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U.S. Department of Veterans Affairs

Assessment

Structured assessment can enhance PTSD disability exams

The gold standard for assessing PTSD in research studies is a structured interview such as the CAPS, the Clinician Administered PTSD Scale. In contrast, although clinicians who perform exams for Veterans seeking compensation for PTSD from the VA use a variety of data sources, research reported previously in the [Oct/Dec 2011 issue of CTU-Online](#) found that structured interviews are rarely used. A new study by VA investigators found that the CAPS, along with a structured interview to assess functioning, improved the quality of disability exams for PTSD. The investigators randomly assigned 384 Veterans from 6 VA Medical Centers to receive usual assessment or a standardized assessment that included the CAPS and the WHO-DAS, an interview developed by the World Health Organization to assess functional status. Expert raters coded audiotapes of the recordings for completeness and accuracy. Although the overall prevalence of PTSD was 68% in structured exams and 71% in unstructured exams, the unstructured exams were substantially less complete; only 30% had sufficient information about all PTSD criteria, versus 85% in

the structured exams. Overall, the expert raters were unable to determine overall diagnosis in 88% of the unstructured exams, versus 36% of the exams based on the structured assessments. The study has important limitations, such as the fact that the expert raters did not perform independent diagnostic assessments to serve as a gold standard for assessing accuracy. However, the results suggest that exam completeness could be enhanced by incorporating structured assessment into the disability exam process. Read the article...<http://www.ptsd.va.gov/professional/articles/article-pdf/id87166.pdf>

Speroff, T., Sinnott, P. L., Marx, B., Owen, R. R., Jackson, J. C., Greevy, R., . . . Friedman, M. J. (2012). Impact of evidence-based standardized assessment on the disability clinical interview for diagnosis of service-connected PTSD: A cluster-randomized trial. *Journal of Traumatic Stress, 25*, 607-615. PILOTS ID: 87166

Another look at PTSD prevalence based on *DSM-IV* versus *DSM-5*

In the [October 2012 issue of CTU-Online](#), we reported on a study suggesting that the new proposed *DSM-5* criteria would yield prevalence estimates of PTSD comparable to those based on *DSM-IV*. A new study by a research

Special Notice

A guide to the 10-year retrospectives of 9/11: The latest issues of the PTSD Research Quarterly (RQ) reviews research articles from commemorative journal issues on the 10 year anniversary of 9/11, including the potential effects of the attacks on children. Some data presented may be relevant to the tragic school shooting in CT and other horrific events that have scarred individuals directly connected to the victims and entire communities throughout the world.

[A Guide to the 10-year Retrospectives of the September 11th Terrorist Attacks](#). RQ Vol. 23(3), 2012, by Norris, F. & Silver, R. C.

team from the Durham VAMC suggests somewhat different findings. A sample of 185 participants completed a measure of trauma exposure and the Clinician-Administered PTSD Scale. To capture *DSM-5* criteria, the researchers added 4 additional items to the CAPS and used the algorithm requiring 2 symptoms from the new “D” cluster (alterations in cognitions and mood) and 2 from the new “E” cluster (hyperarousal and reactivity). The results indicate that when the *DSM-IV* prevalence was .50, the *DSM-5* estimate was nearly identical (.52). However, the estimates became more discordant as the *DSM-IV* prevalence increased or decreased. For example, the observed *DSM-5* estimate was 30% when *DSM-IV* was 25% (an increase of 5%) and 13% when the *DSM-IV* estimate was 5% (an increase of 8%). For *DSM-IV* estimates above 50%, the *DSM-5* criteria would yield slightly lower prevalence, e.g., 86% when *DSM-IV* prevalence was 90%. The reason for the differences between this study and the prior study are unknown. One possibility is the type of assessment: the prior study used a questionnaire, whereas the new study used a structured clinical interview. Ongoing research by other investigators should have answers by the time the *DSM-5* is launched in May 2013. Read the article...<http://dx.doi.org/10.1002/da.220122>

Calhoun, P. S., Hertzberg, J. S., Kirby, A. C., Dennis, M. F., Hair, L. P., Dedert, E. A., & Beckham, J. C. (2012). The effect of draft *DSM-V* criteria on posttraumatic stress disorder prevalence. *Depression and Anxiety*, 29, 1032-1042. PILOTS ID: 39610

Treatment

Effects of Prolonged Exposure on mental health service use

VA has expended significant resources for its national implementation of evidence-based treatment for PTSD because these treatments decrease symptoms and improve functioning. A study by researchers looking at mental health utilization suggests that evidence-based treatment has cost-saving benefits as well. The study sample consisted of 60 Veterans with combat-related PTSD who received Prolonged Exposure (PE). Of these, 44 completed treatment, which was defined as either attending at least 7 90-minute sessions of PE (including at least 4 sessions of imaginal exposure), or terminating before 7 sessions due to clinically significant symptom improvement. Analyses of the entire sample indicated that the average number of mental health appointments in the year after treatment ($M = 5.4$) was significantly less than in the year prior to treatment ($M = 7.4$). The reduction was even more pronounced for treatment completers (from 7.4 to 4.1). Veterans who did not complete PE, however, experienced an increase in average mental health service utilization (7.4 to 8.7 appointments). Completion of PE was also associated with a 44% decrease in the average per-person cost of mental health service utilization, from \$693 in the year before treatment to \$386 in the year after; the cost for noncompleters actually increased by 17%

