“PTSD UPDATES” webinar  10am-12.30 Pacific time

Housekeeping
Keeping to time. Submit questions using the chat feature on BlueJeans. Please submit your question with the name of the presenter.

Link to slides: bit.ly/ptsdslides  Link to survey: bit.ly/ptsdsurvey  Please give us your feedback!

Presenters and topics:

10.00AM Pros and Cons of the 2014 Institute of Medicine Report.  Thomas Neylan, M.D.

10.20AM Group Skills Training and Affective Interpersonal Regulation (STAIR): The benefits of skills focused intervention.  Marylene Cloitre, Ph.D.

10.40AM Improving Veterans’ Access to Evidence-Based Psychotherapy for PTSD – How Are We Doing?”  Craig Rosen, Ph.D.

11.00AM Clinical Approaches for Women Veterans with PTSD.  Julie Weitlauf, Ph.D.

11.20AM Tech/mobile interventions for PTSD.  Eric Kuhn, Ph.D.

11.40AM What’s new in fear?  Steve Woodward, PhD.

12.00PM How can we get better at this: What will it take to improve our PTSD care for veterans?
10.00AM

Pros and Cons of the 2014 Institute of Medicine Report

*Thomas Neylan, M.D.*

Director of the Posttraumatic Stress Disorders (PTSD) Program at the San Francisco Veterans Affairs Medical Center (VAMC), Deputy Associate Chief of Staff for Research at VAMC and Professor, Psychiatry, University of California San Francisco.

Please ensure your audio is on mute. Questions may be submitted using the chat on the right side of the screen. Please submit your question with the name of the presenter.

Link to slides: bit.ly/ptsdsslides  
Link to survey: bit.ly/ptsdsurvey

Please give us your feedback!
Pros and Cons of the 2014 Institute of Medicine Report

Thomas C. Neylan, M.D.
San Francisco VAMC
VISN21 MIRECC
University of California, San Francisco
Background

• 2010 National Defense Authorization Act

• Two-phase study
  • Phase 1 - collect data in VA/DoD on prevention, screening, diagnosis, intervention & rehab
  • Phase 2
    • analyze data and determine rates of success
    • Focus on targeted intervention for active duty
    • Identify research gaps
Phase 1 Report

• Published 2012

• Literature review, 2 public meetings, ad hoc meetings, some VA administrative data

• Five action items
  • Collect and analyze data of all services
  • Implement evidence-based treatments
  • Innovate
  • Overcome barriers
  • Integrate PTSD and primary care
Phase 2 Report - Process

• Site visits

• More detailed review of ongoing research

• Focused inquiry on implementation of evidence-based treatments

• More data gathering - less analysis of data collected in Phase 1
Phase 2 Report Summary

PTSD Management

- DoD
  - “Local, ad hoc, incremental, crisis-driven”
  - Variation across service branches

- VA
  - More unified organizational structure
  - Has PTSD-related performance measures
  - Unclear if performance measures are being met
Phase 2 Report Summary
Leadership and Communication

• DoD
  • Inconsistencies in implementation
  • No overarching authority to enforce PTSD related services

• VA
  • Engagement by leadership in PTSD varies
  • Inconsistent adherence to guidelines
Phase 2 Report Summary
Performance Measurement

• Neither VA or DoD systematically collect data to identify best practices

• VA not fully utilizing potential to track PTSD outcomes in outpatient treatments

• Best VA outcome data limited to specialized intensive PTSD programs (SIPP)

• Most VA PTSD patients are not in specialized PTSD programs
Phase 2 Report Summary
Workforce and Access to Care

• Both DoD and VA have increased mental health staffing

• Workforce increases have not kept pace with demand

• “Provision of evidence-based treatments also implies refraining from services or programs that lack an evidence base…”

• No requirements that fee basis providers are trained in PE and CPT
Phase 2 Report Summary
Evidence-Based Treatment

- Providers in DoD and VA do not consistently provide evidence-based treatment despite policies and performance metrics

- Both services are embracing alternative treatments

- Both services are exploring mobile health despite obstacles

- Virtual reality
Phase 2 Report Summary

Other

• Central Database of Programs and Services

• Family Involvement

• Research Priorities
  • Overcome barriers, disseminate
  • Better understand biological and psychological processes, develop better markers
  • Understand heterogeneity and differential treatment response, primary and secondary prevention strategies
  • Develop new treatments and care models, disseminate
IOM 2014 Report
Pros

• Intensive scrutiny

• Recommendations for Integration, Coordination, and further Research are unassailable

• Recognition of potential of the VA electronic record system to accelerate development of best practices

• Highlights need for adequate workforce
IOM 2014 Report
Cons

• Ad Hoc Process

• Some imbalances in the Committee

• Phase 2 did not actually involve an analysis of data received in Phase 1

• Missed opportunity to better highlight obstacles for implementing EBTs

• Lack of circumspection about the limitations of evidence underpinning treatment guidelines
10.20AM

Group Skills Training and Affective Interpersonal Regulation (STAIR): The benefits of skills focused intervention.

Marylene Cloitre, Ph.D.
Associate Director of Research, Dissemination and Training Division of the National Center for PTSD and Research Professor of Psychiatry and Child and Adolescent Psychiatry at the New York University Langone Medical Center in New York City.

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Please give us your feedback!
Group STAIR
Skills Training in Affective and Interpersonal Regulation

Marylène Cloitre, Ph.D.
Associate Director of Research
National Center for PTSD Division of Dissemination and Training
Palo Alto VA Health Care System
Typical groups in VA for PTSD Clients/
Limited Evidence

• PTSD 101?
• Supportive?
• Anger Management for male Vets (Morland et al, 2010)
• Cognitive Behavior Therapy for male Vets (Sloan, in progress)
Women Veterans?

- No group trials for women Veterans
- 3% of women Veterans health studies are clinical trials
- Research to date has focused on assessment and needs survey
Mental Health Consequences of MST

- Higher rates of PTSD
- Higher rates of co-morbid disorders
- Greater functional impairment
- Request for services to help improve functioning

Maguen et al, 2012
Suris & Lind, 2008
Mattocks et al, 2012
Social and Role Functioning Problems

- Greater difficulty transitioning to civilian life
- Relationship problems
- Low perceptions of social support
- Difficulties coping

Skinner, 2000
Street et al, 2009
Functional Impairment

• Brief streamlined trauma-focused therapies do not consistently improve functioning:

• Pre-to-post effect size Prolonged Exposure = .05 - .47 (Schnurr et al, 2007)

• Effect size for CPT vs WL = .00 - .08 (Monson et al, 2012)
Skills Training in Affective and Interpersonal Regulation (STAIR) focuses on two key skills

- Emotion Regulation (mood management)

- Relationship skills:
  - Partner and family domains
  - Work
  - Social support/social networks
Group STAIR Effective in Civilian Populations

- *Trappler & Neville (2007)* Inpatient STAIR group vs. TAU group (supportive) showed improvement in emotion regulation and social functioning and PTSD (BPRS, IES) while TAU did not.

