Treatment

The promise of DCS to augment exposure therapy for PTSD is still (mostly) just a promise

A drug originally used to treat tuberculosis, D-cycloserine (DCS), is a partial NMDA receptor agonist that facilitates extinction learning—the presumed mechanism underlying the effects of exposure. DCS can enhance the effects of exposure therapy for anxiety disorders such as phobia, panic, and obsessive-compulsive disorder. Unfortunately, a new trial found only limited benefit of DCS for PTSD patients receiving exposure therapy. Investigators in the Netherlands randomized 75 men and women to receive DCS or placebo while undergoing a course of up to 10 sessions of exposure therapy; 67 started treatment and were included in the analyses. PTSD symptoms in both the DCS and placebo groups improved substantially, but there was no difference between groups. However, DCS did enhance treatment response in the subgroup of participants who received the full course of 8-10 sessions and were included in the analyses. PTSD symptoms in both the DCS and placebo groups improved substantially, but there was no difference between groups. However, DCS did enhance treatment response in the subgroup of participants who received the full course of 8-10 sessions, who also had higher initial symptom severity compared with early completers who were allowed to terminate early because of good treatment response. Thus, although the hope of DCS is that it can make treatment more efficient (by requiring fewer sessions) or enhance treatment gains (by leading to greater overall improvement), these data suggest that the benefit may be for individuals who might not otherwise respond well to treatment. Read the article... http://dx.doi.org/10.1016/j.biopsych.2012.02.033

PILOTS ID: 38434

Avoidance and numbing are not the main problems for Veterans with subsyndromal PTSD

Veterans who report PTSD symptoms but do not meet full diagnostic criteria may nevertheless experience significant distress and need treatment to reduce this distress. A new study by investigators at the Philadelphia VA suggests that Veterans with subsyndromal PTSD may have unique needs. The sample was drawn from an integrated primary care mental health clinic in 2010. Out of 3,024 patients triaged, 1,820 reported a history of trauma and completed the Posttraumatic Stress Disorder Checklist, Civilian version (PCL-C). Analyses focused on the 141 (7.7%) Veterans with subsyndromal PTSD, defined by the investigators as having a score of 40-60 on the PCL-C without meeting full symptom criteria. OEF/OIF/OND Veterans made up 35% of the sample. Although the vast majority of Veterans reported reexperiencing (86%) and hyperarousal (80%) symptoms, less than a third (28%) reported symptoms of
the avoidance/numbing cluster. Compared with other Veterans, OEF/OIF/OND Veterans were more likely to report any symptoms of hyperarousal and less likely to report avoidance/numbing symptoms. The OEF/OIF/OND Veterans did not differ in the frequency of reports of reexperiencing. Although evidence-based treatments for PTSD are effective for decreasing all 3 symptom clusters, their efficacy for subsyndromal PTSD has received little attention. The investigators suggest that Veterans with subsyndromal PTSD, especially those who served in recent conflicts, may need treatments focusing on arousal reduction. Read more... http://dx.doi.org/10.1037/a0028082


Assessment

Monitoring PTSD and substance use through cell phone technology

Self-monitoring of symptoms, behaviors, and coping skills is common in cognitive-behavioral treatments for PTSD and substance use. However, adherence is challenging for many patients. Findings from a recent study suggest that cell phones can help. Researchers at the VA Center for Integrated Health Care evaluated the usefulness of self-monitoring through an interactive voice response system in a sample of 50 OEF/OIF Veterans with who had PTSD symptoms and comorbid substance abuse. The Veterans received an automated call at four random times throughout the day for 28 days. They used the phone keypad to respond to pre-recorded multiple-choice questions about their PTSD symptoms and urges to use, as well as their coping styles and self-efficacy. Veterans were compensated for completing each assessment and pre- and post-study interviews. The majority (63%) of Veterans reported no or minimal inconvenience and most (85%) thought the technology would be helpful during treatment, although none were in treatment as part of the study. Adherence was high; Veterans completed an average of 86% of the assessments. Even though the phone assessments indicated decreased symptoms and urges to drink over the course of the study, Veterans reported during the post-study interview the belief that both problems increased. The researchers suggested that the reported increases may have occurred because monitoring enhanced the Veterans' awareness of their symptoms and substance use. These results provide preliminary support for the feasibility of an interactive voice response phone system as a self-monitoring tool, although compensation may have increases compliance. Read more... http://dx.doi.org/10.1037/a0027144


OEF/OIF/OND Veterans

Psychosocial issues linked to violence

Anger and irritability are symptoms of PTSD, so it is not surprising to find that PTSD is associated with increased likelihood of violent behavior. This does not mean that individuals with PTSD are violent. The association is statistical and the types of aggression are rarely extreme, despite media portrayals. However, the topic deserves greater attention—and understanding. A new study by investigators at the Durham VAMC and University of North Carolina suggests that psychosocial factors such as homelessness and employment play an important role, in addition to factors such as PTSD and substance abuse. The investigators conducted a cross-sectional survey of OEF/OIF Veterans, randomly sampling 3,000; 1,388 (46.3%) responded. Severe violence in the past year was defined as using a knife or gun against another person, beating up another person, threatening a person with a knife or gun, or trying to use physical force to have sex. Other physical aggression was defined by items such as kicking, using fists, and getting into fights. One-third of the sample reported some act of violence or aggression in the past year; 11% reported severe violence. PTSD and substance abuse were associated with increased risk of both severe and other types of violence. Other key factors included homelessness, unemployment, and not being able to meet basic needs, as well as younger age, a prior history of arrest, and higher combat exposure (independent of PTSD). The findings have interesting implications for clinical practice because they suggest that interventions targeting psychosocial factors, and not only mental health, could help to reduce violence among returning Veterans. Read more... http://www.ptsd.va.gov/professional/articles/article-pdf/id38856.pdf


