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## *“Closing the efficacy-effectiveness gap”*

*Editor’s note: In an effort to promote awareness about mental health research in the VA, 3-4 newsletter issues per year will be devoted to research reviews on a special topic. The review below marks the first published review of this kind.*

### **Physical Activity and Health: A Brief Review for Mental Health Providers**

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#### Prevalence of Low Levels of Physical Activity and Who Is At Risk

The importance of physical activity to physical and mental health is now widely recognized (43), but health surveillance data indicate only slight improvements in population activity habits during the past 10 years (12). Less than half of American adults engage in the recommended 30 minutes of moderate activity (such as brisk walking) most days of the week (28). Like obesity, physical inactivity is more prevalent among disadvantaged groups, including people with lower education, lower incomes, and those with physical and mental disabilities (14;19;19;20;20;42).

#### Impact of Physical Activity and Fitness on Physical and Mental Health

Cohort studies have found increased mortality risk associated with sedentary lifestyles, after controlling for a number of other factors, including age, sex, race, smoking, obesity, cancer, health status, and income (41). Notably, studies have demonstrated benefit for light and occasional physical activity (e.g., walking, gardening, dancing, bowling) as well as regular moderate to vigorous activity. Regular physical activity has benefits for people of any weight status; obese people with at least moderate physical fitness have less CVD and lower death rates than their sedentary normal weight peers (3). Thirty minutes of walking most days of the week for 12 weeks produces about as much benefit as 60 minutes of walking per day; when compared with diet alone, the combination produces additional health benefits such as decreased waist circumference, and LDL-cholesterol, and increased fitness (6). Physical activity also has a strong inverse relationship with metabolic syndrome, a cluster of CVD risk factors (21), and increased physical activity has the potential to be an effective intervention for metabolic syndrome even without diet or weight change (25).

The literature consistently demonstrates a positive association between physical activity and mental health (11;33;43;45). Recent reviews have concluded that regular physical activity offers the potential for benefit to many mentally ill patients through enhancement of mood and self-esteem, weight management, and other mechanisms (11;40). Intervention studies have demonstrated that vigorous endurance exercise is as effective as medication for treating mild-moderate depression in older men and women and may result in better maintenance of improvement (1;5). Cohort and intervention studies indicate a dose-response relationship. The public health recommended dose of exercise of about 30 minutes most days, or at least

150 minutes per week, of moderate physical activity (37) reduced depression scores by almost 50% in adults with diagnosed mood disorders in a recent study (17). A recent meta-analysis also demonstrated beneficial effects of exercise on several types of cognition in aging adults (13), suggesting that exercise protects the aging brain. In addition to these health benefits, a recent analysis found that per capita medical expenditures were \$2,785 higher for sedentary, as compared with active, people with mental disorders(9).

Walking is a simple physical activity that is accessible to most adults and has many health benefits with few risks (4;18). A recent study of middle aged adults examined effects on CVD risk and psychological status of walking 30 minutes continuously versus 3 separate 10-minute walks separated by several hours (34). Both walking schedules improved HDL-cholesterol, triglycerides, total cholesterol, reduced waist and hip circumference, and reduced tension and anxiety. Thus, “lifestyle” approaches with short bouts of walking may be as effective as one continuous exercise session per day in reducing CVD risk and improving psychological status.

### Lifestyle Interventions for Obesity and Physical Inactivity

With trends suggesting that almost all adults will be overweight in the near future if nothing is done, experts are calling for action by health care providers and policy makers (22;30;35). As long as pharmacologic and surgical treatment options are limited, lifestyle modification through diet and physical activity behavior change is the best choice for most patients (22;23;29). Intensive diet, physical activity, and behavior change counseling programs reliably produce losses of about 10% of body weight over 4 to 5 months (44). Weight changes of this magnitude may seem small, but together with physical activity, produce very significant health improvements (30;36). Although these programs are effective, their impact has been limited because they are accessible only to people who are able and willing to attend the frequent sessions at the clinic. Clinic counseling followed by telephone and mail contacts allow access by patients who cannot attend frequent clinic sessions, but are motivated to try to implement behavior change. Several studies have evaluated these types of interventions for weight management, consistently finding smaller weight losses compared with more intensive programs (7;24). For physical activity, however, single counseling sessions by primary care providers or nurses (2;10), followed by telephone (26;27) and mail contacts (31) have produced significant and long-lasting behavior change. We found that a combination of nurse- and computer-generated phone contacts resulted in about 40% of elderly veterans adopting and maintaining regular walking for health in a year-long study (15).

