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TREATMENT

Veterans say trauma-focused treatments are challenging but beneficial

Patients who are considering trauma-focused treatment may be curious about the actual experiences of individuals who have received these therapies. Recently, investigators from the Michael E. DeBakey VA Medical Center led a qualitative study to explore Veterans' experiences with Prolonged Exposure and Cognitive Processing Therapy. Twenty-three Veterans who received at least 8 sessions of PE or CPT in a VA PTSD clinic completed qualitative interviews that asked what it was like to participate in these treatments. The most common perspective was that treatment was emotionally challenging but beneficial. Although some participants (36% in PE, 25% in CPT) reported an initial worsening of symptoms, most (86% in PE, 75% in CPT) noticed notable symptom improvement as a result of treatment. More PE patients (93%) than CPT patients (25%) considered dropping out of treatment, mostly because they worried treatment would make their symptoms worse. Veterans reported that a number of factors encouraged them to stick with treatment, including commitment to finishing, the therapeutic relationship, and family support. Patients and providers may be reassured that even Veterans who find treatment challenging can benefit from it. The investigators suggest that providers can increase engagement in these treatments by building rapport, emphasizing commitment to treatment, and encouraging family involvement.

Read the article: <http://doi.org/10.1016/j.cbpra.2016.02.003>

Hundt, N. E., Barrera, T. L., Arney, J., & Stanley, M. A. (2016). "It's worth It in the end": Veterans' experiences in prolonged exposure and cognitive processing therapy. *Cognitive and Behavioral Practice*. Advance online publication. PILOTS: 44823

People with PTSD want an active role in treatment decisions

Shared decision-making is a cornerstone of patient-centered care. Research shows that patients with conditions such as cancer or diabetes want to receive information about their treatment options and engage in shared decision-making. In a recent survey, investigators with the National Center for PTSD examined whether the same is true for patients with PTSD symptoms. The 301 adult participants (half of whom were Veterans) were recruited from an online research panel. All screened positive on the Primary Care PTSD Screen. Almost all participants (97%) wanted to be involved in PTSD treatment decisions, and most preferred to assume more control over decisions than their provider. Participants were most interested in receiving information about treatment effectiveness and side effects. They were less interested in learning whether they would need to do homework or talk about their trauma. This study is one of the first to show that people with PTSD want to be involved in choosing which treatment is best for them. Providers can do their part by encouraging patient participation in decisions to the extent each patient prefers.

Read the article: <http://www.ptsd.va.gov/professional/articles/article-pdf/id44824.pdf>

Harik, J. M., Hundt, N. E., Bernardy, N. C., Norman, S. B., & Hamblen, J. L. (2016). Desired involvement in treatment decisions among adults with PTSD symptoms. *Journal of Traumatic Stress*, 29, 221-228. PILOTS: 44824

Group format linked with retention in therapy for Veterans with PTSD

Limited patient engagement in PTSD treatment is a concern for VA. Therapy modality (group or individual) is one factor that may affect retention in treatment. Although each format offers unique advantages, is one more effective in retaining patients? A research team from VA Ann Arbor Health Care System examined whether therapy modality was related to treatment engagement for Veterans with PTSD. The investigators analyzed data from the VA National Patient Care Database on all VA patients ($N = 65,298$) who received a new PTSD diagnosis in FY2010 in specialty PTSD clinical teams. Veterans who started group therapy had more psychotherapy visits ($M = 4.7$) than those who started individual therapy ($M = 2.8$). Additionally, patients who began group therapy were over twice as likely to receive an adequate dose of treatment (defined as 8 or more sessions) than those who began individual therapy (30% vs. 14%). It is important to note that the Veterans were not randomized to therapy modality, so various patient, therapist, and system factors may be contributing to these findings. Additionally, because the study did not measure clinical outcomes, it is not clear whether more group therapy sessions translated to greater improvement in PTSD symptoms. The data also did not indicate whether Veterans received evidence-based treatments. However, these findings suggest that group therapy may promote continued engagement in PTSD treatment.

Read the article: <http://doi.org/10.1037/ser0000077>

Sripada, R. K., Bohnert, K. M., Ganoczy, D., Blow, F. C., Valenstein, M., & Pfeiffer, P. N. (2016). Initial group versus individual therapy for posttraumatic stress disorder and subsequent follow-up treatment adequacy. *Psychological Services*. Advance online publication. PILOTS: 44825

More similarity than difference in long-term outcomes of PTSD prevention

Cognitive-behavioral therapy to prevent PTSD has shown promise for selected populations, such as individuals with acute stress disorder, and also in accelerating recovery. New findings, however, suggest that individuals treated with medication or who do not receive treatment eventually catch up over time. Investigators at New York University Lagone Medical Center used data from a prospective study of Israeli men and women recruited after admittance to a hospital following injury. Participants were randomized to early intervention with PE, cognitive therapy, the SSRI escitalopram, or placebo, or refused psychological treatment. Of the 321 participants, 83% were assessed at 5 months post-trauma (after treatment for the treated groups) and 52% were assessed 3 years later. There were few systematic differences between individuals retained versus those lost to follow-up. At 5 months, there was a clear advantage in the CBT groups, which had lower symptom severity and lower prevalence of PTSD. At 3 years, the groups were more similar; e.g., PTSD prevalence ranged from 29% in PE to 46% in escitalopram, which was not a significant difference. Why the groups that initially had not fared as well continued to improve is not known. Also not known is whether the findings would generalize to other acutely traumatized populations. Regardless, it may be tempting to conclude that early intervention does not matter, but it is important to consider the value of early response—fewer symptoms and better functioning for a longer period of time.

