



CTU-Online contains summaries of clinically relevant research publications including links to the full article (Trouble accessing? See below*) and the PILOTS ID number for easy access. ([What is PILOTS?](#))

Editor: Paula P. Schnurr, Ph.D.
Editorial Manager: Elizabeth Forshay, M.S.W.

Associate Editors: Susan Stevens, Psy.D.
Erin Barnett, Ph.D.

CLINICIAN'S TRAUMA UPDATE 3(6), DECEMBER 2009

Treatment

Mixed success for motivational enhancement as an adjunct to PTSD treatment: VA researchers recently conducted the first randomized controlled trial of motivational enhancement for PTSD. Veterans ($N = 114$) with combat-related PTSD participated in one of the 4-week groups during the second month of a 12-month CBT-based outpatient group PTSD program. They were randomized to receive either motivational enhancement or psychoeducation. Veterans in the motivational enhancement group showed more improvement in problem recognition, attended more PTSD program sessions, had lower PTSD program attrition rates, and reported higher levels of working alliance, treatment engagement, and satisfaction relative to Veterans in the psychoeducation group. Despite these promising findings, Veterans in both groups had comparable shifts in readiness to change after the 4 weeks, even though the motivational enhancement group had a higher "dose" of intervention (longer sessions, homework). As the authors point out, this raises an important question about the theoretical target of motivational enhancement because it is specifically designed to help individuals to make changes in their lives. The lack of differences in readiness to change raises a question about the factors responsible for the changes that did occur. These changes could simply be due to the nonspecific benefits of any active therapeutic intervention, and not to the specific effects of motivational enhancement. Read the article... <http://dx.doi.org/10.1037/a0017577>

Murphy, R.T., Thompson, K.E., Murray, M., Rainey, Q., & Uddo, M.M. (2009). Effect of a motivation enhancement intervention on veterans' engagement in PTSD treatment. *Psychological Services*, 6, 264-278. PILOTS ID 33482.

Guideline-based psychiatric management is an effective treatment for borderline personality disorder: Borderline personality disorder, a serious condition that affects some PTSD patients, presents significant treatment challenges. Research has demonstrated the benefits of using Dialectical Behavior Therapy (DBT), a cognitive-behavioral approach, for managing problems such as high suicidality and self-injurious behavior. However, most studies have contrasted DBT with usual care. Few have compared DBT with active alternative approaches. Now Canadian researchers have reported the results of a randomized clinical trial that compared DBT with rigorous psychiatric management in 180 patients with borderline personality disorder. Psychiatric management is a manualized approach developed based on the American Psychiatric Association's Practice Guideline for Borderline Personality Disorder. Surprisingly, it was comparable to DBT in effectiveness. In fact, there were no differences between psychiatric management and DBT on any outcome. Both treatments, which were delivered over the course of a year, led to reductions in the frequency and severity of suicidal and self-injurious episodes as well as a range of secondary outcomes like service utilization, symptoms, and functioning. The researchers note that their results are important because psychiatrists play a key role in treating patients with borderline personality disorder. Although further investigation of psychiatric management

is needed, this study suggests that psychiatrists can effectively treat patients with borderline personality disorder by adhering to the APA guideline. Read the article... <http://dx.doi.org/10.1176/appi.ajp.2009.09010039>

McMain, S.F., Links, P.S., Gnam, W.H., Guimond, T., Cardish, R.J., Korman, L., & Streiner, D.L. (2009). A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. *American Journal of Psychiatry*, 166, 1365-1374. PILOTS ID 33312.

Decreases in PTSD can improve sexual functioning: Some individuals with PTSD experience sexual problems such as lack of desire and reduced satisfaction or may engage in risky sexual behaviors. Despite the potential impact of impaired sexual functioning on recovery, there have been few studies of the topic, and most have focused on men and on the problems associated with selective serotonin reuptake inhibitors. A new study of female Veterans and active duty personnel reports on how PTSD relates to sexual outcomes in this population and how treatment affects sexual functioning. The 242 participants were randomized to receive 10 weekly sessions of either Prolonged Exposure or Present-Centered Therapy. The investigators examined both sexual concerns and dysfunctional sexual behaviors. At baseline, reexperiencing, numbing, and hyperarousal symptoms were related to problems with one or both sexual outcomes. Although prior analyses had shown that Prolonged Exposure resulted in better PTSD outcomes, there were no differences between treatments for either dysfunctional sexual behavior or sexual concerns. However, loss of PTSD diagnosis was associated with improvements in sexual concerns. This finding is potentially important, because it suggests that substantial, clinically-meaningful improvement in symptoms may be necessary in order to have a tangible impact on at least some aspects of functioning related to PTSD. Read the article...

