that group therapy is effective for PTSD. It is not recommended as a primary treatment in the VA/DoD Practice Guideline for PTSD. However, continued research into group therapy is important, especially because it is widely practiced in VA. Now a new study conducted with civilians offers some encouraging findings. Forty-four men and women who had PTSD due to a motor vehicle accident were assigned to groups of 4-7 members, and then each group was randomly assigned to a cognitive-behavioral treatment for PTSD, or to a waitlist control condition. The treated group received 14 2-hour sessions that included psychoeducation, exposure-based homework, cognitive and behavioral exercises, and mindfulness and relaxation techniques. The researchers contacted participants in the control condition by phone at 4-week intervals during the 14 weeks to collect assessments. After treatment, 88% of the participants who received treatment no longer met criteria for PTSD, compared with 31% of the waitlisted participants. Although this study found that group treatment for PTSD was better than

no treatment, the results do not indicate how group treatment fares in comparison with individual treatment. That kind of information is important to help VA clinicians and administrators determine the best way to optimize effectiveness and efficiency in managing PTSD caseloads. Read the article... <http://dx.doi.org/10.1016/j.beth.2008.01.003>

Beck, J.G., Coffey, S.F., Foy, D.W., Keane, T.M., & Blanchard, E.B. (2009). Group cognitive behavior therapy for chronic posttraumatic stress disorder: An initial randomized pilot study. *Behavior Therapy*, 40, 82-92.

PILOTS ID 32054.

Telehealth

Promises and pitfalls in telehealth care for PTSD: Three recent papers illustrate the ways in which telehealth can be used to improve the care of people with PTSD. Methods such as video and computer-assisted delivery are being applied to clinical assessment and treatment. For the VA, increased use of these strategies promises evidence-based assessment and treatment for Veterans for whom distance from specialists remains a barrier to care. These new studies provide preliminary support for telehealth as a viable approach to care and offer information about limitations that need to be addressed in order to promote more widespread use of telehealth in clinical care.

Room for improvement in PTSD assessment: Investigators at the Ann Arbor VA Healthcare system compared videoconferencing and face-to-face assessments of PTSD among Veterans seeking a PTSD evaluation. Twenty male Veterans referred for a PTSD exam were randomly assigned to first receive a comprehensive face-to-face psychiatric evaluation or a PTSD evaluation by videoconference. The Veterans then received the other assessment. There was an 85% agreement between the two modes of assessment on overall PTSD diagnosis. Sensitivity was high: 94% of PTSD cases diagnosed in person were detected using telehealth assessment. However, videoconference assessment yielded a high rate of false positives. Only 33% of noncases were identified correctly. Veterans reported that they would prefer to see a clinician face-to-face, if possible, but would use videoconferencing to avoid excessive travel time. Working alliance was no stronger in face-to-face format than in videoconference format. When interpreting these findings it is important to consider that the sample was small, and only 3 Veterans were diagnosed with PTSD in person. Nevertheless, the results suggest a need for strategies to enhance the accuracy of diagnoses made by videoconference. Read the article... <http://dx.doi.org/10.1258/jtt.2008.080612>

Porcari, C.E., Amdur, R.L., Koch, E.I., Richard, D.C., Favorite, T., Martis, B., & Liberzon, I. (2009). Assessment of posttraumatic stress disorder in veterans by videoconferencing and by face-to-face methods. *Journal of Telemedicine and Telecare*, 15, 89-94.

PILOTS ID 32025.

Cognitive-behavioral therapy delivered with success by video: A group of researchers from Quebec examined the delivery of cognitive-behavioral therapy for PTSD in a civilian sample. Thirty-two men and women were recruited and treated in-person in Montreal. An additional 16 participants were treated by videoconference; 11 of these were recruited from a remote region in Canada and 5 from Montreal. All patients received 16 to 25 weeks of therapy, depending on trauma type and severity. Eighty-one percent of participants in the videoconferencing condition and 75% in the in-person condition no longer met criteria for PTSD after treatment. Individuals in both groups had a moderate increase in overall functioning, with the majority in both achieving a high overall functioning level. Additionally, initial perception of video conferencing and comfort with remote communication did not affect therapeutic success. Individuals, even ones with reservations about the new technology, were as likely to stay in treatment and to benefit as much from it as those seeing therapists in person. Read the article... <http://dx.doi.org/10.1080/16506070802473494>

Germain, V., Marchand, A., Bouchard, S., Drouin, M.S., & Guay, S. (2009). Effectiveness of cognitive-behavioural therapy administered by videoconference for posttraumatic stress disorder. *Cognitive Behavioural Therapy*, 38, 42-53.
PILOTS ID 32026.