OEF/OIF Veterans and suicide risk

Psychiatric disorder is a known risk factor for suicide in the general population and in Veterans. A new study by VA’s Serious Mental Illness Treatment Resource and Evaluation Center and VA’s Office of Mental Health Services examined whether OEF/OIF Veterans are especially vulnerable. The study authors connected demographic and diagnostic information from VHA’s National Patient Care Database with death records from the Centers for Disease Control Prevention’s National Death Index. Out of the 5,772,282 Veterans who used VA in fiscal years 2007 or 2008, 5.4% (309,108) served in OEF/OIF. In this cohort, there were 1,920 suicide deaths in 2008, with 96
(5.0%) among OEF/OIF Veterans. Analyses based on the entire sample indicated that although OEF/OIF Veterans were not more likely than other Veterans to commit suicide, OEF/OIF status was associated with increased risk of suicide among Veterans who had a mental health condition. Having any psychiatric diagnosis increased the suicide risk over four-fold in OEF/OIF Veterans, compared with two and a half-fold in other Veterans. Substance use, depression, and schizophrenia, but not PTSD, conferred greater risk. The authors speculate that, among Veterans with a mental health condition, the higher suicide risk in the OEF/OIF sample versus other Veterans may be due to the stress of readjustment. The study’s findings indicate that suicide prevention efforts and readjustment assistance are particularly important for OEF/OIF Veterans with mental health problems. Read more... http://dx.doi.org/10.1037/a0028266


Making sense of PTSD prevalence estimates in the OEF/OIF/OND cohort

The wide range of PTSD prevalence estimates from studies of Veterans returning from Iraq and Afghanistan can be confusing. This variability is due to numerous factors, such as how samples are selected, anonymity of responses, time since return from deployment, the choice of assessment measure and cut-off score, and reserve versus active duty status. A meta-analysis from the Walter Reed Army Institute of Research helps to clarify the numbers. The investigators examined studies reporting PTSD prevalence or incidence with samples of at least 200 OEF/OIF/OND personnel, excluding studies of treatment-seeking samples. After applying additional exclusion criteria, the investigators identified 28 studies for analysis. These studies were grouped according to type of military population: units engaged in direct combat, the entire deployed population (including support units), or random samples of the entire population (deployed and nondeployed). The studies were then further stratified by timeframe (pre-, during, or post-deployment) and screening cut-off criterion (strict/specific versus broad/sensitive). The highest pooled prevalence (19.6%) came from studies of operational combat units at post-deployment that used a sensitive cutoff. Even in studies that used a strict screening criterion, the pooled sample prevalence was higher for operational units (13.2%) than for the entire deployed population (5.5%) or random population samples (5.0%). The study offers a helpful way to organize the research to better understand prevalence estimates. The authors suggest that although population-level studies are more representative of the entire deployed force, findings from operational units are more applicable to identifying and developing treatments for more vulnerable groups. Read more... http://dx.doi.org/10.1097/NMD.0b013e182532312


Impairment before deployment interferes with postdeployment readjustment

Most studies of the effects of predeployment functioning on postdeployment outcomes have been based on retrospective reports of predeployment status. Retrospective reports can be valid indicators but also can be biased and subject to memory errors. A study by the Walter Reed Army Institute of Research and the US Army Medical Research and Material Command addressed the topic using data collected from one battalion 2 months before a year-long deployment to Iraq. Investigators also surveyed the 522 soldiers again 3 months after their return. It was the battalion’s first combat deployment. The investigators categorized 15% of the sample as being impaired prior to deployment, using an item from the Patient Health Questionnaire for depression that asked how difficult the problems endorsed on the scale had made it to do work, take care of things at home, or get along with people. This indicator of predeployment depression-related impairment predicted postdeployment symptoms of PTSD, depression, and anger, as well as mental health-related disability. Among soldiers with impairment prior to deployment, those who had the highest combat exposure during deployment had the most severe PTSD after deployment. When interpreting the study’s findings, it is important to remember that the measure of functional impairment was specific to the effects of depression symptoms, although it is possible that the results would generalize to the effects of impairment due to other causes. Read more... http://dx.doi.org/10.1037/a0024373


Subscribe to the CTU-Online

Subscribe to the CTU-Online published 6 times per year and sent via email by the Executive Division of the VA National Center for PTSD in White River Junction, VT. We welcome feedback from readers about content and format. Please email us at ncpptsd@va.gov.

You can search past issues of CTU-Online at www.ptsd.va.gov

Articles authored by National Center for PTSD staff are available in full text. For other articles we provide a link to where you might be able to view or download the full text. VA clinicians might have privileges through their university affiliation; however, VA firewalls sometimes block permissions to access reference materials. If you cannot access the full text of any of these article, we advise that you contact your local librarian or web/internet technical person.