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## TREATMENT

### Current and lifetime PTSD prevalence among Vietnam-era women Veterans

The National Vietnam Veterans Longitudinal Study (NVVLS) provided current and lifetime rates of PTSD among the Vietnam cohort (see the [August 2015 CTU-Online](#)), but included few women. Now, findings from another national survey of Vietnam-era women Veterans, the Health of Vietnam-Era Women's Study, provide information about PTSD in this cohort. Of the 8,742 Vietnam-era women Veterans eligible for the study, 4,219 (48.3%) participated. *DSM-IV* PTSD diagnosis was determined using the Composite International Diagnostic Interview (CIDI), a lay-administered interview that has been used in the National Comorbidity Survey. The weighted prevalence of lifetime military or postmilitary PTSD was 16.9% among women who served in Vietnam, 8.5% among women who served near Vietnam, and 8.9% among women who served within the US; current prevalence was 13.5%, 5.8%, and 6.1%, respectively. Lifetime and current prevalence of premilitary onset PTSD was 2.2%-5.0%. After adjusting for military characteristics and wartime exposures, the investigators found that odds of lifetime PTSD did not differ between women who served in Vietnam versus the U.S. The investigators suggest that the higher prevalence of PTSD in this study compared with the NVVLS is due to differences in measurement (CIDI for *DSM-IV* vs. CAPS for *DSM-5*). Regardless of the difference, both studies are important because they provide information about the current status and needs Vietnam-era women Veterans.

Read the article: <http://www.ptsd.va.gov/professional/articles/article-pdf/id44451.pdf>

Magruder, K., Serpi, T., Kimerling, R., Kilbourne, A. M., Collins, J. F., Cypel, Y., ... & Kang, H. (2015). Prevalence of posttraumatic stress disorder in Vietnam-era women veterans: The Health of Vietnam-Era Women's Study (HealthVIEWS). *JAMA Psychiatry*. Advance online publication. PILOTS ID: 44451

### More evidence for the effectiveness of Prolonged Exposure in Veterans with comorbidity

Numerous randomized controlled trials show that PE results in meaningful reduction in PTSD symptoms. Although these trials often include participants who have other mental health disorders in addition to PTSD, questions remain about the effectiveness of PE for individuals with comorbid substance use disorders or a history of TBI. Two recent studies evaluated PE in Veterans with these comorbidities.

In the first study, investigators from the National Center for PTSD and VA San Diego offered PE to Veterans with comorbid PTSD and substance use disorder (SUD) who were enrolled in a 28-day VA residential treatment program for SUD. Based on therapist availability, 9 of the 30 Veterans were offered individual PE three times each week. The remaining 21 Veterans received treatment as usual, which consisted of PTSD psychoeducation, cognitive restructuring, and in-vivo exposure. All Veterans offered PE finished a full course of the therapy (mean = 10.6 sessions). At posttreatment, Veterans who got PE showed larger decreases on the PTSD Checklist (21 points) than those who received treatment as usual (9 points).

Read the article: <http://www.ptsd.va.gov/professional/articles/article-pdf/id44450.pdf>

A study by investigators at the Tampa VA Medical Center looked at patient records from 51 Veterans and 18 Servicemembers with PTSD and a history of mild, moderate, or severe TBI who received PE as part of their inpatient or outpatient VA care. All inpatients (100%,  $n = 15$ ) and nearly half of outpatients (46.3%,  $n = 29$ ) completed a full course of PE. On average, scores on the PTSD Checklist decreased 28 points after treatment, with two-thirds of participants showing clinically meaningful change (a drop of at least 10 points) in PTSD symptoms.

Read the article: <http://dx.doi.org/10.1002/jts.22029>

Both studies suggest that PE is effective even when PTSD is comorbid with SUD or TBI. And remarkably, across both studies, all Veterans who received PE in residential or inpatient programs completed the full treatment. These results can help to dispel incorrect assumptions about which patients can engage in and benefit from PE and may encourage clinicians to offer this evidence-based treatment to their patients with SUD and TBI.

Norman, S. B., Davis, B. C., Colvonen, P. J., Haller, M., Myers, U. S., Trim, R. S., ... & Robinson, S. K. (2015). Prolonged Exposure with veterans in a residential substance use treatment program. *Cognitive and Behavioral Practice*. Advance online publication. PLOTS ID: 44450

Wolf, G. K., Kretzmer, T., Crawford, E., Thors, C., Wagner, H. R., Strom, T. Q., ... & Vanderploeg, R. D. (2015). Prolonged Exposure therapy with veterans and active duty personnel diagnosed with PTSD and traumatic brain injury. *Journal of Traumatic Stress*, 28, 339-347. PLOTS ID: 44370

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## Literature reviews dispel myths about dropout from PTSD treatment

Two recent literature reviews examined how factors like type of treatment and diagnosis relate to the likelihood of dropout from PTSD treatment. It is important to understand who is at greatest risk for discontinuing treatment prematurely. Although some patients drop out because of rapid symptom response, those who complete PTSD treatment experience greater average improvements than those who drop out.

