Treatment

Intensive cognitive therapy for PTSD gets patients better faster

Compressed versions of evidence-based treatments for PTSD may help fill the need for more efficient, convenient approaches to care. Researchers from the United Kingdom just completed a randomized controlled trial showing that an intensive 7-day cognitive therapy for PTSD worked as well as a standard 12-week version of the treatment. A total of 121 patients were randomized to either 12 weeks of cognitive therapy for PTSD, 7-day intensive cognitive therapy for PTSD, 12 weeks of emotion-focused supportive therapy, or a 12-week waiting list. The content and number of sessions did not differ between the intensive and standard cognitive therapies and number of therapy hours was equal across the 3 treatments. Intent-to-treat analyses revealed that patients who received either version of cognitive therapy achieved comparable reductions in PTSD assessed by the CAPS (pre-post $d = 1.95$) that were greater than reductions from the supportive therapy (pre-post $d = 1.05$). Compared with the standard protocol, the intensive cognitive therapy led to faster improvement. Dropout was low and similar across treatments. Intensive therapies for PTSD may be particularly well-suited for settings where patients can be seen for multiple hours each day for a limited number of days, such as military, residential, and inpatient programs. Read the article...

http://dx.doi.org/10.1176/appi.ajp.2013.13040552


Will trauma-focused therapy make my patient worse?

Previous studies have suggested that some patients undergoing Prolonged Exposure may have increases in distress during treatment. Concerns about symptom worsening may lead providers to prematurely stop trauma-focused treatments like PE. A reanalysis of four clinical trials suggests that improvement – not worsening – is the usual outcome of trauma-focused treatment. Researchers pooled data from 361 female assault survivors who completed trauma-focused treatment ($n = 262$) or a waiting period ($n = 99$). Trauma-focused treatment included PE, CPT, EMDR, or a combination of PE and either stress inoculation training or cognitive restructuring. Reliable change was defined as an increase or decrease larger than 7.5 points on the PTSD Symptom Scale – Interview (used in 2 studies) or 11.4 points on the CAPS (used in the other 2 studies). None of the women who received a trauma-focused treatment experienced reliable worsening of PTSD and 91.6% had reliable improvement. Outcomes for women who completed PE ($n = 135$) were nearly identical (0% worsening and 92.6% improvement). Due to the use of completer analysis, these results may not generalize to patients who drop out of treatment. However, the study suggests that for patients who complete a course of trauma-focused therapy, worsening of PTSD symptoms is extremely unlikely and improvement is the expected outcome. Read the article...

http://www.ptsd.va.gov/professional/articles/article-pdf/id41884.pdf

Meta-analysis compares trauma-specific and non-specific treatments for PTSD

The VA/DoD clinical practice guideline for PTSD recommends several trauma-focused psychotherapies as first line treatments for PTSD. A new meta-analysis suggests that, for certain patients, there may be little difference in effectiveness between treatments that focus specifically on trauma and those that do not. The meta-analysis included 18 randomized controlled trials comparing specific treatments, such as Prolonged Exposure or EMDR, to non-specific treatments, such as supportive psychotherapy or relaxation. Overall, specific treatments were moderately superior to non-specific treatments in reducing PTSD symptoms, with a standardized mean difference of -0.43 between the two treatments. The advantage of specific treatments was small among studies that included clinically complex patients. However, several features of the analyses complicate interpretation of these results. The investigators used a lenient definition of complexity that included patients who typically would not be considered complex (e.g., patients meeting full criteria for PTSD for at least 6 months). Based on this definition, 13 of 18 study samples were complex. If it was unclear whether a study sample met the definition of complex, the sample was assumed to be non-complex. There were also substantial differences in the comparison conditions used in individual studies. For those patients defined as complex, findings from this meta-analysis are at odds with prior studies showing a clear advantage for trauma-focused treatments. For example, results from a large multisite trial of female Veterans with severe, chronic PTSD and multiple comorbidities found that Prolonged Exposure was superior even when compared to a very active non-trauma-focused treatment. Read the article…


