

VA



U.S. Department
of Veterans Affairs



National Center for
PTSD

POSTTRAUMATIC STRESS DISORDER

PTSD Treatment: What Works and What's Coming Next

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(with many thanks to Elissa McCarthy, PhD)

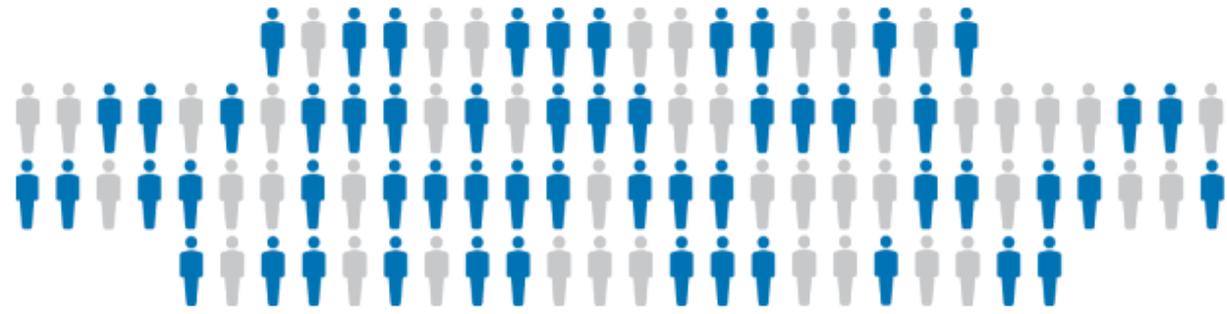


OBJECTIVES

1. Understand at least 3 evidence-based treatments for PTSD.
2. Describe at least 3 novel treatments for PTSD currently in development.
3. Identify at least 3 National Center for PTSD resources and educational products.



TRAUMA EXPOSURE IS COMMON



Most people you meet every day have experienced a trauma.

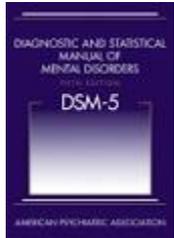
Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry*, 52(12), 1048-1060.



DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS – 5 (DSM-5)

Criterion A: The person was exposed to actual or threatened death, serious injury, or sexual violence:

- Direct personal experience
- Witnessed
- Learned about it happening to close family or friend (violent or accidental)
- Repeated or extreme exposure at work (e.g., first responders, medics)





WHAT IS TRAUMATIC STRESS?

Daily hassles

Can include:

- Car breaking down
- Paying bills

Major life events

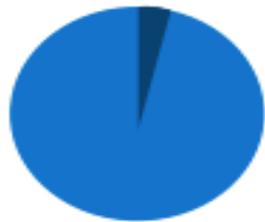
Can include:

- Losing a job
- Divorce
- Buying a new home
- Getting married

Serious traumatic events

Can include:

- War zone exposure
- Physical or sexual assault
- Serious accidents
- Child sexual or physical abuse
- Natural disasters
- Torture



7 to 8%

of the U.S. population will have PTSD at some point in their lives.



What it's like to have PTSD may be different for everyone. There are four types of PTSD symptoms.



Reliving or re-experiencing the event

- Nightmares
- Flashbacks
- Triggers



Hyperarousal or being on guard

- Being jittery or overly alert
- Difficulty sleeping or concentrating
- Feeling angry or irritable



Avoidance

- Avoiding crowds
- Avoiding certain smells, sights, or sounds
- Avoiding talking or thinking about the event

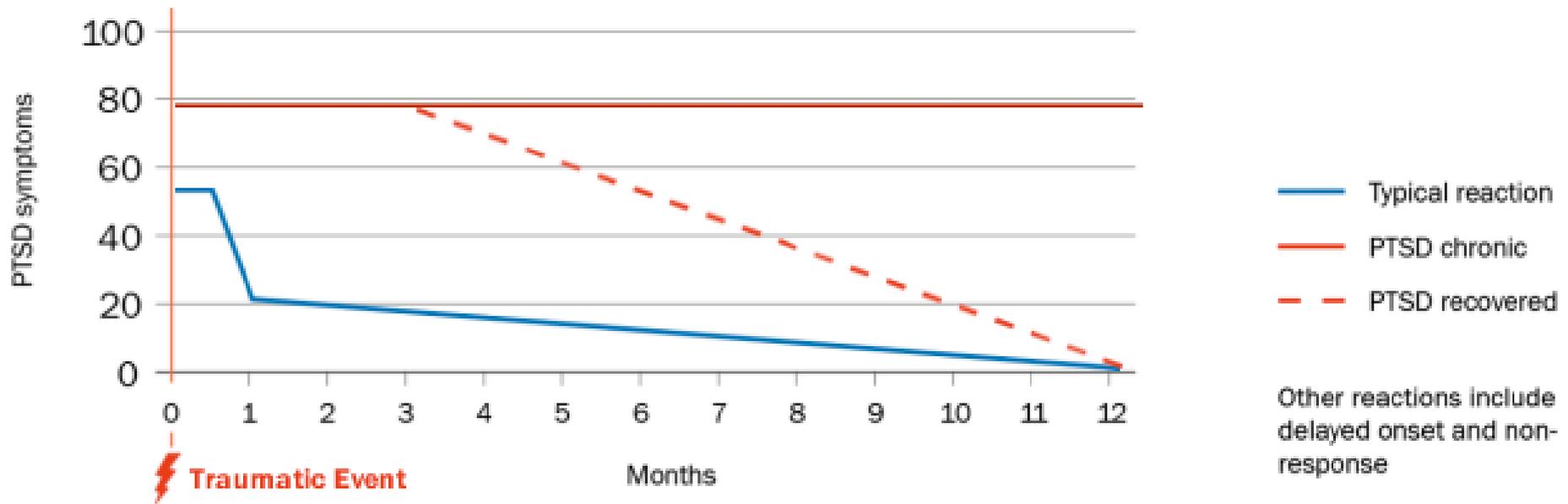


Negative changes in beliefs and feelings

- Losing interest in things you used to enjoy
- Feeling guilty or ashamed
- Unable to trust others



HOW COMMON IS PTSD?



Kessler et al., 1995



COMORBIDITY: PTSD OFTEN CO-OCCURS WITH OTHER PROBLEMS



80% have one or more mental health problem

(depression, anxiety disorders, and substance use disorders)

20% have no other mental health problem

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry*, 52(12), 1048-1060.



OTHER CO-OCCURRING PROBLEMS





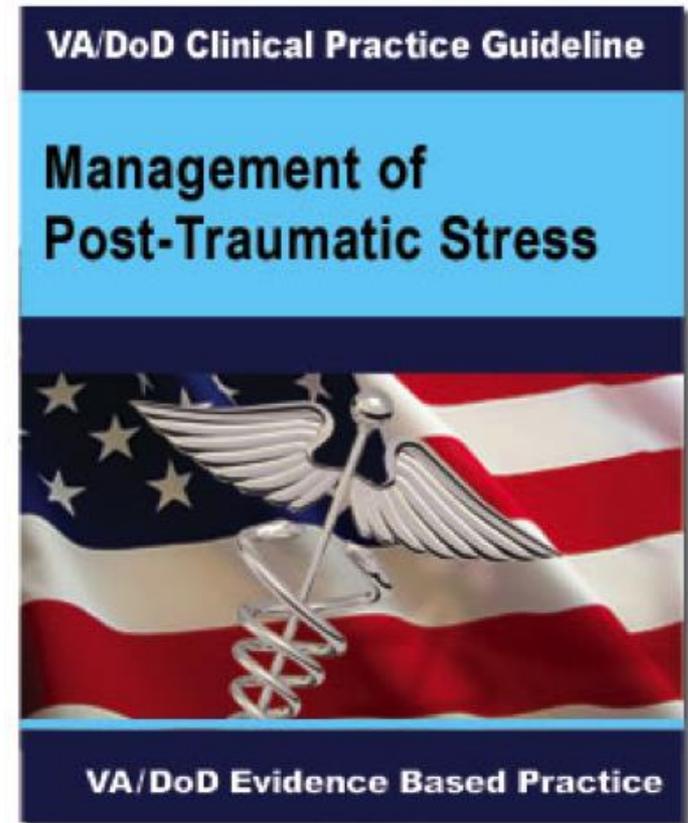
PTSD TREATMENT WORKS

www.ptsd.va.gov



2017 VA/DoD CLINICAL PRACTICE GUIDELINE

- Keeping up with the rapidly expanding evidence base for PTSD treatment represents a difficult challenge for most clinicians.
- The VA/DoD PTSD guideline is designed to **support clinical decision making with evidence-based recommendations**, not to define VA/DoD standards of care or policy.



