

CLINICIAN'S TRAUMA UPDATE

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TREATMENT

Veterans who drop out of therapy often return for a second try

Many people who initiate psychotherapy for any mental health disorder do not receive a full course of treatment (e.g., see the [October 2013 CTU-Online](#)). A recent study by investigators at the VA Ann Arbor Healthcare System examined whether some portion of Veterans who drop out of psychotherapy end up giving treatment another chance. The investigators analyzed medical records from 24,492 Veterans diagnosed with PTSD between 2007-2009 who received a partial course of psychotherapy (1-5 sessions) in a PTSD clinic. Over one third (39%) reengaged in psychotherapy before the end of 2012. The investigators examined differences between those who reengaged and a matched-sample of those who left therapy at a similar date but did not reengage. Veterans who attended more VA healthcare visits (including primary care, non-PTSD mental health care, urgent care, etc.) were more likely to reengage (odds ratio = 1.1-1.8), as were men (OR = 1.2) and racial minorities (OR = 1.1). Older Veterans (OR = .88) and those with a substance use disorder (OR = .92) were less likely to reengage. This study did not examine whether Veterans who reengaged received a full course of psychotherapy on the second attempt. But findings are hopeful in that they suggest that some patients who discontinue psychotherapy prematurely access care again in the future. Results also identify which patients are least likely to reengage and may benefit from targeted outreach.

Read the article: <https://doi.org/10.1016/j.genhosppsy.2017.06.009>

Buchholz, K. R., Bohnert, K. M., Pfeiffer, P. N., Valenstein, M., Ganoczy, D., Anderson, R. E., & Sripada, R. K. (2017). Reengagement in PTSD psychotherapy: A case-control study. *General Hospital Psychiatry, 48*, 20–24. PILOTS ID: 48732

High retention and satisfaction for Warrior Care Network's intensive outpatient programs

The Warrior Care Network provides no-cost treatment and services for post-9/11 Veterans and Servicemembers. The network includes academic medical centers in four major US cities, all of which offer treatment for PTSD in a novel format—a brief intensive outpatient program. Recently, investigators from these medical centers (Massachusetts General Hospital, Emory University, Rush Medical Center, and the University of California-Los Angeles) published data showing high rates of program completion and Veteran satisfaction. From June 2015 to March 2017, 328 Veterans and active-duty military personnel (77% male) enrolled in one of the programs. Each program included daily sessions of trauma-focused psychotherapy (all 4 sites offered CPT, and 2 sites offered PE), although sites differed with respect to program length (ranging from 2-3 weeks), psychotherapy format (group, individual, or both), and additional clinical services offered. Across sites, 95% of enrolled patients completed the program. Among the 287 patients who returned a satisfaction survey, 96% were satisfied with their care and 91% believed their care improved the problems they needed help with. These findings provide growing evidence for the feasibility of intensive delivery of evidence-based PTSD treatment. Although other studies have found compressed versions of trauma-focused psychotherapy to be effective (see the [February 2014 CTU-Online](#)), this study did not report on treatment outcome. These data—which are forthcoming, according to investigators—will be critical to understanding the overall success of the programs.

Read the article: <https://doi.org/10.1176/appi.focus.20170022>

Another potential medication for PTSD falls short of expectations

New medications for PTSD are urgently needed (see the [June 2017 CTU-Online](#)). Unfortunately, medications tested in several recent trials have failed to demonstrate effectiveness or were effective for only some participants (see the [August 2017 CTU-Online](#)). A team led by investigators at Creighton University tested the effectiveness of vilazodone, an antidepressant shown to improve sleep and nightmares, for treating PTSD and comorbid depression in Veterans. Participants with both PTSD and at least mild depression ($N = 59$) were recruited from two VA Medical Centers for this 12-week randomized, double-blind, placebo-controlled study. The investigators excluded participants at higher risk of non-response, such as participants who had previously failed multiple antidepressant trials. Among the 47 completers, both vilazodone (40mg/day) and placebo were associated with improvements in PTSD and other symptoms—but with no superior benefit of vilazodone. Reductions in epinephrine in the vilazodone group were associated with greater reductions in PTSD. Results should be interpreted with caution given that anal-

yses were based only on participants who completed the study, though “completer analyses” typically bias results in favor of an intervention rather than against it. These findings place vilazodone among the growing list of medications for PTSD that were not supported by evidence from randomized clinical trials.