- *Gudiño et al (2014)* Adolescent girls show improvement in social skills, self-concept, anxiety, depression and PTSD relative to assessment only.
Rationale for building in STAIR as part of clinician toolkit

Addresses a gap: Providing an evidence-based treatment that is skills-focused

Can be used alone or to complement trauma-focused therapies (e.g., PE, CPT)
<table>
<thead>
<tr>
<th>Number</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction: The Impact of Trauma and Group Overview</td>
</tr>
<tr>
<td>2</td>
<td>Emotional Awareness</td>
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<tr>
<td>3</td>
<td>Emotion Regulation: Body Channel</td>
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<td>4</td>
<td>Emotion Regulation: Thought Channel</td>
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<td>5</td>
<td>Emotion Regulation: Behavior Channel</td>
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<td>6</td>
<td>Emotionally Engaged Living—Distress Tolerance</td>
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<tr>
<td>7</td>
<td>Understanding Relationship Patterns</td>
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<td>8</td>
<td>Changing Relationship Patterns</td>
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<tr>
<td>9</td>
<td>Assertiveness and Basic Personal Rights</td>
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<tr>
<td>10</td>
<td>Flexibility in Relationships</td>
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<tr>
<td>11</td>
<td>Improving Connections/Intimacy</td>
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<tr>
<td>12</td>
<td>Compassion/Wrap-Up</td>
</tr>
</tbody>
</table>
Psychoeducation
Impact of Trauma on Emotions and Relationships

Trauma’s Impact on Emotions

Which are true for you?

- Difficulty identifying your own emotions
- Feeling overwhelmed by emotions (positive or negative)
- Fear of emotions, see emotions as unsafe
- Wanting to avoid or escape emotions
- Feeling that emotions control you
- Feeling numb or “nothing”

Trauma’s Impact on Relationships

Which are true for you?

- Feel distant or cut-off from others
- Easily irritated by others
- Don’t trust many people
- Believe most people will disappoint me
- Not assertive enough with others
- Too aggressive with others
- Avoid relationships

➢ How healthy are these strategies?
➢ Did these behaviors work long-term?
Goal of Treatment: for client to experience and differentiate many different feelings.
Emotional Regulation

Emotion Surfing

1. Notice your emotion...
2. Notice how it feels in your body
3. Notice your thoughts
4. Notice your behavior
5. Notice the intensity of the emotion
6. Notice how the emotion peaked
7. Notice how the emotion (thoughts, body, behavior) slowly diminishes over time
8. Notice that you can handle it.
Interpersonal Patterns

Holding others at a distance

**Pros**
- Low or no conflict
- Feel protected and safe

**Cons**
- Lonely
- Not always safe

Fused Boundaries (low agency)

**Pros**
- Feel connected and “in-synch”

**Cons**
- Do things unhealthy for self (drugs)
- Lose ethical, practical judgment

Healthy Boundaries (balanced agency)

**Pros**
- Feel connected
- Feel support, despite differences
- Feel safe
Changing Interpersonal Patterns

BASIC PERSONAL RIGHTS

- I have the right to ask for what I want.
- I have the right to say “no.”
- I have the right to be treated with dignity and respect.
- I have the right to be angry at someone I love.
- I have the right to say “I don’t know.”
- I have the right to negotiate for change.
- I have the right not to have to anticipate others’ needs and wishes.
VA Group STAIR Outcomes

Effect Sizes for PTSD Group Treatment, controlling for group effects

Effect Size for Completers (n=13) is .96; ITT (n=27) is .83

*Sloan et al, 2013*
STAIR Module for Individuals - 8 sessions
Webinar on NCPTSD Website (CEU credits)

Go to National Center for PTSD Website

- Professional Section
- Continuing Education
- Skills Training in Affective and Interpersonal Regulation (STAIR)

http://www ptsd va gov/professional/continuing ed/
STAIR online training asp
Lesson Learned and Next Steps

- Integrating technology into care: Use of Videoteleconferencing (VTC) of STAIR for Women with MST

- Integration of apps (complement or reinforce learning).

- Comparison of STAIR vs. Present Centered Therapy (PCT)
Available Apps

- PTSD Coach
- CBT-i coach
- Mindfulness coach
Thank you!!

Questions and Comments
10.40AM

Improving Veterans’ Access to Evidence-Based Psychotherapy for PTSD – How Are We Doing?

_Craig Rosen, Ph.D._
Deputy Director, Dissemination and Training Division of the National Center for PTSD and Associate Professor, Psychiatry and Behavioral Sciences, Stanford University School of Medicine

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Link to slides: bit.ly/ptsdslides

Link to survey: bit.ly/ptsdsurvey

Please give us your feedback!
Improving Veterans’ Access to Evidence-Based Psychotherapy for PTSD – How Are We Doing?

Craig S. Rosen, Ph.D.

National Center for PTSD Dissemination & Training Division
VA Palo Alto Health Care System

Department of Psychiatry and Behavioral Sciences
Stanford University School of Medicine
Acknowledgements and Disclosure

• **Funding**
  – VA Mental Health Services
  – VA National Center for PTSD
  – VA Sierra-Pacific MIRECC
  – VA HSR&D CRE-12-021, *Promoting Effective, Routine & Sustained Implementation of Stress Treatments* (PIs: Sayer & Rosen)

• **Collaborators**
  – Longitudinal Veterans Health Survey: Hana Shin, Mark Greenbaum, Shaili Jain.
  – PE Training: Afsoon Eftekhar, Jill Crowley, Donn Garvert, Eric Kuhn, Joe Ruzek
  – PERSIST: Nina Sayer, David Mohr, Robert Orazem, Brandy Smith, Jill Crowley, Afsoon Eftekhar, Joe Ruzek, Nancy Bernardy, Kate Chard, Joan Cook, Brian Shiner, Sean Nugent, Shannon Kehle-Forbes, Paula Schnurr

• **No financial conflict of interest**

• **Opinions are those of the authors, and do not necessarily reflect the position of the U.S. Department of Veterans Affairs**
Past Decade: Threefold Increase in Number of VA Patients with a PTSD Diagnosis

PTSD Treatments Known to be Efficacious

• Evidence-based practices (Forbes et al., 2010)
  ▪ Prolonged Exposure
  ▪ Cognitive Processing Therapy
  ▪ EMDR
  ▪ Stress Inoculation Training
  ▪ SSRIs/SNRIs