www.healthquality.va.gov/guidelines/MH/PTSD



HOW EFFECTIVE ARE THE BEST TREATMENTS?



Trauma-focused
Psychotherapy

54 OUT OF **100**

people who receive trauma-focused psychotherapy will no longer have PTSD after about 3 months of treatment.



Medication

47 OUT OF **100**

people who take medication will no longer have PTSD after about 3 months of treatment.



No Treatment

12 OUT OF **100**

people who don't get treatment will no longer have PTSD after about 3 months.

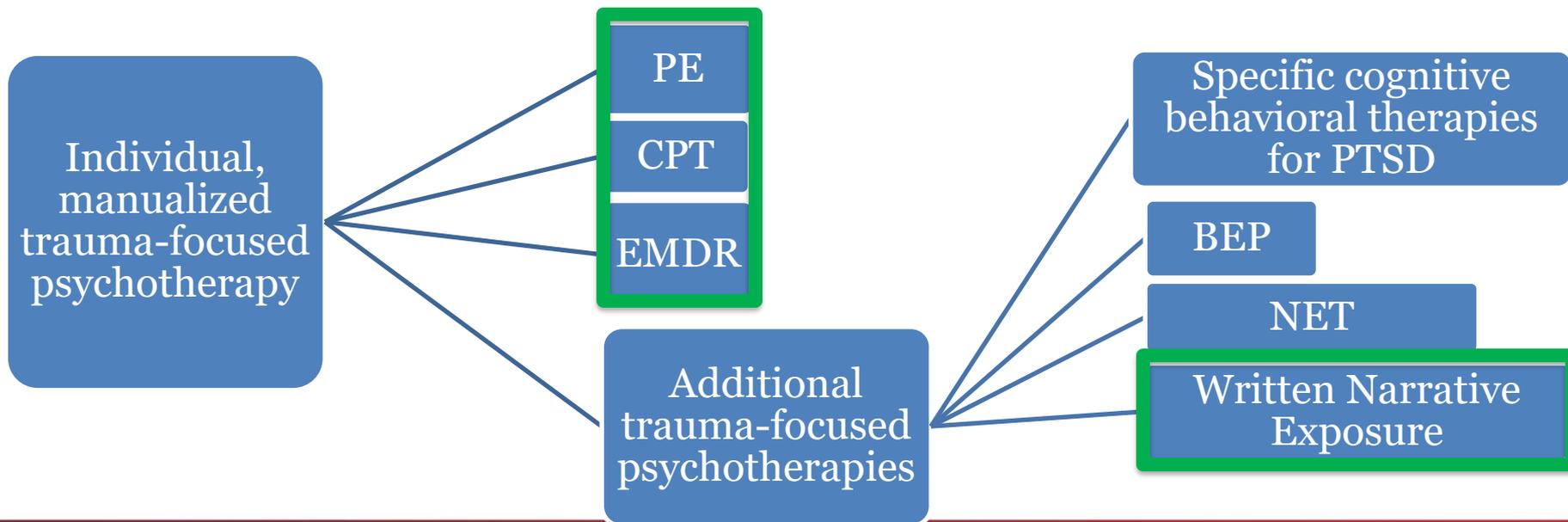
www.ptsd.va.gov/publications/print/PTSD_Best_Treatment.pdf

Hamblen et al., 2022



INDIVIDUAL TRAUMA-FOCUSED PSYCHOTHERAPY

***We recommend* individual, manualized trauma focused psychotherapies that have a primary component of exposure and/or cognitive restructuring to include Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), specific cognitive behavioral therapies for PTSD, Brief Eclectic Therapy (BEP), Narrative Exposure Therapy (NET), and written narrative exposure.**





MEDICATIONS

- Currently recommended:
 - Sertraline (Zoloft) 150mg-200mg (FDA approved)
 - Paroxetine (Paxil) 20mg-60mg (FDA approved)
 - Fluoxetine (Prozac) 20mg-80mg
 - Venlafaxine (Effexor) 225mg-450mg
- Recommended in most clinical practice guidelines
- Can also treat co-morbid depression/anxiety



- Commonly used but not established/
recommended:
 - Other antidepressants
 - Augmentation strategies (e.g., buspirone)
 - Prazosin for nightmares
- Recommended *against*:
 - Benzodiazepines
 - Risperidone and other atypical antipsychotics



Emerging treatments





EMERGING TREATMENTS

- Massed delivery of psychotherapy
- MDMA-Assisted Psychotherapy
- Psychedelics: ketamine, cannabinoids, psilocybin, ayahuasca, others
- Transcranial Magnetic Stimulation (TMS)
- Cranial Electrotherapy Stimulation (CES)
 - E.g., Alpha-Stim, Fisher-Wallace
- Stellate Ganglion Block (SGB)
- Neurofeedback
- Hyperbaric Oxygen Therapy (HBOT)
- (Others: electroconvulsive therapy, vagus nerve stimulation, transcranial direct current stimulation, deep brain stimulation, d-cycloserine)



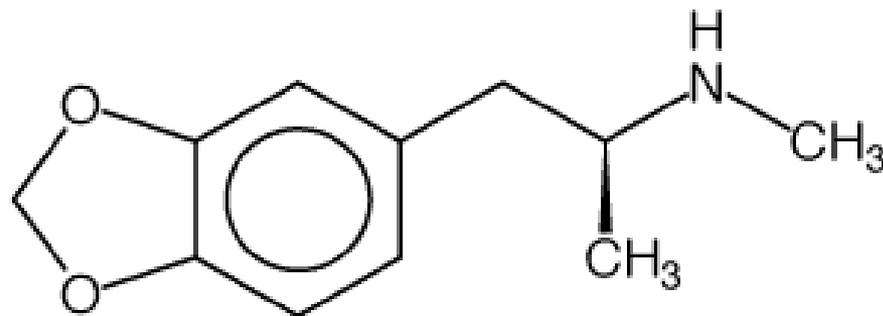
MASSED DELIVERY OF PSYCHOTHERAPY

- Trauma-focused PTSD psychotherapy massed delivery
 - 3 or more times per week
 - Well tolerated, feasible
 - Innovative delivery to decrease avoidance and help reduce barriers to engagement and treatment completion
 - Similar treatment outcomes to weekly treatment delivery

Held et al., 2020; Rauch et al., 2020; Scarrino et al., 2020; Wachen et al., 2019; Yamakowski et al., 2022; Yasinski et al., 2017)



MDMA-ASSISTED PSYCHOTHERAPY



3,4-Methylenedioxyamphetamine (MDMA, ecstasy)

- First synthesized in 1912
- Psychoactive effects reported in 1960's-70's: euphoria, increased sociability and self-confidence
- Adverse effects: dehydration, hyperthermia
- First combined with psychotherapy in 1970's
- “Emergency” Schedule I designation in 1985



