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U.S. Department of Veterans Affairs

Treatment

Treatments that prevent PTSD

While evidence on effective treatments for PTSD continues to grow, information on prevention has lagged behind. A new study by investigators in Israel changes this state of affairs by showing that cognitive-behavioral therapy initiated within the first month after a trauma can cut the risk of PTSD substantially. Investigators randomized 242 acutely injured trauma survivors to receive PE, cognitive therapy, escitalopram (an SSRI), placebo, or no treatment; at 5 months, participants in the no treatment group who still had PTSD received PE. A novel randomization strategy known as "equipose-stratified randomization" allowed participants to choose which treatment alternatives they would accept; e.g., someone who did not want psychotherapy was randomized to only escitalopram or placebo, whereas someone who did not want to wait for treatment was randomized to 1 of the 4 immediate treatment options. Interestingly, fewer participants chose options involving medication, preferring psychotherapy. The results were striking; at 5 months, only 20% of the PE and cognitive therapy groups had PTSD, compared with 60% of the other groups. The picture was the same at 9 months, except that participants who received delayed PE caught

up to the PE and cognitive therapy groups, showing that waiting 5 months to start treatment was not harmful. PE and cognitive therapy did not work for patients with partial PTSD. The study convincingly shows that CBT prevents PTSD, but the findings for medication are less conclusive. Citalopram, a drug similar to escitalopram, is not effective for PTSD, so the findings for medication might have been stronger if the investigators had used an SSRI known to work for PTSD. Read more...<http://dx.doi.org/10.1001/archgenpsychiatry.2011.127>

Shalev, A. Y., Ankri, Y., Israeli-Shalev, Y., Peleg, T., Adessky, R. S., & Freedman, S. A. (2011). Prevention of posttraumatic stress disorder by early treatment: results from the Jerusalem Trauma Outreach and Prevention Study. *Archives of General Psychiatry*. Advance online publication. PILOTS ID: 37529

Integrated care increases mental health contacts but not treatment

Despite VA's success in implementing mental health screening in returning Veterans, evidence continues to show that these Veterans are not receiving the mental health care they need. To address the problem, the San Francisco VAMC developed a post-deployment health clinic that provides integrated primary care with co-located mental

Journal Special Issue:

Trauma-Focused Training and Education: The September 2011 special issue of *Psychological Trauma: Theory, Research, Practice, and Policy* provides 12 articles addressing practices, theory, and data related to trauma education and training within various contexts, including higher education, community clinics, and the VA. The issue is available at <http://psycnet.apa.org/journals/tra/3/3/>.

DePrince, A. & Newman, E. (Eds.). (2011). Trauma-Focused Training and Education [Special issue]. *Psychological Trauma: Theory, Research, Practice, and Policy*, 3(3).

health and social services (similar clinics exist at other VAs). The data from San Francisco show partial success but room for improvement as well. An integrated clinic visit consisted of 3 optional 50-minute sessions with primary care, mental health, and social service providers. Due to scheduling constraints, some Veterans received only standard 1-hr visits with a primary care provider, which enabled the investigators to compare the integrated with usual care. The integrated clinic increased the likelihood of same-day mental health evaluation by 70%, from 51% in usual visits to 89% in integrated visits. The effects were especially pronounced in women, for whom the likelihood of same-day evaluation nearly tripled. Among Veterans who completed an initial mental health evaluation, 42% of the those in the integrated clinic and 29% of those who received usual care had at least one mental health visit within 90 days—a significant difference—but the median number of visits was only 1 in both groups. The authors suggest that strategies such as including a Care Manager in the integrated clinic could facilitate mental health treatment attendance. Read more...<http://dx.doi.org/10.1007/s11606-011-1746-1>

Seal, K. H., Cohen, G., Bertenthal, D., Cohen, B. E., Maguen, S., & Daley, A. (2011). Reducing barriers to mental health and social services for Iraq and Afghanistan veterans: Outcomes of an integrated primary care clinic. *Journal of General Internal Medicine*, 26, 1160-1167. PILOTS ID: 37685

