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## **CLINICIAN'S TRAUMA UPDATE 2(5), OCTOBER 2008**

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### *Treatment*

#### **Army implements collaborative care for treating depression and PTSD in primary care settings**

The wars in Iraq and Afghanistan have heightened awareness of how stigma may prevent some individuals from seeking mental health care. One approach to reaching these individuals is to integrate mental health care into a primary care setting. Researchers have shown that this collaborative approach to care is effective for treating depression and other mental disorders. But no one had evaluated the benefits of collaborative care for PTSD until investigators from Walter Reed Army Medical Center and Dartmouth Medical School conducted a feasibility study of this strategy for treating active duty personnel at Ft. Bragg, North Carolina. Of 4,159 primary care patients screened, 404 (9.7%) had PTSD, depression, or both. Twenty-six of the 30 providers in the study referred patients to collaborative care. Sixty-nine patients participated in care for at least 6 weeks, receiving telephone care management by a nurse care facilitator who assisted primary care providers with follow-up, symptom monitoring, and adjustments to treatment as needed. By 12 weeks, 63% of the patients with depression and 81% of the patients with PTSD had a clinically significant decrease in symptoms. These results are promising because they show that collaborative care is acceptable to patients and providers. The Army is now disseminating the treatment model at 15 bases around the world and VA investigators are conducting a randomized clinical trial of the model at 5 sites in Texas.

Read the article...

Engel, C.C., Oxman, T., Yamamoto, C., Gould, D., Barry, S., Stewart, P., Kroenke, K., Williams, J.W., & Dietrich, A.J. (2008). RESPECT-Mil: Feasibility of a systems-level collaborative care approach to depression and posttraumatic stress disorder in military primary care. *Military Medicine*, 173, 935-940. PILOTS ID 82195. <http://www.ingentaconnect.com/content/amsus/zmm/2008/00000173/00000010/art00013>

## Virtual reality offers a new way to deliver exposure therapy

Exposure therapy is an effective treatment for PTSD and other anxiety disorders. In virtual reality format, the exposure is computer-simulated rather than imagined or experienced in person, as in more common methods of exposure treatment. Now a new meta-analysis provides quantitative information about how well virtual reality therapy works. The study's investigators identified 21 relevant studies published between 1990 and 2006. There were 300 total subjects across the studies. Virtual reality exposure therapy was effective: the average pre-post effect size was  $d = 0.95$ , just under a standard deviation. However, the effect sizes varied substantially among the disorders, ranging from .87 for PTSD to 1.59 for fear of flying and 1.79 for panic with agoraphobia. Because there were only two studies of PTSD available for inclusion in the review, the actual effects for PTSD may be larger or smaller. It would be helpful to know how virtual reality compares with imaginal and in-vivo exposure, and also, for whom virtual reality might be a preferred strategy. Answers may not be far away. Several funded studies of virtual reality therapy for PTSD are ongoing.

Read the article ...

Parsons, T.D., & Rizzo, A.A. (2008). Affective outcomes of virtual reality exposure therapy for anxiety and specific phobias: A meta-analysis. *Journal of Behavior Therapy and Experimental Psychiatry*, 39, 250-61. PILOTS ID 31218.

<http://dx.doi.org/10.1016/j.jbtep.2007.07.007>

## Treating PTSD may improve physical symptoms

Because many individuals with PTSD experience poor physical health, it is logical to think that successfully treating PTSD would improve physical health too. Yet previous research has failed to show such beneficial effects, which makes the results of a newly-published study particularly encouraging. The investigators examined how cognitive-behavioral therapy affected self-reported health difficulties in female sexual assault survivors. The 107 study participants were randomly assigned to receive Prolonged Exposure or Cognitive Processing Therapy or to a waitlist. Although the groups did not differ prior to treatment, after treatment the waitlist group reported a larger number of physical symptoms and worse general functioning than did either of the two treatment groups. According to these findings, effective treatment may reduce physical health complaints and improve functioning in people with PTSD. This interpretation needs to be made cautiously, however, because self-reported physical symptoms also reflect one's mental state, which improved substantially after treatment. In order to document the impact of PTSD treatment on physical health, these findings need to be replicated with additional measures of health status and health functioning, including objective indicators.

Read the article ...

