National Center for PTSD
Posttraumatic Stress Disorder

CTU Online

CLINICIAN'S TRAUMA UPDATE

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Treatment

Evidence-based treatment could pay for itself

The true costs of mental health problems resulting from the wars in Iraq and Afghanistan extend far beyond the suffering experienced by Veterans and their family members. Society pays a price too, in terms of the reduced productivity associated with PTSD and other disorders. Treatment can restore a Veteran's functioning and reduce societal burden, but requires an investment of resources to pay for care. So where is the break-even point? Results of a new study suggest that increased access to evidence-based treatment for OEF/OIF Veterans could be cost-saving. Investigators at the RAND Corporation used a technique known as microsimulation, a type of economic projection modeling that allows events such as disorders, treatment, and employment to be varied to test the effects on costs. The model predicted the 2-year social costs of PTSD and depression as $923 million, with almost 2/3 of the cost due to lost productivity. The investigators then examined what would happen according to three scenarios about the percentage of Veterans who receive treatment and the percentage of treatment that was evidence-based: 50%/30%, 50%/100%, and 100%/100%. All scenarios would reduce costs, despite the increased costs of treatment. In fact, if every Veteran in need received evidence-based care, there would be a 15% reduction in costs, for a savings of almost $138 million. It is important to remember that these estimates are just that—not actual costs—but the findings suggest that VA's investment in evidence-based treatment is likely to pay off.

Read the article...http://dx.doi.org/10.1037/a0020592

Kilmer, B., Eibner, C., Ringel, J. S., & Pacula, R. L. (2011). Invisible wounds, visible savings? Using microsimulation to estimate the costs and savings associated with providing evidence-based treatment for PTSD and depression to veterans of Operation Enduring Freedom and Operation Iraqi Freedom. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*, 201-211. PILOTS ID: 85154

Effect of intimate partner violence on PTSD treatment

An article included in the April 2011 issue of *CTU-Online* reported that Cognitive Processing Therapy for PTSD related to intimate partner violence (IPV) reduced the likelihood of future IPV. The same research team from the National Center for PTSD reports that Cognitive Processing Therapy is effective for reducing PTSD in women regardless of their IPV history. Treatment engagement is another story. Of women with recent IPV (6-12 months prior to enrollment), 39% never started treatment, compared to only 11% with more distant prior IPV (> 1 year prior to enrollment) and 13% with no history of IPV. Once in treatment, women from all three groups were equally likely to complete therapy. Those with recent IPV actually showed the largest improvements in PTSD and depression at post-treatment and 6-month follow-up compared to women with past or no IPV. The findings are good news for women who have experienced IPV in the past and seek out treatment. Whether women with current IPV would also benefit from Cognitive Processing Therapy is unknown because women were excluded if they had experienced IPV in the last 6 months with their current partner.

Women with current IPV are in an environment where violence or the threat of violence remains. The factors that influence engagement in PTSD treatment for these women may or may not be similar to the barriers that led more than a third of the recent IPV group to forgo therapy. Read the article...http://www.ptsd.va.gov/professional/articles/article-pdf/id36057.pdf

Iverson, K. M., Resick, P. A., Suvak, M. K., Walling, S., & Taft, C. T. (2011). Intimate partner violence exposure predicts PTSD treatment engagement and outcome in cognitive processing therapy. *Behavior Therapy, 42*, 236-248. PILOTS ID: 36057

Primary Care

Patients with PTSD often first present within primary care, yet evidence-based treatments may not be feasible in this setting due to the number, frequency, and duration of sessions. Questions exist as to how best to implement PTSD treatment for primary care patients and whether it improves on care as usual. A new study describes what is currently being done within one VA network, while two others evaluate different methods of addressing PTSD within primary care. Authors of the first study found that evidence-based PTSD care is not reaching primary care patients. One reason is that patients commonly decline mental health referrals. Another reason is that integrated primary care sessions do not usually include evidence-based CBT. Thus, there appears to be a clear need to develop treatments for PTSD for patients who present and remain in primary care. One option may be to augment care as usual. The second study evaluated just such a collaborative care approach, finding a modest additive benefit compared with fairly active usual care, though the effects were not statistically significant for the small PTSD sample. The fact that the intervention was delivered by providers who were not mental health specialists suggests it may be easily implemented, particularly in clinics without providers trained in evidence-based PTSD treatments. The third study in this series tested a different option for primary care PTSD care, one that takes advantage of the integrated primary care provider, a clinician with mental health expertise embedded within a primary care clinic. Investigators from the STRONG STAR Multidisciplinary PTSD Research Consortium found that a more intensive PE-based intervention tailored for psychologists in primary care decreased PTSD in OEF/OIF Veterans in an uncontrolled pilot trial. These studies suggest that various avenues exist to help meet the needs of patients who stay within primary care for PTSD treatment. The choice of approach may depend on the particular characteristics of the primary care clinic.