Implementation of best practices via mentoring

The dissemination of evidence-based treatments for PTSD within the VA has created administrative challenges for many clinics. In response, the National Center for PTSD launched the PTSD Mentoring Program in 2008, an initiative that provides training in PTSD clinic development and an ongoing support network to disseminate best management practices. A new article describes the program's implementation, preliminary evaluation, and ways to adapt the mentoring model in other settings. The Mentoring Program consists of a program manager, a steering committee, PTSD program directors who participate as mentees, and two experienced PTSD program directors from each of the 21 VA national geographic regions who serve as mentors. Information is shared through various avenues, including monthly educational training and conference calls, face-to-face meetings, and web-based resources. Although obstacles exist, such as protected work time to accomplish mentoring activities, the VA PTSD Mentoring Program has shown promise as a model approach to disseminate and execute management activities that support evidence-based treatment. To gauge satisfaction and engagement, the program leaders conducted an anonymous online survey. Fifty-nine mentees and 26 mentors responded, representing 40% of all directors in the Mentoring Program. Results revealed that a majority in each group (50-85%, depending on the question) thought that the program helped them rethink clinic design, provided solutions to clinic problems, has been worthwhile, or helped them in their work. Agencies wanting to train new staff or enact procedural changes may want to look to peer-based

mentoring to develop administrative skills, facilitate problem solving, and standardize practices. Read more...<http://www.ptsd.va.gov/professional/articles/article-pdf/id85566.pdf>

Bernardy, N. C., Hamblen, J. L., Friedman, M. J., Ruzek, J. I., & McFall, M. E. (2011). Implementation of a posttraumatic stress disorder mentoring program to improve treatment services. *Psychological Trauma: Theory, Research, Practice, and Policy*, 3, 292-299. PILOTS ID: 85566

Compensation and Pension Issues

Structured interviews not routine in PTSD compensation & pension evaluations

Structured clinical interviews such as the Clinician Administered PTSD Scale (CAPS) are considered the gold standard approach to diagnosis. However, a survey of compensation and pension (C&P) clinicians by VA investigators indicates that use of structured assessment is the exception, rather than the norm. The 138 clinicians who responded represented 73% of the 190 who were surveyed. Most were male psychologists. Contrary to best-practice recommendations, only 20% of the study sample believed that structured diagnostic interviews are necessary for accurate PTSD assessments, less than a third regularly used some type of trauma assessment measure, and 85% indicated rarely or never using the CAPS. Clinicians trained in using standardized interviews believed that such assessments yield higher quality evaluations, yet less than half of the sample reported having received training in administering structured diagnostic interviews for PTSD and 39% disagreed the psychological testing is necessary to get an accurate PTSD assessment. Although 47% believed it would be difficult to incorporate the CAPS or SCID into a disability examination, the time allocated for evaluations did not differ between clinicians who employed testing and those who did not. Findings suggest that training C&P assessors in structured assessments may be key to addressing barriers to their use, but that logistical issues may need to be addressed before their use becomes usual practice. Read more...<http://www.ptsd.va.gov/professional/articles/article-pdf/id85586.pdf>

Jackson, J. C., Sinnott, P. L., Marx, B. P., Murdoch, M., Sayer, N. A., Alvarez, J. M., Greevy, R. A., Schnurr, P. P., Friedman, M. J., Shane, A. C., Owen, R. R., Keane, T. M., & Speroff, T. (2011). Variation in practices and attitudes of clinicians assessing PTSD-related disability among veterans. *Journal of Traumatic Stress*, 24, 609-613. PILOTS ID: 85586

Receiving VA PTSD disability compensation has more than monetary benefits

Studies aimed at understanding the impact of receiving disability benefits for PTSD typically have compared Veterans who already receive or apply for compensation with Veterans who do not pursue compensation. This approach yields data that need to be interpreted cautiously because Veterans who seek

