



Post-Traumatic Stress Disorder *February , 2004*

1: Am J Nurs. 2003 Nov;103(11):32-41; quiz 42.

PTSD in the World War II combat veteran.

Kaiman C.

Psychiatric Mental Health Nursing, New Mexico Veterans Affairs Health Care System, Albuquerque, USA. ckaiman@comcast.net

Publication Types:

Case Reports

Review

Review, Tutorial

PMID: 14625422 [PubMed - indexed for MEDLINE]

2: Am J Psychiatry. 2003 Nov;160(11):2018-24.

The relationship of borderline personality disorder to posttraumatic stress disorder and traumatic events.

Golier JA, Yehuda R, Bierer LM, Mitropoulou V, New AS, Schmeidler J, Silverman JM, Siever LJ.

Department of Psychiatry, Veterans Affairs Medical Center (116-A), 130 West Kingsbridge Road, Bronx, NY 10468, USA. julia.golier@med.va.gov

OBJECTIVE: The authors examined the relationship of borderline personality disorder to posttraumatic stress disorder (PTSD) with respect to the role of trauma and its timing. **METHOD:** The Trauma History Questionnaire and the PTSD module of the Structured Clinical Interview for DSM-III-R were administered to 180 male and female outpatients with a diagnosis of one or more DSM-III-R personality disorders. Path analysis was used to evaluate the relationship between borderline personality disorder and PTSD. **RESULTS:** High rates of early and lifetime trauma were found for the subject group as a whole. Compared to subjects without borderline personality disorder, subjects with borderline personality disorder had significantly higher rates of childhood/adolescent physical abuse (52.8% versus 34.3%) and were twice as likely to develop PTSD. In

the path analysis of the relationship between borderline personality disorder and PTSD, none of the different types of paths (direct path, indirect paths through adulthood traumas, paths sharing the antecedent of childhood abuse) was significant. The associations with both trauma and PTSD were not unique to borderline personality disorder; paranoid personality disorder subjects had an even higher rate of comorbid PTSD than subjects without paranoid personality disorder, as well as elevated rates of physical abuse and assault in childhood/adolescence and adulthood. CONCLUSIONS: The associations of personality disorder with early trauma and PTSD were evident, but modest, in borderline personality disorder and were not unique to this type of personality disorder. The results do not appear substantial or distinct enough to support singling out borderline personality disorder from the other personality disorders as a trauma-spectrum disorder or variant of PTSD.

PMID: 14594750 [PubMed - indexed for MEDLINE]

3: Auton Neurosci. 2003 Oct 31;108(1-2):63-72.

Effects of posttraumatic stress disorder on cardiovascular stress responses in Gulf War veterans with fatiguing illness.

Peckerman A, Dahl K, Chemitiganti R, LaManca JJ, Ottenweller JE, Natelson BH.

VA Medical Center, East Orange, NJ 07018, USA. apeckerm@njneuromed.org

Abnormal cardiovascular stress responses have been reported in Gulf War veterans with chronic fatigue. However, many of these veterans also suffer from posttraumatic stress disorder (PTSD), which could potentially explain the reported abnormalities. To test this hypothesis, 55 Gulf veterans (GVs) with chronic fatigue syndrome (CFS) or idiopathic chronic fatigue (ICF) were stratified into groups with (N=16) and without (N=39) comorbid PTSD, and were compared to healthy Gulf veterans (N=47) on cardiovascular responses to a series of stressors. The CFS/ICF with PTSD group had lower blood pressure responses to speech and arithmetic tasks, and more precipitous declines and slower recoveries in blood pressure after standing up than the controls. Similar trends in the CF/ICF group without PTSD were not significant, however. Both CFS/ICF groups had blunted increases in peripheral vascular resistance during mental tasks. However, only the veterans with comorbid PTSD had diminished cardiac output responses to the mental stressors and excessive vasodilatory responses to standing. Symptoms of posttraumatic stress were significant predictors of hypotensive postural responses, but only in veterans reporting a significant exposure to wartime stress. We conclude that comorbid PTSD contributes to dysregulation of cardiovascular responses to mental and postural stressors in Gulf veterans with medically unexplained fatiguing illness, and may provide a physiological basis for increased somatic complaints in Gulf veterans with symptoms of posttraumatic stress.