(from \$692 to \$810). These findings highlight the value of evidence-based PTSD treatment and the importance of efforts that help Veterans complete treatment. Read the article...<http://www.ptsd.va.gov/professional/articles/article-pdf/id39607.pdf>

Tuerk, P. W., Wangelin, B., Rauch, S. A. M., Dismuke, C. E., Yoder, M., Myrick, H., Eftekhari, A., & Acierno, R. (2012, November 12). Health service utilization before and after evidence-based treatment for PTSD. *Psychological Services*. Advance online publication. PILOTS ID: 39607

Combining additional treatment components with exposure therapy

Prior research has produced conflicting findings on whether adding other treatment components to exposure therapy is beneficial. A new quantitative review suggests that adding active components such as cognitive restructuring to exposure therapy produces further reductions in PTSD, but the effects are small. Researchers from the Minneapolis VAMC analyzed data from 8 randomized controlled trials of treatment for PTSD that compared exposure therapy alone to exposure therapy plus at least one additional active component, usually cognitive restructuring. Analyses revealed that compared to patients who received exposure alone, patients who received combined treatment had significantly greater improvement in clinician-rated PTSD at posttreatment and follow-up (Hedge's $g = .33$ and $.39$, respectively). When the researchers looked at just the 6 studies that supplemented exposure with cognitive restructuring, they found a comparable effect for clinician-rated PTSD, as well as a significant effect for self-reported PTSD ($g = .35$) favoring the combined treatment group. Combined therapy had no effect on dropout either. The results of this study might make clinicians inclined to always offer additional components. However, given the small effects, the authors point out that factors such as client preference and needs, training implications, session number allowances, and cost-effectiveness should also be considered. It also would be important to know whether some patients might be more (or less) appropriate for exposure alone versus combined treatment. Read the article...<http://dx.doi.org/10.1037/a0030040>

Kehle-Forbes, S. M., Polusny, M. A., MacDonald, R., Murdoch, M., Meis, L. A., & Wilt, T. J. (2012, October 22). A systematic review of the efficacy of adding nonexposure components to exposure therapy for posttraumatic stress disorder. *Psychological Trauma: Theory, Research, Practice, and Policy*. Advance online publication. PILOTS ID: 39612

Flexible delivery of Cognitive Processing Therapy is highly effective

One obstacle to greater implementation of evidence-based treatments for PTSD is reluctance of some clinicians to utilize

manualized protocols. A new study of Cognitive Processing Therapy suggests that CPT can be delivered flexibly according to patient progress and still significantly reduce PTSD and related symptoms. In an innovative design, 100 men and women with PTSD were randomized to receive either Cognitive Processing Therapy delivered flexibly ($N = 53$) or to a delayed treatment group ($N = 47$) that participated in daily symptom monitoring, regular assessments, and phone check-ins with therapists. Those in the delayed treatment group were then offered Cognitive Processing Therapy after 10 weeks; 25 initiated treatment. In the flexible protocol, patients received 4 to 18 sessions, depending on their improvement. An additional 2 sessions were available outside of the CPT protocol to address major life stressors. Patients receiving Cognitive Processing Therapy not only showed large improvements in PTSD and significantly better outcomes than those receiving minimal contact, they also showed large improvements in depression, guilt, functioning, and quality of life. A total of 50 patients completed treatment: 33 assigned to CPT and 17 assigned to delayed treatment. At follow-up, 48 of the completers were free of their PTSD diagnosis; 29 required less than 12 sessions and 21 required more than 12 sessions to complete successfully. The study is important because it shows that a manualized protocol can be effectively adapted to meet patients' individual needs. Read the article...<http://dx.doi.org/10.1037/a0030600>

Galovski, T. E., Blain, L. M., Mott, J. M., Elwood, L., & Houle, T. (2012, October 29). Manualized therapy for PTSD: Flexing the structure of cognitive processing therapy. *Journal of Consulting and Clinical Psychology*. Advance online publication. PILOTS ID: 39611

No benefit of telephone monitoring after residential PTSD treatment

Telephone care management improves outcomes following inpatient treatment for depression and substance use disorders. However, a new study suggests that the addition of telephone monitoring and support to aftercare does not improve outcomes in Veterans after being discharged from inpatient treatment for PTSD. Veterans at 5 VAMCs were randomly assigned to either treatment as usual ($N = 425$), which provided standard referrals, or treatment as usual plus telephone care management ($N = 412$), consisting of biweekly calls to assess symptoms and treatment engagement, and to provide encouragement and brief intervention. Veterans in the telephone condition received an average of 4.5 calls of the 6 calls planned. There were no differences between conditions in symptoms of PTSD, aggression, substance use, or quality of life at 4 or 12 months after discharge. A pilot feasibility study had suggested that telephone support would reduce the time between discharge from residential PTSD treatment and the first outpatient visit, but time to rehospitalization and time to first outpatient visit were also similar for both conditions. The authors suggest that the lack of effects in the present trial, compared to previous research on telephone care manage-

ment for other conditions, may be explained by the relative availability of aftercare following PTSD treatment in the VA; telephone support may have pronounced impact only in settings where aftercare is limited. Read the article...<http://www.ptsd.va.gov/professional/articles/article-pdf/id39545.pdf>