Rauch, S.A., Grunfeld, T.E., Yadin, E., Cahill, S.P., Hembree, E., & Foa, E.B. (2008). Changes in reported physical health symptoms and social function with prolonged exposure therapy for chronic posttraumatic stress disorder. *Depression & Anxiety*. Retrieved October 25, 2008 from [www3.interscience.wiley.com/journal/38924/toc](http://www3.interscience.wiley.com/journal/38924/toc) PILOTS ID 31222.

<http://dx.doi.org/10.1002/da.20518>

## Assessment

### Can a single question be used to assess PTSD?

Many people choose to seek mental health treatment in primary care settings rather than going to specialty mental health care. Although depression screening has become widespread in primary care, screening for PTSD is not as common. For example, there is evidence (collected before the VA instituted mandatory screening for PTSD) that VA primary care providers fail to detect many cases of PTSD. Thinking that busy providers might be more likely to screen if screening were very brief, investigators at Walter Reed Army Medical Center developed a one-question screen for PTSD and compared it to the shortest existing screen, the 4-question PC-PTSD. A total of 3,234 primary care patients completed the one-question screen and 213 patients also completed the PC-PTSD and a structured clinician-administered interview. The PC-PTSD screen proved more effective than the one-question screen in accurately assessing who had PTSD and who did not.

Based on this study's findings, the additional time needed to complete the 4 items of the PC-PTSD seems worthwhile. Whether it is possible to effectively identify cases of PTSD by using a briefer method remains to be seen.

Read the article ...

Gore, K.L., Engel, C.C., Freed, M.C., Liu, X., & Armstrong, D.W. 3rd. (2008). Test of a single-item posttraumatic stress disorder screener in a military primary care setting. *General Hospital Psychiatry, 30*, 391-7. PILOTS ID 31206.

<http://dx.doi.org/10.1016/j.genhosppsych.2008.05.002>

## **Questionnaire assessment proves difficult for distinguishing PTSD from other Axis I disorders**

There are a number of well-designed questionnaires for assessing PTSD. The PTSD Checklist is probably the most-often used questionnaire in military and VA settings, but there are others, including the Davidson Trauma Scale, or DTS. Only the PTSD Checklist has been evaluated in OIF/OEF veterans. Now investigators at the Durham VA have reported on how well the DTS performs in assessing PTSD in OIF/OEF veterans, using a sample of 158 veterans who had experienced military or nonmilitary trauma. Like the PTSD Checklist, the DTS includes questions about the 17 symptoms of PTSD according to DSM-IV, but the DTS asks respondents to rate both the frequency and severity of each symptom. The frequency and severity ratings are then summed to obtain a total score. The DTS had high sensitivity, correctly classifying 92% of the veterans with PTSD. It also had high specificity, correctly classifying 91% of the veterans who did not have PTSD or any other disorder. However, the DTS performed less well in classifying veterans who had an Axis I disorder other than PTSD; specificity was only 50%, meaning that half of these veterans were classified as having PTSD. Increasing the threshold for diagnosis improved specificity somewhat, but decreased sensitivity. The findings suggest that the DTS is not optimal as a stand-alone measure for diagnosing PTSD in settings with high rates of other Axis I disorders. In such settings, clinicians should consider using additional assessments.

Read the article...

McDonald, S.D., Beckham, J.C., Morey, R.A., & Calhoun, P.S. (2008). The validity and diagnostic efficiency of the Davidson Trauma Scale in military veterans who have served since September 11th, 2001. *Journal of Anxiety Disorders*. Retrieved October 25, 2008 from [www.sciencedirect.com](http://www.sciencedirect.com)

PILOTS ID 31214.

