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OEF/OIF Veterans

Factors leading to lower treatment retention in OEF/OIF Veterans

Concern exists that OEF/OIF Veterans drop out of treatment prematurely. Whether this cohort of Veterans is receiving fewer mental health visits than Veterans of other eras and why is the focus of a new study by investigators at VA Connecticut. The research examined VA administrative data for predictors of the one-year duration of participation in mental health treatment among 204,184 Veterans who received a new diagnosis of PTSD; 59.6% were Vietnam Veterans, 14.4% were OEF/OIF Veterans, and 26% were either Korean, post-Vietnam, or Persian Gulf Veterans. Compared with their Vietnam-era counterparts, OEF/OIF Veterans dropped out of PTSD treatment at a greater rate (62.4% versus 54%). However, multivariate analyses adjusting for demographic and comorbid diagnoses showed that OEF/OIF Veterans were actually 7% less likely to discontinue treatment. Although the investigators note that the OEF/OIF sample received an average of only 8 mental health visits, compared with an average of 13 for Vietnam Veterans, they did not examine whether treatment discontinuation was premature. Characteristics associated with fewer mental health visits included lower income, younger age, urban residence, and comorbid alcohol or drug use disorder. Clinicians may want to specifically assess and problem solve these potential barriers to treatment participation and follow-through when treatment is initially discussed with their Veteran patients, regardless of era of service. Read the article…http://www.ptsd.va.gov/professional/articles/article-pdf/id35691.pdf

Harpaz-Rotem, I. & Rosenheck, R. A. (2011). Serving those who served: Retention of newly returning veterans from Iraq and Afghanistan in mental health. *Psychiatric Services, 62*, 22-27. PILOTS ID: 35691

Mental health diagnoses before and during deployment

Difficulty in obtaining data on the mental health of Service Members in combat zones has limited understanding of in-theater diagnoses and how they may relate to fitness for duty and predeployment mental health. In a new study, investigators used the Theater Mental Health Encounters Database to shed some light. Out of an estimated 30,000 personnel stationed within the Iraq catchment area studied, 29% of the 1,078 Marine Corps, Army, Navy, and Air Force personnel with a mental health encounter while deployed had a psychiatric diagnosis in their medical record. Adjustment disorder (23%), mood disorder (19%), and PTSD (8%) were the most frequent diagnoses on station. More than half of the personnel given a diagnosis of ADHD or PTSD in Iraq carried a previous diagnosis of the same condition. The investigators only considered the primary diagnosis in analyses and did not examine why personnel sought mental heath services while deployed. These limitations prevent conclusions on whether the heightened incidence of a PTSD diagnosis in deployed personnel with a history of PTSD represents relapse, a reaction to a new trauma, or continuation of symptoms. Regardless, restriction of duties was recommended for only 18% of the care-seeking sample and a record of psychiatric care did not affect the likelihood of return to full duty. Thus, use of mental health care in a combat

zone does not denote functional problems for most personnel and may indicate continuity of care for those with previous psychiatric service utilization. Read the article…http://dx.doi.org/10.1176/appi.ps.62.1.15

Larson, G. E., Konoske, P., Hammer, P. S., Webb-Murphy, J. A., Conway, T. L., Schmitz, K. J.,…Johnson, D. C. (2011). Predeployment and in-theater diagnoses of American military personnel serving in Iraq. *Psychiatric Services, 62*, 15-21. PILOTS ID: 35703