PMID: 14614966 [PubMed - indexed for MEDLINE]

4: Int J Emerg Ment Health. 2003 Fall;5(4):211-5.

Large group crisis intervention for law enforcement in response to the September

11 World Trade Center mass disaster.

Castellano C.

UMDNJ-University Behavioral HealthCare, 151 Centennial Avenue, Piscataway, NJ 08854, USA.

University Behavioral HealthCare, University of Medicine and Dentistry of New Jersey in partnership with the New Jersey Department of Personnel established a program entitled "Cop 2 Cop" in 1999 to assist law enforcement personnel within the state. The events of September 11, 2001, demanded an unprecedented response to address the behavioral health care needs of those individuals in New Jersey and New York. Although the Cop 2 Cop program was initiated as a crisis intervention hotline, the legislature which established the program also identified facilitating Critical Incident Stress Management services for New Jersey law enforcement and their families as needed to be within the scope of function. This paper describes the Cop 2 Cop program interventions with the Port Authority Police Department (PAPD) which involved service provision to over 1,200 PAPD officers and an intensified process entitled an "Acute Stress Management Reentry Program" created for over 200 officers with unprecedented exposure to traumatic events.

PMID: 14730762 [PubMed - indexed for MEDLINE]

5: J Clin Psychiatry. 2004;65 Suppl 1:55-62.

Consensus statement update on posttraumatic stress disorder from the international consensus group on depression and anxiety.

Ballenger JC, Davidson JR, Lecrubier Y, Nutt DJ, Marshall RD, Nemeroff CB, Shalev AY, Yehuda R.

Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, North Carolina, USA. ballengerjc@aol.com

OBJECTIVE: To provide an update to the "Consensus Statement on Posttraumatic Stress Disorder From the International Consensus Group on Depression and Anxiety" that was published in a supplement to The Journal of Clinical Psychiatry (2000) by presenting important developments in the field, the latest recommendations for patient care, and suggestions for future research. **PARTICIPANTS:** The 4 members of the International Consensus Group on Depression and Anxiety were James C. Ballenger (chair), Jonathan R. T. Davidson, Yves Lecrubier, and David J. Nutt. Other faculty who were invited by the chair were Randall D. Marshall, Charles B. Nemeroff, Arieh Y. Shalev, and Rachel Yehuda. **EVIDENCE:** The consensus statement is based on the 7 review articles in this supplement and the related scientific literature. **CONSENSUS PROCESS:** Group meetings were held over a 2-day period. On day 1, the group discussed topics to be represented by the 7 review articles in this supplement, and the chair identified key issues for further debate. On day 2, the group discussed these issues to arrive at a consensus view. After the group meetings, the consensus statement was drafted by the chair and approved by all faculty. **CONCLUSION:** There have been advancements in the science and treatment of posttraumatic stress disorder. Attention to this disorder has increased with recent world events; however, continued efforts are needed to improve diagnosis, treatment,

and prevention of posttraumatic stress disorder.

Publication Types:

Consensus Development Conference
Review

PMID: 14728098 [PubMed - indexed for MEDLINE]

6: J Clin Psychiatry. 2004;65 Suppl 1:11-7.

Structural and functional brain changes in posttraumatic stress disorder.

Nutt DJ, Malizia AL.