Read the article: <https://doi.org/10.4088/PCC.17m02138>

Ramaswamy, S., Driscoll, D., Reist, C., Smith, L. M., Albers, L. J., Rose, J., . . . Hollifield, M. (2017). A double-blind, placebo-controlled randomized trial of vilazodone in the treatment of posttraumatic stress disorder and comorbid depression. *The Primary Care Companion for CNS Disorders, 19*. PILOTS ID: 49046

Randomized trial evaluates Trauma Management Therapy with virtual reality

A previous pilot study led by investigators at the University of Central Florida suggested that Trauma Management Therapy (TMT) can be delivered effectively in an intensive outpatient setting (see the [June 2017 CTU-Online](#)). In a new trial, the same team of investigators evaluated TMT once again, this time in combination with virtual reality exposure (VRE) therapy. The study was a randomized controlled trial that included 92 Iraq and Afghanistan War Veterans and active duty Servicemembers with combat-related PTSD. Participants were randomized to receive 14 individual sessions of VRE followed by either 14

Take NOTE

Report examines use of guideline-concordant PTSD care in military facilities

The RAND Corporation has published the results of their assessment of the Military Health System’s capacity to delivery high quality care for PTSD and major depressive

disorder. The report describes the extent to which mental health providers are using evidence-based treatments and offers specific suggestions to improve quality of care for Servicemembers.

Read the article: https://www.rand.org/pubs/research_reports/RR1692.html

Hepner, K. A., Farris, C., Farmer, C. M., Iyiewuare, P. O., Tanielian, T., Wilks, A., . . . Pincus, H. A. (2017). *Delivering clinical practice guideline-concordant care for PTSD and major depression in military treatment facilities* (Report No. RR-1692-OSD). Santa Monica, CA: RAND Corporation. PILOTS ID: 48713

Overview of the neurobiology underlying pharmacotherapy for PTSD

A recent review article by investigators at the National Center for PTSD summarizes the various neurobiological factors

implicated in PTSD and describes how different pharmacological treatments interact with these factors.

Read the article: <https://www.ptsd.va.gov/professional/articles/article-pdf/id49043.pdf>

Kelmendi, B., Adams, T. G., Southwick, S., Abdallah, C. G., & Krystal, J. H. (2017). Posttraumatic stress disorder: An integrated overview of the neurobiological rationale for pharmacology. *Clinical Psychology: Science and Practice, 24*, 281–297. PILOTS ID: 49043

Meta-analysis of mindfulness based interventions for PTSD

Investigators at the University of New England in Australia conducted a systematic review and meta-analysis of 18 randomized trials testing the effectiveness of mindfulness-based interventions for PTSD symptoms. Results suggest that mindfulness interventions have a small to medium effect on PTSD compared with control conditions.

Read the article: <https://doi.org/10.1016/j.cpr.2017.08.002>

Hopwood, T. L., & Schutte, N. S. (2017). A meta-analytic investigation of the impact of mindfulness-based interventions on posttraumatic stress. *Clinical Psychology Review, 57*, 12–20. PILOTS ID: 49045

group sessions of TMT or psychoeducation and unstructured discussion. TMT targeted anger, depression, and isolation. TMT did not outperform psychoeducation on self-report measures of PTSD severity, depression, anger, and nightmares. Participants in both conditions showed similar significant reductions in each of these domains after VRE, with no further reductions after group treatment. Amount of social interaction was the only outcome on which the conditions differed, with TMT participants reporting more social interaction (100 minutes/day) than psychoeducation participants (48 minutes/day) at the conclusion of the group component of treatment. Overall, results suggest that TMT may offer some benefit related to socialization, but does not enhance the effects of VRE on PTSD and related symptoms.