▪ Present-Centered Therapy (?)
Trauma-Focused Psychotherapies are Effective – Even in Veterans

- Mean Pre-Post ES for PTSD sx
  - All Populations (Bradley, 2005 meta-analysis): 1.43 Trauma Focused Psychotherapies, 0.59 Other Psychotherapies
  - Combat Veterans (Goodson, 2011 meta-analysis): 1.10 Trauma Focused Psychotherapies, 0.16 Other Psychotherapies
Trauma-Focused Psychotherapies are Effective – Even in Veterans

Pre-Post Effect Size (d) for Trauma-Focused Psychotherapy

<table>
<thead>
<tr>
<th>Study Description</th>
<th>Mean Pre-Post ES for PTSD sx</th>
</tr>
</thead>
<tbody>
<tr>
<td>General pop (Bradley, 2005 meta-analysis)</td>
<td>1.43</td>
</tr>
<tr>
<td>Combat Veterans (Goodson, 2011 meta-analysis)</td>
<td>1.10</td>
</tr>
<tr>
<td>PE, female veterans (Schnurr, 2007 trial)</td>
<td>0.80</td>
</tr>
<tr>
<td>Group CPT, male veterans (Morland 2014 trial)</td>
<td>0.78</td>
</tr>
<tr>
<td>PE, veterans (Eftkehari, 2013, PE rollout)</td>
<td>0.87</td>
</tr>
</tbody>
</table>
The American Legion Survey of Patient Healthcare Experiences (n = 2,525):
PTSD and TBI Patients’ Rating of Improvement

10 point Likert scale: 1 = I got worse, 5 = No change, and 10 = I got better
OK, But Not All Veterans Newly Diagnosed with PTSD get Mental Health Treatment…

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&gt; 90-120 day supply</td>
</tr>
<tr>
<td>Medications (Spoont, 2010)</td>
<td>27%</td>
</tr>
<tr>
<td>Psychotherapy (Spoont, 2010)</td>
<td>9%</td>
</tr>
<tr>
<td>SSRI/SNRI (Jain, 2012)</td>
<td>35%</td>
</tr>
<tr>
<td>Psychotherapy (Rosen, 2011)</td>
<td>19%</td>
</tr>
</tbody>
</table>

- 8-9 sessions

- < 8-9 sessions
Yet More PTSD Treatment Does Not Always Produce Better Outcomes...

Symptom Course by SSRI/SNRI Refills (n = 447)

(Shin, Greenbaum, Jain, & Rosen, Psychiatric Services, 2014)
Yet More PTSD Treatment Does Not Always Produce Better Outcomes...

Symptom Course by Psychotherapy Visits (n = 472)

(Shin, Greenbaum, Jain, & Rosen, Psychiatric Services, 2014)
VA Efforts Since 2006 to Expand Use of Evidence-Based Psychotherapies

• Hiring over 70% more MH staff
• Uniform Mental Health Services policy
  – PTSD specialty clinics in every medical center
  – Mandate making EBPs for PTSD available
• Training of over 6,400 VA providers in EBPs, including:
  – PTSD: Prolonged Exposure and Cognitive Processing Therapy
  – Depression: CBT and Acceptance & Commitment Therapy for Depression
  – Insomnia: CBT-I

(Karlin and Cross, American Psychologist, 2013)
But Most Veterans Still Do Not Receive Evidence-Based PTSD Treatment

• Surveys conducted in 1999 and 2001 showed fewer than 10% of VA clinicians who specialized in treating PTSD routinely used any manualized therapy or discussed traumatic events more than once (Rosen et al., 2004)

• NLP review of chart notes in FY 2010 in one VISN found that only 6% of patients getting individual psychotherapy in PTSD specialty clinics received an EBP (Shiner et al., 2012; Watts et al., 2013).

• Preliminary NLP review of 2012 chart notes found that median of 20% of PTSD psychotherapy patients’ chart notes mention an EBP (Sayer et al., 2014, unpublished).
  – Varies widely by site, from < 5% to > 45%
Prolonged Exposure (PE) Training Program: Trainning Model

• Trainees nominated by regional leadership.

• Two-phase training model
  ➢ Attend 4-day interactive workshop.
  ➢ Expert consultation on at least two cases.

• Training effort coordinated by National Center for PTSD Dissemination & Training Division

• To date, over 1,700 providers trained.
Prolonged Exposure (PE) Training Cases
Clinicians Can Learn to Deliver PE Effectively

• Mean pre-post effect size (d) = .87
  – 62% of patients show clinically significant improvement (improve 10 or more points on PCL)
  – Yet 46% remain above threshold for likely PTSD (PCL > 50) at end of treatment.

• Outcomes do not vary by clinician orientation or prior experience...
  – Social Workers slightly better than Psychologists

(Eftekhari, Ruzek, Crowley, et al., JAMA Psychiatry 2013; Eftekhari, Crowley, Garvert et al., Jrnl of Truamatic Stress, in press)
Clinicians Beliefs About PE Improve During Training (n = 656)

- PE helps patients: Before Training 5.7, After Workshop 6.2, After consultation 6.3
- PE may harm patients: Before Training 3.5, After Workshop 3.2, After consultation 2.9
- PE is emotionally burdensome: Before Training 2.9, After Workshop 2.9, After consultation 2.5
- PE time consuming: Before Training 2.7, After Workshop 2.7, After consultation 2.3
- Self-efficacy to deliver PE: Before Training 5.5, After Workshop 6.0, After consultation 6.4

(Ruzek, Eftekhari, Rosen et al, under review)
Prolonged Exposure (PE) Training Program: Post-Consultation Intent to Use PE is High

(Rosen, Eftekhari, Crowley, et al., ISTSS 2014)
Prolonged Exposure (PE) Training Program:
Yet Most Trained Clinicians Use PE with Only 1 or 2 Patients at a Time

Current PE Patients 6 Months After Training

<table>
<thead>
<tr>
<th>Patients</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11+</th>
</tr>
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<tbody>
<tr>
<td>Percentage</td>
<td>23</td>
<td>23</td>
<td>25</td>
<td>10</td>
<td>7</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
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</tbody>
</table>

Mean = 2.29 (SD = 2.93)
Median = 2.00

(Rosen, Eftekhari, Crowley, et al., ISTSS 2014)
### Predictors of Number of PE Cases At Six Month Follow Up (Poisson Regression Weights)

