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## CLINICIAN'S TRAUMA UPDATE 4(1), FEBRUARY 2010

**Free issue of the *Journal of Traumatic Stress*:** Each year, Wiley-Blackwell makes the first issue of every journal it publishes available for free downloading. This year, the first issue of the *Journal of Traumatic Stress* contains a special issue on OEF/OIF Veterans that includes the Seal et al. and Chard et al. articles described below, along with others on a range of topics relevant to this cohort. Visit the Wiley site for access to these and the other articles.

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### OEF/OIF Veterans

**Are OEF/OIF Veterans getting enough PTSD treatment?** The answer to this question depends on another: *compared to what?* Investigators at the San Francisco VAMC recently reported that among OEF/OIF Veterans with a mental health diagnosis, those with PTSD were 63% more likely than those without PTSD to have at least 1 follow up visit in the year after being diagnosed. That's good news for Veterans with PTSD. However, few Veterans in either group received an adequate amount of treatment. The sample included 84,972 OEF/OIF Veterans who used VA between 2002-2008 and received a new mental health diagnosis; 58% (49,425) had PTSD. In the year following diagnosis, 9.2% of Veterans without PTSD attended 9 or more sessions. Only 3.6% attended 9 or more sessions within a 15-week period, which the investigators noted was a time frame consistent with the delivery of an evidence-based protocol. The corresponding figures were higher in the PTSD group—27% and 9.5%, respectively—but still show that a minority of these Veterans received what would be characterized as a minimally adequate amount of care. Receiving 9 or more visits was associated with being diagnosed in mental health (vs. primary care or other settings), comorbidity, female gender, and older age. VA has undertaken a number of initiatives to provide care to returning OEF/OIF Veterans. These efforts seem to be working: the most recent data indicate that 46% of separated OEF/OIF Veterans have used VA, which is higher than the percentage in other cohorts. VA has also undertaken efforts to enhance care for mental disorders with the creation of the Uniform Services Package and national rollouts of evidence-based treatment. Nevertheless, these findings indicate that there is unmet need. Ongoing efforts to reduce stigma and other barriers to care are likely to play a major role in helping OEF/OIF Veterans with PTSD access the care that is available. Read the article... <http://dx.doi.org/10.1002/jts.20493>

Seal, K.H., Maguen, S., Cohen, B., Gima, K.S., Metzler, T.J., Ren, L., ... Marmar, C.R. (2010). VA mental health services utilization in Iraq and Afghanistan veterans in the first year of receiving new mental health diagnoses. *Journal of Traumatic Stress*, 23, 5-16. PILOTS ID 83685.

**OEF/OIF Veterans respond better than Vietnam Veterans to Cognitive Processing Therapy:** A commonly held belief is that OEF/OIF Veterans are more responsive to treatment relative to other Veteran cohorts. It makes sense that treating PTSD soon after it develops would enhance the likelihood of recovery. Now, a new study conducted at the Cincinnati VA provides evidence that this seems to be

the case. The investigators delivered Cognitive Processing Therapy to 51 OEF/OIF Veterans and 50 Vietnam Veterans; all were men who had served in combat. Although there were no differences between groups in responsiveness according to self-reports of PTSD or depression, OEF/OIF Veterans as a group responded better to treatment according to the Clinician-Administered PTSD Scale. However, the difference between cohorts depended on the severity of a Veteran's PTSD symptoms before treatment. There was no cohort difference in treatment response among Veterans with the lowest initial severity, whereas the difference was greatest among Veterans with the highest initial severity. Both cohorts had clinically meaningful improvements in symptoms, and 59% of OEF/OIF Veterans and 40% of Vietnam Veterans no longer met PTSD diagnostic criteria. When interpreting these findings, it is important to remember that Vietnam Veterans did improve. This is good news because some Veterans think they can never get better. The findings from this study indicate that treatments like Cognitive Processing Therapy can change that. Read the article... <http://dx.doi.org/10.1002/jts.20500>

Chard, K.M., Schumm, J.A., Owens, G.P., & Cottingham, S.M. (2010). Psychological consequences of the Wars in Iraq and Afghanistan: A comparison of OEF and OIF veterans and Vietnam veterans receiving cognitive processing therapy. *Journal of Traumatic Stress, 23*, 25-32. PILOTS ID 83687.