Read the article: <dx.doi.org/10.4088/JCP.15m09932>

Shalev, A. Y., Ankri, Y., Gilad, M., Israeli-Shalev, Y., Adessky, R., Qian, M., & Freedman, S. (2016). Long-term outcome of early interventions to prevent posttraumatic stress disorder. *Journal of Clinical Psychiatry*, 77, 580-587. PILOTS: 44826

Meta-analysis offers updated look at effectiveness of PTSD treatment

A meta-analysis led by investigators with the Army's Office of Evidence Based Practice examined 58 randomized controlled PTSD treatment trials. The study found that psychotherapies had larger effect sizes than medications, which replicates the results of a prior meta-analysis of PTSD treatments (see [August 2013 CTU-Online](#)).

Read the article:

<http://www.ptsd.va.gov/professional/articles/article-pdf/id44832.pdf>

Lee, D. J., Schnitzlein, C. W., Wolf, J. P., Vythilingam, M., Rasmussen, A. M., & Hoge, C. W. (2016). Psychotherapy versus pharmacotherapy for posttraumatic stress disorder: Systemic review and meta-analyses to determine first-line treatments. *Depression and Anxiety*. Advance online publication. PILOTS: 44832

Special series on change processes in PTSD treatment

A special series in *Behavior Therapy* features four articles that focus on the process of therapeutic change in PTSD treatment. Each of the articles investigates key factors that may impact treatment outcome.

Read the series:

<http://www.ptsd.va.gov/professional/articles/article-pdf/id44904.pdf>

Nixon, R. D. V., & Sloan, D. M. (Eds.). (2016). Treating PTSD: Innovations and understanding processes of change [Special series]. *Behavior Therapy*. Advance Online Publication. PILOTS: 44904

Take
NOTE

Examining three different approaches to PTSD screening

Screening is an important first step towards diagnosing and treating PTSD. Three recent manuscripts examine different approaches to PTSD screening, highlighting the unique benefits and drawbacks of each.

In the first study, investigators from the National Center for PTSD examined the diagnostic accuracy of the Primary Care PTSD screen for *DSM-5* (PC-PTSD-5). A sample of 398 Veterans completed both the PC-PTSD-5, which consists of 5 yes/no items, and a short diagnostic interview (the PTSD module of the MINI). Overall, the PC-PTSD-5 showed strong diagnostic accuracy compared with the MINI (area under the curve = .94). However, PC-PTSD-5 performance depended on the cut score used. A cut score of 3 showed the best sensitivity, accurately identifying 95% of participants diagnosed with PTSD on the MINI. In comparison, a cut score of 5 was less sensitive (identifying only 56% of those with PTSD), but produced relatively fewer false positives among those who did not meet PTSD criteria on the MINI (3% vs. 15%).

Read the article: <http://www.ptsd.va.gov/professional/articles/article-pdf/id44829.pdf>

A separate study by investigators with the National Center for PTSD and Yale University evaluated the screening utility of a different PTSD measure: the 17-item PTSD Checklist-military version (PCL-M) for *DSM-IV*. Investigators reviewed the medical records of 327,093 Veterans who received a PCL-M between 2008 and 2012 to see whether PCL-M scores aligned with clinician-documented PTSD diagnoses. The study tested various PCL-M scoring methods (i.e., cut points of 35, 44, and 50 with or without requiring that symptoms align with *DSM-IV* criteria). As expected, more Veterans (62–84%, depending on scoring) screened positive on the PCL-M than received clinician-documented diagnosis (40%). The optimal PCL-M cut score differed depending on patient characteristics; the investigators recommend a cut score of 44 for men, and 35 for women, and 38 for Iraq and Afghanistan Veterans. These cutpoints do not apply to the *DSM-5* version, which has 20 symptoms and is scored on a 0–4 scale. The finding of different cutpoints, however, has important implications for diagnostic scoring using the PCL for *DSM-5*.

