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U.S. Department of Veterans Affairs

Treatment

Prolonged Exposure for combat-related PTSD in older Veterans

Most research on the treatment of PTSD has been conducted with younger and middle-aged adults. The potential effects of cognitive decline and chronic medical conditions on treatment outcome in older adults are unknown. Findings from a study of Prolonged Exposure at the Charleston VA suggest that PE is both safe and effective for older Veterans. Researchers examined archival data from 65 male Veterans age 60 years and older who were treated with PE for combat-related PTSD as part of standard clinical care in a specialized PTSD clinic. Nearly all Veterans (85%) successfully completed treatment, defined as either attending the recommended 8 sessions of PE or completing at least 4 sessions and experiencing a clinically significant improvement in PTSD. Age, race, military branch, and service-connection were unrelated to treatment response. Posttreatment reductions in PTSD were statistically and clinically significant, with 65% of the entire sample and 75% of treatment completers scoring below 50 on the PCL. Although physical health and cognitive capacity were not formally assessed, there were no reported adverse health events and no indication that participation in PE was diminished due to physical or

cognitive limitations. These findings provide preliminary support for the tolerability and effectiveness of PE in older Veterans. Read the article... <http://dx.doi.org/10.2190/PM.45.2.b>

Yoder, M., Lozano, B., Center, K., Miller, A., Acierno, R., & Tuerk, P. (2013). Effectiveness of Prolonged Exposure for PTSD in older Veterans. *International Journal of Psychiatry in Medicine*, 45, 111-124. PILOTS ID: 41383

Veteran perspectives on Group-Based Exposure Therapy

Ten years ago, a VA Cooperative Study found minimal benefit of trauma-focused group therapy and no difference from the benefits of present-centered group therapy. However, another group-based exposure protocol has shown promising results in an uncontrolled pilot study. Researchers from the Atlanta and Houston VAMCs recently reported additional outcome data, as well as tolerability and patient perspectives. Two groups of 10 Veterans each received twice weekly 3-hour sessions for 12-weeks. Data from the first group were collected for the initial pilot; the second group was conducted in clinical care. Veterans presented their trauma to the group on two occasions. Even though many Veterans ($n = 14$) considered dropping out, all but one fully completed treatment. The most common

Special Notice

Special Section on DSM-5 in the Journal of Traumatic Stress: The October 2013 issue of *JTS* contains a special section on the new American Psychiatric Association's diagnostic criteria for PTSD. Articles and commentaries cover the differences in diagnostic outcome between the *DSM-IV* and the *DSM-V*, the process of reclassifying and revising the PTSD diagnosis, and comparisons between *DSM-5* and the *ICD-11*. Read the issue... [Weiss, D. S. \(Ed.\). \(2013\). Journal of Traumatic Stress, 26\(5\).](#)

reason ($n = 9$) for continuing was commitment to the group. No Veteran perceived negative effects from others' in-session exposures and half the sample indicated positive effects (e.g., normalizing their experience and group cohesion). The support from group members during in-session exposures was perceived as the most helpful part of the therapy. Importantly, nearly all treatment completers experienced a reliable reduction in PTSD (5 points on the PCL), with a group average of 20 points. Three Veterans reported symptom exacerbation during exposure, but only one terminated. The findings suggest that Group-Based Exposure Therapy is well tolerated and positively received. However, a randomized controlled trial is needed to demonstrate the efficacy of Group-Based Exposure Therapy. Read the article... <http://dx.doi.org/10.1037/a0029386>

Mott, J. M., Sutherland, R., Williams, W., Lanier, S., Ready, D. J., & Teng, E. J. (2013). Patient perspectives on the effectiveness and tolerability of group-based exposure therapy for posttraumatic stress disorder: Preliminary self-report findings from 20 Veterans. *Psychological Trauma: Theory, Research, Practice, and Policy*, 5, 453-461. PILOTS ID: 87772

