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Treatment
Adoption of PE and CPT within VA PTSD Residential Programs

Over the past several years, over 4,000 VA clinicians have received training in Prolonged Exposure or Cognitive Processing Therapy. Investigators from the National Center for PTSD and Yale University recently reported on the extent of PE and CPT implementation in VA PTSD residential treatment programs. Knowing how these treatments are used in practice is important in order to identify barriers and facilitators to implementation. From 2008 to 2011, the investigators visited 38 PTSD residential programs to interview staff and observe activities. Ratings of adoption levels were determined by study team consensus. A total of 142 of the 179 staff eligible for training participated in either PE (37.4%) or CPT (64.2%) training, with 51 of these providers receiving both. Only 10 programs (26.3%) fully integrated CPT as their core intervention and no programs fully integrated PE; 8 (21.1%) used PE or CPT without consistent protocol adherence and 15 (39.4%) offered the treatments to only select patients. In fact, 21 programs (55.3%) reported no use of PE and 12 (31.6%) reported no use of CPT. The most common reasons cited for non-adoption were incompatibility with program structure and lack of time for training or consultation. Variable protocol use and selective offering of treatment were related to provider preferences and concerns. Although these findings show relatively low levels of implementation, the investigators offered an important caution regarding the interpretation of their data: that adoption of PE and CPT has likely increased since the data were collected given continuing dissemination efforts. Read the article...http://www.ptsd.va.gov/professional/articles/article-pdf/id87372.pdf


Patient and provider perceptions of computer-based therapy

Trials of various internet-delivered psychological interventions are showing promising results, but a new study by researchers from Boston University suggests that positive outcomes may not be enough to get people to accept these interventions. The investigators surveyed 55 adult patients seeking care for

Special Notice
Evidence review of PTSD screening in primary care: The VA Evidence-based Synthesis Program recently released a report on PTSD screening within VA primary care clinics. The review describes methods used for screening, the properties of specific screens, implementation of screens, and whether properties of screens differ depending on patient characteristics.

depression or anxiety at an outpatient clinic and 26 clinicians from the same and another local clinic. The clinicians reported regular use of evidence-supported treatments for mood and anxiety disorders. Results indicated that patients held neutral or somewhat negative perceptions of computer-based treatment. Provider perceptions were only somewhat more favorable. The lowest-rated perceptions for both groups were in the area of observability; patients and providers had little knowledge of, had rarely seen, or did not know others who used computer-based approaches. Patients’ perceptions were not correlated with general attitudes toward seeking professional care, age, or distance from clinic. Ratings of future intentions to use computerized therapy were low among patients and providers. If offered computer-based treatment, patients indicated the greatest preference for therapist-assisted delivery methods (e.g., webcam) and least preference for email-based or pure self-help modalities. Generalizability of the patient findings is limited by the fact that the sample was small, actively seeking face-to-face mental health services, and highly educated. However, such patients could be a target audience, so the study’s findings indicate that efforts may be needed to increase the public’s and providers’ knowledge of internet treatment options. Read the article...http://dx.doi.org/10.1007/s10488-011-0377-5


Is higher dropout in trauma-focused treatment a myth or reality?

Research findings are mixed on whether trauma-focused treatments for PTSD result in higher dropout than other treatments. A new meta-analysis by investigators from the Seattle and Bedford VA Medical Centers offers more definitive information—and indicates that concerns about trauma focus leading to higher dropout are unwarranted. The analysis included 42 randomized controlled trials of 54 PTSD interventions. Most treatments (n = 41) were trauma-specific (i.e., involved retelling of the trauma), 10 were trauma-neutral (i.e., allowed discussion but not retelling of the trauma), and 3 were trauma-avoidant (i.e., no discussion of trauma allowed). The average rate of dropout, defined as failure to complete the expected number of sessions, was 18.3%. Neither trauma focus in general, nor Prolonged Exposure specifically, was associated with higher dropout. There was one exception, however. The odds of dropout were doubled in trauma-specific treatments relative to Present-Centered Therapy, designed as an active treatment to control for the nonspecific benefits of psychotherapy. Other factors related to higher dropout were group format (see the following article for more information on dropout in group therapy), a greater number of sessions, and larger study size. The investigators acknowledged that their findings do not answer the question of whether higher dropout reflects greater intolerance or quicker improvement. Nevertheless, the study’s findings suggest there is no empirical basis for expecting that dropout will be higher in trauma-focused treatments for PTSD. Read the article...http://dx.doi.org/10.1037/a0031474


Should group treatment include exposure?