Who receives primary care mental health services and what do they actually get?

Knowing what influences which mental health services Veterans with PTSD actually use can suggest if needs are being met appropriately. A new study indicates that severity of illness and patient preference differentially predict PTSD treatment from either a primary care provider, a mental health provider integrated within primary care, or a specialty mental health professional. Investigators from the VA Center for Integrated Healthcare examined records of Veterans with PTSD who had been seen by a primary care provider in VISN 2. Of the 6,637 Veterans, 813 (12%) continued to receive mental health treatment from their primary care provider only, 1,285 (19%) received integrated primary care services, and 4,539 (69%) received specialty mental health care. Detailed review of charts from 133 Veterans found that primary care patients who do not go on to receive specialty mental heath care are not as severely ill as those who do, and so it may be appropriate to deliver PTSD treatment for such patients within primary care rather than a more intensive setting. The fact that nearly a third of patients in need of PTSD treatment remained in primary care, along with findings from the chart review that 67% of patients seen only by primary care providers declined referrals for mental health, points to the necessity to address PTSD in primary care. There is an urgent need to find brief psychotherapeutic approaches that are feasible and effective in this setting. Read the article...http://dx.doi.org/10.1037/a0022704

Possemato, K., Ouimette, P., Lantinga, L. J., Wade, M., Coolhart, D., Schohn, M.,...Strutynski, K. (2011). Treatment of Department of Veterans Affairs primary care patients with posttraumatic stress disorder. *Psychological Services, 8*, 82-93. PILOTS ID: 36637

Is evidence-based collaborative care better than usual care for PTSD?

Coordinated Anxiety Learning and Management (CALM) is a brief, multi-modal stepped care approach for treating anxiety disorders in primary care. An RCT had found it was more effective than usual care across disorders. Recent further analyses within diagnostic groups, however, indicate that the approach did not significantly outperform usual care for PTSD. A total of 1,004 patients with panic disorder, GAD, SAD, or PTSD from 17 community primary care clinics were randomized to either CALM or usual care. CALM participants chose to receive pharmacotherapy management, computer-assisted CBT, or both. The collaborative care was administered by a provider with limited mental health training and nearly 90% of patients completed all visits by 6 months. Three of the 8 modules of the CBT program, 1 on cognitive restructuring and 2 on exposure, were tailored to each of the 4 anxiety disorders. Among the 61 PTSD patients, the CALM and usual care groups did not differ in symptom severity at any posttreatment assessment. However, 6-, 12-, and 18-month effect sizes (d = -0.29, -0.43, and -0.48, respectively), though modest, were similar to those of the other disorders, so statistical power may partially explain the lack of differences in PTSD. The limited changes in symptoms may suggest that some patients with anxiety disorders may need a larger dose of evidence-based interventions in order to impact distress to a greater extent. Read the article...http://dx.doi.org/10.1001/archgenpsychiatry.2011.25

Craske, M. G., Stein, M. B., Sullivan, G., Sherbourne, C. D., Bystritsky, A., Rose, R. D.,...Roy-Byrne, P. P. (2011). Disorder-specific impact of coordinated anxiety learning and management treatment for anxiety disorders in primary care. *Archives of General Psychiatry, 68*, 378-388. PILOTS ID: 36315