compensation are more disabled initially. A new prospective study examines long-term outcomes in a large sample of Veterans studied before and after their claims were determined. Between 1998 and 2000, researchers at the Center for Chronic Disease Outcomes Research at the Minneapolis VA surveyed a nationally representative sample of 3,337 Veterans who first applied for VA PTSD disability benefits between 1994 and 1998. At the time of this initial study assessment, 2,060 had received a disability award and 1,277 had their claims denied. Follow-up data for 2,551 members of this cohort were gathered between 2004 and 2006. After matching and adjustment for other differences between beneficiaries and denied claimants, analyses revealed that only those Veterans who received benefits had clinically meaningful reductions in PTSD symptoms and work, family, and social functioning at follow-up. Denial of benefits had other negative effects; the poverty rate was nearly 3 times higher and homelessness almost double in Veterans whose claims were denied compared with those receiving benefits. However, both groups continued to report significant PTSD and poor functioning and health. Thus, although receiving disability benefits is associated with improved symptoms and quality of life, all Veterans might benefit from additional treatment, regardless of disability status. Read more...<http://dx.doi.org/10.1001/archgenpsychiatry.2011.105>

Murdoch, M., Sayer, N. A., Spont, M. R., Rosenheck, R. A., Noorbaloohi, S., Griffin, J. M., Arbisi, P. A., & Hagel, E. M. (2011). Long-term outcomes of disability benefits in US veterans with posttraumatic stress disorder. *Archives of General Psychiatry*, 68, 1072-1080. PILOTS ID: 37515

Assessment

Anonymity may be key in screening

The results of post-deployment screening for PTSD and other mental health issues become part of a soldier's medical record. This inherent lack of anonymity may lead some respondents to underreport problems. A new study is the first to directly compare soldiers' willingness to report mental health concerns on a anonymous survey and personally identifiable measures. As required by US Army medical policy, all 3,502 members of an infantry brigade of US soldiers completed the Post-Deployment Health Assessment (PDHA) within 30 days after returning from their deployment in Iraq. Immediately following the PDHA, 2,500 of these soldiers were invited to complete an anonymous survey for research purposes and 69%, (1,712 soldiers) participated. Of these, 7.7% screened positive for PTSD and 7.0%

for depression, compared with only 3.3% and 1.9%, respectively, of those who completed the PDHA. Twenty percent of soldiers who reported experiencing PTSD or depression on the research survey indicated that they were uncomfortable providing honest responses on the PDHA. A necessary limitation of the study was the use of group-level comparisons, because matching responses on the two different assessments would have compromised the anonymity of the research survey. The 2- to 4-fold differences between the PDHA and the anonymous survey are very large and suggest that the results of screening may be underestimating the true need. Read more...<http://dx.doi.org/10.1001/archgenpsychiatry.2011.112>

Warner, C. H., Appenzeller, G. N., Grieger, T. A., Belenkiy, S., Breitbart, J. E., Parker, J. R., Warner, C. M., & Hoge, C. W. (2011). Importance of anonymity to encourage honest reporting in mental health screening after combat deployment. *Archives of General Psychiatry*, 68, 1065-1071. PILOTS ID: 37541

Screening for perpetration of partner violence

VA providers do not routinely screen their male patients about intimate partner violence, but perhaps they should. A new study confirms that a high proportion of male Veterans with PTSD report acts of aggression against their partner when asked, but few are being screened. VA researchers conducted a retrospective review of medical records from a random sample of 507 male Veterans who received PTSD treatment at a Northwest VA Medical Center between 2002 and 2007. Screening for partner violence was documented in the chart for only 24% of Veterans; and of those screened, 61% reported aggression toward their partner. The low screening rate leaves many perpetrators unidentified and therefore without an opportunity for getting help. The results also suggest that providers cannot rely on patients to disclose partner violence on their own; only 13% of all the documented reports of violence were unsolicited. Furthermore, other research findings suggest that how you ask about partner aggression matters. Best practice guidelines recommend that providers use direct, specific, and nonjudgmental language to improve the validity of responses. We do not know how the providers in this study conducted the screens, and it is possible that the disclosure rate of 61% underestimates the true prevalence. Read more...<http://dx.doi.org/10.1097/01.NAJ.0000407296.10524.d7>

Gerlock, A. A., Grimesey, J. L., Pisciotto, A. K., & Harel, O. (2011). Documentation of screening for perpetration of intimate partner violence in male veterans with PTSD. *American Journal of Nursing*, 111, 26-32. PILOTS ID: 37448

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