New study questions conventional clinical wisdom about Prolonged Exposure

In Prolonged Exposure, patients retell their trauma in session with the goal that the traumatic memory will become less distressing over time. Providers may assume that a decrease in distress during these exposures is necessary for PE to work. A recent study led by investigators from the University of Washington shows that many patients benefit from treatment even when they continue to report high levels of distress during imaginal exposure over a course of PE. The study examined changes in Subjective Units of Distress (SUDS) between the first and the final imaginal exposure for 116 male and female interpersonal assault survivors who received PE. Most participants (64.7%) did not experience a reduction in peak SUDS. Participants without a SUDS reduction showed smaller decreases in symptom severity than participants with a SUDS reduction, but were equally likely to lose their PTSD diagnosis. These findings suggest that reduction in SUDS during exposure is not essential for a good treatment response. On the basis of this study, providers may feel increased confidence continuing the PE protocol with patients whose high SUDS levels persist across sessions. Read the article…


Clinic and provider characteristics predict use of evidence-based psychotherapy for PTSD

Previously, investigators at the White River Junction VA Medical Center used computerized natural language processing to review patient charts and determine who received evidence-based psychotherapy for PTSD in specialized VA PTSD outpatient clinics in Northern New England. The investigators reviewed the charts of 1,924 Veterans across 6 of these clinics and found that only 6% received any EBP. Recently, these investigators examined how EBP use varied across these 6 clinics and why certain clinics were more successful at implementing these treatments. The proportion of patients receiving either Cognitive Processing Therapy or Prolonged Exposure varied substantially across clinics (4%-14%), as did the median number of sessions received (2-9 sessions). Based on qualitative interviews with clinic staff and leadership, providers’ experience delivering these protocols was the characteristic that most strongly predicted EBP use. Continued contact with trainers and leadership promoting EBP, as well as EBP training tailored to providers’ individual needs, also was associated with greater implementation. By identifying important and modifiable provider and clinic factors that affect EBP use, this study highlights potential opportunities to improve EBP implementation. One caveat is that qualitative data were collected several months after the patient charts were reviewed. Data were collected in 2010, so results may not reflect current use of EBP given that VA has continued to train providers in CPT and PE since that time. Read the article…


Growing evidence on the comparative effectiveness of PTSD treatments

A report by the Institute of Medicine in 2009 calls for more comparative effectiveness research “…to assist consumers,
clinicians, purchasers, and policy makers to make informed decisions that will improve health at both the individual and population levels.” Two new comparative effectiveness studies add to increasing knowledge about cognitive-behavioral therapy for PTSD—and illustrate two of the important characteristics of comparative effectiveness research: the analysis of outcomes for different subgroups and measurement in real-world populations.

One of the studies was based on a review of charts from Veterans who received PE or CPT at an outpatient PTSD clinic in the South Texas VA Healthcare System between 2006 and 2010. (Comparative effectiveness studies do not have to be randomized trials. Meta-analyses and observational cohort studies also can provide information about comparative effectiveness, although within the limits of any nonrandomized design.) Of the 528 male and female Veterans seen at the clinic, 396 had PTSD Checklist scores 1 month before and after treatment; 263 completed treatment, which was defined as attending at least 2/3 of recommended treatment sessions. PCL scores dropped an average of 13.2 points in Veterans who received CPT (d = .96) and 26.4 points (d = 2.04) in Veterans who received PE. Because this was not a randomized trial, Veterans who received PE were almost 20 years younger than those who received CPT. There were few women, but the CPT group (< 1.0%) had even fewer than the PE group (5.9%). However, when investigators accounted for these factors and other demographic and treatment variables in multivariate analyses, the amount of improvement was still greater in PE than in CPT. It is difficult to draw firm conclusions about the difference between PE and CPT because of the pronounced differences between treatment groups before treatment. Statistically controlling for preexisting differences can go only so far to reduce bias due to lack of randomization. Other methods can achieve better control, but the best control is achieved by a randomized trial. For now, the most certain conclusion is that both treatments are highly effective for a range of Veterans. Read the article…

The other study examined predictors of response to Cognitive Processing Therapy and usual care in 59 male Australian Veterans who were treated in one of three community counseling centers in a randomized clinical trial. Higher baseline anger was associated with poorer response to CPT, whereas higher baseline anxiety was associated with better response to usual care. Depression and alcohol problems were unrelated to outcomes in either condition. Among the explanations for these findings, the authors suggest that there may be a gender difference in how anger affects response to CPT, citing a prior CPT study that had not found an effect of anger in women. Read the article…

Both studies serve as examples of the kind of questions that need to be addressed in order to optimally deliver evidence based care: how do treatments compare with one another, and which treatments are best for which patients?


