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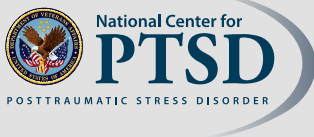
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TREATMENT

Unexpected results from a randomized trial of Acceptance and Commitment Therapy

Despite the interest in Acceptance and Commitment Therapy—ACT—as a treatment for trauma survivors, there has never been a randomized controlled trial of ACT for this population. A recent trial examined ACT in a sample of Iraq and Afghanistan War Veterans who had an anxiety or depressive disorder following their return from deployment. The results were not as expected. The 160 male and female participants were randomized to 12 weekly sessions of ACT or Present-Centered Therapy (PCT), both of which were delivered according to a transdiagnostic protocol that applied to all included disorders. Although a PTSD diagnosis was not required, 82% of the sample had PTSD. The Brief Symptom Inventory Global Severity Index was the primary outcome given the transdiagnostic focus of the study. Satisfaction with treatment was high, but pre-post change was modest ($d = .74$) and did not differ between groups ($d = .16$). There were no differences on any other measures of symptoms or functioning, including the PCL-M, except that ACT was more effective than PCT for insomnia. Treatment dropout was 48% in ACT and 36% in PCT, which is higher than the 20-25% typically found for PCT. The explanation for the disappointing findings is not obvious. One possibility is that ACT might have been more effective if it focused on a person's primary disorder, e.g., in focusing on trauma specifically in the case of PTSD. It is easy to say "more research is needed," but in this case the phrase seems to fit.

Read the article: <http://www.ptsd.va.gov/professional/articles/article-pdf/id45099.pdf>

Lang, A. J., Schnurr, P. P., Jain, S., He, F., Walser, R. D., Bolton, E., . . . Chard, K. M. (2016). Randomized controlled trial of acceptance and commitment therapy for distress and impairment in OEF/OIF/OND Veterans. *Psychological Trauma: Theory, Research, Practice, and Policy*. Advance Online Publication. PILOTS ID: 45099

Collaborative telecare leads to more care and improved PTSD for Servicemembers

The three prior trials of collaborative care for PTSD have met with mixed results. Recently, investigators with RAND Corporation added to this body of literature with two manuscripts from the STEPS-UP (Stepped Enhancement of PTSD Service using Primary Care) study, a randomized trial of stepped collaborative telecare for active duty military personnel. This 18-site study enrolled 666 U.S. Servicemembers. Most were male (81%) and the majority had PTSD (85%). Participants were randomized to centrally assisted collaborative telecare (STEPS-UP; $n = 332$) or usual care ($n = 334$). Usual care consisted of a standard collaborative care model used in Army primary care centers for almost a decade. The STEPS-UP model consisted of usual care plus additional elements: access to web or phone-based cognitive behavioral treatments, online symptom assessment, assistance from a telepsychologist or telepsychiatrist, and phone coaching for care managers. Investigators tracked participants' symptoms and service use for one year after enrollment.

The first manuscript reported that STEPS-UP was associated with improved clinical outcomes. Compared with usual care, STEPS-UP led to significantly greater reductions in self-reported symptoms of PTSD and depression. However, improvements were modest. On average,

STEPS-UP participants dropped 6 points on the Posttraumatic Diagnostic Scale and less than 1 point on the Symptom Checklist Depression Scale. STEPS-UP also outperformed usual care on improvement in somatic symptoms and mental health related functioning, though again improvements were small.

Read the article: <http://doi.org/10.1001/jamainternmed.2016.2402>

The second manuscript reported a link between STEPS-UP and increased mental health service use. STEPS-UP participants had more primary care mental health visits (median = 8) than usual care participants (median = 4) and were more likely to receive psychiatric medication (odds ratio = 1.7). In the STEPS-UP condition, participants with greater clinical complexity were more likely than less complex patients to receive specialty care, suggesting that STEPS-UP successfully triaged patients according to clinical need. In contrast, clinical complexity was not associated with specialty care use among usual care participants.

Read the article: <http://dx.doi.org/10.1097/mlr.0000000000000545>

Taken together, results show that stepped collaborative telecare can improve access and patient outcomes. A commentary accompanying the first manuscript highlighted why findings from the STEPS-UP study are so important: It is one of a small number of studies to examine collaborative care for PTSD and the first to do so in an active duty sample, which may have a particular need for PTSD management in primary care.