Treatment

Multicomponent exposure therapy yields varied outcomes

Because PTSD patients often have comorbid symptoms and functional difficulties, some authors have argued that it is necessary to combine treatments that target PTSD with interventions for these additional problems. Other authors have argued that good treatment is all that is necessary, citing evidence of improvement in depression, psychosocial functioning, and other outcomes following effective treatment for PTSD. Results of a new study lend support to both positions. The investigators randomized 30 Veterans with chronic PTSD to receive Trauma Management Therapy (TMT), a multi-component intervention that combines 14 sessions of exposure therapy followed by 14 group sessions of social skills and anger management training, or to 14 sessions of exposure followed by 14 sessions of group psychoeducation. Both conditions had comparable decreases in PTSD symptoms after treatment. The reductions in PTSD were modest, however, perhaps because imaginal exposure was conducted only within clinic sessions and not as homework. As expected, Veterans who received TMT had a greater increase in social activities, and this change occurred after the adjunct skills training was administered. Physical rage episodes also decreased in TMT, but only before the adjunct skills training. Neither TMT nor exposure plus psychoeducation improved self-reported anger or quality of life. Readers may question whether the small benefits of TMT are justified by the additional treatment length. It would be helpful to see how TMT compares with a typical—and shorter—course of individual CBT. Read the article…http://dx.doi.org/10.1016/j.janxdis.2010.09.006

Beidel, D. C., Frueh, B. C., Uhde, T. W., Wong, N., & Mentrikoski, J. M. (2011). Multicomponenet behavioral treatment for chronic combat-related posttraumatic stress disorder: A randomized controlled trial. *Journal of Anxiety Disorders, 25*, 224-231. PILOTS ID: 35248

Promising new results on Dialectical Behavior Therapy for PTSD

Several exposure therapy protocols for chronic PTSD related to childhood sexual abuse have incorporated or added skills from Dialectical Behavior Therapy (DBT). Now, researchers in Germany provide preliminary evidence for DBT-PTSD, an intensive treatment completely structured around DBT. In the study, 29 female patients received 4 to 5 hours of group therapy and two 35-minute sessions of individual therapy per week for 3 months. About one quarter of the individual sessions were dedicated to exposure. Along with chronic PTSD, patients had an average of 3.8 Axis I or II diagnoses, and had not responded to previous PTSD treatments. Possibly related to the residential nature of the treatment, there were no treatment drop outs. Effect sizes for the 25 treatment completers were large: 1.22 for PTSD and 1.04 for depression at 6-week follow-up. The study did not include measures of emotion regulation or other outcomes presumed to be specific targets of DBT. As the authors note, because of the lack of randomization and multi-component nature of the program, it is not possible to conclusively determine whether the changes were due to the DBT, exposure, or other program components. Given the intensive and time consuming protocol, PTSD-DBT appears well suited as a residential approach and would likely need adaptation for outpatient settings. Read the article… http://dx.doi.org/10.1002/jts.20617

Steil, R., Dyer, A., Priebe, K., Kleindienst, N., & Bohus, M. (2011). Dialectical behavior therapy for posttraumatic stress disorder related to childhood sexual abuse: a pilot study of an intensive residential treatment program. *Journal of Traumatic Stress, 24,* 102-106. PILOTS ID: 84557

Assessment

In VA administrative data, 2 PTSD diagnoses are better than 1

VA's electronic medical record system has enabled investigators to learn valuable information about service delivery across the VA system. However, the validity of the data is unknown for some conditions, such as PTSD—which prompted investigators at the Center for Chronic Disease Outcomes Research in Minneapolis to examine how well diagnoses in administrative records correspond to diagnoses made based on a validated questionnaire. The investigators examined records of almost 4,800 Veterans who had a new PTSD diagnosis in the administrative data in 2008-2009. The primary outcome was the positive predictive value (PPV) of the administrative diagnosis: the probability that the diagnosis corresponded to a score of 50 or higher on the PTSD Checklist (PCL). The overall PPV was 75%, but it was even better—82%—when the investigators defined PTSD as ≥2 diagnoses in the administrative data within a 4-month period. The effect of the stricter definition was especially large for older veterans and those treated in primary care. The authors discuss several important limitations of their study. An additional limitation is that the PCL, despite being an excellent questionnaire, is not the gold standard for PTSD diagnosis. The validity of administrative data should be established using an interview such as the Clinician-Administered PTSD Scale.