**Findings from a randomized clinical trial of Battlemind:** The Army developed Battlemind as an early intervention protocol to facilitate adjustment following a combat deployment. It is widely used across the military, yet until recently, there were few conclusive data to demonstrate its efficacy. A study published late in 2009 by investigators from the Walter Reed Army Institute of Research shows that Battlemind is effective, but only for some Service Members. The investigators randomized 2,297 Army personnel by platoons within a few days of return from Iraq to receive Battlemind in either a large or small group format, Battlemind debriefing (which emphasizes transition from combat to home rather than focusing on difficult events in combat), or stress education. The interventions lasted 40-50 minutes. Follow-up surveys were conducted with 1,060 Soldiers 4 months later; loss to follow-up was primarily due to necessary military rotation and availability on the day the survey was collected. Relative to stress education, all Battlemind formats were effective in reducing symptoms of PTSD, but only for Soldiers who experienced high levels of combat. A similar pattern emerged for other outcomes (depression, sleep, and stigma), although the results were less consistent across formats. The study's findings are important not only because they offer solid evidence that Battlemind is an effective early intervention, but also because they show how the effectiveness varies depending upon an individual's risk for readjustment difficulties. If the investigators had not examined how level of combat exposure modifies responsiveness, they would have concluded that Battlemind had much more limited effectiveness. Read the article... <http://dx.doi.org/10.1037/a0016877>

Adler, A.B., Bliese, P.D., McGurk, D., Hoge, C.W., & Castro, C.A. (2009). Battlemind debriefing and Battlemind training as early interventions with soldiers returning from Iraq: Randomization by platoon. *Journal of Consulting and Clinical Psychology, 77*, 928-940. PILOTS ID 33247.

## Treatment

**Being diagnosed in a PTSD specialty clinic leads to better treatment:** Over 300 PTSD specialty programs have been created in VAs across the country. But does receiving a PTSD diagnosis in a specialty clinic compared to other sectors result in increased likelihood of a Veteran receiving an adequate amount of treatment? Findings from a recent VA investigation suggest yes. The investigators analyzed VA administrative data on 20,284 Veterans (most of whom were middle-aged, male, and from the Vietnam era) who received a new diagnosis of PTSD in 2004 or 2005. Overall, 64% of the sample received either medication or counseling in the 6 months following the diagnosis. Yet only 33% received a minimally adequate trial of treatment, as indicated by at least 4 monthly psychotropic medication prescriptions or 8 counseling sessions. Veterans initiated and received adequate treatment more often if they were diagnosed in a PTSD specialty clinic, followed by a mental health and then a primary care clinic. The authors suggest two possible explanations for the findings. First, the higher utilization in the Veterans diagnosed in specialty clinics might be due to a higher level of provider expertise in these clinics. Second, the findings could be explained by barriers to crossing sectors between diagnosis and treatment, more specifically, problems in the referral process from the medical sector to PTSD specialty clinics. This is important to understand because research has shown the greater effectiveness of the evidence-based psychotherapies that are typically delivered in PTSD specialty clinics over mental health treatment-as-usual and medications. Read the article... <http://dx.doi.org/10.1176/appi.ps.61.1.58>

Spoont, M.R., Murdoch, M., Hodges, J., & Nugent, S. (2010). Treatment receipt by veterans after a PTSD diagnosis in PTSD, mental health, or general medical clinics. *Psychiatric Services, 61*, 58-63. PILOTS ID 33766.