Read the commentary: <http://www.ptsd.va.gov/professional/articles/article-pdf/id45004.pdf>

Belsher, B. E., Jaycox, L. H., Freed, M. C., Evatt, D. P., Liu, X., Novak, L. A., ... & Engel, C. C. (2016). Mental health utilization patterns during a stepped, collaborative care effectiveness trial for PTSD and depression in the military health system. *Medical Care*, 54, 706-713. PILOTS ID: 45093

Engel, C. C., Jaycox, L. H., Freed, M. C., Bray, R. M., Brambilla, D., Zatzick, D., ... Katon, W. J. (2016). Centrally assisted collaborative telecare for posttraumatic stress disorder and depression among military personnel attending primary care: A randomized clinical trial. *JAMA Internal Medicine*, 176, 948-956. PILOTS ID: 45003

Schnurr, P. P. (2016). *Extending collaborative care for posttraumatic mental health* [Peer commentary on "Centrally assisted collaborative telecare for posttraumatic stress disorder and depression among military personnel attending primary care: A randomized clinical trial" by C. C. Engel et al.]. *JAMA Internal Medicine*, 176, 956-957. PILOTS ID:45004

Benefits of trauma-focused psychotherapy extend to psychotic symptoms

There is ample evidence that trauma-focused psychotherapy can reduce symptoms of depression comorbid with PTSD. Using data from their recent randomized controlled trial of Prolonged Exposure and EMDR in patients with serious mental illness (see [February 2015 CTU-Online](#)), investigators from the Netherlands examined whether these treatments can also improve comorbid psychotic symptoms. In the trial, 155 adults with PTSD and either schizophrenia or schizoaffective disorder were randomized to PE, EMDR, or a waitlist. Three types of psychotic symptoms (paranoid thoughts, delusions, auditory hallucinations) were assessed at baseline, immediately after treatment, and again 6 months later. Compared with waitlist, both PE and EMDR were associated with significant improvements in paranoid thoughts at posttreat-

Take NOTE

Review of online cognitive behavioral therapy for PTSD

A new review and meta-analysis by investigators at VU University Amsterdam synthesizes the empirical evidence on internet-delivered CBT interventions for PTSD.

Read the article: <http://dx.doi.org/10.1002/da.22533>

Sijbrandij, M., Kunovski, I., & Cuijpers, P. (2016). Effectiveness of internet-delivered cognitive behavioral therapy for posttraumatic stress disorder: A systematic review and meta-analysis. *Depression and Anxiety*. Advance Online Publication. PILOTS ID: 45101

Meta-analysis of D-cycloserine plus exposure therapy

Investigators with the Semel Institute for Neuroscience and Human Behaviors conducted a meta-analysis of 20 randomized controlled trials of D-cycloserine-augmented exposure therapy for anxiety, OCD, or PTSD.

Read the series: <http://dx.doi.org/10.4088/JCP.15r10334>

McGuire, J. F., Wu, M. S., Piacentini, J., McCracken, J. T., & Storch, E. A. (2016). A meta-analysis of D-cycloserine in exposure-based treatment: Moderators of treatment efficacy, response, and diagnostic remission. *The Journal of Clinical Psychiatry*. Advance Online publication. PILOTS ID: 45100

Systematic review and meta-analysis of Cognitive Processing Therapy

The Canadian Agency for Drugs and Technologies in Health conducted an extensive review and meta-analysis of the clinical effectiveness of CPT. The report also focuses on patient preferences for CPT, implementation and access, and cost-effectiveness.

Read the article: <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0087723/>

Tran, K., Moulton, K., Santesso, N., & Rabb, D. (2016). *Cognitive processing therapy for post-traumatic stress disorder: A systematic review and meta-analysis* (CADTH Health Technology Assessment No. 141). Ottawa, Canada: Canadian Agency for Drugs and Technologies in Health. PILOTS ID: 45095

ment and 6-month follow up. Participants in all three conditions showed improvement in delusions and auditory hallucinations, but the treatments did not outperform waitlist. The investigators also assessed the number of patients who no longer met criteria for a psychotic disorder after treatment. PE and EMDR participants were more likely to achieve remission than waitlist participants, and PE demonstrated an advantage over EMDR. That some types of psychotic symptoms responded to treatment (and none worsened with treatment) helps build the case for trauma focused-psychotherapy as a viable option for patients with PTSD and psychosis.