Brief PE/CPT primary care intervention for PTSD in OEF/OIF Veterans

Rather than simply including a few sessions of CBT when addressing PTSD within primary care, another option is a more intensive and time-limited approach based on evidence-based PTSD treatments. Investigators from the STRONG STAR Consortium provide preliminary findings for such a protocol from an uncontrolled trial with OEF/OIF Veterans. The treatment involved 4-6 30-minute sessions of Prolonged Exposure, with some aspects of Cognitive Processing Therapy, delivered every other week by psychologists with specialized training in the modalities. There were large decreases in clinician-rated and self-reported PTSD symptoms from pretreatment to 1-month follow-up for the entire sample of 15 Veterans, and half of the 10 treatment completers no longer met PTSD criteria. These preliminary results suggest that the intervention should be evaluated in a larger controlled format. However, the findings need to be interpreted with caution because the intent-to-treat (ITT) analyses were performed by the last-observation-carried-forward method of handling missing data, which can cause severe bias. In addition, the severity of self-reported PTSD symptoms remained high, despite the improvement from pre-to posttreatment. Nevertheless, the positive results suggest that PTSD patients in primary care may benefit from concise interventions tailored to a primary care setting but based on proven treatments for PTSD. Read the article...http://dx.doi.org/10.1037/a0022740

Cigrang, J. A., Rauch, S. A. M., Avila, L. L., Bryan, C. J., Goodie, J. L., Hryshko-Mullen, A., & Peterson, A. L. (2011). Treatment of active-duty military with PTSD in primary care: Early findings. *Psychological Services, 8*, 104-113. PILOTS ID: 36597

OEF/OIF Veterans

New study finds men and women have similar responses to combat

The expanded roles of women serving in the current wars in Iraq and Afghanistan have created an opportunity to study whether men and women differ in response to combat. In the general population, women are twice as likely as men to develop PTSD. However, meta-analytic findings based on data from prior wars (in which few women had combat exposure that was comparable to men's) had shown that the difference did not exist in Veteran samples. The new study, led by investigators at the National Center for PTSD in Boston, confirmed these meta-analytic findings. The investigators sampled 1,833 OEF/OIF military personnel, receiving surveys from 595; the data were statistically weighted to enhance the generalizability of findings. Men had higher levels of exposure to traditional combat stressors except for perceived threat, and women had higher exposure to prior life stressors and sexual assault. However, men and women did not differ in severity of PTSD symptoms, depression, or mental health functioning, although men had higher levels of substance abuse. In multivariate analyses that that tested gender differences in response to four aspects of combat exposure, only 1 of 16 interactions was significant, indicating that men and women had comparable responses to the combat they experienced. The investigators caution that their data should not be interpreted as indicating that gender difference are unimportant and recommend recognition of the different experiences men and women have prior to, during, and after deployment. Read the article...http://www.ptsd.va.gov/professional/articles/article-pdf/id36638.pdf.

Vogt, D., Vaughn, R., Glickman, M. E., Schultz, M., Drainoni, M., Elwy, R., & Eisen, S. (2011). Gender differences in combat-related stressors and their association with postdeployment mental health in a nationally representative sample of U.S. OEF/OIF veterans. *Journal of Abnormal Psychology*. Advance Online Publication. PILOTS ID: 36638

Traumatic Brain Injury

Veterans with moderate or severe TBI can benefit from residential PTSD treatment

The high comorbidity between PTSD and symptoms related to traumatic brain injury in OEF/OIF Veterans has generated much discussion about how to best treat patients who have both problems. One concern is that evidence-based cognitive-behavioral treatments for PTSD may need to be modified in order to allow Veterans with cognitive difficulties to participate. Findings from a residential program at the Cincinnati VA indicate that a version of Cognitive Processing Therapy (CPT) shown to be effective in patients without head injury can be used successfully in Veterans with PTSD and TBI. Veterans received 7 weeks of individual and group CPT-C, along with speech therapy 2-3 times/week and 23 hours/week of psychoeducational group treatment. CPT-C, as it is known, omits the writing and reading of a trauma narrative that is part of standard CPT. Forty-two of 47 Veterans completed the program, 28 with mild TBI and 14 with moderate or severe TBI. The groups had similar substantial improvements in PTSD and depression symptoms. There even was evidence that the moderate/severe group had greater pre-post change in PTSD symptoms, e.g., Clinician-Administered PTSD Scale scores declined from 75 to 49 in the mild TBI group and from 81 to 38 in the moderate/severe group. Although the amount of other treatment Veterans received prevents any firm conclusions about the specific effects of CPT-C, these findings demonstrate that CPT-C is feasible for Veterans with PTSD who have experienced TBI. Read the article... http://www.ptsd.va.gov/professional/articles/article-pdf/id85169.pdf