<http://dx.doi.org/10.1089/jwh.2008.1165>

Schnurr, P.P., Lunney, C.A., Forshay, E., Thurston, V.L., Chow, B.K., Resick, P.A., & Foa, E.B. (2009). Sexual function outcomes in women treated for posttraumatic stress disorder. *Journal of Women's Health*, 18, 1549-1557. PILOTS ID 33493.

OEF/OIF

Chronic pain, PTSD, and persistent postconcussive symptoms: Also known as the polytrauma clinical triad, the co-occurrence of these conditions in OEF/OIF Veterans has received much attention throughout the VA system. VA has established a Polytrauma System of Care and initiated clinical and research conferences to address the challenges of assessing and treating Veterans with this unique combination of disorders. Now a recent investigation is the first to report on the triple comorbidity. Of the 340 OEF/OIF Veterans in the sample, 82% met criteria for chronic pain, 68% for PTSD, and 67% for persistent postconcussive symptoms. Comorbidity was the rule rather than the exception. Although the co-occurrence of PTSD and symptoms related to traumatic brain injury has been widely reported, there has been much less attention paid to the additional problem of chronic pain. Yet the majority of patients with either PTSD or persistent postconcussive symptoms also had pain, and 42% of the sample met criteria for all three diagnoses. The most commonly-reported pain locations were back (58%) and head (55%), followed by shoulder (21%), neck (19%), and knee (18%). The authors discuss the complexity of assessing and treating Veterans who have PTSD, persistent postconcussive symptoms, and pain, emphasizing the importance of multidisciplinary teams in order to facilitate care coordination. VA researchers are currently investigating the efficacy of an integrated treatment approach for Veterans presenting with the three disorders. Read the article...

<http://dx.doi.org/10.1682/JRRD.2009.01.0006>

Lew, H.L., Otis, J.D., Tun, C., Kerns, R.D., Clark, M.E., & Cifu, D.X. (2009). Prevalence of chronic pain, posttraumatic stress disorder, and persistent postconcussive symptoms in OIF/OEF veterans: Polytrauma clinical triad. *Journal of Rehabilitation Research & Development*, 46, 697-702. PILOTS ID 33379.

More evidence of the need to address stigma in the military: The shootings at Ft. Hood in November 2009 have generated much discussion about the adequacy of mental health care in military settings. The authors of a provocative new article offer an interesting perspective on Ft. Hood based on data they collected while conducting trainings earlier in 2009 with 100 nurse care managers and 300 Soldiers assigned to the Warrior Transition Unit (WTU) there. The unit is home to several hundred active duty Soldiers who are excused from

Army duties and undergo intensive mental health treatment. One of the most significant findings was the negative view of PTSD expressed by the Soldiers who command the WTU. Even though they might be expected to be more knowledgeable about mental health issues in comparison with other Soldiers, almost 1 in 5 (18%) reported little or no confidence that PTSD is a real illness caused by military service and 72% said that half or more of the Soldiers with PTSD were faking or exaggerating their symptoms. The corresponding percentages among the nurses were far lower, 5% and 27%, respectively, indicating a profound difference between medical and nonmedical personnel in the understanding of PTSD. Although these data may not generalize to other settings in the Army or other services, the negative attitudes expressed underscore the continuing need to address stigma and disseminate objective, reliable information about mental health problems related to military service. Read the article...

<http://www.cnsspectrums.com/asp/articleDetail.aspx?articleid=2420>

Stahl, S.M. (2009). Crisis in Army psychopharmacology and mental health care at Fort Hood. *CNS Spectrums*, 14, 677-684. PILOTS ID 33377.

Phenomenology and Course

Addressing moral injury related to warzone exposure: A recent article offers a useful model for conceptualizing the consequences of moral and ethical conflicts arising from traumatic events encountered in a warzone. The authors propose that certain experiences—specifically “perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations”—create dissonance with an individual’s moral and ethical beliefs. According to the model, failure to resolve this dissonance can result in *moral injury*, a cascade of negative changes in beliefs about self and the world, emotions such as shame and guilt, self-blame or lack of forgiveness, and PTSD symptoms as well as self-harm and demoralization. The concept of moral injury can help patients gain a new way of understanding themselves and their symptoms. It also has important implications for treatment. The authors proposed approach consists of both familiar and novel elements: (1) strong working alliance; (2) psychoeducation about moral injury and development of a collaborative plan for addressing it; (3) exposure-based processing; (4) directed examination of the implications of the trauma for self- and other schemas; (5) an imaginary dialogue with a respected moral authority such as a parent or clergy; (6) fostering reparation and self-forgiveness; (7) fostering reconnection with important communities, e.g., faith, family; and (8) assessment of goals and values. The article provides a thoughtful discussion on how to implement these elements in practice. Read the article... <http://dx.doi.org/10.1016/j.cpr.2009.07.003>

