Treatment

Will Cognitive Processing Therapy work for me (or for my patient)?

There are now a variety of effective treatments for PTSD, but there is very little information to guide decision-making by patients who want to know if a treatment will be effective for them. Clinicians need answers as well. Three new studies of Cognitive Processing Therapy help answer this question. For trauma-focused treatments in particular, some authors have suggested that factors such as psychiatric comorbidity along with patient and trauma characteristics impede participating in or benefiting from treatment, although there is no conclusive evidence indicating that such factors are actual barriers. In fact, it is the norm rather than the exception for studies to find comparable treatment response among individuals with or without a given characteristic. Typically, characteristics thought to predict poor outcome are unrelated to differential responsiveness, although may be related to higher severity before and after treatment.

All of the studies were based on data collected from clinical programs at the Cincinnati VAMC. In the first study, investigators reviewed charts of 110 female Veterans undergoing residential care for PTSD related to military sexual trauma, comparing outcomes in those with and without childhood sexual trauma. The investigators described CPT as the overarching framework for the program, with CPT ideas integrated into the programming throughout the course of treatment. Patients received group and individual CPT along with about 25 hours of additional treatment per week. The two groups did not differ before treatment on the CAPS, PCL, or BDI-II. At the end of treatment, both groups had improved substantially and did not differ on any outcome. Because this study did not examine the effectiveness of CPT alone, it is possible that childhood sexual trauma might predict differential outcome is delivered without the other concurrent treatments. However, the results are still encouraging because they suggest that sexual trauma in childhood is not a barrier to CPT. Read the article... http://dx.doi.org/10.1177/0886260513506055

The second study examined treatment outcomes of Veterans with and without alcohol use disorder. There is very little information about treatment outcome in cognitive-behavioral therapies for PTSD among individuals who are actively using substances. The majority of trials have allowed substance abusing, but not substance-dependent patients to enter. Few do. And despite several recent trials of exposure-based treatments in dually-diagnosed patients, there have been no such trials for predominantly cognitive in-
terventions such as CPT. The investigators therefore examined data from 536 male and female Veterans undergoing outpatient CPT, comparing outcomes among those with no history of alcohol use disorder, past disorder, and current disorder. There were no differences in treatment outcome across groups for PTSD or depression (on the CAPS, PCL, or BDI-II). There also were no differences in number of sessions attended or in the percentage who received at least 12 sessions of treatment. Read the article… http://dx.doi.org/10.1016/j.addbeh.2013.08.016

The third study addressed a different kind of population: individuals who have partial PTSD. By definition, these individuals do not meet full diagnostic criteria, so it is not clear whether they would benefit from a treatment developed for individuals with greater PTSD severity. The data from this new study suggest that individuals with partial PTSD can benefit substantially. The investigators examined data from 534 male and female Veterans who received outpatient CPT, comparing 483 who met full DSM-IV diagnostic criteria for PTSD with 51 who partially met the DSM-criteria. Although PTSD and depression severity were lower in the partial PTSD group at the beginning of treatment, the full and partial groups responded similarly and the partial group still had lower scores than the full PTSD group at the end. For example, PCL scores in the partial PTSD group dropped from 46.0 to 30.1 and from 59.7 to 36.7 in the full PTSD group. Knowing that existing PTSD treatments are effective in partial PTSD is important because other studies have demonstrated substantial comorbidity and functional impairment among symptomatic individuals who fail to meet full diagnostic criteria. Read the article… http://dx.doi.org/10.1002/jts.21869

Studies based on administrative data have both strengths and weaknesses. They offer high generalizability to clinical practice because they are based on information about actual patients. They also often may be large, permitting refined subgroup analyses. However, they can be limited by the kind of measures typically collected in clinical settings, where time and resources usually prevent the use of standardized assessment. These three studies were based on patients who had been diagnosed with the CAPS and followed with either the CAPS or the PCL, which enhances the validity of the findings. They represent an important direction for research on all treatments for PTSD.


