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## Assessment

### Making the switch to *DSM-5*

PTSD diagnostic criteria were revised for the *DSM-5*, representing an important new phase in the evolution of how we define PTSD. As clinicians and researchers transition to *DSM-5*, questions remain about how these new criteria will impact the field. Four recent articles investigate the implications of *DSM-5* on the construct, prevalence, and assessment of PTSD.

A comprehensive review by investigators at Auburn University and the National Center for PTSD summarized key changes to *DSM-5* PTSD criteria. With the exception that fear, helplessness, or horror during the trauma is no longer required, little was removed from the *DSM-IV* criteria. Most changes involved modifying existing symptoms or adding new ones. There are now 20 symptoms organized into 4 clusters (rather than 3), as well as a dissociative subtype and criteria for preschool children. The revisions were based on research, and the article describes the rationale and evidence-base justifying each change. Read the article... <http://www.ptsd.va.gov/professional/articles/article-pdf/id42271.pdf>

A primary question is how the new *DSM-5* criteria will affect PTSD prevalence. Australian investigators assessed PTSD in 510 injury survivors. Prevalence was similar according to the criteria for *DSM-5* (6.7%) and *DSM-IV* (5.9%). However, the two sets of diagnostic criteria captured different participants. Approximately 35.3% of those with *DSM-5* PTSD did not meet *DSM-IV* criteria, and 26.7% of those with *DSM-IV* PTSD did not meet *DSM-5* criteria. So, although most people diagnosed with PTSD in the past will retain their diagnosis, some may fail to meet *DSM-5* criteria. Read the article... <http://dx.doi.org/10.1192/bjp.bp.113.135285>

A separate study led by investigators at the University of California also examined prevalence, but this time focusing specifically on two of the new *DSM-5* symptoms: persistent negative beliefs (D2) and distorted blame (D3). Based on results of the National Stressful Events Survey (NSES) in a national sample ( $N = 2,498$ ), the investigators found that D2 and D3 symptoms were common, present in 74.6% and 80.6% of respondents with PTSD, respectively. Read the article... <http://dx.doi.org/10.1002/jts.21925>

Data from these studies suggest that the *DSM-5* definition may improve upon prior conceptualizations of PTSD by better capturing

## Special Notice

### A new meta-analysis of PTSD treatments

The best way to compare the efficacy of different treatments for PTSD is with trials using direct head-to-head contrasts. Such trials are rare. A novel statistical approach, network meta-analysis, allows direct head-to-head comparisons pooled from existing studies. Using this method, a Swiss research team found no differences between specific treatments for PTSD, such as cognitive therapy, Prolonged Exposure, and EMDR, but did find that specific treatments outperformed nonspecific treatments, such as stress management and supportive therapies. Read the article... <http://dx.doi.org/10.1017/S0033291714000853>

Gerger, H., Munder, T., Gemperli, A., Nüesch, E., Trelle, S., Jüni, P., & Barth, J. (2014). Integrating fragmented evidence by network meta-analysis: Relative effectiveness of psychological interventions for adults with post-traumatic stress disorder. *Psychological Medicine*. Advance online publication. PILOTS ID: 42402

ing common cognitive symptoms of PTSD and by identifying a new subset of PTSD patients who would not have been diagnosed according to *DSM-IV*. In light of these changes, it will be important to test whether interventions developed under the *DSM-IV* system will be equally effective for people with *DSM-5* PTSD.

Changes to PTSD diagnostic criteria have also made it necessary to update assessment measures. The review mentioned above describes the new *DSM-5* versions of the Life Events Checklist (LEC-5), PTSD Checklist (PCL-5), and Clinician Administered PTSD Scale (CAPS-5) ([available from the National Center for PTSD by request](#)). Each measure includes new and reworded items, and the PCL-5 and CAPS-5 have new response scales. Although future studies are needed to directly compare *DSM-IV* and *DSM-5* versions, the authors predict high correspondence in terms of both psychometric properties and diagnosis. And while these investigators have been updating existing measures, investigators at the University of California have created a new *DSM-5* PTSD measure. The National Stressful Events Survey-Short Scale is a 9-item questionnaire that assesses *DSM-5* PTSD severity in adults. The scale, which is a streamlined version of the online questionnaire used in the NSES, showed good psychometric properties in a trauma-exposed nonclinical sample, but has yet to be validated with a clinical sample. Read the article... <http://www.ptsd.va.gov/professional/articles/article-pdf/id42404.pdf>