Read the article: <https://doi.org/10.1016/j.janxdis.2017.08.005>

Beidel, D. C., Frueh, B. C., Neer, S. M., Bowers, C. A., Trachik, B., Uhde, T. W., & Grubaugh, A. (2017). Trauma management therapy with virtual-reality augmented exposure therapy for combat-related PTSD: A randomized controlled trial. *Journal of Anxiety Disorders*. Advance online publication. PII: S0887-9616(17)30192-0

Higher fidelity to CPT linked to improved treatment outcomes

A number of variables can contribute to the success of evidence-based treatments such as Cognitive Processing Therapy. Researchers from the VA North Texas Healthcare System examined the effect of therapist fidelity on patient outcomes in a randomized clinical trial of CPT for Veteran survivors of military sexual trauma. This secondary analysis included the 72 male and female Veterans with PTSD randomized to receive CPT in the parent study. A fidelity expert reviewed videotapes of selected CPT sessions and rated the four study therapists for adherence and competence to the essential elements of CPT, the presence of essential but not unique elements (such as accurate empathy), and overall skill on a scale ranging from “poor” (1) to “excellent” (7). The ratings demonstrated that two of the therapists had significantly lower fidelity scores than the other two therapists (mean scores = 3.3 and 4.4 vs. 5.0 and 5.3). Importantly, Veterans treated by the “good” fidelity therapists had significantly greater decreases in PTSD, depression, and trauma-related negative cognitions compared with “below average” therapists (all $ps < .05$). Although limited by the small therapist sample, these findings suggest that therapists who choose to adhere closely to evidence-based

protocols may increase the odds that their patients will benefit from treatment.

Read the article: <https://doi.org/10.1080/16506073.2017.1357750>

Holder, N., Holliday, R., Williams, R., Mullen, K., & Surís, A. (2017). A preliminary examination of the role of psychotherapist fidelity on outcomes of Cognitive Processing Therapy during an RCT for military sexual trauma-related PTSD. *Cognitive Behaviour Therapy*. Advance online publication. PII: S0165-0325(17)30192-0

Link between therapist factors and treatment retention depends on patient race and ethnicity

Veterans of minority race and ethnicity are more likely than white Veterans to drop out of PTSD treatment (see the [December 2014 CTU-Online](#)). A new study led by investigators from the National Center for PTSD examined how patients’ perceptions of their mental health providers may play a role in this disparity. This secondary analysis of a prospective national cohort study included 2,452 Latino, African American, and white Veterans newly diagnosed with PTSD in a VA facility. Veterans completed questionnaires after their diagnosis and 6 months later. Mental health service use for this 6-month period was also examined. White Veterans were more likely than Latinos to receive a minimal dose of psychotherapy (8 sessions) and more likely than Latinos or African Americans to receive a minimal dose of pharmacotherapy (4 months). The therapist factors that predicted treatment retention differed depending on patient race and ethnicity. Latino Veterans were more likely to stay in psychotherapy if they perceived the therapist cared, whereas this factor was less important for white Veterans and even less important for African American Veterans. For pharmacotherapy, retention was substantially lower for African Americans who did not perceive that their providers helped them manage medication side-effects. Results suggest that efforts to increase treatment retention should take into account the unique provider factors that may be particularly salient for different racial and ethnic groups.