Litz, B.T., Stein, N., Delaney, E., Lebowitz, L., Nash, W.P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical Psychology Review*, 29, 695-706. PILOTS ID 33165.

The effects of killing on posttraumatic adaptation in Veterans: Although killing is an inherent aspect of war, the specific consequences of taking another person’s life in a warzone—apart from the general effects of combat—are not well-understood. Prior research based on data from the National Vietnam Veterans Readjustment Study has shown a link between killing and the development of PTSD. The authors of a recent study conducted new analyses of these data to examine a wider range of outcomes in addition to PTSD. The study was based on 1,200 male Vietnam Veterans who were assessed by lay interviewers, including 259 Veterans who had undergone additional clinical interviews. Half of the Veterans (47%) reported that they believed they had killed or had participated in killing, which is comparable to findings in OEF/OIF samples. Furthermore, 13% of the Veterans reported they had been involved in a situation in which civilians were killed. Even after statistically accounting for the effects of combat, the authors found that killing combatants was associated not just with PTSD symptoms, but also with other problems, including dissociation, functional impairment, and violent behaviors. The authors suggest that failing to ask about killing when working with Veterans may communicate that this kind of trauma is too shameful to discuss. They urge clinicians to facilitate therapeutic outcome by creating an environment in which Veterans feel safe disclosing such difficult experiences. Read the article... <http://dx.doi.org/10.1002/jts.20451>

Maguen, S., Metzler, T.J., Litz, B.T., Seal, K.H., Knight, S.J., & Marmar, C.R. (2009). The impact of killing in war on mental health symptoms and related functioning. *Journal of Traumatic Stress*, 22, 435-443. PILOTS ID 83063.

Differences between delayed- and immediate-onset PTSD: The concept of delayed-onset PTSD (onset > 6 months after event) has generated controversy, in part due to the lack of research exploring its etiology and presentation. In hopes of shedding light on the topic, investigators from the United Kingdom compared 142 male Veterans with delayed-onset, immediate-onset, or no PTSD. The delayed- and immediate-onset groups reported similar levels of psychopathology before entering military service and at the onset of PTSD, as well as severity and symptom profiles of PTSD at onset. However, before their index trauma, Veterans with delayed onset had more early subthreshold PTSD symptoms that steadily worsened. They also reported more depression and alcohol abuse while in the service, more combat and war-zone traumas, less peritraumatic dissociation, anger, and shame, and more severe life stressors the year preceding the onset of PTSD. The authors speculated that the coping skills of those with delayed onset, which likely included substance use, eroded when they were no longer in a military context and after experiencing severe life stressors. Results also indicated that symptom acquisition before delayed onset began primarily with hyperarousal. As such, clinicians might target anxiety management early in treatment for patients with this presentation. Findings also suggest that active duty personnel be monitored for severe life stressors and subthreshold PTSD during service and at least 2 to 3 years post-discharge, as the median number of months between trauma exposure and PTSD onset was 31 for delayed-onset cases. Read the article... <http://dx.doi.org/10.1037/a0017203>

Andrews, B., Brewin, C.R., Stewart, L., Philpott, R., & Hejdenberg, J. (2009). Comparison of immediate-onset and delayed-onset posttraumatic stress disorder in military veterans. *Journal of Abnormal Psychology*, 118, 767-777. PILOTS ID 33440.

[Subscribe to the CTU-Online](#) newsletter published 6 times per year and sent via email. To search archives of the CTU-Online, use the [Advanced Search](#).

CTU-Online is published by the Executive Division of the VA National Center for Posttraumatic Stress Disorder in White River Junction, VT. We welcome feedback from readers about content and format. Please email us at ncptsd@ncptsd.va.gov.

*Articles authored by National Center for PTSD staff we make available in full text. For other articles we provide a link to where you might be able to view or download the full text. VA clinicians might have privileges through their university affiliation, however VA firewalls sometimes block the permissions to access reference materials. If you cannot access the Full Text version of any of these articles, we advise that you contact your local librarian or web/internet technical person.