Read the article: <http://doi.org/10.1017/S0033291716001094>

de Bont, P. A. J. M., van den Berg, D. P. G., van der Vleugel, B. M., de Roos, C., de Jongh, A., van der Gaag, M., & van Minnen, A. M. (2016). Prolonged exposure and EMDR for PTSD v. a PTSD waiting-list condition: Effects on symptoms of psychosis, depression and social functioning in patients with chronic psychotic disorders. *Psychological Medicine*, 46, 2411–2421. PLOTS ID: 45096

Studies identify similar patterns of symptom change during PE and CPT

Providers who deliver trauma-focused psychotherapy may hope to see steady decreases in patients' PTSD symptoms each week. But two new studies examining symptom trajectories during Prolonged Exposure and Cognitive Processing Therapy show that improvement is not always linear. Both studies identified three distinct trajectories of change and found that certain trajectories were linked with better outcomes at the end of treatment.

A team led by investigators at the University of Wyoming reviewed treatment records of 109 Veterans receiving PE in a VA clinic and examined patterns of PTSD symptom change in the first 10 weeks. Results revealed three different trajectories. *Rapid responders* (18%) demonstrated immediate symptom reductions after week 1 and again after week 5, followed by more gradual decreases. *Linear responders* (40%) had relatively steady symptom reduction throughout treatment. *Delayed responders* (41%) showed little change during the first 10 weeks of treatment; however, 40% of delayed responders achieved at least a 10-point drop on the PTSD Checklist (PCL) by the final session, which often exceeded the 10-week window. At the end of treatment, rapid responders demonstrated lower PCL scores compared with the other two groups, suggesting that sudden gains in treatment were linked with improved outcomes.

Read the article: <http://doi.org/10.1002/da.22534>

Investigators at the National Center for PTSD conducted a similar study examining response trajectories during CPT. Participants were 69 men and women with PTSD who received variable-length CPT as part of a prior randomized controlled trial. Three individual patterns of change were identified: *Initial responders* (low initial PTSD symptoms and rapid changes at the beginning of treatment, 48%), *consistent responders* (steady decreases in PTSD symptoms, 45%), and *partial responders* (high initial PTSD symptoms and slow changes at the beginning of

treatment, 7%). Initial PTSD and depression severity predicted group membership; the most severe levels of PTSD and depression were found in the partial responder group and resulted in the least symptom improvement.

Read the article: <http://www.ptsd.va.gov/professional/articles/article-pdf/id44827.pdf>

Both studies demonstrated that patients who respond more quickly to treatment may have the greatest gains, while additional sessions may help those with slower change trajectories to achieve better outcomes. These findings suggest that frequent monitoring of symptom change can inform treatment, particularly in determining which individuals may benefit from an extended course of therapy.

Clapp, J. D., Kemp, J. J., Cox, K. S., & Tuerk, P. W. (2016). Patterns of change in response to prolonged exposure: Implications for treatment outcome. *Depression and Anxiety*. Advance Online Publication. PLOTS ID: 45094

Galovski, T. E., Harik, J. M., Blain, L. M., Farmer, C., Turner, D., & Houle, T. (2016). Identifying patterns and predictors of PTSD and depressive symptom change during cognitive processing therapy. *Cognitive Therapy and Research*. Advance Online Publication. PLOTS ID: 44827

First randomized trial of quetiapine for PTSD

As a medication class, atypical antipsychotics are not recommended as a stand-alone PTSD treatment in current practice guidelines. However, some specific atypical antipsychotic agents have never been evaluated for PTSD. Recently, investigators from the Raymond G. Murphy and Ralph H. Johnson VA Medical Centers conducted the first randomized controlled trial of quetiapine as a monotherapy for PTSD. Between 2004 and 2008, investigators enrolled 119 male and female Veterans with PTSD. Of these, 80 Veterans were randomized to 12 weeks of quetiapine (50-800mg) or placebo. After 12 weeks, the quetiapine group had greater reductions than the placebo group on the Clinician Administered PTSD Scale ($d = .49$). Quetiapine also outperformed placebo on posttreatment measures of depression and anxiety, but not sleep. Side effects in the quetiapine group—most commonly dry mouth (16%), sedation (7%), and somnolence (13%)—were generally mild. Dropout was high in both conditions (31% for quetiapine, 53% for placebo). These results should be generalized with caution because the strategy for handling missing data (replacing missing posttreatment scores with pretreatment scores) may have biased results, especially given the high study dropout. Nonetheless, it will be important for future trials to examine whether there may be important variation in the efficacy of individual atypical antipsychotics for treating PTSD.