Weathers, F. W., Marx, B. P., Friedman, M. J., & Schnurr, P. P. (2014). Posttraumatic stress disorder in *DSM-5*: New criteria, new measures, and implications for assessment. *Psychological Injury and Law*, 7, 93-107. PILOTS ID: 42271

O'Donnell, M. L., Alkemade, N., Nickerson, A., Creamer, M., McFarlane, A. C., Silove, D., ... & Forbes, D. (2014). Impact of the diagnostic changes to post-traumatic stress disorder for *DSM-5* and the proposed changes to ICD-11. *The British Journal of Psychiatry*. Advance online publication. PILOTS ID: 42263

Cox, K. S., Resnick, H. S., & Kilpatrick, D. G. (2014). Prevalence and correlates of posttrauma distorted beliefs: Evaluating *DSM-5* PTSD expanded cognitive symptoms in a national sample. *Journal of Traumatic Stress*, 27, 299-306. PILOTS ID: 42385

LeBeau, R., Mischel, E., Resnick, H., Kilpatrick, D., Friedman, M., & Craske, M. (2014). Dimensional assessment of posttraumatic stress disorder in *DSM-5*. *Psychiatry Research*, 218, 143-147. PILOTS ID: 42404

## The strengths—and weaknesses—of VA administrative data on PTSD

The analysis of VA administrative data offers valuable information about VA's healthcare system. However, the information is not collected in the same standardized way that research data are collected—which makes the results of a new study on the validity of PTSD diagnoses in VA data especially informative. A team of investigators led by the National Center

for PTSD administered the SCID, the Structured Clinical Interview for *DSM-IV*, to 1,649 male and female Iraq and Afghanistan War veterans, comparing diagnoses based on the SCID with diagnoses in participants' VA medical records. According to diagnostic information in the problem list (which was slightly more accurate than diagnosis based on clinical encounters), agreement with the SCID was 72.3% for current PTSD and 79.4% for lifetime PTSD. Additional analyses focused on understanding disagreement between the current SCID diagnosis and the problem list; 14.7% of PTSD cases were false negatives (SCID diagnosis but no medical record diagnosis) and 24.6% of non-cases were false positives (no SCID diagnosis but PTSD diagnosis in the medical record). Relative to cases of agreement, cases of disagreement differed in several ways, e.g., false negatives had less combat exposure, whereas false positives had less combat exposure and were more likely to have sought treatment for emotional problems. Although overall agreement between the SCID and medical records was good, both clinicians and researchers need to be aware of the limitations of administrative data—with researchers attempting to address these limitations when possible. Read the article... <http://www.ptsd.va.gov/professional/articles/article-pdf/id42221.pdf>

Holowka, D. W., Marx, B. P., Gates, M. A., Litman, H. J., Ranganathan, G., Rosen, R. C., & Keane, T. M. (2014). PTSD diagnostic validity in Veterans Affairs electronic records of Iraq and Afghanistan Veterans. *Journal of Consulting and Clinical Psychology*, 82, 569-579. PILOTS ID: 42221

## Emerging support for the use of telehealth technology in PTSD assessment

A growing body of research shows that psychotherapy for PTSD delivered via telehealth is as effective as face-to-face therapy (see Morland et al., 2014, in this issue). But before PTSD treatment can begin, patients must be accurately diagnosed. Investigators from the Boston VA and the National Center for PTSD examined whether telehealth technology can also be used to assess PTSD—and whether patients are comfortable with this type of evaluation. The study enrolled 30 Veterans who completed two separate CAPS interviews with two different clinicians—one interview in person and one through videoconferencing. The two assessment methods yielded similar total and item-level CAPS scores, supporting the validity of tele-assessment. The only exception was that Veterans reported more sleep difficulties in person. Tele-assessment was generally well received by Veterans, with only 9.5% of the sample reporting discomfort with the lack of person-to-person contact. However, most Veterans preferred the in-person assessment (44.8%) or reported no preference (41.4%). Only one Veteran actually preferred tele-assessment. It is important to consider that study participants were recruited during a VA visit, so this group of Veterans may have been used to accessing in-person care. The investigators suggest that there may be a stronger preference for tele-assessment

among Veterans with more limited access, such as those facing long travel times or with significant anxiety about visiting a VA facility. Read the article... <http://www.ptsd.va.gov/professional/articles/article-pdf/id42406.pdf>