<table>
<thead>
<tr>
<th></th>
<th>Before Training</th>
<th>Change During Workshop</th>
<th>Change During Consult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incremental Model Fit</td>
<td>$\chi^2 (15 \text{ df}) = 182.6^{***}$</td>
<td>$\chi^2 (8 \text{ df}) = 26.3^{***}$</td>
<td>$(\chi^2 (8 \text{ df}) = 49.8^{***}$</td>
</tr>
<tr>
<td><strong>Context</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD specialty clinic</td>
<td>.341^{***}</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male provider</td>
<td>.226^{***}</td>
<td></td>
<td></td>
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<tr>
<td><strong>Outcome Beliefs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PE benefits patients</td>
<td>.132^{**}</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>PE may harm patients</td>
<td>-.090^{*}</td>
<td>-.069^{**}</td>
<td>--</td>
</tr>
<tr>
<td>PE time consuming</td>
<td>-.070^{*}</td>
<td>-.065^{*}</td>
<td>--</td>
</tr>
<tr>
<td>PE emotionally demanding</td>
<td>--</td>
<td>.105^{**}</td>
<td>.093^{*}</td>
</tr>
<tr>
<td><strong>Control Beliefs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-efficacy deliver PE</td>
<td>--</td>
<td>--</td>
<td>.179^{***}</td>
</tr>
<tr>
<td>Self-efficacy promote PE</td>
<td>.125^{**}</td>
<td>--</td>
<td>.114^{**}</td>
</tr>
<tr>
<td>Control over schedule</td>
<td>--</td>
<td>--</td>
<td>.077^{*}</td>
</tr>
</tbody>
</table>

*** p < .001; ** p < .01; * p < .05. Only significant effects are shown.
What Is Limiting Use of PE?

- Use of CPT as an alternative

- Organizational Issues!
  - Time demands
    - Other mandates compete for time spent delivering EBP
    - Can clinic graduate/discharge patients after EBP?
  - Doubts about which patients are “ready” for PE
    - Many VA clinics require patients to complete preparatory psychotherapy prior to EBP – is this really needed?
  - Difficulty marketing PE to patients and colleagues
  - No monitoring of whether patients get EBPs
Summary

• VA is undergoing a historic change in its treatment of PTSD and other mental disorders.
  – Strong policy impetus to bring science into practice.
  – The health care system is undergoing exposure to overcome “vicarious avoidance”.

• Penetration of EBPs still not where needs to be to reach our patient population
  – Large-scale training giving providers needed skills.
  – Still working to addressing organizational and systems-level barriers.
11.00AM

Clinical Approaches for Women Veterans with PTSD

*Julie Weitlauf, Ph.D.*
Director, Women’s Mental Health Core, Sierra Pacific MIRECC, VA Palo Alto Health Care System and Clinical Associate Professor (affiliated) Psychiatry and Behavioral Sciences, Stanford University School of Medicine

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Link to slides: bit.ly/ptsdslides  
Link to survey: bit.ly/ptsdsurvey

Please give us your feedback!
Gender-Tailored Treatment Approaches for PTSD in Women

JULIE WEITLAUF, PH.D.
VA PALO ALTO HEALTH CARE SYSTEM
STANFORD UNIVERSITY SCHOOL OF MEDICINE
CLINICAL ASSOCIATE PROFESSOR (AFFILIATED), PSYCHIATRY
AND BEHAVIORAL SCIENCES
Co-Investigators:

Funding Sources:
- VHA HSR & D
- Stanford Comprehensive Cancer Center
- National Center for PTSD

Conflicts of Interest: None.

The views expressed in this presentation are those of the author and do not necessarily represent the views of the Department of Veterans Affairs.
Prior work on gender and PTSD has focused on women’s disproportionate vulnerability to interpersonal violence, particularly sexual trauma as a primary etiologic factor in the development of trauma related psychopathology.

Many psychotherapeutic approaches to the treatment of PTSD were specifically designed around interpersonal violence exposure (e.g., prolonged exposure therapy) which may explain historic data suggesting women’s superior treatment response to these modalities.

While this work provides a strong foundation, future must address more nuanced questions about gender and PTSD in women, specifically considering the role of medical providers in identifying and treating this disabling disorder in women.
Four Critical Roles of Women’s Health Providers

- Universal Screening
  - Interpersonal Abuse Exposure
  - PTSD

- Management of Traumatic Reactions to Care

- Safe Prescribing

- PTSD Management During Vulnerable Periods:
  - Pregnancy
  - Post-Partum/Nursing
### Moving Beyond Universal Screening For Abuse Exposure

<table>
<thead>
<tr>
<th></th>
<th><strong>Current Abuse</strong></th>
<th><strong>Prior Abuse Exposure</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PTSD+ (Current)</strong></td>
<td>Addressing Injury, Safety Planning/Resources, Mandatory Reporting</td>
<td>Possible Mandatory Reporting</td>
</tr>
<tr>
<td></td>
<td>Traumatic Reactions to Care, PTSD Symptom Management</td>
<td>Traumatic Reactions to Care, PTSD Symptom Management</td>
</tr>
<tr>
<td><strong>PTSD-</strong></td>
<td>Addressing Injury, Safety Planning/Resources, Mandatory Reporting</td>
<td>Possible:</td>
</tr>
<tr>
<td></td>
<td>Possible: Traumatic Reactions to Care, Trauma Symptom Management</td>
<td>Mandatory Reporting, Traumatic Reactions to Care, Trauma Symptom Management</td>
</tr>
</tbody>
</table>
How do sexual violence, PTSD affect experiences with the pelvic examination?

**Design:** Cross Sectional; Structured Clinical Interviews

**Methods:** Interviewed women immediately following completion of the pelvic examination

**Participants:** Random sample of 67 female veterans attending a VHA women’s health clinic for cervical cancer screening.
A

No Sexual violence; $N = 9$; Sexual violence only: $N = 25$

Sexual Violence + PTSD: $N = 15$

Lee et al., 2007; Weitlauf et al, 2007; Weitlauf et al, 2008
Dose Response Relationship Between Hyper Arousal and Examination Related Distress?

- **Low** (Cluster D Scores < 1)
  - 25th Percentile
  - N = 13
  - No PTSD

- **Moderate** (Cluster D Scores = 1 - 12.9)
  - 25-75th Percentile
  - N = 18
  - 10 PTSD; 8 No PTSD

- **High** (Cluster D Scores > 13)
  - 75th Percentile
  - N = 9
  - 7 PTSD; 2 No PTSD
Participant Quotes:

- “When I’m sitting in the stirrups waiting for the examination to begin, I wonder if {the man who raped me} is out there and knows where I am. What if he were here?”

- “You know, it’s weird but I thought I saw him {the man who raped me} in the parking lot this morning. I haven’t seen him in forever and I don’t know where he is...wouldn’t it be weird if he were here?”