### Patient and provider perspectives on mobile apps for PTSD

Mobile phone applications have the potential to offer individuals with PTSD access to education, tools, and resources, whenever and wherever needed. Investigators from the National Center for PTSD partnered with the National Center for Telehealth and Technology to create a self-help app, PTSD Coach, and a treatment-companion app, PE Coach. The investigators now report on the first studies to evaluate the apps. PTSD Coach was designed to help survivors of trauma to learn about PTSD, assess and manage symptoms, and access social support and crisis services. PE Coach aims to support the patient and the provider during a course of Prolonged Exposure, with relaxation tools, session recording, personalized homework, and symptom tracking. The evaluation of PTSD Coach offers a preliminary look at how helpful the app is for Veterans in PTSD care, while the PE Coach study examines PE providers’ attitudes about using the app with patients.

Participants in the PTSD Coach evaluation were 45 patients attending one of two VA PTSD residential treatment programs; those who did not own a smartphone were supplied with iPod devices. After 3 days of use, nearly 90% of patients were generally satisfied with the app and the majority found the app moderately to very helpful for its intended functions. Researchers did not examine whether the app reduced patients’ PTSD symptoms. PTSD Coach Online, a desktop version of the app that expands on its tools and features, is now available and an evaluation underway. Read the article…

A total of 163 PE-trained VA providers were recruited via email for the PE Coach study. Because the app was not yet available, providers read a brief description of the app. Based on an online survey, over 75% of providers believed PE Coach would make PE sessions and homework easier, believed patients would find it valuable, and intended to use it when available. More than half thought the app would help patient engagement, make assessment easier, or improve outcomes. Few thought the app would be too complicated for them or...
contradict the 2002 study. Investigators from the National Center for PTSD reanalyzed data from a large multi-site VA study comparing PE to present-centered therapy in female Veterans. Out of 283 participants, 57 were on benzodiazepines at the beginning of treatment and most reported continued use at study end. Surprisingly, participants on benzodiazepines did just as well during PE and at follow-up as did participants who were not on benzodiazepines. The same was not true for present-centered therapy; participants on benzodiazepines fared worse at follow-up compared to benzodiazepine-free participants. On the basis of these findings, should clinicians be unconcerned if participants beginning PE are taking benzodiazepines? The study does not provide a definitive answer. As in the 2002 study, participants were not randomly assigned to receive benzodiazepines and dose was not controlled. It is possible that daily use (i.e., for PTSD management) could affect PE outcomes, whereas intermittent or nighttime use (e.g., for sleep) may not. Regardless, the results should not be interpreted as encouraging use of benzodiazepines by patients with PTSD. Beyond the VA/DoD practice guideline warning against benzodiazepines for the treatment of PTSD, their side effects and potential for abuse warrant judicious and limited prescription.  

Read the article…  

http://www.ptsd.va.gov/professional/articles/article-pdf/id41885.pdf

New findings about benzodiazepines and Prolonged Exposure

A 2002 study by investigators from the Netherlands (PILOTS ID: 24448) found that patients who were taking benzodiazepines daily at the start of Prolonged Exposure had less improvement at one month follow-up. New findings contradict the 2002 study. Investigators from the National Center for PTSD reanalyzed data from a large multi-site VA study comparing PE to present-centered therapy in female Veterans. Out of 283 participants, 57 were on benzodiazepines at the beginning of treatment and most reported continued use at study end. Surprisingly, participants on benzodiazepines did just as well during PE and at follow-up as did participants who were not on benzodiazepines. The same was not true for present-centered therapy; participants on benzodiazepines fared worse at follow-up compared to benzodiazepine-free participants. On the basis of these findings, should clinicians be unconcerned if participants beginning PE are taking benzodiazepines? The study does not provide a definitive answer. As in the 2002 study, participants were not randomly assigned to receive benzodiazepines and dose was not controlled. It is possible that daily use (i.e., for PTSD management) could affect PE outcomes, whereas intermittent or nighttime use (e.g., for sleep) may not. Regardless, the results should not be interpreted as encouraging use of benzodiazepines by patients with PTSD. Beyond the VA/DoD practice guideline warning against benzodiazepines for the treatment of PTSD, their side effects and potential for abuse warrant judicious and limited prescription.  

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Special Notice
Early findings from the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)

Three articles published online on March 3rd in JAMA Psychiatry report important findings on suicide and mental health from the Army STARRS. This groundbreaking longitudinal study is designed to identify risk and protective factors among soldiers using large administrative data sets and behavioral, neurobiological, and genetic markers. Investigators will also examine the impact of intervention strategies.

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