Litwack, S. D., Jackson, C. E., Chen, M., Sloan, D. M., Hatgis, C., Litz, B. T., & Marx, B. P. (2014). Validation of the use of video teleconferencing technology in the assessment of PTSD. *Psychological Services, 11*, 290-294. PILOTS ID: 42406

## Identifying Veterans with an elevated risk of violence

A measure to assess modifiable risk factors for violence in Veterans could help clinicians identify Veterans who might benefit from further assessment and intervention. Investigators from the Durham VA Medical Center report promising findings on just such a measure. The study used a nationally-representative sample of 1,090 OEF/OIF Veterans and a self-selected sample of 197 dyads consisting of an OEF/OIF Veteran plus a collateral informant (either a family member or friend). At an initial assessment, participants completed measures of 5 variables associated with violence in prior research: alcohol misuse, combat experience, financial instability, probable PTSD plus anger, and a history of violence or arrests. The investigators then constructed a brief screen, the Violence Screening and Assessment of Needs (VIO-SCAN), using a single question to capture each risk factor. A year later, participants were asked about severe violence or other physical aggression in the past year. Multiple logistic regression revealed that each risk factor uniquely increased the odds of one or both types of violence. Predicted probability of severe violence increased as the total summed risk score increased, although the screen's overall accuracy was modest. However, the investigators stress that the VIO-SCAN is not to be used to determine whether a Veteran will be violent or as a measure of acute violence risk or imminent danger. Rather, it is intended to identify Veterans who may benefit from interventions to mitigate individual risk factors based on a comprehensive risk assessment. Read the article... <http://dx.doi.org/10.1176/appi.ajp.2014.13101316>

Elbogen, E. B., Cueva, M., Wagner, H. R., Sreenivasan, S., Brancu, M., Beckham, J. C., & Van Male, L. (2014). Screening for violence risk in military veterans: Predictive validity of a brief clinical tool. *American Journal of Psychiatry, 171*, 749-757. PILOTS ID: 42409

## Treatment

### Exposure therapy online

Clinicians may wonder how well imaginal and in vivo exposure work if delivered online, or may have concerns about the safety of online delivery. Investigators from Australia's Macquarie

University sought to answer these questions by comparing an online trauma-focused intervention with and without exposure components. The 125 participants (nearly all of whom met *DSM-IV* criteria for PTSD) were randomly allocated to an online trauma-focused cognitive-behavioral therapy with either in vivo and imaginal exposure (total of 6 weekly lessons) or no exposure (total of 4 weekly lessons). A clinician also contacted participants weekly via phone or email to answer questions, normalize symptoms, and encourage progress. Both groups improved equally, contrary to the researchers' expectation that adding exposure would increase efficacy. However, exposure was not associated with symptom deterioration, lower treatment engagement, or serious adverse events. The study suggests that online exposure may not add benefit to this intervention but that it is safe and acceptable to patients. Several factors limit conclusions about efficacy. The amount of exposure may not have been an adequate dose, the sample size could detect only medium to large group differences, and the one clinician who assessed and contacted participants was not blinded to their group allocation. Thus, it is too early to know whether exposure would not add benefits, or risks, to an online intervention with minimal clinician contact. A related question is the efficacy and safety of online exposure-based treatments without any clinician involvement. Read the article... <http://dx.doi.org/10.1016/j.jad.2014.03.009>

Spence, J., Titov, N., Johnston, L., Jones, M. P., Dear, B. F., & Solley, K. (2014). Internet-based trauma-focused cognitive behavioural therapy for PTSD with and without exposure components: A randomized controlled trial. *Journal of Affective Disorders, 162*, 73-80. PILOTS ID: 42408

### Testing a novel biological pathway for PTSD treatment

Available first-line medications for PTSD involve the serotonin and norepinephrine systems. Glutamate is another transmitter thought to contribute to the stress response and pathophysiology of PTSD. Investigators from the Icahn School of Medicine at Mount Sinai report on a trial of ketamine, a glutamate antagonist that has been used for anesthesia and as a treatment for chronic depression. Feasibility and short-term efficacy findings are promising. A total of 41 men and women with a primary diagnosis of PTSD were randomized to receive either a single subanesthetic intravenous dose of ketamine hydrochloride (0.5 mg/kg) or the benzodiazepine midazolam (0.045 mg/kg). PTSD improved for both groups 24 hours later, but participants who received ketamine had greater improvement. Effects were seen in total PTSD severity and each symptom cluster. Improvements in PTSD were independent of improvements in comorbid depression. PTSD severity increased in both groups 48 hours after infusion yet remained below baseline levels at 1 week. Ketamine was also generally well tolerated. Although replication is needed, these findings suggest that ketamine may offer rapid benefit in PTSD. An interven-

tion that quickly lowers PTSD symptoms may help patients maintain functioning, such as employment, or boost follow-through with additional treatment for further symptom relief.