Psychopharmacology Unit, University of Bristol, Bristol, United Kingdom.
david.j.nutt@bristol.ac.uk

Posttraumatic stress disorder (PTSD) is a highly disabling condition that is associated with intrusive recollections of a traumatic event, hyperarousal, avoidance of clues associated with the trauma, and psychological numbing. The field of neuroimaging has made tremendous advances in the past decade and has contributed greatly to our understanding of the physiology of fear and the pathophysiology of PTSD. Neuroimaging studies have demonstrated significant neurobiologic changes in PTSD. There appear to be 3 areas of the brain that are different in patients with PTSD compared with those in control subjects: the hippocampus, the amygdala, and the medial frontal cortex. The amygdala appears to be hyperreactive to trauma-related stimuli. The hallmark symptoms of PTSD, including exaggerated startle response and flashbacks, may be related to a failure of higher brain regions (i.e., the hippocampus and the medial frontal cortex) to dampen the exaggerated symptoms of arousal and distress that are mediated through the amygdala in response to reminders of the traumatic event. The findings of structural and functional neuroimaging studies of PTSD are reviewed as they relate to our current understanding of the pathophysiology of this disorder.

Publication Types:

Review
Review, Tutorial

PMID: 14728092 [PubMed - indexed for MEDLINE]

7: J Clin Psychiatry. 2004;65 Suppl 1:29-36.

Risk and resilience in posttraumatic stress disorder.

Yehuda R.

Bronx VA Medical Center, Mt. Sinai School of Medicine, Bronx, NY, USA.
rachel.yehuda@med.va.gov

Posttraumatic stress disorder (PTSD) is a fairly common psychiatric disorder that is associated with a lifetime prevalence of approximately 9% in the United

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States. In light of recent war and terrorist activity worldwide, it is likely that increased numbers of individuals will be exposed to severe or life-threatening trauma, and the incidence of PTSD may be even higher than previously indicated in epidemiologic studies. PTSD may develop after exposure to a traumatic event in which the individual experienced, witnessed, or was confronted by either actual or threatened loss of life or serious injury. Patients with PTSD often reexperience intrusive recollections of the event in ways that are highly distressing and may be described as reliving the memory. Not surprisingly, symptoms of avoidance are noted because individuals with PTSD often wish to escape recollections (thoughts, feelings, conversations, places) related to the trauma. Patients also experience symptoms of hyperarousal associated with difficulty concentrating or exaggerated startle response. Notably, individuals who develop PTSD represent only a subset of those exposed to trauma. It is of interest why certain individuals are at risk for development of PTSD after traumatic exposure, whereas others appear to be more resilient to the effects of trauma. Studies suggest that previous exposure to trauma and intensity of the response to acute trauma may affect the development of PTSD. In addition, however, neuroendocrine changes, such as lower cortisol levels, also may influence formation and processing of traumatic memories and may be associated with the underlying pathology of PTSD.

Publication Types:

Review
Review, Tutorial

PMID: 14728094 [PubMed - indexed for MEDLINE]

8: J Clin Psychiatry. 2004;65 Suppl 1:37-43.

Science for the community: assessing mental health after 9/11.

Marshall RD, Galea S.

New York State Psychiatric Institute, New York, NY 10032, USA.
randall@nyspi.cpmc.columbia.edu

Reactions to the September 11 attacks across the United States were pervasive, and persons throughout the country reported experiences akin to posttraumatic stress disorder (PTSD) in the first week following the attacks. In the New York area, 2 major surveys conducted 4 to 8 weeks after the attacks found that approximately 1 in 10 persons probably met full criteria for PTSD related to September 11. Although tobacco, alcohol, and marijuana use did increase, it was largely among persons already using these substances. The greatest increase, not surprisingly, occurred among persons with PTSD and major depressive disorder. Nationwide during the same time period, rates of PTSD related to September 11 were estimated at 2.7% to 4.3%, a striking finding in that the attacks were witnessed primarily on television outside the New York area. In all studies, having anxiety symptoms or meeting criteria for PTSD was strongly associated with number of hours of television watched on September 11 and in the days afterward. A number of explanations for this new finding are possible. These data can inform our understanding of trauma-related diagnoses, further the evolving diagnostic definitions of the Diagnostic and Statistical Manual of Mental Disorders, and contribute to etiologic models of PTSD. Future directions for postdisaster survey research are briefly discussed.

