Treatment

Early Exposure Therapy may prevent later PTSD

Although effective treatments for chronic PTSD have been established, there has been less progress in identifying prevention strategies. A new study led by investigators at Emory University suggests that a brief version of Prolonged Exposure can reduce later symptoms and decrease the likelihood that someone will develop PTSD. The investigators randomized 137 patients who had presented to an emergency room following a traumatic event. Initial assessment took place an average of 12 hours later. The patients were then randomized to receive continued assessment only (without treatment) or to receive 3 weekly PE sessions. Clinician-rated PTSD symptoms were lower at 4 and 12 weeks in the PE group. Analyses of self-reported outcomes, which were assessed at 4 weeks only, found that the PE group also had lower depression, but not self-reported PTSD. At 4 weeks the groups did not differ in the likelihood of having PTSD, although at 12 weeks, the PE group was less likely than the assessment only group to have PTSD: 26% versus 47%, respectively. The benefits of PE were most pronounced in sexual assault survivors but were mixed in survivors of transportation accidents; PE offered no advantage for survivors of physical assault. These results should be viewed as promising and not conclusive because they do not account for the differential amount of attention received in the PE group. However, the study is important because it demonstrates the value and feasibility of using early psychotherapy with acutely traumatized individuals. Read the article...http://dx.doi.org/10.1016/j.biopsych.2012.06.002


Journal Special Issues

Clinical Practice Guideline for PTSD: A recent issue of Journal of Rehabilitation Research & Development focuses on the 2010 VA/DoD Clinical Practice Guideline for the Management of PTSD. Along with editorials describing the Guideline’s development and impact, 11 articles discuss best practices in the assessment and treatment of PTSD, as well as comorbid pain, anger, and TBI.

The issue is available at http://www.rehabresearch.va.gov/jour/2012/495/contents495.html

Psychological Health and TBI: The August 2012 supplement issue of Military Medicine, sponsored by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, presents the latest in the epidemiology, prevention, assessment, treatment, and research on PTSD, depression, substance use, and TBI.

The issue is available at http://www.ingentaconnect.com/content/amsus/zmm/2012/00000177/a00108s1
Olanzapine may be effective for PTSD, but not without side effects

In the April 2010 CTU-Online, we reported findings from a VA multi-site randomized controlled trial showing that the atypical antipsychotic risperidone was not effective as an adjunctive medication for PTSD patients who did not respond to antidepressants. However, South African researchers recently found initial support for another antipsychotic, olanzapine, as a stand-alone PTSD treatment. Twenty-eight men and women with PTSD, mostly related to domestic or criminal violence, were randomized to receive either olanzapine with flexible dosing or a placebo for 8 weeks. At posttreatment, those who received olanzapine showed greater improvement than the placebo group in PTSD symptom severity on both the Clinician-Administered PTSD Scale (CAPS, d = .43) and a self-report questionnaire, the Davidson Trauma Scale (d = .50). The olanzapine group also had greater improvements in functional impairment.

All 14 participants treated with olanzapine achieved PTSD remission (defined as CAPS severity < 50) and 10 of them reported more than 50% reduction in CAPS scores, compared with only 3 in the placebo group. These results should be generalized with caution because the study was small and the investigators used the last-observation-carried-forward method of handling missing data, which can create bias. Furthermore, the benefits of olanzapine may not be without some drawbacks. Eleven of the 14 participants who received olanzapine reported sedation, and all of them gained weight; nearly half gained 13-22 lb over the study. Although antidepressants such as selective serotonin-reuptake inhibitors confer their own unwanted side effects, there is more evidence for their efficacy in treating PTSD. Read the article... http://dx.doi.org/10.1002/hup.2238


Couple therapy as an alternative for treating PTSD

Small uncontrolled pilot trials have provided preliminary support for cognitive-behavioral couple therapy (CBCT) in improving PTSD and relationship satisfaction among both partners. A new randomized controlled trial by a team of researchers from Canada’s Ryerson University and National Center for PTSD offers more definitive evidence that couple therapy is an effective treatment for PTSD. Forty couples in which one partner met criteria for PTSD were allocated to either 15 sessions of CBCT or a 3-month wait-list group. CBCT consists of three phases: education and safety, the role of avoidance in PTSD and relationship problems, and beliefs contributing to PTSD and relationship problems. Using intention-to-treat analysis, the investigators found that the partners with PTSD who received CBCT reported a three-fold greater decrease in PTSD severity and a four-fold greater increase in relationship satisfaction (accessed via the Dyadic Adjustment Scale) than the partners with PTSD in the wait list condition. Treatment gains were maintained at the 3-month follow-up. However, there were no differences between CBCT and the wait list group in relationship satisfaction as reported by the partners. The investigators suggest that the lack of benefits for the partners in this study may have been due to several factors, including the small sample size and the heterogeneity of the sample. Future research is needed to test CBCT against evidence-based individual PTSD treatments and traditional couple therapy that does not include a focus on PTSD. Read the article... http://www.ptsd.va.gov/professional/articles/article-pdf/id39124.pdf