Cognitive Therapy for PTSD in clinical practice

Evaluations of VA's dissemination of trauma-focused psychotherapies indicate that these treatments are effective in clinical settings. Investigators from the United Kingdom hoped to find similar results in their evaluation of one clinic's implementation of Cognitive Therapy for PTSD. A total of 34 therapists treated 330 patients at a community hospital clinic. The sample was diverse, with 50% women and 44% ethnic minorities. Patients received an average of 10.6 weekly and 2 monthly booster sessions of Cognitive Therapy for PTSD. Posttreatment reductions in PTSD, depression, and anxiety were large ($d_s = 1.39$, $.91$, and $.97$, respectively) and maintained at 9 months, even with training cases included in analyses. Dropout was low (13.9%), but more likely for patients whose therapists were inexperienced in the treatment (18.1%) and among patients with social problems (18.5%), such as difficulty acquiring housing or disability benefits. Few factors moderated outcomes in multivariate analyses; patients with multiple traumas and those with social problems had somewhat less improvement. These patients also attended fewer sessions or attended irregularly, and their sessions were less trauma-focused than the sessions of other patients. Because clinically significant change was associated with greater trauma focus, the investigators hypothesized that patients with multiple traumas or difficult life circumstances did not receive enough trauma-specific treatment and suggest that they may benefit from case management and additional trauma-focused sessions. Read the article... <http://dx.doi.org/10.1016/j.brat.2013.08.006>

Ehlers, A., Grey, N., Wild, J., Stott, R., Liness, S., Deale, A., . . . Clark, D. M. (2013). Implementation of cognitive therapy for PTSD in routine clinical care: Effectiveness and moderators of outcome in a consecutive sample. *Behaviour Research and Therapy*, 51, 742. PILOTS ID: 41272

Increased use of psychotherapy in VA mental health care

VA has hired additional mental health professionals and implemented efforts such as national training programs in evidence-based psychotherapies in order to enhance delivery of mental health care to Veterans. A new study by investigators at the Houston VA Medical Center suggests that VA's efforts have been successful in increasing Veterans' use of psychotherapy. The investigators selected patients who received a new diagnosis of depression, PTSD, or another anxiety disorder in 2004 ($N = 424,428$), 2007 ($N = 494,318$), or 2010 ($N = 583,733$) and examined their use of psychotherapy in the 12 months following their initial diagnosis. Veterans with PTSD had greater use of psychotherapy than the other groups at all intervals. There was no increase over time in the PTSD group, whereas Veterans with depression had a 40% increase and Veterans with anxiety had a 59% increase. In 2010, 34.2% of Veterans with PTSD had at least 1 session of psychotherapy, compared with 26.2% of Veterans with depression and 22.5% of Veterans with anxiety. The findings indicate most Veterans did not receive many sessions at any time. By 2010, only 8.9% of the PTSD group, 5.5% of the depressed group, and 4.3% of the anxiety group had 8 or more sessions during the 12-months after being diagnosed. But overall, the study suggests that programmatic efforts have made a difference in enhancing mental health care for Veterans. Read the article... <http://dx.doi.org/10.1176/appi.ps.201300056>

Mott, J., Hundt, N., Sansgiry, S., Mignogna, J., & Cully, J. (2013). Changes in psychotherapy utilization among Veterans with depression, anxiety, and PTSD. *Psychiatric Services*. Advance online publication. PILOTS ID: 41383

Improved trends in VA prescribing practices—but room for improvement

Selective serotonin reuptake inhibitors and serotonin-norepinephrine reuptake inhibitors are the only classes of medications recommended in the VA/DoD Practice Guideline for treating PTSD. Many patients receive different medications "off-label" instead of or in addition to these recommended treatments, perhaps because the recommended treatment was not completely effective or because the patient could not tolerate its side effects. Three recent articles report on prescribing trends in two classes of off-label medications that are widely used in VA: second-generation antipsychotics (SGAs) and benzodiazepines. Although both types of medications are effective for some disorders, neither is a recommended treatment for PTSD and both can have significant side effects—which raises a question about why these medications are prescribed. This question is the topic of one of the articles, and the answer itself raises further questions.

