CLINICIAN'S TRAUMA UPDATE

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VIETNAM VETERANS

A 25-year follow-up survey of psychological health among Vietnam Veterans

The National Vietnam Veterans Readjustment Study (NVVRS), conducted 10 years after the war ended, was a landmark study that advanced understanding of postwar mental health among Veterans. Results yielded the first national probability estimates of current and lifetime PTSD and other disorders among in-theater and Vietnam-era Veterans. A research group that included some of the original NVVRS investigators recently conducted a longitudinal follow-up, the National Vietnam Veterans Longitudinal Study (NVVLS).

Of the 1,839 NVVRS Vietnam Veterans alive when the NVVLS began, 1,409 (78.8%) completed a questionnaire, 1,238 (67.3%) completed both the questionnaire and a telephone-based interview, and 400 went on to also participate in clinical diagnostic interviews. Based on the CAPS-5, 4.5% of male Veterans and 6.1% of female Veterans had current warzone-related PTSD; lifetime prevalence was 17.0% and 15.2%, respectively. Estimates of current warzone-related PTSD according to a PCL-IV modified to assess *DSM-5* criteria were higher: 11.2% for men, 6.6% for women. The investigators compared change in PTSD severity over time among 1,370 Veterans who completed the Mississippi Scale for Combat-related PTSD, the only PTSD measure administered during both surveys. Whereas Vietnam era Veterans had no change in PTSD, 16.0% of theater Veterans reported a clinically meaningful increase and only 7.6% showed improvement. Given that the surveys were one-time assessments, how PTSD fluctuated over the 25 years between them is unknown. What is clear is that a significant number of Vietnam Veterans continue to experience PTSD.

Read the article: http://dx.doi.org/10.1001/jamapsychiatry.2015.0803

Marmar, C. R., Schlenger, W., Henn-Haase, C., Qian, M., Purchia, E., Li, M., . . . Kulka, R. A. (2015). Course of posttraumatic stress disorder 40 years after the Vietnam War: Findings from the National Vietnam Veterans Longitudinal Study. *JAMA Psychiatry, 72*(9), 875-881. PILOTS ID: 44259

TREATMENT

MBSR shows promise for treating PTSD

Results of a new randomized clinical trial conducted by investigators at the Minneapolis VAMC suggest that Mindfulness-Based Stress Reduction—MBSR—can reduce PTSD symptom severity and increase quality of life among Veterans. MBSR includes training in 3 meditation techniques: body-scan, sitting meditation, and mindful yoga.

The investigators randomized 116 male and female Veterans with full or subthreshold PTSD to 9 weeks of group MBSR or Present-Centered Group Therapy (PCGT). Assessments occurred twice during treatment and then at post-treatment and 2-month follow-up. MBSR included 8 weekly 2.5-hour sessions and a day-long retreat. PCGT included 9 weekly 1.5 hour sessions. Scores on the PCL, the primary outcome, decreased from 63.6 to 54.4 in the MBSR group and from 58.8 to 56.0 in PCGT. Quality of life, but not depression, also improved more in MBSR than in PCGT. Although the overall amount of improvement in PTSD was more modest than that observed in studies of evidence-based psychotherapy, the study demonstrates that this

type of meditation can be beneficial. What are the next steps? Replicating the findings with a larger sample that was more evenly matched at baseline is important, as is finding ways to deliver treatments such as MBSR that may be challenging to schedule in VA clinical settings. One question is how best to include complementary and integrative health interventions with traditional treatments in order to optimize outcomes for Veterans.

Read the article: http://dx.doi.org/10.1001/jama.2015.8361

Polusny, M. A., Erbes, C. R., Thuras, P., Moran, A., Lamberty, G. J., Collins, R. C., . . . Lim, K. O. (2015). Mindfulness-based stress reduction for posttraumatic stress disorder among veterans: A randomized clinical trial. *JAMA, 314*(5), 456-465. PILOTS ID: 44257

Mixed findings on combination versus monotherapy for PTSD

Selective serotonin reuptake inhibitors, or SSRIs, have the strongest evidence base for treating PTSD, but not every patient has an optimal response. A team led by investigators from the New York State Psychiatric Institute examined whether combing the SSRI sertraline with mirtazapine, an antidepressant that enhances serotonergic activity indirectly, would result in better outcomes than sertraline alone.