MDMA-ASSISTED PSYCHOTHERAPY

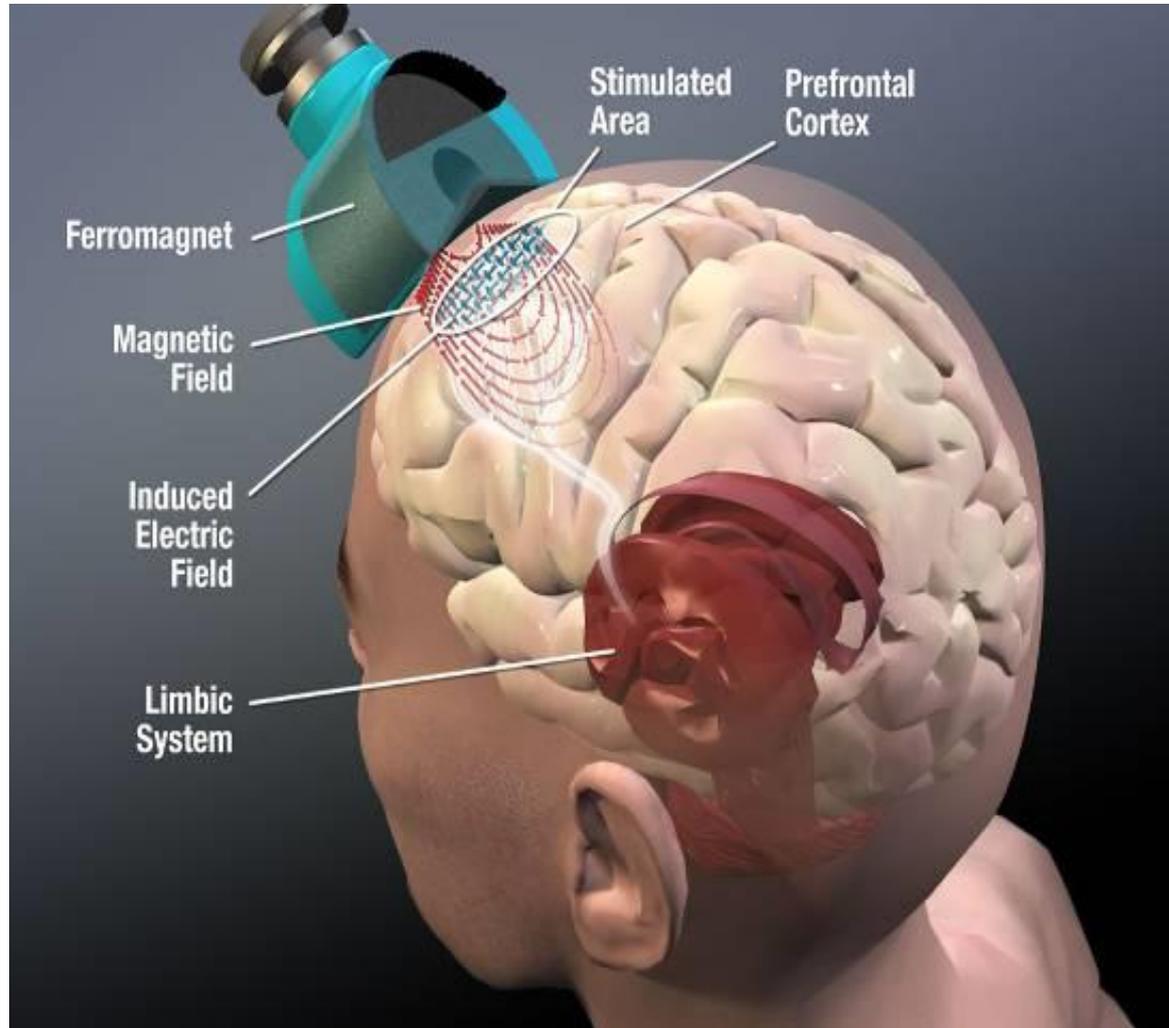
- Novel form of psychotherapy:
 - Two 8-hour psychotherapy sessions one month apart; two therapists present
 - MDMA given prior to each session
 - Preparatory and “integration” sessions before and after each session
- Efficacy
 - Several, small randomized, controlled trials suggest efficacy
 - One larger RCT (n=90) supported efficacy (MAPS)
 - Studies have differed in control conditions making blinding difficult and increasing likelihood of bias
- Confirmatory trial underway (MAPS)
 - Has received “breakthrough therapy” designation from FDA to fast-track approval decision



- Ketamine
 - Clear, rapid benefit for treatment-resistant depression; currently available clinically in IV and intranasal forms
 - Three randomized controlled trials in PTSD:
 - Single dose in community sample (n=41) showed benefit
 - Repeated doses in community sample (n=30) showed more sustained benefit
 - Repeated doses in active-duty/veteran sample (n=158) showed benefit for depressive symptoms but not PTSD
- Cannabinoids: negative RCT for smoked cannabis for PTSD
- Psilocybin, ayahuasca, others: no data



TRANSCRANIAL MAGNETIC STIMULATION (TMS)



- Uses rapidly changing magnetic field to induce current in cortex
- Depolarizes cortical neurons focally
- Distant effects in connected regions throughout the network
- Non-invasive, no anesthesia, patient awake during stimulation



rTMS: ANTIDEPRESSANT EFFICACY

- Studied for depression since 1993
- Multiple meta-analyses confirm statistically significant antidepressant effects
 - Response rates ~20%-40%; up to 60% open-label
- Two large, multi-center trials (combined N= \sim 500) demonstrate antidepressant effects of left dorsolateral prefrontal 10 Hz rTMS
- FDA-cleared in 2008



- Multiple FDA-cleared TMS devices
- Several variations in stimulation approach





- Studied since 1998
- Meta-analyses support efficacy for PTSD, but:
 - Heterogeneity in parameters
 - Small sample size
- May have benefit when provided together with evidence-based psychotherapy



CRANIAL ELECTROTHERAPY STIMULATION



'The Black Box' (MECANET Model IV) as shown on the BBC film, with Meg demonstrating the controls. 1980



Meg with Pete Townshend, after his treatment. 1982

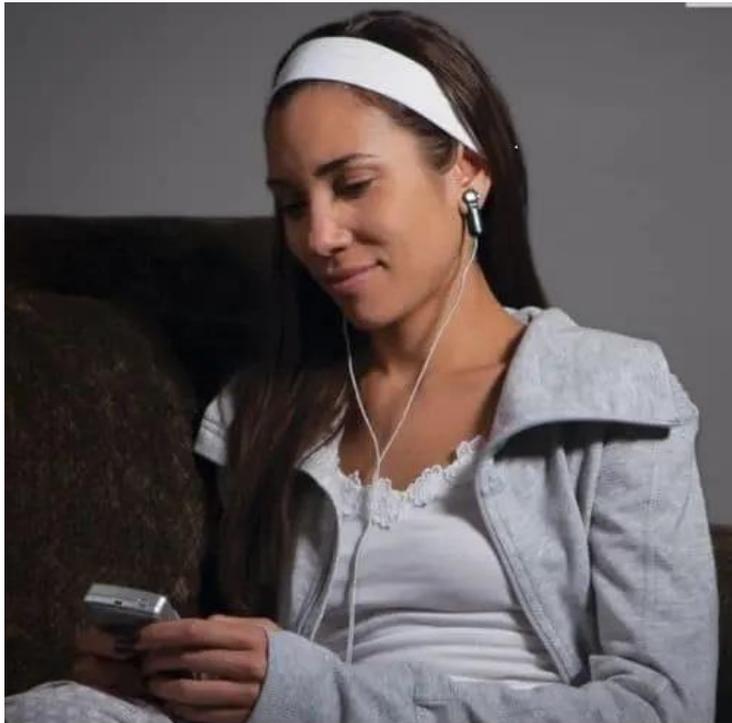


CRANIAL ELECTROTHERAPY STIMULATION

- Two or more cutaneous electrodes
 - Similar to TENS, but not TENS
- Parameters:
 - Alternating current (not TMS)
 - 0.5 to >60 Hz; up to 4 mA
 - ~30 min stimulation per day
 - Can be used over several days
- Mechanism:
 - Does not depolarize neurons
 - May alter cortical excitability of underlying cortex
 - May alter concentrations of various neurotransmitters