New findings on DCS for exposure therapy

D-cycloserine (DCS), a medication used for treating tuberculosis, facilitates fear learning and extinction in animals and reduces the length of treatment for some anxiety disorders. Prior studies in PTSD patients have yielded discouraging results, but a new study reports that DCS enhanced the outcomes of virtual reality exposure therapy for PTSD. Investigators at Weill Cornell Medical College randomized 25 patients with PTSD related to the 9/11 attacks on the World Trade Center to receive 100mg of DCS or placebo while undergoing virtual reality exposure therapy. The computerized protocol simulated the attacks in order to enhance imaginal exposure. Participants received DCS or placebo 90 minutes before each of the 10 exposure sessions in the 12-week protocol. At the end of treatment, the DCS group had a decrease of 62% in PTSD severity on the CAPS, versus 43% in the placebo group, but the difference was not statistically significant (Hedges’ g = .68). At 6-month follow-up, the DCS group had dropped significantly more than the placebo group: 75% and 38%, respectively. Remission was higher in the DCS group than in the placebo group at posttreatment (46% vs. 8%) and follow-up (69% vs. 17%). So why did this trial have better results than in the two prior trials? Possibilities include the 100mg dose of DCS, which was larger than the 50mg dose in other trials, along with a greater amount of exposure and the use of virtual reality to enhance exposure. Read the article… http://dx.doi.org/10.1038/npp.2013.317


Therapeutic alliance in Prolonged Exposure: If it’s broke, fix it

Some clinicians may believe that evidence-based treatments for PTSD, such as Prolonged Exposure, minimize the importance of the therapeutic relationship. In reality, building the provider-patient alliance is a key part of PE. A study led by investigators from Case Western Reserve University showed just how significant alliance is to treatment outcomes. Treatment-seeking men and women (N = 116) with PTSD were randomly assigned to or chose to receive PE as part of a clinical trial. Participants rated alliance throughout treatment using the California Psychotherapy Alliance Scale. The investigators defined a clinically significant rupture in alliance and any subsequent repair by calculating the standard error of the differ-
Long-term sleep outcomes of CPT and PE

A 2009 reanalysis of data from a 2002 randomized controlled trial comparing PE and CPT found that both treatments improved sleep problems in women with rape-related PTSD (see June 2009 CTU-Online). However, the results also showed that the women continued to experience clinically significant sleep issues. In an analysis of data from the same study, researchers from the National Center for PTSD and VA Boston took a look at the trial’s long-term follow-up. The researchers used multilevel modeling to examine the impact of treatment type on sleep outcomes from pre-treatment through 6-year follow-up. Analyses controlled for the use of sleep medication. Outcomes included indices of sleep quality and disturbance, measured by the Pittsburgh Sleep Quality Index, and insomnia and nightmare severity, measured via two items from the CAPS. Improvement on all sleep outcomes was maintained through the long-term assessment, with no difference between treatments. However, sleep problems were still present at long-term follow-up, and had changed little from posttreatment.

The researchers suggest that adding a sleep intervention, such as Cognitive-Behavioral Therapy for Insomnia, either before or after a course of PTSD treatment, may help to fully treat sleep problems. A trial comparing Prolonged Exposure plus imagery rehearsal therapy for OEF/OIF/OND Veterans is underway at VA San Diego. Read the article... http://www.psc_doi.org/10.1037/a0034696


What Veterans with PTSD want from treatment

Evidence-based practice involves considering patient preferences in treatment decisions. Two new studies help clinicians understand Veterans’ treatment goals and preferences, and how these vary by patient characteristics and treatment setting.

A study by the National Center for PTSD surveyed Veterans about to enter either outpatient or residential PTSD treatment about their therapy goals. Previous research has shown that alignment of patient and clinician goals improves treatment outcomes, but no studies have examined whether outpatients and inpatients have different goals. In a separate study, researchers from the Medical University of South Carolina asked Veterans about their treatment preferences for comorbid PTSD/substance use disorder. Understanding which Veterans seek an integrated, versus sequential, therapy and which Veterans want psychotherapy, medication, or both can help tailor treatments for PTSD/SUD.