Read the article: <http://www.ptsd.va.gov/professional/articles/article-pdf/id44830.pdf>

A third study by investigators at the Medical University of South Carolina examined whether a streamlined version of the PTSD Checklist for *DSM-5* (PCL-5) could be useful for screening. In a sample of 403 trauma-exposed participants, the investigators tested different versions of the PCL-5 that used various subsets of items. Two brief versions—a 4-item scale and an 8-item scale—correlated highly with the full-length, 20-item PCL-5. The investigators then administered the PCL-5 and the MINI to 133 Veterans referred for psychotherapy at a local VA. The 4-item, 8-item, and full-length PCL-5 showed similar diagnostic accuracy compared with the MINI (area under the curve = .71–.72). The three versions

had comparable sensitivity and specificity, except that the full PCL-5 had better specificity than the 4-item version.

Read the article: <http://doi.org/10.1016/j.psychres.2016.03.014>

Collectively, these studies suggest that the utility of each tool depends on how it is scored and who is being screened. When selecting a screening (and scoring) method, providers should consider their patient population and screening goals (for example, to identify as many potential PTSD cases as possible, or to balance identification with the cost of false positives). Providers should also note that although these screens can accurately identify those with probable PTSD, their usefulness for monitoring change in symptoms over time remains unknown.

Price, M., Szafranski, D. D., van Stolk-Cooke, K., & Gros, D. F. (2016). Investigation of abbreviated 4 and 8 item versions of the PTSD Checklist 5. *Psychiatry Research*, 239, 124–130. PILOTS: 44831

Prins, A., Bovin, M. J., Smolenski, D. J., Marx, B. P., Kimerling, R., Jenkins-Guarnieri, M. A., ... Tiet, Q. Q. (2016). The Primary Care PTSD Screen For *DSM-5* (PC-PTSD-5): Development and evaluation within a Veteran primary care sample. *Journal of General Internal Medicine*. Advance online publication. PILOTS: 44829

Tsai, J., Pietrzak, R. H., Hoff, R. A., & Harpaz-Rotem, I. (2016). Accuracy of screening for posttraumatic stress disorder in specialty mental health clinics in the U.S. Veterans Affairs Healthcare System. *Psychiatry Research*, 240, 157–162. PILOTS: 44830

Biomarkers offer clues about who will respond to PTSD treatment

Some patients who receive PTSD treatment will see dramatic improvements whereas others will experience more modest gains. Findings from two new studies suggest that biomarkers such as blood pressure and heart rate may be one way to tell which patients are likely to benefit from specific PTSD treatments.

In the first study, investigators with the Puget Sound Health Care System examined data from a randomized controlled trial of the medication prazosin (see [August 2013 CTU-Online](#)) to see whether patients' standing blood pressure prior to treatment was linked with treatment response. The trial enrolled male and female active duty soldiers diagnosed with combat-related PTSD after returning from Iraq or Afghanistan. Participants received 15 weeks of prazosin, a hypertension medication that is effective for trauma-related nightmares ($n = 32$), or placebo ($n = 35$). For prazosin participants, higher baseline blood pressure was related to greater improvements on the Clinician Administered PTSD Scale at the end of treatment. Blood pressure was unrelated to treatment response among placebo participants.

Read the article: <http://dx.doi.org/10.1016/j.biopsych.2016.03.2108>

A separate study led by investigators from Emory University School of Medicine examined whether Veterans' baseline physiological and hormonal reactivity to combat-related cues predict-

ed their response to virtual reality (VR) exposure therapy. Fifty combat Veterans with PTSD underwent 6 sessions of VR exposure therapy combined with either D-cycloserine (DCS, a drug shown to enhance exposure therapy in some anxiety disorders), alprazolam (a benzodiazepine), or placebo. Prior to starting treatment, participants viewed standardized VR combat scenes to assess their physiological reactivity in response to these scenes. Greater startle, heart rate, and skin conductance during the initial VR scenes predicted greater improvement in PTSD at 6-month follow-up among DCS participants, but not among alprazolam or placebo participants. Across conditions, cortisol response to the initial VR scenes did not predict improvements in PTSD at 6-month follow-up.

Read the article: <http://doi.org/10.1016/j.brat.2016.05.002>

These studies show that biomarkers can predict differential response to treatment. This is important because there is so little

evidence that patient characteristics can inform clinical decision-making. Identifying prescriptive predictors of treatment response is particularly helpful for matching patients to an optimal treatment. The investigators from both studies also recommend that physiological assessment before, during, and after treatment may be valuable for monitoring treatment progress.

Norrholm, S. D., Jovanovic, T., Gerardi, M., Breazeale, K. G., Price, M., Davis, M., ... Rothbaum, B. O. (2016). Baseline psychophysiological and cortisol reactivity as a predictor of PTSD treatment outcome in virtual reality exposure therapy. *Behaviour Research and Therapy*, 82, 28–37. PLOTS: 44828

Raskind, M. A., Millard, S. P., Peterson, K., Williams, T., Hoff, D. J., Hart, K., ... & Peskind, E. R. (2016). Higher pretreatment blood pressure is associated with greater PTSD symptom reduction in soldiers treated with prazosin. *Biological Psychiatry*. Advance Online Publication. PLOTS:44908



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