CRANIAL ELECTROTHERAPY STIMULATION





CRANIAL ELECTROTHERAPY STIMULATION FOR PTSD

- CES is *FDA-cleared* for treatment of depression, anxiety, insomnia
- Very limited database on efficacy (e.g., few RCTs, suboptimal symptom scales, small sample size)
- No high-quality data exist for CES for treatment of any psychiatric disorder, including PTSD
- Recent open-label, uncontrolled trial suggests benefit for PTSD (Rustad et al., 2022)



Rustad et al., 2022: Results

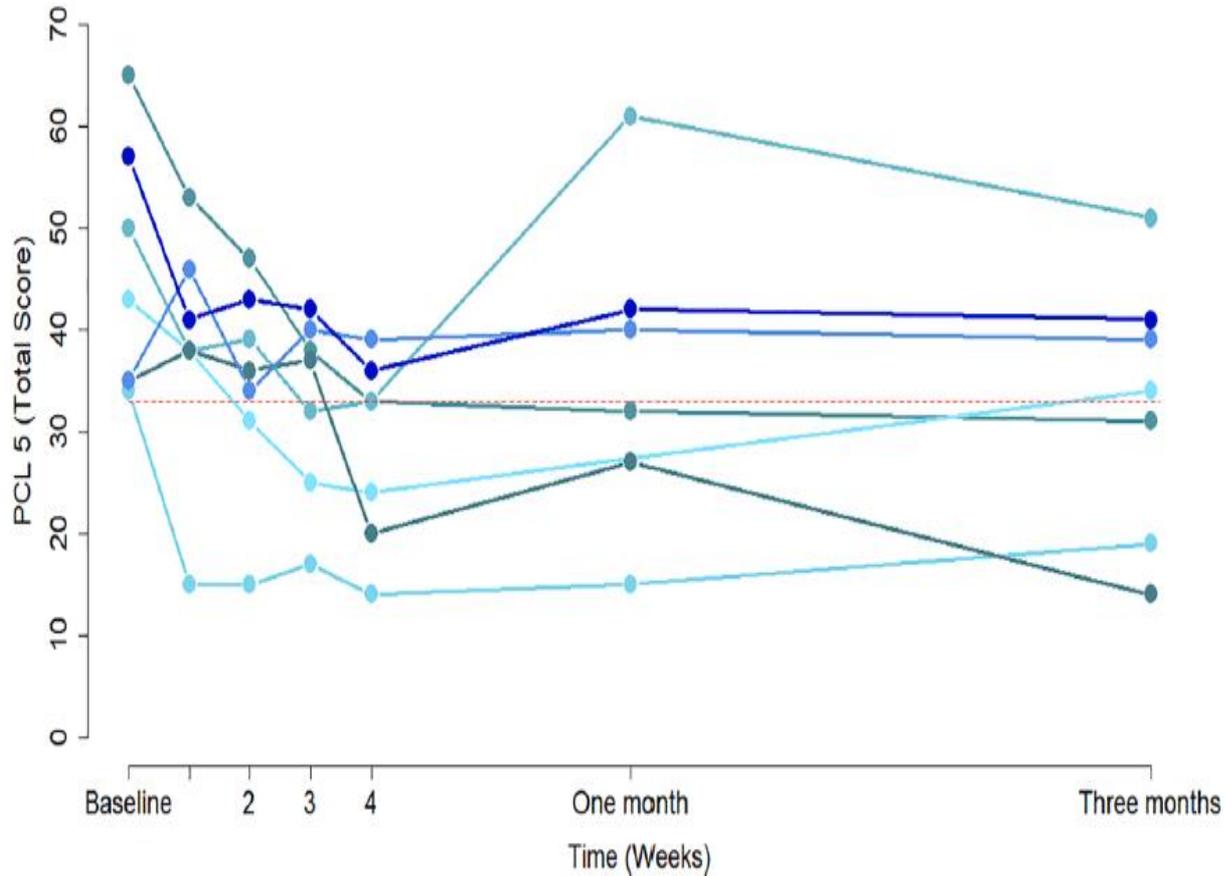
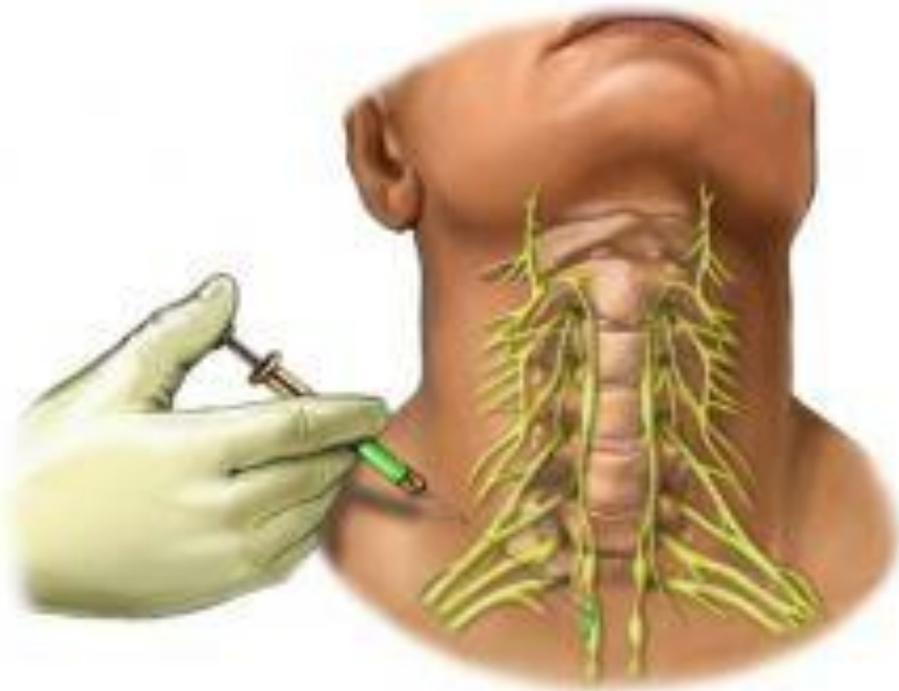


Fig. 1. Total PCL-5 over time by individual Change in PCL-5 total score by individual. Dashed line indicates threshold for presumed loss of diagnosis (PCL-5 total score of 33).