There have been very few studies focusing on lifestyle change for patients with diagnosed mental disorders (11;19;20;40). In a pilot study supported by the South Central MIRECC, we found that severely mentally ill patients with stable mental status gave valid responses to national physical activity survey questions as validated by motion sensors worn for 5 days (16). Only a handful of studies have examined exercise interventions for severely mentally ill patients, but a series of pilot studies were described in a 2005 issue of *Psychiatric Services*, suggesting increasing interest (32;38;39). One 18-week program (weekly for 6 weeks, then monthly for 3 months) for 34 seriously mentally ill individuals that included nutrition, physical activity, behavior modification, and 15 minute group walks resulted in 5.3 lb. weight losses (39). A more comprehensive 12-week program that included meal replacements as well as behavioral methods (diaries, goal setting, pedometers, measuring cups, frequent feedback) found decreases in weight (5.8 lb.) and waist circumference (8). A 12-week nurse-managed walking program at a psychiatric rehabilitation center improved mood for 13 of 15 patients (32). Another nurse-managed telephone pilot study combining cognitive-behavioral therapy and a walking program for diabetics with depression resulted in increases of 20 minutes of activity per day in 5 of 8 patients (38).

### Summary and Practice Recommendations

Concerns about obesity and low levels of physical activity, and their associated increased risk for CVD, depression, and cognitive decline with age are justified because so many people are potentially at risk. Disadvantaged groups including people with mental illness are at even greater risk due to biological and psychosocial factors. Increasing physical activity can reduce chronic disease risks and improve quality of life. Physical activity counseling therefore may be especially important for many patients seen in mental

health settings. If these patients start engaging in regular physical activity, they are likely to benefit even if they are not successful in smoking cessation or weight loss.

After ruling out any contraindications to increased physical activity (consultation may be needed for some patients), clinicians can assess motivation for increased activity by describing to their patients how changes in physical activity can improve their physical and mental health and asking them if they are ready to become more active. Counseling should be tailored to the patient's specific physical and mental health conditions. Recommendations should start with small changes that patients feel very confident they can achieve and that are accessible given the patients' living environment, income, and skills. Scrubbing floors, washing the car, or walking alone can be healthy physical activities, but they may not sound as attractive as a plan for working out at an exercise club. However, performing these everyday activities with an inexpensive head set music player and positive self talk, such as "I'm working off the fat/blues!" or "I'm getting stronger every day" may improve motivation. Keeping a simple diary, such as marking each 10 minutes of exercise on a calendar each day and bringing this back to show the provider at the next visit, is highly associated with success. Patients with low energy and confidence may be more likely to succeed if they can be helped to identify a partner who will exercise with them and encourage them. As with other lifestyle change efforts, lapses and relapses are very common, especially in times of stress and illness. Providers can help their patients understand these events as predictable and sometimes unavoidable, and help them find "lessons learned" so that their future efforts can be more successful. One word of caution--health providers should prescribe activity only if they have the appropriate competencies or privileges. And, a word of advice to health care providers--we are likely to be most effective in healthy lifestyle counseling, and healthier and happier in our own lives, if we also follow the advice that we give our patients.

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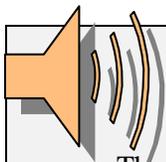


### Trauma Conference May 14-15, Houston

The South Central MIRECC trauma conference entitled, ***“Old Traumas, New Traumas, and New Approaches to Treating Trauma,”*** is scheduled for **May 14-15, 2007** at the Hotel Derek, Houston, TX. The meeting will focus on innovative approaches to treating trauma related to combat in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), as well as the effects of Hurricanes Katrina and Rita on individuals and on the health care system in the Gulf Coast area. Presentations include new psychopharmacological treatments, assessment of traumatic brain injury, telemedicine approaches for treating PTSD, effect of deployment in hurricane disaster areas on National Guard units, and effect of the hurricanes on mental health care, to name a few.

This conference is a partnership with the Department of Veterans Affairs Employee Education System (EES); South Central MIRECC; Texas A&M University, Department of Psychiatry; VISN 17 PTSD Subcommittee; Texas Department of State Health Services (DSHS); Texas Army National Guard; Menninger Department of Psychiatry & Behavioral Sciences, Baylor College of Medicine; and The Menninger Clinic.