The first study used VA national administrative data from a sample of over 700,000 Veterans with PTSD to examine trends from 2003-2010 in the prescription of SGAs. In the initial release of the 2010 PTSD guideline, the evidence for SGAs to augment another treatment was listed as “fair.” Following the publication of a large VA Cooperative Study in 2011, the evidence for risperidone was changed to “contraindicated” and for all other SGAs to “insufficient.” Although the absolute number of VHA patients with PTSD who received an SGA grew from 45,268 to 84,197 between 2003 and 2010, the percentage dropped from 28.6% to 21.5%—clearly a trend in the right direction given the updated guideline. Greater likelihood of receiving an SGA was associated with patient demographic factors such as non-White race and comorbidity such as depression. There were regional differences as well, with Veterans living in the South having the highest likelihood of receiving an SGA. Read the article... <http://www.ptsd.va.gov/professional/articles/article-pdf/id41343.pdf>

The second study also used VA administrative data on SGA prescriptions but focused on prescribers in addition to patients. The investigators surveyed clinicians located at a single VA Medical Center any time during a 20-month period in 2007-2009 when they wrote a new prescription for an SGA. The 2,613 surveys collected represented virtually 100% of the prescriptions written because the electronic system would not allow providers to complete a prescription request without also completing the survey. Of the patients, 13.0% had PTSD only, 9.0% had PTSD plus another psychiatric disorder, and 78.0% had another psychiatric disorder only. Efficacy was the most common reason providers cited to explain why they prescribed an SGA, but was cited less often when the patient had PTSD only (43.6%) than when the patient had PTSD plus another disorder (48.6%) or another disorder only (52.6%). Increasing sleep or sedation was the next most commonly cited reason in PTSD only cases (38.5%), compared with PTSD plus another disorder (35%) or another disorder only (30.7%). Read the article... <http://dx.doi.org/10.1017/S2045796013000449>

The third study focused on adverse events associated with benzodiazepines and opioids, an important topic given the potential side effects of these medications. The investigators examined the occurrence of adverse events in over a 2-year interval in 5,236 VA patients with PTSD who had a new episode of treatment with an SSRI or SNRI: 14.3% also received a benzodiazepine, 5.8% received a benzodiazepine plus an opioid, and 79.9% had an SSRI/SNRI only. Compared with the patients who received an SSRI/SNRI, those who received a concurrent benzodiazepine but not an opioid had an increased risk of mental health hospitalization. But those who also receive a concurrent opioid had increased risk of numerous additional harmful outcomes, including hospitalization for medical problems, an emergency department visit, and a harmful event such as a fall, accident, suicide attempt, poisoning, adverse drug event, injury, or death. The combined group was distinctive in terms of being much more likely to have pain, sleep diffi-

culties, and all of the adverse events studied in the 6 months prior to the 2-year observation period. However, further analyses limited to less ill patients and patients who had none of the adverse events in the prior 6 months replicated the main findings. Read the article... <http://dx.doi.org/10.1097/ADM.0b013e31829e3957>

There are effective treatments for PTSD that can substantially help many patients. The results of all three studies show a need for continued efforts to enhance implementation of the PTSD Practice Guideline and to increase awareness of alternative treatments such as cognitive-behavioral therapy that can be used to treat comorbid pain or sleep problems that do not resolve following a course of evidence-based treatment.

Bauer, M., Lee, A., Li, M., Bajor, L., Rasmussen, A., & Kazis, L. (2013). Off-label use of second generation antipsychotics for post-traumatic stress disorder in the Department of Veterans Affairs: Time trends and sociodemographic, comorbidity, and regional correlates. *Pharmacoepidemiology and Drug Safety*. Advance online publication. PILOTS ID: 41343

Hermes, E., Sernyak, M., & Rosenheck, R. (2013). The use of second generation antipsychotics for post-traumatic stress disorder in a US Veterans Health Administration medical center. *Epidemiology and Psychiatric Sciences*, no volume specified, 1-8. PILOTS ID: 41386

Hawkins, E., Malte, C., Grossbard, J., Saxon, A., Imel, Z., & Kivlahan, D. (2013). Comparative safety of benzodiazepines and opioids among Veterans Affairs patients with posttraumatic stress disorder. *Journal of Addiction Medicine*, 7, 354-362. PILOTS ID: 41385