STELLATE GANGLION BLOCK (SGB)



- Local anesthetic injected into neck
- Target: stellate ganglion of sympathetic nervous system
- Efficacy for Complex Regional Pain Syndrome (aka Reflex Sympathetic Dystrophy)



STELLATE GANGLION BLOCK (SGB) FOR PTSD

- Proposed mechanism: modulating the sympathetic nervous system might alter autonomic activity in PTSD
- May specifically work via ameliorating hyperarousal
- Efficacy:
 - Several case series suggesting benefit
 - RCT (n=41): no benefit of SGB vs. sham
 - RCT (n=113): SGB superior to sham for PTSD symptom improvement



SGB FOR PTSD: DATA LIMITATIONS

- Short duration of follow-up (~6-8 weeks)
- RCT data collected in largely active duty (not VA) population
 - Less chronic?
 - Less severe trauma history?
 - Fewer comorbidities?
- Study design not triple-blind (person doing SGB aware of treatment arm)



SGB FOR PTSD

- Generally safe, well-tolerated
- Common side effects: neck pain, stiffness, Horner's syndrome
- Rare side effect: pneumothorax
- *Not* regulated by the FDA
- Not recommended for the treatment of PTSD; large VA study ongoing



NEUROFEEDBACK

- A form of biofeedback where patients are trained to modulate brain activity via real-time EEG/fMRI feedback
- Efficacy:
 - Several studies validating proof of principle
 - RCT (N=52): EEG-based NF showed statistically significant improvements in PTSD vs. waitlist
 - Additional trials support benefit but often using different paradigms
- Safety: no concerns
- Not currently recommended for PTSD; research ongoing





HYPERBARIC OXYGEN THERAPY (HBOT)





HYPERBARIC OXYGEN THERAPY (HBOT)

- FDA-cleared for decompression sickness, carbon monoxide poisoning and several other medical conditions
- Not FDA-cleared for any psychiatric condition
- Efficacy: Three negative RCTs
- A fourth RCT showed acute benefits for post-concussive symptoms and PTSD after 13 weeks
 - BUT, positive PTSD effects were no different from sham at 6 months
 - No benefits of HBOT vs. sham at 12 months



HYPERBARIC OXYGEN THERAPY (HBOT)

- Generally safe and well-tolerated
- Common, mild side effects:
 - Sinus pain, ear pressure, joint pain
- Rare, serious side effects:
 - Air embolism, paralysis



All resources are free and publicly available.

Unless otherwise noted, you can find them at www.ptsd.va.gov





Trauma-Informed Care

Realize the Prevalence

Recognize the Impact

4 R's of Trauma-informed Care

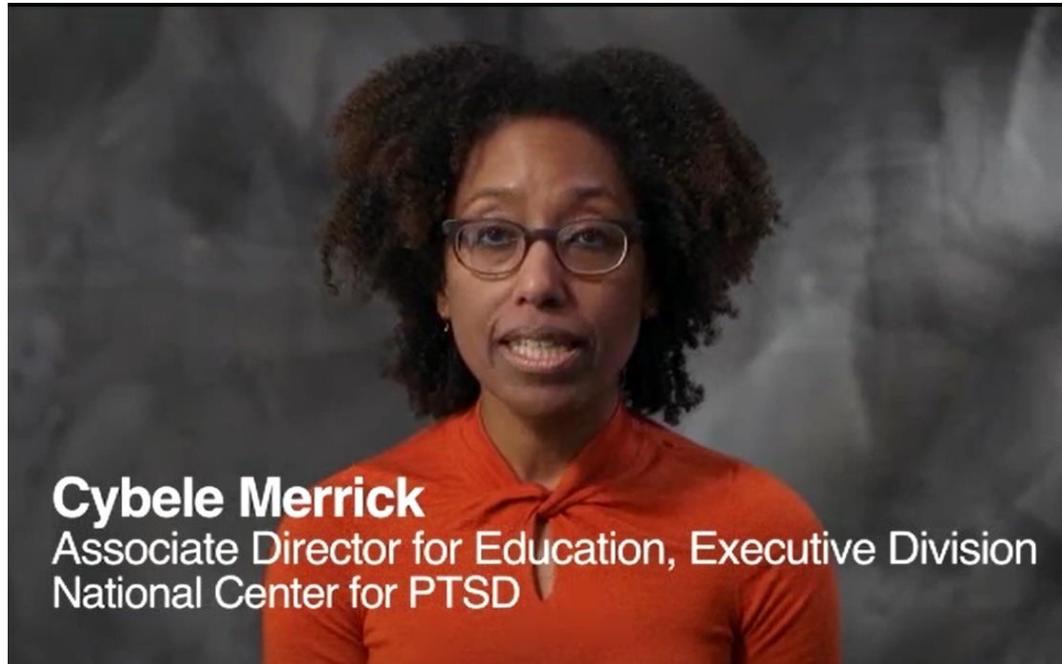
Respond Appropriately

Resilience through
Skill-building

[Health Care Provider's Guide to Trauma-Informed Care \(army.mil\)](http://army.mil)



PTSD Awareness in Health Care Settings



- This 15-minute video for medical center staff shows how patients' PTSD symptoms may come into play in health care settings.
- Facilitator's guide for PTSD Awareness in Health Care Settings



AboutFace VIDEO GALLERY

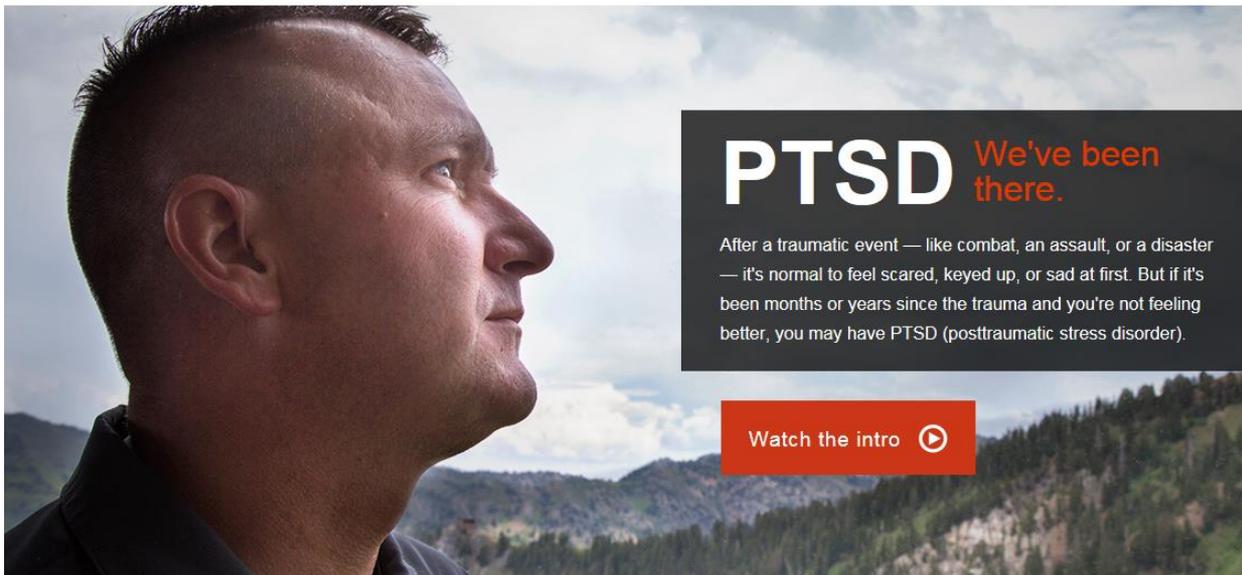
ABOUTFACE

Home

Watch ▼

Learn More ▼

Get Help



PTSD We've been there.

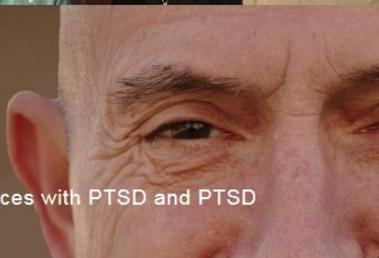
After a traumatic event — like combat, an assault, or a disaster — it's normal to feel scared, keyed up, or sad at first. But if it's been months or years since the trauma and you're not feeling better, you may have PTSD (posttraumatic stress disorder).