Investigators from Massachusetts General Hospital reviewed studies of outpatient psychotherapy provided to Iraq and Afghanistan Veterans with combat-related PTSD. The review included 20 studies: 10 were randomized controlled trials ( $n = 350$  Veterans) and 10 were non-randomized trials conducted in routine care ( $n = 895$  Veterans). Across studies, the average dropout was 36.0% (range: 0.0%-68.0%). Dropout was significantly higher for group (54.4%) than individual (31.1%) interventions, but did not differ significantly by study type (RCT vs. clinical care), exclusion or inclusion of substance dependence, and delivery format (telehealth vs. in-person). Results also replicated prior reviews showing that use of exposure was not associated with increased dropout.

Read the article: <http://dx.doi.org/10.1002/jts.22038>

A meta-analysis led by investigators at the University of Texas examined dropout from 115 studies of cognitive behavioral therapy for PTSD or other psychiatric conditions (i.e., depression, anxiety disorders, eating disorders, psychotic disorders, and substance use disorders). Investigators calculated pretreatment dropout (dropout after agreeing to treatment but before session 1) and treatment dropout (dropout after session 1) separately. For all disorders, more participants dropped out during the treatment phase than the pretreatment phase, although dropout varied by diagnosis. PTSD had one of the lowest rates of pretreatment dropout (7.8%), second only to psychotic disorders (5.6%). Treatment dropout ranged from 19.6% (anxiety disorders) to 36.4% (depression and substance use disorders), with PTSD in the middle of the pack (27.2%).

Read the article: <http://dx.doi.org/10.1037/ccp0000044>

A major challenge when synthesizing information on dropout is that individual studies define dropout differently, which may have contributed to the wide range in dropout across studies. However, findings from these reviews suggest that few treatment characteristics are associated with dropout and that Veterans are no more likely to drop out from research studies than from clinical care. The finding that dropout from cognitive-behavioral PTSD treatment is similar to—and in many cases lower than—dropout from treatment for other disorders is important because cognitive-behavioral treatments for PTSD tend to be trauma-focused. Concerns have been raised about trauma-focused treatments leading to increased dropout, but the evidence suggests that the amount of dropout in PTSD is not unique.

Fernandez, E., Salem, D., Swift, J. K., & Ramtahal, N. (2015). Meta-analysis of dropout from cognitive behavioral therapy: Magnitude, timing, and moderators. *Journal of Consulting and Clinical Psychology*. Advance online publication. PLOTS ID: 44449

Goetter, E. M., Bui, E., Ojserkis, R. A., Zakarian, R. J., Brendel, R. W., & Simon, N. M. (2015). A systematic review of dropout from psychotherapy for posttraumatic stress disorder among Iraq and Afghanistan combat veterans. *Journal of Traumatic Stress*, 28, 401-409. PLOTS ID: 44452

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## Pilot study investigates methylphenidate and galantamine for PTSD and TBI

A new randomized clinical trial led by investigators at Indiana University examined two medications, methylphenidate (a stimulant used to treat attention deficit disorder) or galantamine (a cholinesterase inhibitor used to treat memory impairment), for treating symptoms of both PTSD and mild TBI. In the multisite trial, 32 participants (18 men and 14 women) with PTSD-only (34.4%), mTBI-only (43.8%), or both (21.9%) were randomized to 12 weeks of methylphenidate (20 mg), galantamine (12 mg), or placebo. Methylphenidate resulted in greater decreases in PTSD symptoms than placebo ( $d = .88$ ), with an average drop of 13 points on the PTSD Checklist at posttreatment. Methylphenidate also led to greater improvements than placebo on postconcussive symptoms and cognitive function. For most outcomes, the advantage of methylphenidate was apparent after only 4 weeks. Galantamine outperformed placebo on one measure of memory

but otherwise showed no advantage. The study ended early due to challenges with recruitment and medication availability. Although the sample size was too small to examine whether participants with comorbid PTSD and mTBI responded as well as participants with one of the diagnoses, initial data suggest that methylphenidate can improve symptoms associated with PTSD and mTBI. The investigators note that in the past, clinicians were concerned that stimulants like methylphenidate could worsen hyperarousal and sleep problems in people with PTSD. These results suggest the opposite may be true.