PMID: 14728095 [PubMed - indexed for MEDLINE]

9: J Clin Psychiatry. 2004;65 Suppl 1:44-8.

Long-term treatment and prevention of posttraumatic stress disorder.

Davidson JR.

Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, NC 27710, USA. jonathan.davidson@duke.edu

Posttraumatic stress disorder (PTSD) is a disabling condition almost universally associated with psychiatric comorbidity, reduced quality of life, and a chronic, often lifelong, course. Although acute treatment with selective serotonin reuptake inhibitors (SSRIs) has been shown to be effective, successful strategies for preventing PTSD have not been established. In addition, studies of the long-term treatment of chronic PTSD are just beginning to emerge. This review considers available evidence for the secondary prevention of PTSD in the acute aftermath of trauma and the long-term treatment of established PTSD. Unanswered questions pertaining to duration of treatment, candidates for long-term treatment, and potentially harmful treatments will also be considered.

Publication Types:

Review

Review, Tutorial

PMID: 14728096 [PubMed - indexed for MEDLINE]

10: J Clin Psychiatry. 2004;65 Suppl 1:49-54.

Posttraumatic stress disorder in primary care: a hidden diagnosis.

Lecrubier Y.

Hopital la Salpetriere, INSERM, Paris, France. lecru@ext.jussieu.fr

Posttraumatic stress disorder (PTSD) is common worldwide, with prevalence rates ranging from 1% to nearly 40%, depending on the population studied. The disability and natural course of PTSD in psychiatric patients have been well characterized. However, even though the primary care setting has been described as the "de facto mental health care system," surprisingly little is known about PTSD in primary care. Available data from primary care clinics in the United States and Israel suggest that PTSD may be as prevalent in this setting as has been reported in large epidemiologic studies. Patients may be unlikely to endorse traumatic experiences or may not consider them related to their current psychological problems. The prevalence of PTSD in primary care may indeed be higher than expected because of underreporting of domestic violence and other histories of trauma. Recognition of PTSD in primary care could be greatly improved if simple trauma histories were integrated into routine medical examinations. Primary care clinicians who maintain a high index of suspicion for PTSD in their patients with positive histories of trauma plus symptoms of

depression or anxiety or other signs of psychological distress, suicidal thoughts or actions, alcohol or substance abuse, or excessive health care service utilization may increase the recognition rate of this disorder in their practices.

Publication Types:

Review

Review, Tutorial

PMID: 14728097 [PubMed - indexed for MEDLINE]

11: J Clin Psychiatry. 2003 Oct;64(10):1230-6.

Mental health treatment received by primary care patients with posttraumatic stress disorder.

Rodriguez BF, Weisberg RB, Pagano ME, Machan JT, Culpepper L, Keller MB.

Department of Psychiatry and Human Behavior, Brown University Medical School, Providence, R.I., USA. benrodii@siu.edu