Watch the intro 



This is AboutFace

In these videos, Veterans, family members, and clinicians share their experiences with PTSD and PTSD treatment. Choose a topic below to hear what they have to say.



www.ptsd.va.gov/aboutface



MAKE THE CONNECTION



U.S. Department
of Veterans Affairs

*I'm a Veteran.
I know what it's like.*

**MAKE THE
CONNECTION**

www.MakeTheConnection.net



Hear my story at
MakeTheConnection.net

www.maketheconnection.net



WHITEBOARD VIDEOS

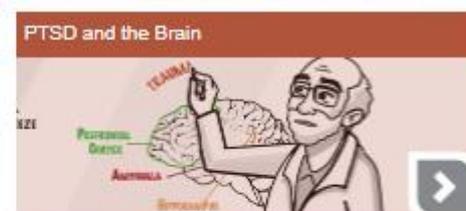
- NCPTSD created a series of whiteboards, including one for professionals about PTSD and effective treatments.
- Short (~3 minute), engaging videos that are easily shared via email or Facebook.

Whiteboards

Watch these short animated videos to learn about PTSD and effective treatments.



<https://www.ptsd.va.gov/appvid/video/index.asp>



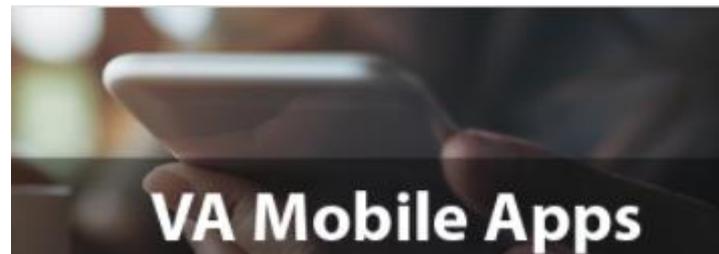


INTEGRATING TECHNOLOGY INTO CARE

Tech into Care



<https://www.ptsd.va.gov/professional/tech-care/>



[Mobile Apps - PTSD: National Center for PTSD \(va.gov\)](https://www.ptsd.va.gov/professional/tech-care/)



MOBILE APPS TO SUPPORT TREATMENT & SELF-CARE

Self-Help

- These apps provide support and guidance in living with PTSD.

Treatment Companion

- These apps offer additional help for PTSD treatments.

Related

- These apps help with related issues affecting people with PTSD.

<https://www.ptsd.va.gov/appvid/mobile/index.asp>



PRESCRIPTION FOR BEHAVIORAL HEALTH

Mobile & Web Resources

- | | | | | | | | | |
|--------------------------|---|--|--------------------------|--|--|--------------------------|--|---|
| <input type="checkbox"/> |  | ACT Coach
  | <input type="checkbox"/> |  | COVID Coach
  | <input type="checkbox"/> |  | PE Coach
  |
| <input type="checkbox"/> |  | AIMS for Anger Management
www.veterantraining.va.gov
   | <input type="checkbox"/> |  | Insomnia Coach/
Path to Better Sleep
www.veterantraining.va.gov
   | <input type="checkbox"/> |  | PTSD Coach/Online
https://go.usa.gov/xN9Hb
   |
| <input type="checkbox"/> |  | Beyond MST
  | <input type="checkbox"/> |  | Mindfulness Coach
  | <input type="checkbox"/> |  | PTSD Family Coach
  |
| <input type="checkbox"/> |  | CBT-i Coach
  | <input type="checkbox"/> |  | Moving Forward
www.veterantraining.va.gov
 | <input type="checkbox"/> |  | STAIR Coach
 |
| <input type="checkbox"/> |  | CPT Coach
  | <input type="checkbox"/> |  | Parenting
www.veterantraining.va.gov
 | <input type="checkbox"/> |  | VetChange
www.ptsd.va.gov/apps/change
   |
| <input type="checkbox"/> |  | Couples Coach
  | RECOMMENDATION: | | | | | |



PTSD COACH APP



- App provides:
 - Education about PTSD and PTSD treatment
 - A self-assessment tool
 - Portable skills to address acute symptoms
 - Direct connection to crisis support
- Used as stand-alone education and symptom management tool, or with face-to-face care
- Tools are easily accessible when they are needed most

www.ptsd.va.gov/appvid/mobile/ptsdcoach_app.asp



PTSD Coach online



skip to content

National Center for PTSD
Posttraumatic Stress Disorder

PTSD COACH ONLINE

VA

U.S. Department of Veterans Affairs
Veterans Health Administration
National Center for PTSD

Home FAQs

I want to work on my

Choose a problem to work on from the list or [view all tools](#)

worry or anxiety

- anger
- sadness or hopelessness
- sleep problems
- trauma reminders
- avoidance of stressful situations
- disconnection from people
- disconnection from reality
- problem solving skills
- direction in life

Welcome to PTSD Coach Online.
Tools to help you manage stress.

VA PTSD Coach Online: Intr...

Cybele Morris, MA, MS
Education Specialist
National Center for PTSD

Meet a coach

PTSD Coach Online is for anyone who needs help with upsetting feelings. Trauma survivors, their families, or anyone coping with stress can benefit.

www.ptsd.va.gov/apps/ptsdcoachonline

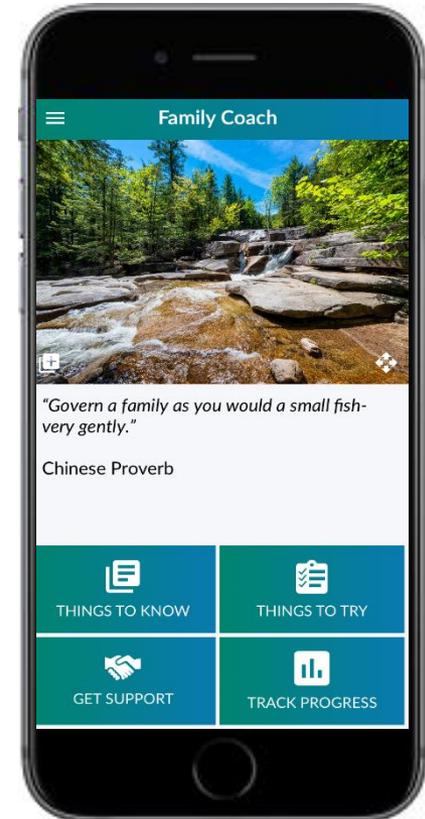
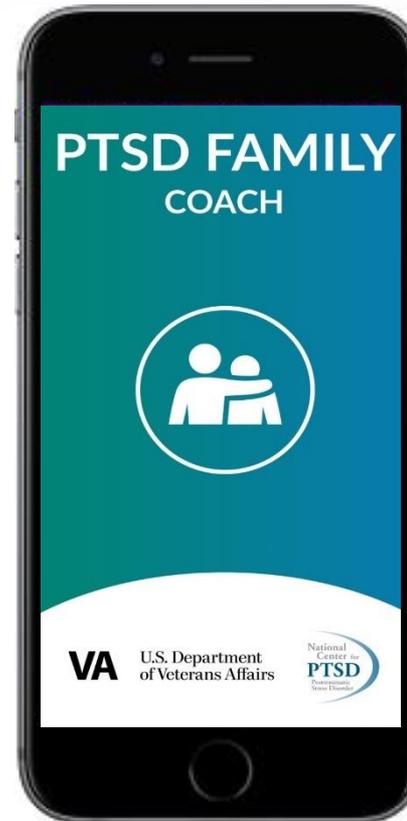


PTSD FAMILY COACH APP

PTSD Family Coach is for family members of those living with PTSD.