Read the article: <http://dx.doi.org/10.1176/appi.ajp.2016.15070967>

Villarreal, G., Hamner, M. B., Cañive, J. M., Robert, S., Calais, L. A., Durklaski, V., . . . Qualls, C. (2016). Efficacy of quetiapine monotherapy in posttraumatic stress disorder: A randomized, placebo-controlled trial. *American Journal of Psychiatry*. Advance Online Publication. PLOTS ID: 45102

Do participants in PTSD clinical trials represent real world patients?

Randomized clinical trials (RCTs) are widely used to test the efficacy of psychotherapy and medication treatments for PTSD. But providers may wonder if RCT participants are similar to patients seen in clinical practice. A study led by researchers from Columbia University looked closely at the eligibility criteria used in psychotherapy and medication clinical trials to see whether community adults with PTSD would meet these criteria. Data were from the 2004-2005 National Epidemiologic Survey on Alcohol and Related Conditions, which used a large nationally representative adult sample. Of the 1,715 participants who met *DSM-IV* PTSD criteria in the past year, 64% would have been excluded by at least one criterion in medication trials, whereas only 19% would have been excluded from psychotherapy trials. Among the 366 participants who reported they were currently

receiving psychotherapy, a higher percentage would have been excluded from medication (75%) and psychotherapy trials (27%). Because so many individuals would be excluded from medication studies, results from these trials may not apply to community or treatment-seeking samples. Results of psychotherapy trials may more accurately reflect the true treatment effects in routine care patients. These findings should help alleviate clinicians' concerns that psychotherapies found to be effective in a research setting may not work for their own patients, although the generalizability of medication trials may be more limited.

Read the article: <http://doi.org/10.4088/JCP.15m10060>

Franco, S., Hoertel, N., McMahon, K., Wang, S., Md, J. M., Peyre, H., ... & Blanco, C. (2016). Generalizability of pharmacologic and psychotherapy clinical trial results for posttraumatic stress disorder to community samples. *The Journal of Clinical Psychiatry*. Advance Online Publication. PILOTS: 45097

ASSESSMENT

Identifying optimal cutoff scores for PTSD measures

In the June 2016 issue of *CTU-Online*, we reviewed three studies showing that the utility of PTSD screening measures depends on how they are scored. New analyses of the National Vietnam Veterans Longitudinal Study (NVVLS) add to this line of research by examining the best method for establishing cutoff scores for probable PTSD on self-report measures. Investigators examined data from 390 Veterans from the NVVLS, a long-term follow-up of participants in the National Vietnam Veterans Readjustment Study. Participants' scores on two self-report measures, the PCL-5 and the Mississippi Scale for Combat-Related PTSD (M-PTSD based on the *DSM-III*), were examined in relation to the CAPS-5, the gold standard clinical interview. Investigators compared five different methods for computing cutoff scores. These methods produced different recommended cutoffs for the PCL-5 (range:

37-43) and the M-PTSD (range: 89-122). For both measures, the same method (which maximized the sum of sensitivity and specificity) was optimal. Based on this method, the investigators suggest that cutoff scores of 37 on the PCL-5 and 106 on the M-PTSD are ideal in this sample of Vietnam Veterans. These results differ slightly from PCL-5 and M-PTSD cutoffs suggested by previous studies, though it is not clear whether the variation in recommended cutoffs is the result of methodological differences across studies or differences in the study samples.

Read the article: <http://doi.org/10.1037/pas0000307>

Ho, C.-L., Schlenger, W. E., Kulka, R. A., & Marmar, C. R. (2016). The influence of different criteria for establishing optimal cutoff scores on performance of two self-report measures for warzone PTSD. *Psychological Assessment*. Advance Online Publication. PILOTS: 45098

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