Participants were 38 outpatients with PTSD randomized to receive sertraline (50-200 mg/day) plus mirtazapine (15-45 mg/day) or sertraline plus placebo for 24 weeks, and assessed every 4 weeks. Treatment dropout did not differ between the groups but was substantial (67% in the combined and 75% in the sertraline only arm). Intent-to-treat analyses failed to find differences between the treatment groups on overall CAPS change scores or response (defined as a >30% decrease in CAPS and improvement rating on the Clinical Global Impression of Change scale). However, participants in the combined group were more than four times as likely than participants in the sertraline-only group to remit from PTSD (defined as a CAPS <20 at 24 weeks) (OR = 4.70) and they had greater improvement in depression (between-groups *d* = -.63). A larger trial may help determine if the limited findings in this study were related to the small sample and for which patients the combination treatment may be best suited.

Read the article: http://dx.doi.org/10.1002/da.22384

Schneier, F. R., Campeas, R., Carcamo, J., Glass, A., Lewis-Fernandez, R., Neria, Y., . . . Wall, M. M. (2015). Combined mirtazapine and SSRI treatment of PTSD: A placebo-controlled trial. *Depression and Anxiety, 32*, 570-579. PILOTS ID: 44165

Take NOTE

JAMA theme issue

The August 4, 2015, issue of the *Journal of the America Medical Association* focuses on violence and human rights. Papers include a narrative review of psychotherapy trials for military-related PTSD (see notice below), a systematic review of PTSD screening measures (covered in this *CTU-Online*), and a trial of mindfulness-based stress reduction for PTSD (also in this *CTU-Online*).

Read the issue: http://jama.jamanetwork.com/issue.aspx?journalid=67&issueid=934282&direction=P

Malani, P. N., & Cole, T. B. (Associate Eds.). (2015). Violence/Human Rights [Theme issue]. *JAMA, 314*(5).

EBTs for PTSD improve depression

Investigators from the White River Junction VA and National Center for PTSD examined 93 randomized clinical trials of PTSD treatment that included depression outcomes. Their meta-analysis indicates that evidence-based PTSD treatments (EBTs) also work to reduce depression, with paroxetine, PE, CPT, and EMDR resulting in large effects.

Read the article: http://www.ptsd.va.gov/professional/articles/article-pdf/id43971.pdf

Ronconi, J. M., Shiner, B., & Watts, B. V. (2015). A meta-analysis of depressive symptom outcomes in randomized, controlled trials for PTSD. *The Journal of Nervous and Mental Disease, 203*, 522-529. PILOTS ID: 43971

Reviews of PTSD treatments for Veterans and Servicemembers

In the first study, a team of VA and DoD investigators provide a descriptive review of 36 randomized clinical trials of PTSD psychotherapies.

Read the article: http://dx.doi.org/10.1001/jama.2015.8370

In the second study, investigators from the Netherlands performed a rigorous metaregression on 57 studies to examine not only the efficacy of first-line psychotherapies for PTSD but also predictors of treatment outcome.

Read the article: http://dx.doi.org/10.1016/j.cpr.2015.06.008

Steenkamp, M. M., Litz, B. T., Hoge, C. W., & Marmar, C. R. (2015). Psychotherapy for military-related PTSD: A review of randomized clinical trials. *JAMA, 314*(5), 489-500. PILOTS ID: 44255

Haagen, J. F., Smid, G. E., Knipscheer, J. W., & Kleber, R. J. (2015). The efficacy of recommended treatments for veterans with PTSD: A metaregression analysis. *Clinical Psychology Review, 40*, 184-194. PILOTS ID: 44237

Evidence on video-teleconferencing for PTSD treatment continues to grow

Trauma-focused PTSD treatment via videoteleconferencing (VTC) has been shown to be effective in several trials, including a randomized clinical trial comparing VTC to in-person administration (see the June 2014 *CTU-Online*). Investigators from the National Center for PTSD, building on their prior studies, have reported further positive findings.