App provides:

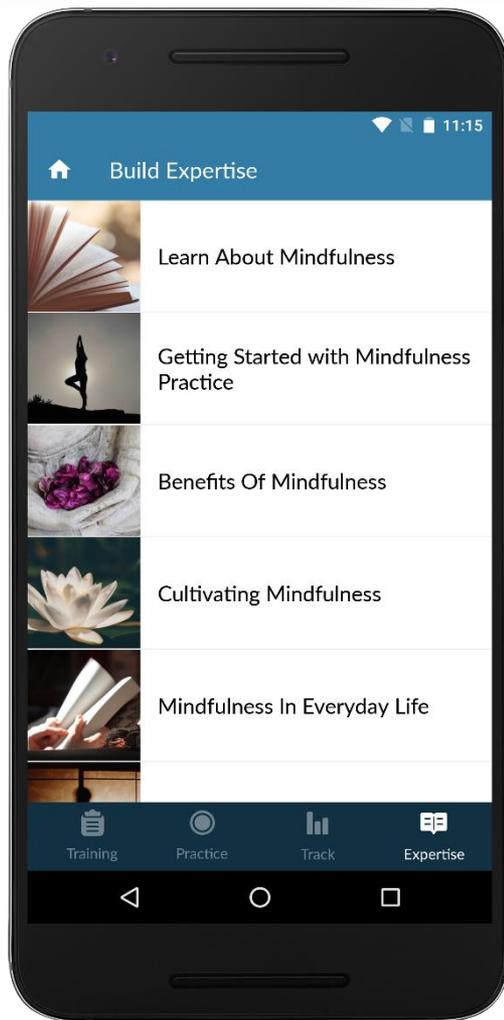
- Education about PTSD and self-care
- Information to help take care of your relationship and children
- Resources to help a loved one get treatment for PTSD
- Tools to manage stress and build social networks
- Tracking for stress level over time



www.ptsd.va.gov/appvid/mobile/familycoach_app.asp



MINDFULNESS COACH APP



- Education about the benefits of mindfulness
- Mindfulness exercises to practice on your own or with guidance
- Strategies to help overcome challenges to mindfulness practice
- Log of mindfulness exercises to track your progress
- Reminders to support your mindfulness practice

https://www.ptsd.va.gov/appvid/mobile/mindfulcoach_app.asp



VETCHANGE ONLINE TOOL AND MOBILE APP

VETCHANGE Helping Veterans Help Themselves

My Dashboard - Using VetChange About Resources - Welcome newuser

Welcome to **VETCHANGE** [Get Started](#)

A free online program for Veterans concerned about their drinking

VetChange is a free self-management program for active duty military and Veterans concerned about their drinking. VetChange can help you build skills to better manage your drinking and other problems that can happen after deployment, including symptoms of posttraumatic stress disorder (PTSD).

Register now to get started, read more about the program, or view this video to learn how VetChange can help you:

With VetChange you'll be able to:

- Set goals**
Do you want to stop drinking, or cut back? Make the choice that's right for you.
- Track your progress**
See what's working with daily check-ins and personalized feedback.
- Educate yourself**
Learn to manage risky situations for drinking—like stress, sleep, anger, or other feelings.

VetChange is a self-management program designed for Veterans and active duty Servicemembers who are concerned about their drinking.

This tool helps users learn skills to manage drinking and other problems that can happen after deployment (e.g., PTSD symptoms, anger, trouble sleeping).

www.ptsd.va.gov/apps/change





Resources from the National Center for PTSD

www.ptsd.va.gov/COVID



[Mobile App: COVID Coach](#)

Coronavirus (COVID-19): Resources for Managing Stress

For Everyone

For Health Care Workers and Responders

For Employers and Community Leaders



INCLUDES A VARIETY OF RESOURCES FOR

- Everyone (including Veterans, their families, and the general public)
- Health Care Workers and Responders
- Employers and Community Leaders



Coping with Current Events in Ukraine



[Coping with Current Events in Ukraine - PTSD: National Center for PTSD \(va.gov\)](#)

[Provider Guide to Addressing Veterans' Reactions to Current Events in Ukraine - PTSD: National Center for PTSD \(va.gov\)](#)



PROVIDER SELF-CARE TOOLKIT

Provider Toolkit

Home

Working with Trauma Survivors

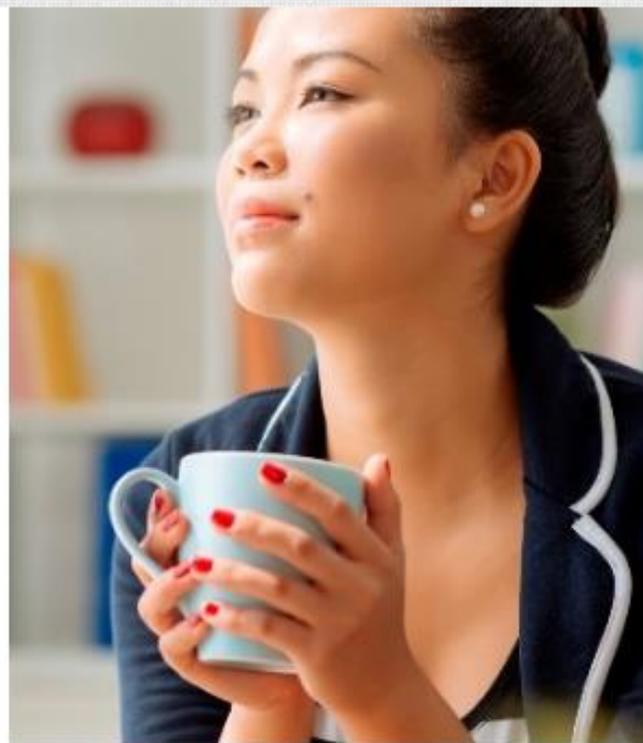
Self-Assessment

Self-Help Strategies

Resources

Provider Self-Care Toolkit

This toolkit is for providers who work with those exposed to traumatic events, to help reduce the effects of job-related stress, burnout, and secondary traumatic stress. Working with trauma survivors is rewarding, yet such work can create challenges. Hearing trauma survivors' stories can be difficult and some providers may find they experience burnout or secondary traumatic stress as a result. In this toolkit you will find assessment tools, strategies, and resources to help you care for yourself while working with those who have experienced trauma or have posttraumatic stress disorder (PTSD).



www.ptsd.va.gov/professional/treat/care/toolkits/provider/



COMMUNITY PROVIDER TOOLKIT

Community Provider Toolkit

Asking about Military Experience

Working with Veteran Populations

Supporting Veteran Mental Health & Wellness

Navigating Veteran Benefits & Services



Information &
Resources for
Providers who
Serve Veterans

<https://www.mentalhealth.va.gov/communityproviders/index.asp>



RURAL PROVIDER TOOLKIT

Rural Provider PTSD Toolkit

Home

Rural Health Care
Realities

Ensuring Core PTSD
Services

Optimizing Rural
Care

The Right Tool
for the Job

Welcome to the Rural Provider PTSD Toolkit. Both Veterans with a diagnosis of PTSD and providers working to deliver care to them in rural settings face unique challenges. In particular, disparities in the availability and use of effective psychotherapies and medications have been noted.

This toolkit compiles information and resources to help you, the rural health care provider. By recognizing the benefits and barriers of rural care provision, you can improve the lives of rural Veterans with PTSD by reducing obstacles to effective treatments and improving care coordination between Veterans Affairs (VA) and community services. Learn how to access tools that optimize PTSD care, support your patients, and help you manage your own self-care.



<https://www.ptsd.va.gov/professional/treat/care/toolkits/rural/>



CONTINUING EDUCATION COURSES

Over 50 hours of web-based courses aimed at professionals.

All courses are **free** and most offer continuing education for multiple disciplines.

Courses can be viewed without intention to seek certification credits.



