Treatment

Prolonged exposure outperforms non-specific therapy, but not other active treatments

Authors of a previous meta-analysis of active psychotherapies for PTSD found no differences between treatments on outcome and suggested that efficacy may not depend on specific ingredients. A new meta-analysis indicates that such a conclusion may have been premature. The study by investigators at the University of Pennsylvania compared the efficacy of Prolonged Exposure (PE) to both active treatments (EMDR, Cognitive Processing Therapy, Cognitive Therapy, and Stress Inoculation Therapy) and nonspecific treatments (supportive counseling, relaxation, Present Centered Therapy, Time Limited Psychodynamic Therapy, and treatment as usual). The investigators examined 13 RCTs. In all studies, PE involved both imaginal and in vivo exposure. PE was superior to nonspecific treatment for PTSD and general subjective distress, including depression and anxiety. Between-group effect sizes were medium to large at posttreatment and follow-up, e.g., at posttreatment, Hedges’ g was 0.65 for PE compared with nonspecific therapy. In 6 studies that compared PE to an active treatment, there were no differences between PE and active treatment. The effect size for PE was not related to time since trauma, trauma type, or number of PE sessions. Given the equivalent outcomes between PE and other active treatments, availability of trained clinicians and patient preferences may be useful to consider when selecting a treatment. Read the article... [link]


Special Article

A guide to guidelines on PTSD treatment

The proliferation of US and international guidelines on the treatment of PTSD can make it difficult for clinicians to determine which treatments are the recommended standard of care. Not all guidelines make the same recommendations. Should a psychiatrist who works in VA and is a member of the International Society for Traumatic Stress Studies follow the guideline issued by the American Psychiatric Association? Or the VA/DoD guideline? Or the ISTSS guideline? Now a new paper critically reviews existing guidelines in order to help clinicians understand the differences between guidelines and make informed choices about the best treatments for their patients. Read the paper... [link]

Intensive CBT for PTSD offers faster benefit

Trauma-focused CBT is an evidence-based approach for PTSD, typically administered through weekly sessions over several months. The authors of one such treatment, Cognitive Therapy for PTSD (CT-PTSD), recently reported on acceptability and outcomes of a new concentrated format. The trial involved 14 patients with chronic PTSD related to one or two events in adulthood. On average, patients received an average of 9.4 morning and/or afternoon sessions of 90 minutes over 5 to 7 days, followed by 2.6 booster sessions during the subsequent 3 months. Similar to weekly 3-month CT-PTSD, patients completed an average of 107 minutes of imaginal exposure or narrative writing. No patient dropped out. Ten patients no longer met criteria for PTSD at 3 weeks, 12 at 3 months, and 13 at 9 months. Improvements in anxiety and PTSD-related disability were comparable to those of the weekly treatment. Intensive CT-PTSD was superior to the weekly version for PTSD symptoms at 3 weeks and for depression at each assessment. When interpreting the findings, readers should remember that the study was small and had no comparison group. However, these findings suggest that intensive trauma-focused treatment is tolerable and results in faster improvement than may be achieved using a traditional weekly format. Intensive CT-PTSD may be particularly suited for patients with discrete traumatic experiences and in settings offering short residential stays. Read the article... [dx.doi.org/10.1017/S1352465810000214](http://dx.doi.org/10.1017/S1352465810000214).


Unexpected findings on imagery rehearsal for Veterans with PTSD

Nightmares and other sleep disturbances in PTSD patients may be more resistant to treatment than other posttraumatic symptoms. This has led to the development of interventions that target sleep problems specifically, such as imagery rehearsal. The treatment has shown promise in previous studies. However, in a new study—the most rigorous to date—the effects of imagery rehearsal did not differ from the effects of standard sleep and nightmare management on nightmare frequency, sleep quality, PTSD, or other symptoms. Male Vietnam Veterans (n = 124) with PTSD and combat-related nightmares were randomly assigned to six 90-minute group sessions of one of the two treatments. Participants in both groups reported modest improvements in PTSD symptoms and overall sleep quality at posttreatment and follow-up, but not in nightmare frequency, the primary outcome, or in secondary outcomes of general physical and mental health, depression, and nightmare intensity. The authors speculate that the current sample of male Vietnam Veterans with chronic PTSD may be more treatment-resistant than the younger, female samples used in earlier clinical trials. It might also be that imagery rehearsal only reduces nightmares after traditional PTSD treatment has been delivered, as was the case in some former studies. Read the article... [dx.doi.org/10.1002/jts.20569](http://dx.doi.org/10.1002/jts.20569).