Meta-analytic support for Imagery Rehearsal

Some authors have called for treatments that specifically target posttraumatic nightmares in order to address this prevalent problem. One such treatment, Imagery Rehearsal, involves scripting and rehearsing new dreams to replace nightmare scenarios. According to a new meta-analysis by researchers from the National Center for PTSD, Imagery Rehearsal is helpful for treating nightmares and other symptoms—but may not be more helpful than more general treatment for insomnia. The meta-analysis of 13 studies (n = 511) indicated that Imagery Rehearsal resulted in medium improvements in nightmares, sleep quality, and PTSD over the course of treatment that were sustained over time. However, the meta-analysis was conducted using only data from treatment completers, which is likely to have inflated the treatment effects. There were no differences between civilian and Veteran samples. Among the five randomized controlled trials in the meta-analysis, the average between-group effect for each outcome was moderate. However, only one of these trials compared Imagery Rehearsal to an active treatment (psychoeducation about PTSD nightmares and sleep disturbances plus CBT for insomnia), rather than a wait-list or treatment-as-usual. This study found no between-group difference on any outcome. Given these results, Imagery Rehearsal appears to be effective for PTSD symptoms, nightmares, and sleep concerns for patients who complete the therapy, but is no better than an existing PTSD-informed sleep and nightmare management treatment. Read the article... http://dx.doi.org/10.1016/j.cpr.2012.06.002

Comorbidity

Do comorbid problems lessen response to PTSD treatment?

New reanalyses of data from three previously published trials tested whether co-occurring problems hamper response to evidence-based PTSD treatment. Two studies on dissociation suggest that some PTSD treatment components matter more than others for optimal outcomes. A third study reports that a PTSD/TBI residential treatment had benefits for all patients, regardless of comorbid depression. In all three trials, the comorbid problem improved following PTSD treatment. Results of the first study on dissociation suggests that women with dissociation do best in a staged treatment approach that offers skills building (STAIR) before exposure, relative to a sequence of supportive counseling before exposure or STAIR before supportive counseling. The second study calls into question the need for a preparatory treatment phase for patients who dissociate. The investigators found that dissociative patients benefited most from standard Cognitive Processing Therapy, whereas patients who do not dissociate benefited most in a modified version that did not include CPT’s written trauma component. Lastly, a study of a CPT-based residential program for veterans with PTSD and TBI found that although comorbid depression was associated with higher symptom severity before and after treatment, both Veterans with and without depression had comparable improvements in PTSD.

New findings on the effects of dissociation on response to PTSD treatment

Some authors have cautioned against using trauma-focused treatments with dissociative patients. Results of a study by researchers at the National Center for PTSD and New York University suggest that dissociation has some effects on response to trauma-focused treatment but that overall treatment response is good regardless of dissociation levels. The researchers reanalyzed data from their previously-published randomized controlled trial of a combination of Skills Training in Affect and Interpersonal Regulation (STAIR) followed by an exposure-based technique called Narrative Story-Telling. In that study, 104 women with PTSD related to childhood sexual and/or physical abuse received either STAIR followed by exposure, STAIR followed by supportive counseling, or supportive counseling followed by exposure. As reported in the October 2010 CTU-Online, women treated with STAIR/exposure had the best PTSD outcome. The reanalysis found that the severity of dissociative symptoms before treatment did not affect treatment response for PTSD symptoms. However, among women with higher levels of dissociation, those who received STAIR/exposure had the greatest improvements in dissociative symptoms. Across treatments, women with higher levels of dissociation were less likely than women with low dissociation to drop out. These findings are encouraging because they demonstrate that even high levels of dissociation do not prevent patients from benefiting from trauma-focused treatment. Read the article...http://www.ptsd.va.gov/professional/articles/article-pdf/id38681.pdf


Optimizing CPT for patients who dissociate

A randomized controlled dismantling study of cognitive processing therapy (CPT), reported on in the April 2008 CTU-Online, found no differences in PTSD outcomes between women who received the full CPT protocol, the cognitive therapy component only, or the written trauma accounts only. However, women assigned to cognitive therapy alone improved faster than patients assigned to written exposure. In a new study, the same team reanalyzed the data to examine the impact of dissociation. In the dismantling trial, 150 women with a history of interpersonal violence completed measures of PTSD and dissociation. The reanalysis indicated that women with high pretreatment levels of dissociation on the Trauma Symptom Inventory experienced an equal amount but faster rate of PTSD improvement in full CPT than in only cognitive therapy. The effect of dissociation was similar when measured by another scale, the Multiscale Dissociation Inventory, although higher pre-treatment scores on this scale were associated with greater, not just quicker, improvement in PTSD in full CPT versus cognitive therapy only. For women with low levels of dissociation, those in the cognitive therapy only condition improved more quickly and to a greater extent than women who received the full CPT protocol. Thus, the combination of writing and cognitive therapy may be best for patients with high levels of dissociation, but not optimal for patients without dissociation. Dissociation decreased significantly and equally in all groups. Read the article...http://www.ptsd.va.gov/professional/articles/article-pdf/id38424.pdf


Residential PTSD treatment for Veterans with PTSD and TBI...and MDD

As reported on in the June 2011 CTU-Online, a study by researchers from the Cincinnati VA suggested that trauma-focused PTSD residential treatment is effective for Veterans with a history of TBI. Now, the same research team tested whether major depression affects response to residential treatment. The researchers examined archival data from 47 male Veterans who completed an 8-week PTSD/TBI residential treatment program. The program consisted of a version of
Cognitive-Processing Therapy that includes the cognitive component but omits the written trauma account (CPT-C). Veterans also engaged in other psychoeducational process groups, aspects of dialectical behavior therapy, and CogSmart, a cognitive enhancement group. Veterans with comorbid major depressive disorder (MDD) at baseline reported more severe PTSD and depression symptoms both before and after treatment. However, the percentage of Veterans who lost their PTSD diagnosis at posttreatment did not differ significantly based on pretreatment MDD diagnosis. The treatment also helped more than half of the Veterans with pretreatment MDD lose their MDD diagnosis. Read the article...http://dx.doi.org/10.1002/jts.21722