Computer-assisted therapy may be way to disseminate specialized treatment: The last study sought to increase the delivery of evidence-based treatment for anxiety disorders such as PTSD in primary care settings. Primary care providers often have multiple roles and are without specialized training in the treatment of anxiety disorders or other mental health problems. The study, carried out across 13 primary care clinics at 4 metropolitan sites, examined the effectiveness of a computer-assisted program in which clinicians and patients proceed together through various prompts. Thirteen clinicians without expertise in anxiety management or cognitive-behavioral therapy were trained over 5 days of workshops to use a computer-assisted program to deliver CBT for four different anxiety disorders: panic disorder, generalized anxiety disorder, social anxiety disorder, and PTSD. The 261 civilian patients attended an average of almost 8 sessions. Clinician satisfaction and patient homework compliance were very good. Data from a randomly selected subgroup (n = 76) showed reduction in self-reported symptoms of anxiety and depression, and increases in expectancy of treatment success and ability to carry out treatment requirements from before to after treatment. This study suggests a potentially feasible approach to delivering evidence-based treatment to individuals who have limited access to specialty mental health care. The next step is to determine how outcomes compare with outcomes among individuals who receive the care that is typically provided in primary care settings. Read the article... <http://dx.doi.org/10.1002/da.20542>

Craske, M.G., Rose, R.D., Lang, A., Welch, S.S., Campbell-Sills, L., Sullivan, G., Sherbourne, C., Bystritsky, A., Stein, M.B., & Roy-Byrne, P.P. (2009). Computer-assisted delivery of cognitive-behavioral therapy for anxiety disorders in primary care settings. *Depression and Anxiety*, 26, 235-242.
PILOTS ID 31986.

Comorbidity

Veterans' PTSD symptoms exacerbate family readjustment problems: Veterans returning from Iraq and Afghanistan have to contend with the process of readjusting to family life, which can be challenging even in happy families. Veterans' mental health problems, including PTSD, can increase the challenges and lead to significant family problems. A new study conducted at the Philadelphia VA Medical Center illustrates what can happen. Investigators examined the rates of readjustment problems in recently returning Veterans and explored the connection between role-related family distress and PTSD in 199 Veterans (178 men, and 21 women) who had returned from Iraq or Afghanistan within the past two years. As expected, Veterans with depressive and anxiety symptoms had higher rates of family problems than Veterans without those symptoms. Veterans with PTSD were more likely than Veterans without PTSD to experience difficulties reestablishing relationships with their children (reporting that their children acted afraid of them or were not warm toward the Veteran), and feeling included and part of their family again (feeling "like a guest in their own home"). The study adds to the growing evidence that PTSD negatively affects relationships as well as individuals and that interventions should attend to the systemic effects of PTSD. Read the article... <http://dx.doi.org/10.4088/JCP.07m03863>

Sayers, S.L., Farrow, V.A., Ross, J., & Oslin, D.W. (2009). Family problems among recently returned military veterans referred for a mental health evaluation. *Journal of Clinical Psychiatry*, 70, 163-170.
PILOTS ID 31842.

New findings on headaches and PTSD. Headaches are one of the symptoms associated with TBI that can persist long after the acute phase of injury. Understanding the relationship between headaches and PTSD is important because individuals with TBI often have comorbid PTSD. Now a recent study indicates that PTSD can exacerbate the problems of headache sufferers. The authors examined the occurrence of PTSD in 593 headache patients from 6 headache clinics in the US. Two-thirds of the patients had episodic migraines and 1/3 had chronic daily headaches. Over 90% were women. The patients completed self-report questions about headache disability, depression, and PTSD. One-quarter of the patients had PTSD according to the civilian version of the PTSD Checklist. PTSD prevalence was higher among patients with chronic daily headaches (30.3%) than among patients with episodic migraine (22.4%), although the difference was not statistically significant in analyses that accounted for depression and demographic factors. In addition, patients with PTSD reported greater headache-related disability than patients without PTSD. It is difficult to interpret the prevalence data from this study because of the lack of a patient control group; although the prevalence of current PTSD was much higher than in the general population, prevalence is elevated in treatment-seeking samples. However, the findings on disability are useful because they indicate that PTSD confers additional burden in headache patients. Read the article...

<http://dx.doi.org/10.1111/j.1526-4610.2009.01368.x>

Peterlin, B.L., Tietjen, G.E., Brandes, J.L., Rubin, S.M., Drexler, E., Lidicker, J.R., & Meng, S. Posttraumatic stress disorder in migraine. *Headache*, 49, 541-551.
PILOTS ID 32027.

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