Read the article... <http://dx.doi.org/10.1001/jamapsychiatry.2014.62>

Feder, A., Parides, M. K., Murrough, J. W., Perez, A. M., Morgan, J. E., Saxena, S., ... & Charney, D. S. (2014). Efficacy of intravenous ketamine for treatment of chronic posttraumatic stress disorder: A randomized clinical trial. *JAMA Psychiatry*, 71, 681-688. PILOTS ID: 42218

## Study investigates effectiveness of CPT-C delivered via videoconferencing

Investigators from the National Center for PTSD previously demonstrated that videoconferencing is as effective as in-person delivery of an anger management intervention for PTSD. Recently, this research team set out to answer a new question: Are in-person delivery and videoconferencing equally effective for *trauma-focused* PTSD treatments? Rural Veterans with PTSD were randomized to either group Cognitive Processing Therapy-Cognitive only (CPT-C) in person ( $n = 64$ ) or group CPT-C via videoconferencing ( $n = 61$ ). The investigators used noninferiority analyses to test whether the two types of CPT-C were equivalent. Participants in both conditions showed improvement in their PTSD symptoms over the course of treatment, as measured by their scores on the CAPS ( $d = 0.8$ ), and the videoconferencing condition had outcomes that were similar to the in-person condition. Treatment satisfaction and compliance was high and equal for both methods of delivery. Therapeutic alliance was strong in both groups, suggesting that patients in PTSD treatment can form good rapport with a therapist even without face-to-face meetings. Not only did this study evaluate a trauma-focused treatment delivered via videoconferencing, it is also the first large-scale study to evaluate group CPT-C. These findings suggest that videoconferencing delivery of trauma-focused treatment is well-received and does not compromise effectiveness—and therefore holds promise as one way to improve access to evidence-based PTSD care. Read the article... <http://www.ptsd.va.gov/professional/articles/article-pdf/id42407.pdf>

Morland, L. A., Mackintosh, M. A., Greene, C. J., Rosen, C. S., Chard, K. M., Resick, P., & Frueh, B. C. (2014). Cognitive processing therapy for posttraumatic stress disorder delivered to rural veterans via telemental health: A randomized noninferiority clinical trial. *The Journal of Clinical Psychiatry*, 75, 470-476. PILOTS ID: 42407

## A brief alcohol intervention, with and without the provider

Alcohol misuse among Veterans is often first identified in primary care, yet providers in this setting have limited time to deliver substance use interventions. A trial by investigators from the Memphis VA suggests that provider involvement may not be necessary for delivering a PTSD-informed single-session alcohol intervention. Sixty-eight Veterans who screened positive for an alcohol use disorder (57.4% also had PTSD) were randomly assigned to one of two single-session interventions. Both interventions included a packet of general information on post-deployment adjustment, PTSD, depression, coping, substance misuse, and maladaptive alcohol use, as well as personalized feedback based on each Veteran's baseline assessment. In one intervention, a provider discussed the packet using motivation interviewing. In the other intervention, Veterans reviewed the packet alone for 30 minutes. Six weeks later, all Veterans, regardless of intervention group, reported similar improvements on all drinking outcomes. Effects were small to medium in magnitude and maintained at 6-months. Just over 40% of the Veterans contacted at 6 months no longer screened positive for an alcohol use disorder. Although these findings are encouraging, the lack of a control group makes it difficult to know if the positive outcomes are due to the intervention. If further research indicates efficacy, this brief intervention has the potential to help the large number of Veterans with alcohol misuse seen in primary care. Read the article... <http://dx.doi.org/10.1037/a0036714>

McDevitt-Murphy, M. E., Murphy, J. G., Williams, J. L., Monahan, C. J., Bracken-Minor, K. L., & Fields, J. A. (2014). Randomized controlled trial of two brief alcohol interventions for OEF/OIF Veterans. *Journal of Consulting and Clinical Psychology*, 82, 562-568. PILOTS ID: 42262

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