Chard, K. M., Schumm, J. A., McIlvain, S. M., Bailey, G. W., & Parkinson, R. B. (2011). Exploring the efficacy of a residential treatment program incorporating cognitive processing therapy-cognitive for veterans with PTSD and traumatic brain injury. *Journal of Traumatic Stress, 24*, 347-351. PILOTS ID: 85169

Imaging marker helps identify mild TBI

A new study in active duty OEF/OIF personnel suggests that diffusion tensor imaging (DTI) may detect signs of mTBI not observed via currently used technologies. DTI is an advanced form of magnetic resonance imaging that can be performed on most clinical scanners. For the study, 63 service members with a positive mTBI screen and a head injury from a blast exposure were scanned within 90 days of injury. Twenty-one service members who were exposed to blasts but screened negative for mTBI served as the comparison group. Of the 63 participants with a positive mTBI screen, only one showed a brain anomaly related to TBI using conventional MRI, while 38 (60%) showed at least one abnormality on DTI. The abnormalities cannot be solely attributed to blast exposure, however, because all service members also had another mechanism of head injury, such as a fall or motor vehicle accident. The findings suggest that DTI could be a helpful component of diagnostic evaluation, especially when conventional imaging fails to detect evidence of brain injury. The method is not sufficient for confirming a diagnosis given the high percentage of service members who screened positive without showing any abnormalities. And if its diagnostic performance can be enhanced, perhaps DTI could someday be used to help differentiate PTSD from post-concussive symptoms related to mTBI. Read the article... http://dx.doi.org/10.1056/NEJMoa1008069

Mac Donald, C. L., Johnson, A. M., Cooper, D., Nelson, E. C., Werner, N. J., Shimony, J. S.,...Brody, D. L. (2011). Detection of Blast-Related Traumatic Brain Injury in U.S. Military Personnel. *New England Journal of Medicine, 36*4, 2091-2100. PILOTS ID: 36540

Assessment

Changing instructions for the PTSD Checklist (PCL) does not change outcomes

The specific version of the PTSD Checklist, the PCL-S, asks respondents to identify a traumatic event and then use that event when answering the 8 DSM-IV symptoms that explicitly reference a traumatic event. The instructions describe symptoms as "problems and complaints." Findings from investigators at Walter Reed Army Medical Center suggest that wording changes intended to enhance the clarity of the instructions—and presumably the accuracy of the data—do not affect symptom reports. Almost 1,700 Active Duty soldiers, most of whom were members of Special Operations Command Units, were randomly assigned to complete the regular PCL-S or one of two other versions: one that specified the DSM-IV PTSD criterion A in the instructions and one that replaced "problems and complaints" with "reactions." There were no differences across groups in symptom endorsement or PTSD prevalence. What does seem to matter, at least in terms of PTSD prevalence, is how symptoms are scored. Based on the standard PCL-S, prevalence was 6.9% when defined according to DSM-IV criteria of 1 reexperiencing, 3 avoidance/numbing, and 2 hyperarousal symptoms (rated at least moderate or higher; "3" on the 1-5 scale). Prevalence dropped to 3.4% when diagnosis also required a minimum severity of 50. The low prevalence of PTSD in this sample may limit the generalizability of findings to VA patients and other populations in which prevalence is higher. Read the article...http://dx.doi.org/10.1097/NMD.0b013e31820caee4

Riviere, L. A., Edens, E. N., Adler, A. B., Bliese, P. D., Klocko, R. P., & Hoge, C. W. (2011). Modifying instructions on the Posttraumatic Stress Disorder Checklist for military populations does not change symptom reporting. *Journal of Nervous and Mental Disease, 199*, 199-202. PILOTS ID: 35976

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