- “Is that guy in the waiting room just waiting for me to get undressed and then burst in on me?”

- “How would I know if the doctor is doing what he/she is supposed to be doing down there?”
Common Provider Pitfalls

- Rushing (forcing the examination)
  - Let’s just get it over with quick and she’ll feel better

- Tug of War (educating, cajoling)
  - If she understood the importance she would feel better about the examination

- Stigmatizing the patient (labeling “difficult”)
  - “She’s impossible”
Implications for Health Care providers

- Systematic Identification (Universal Screening) of Sexual Violence and PTSD in the Women’s Health Setting.

- Coaching of Health Care Providers to Recognize Traumatic Hyper-arousal and Understand its Impact on Women’s Health Care.

- Preventing/Managing Perceptions of Abuse in Health Care: Rift Identification and Reparation Interactions.
Tiger as Trauma Metaphor
<table>
<thead>
<tr>
<th>HC Provider Implemented Interventions</th>
<th>Patient Level Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>- The Pre-Examination Interview and Intervention.</td>
<td>- Traditional Psychotherapeutic Treatment for PTSD</td>
</tr>
<tr>
<td>- Environmental Changes (including the examination table) in the Health Care setting.</td>
<td>- Prolonged Exposure with Vaginal Penetration (speculum insertion) as the Target Trauma for women with Genito-Pelvic Pain/ Penetration Disorder.</td>
</tr>
<tr>
<td>- Follow-up Interview/Screening Efforts.</td>
<td></td>
</tr>
</tbody>
</table>
Future Directions

- Targeted psychotherapeutic treatment of sexual dysfunction of traumatic etiology
- Safe prescribing during women’s reproductive years
- Effective management of PTSD and mood symptoms in Pregnancy and Post Partum Periods
- Traumatic reactions to other procedures within reproductive health:
  - Child Birth
  - Colposcopy
  - Etc.
Questions?

wjulie1@stanford.edu
11.20AM

Tech/mobile interventions for PTSD

_Eric Kuhn, Ph.D._
Clinical Research Program Manager, Dissemination and Training Division of the National Center for PTSD and Clinical Assistant Professor (affiliated), Psychiatry and Behavioral Sciences, Stanford University School of Medicine

Please ensure your audio is on mute. Questions may be submitted using the chat on the right side of the screen. Please submit your question with the name of the presenter.

Link to slides: bit.ly/ptsdslides  
Link to survey: bit.ly/ptsdsurvey

Please give us your feedback!
Technology and Mobile Interventions for PTSD

Eric Kuhn, Ph.D., Julia Hoffman, Psy.D., & Jason Owen, Ph.D
VA National Center for PTSD, Dissemination and Training Division
Mobile App Target Users

Veterans & Service Members
  VA Patients
    Patients Enrolled in Evidence-Based Psychotherapies

Healthcare Providers
  VA Providers
  Community Providers

Concerned Significant Others
  Children
  Adults
    Care-givers
The Promise of Mobile Technology

IMPROVE TREATMENT DELIVERY.
INCREASE TREATMENT EFFECTIVENESS.

Aid Self-Management

Enhance Clinical Care

Support Families

Enable Healthcare Providers

Support Evidence-Based Psychotherapy

Educate/Train/Increase Efficiencies
VA PTSD Patients and Mobile Devices

Residential PTSD Patients
PE Provider Estimate of PE Patients
PCT Patients

2011 2012 2013

44%
45%
76%

(smartphones only)
(smartphones only)
(any app-running mobile device)

Kuhn, et al. (in press)
Apps for Veterans with PTSD

Examples:

- PTSD
- VA PTSD COACH
- coach

Partners:

- National Center for PTSD (Posttraumatic Stress Disorder)
- MIRECC
- Open mHealth
- STANFORD HOSPITAL & CLINICS
- University of California San Francisco
- CENTER FOR DEPLOYMENT PSYCHOLOGY
- CORNELL NYCTECH
Some of Our Apps…
PTSD Coach Screenshots
Tool Examples

1. **Deep Breathing**
   - **Example:** Listen to the audio and follow along with the exercise.

2. **Positive Imagery**
   - **Example:** Make yourself comfortable, so that your thoughts are on the image and nothing else.

3. **Soothing Pictures**
   - **Example:** Look at a picture that is meaningful or soothing to you. (Tap on the plus sign to zoom in.)

4. **Make A Plan**
   - **Example:** Choose a person from your contact list to meet up with: Joe Johnson
   - **Example:** Select an activity to do with this person: Go out for a meal
PTSD Coach Metrics of Success

- Versioned for various countries and traumatic events
- Successful research & evaluation efforts
- 2011 FCC Chairman’s Award for Advancements in Accessibility
- 2012 ATA President’s Innovation Award
- 2011 Nextgov.com Best Government App
- 2011 Yahoo’s Top 10 Health Apps
- 2014 Finalist, Excellence.gov Innovations in Healthcare IT
- 2014 Webby: Health & Fitness Apps

Customer Reviews

- **About time ★★★★★
  by STROKER-ACE-KID
  Being a vet with PTSD i hope this will work in some way. Even if it helps in the slightest way I would rate it 10 stars**

- **Outstanding! ★★★★★
  by Fit Medic
  Great app! A must for all active military + vets for help with dealing with things known only to them. Also get the Breath2Relax app for help with those tough situations. Keep the faith.**

- **Thank you for this app! ★★★★★
  by danwatson1
  I have been struggling with PTSD for a while and this app has become a great tool for me especially when I don’t know what to do. It easy to use and a big help. I would recommend this app everyday of the week!**
Evaluation of PTSD Coach with Veterans

(Kuhn, Greene, Hoffman, et al. 2014)

• Purpose: Feasibility, acceptability, perceived helpfulness

• Sample: 45 VA PTSD Residential Patients
  – 34 men, 11 women
  – Age range 24-69 (mean of 45)
  – 48% white, 17% AA, and 15% Hispanic

• Method
  – Pre-use session, baseline measures, and consenting ($N = 52$)
  – Patients used app over 3-days (weekend)
  – Post-use survey and focus group
# Satisfaction and Perceived Helpfulness