BACKGROUND: Posttraumatic stress disorder (PTSD) is receiving growing attention as a pervasive and impairing disorder but is still undertreated. Our purpose was to describe the characteristics of mental health treatment received by primary care patients diagnosed with PTSD. **METHOD:** 4383 patients from 15 primary care, family practice, or internal medicine clinics were screened for anxiety symptoms using a self-report questionnaire developed for the study. Those found positive for anxiety symptoms (N = 539) were interviewed with the Structured Clinical Interview for DSM-IV. Of these patients, 197 met diagnostic criteria for PTSD and were examined in the present study regarding the rates and types of mental health treatment they were currently receiving. Data were gathered from July 1997 to May 2001. **RESULTS:** Nearly half (48%) of the patients in general medical practice with PTSD were receiving no mental health treatment at the time of intake to the study. Of those receiving treatment, psychopharmacologic interventions were most common. Few patients were receiving empirically supported psychosocial interventions. Current comorbid major depressive disorder and current comorbid panic disorder with agoraphobia were significantly associated with receiving mental health treatment (major depressive disorder, $p < .10$; panic disorder with agoraphobia, $p < .05$). The most common reason patients gave for not receiving medication was the failure of physicians to recommend such treatment, which was also among the most common reasons for not receiving psychosocial treatment. **CONCLUSIONS:** Despite the morbidity, psychosocial impairment, and distress associated with PTSD, substantial proportions of primary care patients with the disorder are going untreated or are receiving inadequate treatment. Results suggest a need for better identification and treatment of PTSD in the primary care setting.

PMID: 14658973 [PubMed - indexed for MEDLINE]

12: J Okla State Med Assoc. 2003 Nov;96(11):526-9.

Psychological issues associated with terrorism: a guide for physicians.

Pfefferbaum RL, Brandt EN Jr, Patel HP, Gurwitch RH, Schreiber MD, Pfefferbaum B.

Phoenix College, Phoenix, Arizona, USA.

PMID: 14699655 [PubMed - indexed for MEDLINE]

13: J Trauma Stress. 2003 Oct;16(5):495-502.

Psychometric properties of the PTSD Checklist-Civilian Version.

Ruggiero KJ, Del Ben K, Scotti JR, Rabalais AE.

Department of Psychiatry and Behavioral Sciences, National Crime Victims Research and Treatment Center, Medical University of South Carolina, Charleston, South Carolina 29425, USA. ruggierk@musc.edu

We examined the psychometric properties of the PTSD Checklist (PCL), a self-report instrument designed to assess symptoms of posttraumatic stress disorder. Three hundred ninety-two participants recruited in a university setting completed the PCL in addition to several well-established self-report instruments designed to assess various forms of psychopathology (e.g., depression, general anxiety, PTSD). Ninety participants returned for readministration of selected measures. Findings provided support for psychometric properties of the PCL, including internal consistency, test-retest reliability, convergent validity, and discriminant validity. Additional strengths of the PCL are discussed.

Publication Types:
Clinical Trial

PMID: 14584634 [PubMed - indexed for MEDLINE]

14: J Trauma Stress. 2003 Oct;16(5):503-7.

Symptom exaggeration and compensation seeking among combat veterans with posttraumatic stress disorder.

DeViva JC, Bloem WD.

Department of Psychiatry, Dartmouth Medical School, Lebanon, New Hampshire 03756-0001, USA. jason.deviva@dartmouth.edu

Combat veterans seeking treatment for posttraumatic stress disorder (PTSD) tend to report high levels of psychopathology on self-report instruments. The purpose of the current archival study was to replicate research on the relationships among symptom exaggeration, attempts to obtain compensation, and treatment outcome on the Beck Depression Inventory, the Mississippi Scale for Combat-Related PTSD, and selected MMPI-2 and MCMI-II subscales. Results indicated that symptom exaggeration as defined by an MMPI-2 F-K index over 13 was related to higher scores on all scales examined. Compensation seeking was

not related to assessment scores or exaggeration. Neither compensation seeking nor exaggeration was related to treatment outcome. Limitations of the study and implications for future research are discussed.

PMID: 14584635 [PubMed - indexed for MEDLINE]

15: J Trauma Stress. 2003 Oct;16(5):509-13.

Imagery rehearsal in the treatment of posttraumatic nightmares in Australian veterans with chronic combat-related PTSD: 12-month follow-up data.

Forbes D, Phelps AJ, McHugh AF, Debenham P, Hopwood M, Creamer M.