Learn from the experts and get CE/CME Credit!

Research-based courses at your convenience (24/7).

[Find a Course](#)



**MISSION Act Section 133:
PTSD Course for Community Providers**

**Understanding the Context
of Military Culture in
Treating the Veteran with PTSD**

www.ptsd.va.gov/professional/continuing_ed/index.asp



PTSD_{pubs}

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This database, formerly called PILOTS, is produced by the U.S. Department of Veterans Affairs National Center for PTSD. The database provides citations and abstracts to the worldwide literature on PTSD and other psychological effects of trauma.

[Want to Learn More?](#)

PTSD_{pubs} database (formerly PILOTS) is a freely available, online database providing access to the worldwide literature on PTSD and other mental health consequences of exposure to traumatic events. It is produced by the National Center for PTSD.

<https://www.proquest.com/ptsdpubs/index>



STAY UP TO DATE AND CONNECT WITH US

CLINICIAN'S TRAUMA UPDATE

CTU-ONLINE | www.ptsd.va.gov

ISSUE 15(5)
OCTOBER 2021

TREATMENT

EBPs for PTSD delivered by telehealth in clinical practice

Outcomes for EBPs for PTSD delivered via telehealth are comparable to those of EBPs delivered in-person (e.g., see the August 2015 CTU Online). Increasing understanding of the real-world effectiveness of different types of telehealth delivery of EBPs for PTSD is of particular importance given the increased use of telehealth during the ongoing COVID-19 pandemic. Investigators at the Fargo VA Health Care System used medical record data to compare outcomes in PE and CPT delivered via video-to-home, clinic-to-clinic telehealth, and in-person among rural Veterans. The study included 587 Veterans in the Fargo VA catchment area who started CPT or PE and completed measures of PTSD (PCL-5) and depression (BDI-II) during treatment. Neither outcomes ($d = 0.5$ for both PTSD and depression), treatment completion (defined as completing 8 or more sessions), nor homework compliance differed across treatments and delivery modalities. The video-to-home group had the highest treatment completion (50%) and attended the highest number of sessions (8.9), and the clinic-to-clinic telehealth group had the lowest (46.0% and 6.2, respectively), although the authors did not report the statistical significance of these differences. Nevertheless, the study's findings suggest that video-to-home promotes treatment engagement and further support the delivery of EBPs for PTSD via telehealth as a viable strategy for increasing access to care, particularly among rural Veterans.

Read the article: <https://doi.org/10.1037/a0049000>
Knaflitz, C. H., & Nelson, K. G. (2021). PTSD telehealth treatments for veterans: Comparing outcomes from in-person, clinic-to-clinic, and home-based telehealth therapies. *Journal of Rural Mental Health, 45*, 243-255. <https://doi.org/10.1080/15338420.2021.1913948>

New research explores accelerated deliveries of CPT

CPT is traditionally delivered once or twice weekly over the course of 6-12 weeks. Massed or intensive formats utilize an accelerated schedule to deliver treatment more frequently and over a shorter period, than the standard weekly format. Two recent studies provide new insights on the efficacy of accelerated CPT delivery. A team led by investigators at the National Center for PTSD tested the relative effectiveness of massed CPT compared with standard weekly delivery of CPT in women survivors of intimate partner violence (58% White, age range = 21-55) with PTSD. The multiple subject, single case design ($N = 12$) matched six pairs of participants receiving massed or standard CPT on criteria such as 18th history PTSD severity, and demographic characteristics. Massed treatment was delivered in 12 1-hour sessions over 9 days and standard treatment once weekly for 12 weeks. Both conditions showed large improvements in PTSD symptoms from pre- to post-treatment (massed $d = 1.92$; standard $d = 1.32$) and from pretreatment to 3-month follow-up (massed $d = 1.55$; standard $d = 2.38$), with no difference between modalities. Depression, stress, and anxiety also significantly improved, with no differences between modalities. Although the small sample limited power to find statistical differences between groups, results suggest that CPT can be effectively delivered over a brief period with female civilian survivors of IPV.

As in standard-length treatments, individual responses to intensive treatments for CPT vary. Investigators at Rush University Medical Center examined trajectories of symptom change among Veterans completing CPT within a 3-week intensive PTSD program. Participants were 452 Veterans with PTSD (86% male, 68% White, average age = 41). Veterans received 14 daily 50-minute sessions of individual CPT, 13 daily 120-minute sessions of group CPT and daily group sessions of mindfulness, yoga, and psychoeducation. Self-report symptoms were assessed at

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Moral Injury

Over the past decade, the concept of moral injury has garnered a great deal of attention from Veterans, clinicians, researchers, and the general public. The concept resonates with many because it captures the emotional and spiritual pain that can occur when deeply held values are violated. Yet, there is a great deal of work to do to understand the underpinnings of moral injury and how to best identify, measure, and effectively intervene to improve its core emotional, cognitive, and behavioral symptoms. Below we summarize what we know about moral injury and identify critical areas for further research.

Definition and Model

There is currently no consensus definition or conceptual model of moral injury. The most frequently used definition and model was proposed by Litz and colleagues (2009) who stated that moral injury is "perpetrating, failing to prevent, bearing witness to, or hearing about acts that transgress deeply held moral beliefs and expectations" about the rules or codes of conduct. Further, they proposed that for moral injury to occur, individuals must experience a potentially morally injurious event (PMIE) that is perceived as a transgression of deeply held morals or values. PMIEs can involve acts of commission which are doing something that goes against values like killing; acts of omission that are failing to do something in line with values; or witnessing or hearing about acts that are immoral. Moral injury is the resulting psychological, behavioral, social and sometimes spiritual distress and associated hallmark symptoms such as guilt, shame, anger, and/or disgust. Moral injury is also characterized by an inability to self-forgive, engagement in self-sabotaging behaviors, and

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elevated suicide risk. Some have argued that betrayal is also part of the moral injury construct, particularly by leadership in a high stakes situation such as combat (Shay, 2014), while others postulate that betrayal should be considered a separate construct or an associated symptom of moral injury.

Assessment

Moral injury measures have thus far been primarily validated with Veterans and ask about PMIEs that may occur in the context of war. The measures generally assess either exposure to PMIEs or moral injury symptoms (e.g., guilt), sometimes without clearly indexing to specific PMIEs. These measures do not have validated cut scores for either items or the entire scale, and moral injury is measured by creating a sum score. It is unclear if existing measures are valid to measure change over time or treatment, as most measurement studies are cross-sectional. There are measures currently under development that will fill some of the gaps in the currently available measures. The most widely used and first measure for moral injury assessment, the Moral Injury Events Scale (MIES; Nash et al., 2018), assesses exposure to PMIEs related to perpetration (omission and commission), witnessing, and betrayal, and asks whether individuals are troubled by these experiences as a proxy for distress.

Prevalence

The few studies that have looked at prevalence rates of moral injury have focused on Veterans and almost all used the MIES. A study of United States (US) combat Veterans using data from the National Health and Resilience in Veterans Study (NHRVS);

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U.S. Department of Veterans Affairs
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Be Present with Mindfulness Practice - PTSD Monthly Update, October 2021
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April 20, 2022	PTSD Treatment for Veterans with Disabilities	Erin Andrews, PsyD, ABPP
May 18, 2022	Eye Movement Desensitization and Reprocessing (EMDR) to Treat PTSD	Sonya Norman, PhD & Marianne Silva, LCSW
June 15, 2022	Ethical Considerations in Shared Decision-Making for PTSD Treatment	Lisa-Ann Cuccurullo, Psy.D
July 20, 2022	Troubleshooting Lack of Progress in PTSD Treatment	Abigail Angkaw, PhD & Cynthia Yamokoski, PhD



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Questions?



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