A total of 126 women, including 21 Veterans, received 12 individual Cognitive-Processing Therapy sessions at a VA clinic delivered either using VTC or in-person. For VTC to be considered non-inferior to in-person delivery, CAPS outcomes in the VTC group had to be within 10 points of outcomes in the in-person group, a difference considered clinically meaningful. Groups did not differ in treatment retention and engagement. Both intention-to-treat and completer analyses confirmed that the VTC and in-person groups had comparable and clinically significant reductions in PTSD severity at posttreatment through 6-months. Across both modalities, however, Veterans had less improvement than non-Veterans in PTSD. The investigators suggest that perhaps the Veteran women, who were current VA users and thus may have had past PTSD treatment, represent a more treatment resistant group. Nevertheless, the overall message from the trial is that VTC is an effective and feasible way to deliver an evidence-based PTSD treatment to those who cannot access in-person therapy.

Read the article: http://www.ptsd.va.gov/professional/articles/article-pdf/id44260.pdf

Morland, L. A., Mackintosh, M. A., Rosen, C. S., Willis, E., Resick, P., Chard, K., & Frueh, B. C. (2015). Telemedicine versus in-person delivery of Cognitive Processing Therapy for women with posttraumatic stress disorder: A randomized noninferiority trial. *Depression and Anxiety*. Advance online publication. PILOTS ID: 44260

New findings from VA Cooperative Study #494, "A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women"

CSP #494 was a randomized clinical trial that examined Prolonged Exposure for the treatment of PTSD in female Veterans and Army soldiers—the first study of psychotherapy for PTSD in this population. In the study, 284 women were randomized to 10 weekly sessions of PE or Present-Centered Therapy (PCT), a nonspecific comparison treatment designed to control for the benefits of psychotherapy. In the original trial, published in 2007, the investigators found that PE was more effective than PCT. Since that time, numerous secondary studies have been conducted to address a range of questions, including those posed in two new studies.

One study addressed the question of whether dissociation impairs response to PE. Using latent profile analysis, the investigators identified three groups: one with high PTSD severity and dissociation (n = 73) and two non-dissociative groups, one with high PTSD (n = 64) and one with moderate PTSD (n = 98). Regardless of whether they received PE or PCT, women in the dissociative group did not improve as much as women in the other groups. The magnitude and clinical significance of these differences were small, however, and women with dissociative symptoms experienced significant improvements in PTSD following both therapies. At the 6-month follow-up, the dissociative group showed an average drop of 18 points on the CAPS and 26.1% no longer met PTSD criteria.

Read the article: http://www.ptsd.va.gov/professional/articles/article-pdf/id44147.pdf

The other study examined the differential effects of PE on PTSD symptom clusters and individual PTSD symptoms. By using PCT to control for the nonspecific benefits of psychotherapy, the investigators were able to isolate the unique benefits of PE. According to the CAPS, PE had unique effects on the avoidance and numbing clusters (d's = 0.20-0.40) and on one reexperiencing symptom (distress in response to trauma reminders). The effects of PE were more widespread according to the PCL, on which PE outperformed PCT on all four symptom clusters and most individual symptoms within those clusters.

Read the article: http://www.ptsd.va.gov/professional/articles/article-pdf/id44119.pdf

These studies suggest that trauma-focused therapies can improve PTSD among patients with high levels of dissociation and that avoidance and numbing symptoms are particularly responsive to PE. The findings can help identify the types of patients who are likely to benefit from these treatments and inform patients' and clinicians' decisions regarding PTSD care.

Wolf, E. J., Lunney, C. A., & Schnurr, P. P. (2015). The influence of the dissociative subtype of posttraumatic stress disorder on treatment efficacy in female veterans and active duty service members. *Journal of Consulting and Clinical Psychology.* Advance online publication. PILOTS ID: 44147

Schnurr, P. P., & Lunney, C. A. (2015). Differential effects of Prolonged Exposure on posttraumatic stress disorder symptoms in female veterans. *Journal of Consulting and Clinical Psychology.* Advance online publication. PILOTS ID: 44119

Studies investigate timing of dropout from trauma-focused psychotherapy

Determining when patients discontinue PTSD treatment is key to identifying which phases of therapy pose the greatest risk for dropout. Two recent studies looked at patterns of dropout from trauma-focused cognitive-behavioral therapies and investigated whether specific treatment protocols differ in terms of when patients discontinue treatment.