For more information about the conference, contact [Michael.kauth@va.gov](mailto:Michael.kauth@va.gov).



### Web-based Presentation May 17 on Recovery

The South Central MIRECC *Bringing Science to Practice* web-based conference series presents **Lisa Martone, APN, on “VISN 16 Recovery Implementation: An Update,” May 17, 2007 at noon CT.** Ms. Martone is an advance practice nurse and coordinator of the Central Arkansas Veterans Health Care System MHICM team in Little Rock, AR. She has been instrumental in coordinating training in recovery and psychosocial rehabilitation for VISN 16 and 17. She is the first VISN 16 staff member to obtain certification as a Psychiatric Rehabilitation Practitioner (CPRP). Ms. Martone also serves as a member of the VISN 16 Recovery Committee.

PowerPoint slides for Ms. Martone’s presentation can be downloaded from a VA-networked computer at <http://vaww.visn16.med.va.gov/mirecc.htm> beginning May 16. The live audioconference can be accessed May 17 at **1-800-767-1750, access code 45566#**. This presentation is accredited for 1.0 hour of discipline-specific continuing education by the VA Employee Education System.

For additional information about this series, contact [Randy.burke@med.va.gov](mailto:Randy.burke@med.va.gov)

## Meet the MIRECC Researchers: Dr. Nancy Jo Dunn

### Nancy Jo Dunn, Ph.D.

Clinical Psychologist, Trauma Recovery Program  
Psychology Director, VA South Central MIRECC Special Fellowship in Advanced Psychiatry and Psychology, Michael E. DeBakey VA Medical Center, Houston  
Associate Professor, Menninger Department of Psychiatry & Behavioral Sciences, Baylor College of Medicine

**Editor:** *What is your area of research?*

**Dr. Dunn:** My primary research focus in the Trauma Recovery Program (TRP) at the Michael E. DeBakey VA Medical Center (MEDVAMC) has been on the treatment of Posttraumatic Stress Disorder (PTSD) and other related anxiety conditions. We know that the majority of our veterans with chronic PTSD have a complicated clinical presentation that includes a number of other co-existing conditions, such as depression and substance abuse, that can significantly impact the course of therapy. My research has focused on better understanding these co-morbid conditions, providing the latest evidence-based psychotherapies to our veterans, and evaluating the most effective way of implementing these psychotherapies within our fast-paced clinical setting. These types of studies are consistent with the theme of our MIRECC to “close the gap” between what services have the potential to do and what services actually do in usual clinical practice.

**Editor:** *How did you get started in this area of research?*

**Dr. Dunn:** I left a tenured university position in 1992 to become a member of the newly formed Posttraumatic Stress Disorders Clinical Team (now the TRP) at the MEDVAMC. This position offered me the opportunity to return to the Texas Medical Center in Houston where I had previously completed my postdoctoral training. The newly formed clinic offered the promise of integrating many of my previous activities in the location that I desired. Although this position primarily afforded clinical opportunities initially, I’ve been able to bring my unique academic background to the MEDVAMC and develop a strong emphasis on clinical, research, and teaching endeavors.

**Editor:** *What active studies do you have going?*

**Dr. Dunn:** Notably, we’ve completed an extensive, 5-year, VA Health Services Research and Development (HSR&D) funded study that was a randomized clinical trial on the efficacy and cost-effectiveness of Self-Management Therapy (SMT), a well-validated group cognitive-behavioral therapy for depression, as compared to a Psychoeducational Group Therapy in veterans with chronic PTSD and depression. The impetus for this work was the clinical observation that many of our veterans were significantly depressed and consequently were having difficulty in availing themselves of the PTSD-focused interventions in our clinic. Based on earlier pilot work, we felt that providing a primary focus on alleviating depressive symptoms would also help to facilitate the PTSD treatment. Results of this study are currently in press and indicated that the depression treatment was somewhat effective during the course of treatment. There was also a decrease in utilization of services over time. The clear challenge for future research in these chronic conditions, however, is to sustain treatment gains over time. This study was one of the first efforts to integrate clinical and research endeavors in our clinical setting. It also afforded me the opportunity to train graduate students at a local university in clinical-research endeavors, and interns and postdoctoral fellows with our training program.