Debate exists whether trauma disclosures and exposure exercises are appropriate in group therapy for PTSD. The question is particularly relevant for VA, where group treatment for PTSD is widespread. A recent meta-analysis by VA researchers suggests that cognitive behavioral group treatments for PTSD are effective whether or not exposure is included, but that exposure is associated with higher dropout. The meta-analysis included 9 randomized controlled trials (n = 651) with 12 outpatient group conditions. Five of the treatments included in-session exposure, defined as retelling of traumatic event(s) or trauma-related nightmare(s). Within-group effect sizes were large for treatments with exposure (d = 1.16) and for those without (d = 1.11). Effects were smaller in studies of Veterans than in studies of non-Veterans, a pattern also found in research on individual treatment. Dropout was higher in groups with exposure (26.4%) versus groups without exposure (18.9%, respectively), but not higher than in individual exposure-based treatments. An important caveat to the findings is that the exposure-based treatments varied in the kind of exposure used, with several studies of Imagery Rehearsal Therapy and no studies of Prolonged Exposure. The authors also reported concerns with the quality of some studies included in the meta-analysis. Nevertheless, findings suggest that incorporating trauma disclosure in group PTSD treatment is feasible and does not diminish effectiveness. Read the article...http://dx.doi.org/10.1016/j.cpr.2012.09.005


Therapist effects in Cognitive Processing Therapy

Understanding how therapist characteristics are related to patient outcomes in PTSD treatment may help improve treatment effectiveness. Investigators in a recent study took a novel approach to identifying the characteristics that help make therapists successful when delivering Cognitive Processing Therapy. The study captured a 3-year period in which 25 VA therapists in a PTSD clinic received expert training and supervision as part of VA’s rollout of Cognitive Processing Therapy. Treat-
ment effects were large \((d = .71)\) for the 192 Veterans who completed the 12-session protocol. The investigators first calculated therapist effects, finding that therapists accounted for 12% of PTSD outcome variability. Next, the investigators showed that retrospective ratings of therapist effectiveness made by the study’s expert supervisor predicted patient outcomes. The investigators then interviewed the supervisor and performed qualitative analysis of her comments about what makes therapists effective. The characteristics included non-specific factors, such as interpersonal flexibility and strong therapeutic alliance, as well as competency-based factors, such as effectively managing avoidance in session and using language reflecting skills in both general therapy delivery and CPT specifically. Based on the findings, the authors suggest that in addition to focusing on skills specific to the protocol, building therapists’ interpersonal skills has the potential to improve patient care. Monitoring patient outcomes as treatment progresses could also increase therapist accountability and guide treatment planning. Read the article... http://dx.doi.org/10.1037/a0031294


Emotional Freedom Techniques for treating trauma symptoms in Veterans

Treatment using Emotional Freedom Techniques (EFT) combines trauma focus with a somatic component. After recalling a traumatic event, a patient pairs the memory with a self-affirming statement and then taps a sequence of body points repeatedly until distress (measured in SUDs, subjective units of distress) goes to 0. Investigators recently reported promising initial findings from a randomized trial of EFT in military Veterans. A total of 59 participants in ongoing care were randomized to receive either 6 sessions of EFT or to a waitlist. Fifteen therapists treated from 1-12 Veterans each. Participants were assessed at the end of treatment \((M = 59\) days) or after 30 days on the waitlist \((M = 29\) days), and at 3- and 6-month follow-up. There were substantial reductions in PTSD symptoms and other problems in the treated group relative to the comparison group. These results are encouraging, but should be interpreted as preliminary. Several aspects of the analyses (use of completer analysis, handling of the difference between groups in the timing of the initial assessment, and failure to account for therapist effects) could have led to an overestimate of the true effect of EFT. Also, novel treatments may be especially affected by placebo effects, so it would be helpful to evaluate EFT relative to a treatment that controlled for these effects, perhaps by using tapping on sham body points that are not theorized to engage the human energy system. Read the article... http://dx.doi.org/10.1097/NMD.0b013e31827f6351


Comorbidity

PTSD and cognitive functioning in older adults

The Veteran population is rapidly aging. Research suggesting an association between PTSD and worse cognitive performance in the elderly is mixed. A recent meta-analysis—the first of its kind—provides a clearer picture of the effect of PTSD on cognition in older adults. The investigators reviewed 11 studies. The average sample age range was 62-80 years. Across studies, samples, and cognitive domains, individuals with PTSD performed significantly worse in all cognitive domains compared with trauma-exposed adults without PTSD and healthy controls. The largest effects were in processing speed, learning, memory, and executive functioning. The average effect of PTSD on cognition was medium to large among the 5 studies of US Veterans with combat trauma \((g = -0.74\) to \(-0.91\)) and small to moderate among the 6 studies of Holocaust survivors \((g = -0.44\) to \(-0.66\)). The authors noted that nearly all of the studies were cross-sectional, limiting conclusions about the PTSD course and symptoms change on cognition. In addition, many of the studies did not account for possible confounds, such as comorbidities and pre-morbid functioning. Nevertheless, the meta-analysis suggests that PTSD is related to worse functioning across all cognitive domains among older adults. The findings highlight the importance of neurocognitive assessment within the clinical care for this population. Read the article... http://dx.doi.org/10.1016/j.janxdis.2013.01.001