The first study suggests that treatment setting, gender, and war era influence the particular goals of Veterans using VA care. Veterans with PTSD about to start either outpatient psychotherapy (n = 216) or a residential program (n = 812) were asked to describe the 3 problems they most wanted to address. The most commonly noted problems in both samples were anger, sleep problems, and nightmares. Residential patients were more likely to identify estrangement/isolation and depression, whereas outpatients were more likely to want help with nightmares, sleep, and dealing with sexual abuse. War era mattered only among outpatients; Veterans from OEF/OIF noted anger and hypervigilance more often and nightmares less often than Veterans from other cohorts. Gender mattered in both samples; Women were more likely to want help with coping/functioning, self-concept, and sexual trauma, whereas men wanted help with anger and sleep. Read the article... http://www.psc_doi.org/professional/articles/article-pdf/...id87766.pdf

The second study validated Veterans’ preference for integrated approaches for PTSD/SUD. A total of 35 Veterans (21 OEF/OIF) who screened positive for substance use disorder and PTSD completed individual or group interviews and a questionnaire. Nearly all Veterans (94.3%) perceived a relationship between their PTSD symptoms and substance use. Only 20% of Veterans wanted to target their SUD first; even fewer (8.6%) preferred to start with PTSD treatment. A majority (65.7%) of Veterans preferred integrated PTSD/SUD treatment, but less than a quarter (22.9%) reported actually receiving it. Although war era did not influence preference for integrated psychotherapy, OEF/OIF Veterans were more likely than Veterans from other eras to want a combination of psychotherapy and medications. Read the article... http://dx.doi.org/10.1016/...j.addbeh.2013.09.017

These studies suggest at least two ways to enhance patient-centered care. Clinicians may facilitate PTSD treatment en-
gagement and outcomes by asking Veterans about specific problems and linking these directly to therapy rationales. Also, given that Veterans want treatment targeting both PTSD and SUD but are not getting it, efforts are needed to validate and disseminate integrated approaches to PTSD/SUD care.


Army providers’ use of evidence-based psychotherapy for PTSD

Paralleling VA, the DoD is disseminating evidence-based treatments for PTSD. However, researchers from the Army and the American Psychiatric Foundation recently discovered that Army providers’ delivery of evidence-based psychotherapies (EBPs) may fall short of full implementation. The researchers emailed the majority of all Army behavioral health providers (N = 2,310) a link to an anonymous survey asking about their first patient of the last week; 543 surveys were completed. Analyses focused on data from 110 providers (28%) who reported seeing a Soldier with a PTSD diagnosis. Most providers were either a social worker (43%) or psychologist (35%) and 91% were confident in their ability to treat PTSD. Providers reported that 86% of their patients with PTSD had received an EBP, through either them or another provider. But few providers reported using EBPs with fidelity. Of the 57 providers who reported using Cognitive Processing Therapy, only 15% reported using all core CPT techniques and 21% said they used none. Of 16 providers who reported using Prolonged Exposure, only 21% used all core PE techniques. It is difficult to interpret these findings given the low response rate and the lack of objective measures of protocol adherence, but the results raise concerns about whether treatments are being delivered with enough fidelity to be effective. Read the article… http://dx.doi.org/10.1521/psyc.2013.76.4.336


Traumatic Brain Injury

Longitudinal study finds TBI during deployment strongly linked to postdeployment PTSD

A number of cross-sectional studies have shown that experiencing a TBI during deployment is associated with PTSD—which makes sense given that the same traumatic event could cause both conditions. A report from the Marine Resiliency Study, a longitudinal cohort study of 2,600 Marines and Navy Servicemembers, provides even stronger evidence linking TBI and PTSD. The investigators analyzed data from 1,648 members of the cohort who completed a Clinician-Administered PTSD Scale interview before and after deployment. Participants also were asked about head injuries during and prior to deployment. The investigators used strict CAPS severity cutpoints for diagnosing PTSD (65+) and partial PTSD (40-64); different scoring rules can be used to optimize sensitivity and specificity, but the CAPS manual classifies scores 40 and above as indicating PTSD. A total of 6.4% of Servicemembers with deployment-related TBI versus 1.4% of Servicemembers without deployment-related TBI had PTSD, and 18.7% versus 6.1% had partial PTSD, respectively. In analyses that adjusted for predeployment TBI and PTSD along with other factors, combat severity and TBI emerged as independent predictors of postdeployment PTSD symptoms. According to the statistical model, individuals with more severe predeployment PTSD, high combat, and deployment-related TBI had the greatest likelihood of postdeployment PTSD: 34.4%. Although these findings may not seem surprising given the prior literature, they provide more conclusive evidence about the association between TBI and PTSD and also highlight the role of predeployment characteristics in predicting postdeployment outcomes. Read the article… http://www.ptsd.va.gov/professional/articles/article-pdf/id41645.pdf