Nevertheless, the study offers important guidance for researchers (to use 2 rather than 1 diagnosis for defining PTSD) and can help clinicians and policymakers have greater confidence in reports based on VA administrative data. Read the article… http://dx.doi.org/10.1682/JRRD.2009.08.0116

Gravely, M. A., Cutting, A., Nugent, S., Grill, J., Carlson, K., & Spoont, M. (2011). Validity of PTSD diagnoses in VA administrative data: Comparison of VA administrative PTSD diagnoses to self-reported PTSD Checklist scores. *Journal of Rehabilitation Research & Development, 48*, 21-30. PILOTS ID: 36002

MMPI-2 validity scales helpful for assessing PTSD symptom exaggeration in Veterans

The MMPI-2 validity scales perform well in psychometric validation studies using the traditional criterion-group validation design, in which a patient sample is compared with a non-patient sample instructed to fake symptoms. Recently, a group of VA and non-VA investigators examined the value of these scales using a method more reflective of the complex VA clinical context. Mixed group validation was chosen to examine how well the MMPI-2 scales detect symptom exaggeration in compensation seeking versus non-compensation seeking Veterans because it allows comparison of scores between two groups that are thought to each contain both exaggerating and nonexaggerating individuals. Of the sample of 377 Veterans seen for clinical services, 77% were seeking a new or increased service-connected compensation and 23% were not. Estimates of exaggeration for each group were drawn from four studies in the PTSD literature and varied from low (30% in compensation seeking vs. 8% in non-compensation seeking) to high (61% vs. 38%). Results showed that all the MMPI-2 indices accurately detected symptom exaggeration, demonstrating adequate sensitivity, specificity, and efficiency across the base rate estimates. Being mindful that the study's aim was not to evaluate the accuracy of the estimates used, VA clinicians evaluating Veterans for PTSD may find the MMPI-2 validity scales more useful than other measures of symptom exaggeration validated only with criterion-group validation, since both compensation seeking and non-compensation-seeking Veterans likely include a combination of exaggerating and nonexaggerating individuals. Read the article…www.ptsd.va.gov/professional/articles/article-pdf/id35534.pdf

Tolin, D. F., Steenkamp, M. M., Marx, B. P., & Litz, B. T. (2010). Detecting symptom exaggeration in combat veterans using the MMPI–2 symptom validity scales: A mixed group validation. *Psychological Assessment, 22*, 729-746. PILOTS ID: 35534

Assessing mental health in spouses of OEF/OIF Veterans with PTSD

While PTSD frequently leads to major strain on close relationships, support from these relationships may play a major role in Veterans' recovery from PTSD. Given these findings, the Caregivers Act of 2010mandated VA to document the effects of PTSD on family members and assess caregiver needs and resources. A recent collaboration of VA and other researchers aimed to identify domains and measures to assess family members of OEF/OIF Veterans with PTSD. Members of an expert panel created a preliminary list of domains and assessment instruments that was then shared with a focus group comprised of 7 spouses of OEF/OIF Veterans who were enrolled in PTSD treatment at a Midwest VA. A second panel review led to the recommendation of 14 measures capturing 10 domains (e.g., caregiver burden, conflict, coping resources). The researchers plan to examine measurement characteristics in a follow-up study in hopes of reaching convergence on a final recommended battery. Although these measures are specific to spouses of OEF/OIF Veterans with PTSD, findings could help guide VA toward standardizing a battery of assessments for a variety of caregivers and Veterans of other eras. Such assessments may inform interventions that aim not only to improve family and caregiver well-being but also Veteran outcomes via enhanced relationships; clinicians ought to stay tuned. Read the article… http://dx.doi.org/10.1682/JRRD.2009.04.0049

Hayes, J., Wakefield, B., Andresen, E. M., Scherrer, J., Traylor, L., Weigmann, P.,…DeSouza, C. (2010). Identification of domains and measures for assessment battery to examine well-being of spouses of OIF/OEF veterans with PTSD. *Journal of Rehabilitation Research & Development, 47,* 825-840. PILOTS ID: 35501

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