Rosen, C. S., Tiet, Q. Q., Harris, A. H. S., Julian, T. F., McKay, J. R., Moore, W. M., . . . Schnurr, P. P. (2012, November 1). Telephone monitoring and support after discharge from residential PTSD treatment: A randomized controlled trial. *Psychiatric Services*. Advance online publication. PILOTS ID: 39545

Study reports sustained benefits of MDMA-augmented psychotherapy for PTSD

In 1985, the drug 3,4-methylenedioxymethamphetamine, MDMA—commonly known as “Ecstasy”—was classified as a Schedule 1 controlled substance in the US. Before that, beginning in the 1970s, some therapists had used MDMA to augment the benefits of psychotherapy. Results of a new study suggest that this kind of treatment may have long-term benefits in treatment-refractory patients with PTSD. In a study published in 2011, Mithoefer and colleagues had reported promising short-term results in 20 patients who were randomized to receive MDMA or placebo during 2-3 psychotherapy sessions, along with additional therapy before and after the augmented sessions. In the new follow-up study, 12 patients who had been assigned to MDMA and 7 placebo patients who had received open-label MDMA treatment after completing the 2-month follow-up were reassessed an average of almost 4 years later using the Clinician-Administered PTSD Scale. The substantial gains that had been found at 2 months were maintained, and both the initial and long-term gains were clinically meaningful. However, it is important to note that blinding was not achieved in the original trial—19 of the 20 participants and all therapists correctly guessed participants' treatment assignment. Also, another recent pilot study (Ohren et al., 2012) by an independent group failed to find the substantial benefits observed in the initial trial. Nevertheless, research on novel treatments like this represents an important step in the treatment of PTSD. Read the article...<http://dx.doi.org/10.1177/0269881112456611>

Mithoefer, M. C., Wagner, M. T., Mithoefer, A. T., Jerome, L., Martin, S. F., Yazar-Klosinski, B., . . . Doblin, R. (2013). Durability of improvement in post-traumatic stress disorder symptoms and absence of harmful effects or drug dependency after 3,4-methylenedioxymethamphetamine-assisted psychotherapy: a prospective long-term follow-up study. *Journal of Psychopharmacology*, 27, 28-39. PILOTS ID: 39613

Mithoefer, M. C., Wagner, M. T., Mithoefer, A. T., Jerome, L., & Doblin, R. (2011). The safety and efficacy of \pm 3,4-methylenedioxymethamphetamine-assisted psychotherapy in subjects with chronic, treatment-resistant posttraumatic stress disorder: The first randomized controlled pilot study. *Journal of Psychopharmacology*, 25, 439-452. doi: 10.1177/0269881110378371

Oehen, P., Traber, R., Widmer, V., & Schnyder, U. (2013). A randomized, controlled pilot study of MDMA (\pm 3,4-Methylenedioxyamphetamine)-assisted psychotherapy for treatment of resistant, chronic posttraumatic stress disorder (PTSD). *Journal of Psychopharmacology*, 27, 40-52. doi: 10.1177/0269881112464827

OEF/OIF/OND

Primary care-mental health clinic as a gateway to mental health care

The VA's Primary Care-Mental Health Integration program has shown promise in increasing mental health visits among Veterans. Results of a study by researchers from the South Texas VA Healthcare System suggest that the program can increase mental health service utilization in a population that can be challenging to engage in treatment: OEF/OIF Veterans. The researchers analyzed VA administrative data for 2,470 OEF/OIF Veterans who received care from FY 2006 through FY 2009, comparing those who received care in PC-MHI versus those who received care in other settings. Veterans seen in the PC-MHI program in 2007 or 2008 were over 3 times as likely to use mental health services the following year, even accounting for differences in clinical and demographic factors between groups. Analysis of a subsample of 181 Veterans who used the PC-MHI for the first time during the study period indicated that nearly 60% had their next mental health visit within 1 month, 79% within 6 months, and 82% within one year. In the entire study sample, Veterans with PTSD in 2006 were nearly four times more likely to remain in VA mental health care through 2009 than Veterans without PTSD. The finding that Veterans with PTSD are especially likely to stay engaged, regardless of PC-MHI use, may reflect VA's efforts at outreach, education, and specialty care targeting Veterans with PTSD. Read the article...<http://dx.doi.org/10.1037/a0028308>

Tsan, J. Y., Zeber, J. E., Stock, E. M., Sun, F., Copeland, L. A. (2012). Primary care-mental health integration and treatment retention among Iraq and Afghanistan war veterans. *Psychological Services*, 9, 336-348. PILOTS ID: 39614

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