Support for phase-based treatment of chronic PTSD

Some clinicians have questioned whether PTSD patients who have significant interpersonal and emotion regulation problems require skills building before engaging in trauma-focused treatment. In an effort to answer this question, researchers at New York University tested a phase-based approach that sequences Skills Training in Affect and Interpersonal Regulation (STAIR) before exposure therapy. Multiply-traumatized women (n = 104) with PTSD who were physically or sexually abused as children and had additional psychiatric disorders were randomly assigned to receive 8 sessions of either STAIR or supportive counseling before 8 sessions of exposure, or 8 sessions of STAIR before 8 sessions of supportive counseling. Patients who received STAIR before exposure had better outcomes relative to patients who received one of the other combined treatments. Typically, the STAIR/supportive counseling group fell between the other groups, which may seem surprising given the positive evidence regarding exposure therapy. It is important to remember that participants received less exposure than in a standard 10-12 session exposure protocol; without STAIR, the amount of exposure may not have been enough active treatment. Regardless, STAIR/exposure had very good results with a difficult population. Now, the next step is to compare STAIR/exposure with a standard exposure protocol or with another evidence-based treatment to determine if the skills training adds benefit. Read the article... [dx.doi.org/10.1176/appi.ajp.2010.09081247](http://dx.doi.org/10.1176/appi.ajp.2010.09081247).


African-American women have problems completing PTSD treatment

Racial minorities are less likely than Whites to complete a course of psychotherapy. Now, a new study demonstrates that this difference holds true for women in PTSD treatment. Investigators combined data from two trials of cognitive-behavioral therapy, resulting in a sample of 94 African-American and 214 White female victims of interpersonal violence. African-American participants were 1.5 times less likely than Whites to
complete treatment (45% vs. 73%, respectively), even according to analyses that controlled variables such as education and income. In fact, African-Americans were 3 times less likely to start treatment in the first place after enrolling in one of the two studies. Yet despite the differences in participation, race had no effect on PTSD outcomes. The investigators speculate that the lack of difference in outcome may have been due to a higher rate of improvement in the African-American versus the White dropouts. Given the lower participation among African Americans, the investigators discuss ways to improve treatment completion, including building rapport, discussing cultural issues at the outset of treatment, and socializing racial minorities to the process of psychotherapy. Read the article... [link]


Telemental health and the group therapy process

Researchers at the National Center for PTSD have found that group anger management therapy for Veterans with PTSD delivered by videoteleconferencing is as effective as when the therapy is delivered in-person. The investigators recently reported that the modalities have generally comparable effects on therapeutic process as well, with one exception. The study involved 112 male Veterans who were randomized to receive 12 sessions of group therapy either in-person or by videoteleconference with therapists at a remote location. Participants in both modalities reported satisfaction ratings in the very good to excellent range. Participants in the videoteleconferencing condition reported more variable and lower levels of alliance in the relationship between themselves and the group leader, although the average rating still indicated a positive alliance. The modalities did not differ in drop-out, attendance, or homework completion, or in ratings of cohesion among group members and between the leader and other members. These findings provide further support for the benefit and acceptability of telemental health approaches, even for patients presenting with such challenging issues as PTSD and anger. Telemental health offers both VA and non-VA clinicians working in rural areas or offering specialized services a way to expand their therapeutic reach. Read the article... [link]


Comorbidity

Greater risk of developing dementia in Veterans with PTSD

The July 2010 Issue of CTU-Online highlighted a study reporting that Veterans with PTSD were 1.8 times more likely than those without PTSD to be diagnosed with dementia. Now, a team from the Houston VAMC provides independent corroboration of an association between PTSD and dementia. Using Purple Heart status as a proxy for combat-related injury, the investigators followed 10,481 Veterans age 65 and older for 11 years. After excluding 1,044 Veterans who developed dementia or died during the first 2 years, the investigators found that the incidence of dementia was highest among Veterans with PTSD: 9.5% for those without a Purple Heart and 6.8% for those with a Purple Heart. These groups did not differ in multivariate analyses that controlled for demographic characteristics and comorbid health conditions. However, compared with Veterans who did not have PTSD, only the PTSD/no Purple Heart group had a greater incidence of dementia, e.g., their odds were 2.2 times greater than the odds among Veterans without PTSD or a Purple Heart. This finding is puzzling if one assumes that the combination of PTSD and a Purple Heart would cause the greatest risk for dementia; a possible explanation is higher mortality before the study, resulting in a healthier subset of these Veterans being enrolled. Findings from this and the previous study stress the importance of determining how PTSD comports an independent risk for dementia and how to reduce this risk through treatment. Read the article... [link]