**Pilot study shows mixed outcomes for virtual reality exposure therapy in older Veterans:** Virtual reality exposure therapy has received recent attention as a potential treatment alternative for anxiety disorders and PTSD. Some think that virtual reality might have benefits over imaginal and in vivo exposure by inducing higher levels of immersion into the exposure exercise and more efficient activation of a patient's fear structure. Investigators in Portugal recently randomized 10 Veterans with chronic PTSD (average age 63 years) to virtual reality exposure therapy, imaginal exposure, or a waitlist control. Although PTSD scores did not change significantly from pre- to post-treatment in any of the groups, self-reported depression symptoms decreased more in the virtual reality group than the other two groups across time. Within the virtual reality group, depression scores dropped by 30%, and somatization and anxiety scores decreased as well. Low power made it difficult to find statistical significance. But even so, in general, pre- to post- treatment changes in PTSD scores in the two experimental groups did not show advantage over the waitlist condition. One exception was a larger decrease over time in avoidance symptoms (38%) for those in the virtual reality group relative to the other groups. This trend fits with the conceptual model of virtual reality exposure therapy - by activating the fear structure of patients with PTSD, virtual reality directly targets avoidance symptoms. Read the article... <http://www.liebertonline.com/doi/pdfplus/10.1089/cyber.2009.0237>

Gamito, P., Oliveira, J., Rosa, P., Morais, D., Duarte, N., Oliveira, S., & Saraiva, T. (2010). PTSD elderly war veterans: A clinical controlled pilot study. *Cyberpsychology, Behavior, and Social Networking*, 13, 43-48. PILOTS ID 33784.

**Therapists do not always use the PTSD treatments they find most credible:** Researchers in the Netherlands asked 255 expert trauma therapists about their use of four treatments for PTSD (imaginal exposure, EMDR, medication, and supportive counseling), along with perceptions of the treatments' credibility and perceived barriers to use. The investigators also presented video vignettes of PTSD patients. Therapists' ratings of treatment credibility as well as patient preferences for trauma-focused treatment strongly influenced therapists' choices, regardless of whether depression was present or the patient had a single adult trauma or multiple childhood traumas. Yet use did not correspond with credibility ratings. Although trauma-focused treatments such as EMDR and imaginal exposure were rated as most credible, therapists most often used supportive counseling. Perceived barriers, which were rated highest for imaginal exposure followed by medication, affected the choice of treatment only for patients who had multiple childhood traumas; therapists chose trauma-focused treatments less frequently for these patients than for patients with a single adult trauma. The discrepancy between high credibility ratings and infrequent use of trauma-focused treatments is concerning because these treatments have the strongest research support. Active dissemination strategies are still needed for evidence-based treatments. Trainings need to address clinicians' perceived barriers to delivering these treatments and present research findings showing that trauma-focused treatments are accepted and effective with even the most complex cases. Read the article... <http://dx.doi.org/10.1016/j.brat.2009.12.003>

van Minnen, A., Hendricks, L., & Olf, M. (2010). When do trauma experts choose exposure therapy for PTSD patients? A controlled study of therapist and patient factors. *Behaviour Research and Therapy*. Published online ahead of print, Jan. 5. PILOTS ID 33786.

## Family Members

**Extended deployments increase mental health illnesses for army wives:** Researchers recently conducted a study comparing the mental health of wives of husbands who had been deployed to Iraq and Afghanistan with wives whose husbands had not been deployed. The researchers analyzed the electronic medical records of 250,626 wives who were seen for outpatient medical visits between the years of 2003-2006. Wives whose husbands were deployed for 1 to 11 months were diagnosed more often with depression, anxiety, acute stress disorder, and sleep problems relative to the wives whose husbands were not deployed. When the researchers looked at wives whose husbands were deployed longer than 11 months, they found that the number of diagnoses increased even more, with 24% more depressive disorders, 40% more sleep disorders, and 39% more acute stress reactions and adjustment disorders. Although this study will surprise few clinicians who already grapple with the stress deployment causes for spouses and families, the tangible evidence can increase broader attention among policymakers and the general public. Furthermore, clinicians can use these findings to normalize wives' reactions to deployment-related stress. Read the article... <http://dx.doi.org/10.1056/NEJMoa0900177>

Mansfield, A.J., Kaufman, J.S., Marshall, S.W., Gaynes, B.N., Morrissey, J.P., & Engel, C.C. (2010). Deployment and the use of mental health services among U.S. Army wives. *New England Journal of Medicine*, 362, 101-109.

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