Read the article: <https://www.ptsd.va.gov/professional/articles/article-pdf/id48791.pdf>

Spoont, M. R., Nelson, D. B., van Ryn, M., & Alegria, M. (2017). Racial and ethnic variation in perceptions of VA mental health providers are associated with treatment retention among Veterans with PTSD. *Medical Care*, 55, 33–42. PII: S0025-7375(17)30192-0

ASSESSMENT

DSM-5 and ICD-11 perform similarly despite considerable differences in PTSD diagnostic criteria

One goal of the ICD-11 Task Force on PTSD was to limit the diagnostic criteria to symptoms that do not overlap with other disorders in an attempt to improve diagnostic specificity and reduce the risk of inflated comorbidity rates. A study led by investigators at the VA Boston Healthcare System examined the diagnostic utility of symptoms from both the ICD-11 and DSM-5 classifica-

tion systems to see if the planned ICD-11 criteria performed as intended. To evaluate test quality indices and rates of comorbidity, the investigators used data from 1,347 Veterans participating in a larger longitudinal study of PTSD and common comorbidities. There were no significant differences in PTSD diagnostic prevalence or sex-based differences in diagnostic profiles between DSM-5 and ICD-11. Importantly, the two classification systems were similar with respect to the prevalence of comorbid depression, GAD, panic, alcohol abuse, and functional impairment. Individual items from DSM-5 and ICD-11 performed similarly, with

most in the fair to poor range on quality indices. The authors note, however, that the PTSD diagnosis as a whole is more than the sum of its parts and in combination these symptoms likely have greater utility in detecting PTSD. Based on these results, the hypothesized improvements in diagnosis and comorbidity rates with the limited symptoms of the *ICD-11* do not appear to be realized.

Read the article: <https://www.ptsd.va.gov/professional/articles/article-pdf/id48703.pdf>

Green, J. D., Annunziata, A., Kleiman, S. E., Bovin, M. J., Harwell, A. M., Fox, A. M. L., . . . Marx, B. P. (2017). Examining the diagnostic utility of the *DSM-5* PTSD symptoms among male and female returning Veterans. *Depression and Anxiety, 34*, 752–760. PILOTS ID: 48703

PTSD symptom clusters differentially relate to consequences of alcohol use

Substantial evidence shows high comorbidity between PTSD and alcohol use disorder (AUD). To better understand the link between these two disorders, investigators at the University of Toledo recently examined the relationship between specific PTSD symptom clusters and alcohol use problems. Specifically, they evaluated a 7-factor model of *DSM-5* PTSD (intrusions, avoidance, negative affect, anhedonia, externalizing behaviors, anxious

arousal, dysphoric arousal) and a 2-factor model of AUD (alcohol consumption and negative consequences) based on the AUDIT. Data from 913 Veterans were drawn from the National Health and Resilience in Veterans Study. The investigators hypothesized that internalizing PTSD clusters (negative affect, dysphoric arousal, and anhedonia) would be uniquely related to negative alcohol-related consequences, and that externalizing behaviors and anxious arousal would be uniquely related to alcohol consumption. Only one of these hypotheses was supported. Each of the internalizing clusters correlated significantly with negative consequences ($r_s = .29-.31$) and were more strongly linked to negative consequences than were other PTSD clusters. Externalizing behaviors were correlated with alcohol consumption ($r = .21$), but relative to other PTSD clusters, neither externalizing behaviors nor anxious arousal were uniquely related to consumption. According to the authors, these findings suggest it would be helpful to assess drinking-related problems in addition to amount of drinking, especially when internalizing PTSD symptoms are part of a patient's clinical presentation.

Read the article: <https://www.ptsd.va.gov/professional/articles/article-pdf/id48785.pdf>

Claycomb Erwin, M., Charak, R., Durham, T. A., Armour, C., Lv, X., Southwick, S. M., . . . Pietrzak, R. H. (2017). The 7-factor hybrid model of *DSM-5* PTSD symptoms and alcohol consumption and consequences in a national sample of trauma-exposed veterans. *Journal of Anxiety Disorders, 51*, 14–21. PILOTS ID: 48785



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