We’ve continued to conduct treatment outcome studies in our clinic that also include a focus on other anxiety conditions that are co-morbid with PTSD. Within this realm, I’ve continued to mentor trainees and junior investigators in the development, implementation, and evaluation of evidence-based programs within our clinic. I’m particularly pleased that we were able to recruit Dr. Ellen Teng, one of the former MIRECC psychology postdoctoral fellows whom I

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mentored, into a research psychologist position in the Trauma Recovery Program (TRP). This is one example of a focus within our MIRECC to “grow our own” researchers. Dr. Teng is continuing her earlier postdoctoral work on cognitive-behavioral interventions for our patients who have PTSD and panic disorder, a combination that is extremely distressing to veterans, but very treatment responsive. The initial randomized controlled trial of providing a cognitive-behavioral intervention to treat panic attacks in veterans with PTSD and panic attacks versus supportive therapy has proven to be quite effective. Additional work has focused on novel ways to implement the treatment in our clinical setting.

Finally, I’m also the site Principal Investigator on a multi-site, HSR&D grant (PI: Mary Sano, Ph.D.) that is evaluating a bioterrorism preparedness campaign for veterans. Overall, the PTSD area has provided me with exciting opportunities in both chronic and acute PTSD and in conducting cutting-edge research on topics of considerable importance in today’s world. My goal for future work is to extend these efforts into treating our veterans who are now returning from Iraq and Afghanistan.

**Editor:** *What are the implications or potential benefits of your research?*

**Dr. Dunn:** I’ve always felt strongly that it’s important to bring the most current research findings into mainstream clinical practice in a timely manner. The research that I conduct has implications for determining whether therapies proven effective in other settings are also effective with our patient population, and determining ways to best implement them into routine clinical care.

**Editor:** *What person or experience had the most influence on your research career?*

**Dr. Dunn:** I’ve been very fortunate throughout my career to have strong mentors and collaborators. My graduate school mentor, Dr. Theodore Jacob, taught me the importance of conducting rigorous, high quality research that has the potential to make a difference in our scientific understanding of various conditions and that could ultimately have an impact on the individuals whom we study. My postdoctoral training program under Dr. George Niederehe included both psychologists and psychiatrists and highlighted the importance of disciplines working together in providing stellar research and clinical services. That training has served me well in my current position as the Psychology Director of the South Central MIRECC VA Special Fellowship in Advanced Psychiatry and Psychology. Finally, I’ve valued my collaborations with Drs. Vance Hamilton (MEDVAMC Mental Health Care Line Executive) and Dr. Lynn Rehm (Professor of Psychology at the University of Houston) in trying to provide the best treatments for our veterans who suffer from PTSD and depression. I’ve learned a lot from their research, clinical, and administrative expertise in translating research into clinical practice.

**Editor:** *What advice would you give to junior investigators and to people who are new to research?*

**Dr. Dunn:** I believe that it’s important to have a passion for the general area of research that is chosen. Specific funding priorities may change over time, but true commitment to an area can sustain a researcher through the ups and downs that are always a part of the research endeavor. Finding a mentor who has the time, commitment, and experience to guide a junior investigator is also critically important.

**Editor:** *How can people get in touch with you if they have questions about your work?*

**Dr. Dunn:** I can be reached most easily at my VA email address: [Dunn.NancyJ@med.va.gov](mailto:Dunn.NancyJ@med.va.gov)



**The May MIRECC Research Rounds is Cancelled  
Due to the Trauma Conference**

## May Conference Calls 1-800-767-1750

- 7—Education Core, 2:00 PM CT, access code 16281#
- 8—Directors Call, 3:30 PM CT, access code 19356#
- 14—Research Rounds, 2:00 PM CT, *cancelled due to the Trauma Conference*
- 16—Program Assistants, 2:00 PM CT, access code 43593#
- 17—PSR Group Call, noon PM CT, access code 85388#
- 22—Directors Call, 3:30 PM CT, access code 19356#
- 26—National MIRECC Recovery Interest Group, noon CT, access code 22233#



The next issue of the *South Central MIRECC Communiqué* will be published June 4, 2007. Deadline for submission of items to the June newsletter is May 28. Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Michael R. Kauth, Ph.D., at [Michael.Kauth@med.va.gov](mailto:Michael.Kauth@med.va.gov).

South Central MIRECC Internet site: [www.va.gov/scmirecc](http://www.va.gov/scmirecc)

SC MIRECC intranet site: [yaww.visn16.med.va.gov/mirecc/mirecc.htm](http://yaww.visn16.med.va.gov/mirecc/mirecc.htm)

National MIRECC Internet site: [www.mirecc.va.gov](http://www.mirecc.va.gov)