Australian Centre for Posttraumatic Mental Health, West Heidelberg, Victoria, Australia. dforbes@unimelb.edu.au

Nightmares are often a distressing symptom for veterans with chronic combat-related posttraumatic stress disorder (PTSD). A psychological treatment that has recently shown considerable promise is Imagery Rehearsal Therapy (IRT). In a pilot study by the current authors, IRT was demonstrated to be effective in the treatment of posttraumatic nightmares in a group of combat veterans up to 3-month posttreatment. This study reports the 12-month follow-up data of the pilot study, examining the longer term outcome of the IRT treatment. Twelve Australian Vietnam veterans with chronic combat-related PTSD were treated with 6 once weekly sessions of imagery rehearsal and assessed using standardised measures of nightmare frequency and intensity, PTSD, depression, anxiety and broader symptomatology at intake, posttreatment, and 3- and 12-month follow-up. Significant improvements in targeted nightmare frequency and intensity were evident to 12-month posttreatment. Similarly, improvements in overall PTSD, depression, anxiety, and broader based symptomatology were also maintained to 12 months. This study provides preliminary evidence that the positive treatment effects of IRT on posttraumatic nightmares, PTSD, and broader symptomatology in males with chronic combat-related PTSD are maintained in the longer term.

Publication Types:
Clinical Trial

PMID: 14584636 [PubMed - indexed for MEDLINE]

16: J Trauma Stress. 2003 Oct;16(5):519-22.

Posttraumatic stress disorder (PTSD) in the Armed Forces: health economic considerations.

McCrone P, Knapp M, Cawkill P.

Centre for the Economics of Mental Health, Health Services Research Department, Institute of Psychiatry, King's College London, United Kingdom.
p.mccrone@iop.kcl.ac.uk

This paper addresses the use of health economics in relation to posttraumatic stress disorder (PTSD) in the Armed Forces, with a view to assessing the

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feasibility of carrying out future evaluative studies. Although psychological and pharmacological interventions can be used to treat PTSD, no economic evaluations are known to exist. There is an economic burden associated with PTSD, and treatments require the use of scarce resources. Health economics provides tools (including cost-effectiveness, cost-benefit, and cost-utility analyses) to ascertain the relative efficiency of different treatment options. The paper concludes that the quality of life and resource consequences of PTSD require a better understanding of the economics of the disorder and the alternative ways to treat it.

PMID: 14584638 [PubMed - indexed for MEDLINE]

17: New Dir Youth Dev. 2003 Summer;(98):11-28.

Threat and trauma: an overview.

Macy RD, Barry S, Noam GG.

Center for Trauma Psychology, National Center for Child Traumatic Stress Network-Category III, Community Services, Trauma Center-Boston, USA.

Common responses after exposure to threat include reexperiencing the event, intrusive thoughts and images, hyperarousal, avoidance and numbing, a sense of a foreshortened future, and shattered assumptions about control and safety.

PMID: 12970985 [PubMed - indexed for MEDLINE]

18: Trauma Violence Abuse. 2003 Apr;4(2):112-26.

Ask not for whom the bell tolls: controversy in post-traumatic stress disorder treatment outcome findings for war veterans.

Scurfield RM, Wilson JP.

University of Southern Mississippi, USA.

This article reviews and analyzes two national studies of the efficacy of treatment for war veterans suffering from post-traumatic stress disorder (PTSD). A careful analysis of the studies conducted by the Department of Veterans Affairs (DVA) Northeast Program Evaluation Center (NEPEC) reveals conceptual, methodological, and design flaws in the research, which reports minimal treatment efficacy for PTSD. Based on this limited, if not biased, data, the results were used for policy purposes to dismantle inpatient PTSD hospital units and trauma-focus treatments. A critique is offered as a review to suggest how future studies might be conducted, designed, and evaluated, including the need for independent, "outside" peer reviews inasmuch as the issue of treatment outcomes generalizes to many nonmilitary populations.

Publication Types:

Review

Review, Tutorial

PMID: 14697118 [PubMed - indexed for MEDLINE]