<table>
<thead>
<tr>
<th>Feature</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall satisfaction</td>
<td>89%</td>
</tr>
<tr>
<td>Help me track symptoms</td>
<td>89%</td>
</tr>
<tr>
<td>Feeling that there is something I can do</td>
<td>89%</td>
</tr>
<tr>
<td>Better understand my experiences</td>
<td>84%</td>
</tr>
<tr>
<td>Assess when I’m doing better or worse</td>
<td>82%</td>
</tr>
<tr>
<td>Learn about treatment for PTSD</td>
<td>82%</td>
</tr>
<tr>
<td>Learn about symptoms of PTSD</td>
<td>80%</td>
</tr>
<tr>
<td>Feel more comfortable in seeking support</td>
<td>76%</td>
</tr>
<tr>
<td>Clarify myths about PTSD</td>
<td>73%</td>
</tr>
<tr>
<td>Increase access to resources</td>
<td>72%</td>
</tr>
<tr>
<td>Provide a way for me to talk about experiences</td>
<td>71%</td>
</tr>
<tr>
<td>Overcome stigma of mental health</td>
<td>69%</td>
</tr>
<tr>
<td>Provide practical solutions</td>
<td>67%</td>
</tr>
<tr>
<td>Enhance knowledge of PTSD</td>
<td>66%</td>
</tr>
<tr>
<td>Find effective ways to manage my symptoms</td>
<td>64%</td>
</tr>
</tbody>
</table>

*% endorsed at “moderately” to “extremely helpful”*
Focus Group Highlights

Ways It Was Used
- When needed to manage symptoms,
- At scheduled times
- At night/ for sleep

Perceived Value
- Improved symptoms, social condition, knowledge of PTSD, validation of PTSD
- Likes: convenient, easy to use, accessible, specific features, customization
- Dislikes and remedial suggestions: specific features, missing features, design elements
- Endorsements: positive recommendations, testimonials, and suggestions

Suggested Enhancements
- Add new features
- Improve existing features
PTSD Coach in the Community
(Miner, Kuhn, Hoffman, et al., under review)

• Purpose:
  – Feasibility, acceptability, and effect size estimate

• Sample:
  – 49 volunteers from community with significant PTSD sxs (40 women)
  – Mean age = 47 years (range = 24-70)

• Method
  – Baseline: consent, baseline measures, randomly assigned to a 1-month condition
    • PTSD Coach
    • Waitlist
  – Post-condition assessment
  – 2-month follow-up (waitlist group assigned to use PTSD Coach)
PTSD Checklist Changes

Baseline vs. Post-Treatment PCL Scores
- PTSD Coach
- Waitlist
Using PTSD Coach in VA Primary Care
(Possemato, Kuhn, Hoffman, et al. in preparation)

• Pilot RCT of PTSD Coach with clinician support (CS) in VA primary care ($N = 20$)
• $M$ age = 42 (12), Range 24-66
• CS entailed 4 brief (20-30 min) visits with PC-MHI provider over 8 weeks to support PTSD Coach use
PTSD Coach in the Wild
(Owen, Jaworski, Kuhn, et al., under review)

• Using novel data to understand the reach, reception, use, and impact of PTSD Coach in the wild
  • Analyzed aggregate mobile analytics data from 153,834 downloads
  • Qualitative analysis of 156 app store reviews
Flurry Analytics Data on 153,834 downloads (March 2011 to February 2014)
### 3 Months of Session Event Logs

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
<th>K</th>
<th>L</th>
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<td></td>
</tr>
<tr>
<td>4/15/2014 6:44</td>
<td>22</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** N = 3,462 1st time sessions; N = 12,449 return visit sessions
App Store: Star Ratings ($N = 80$) and Written Reviews ($N = 56$)
Google Play: Star Ratings ($N = 329$) and Written Reviews ($N = 103$)
Reach: How many is PTSD Coach reaching?

• Downloaded >165,000 times since March 2011
• 69% iOS
• Very stable reach over time: ~55,000 downloads each year, with no drop over time
• Average # of unique users = 10,600 per month
Reach: Who is PTSD Coach Reaching?

• PCL Scores
  – First-time users: $M = 57.2$ ($SD = 15.7$)
  – Return users: $M = 55.1$ ($SD = 16.6$)

• 25% of app marketplace reviews reported demographics
  – Both veterans (73%) and non-veterans represented
  – Different types of trauma, including combat trauma, sexual trauma, past childhood abuse, and medical trauma
  – Few reported PTSD diagnosis ($n = 8$)
  – Some reported being mental health professionals

“As a wounded veteran of Iraq and Afghanistan, diagnosed with PTSD, I highly recommend this application”
What Has Been the Reception of PTSD Coach?

- Star ratings indicated favorable views of the app
  - $M_{iOS} = 4.6$ ($SD = 0.9$); $M_{Android} = 3.1$ ($SD = 1.7$)***
- App marketplace reviews were
  - positive (58.3%, $n = 91$),
  - negative (25.6%, $n = 40$),
  - ambivalent (16.0%, $n = 25$).
  - 89% of iOS reviews were classified as entirely positive vs. 42.7% of Android reviews***
### How Much is PTSD Coach Being Used?

<table>
<thead>
<tr>
<th></th>
<th>iOS</th>
<th>Android</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean # of Sessions per User</td>
<td>6.8</td>
<td>5.2</td>
<td>6.3</td>
</tr>
<tr>
<td>Median Time per Session</td>
<td>47.8</td>
<td>47.6</td>
<td>47.7</td>
</tr>
<tr>
<td>(seconds)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avg Total Time of Use</td>
<td>325</td>
<td>250</td>
<td>301</td>
</tr>
<tr>
<td>(seconds)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
How Long is PTSD Coach Being Used?

• 61.1% used the app after the day it was installed
• 52.1% used the app after the 1st week
• 41.6% used the app after the 1st month
• 28.6% used the app after 3 months
• 19.4% used the app after 6 months
• 10.6% used the app after 1 year
What is the **Impact** of PTSD Coach?

<table>
<thead>
<tr>
<th></th>
<th>First-Time Sessions (N = 3,462 unique users)</th>
<th>Return-Visit Sessions (N = 12,449 sessions aggregated across users)</th>
<th>Between-group differences (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>57.2 (15.7)</td>
<td>55.1 (16.6)</td>
<td>.024</td>
</tr>
<tr>
<td>n (%)</td>
<td>359 (10.3%)</td>
<td>2,599 (20.9%)</td>
<td></td>
</tr>
<tr>
<td><strong>Momentary Distress (SUDS)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>6.7 (2.1)</td>
<td>7.0 (2.1)</td>
<td>.005</td>
</tr>
<tr>
<td>n (%)</td>
<td>440 (12.7%)</td>
<td>2,518 (20.2%)</td>
<td></td>
</tr>
<tr>
<td>SUDS reduction after use of symptom management tool</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean reduction (SD)</td>
<td>1.6 (2.6)***</td>
<td>2.0 (2.3)***</td>
<td>.13</td>
</tr>
<tr>
<td>n (%)</td>
<td>93 (21.1%)</td>
<td>548 (21.8%)</td>
<td></td>
</tr>
</tbody>
</table>
Future Directions

• Connected apps with provider dashboards
• Inclusion of objective measures
  – Wearable and place-able sensors
  – Tracking, background sensing, and incorporating other data sources
• Automated, large-scale/population-level research
  – E.g., using social media with PTSD Family Coach
“When the expectations of wireless experts are realized everyone will have his own pocket telephone and may be called wherever he happens to be...When that invention is perfected, we shall have a new series of daily miracles.”