<http://dx.doi.org/10.1016/j.janxdis.2008.07.007>

## **Comorbidity**

### **Gun ownership and gun laws associated with suicide by firearm in veterans**

The problem of suicide in veterans and military personnel has received a great deal of attention since the wars in Iraq and Afghanistan. Investigators of a recently-published study examined how individual characteristics such as psychiatric disorder and state characteristics such as gun-control laws and social capital (a measure of social cohesion and trust in one's community) related to suicide in over 100,000 veterans who received inpatient psychiatric care from the VA between 1994 and 1998. The veterans had a diagnosis of major depression, bipolar disorder, PTSD, or schizophrenia. The rate of suicide (0.89%) was high but comparable to the rate among psychiatric patients. The rate of suicide by firearm (41.6% of completed suicides) was somewhat lower than population rates. (According to the investigators, this may be due to the restricted access to guns among psychiatric patients.) According to multivariate analyses, only depression was related to increased risk of suicide and only PTSD was associated with increased risk of gun-related suicide. More restrictive gun control laws, a higher level of gun ownership, and lower social capital were related to suicide and gun-related suicide. When each state's suicide rate was taken into account, these factors increased risk of gun suicide only. The study's findings suggest the need for public health intervention, and depending on one's politics, also suggest the need for legislative remedies to control access to guns. Politics aside, it is clear that gun ownership should be addressed as a clinical issue in veterans who have a psychiatric disorder.

Read the article ...

Desai, R.A., Dausey, D., & Rosenheck, R. A. (2008). Suicide among discharged psychiatric inpatients in the Department of Veterans Affairs. *Military Medicine*, 173, 721-728. PILOTS ID 82091.  
<http://www.ingentaconnect.com/content/amsus/zmm/2008/00000173/00000008/art00015>

### **Although problem drinking is common among veterans of Iraq and Afghanistan, risk-reduction counseling is not**

Military personnel have higher rates of alcohol misuse than civilians. Deployment to a war zone may increase the chance of dangerous drinking—so it is important to know how regularly VA clinicians are advising veterans about the risks of heavy alcohol consumption. Investigators recently assessed the rates of alcohol problems in OEF/OIF veterans and the rates of risk-reduction counseling offered these veterans by their VA caregivers. The data came from a survey of 1,508 randomly sampled VA outpatients who completed the AUDIT-C (a standard and well validated measure of alcohol consumption) and also were asked if they had received risk reduction counseling. Forty percent of the veterans screened positive for hazardous drinking, but only 31% of these veterans reported that a VA provider had advised them to stop or reduce their drinking. Higher AUDIT-C scores, lower education, and lower income were associated with a higher likelihood of risk reduction counseling. This findings of this study show there is substantial room for improvement in the provision of risk-reduction counseling to OIF-OEF veterans. Helping these veterans gain control over their drinking could be an important key to facilitating readjustment to civilian life and preventing long-term difficulties related to excessive alcohol consumption.

Read the article ...

Calhoun, P.S., Elter, J.R., Jones, E.R., Kudler, H., & Straits-Troster, K. (2008). Hazardous alcohol use and receipt of risk-reduction counseling among US veterans of the wars in Iraq and Afghanistan. *Journal of Clinical Psychiatry*. Retrieved October 25, 2008 from  
<http://www.psychiatrist.com/abstracts/abstracts.asp?abstract=oap/ej07m03835.htm>  
PILOTS ID 31197.  
<http://www.psychiatrist.com/abstracts/abstracts.asp?abstract=oap/ej07m03835.htm>

### **Sexual trauma and chronic pain in female veterans**

Sexual trauma and persistent pain are both highly prevalent among women in the military. This leads to questions about how the two problems may be related. Studies of women in general have produced conflicting results, and little research has been done on a female military population at all. In a recent study of female veterans receiving primary care in a women's health clinic at the West Haven VA Medical Center, investigators examined the prevalence of persistent pain and the relationship between chronic pain and reports of sexual trauma. The 213 participants completed questionnaires that asked about pain, sexual trauma history, physical diagnoses, depression, and changes in functioning related to pain. Almost 4 out of 5 women—an astonishing 78%—reported long-lasting pain. Sexual trauma was not directly associated with the existence of enduring pain, but for those women already experiencing pain, sexual trauma was connected to greater pain intensity and more disruptions in social functioning because of pain. This study suggests the need for focused treatment of pain in female veterans who have had sexual trauma. Addressing their pain should be an essential component of meeting their overall health needs.

Read the article ...

Haskell, S.G., Papas, R.K., Heapy, A., Reid, M.C., & Kerns, R.D. (2008). The association of sexual trauma with persistent pain in a sample of women veterans receiving primary care. *Pain Medicine*, 9, 710-717. PILOTS ID 31207.  
<http://dx.doi.org/10.1111/j.1526-4637.2008.00460.x>

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