Assessment

Optimal cutpoints for scoring the PTSD Checklist in primary care settings

A 2007 study by researchers from the Charleston VA (see the [August 2007 CTU-Online](#)) indicated that a cutoff score of 31 on the PCL provided an ideal balance between sensitivity (81%) and specificity (81%) in VA primary care patients. A recent study of DoD patients confirmed this finding but new analyses of the VA study suggest that the optimal score varies for different age groups. Both studies used Receiver Operator Characteristic analyses to define optimal cut scores for the PCL relative to a *DSM-IV* PTSD diagnosis determined from structured clinician interviews.

The DoD study included 213 patients drawn from 3 military primary care clinics. Although 68% of the participants were active duty Servicemembers, the sample also included retired personnel (14%) and family members (18%). Three commonly used PCL total scores (31, 44, and 50) were examined as potential optimal cutoffs. As in the VA primary care sample, a score of 31 most effectively balanced sensitivity and specificity in the DoD sample. The best cutoff score varied only by 1

point (i.e., 30) when just the active duty subsample was examined. Read the article... <http://www.ptsd.va.gov/professional/articles/article-pdf/id41388.pdf>

The Veteran sample ($n = 858$) was randomly selected from primary care patients seen at four VA medical centers. The optimal cutpoint varied by three defined age categories, from 43 for Veterans 21-49 years of age, to 34 for those 50-64, and to 24 for those 65 and older. Read the article... <http://dx.doi.org/10.1016/j.jagp.2013.03.009>

These findings suggest that using one overall cutpoint for all patients seen in primary care would result in overdetection among younger patients and underdetection among older patients. With the release of *DSM-5*, studies will be needed to determine the optimal cutoff scores on the revised PCL-5 for specific care settings and by patient demographic characteristics.

Gore, K. L., McCutchan, P. K., Prins, A., Freed, M. C., Liu, X., Weil, J. M., & Engel, C. C. (2013). Operating characteristics of the PTSD checklist in a military primary care setting. *Psychological Assessment*, 25, 1032-1036. PILOTS ID: 41388

Yeager, D., & Magruder, K. (in press). PTSD Checklist scoring rules for elderly Veterans Affairs outpatients. *The American Journal of Geriatric Psychiatry*. PILOTS ID: 41387

Additional Recommended Reading

Stay up-to-date with four new review articles

VA's implementation of evidence-based psychotherapies: Karlin, B. E., & Cross, G. (2013). From the laboratory to the therapy room: National dissemination and implementation of evidence-based psychotherapies in the U.S. Department of Veterans Affairs Health Care System. *American Psychologist*. Advance online publication. PILOTS ID: 41382. [doi:10.1037/a0033888](https://doi.org/10.1037/a0033888)

Comprehensive review of gender differences in postdeployment PTSD: Crum-Cianflone, N. F., & Jacobson, I. (2013). Gender differences of postdeployment post-traumatic stress disorder among Service Members and Veterans of the Iraq and Afghanistan conflicts. *Epidemiologic Reviews*. Advance online publication. PILOTS ID: 41372. [doi:10.1093/epirev/mxt005](https://doi.org/10.1093/epirev/mxt005)

Update on medications for comorbid PTSD and substance use disorder: Sofuoglu, M., Rosenheck, R., & Petrakis, I. (2014). Pharmacological treatment of comorbid PTSD and substance use disorder: Recent progress. *Addictive Behaviors*, 39, 428-433. PILOTS ID: 41230. <http://www.ptsd.va.gov/professional/articles/article-pdf/id41230.pdf>

PTSD and suicide in Veterans: Pompili, M., Sher, L., Serafini, G., Forte, A., Innamorati, M., Dominici, G., . . . Girardi, P. (2013). Posttraumatic stress disorder and suicide risk among veterans: A literature review. *Journal of Nervous and Mental Disease*, 201, 802-812. PILOTS ID: 41336. [doi:10.1097/NMD.0b013e3182a21458](https://doi.org/10.1097/NMD.0b013e3182a21458)

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