Hampton’s Magazine, circa 1908

Questions?

Eric Kuhn, Ph.D.
Eric.Kuhn@va.gov
11:40AM

What’s new in fear?

Steve Woodward, Ph.D.
Psychologist at the Dissemination and Training Division of the National Center for PTSD

Please ensure your audio is on mute. Questions may be submitted using the chat on the right side of the screen. Please submit your question with the name of the presenter.

Link to slides: bit.ly/ptsdslides
Link to survey: bit.ly/ptsdsurvey

Please give us your feedback!
What’s New in Fear

Steven H. Woodward, PhD

PTSD Updates Webinar

11/14/14
The Latest from ISTSS on:

GWAS
Candidate Genes, Epigenetics, FKBP5
Potential Implications for PTSD Treatment
PTSD GWAS, N = ~6500
Schizophrenia GWAS, N = 11,244, 13 new hits implicating “neuronal calcium signaling”
REVIEW

The role of FKBP5, a co-chaperone of the glucocorticoid receptor in the pathogenesis and therapy of affective and anxiety disorders

Elisabeth B. Binder\textsuperscript{a,b,c,*}

---

Allele-specific \textit{FKBP5} DNA demethylation mediates gene–childhood trauma interactions

Torsten Klengel\textsuperscript{1}, Divya Mehta\textsuperscript{1}, Christoph Anacker\textsuperscript{2}, Monika Rex-Haffner\textsuperscript{1}, Jens C Pruessner\textsuperscript{3}, Carmine M Pariente\textsuperscript{2}, Thaddeus W W Pace\textsuperscript{4}, Kristina B Mercer\textsuperscript{5}, Helen S Mayberg\textsuperscript{4}, Bekh Bradley\textsuperscript{4,6}, Charles B Nemeroff\textsuperscript{7}, Florian Holsboer\textsuperscript{1}, Christine M Heim\textsuperscript{4,8}, Kerry J Ressler\textsuperscript{4,5,9}, Theo Rein\textsuperscript{1} & Elisabeth B Binder\textsuperscript{1,4}
Klengel et al found the risk-conferring version of this gene to associate with higher FKBP5 expression and relatively reduced GR sensitivity as well as impaired recovery of cortisol levels in response to stress.”

Implications?

Delayed recovery from episodes of stress will result in more strongly consolidated fear memories which are more resistant to treatment
The role of FKBP5 genotype in moderating long-term effectiveness of exposure-based psychotherapy for posttraumatic stress disorder

S Wilker¹, A Pfeiffer², S Kolassa³, T Elbert⁴, B Lingenfelder⁴, E Ovuga⁴, A Papassotiropoulos⁵, D de Quervain⁶ and I-T Kolassa¹
<table>
<thead>
<tr>
<th></th>
<th>Intron 7, Bin 2</th>
<th>p value</th>
<th>Intron 7, Bin 2</th>
<th>p value</th>
<th>Fisher z score</th>
<th>p value (two tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CTQ total</strong></td>
<td>0.646</td>
<td>&lt;0.001</td>
<td>0.414</td>
<td>0.078</td>
<td>-4.23</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Log CTQ total</strong></td>
<td>0.690</td>
<td>&lt;0.001</td>
<td>0.410</td>
<td>0.081</td>
<td>-4.49</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Log CTQ physical abuse</strong></td>
<td>0.641</td>
<td>&lt;0.001</td>
<td>0.378</td>
<td>0.111</td>
<td>-4.05</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Log CTQ sexual abuse</strong></td>
<td>0.656</td>
<td>&lt;0.001</td>
<td>0.599</td>
<td>0.007</td>
<td>-5.17</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Log CTQ emotional abuse</strong></td>
<td>0.685</td>
<td>&lt;0.001</td>
<td>0.321</td>
<td>0.181</td>
<td>-4.1</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

**FKBP5 risk allele carrier**
N=55

**FKBP5 protective allele carrier**
N=19
Amygdala Volume in Combat-Exposed Veterans With and Without Posttraumatic Stress Disorder

A Cross-sectional Study

Janice R. Kuo, PhD; Danny G. Kaloupek, PhD; Steven H. Woodward, PhD

Arch Gen Psychiatry. 2012;69(10):1080-1086

Early adversity and combat exposure interact to influence anterior cingulate cortex volume in combat veterans

Steven H. Woodward a,⁎, Janice R. Kuo b, Marie Schaer c, Danny G. Kaloupek d,⁎, Stephan Eliez c

Neuroimage: Clinical 2 (2013) 670-674
This work has promoted PTSD and the relationship of early trauma to PTSD to marquee status in the field of psychiatric epigenetics.

In a commentary on the Klengel et al paper, Moshe Szyv, the father of psychiatric epigenetics, described it as the first demonstration of “the molecular plausibility of gene-environment interactions.”
20. Did the Veteran suffer another traumatic incident within his/her lifetime that was not related to combat? (The traumatic incident should meet DSM Criteria A definition as determined by the clinician).

   0. No   1. Yes

20A. If Yes, which other type of traumatic incident (include both military and non-military)? (Check all that apply)

   1. Military Sexual Trauma
   2. Non-Military Sexual Trauma
   3. Vehicle accident
   4. Other Accident
   5. Victim of violence (e.g. child abuse)
   6. Natural disaster
   7. Other
Table 2. Trauma Types Experienced by Veterans in Each Treatment Preference Group

<table>
<thead>
<tr>
<th>Group</th>
<th>Total</th>
<th>Combat trauma</th>
<th>MST</th>
<th>Other</th>
<th>Childhood trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Initiated EBP</td>
<td>95</td>
<td>72</td>
<td>80.9</td>
<td>13</td>
<td>13.7</td>
</tr>
<tr>
<td>Group</td>
<td>21</td>
<td>15</td>
<td>71.4</td>
<td>5</td>
<td>23.8</td>
</tr>
<tr>
<td>No psychotherapy</td>
<td>53</td>
<td>46</td>
<td>86.8</td>
<td>6</td>
<td>11.3</td>
</tr>
<tr>
<td>Non-trauma psychotherapy</td>
<td>30</td>
<td>23</td>
<td>76.7</td>
<td>7</td>
<td>23.3</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>156</td>
<td>78</td>
<td>31</td>
<td>15.5</td>
</tr>
</tbody>
</table>
### Veterans who completed an EBP attended 13.8 (SD = 5.74) sessions.