In the first study, investigators at the Minneapolis VA used archival data to examine treatment dropout among 427 male and female Veterans who were referred to a PTSD specialty clinic and offered CPT and/or PE. Seventy-six participants (17.8%) declined these therapies. Of the 351 Veterans who started CPT or PE, 38.5% did not have a treatment completion note in their medical record and were classified as treatment dropouts. Veterans who dropped out of treatment attended an average of 4.5 sessions, and approximately one-quarter of the dropouts occurred between sessions 1 and 3. Dropout patterns differed between the

two treatments; CPT participants were more likely than PE participants to drop out earlier in treatment.

Read the article: http://www.ptsd.va.gov/professional/articles/article-pdf/id44116.pdf

A separate study by investigators at the National Center for PTSD pooled data from two prior randomized controlled trials in which female interpersonal trauma survivors with PTSD ($N = 321$) received either PE or one of three versions of CPT: full CPT, CPT-C ("Cognitive," without a written account), or the Written Account only. Overall, 39.3% of participants did not complete a full course of treatment and were considered dropouts. The greatest risk for dropout was after the intake assessment, with 39.7% of dropouts occurring prior to the first treatment session. There was no single treatment session that stood out as the most common point of dropout. In general, however, participants tended to drop out early in treatment, with 24.6% of dropouts occurring between sessions 1 and 3. Although the treatments were different lengths (ranging from 7-12 sessions) and used different techniques, the investigators did not detect differences between the treatments in terms of dropout patterns.

Read the article: http://www.ptsd.va.gov/professional/articles/article-pdf/id44115.pdf

Despite including different trauma populations and using different definitions of treatment dropout, these studies are consistent in their findings that patients are dropping out early on in therapy—often even before they have attended an initial session. Both studies found that roughly a quarter of patients who were offered trauma-focused CBT did not make it to session 3, which means that patients are terminating before many of the active components of the intervention are introduced. Results were mixed, however, regarding whether specific protocols may have unique dropout patterns. Overall, the observed high rates of early dropout across several CBT interventions suggest that it is critical to keep patients engaged during their initial sessions.

Kehle-Forbes, S. M., Meis, L. A., Spoont, M. R., & Polusny, M. A. (2015). Treatment initiation and dropout from Prolonged Exposure and Cognitive Processing Therapy in a VA outpatient clinic. *Psychological Trauma: Theory, Research, Practice, and Policy*. Advance online publication. PILOTS ID: 44116

Gutner, C. A., Gallagher, M. W., Baker, A. S., Sloan, D. M., & Resick, P. A. (2015). Time course of treatment dropout in cognitive–behavioral therapies for posttraumatic stress disorder. *Psychological Trauma: Theory, Research, Practice, and Policy*. Advance online publication. PILOTS ID: 44115

ASSESSMENT

For PTSD screening, two options come out on top

Busy clinicians need to know which PTSD screening measures optimally identify patients most likely in need of further assessment and treatment. A team led by investigators from the Minneapolis VA conducted a systematic review of the literature to find the most diagnostically accurate PTSD screens.

Their review focused on 23 studies, each evaluating a measure for PTSD screening within primary care settings or in high-risk groups, with at least 50 adult participants, and using a structured diagnostic PTSD interview for comparison. Investigators examined 7 measures that were PTSD-specific and 5 that covered multiple conditions or were anxiety-focused. Overall, the non-specific measures performed less well than specific measures. Most measures were only evaluated in one or two studies; the PTSD Checklist (PCL), a self-report symptom scale with 20 studies, and the Primary Care PTSD Screen (PC-PTSD), with 14 studies, were the exceptions. The PCL and the PC-PTSD also had the best performance characteristics (sensitivity and specificity) and yielded the most precise likelihood ratio estimates (diagnostic accuracy). Diagnostic accuracy did not differ between the PC-PTSD and the PCL or for the PCL across different clinical settings. The investigators recommend these two measures over others for screening. Given that all studies in this review used *DSM-IV* criteria for PTSD, evaluation of screening measures based on *DSM-5* is needed.

Read the article: http://www.ptsd.va.gov/professional/articles/article-pdf/id44256.pdf

Spoont, M. R., Williams, J. W., Kehle-Forbes, S., Nieuwsma, J. A., Mann-Wrobel, M. C., & Gross, R. (2015). Does this patient have posttraumatic stress disorder? Rational clinical examination systematic review. *JAMA, 314*(5), 501-510. PILOTS: 44256

Veterans Health Administration

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