Read the article: <http://dx.doi.org/10.1038/npp.2015.282>

McAllister, T. W., Zafonte, R., Jain, S., Flashman, L. A., George, M. S., Grant, G. A., ... & Stein, M. B. (2015). Randomized placebo-controlled trial of methylphenidate or galantamine for persistent emotional and cognitive symptoms associated with PTSD and/or traumatic brain injury. *Neuropsychopharmacology*. Advance online publication. PIILOTS ID: 44551

## A new couples therapy for Veterans with combat-related PTSD

The evidence for cognitive-behavioral couple therapy (CBCT) as a treatment for trauma survivors' PTSD and partner distress has been growing (see [August 2012 CTU-Online](#)). A research team led by investigators from the Southern Louisiana VA report findings from a randomized controlled trial of a treatment for returning Veterans with combat-related PTSD and their partners, the largest trial of a conjoint therapy with Veterans to date. A total of 57 couples received either 12 sessions of structured approach therapy (SAT) or manualized PTSD education. SAT, based on stress inoculation, is thought to reduce PTSD via repeated disclosure, which allows extinction and trauma processing, and via improved dyadic coping and emotion regulation. Following 2 psychoeducation sessions and 4 sessions of behavioral activation and skills training, Veterans discuss trauma-related memories and emotions with their partners over 6 sessions. Couples also engage in trauma disclosure between sessions. Treatment completion was high (72.4% for SAT, 75.0% for education). At posttreatment and 12-week follow-up, SAT outperformed education in reducing PTSD severity, with large effects, and led to higher PTSD remission (52.0%, vs. 7.0% in education). Relationship adjustment improved only for the SAT group and only among Veterans and not their partners. Partners in the SAT group reported reduced relationship anxiety. The findings parallel those of a 2012 RCT of

CBCT and provide further support for couples therapy for combat-related PTSD.

Read the article: <http://dx.doi.org/10.1037/ser0000032>

Sautter, F. J., Glynn, S. M., Cretu, J. B., Senturk, D., & Vaught, A. S. (2015). Efficacy of structured approach therapy in reducing PTSD in returning veterans: A randomized clinical trial. *Psychological Services*, 12, 199-212. PIILOTS ID: 44509

## Impact of VA's primary care-mental health integration on PTSD care

For Veterans who screen positive for PTSD in a primary care setting, primary care-mental health integration (PC-MHI) may improve delivery of follow-up assessment and treatment and offer an effective alternative to specialty mental health care. Investigators from VA's Serious Mental Illness Treatment Resource and Evaluation Center tested this hypothesis through a national evaluation. Investigators analyzed data from a randomly selected subsample of VA primary care patients ( $n = 21,427$ ) who screened positive for PTSD in fiscal year 2010 but did not have a PTSD diagnosis and had not visited PC-MHI or specialty mental health in the previous year. Analyses were adjusted for various patient characteristics. Compared with Veterans who only received primary care services on the day they screened positive, Veterans also seen in PC-MHI were 2.23 times more likely to be diagnosed with PTSD that day, and those also seen in specialty mental health 2.56 times more likely. Among Veterans who received a same-day diagnosis ( $n = 5,966$ ), PC-MHI also increased the odds of treatment initiation (i.e., a PTSD clinic visit, psychotherapy, antidepressant prescription, or any combination of the three within 12 weeks) compared with receipt of only primary care (AORs = 1.66-4.12). These odds were similar to those conferred by same-day specialty mental health care, with the exception of lower odds of receiving an antidepressant prescription. The study adds to existing findings of the benefits of integrated care for Veterans with mental health needs.

Read the article: <http://dx.doi.org/10.1176/appi.ps.201500035>

Bohnert, K. M., Sripada, R. K., Mach, J., & McCarthy, J. F. (2015). Same-day integrated mental health care and PTSD diagnosis and treatment among VHA primary care patients with positive PTSD screens. *Psychiatric Services*. Advance online publication. PIILOTS ID: 44454

### ASSESSMENT

## Alternatives to the GAF for measuring PTSD-related disability

With the removal of the Global Assessment of Functioning (GAF) scale from the *DSM-5*, alternative means of determining functional impairment are being explored. A valid measure is particularly important for compensation and pension examinations. To address this need, a research team led by investigators from the

National Center for PTSD examined the performance of two different measures of disability. Investigators examined data from a randomized clinical trial showing that structured assessments can improve the quality of PTSD disability exams (see the [December 2012 CTU-Online](#)). In the trial, exams included the Clinician Administered PTSD Scale and three measures of impairment: (1) the GAF, (2) the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0), a clinician-administered measure

of disability related to medical and psychiatric disorders, and (3) the Inventory of Psychosocial Functioning (IPF), a self-report measure of disability specifically related to PTSD. Factor analysis indicated that the WHODAS 2.0 and IPF outperformed the GAF as indices of functioning. All three measures performed equally well in correctly identifying Veterans with clinician-rated impairment (based on two relevant items on the CAPS). The WHODAS and IPF showed similar correlations with examiners' rating of service connection and with PTSD severity. The results suggest that clinicians and C&P examiners have two valid measures of PTSD-relat-

ed impairment to choose from, a clinician-administered measure and a self-report inventory.

Read the article: <http://www.ptsd.va.gov/professional/articles/article-pdf/id44442.pdf>

Marx, B. P., Wolf, E. J., Cornette, M. M., Schnurr, P. P., Rosen, M. I., Friedman, M. J., ... & Speroff, T. (2015). Using the WHODAS 2.0 to assess functioning among veterans seeking compensation for posttraumatic stress disorder. *Psychiatric Services*. Advance online publication. PILOTS ID: 44442



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