### Veterans who dropped out of treatment attended a mean of 4.5 (SD = 2.30) therapy sessions.

#### Table 3.

**Individual EBP Outcomes**

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total EBP referrals</strong></td>
<td>200</td>
<td></td>
</tr>
<tr>
<td><strong>Individual CPT/PE</strong></td>
<td>95</td>
<td>47.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Combat trauma</th>
<th>MST</th>
<th>Other</th>
<th>Childhood trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td><strong>Completed EBP</strong></td>
<td>52 55</td>
<td>43  60</td>
<td>5  42</td>
<td>8  47</td>
</tr>
<tr>
<td><strong>Dropped out EBP</strong></td>
<td>43 45</td>
<td>29  40</td>
<td>7  48</td>
<td>7  53</td>
</tr>
</tbody>
</table>
National Vietnam Veterans Longitudinal Study

• early abuse a major predictor of chronic PTSD persisting into the 7th decade of life in the Vietnam cohort

• two other major predictors - failure to complete high school and early age of entry into the military - probably partially confounded with early abuse
ISTSS 2014 summary

- Childhood trauma (keynote and twenty sessions)
- Genetics/Genomics (five sessions)

- Serotonin transporter
- Prazosin
- TBI
Questions?
How can we get better at this: What will it take to improve our PTSD care for veterans?

Josef Ruzek, Ph.D.
Director, Dissemination and Training Division of the National Center for PTSD, Clinical Professor (affiliated) Psychiatry and Behavioral Sciences, Stanford University School of Medicine and Associate Professor, Palo Alto University

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Link to slides: bit.ly/ptsdslides
Link to survey: bit.ly/ptsdsurvey
Please give us your feedback!
How Can We Get Better At This: What will it take to improve our care for Veterans with PTSD?

Josef I Ruzek, Ph.D.
National Center for PTSD Dissemination and Training Division
VAPAHCS
Core Challenges in PTSD Treatment Delivery?

• Implementing EBTs and other best practices
• Extending clinician impact
• Monitoring and using outcomes information
• Supporting clinicians
• Developing a culture of experimentation and learning
EBTs and Other Best Practices

- Evidence-based treatments
  - They work, but...
  - They are not being used for enough patients
  - CAN YOU DO MORE?
- Other best practices exist: VA-DoD Clinical Practice Guidelines
- What else (whole person)?
  - Skills training (e.g., STAIR)
  - Work/school success
  - Family supports
  - Symptom-specific problems
    - TBI, pain, sleep, alcohol, drugs, smoking
  - Alumni programs
Spouse/Partner/Family Involvement in Care?

- Not just the province of family clinics
- Partners/Parents
  - Include in assessment process
  - Involve in treatment planning if possible
  - Involve in treatment
PTSD Alumni Programs

• Importance of “Recovery Model”
• Need for mutual support
• Aging Veterans with PTSD
• Mechanism for involvement of families
• Relapse prevention
• Evidence in civilian sector
• Cost-effectiveness advantages

• A different role for us?
Extending Clinician Impact?

- Lots of patients with lots of problems
- How can clinicians see more people with less face time while increasing effectiveness?
Patients, Clinicians, and Technologies: Towards a Partnership

• Web and phone interventions can....
  – Increase our effectiveness
  – Make it easier to implement evidence-based treatments
  – Help us address more patient and family needs
  – Help us access data

• The future: Stepped care?
Monitoring and Using Outcomes Information

• Benefits to patient and provider
  – Is treatment working?
  – Informs treatment modification
  – Patient can review progress
  – Allows evaluation of treatment improvement over time

• Feasible with automation of assessment
• Directives coming from MHS/OMHO
Monitoring Outcomes: Are We Afraid?

- Yes, but…

- It’s coming anyway
- It’s good for us (easy for me to say)
- It’s the master change underlying all other useful changes
- It’s why we went into mental health treatment
- Take the risk
Supporting Clinicians?

- Burnout and motivation
- Learning and supervision
- Quality improvement projects
- More helpful resources
- More sharing across clinicians and programs
Developing a Culture of Experimentation and Learning

• Increasing innovation
• Increasing using new practices
• Some ideas
  – Practice-Based Implementation Networks
  – PTSD Practitioner Registry
  – PTSD PRO (Practitioner Resources Online)
The New Practitioner

• Adaptability
• Constant (lifelong) learning: frequent changes in practice
  – Willingness to change
  – Training/sharing mechanisms
• Practitioner as innovator
• Monitoring outcomes
• Using evidence to drive decision-making
• Routine linkage with colleagues
• Increased awareness of national developments
The Change Process: 360 Degree Listening

• Dissemination is unlikely to succeed if changes are only initiated “top down”
  • Problems with previous efforts at dissemination may have been their unidirectional nature
    – Emphasis on changing practitioner behavior as decided by researchers or administrators
• Professional tasks are non-routine, their effective performance requires committed performance
• Research only speaks to some clinical issues at present
• Clinicians and managers as partners in the change process
• Managers and researchers must enter into dialogue with clinicians
Summary: Improving PTSD Care

• More powerful PTSD interventions
• Integrating technology into care
• More attention to families and functioning
• Building a recovery community via PTSD alumni programs
• Outcomes measurement as the “master” change
• Finding ways to support clinicians and increase innovation/experimentation
What Can You Do?

• Become an “Early Adopter”
  – Use EBTs with more Veterans
  – Monitor outcomes and think about them
  – Use phone apps and web interventions
  – Participate in training workshops and try something new
  – Join our PTSD Provider Registry or RCT of online training
  – Join our PBI Network
Thank you!
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**Presenters and topics:**

10.00AM Pros and Cons of the 2014 Institute of Medicine Report.  
*Thomas Neylan, M.D.*

10.20AM Group Skills Training and Affective Interpersonal Regulation (STAIR): The benefits of skills focused intervention.  
*Marylene Cloitre, Ph.D.*

10.40AM Improving Veterans’ Access to Evidence-Based Psychotherapy for PTSD – How Are We Doing?”  
*Craig Rosen, Ph.D.*

11.00AM Clinical Approaches for Women Veterans with PTSD.  
*Julie Weitlauf, Ph.D.*

11.20AM Tech/mobile interventions for PTSD.  
*Eric Kuhn, Ph.D.*

11.40AM What’s new in fear?  
*Steve Woodward, PhD*

12.00PM How can we get better at this: What will it take to improve our PTSD care for veterans?  
*Josef Ruzek, PhD*