Knowledge Gap Exists on Best Practices for PTSD

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CHICAGO — Two studies suggest that community-level mental health professionals are likely to assist active military personnel, veterans, and their families, but many feel unequipped to do so effectively.

Responses to a 38-item online survey of 132 mental health and spiritual care providers registered for a disaster mental health conference showed that none was “very familiar” or “somewhat familiar” with the research literature on assessment and treatment of active personnel, veterans, or military families.

When asked to indicate how confident they were in their ability to deliver services across a range of modalities and treatment domains, no mean value reached “somewhat confident,” Dr. James Halpern, Ph.D., and his colleagues reported at the annual meeting of the International Society for Traumatic Stress Studies (ISTSS).

Respondents lacked confidence to the greatest extent with delivering cognitive processing therapy and eye-movement desensitization and reprocessing (EMDR)—both of which are recommended in the new ISTSS best-practice guidelines for the treatment of posttraumatic stress disorder (PTSD).

The guidelines were presented at last year’s ISTSS annual meeting and formally published in November 2008, and recommend prolonged exposure therapy, cognitive processing therapy, stress inoculation training, other forms of cognitive therapy, EMDR, and medication.

In late 2007, the Institute of Medicine concluded that only exposure therapy had sufficient evidence supporting its effectiveness.

Only 14% of the 43 respondents now treating military personnel with PTSD used exposure therapy, cognitive therapy, or EMDR, while 67% used cognitive-behavioral therapy and 52.4% used psychoeducation and skills training.

Only 24% of all respondents endorsed exposure therapy, 27% endorsed EMDR, and 47.4% endorsed cognitive therapy. When asked to indicate areas that were vital for a colleague new to treating military personnel, only 24% endorsed exposure therapy, reported Dr. Halpern and co-principal investigator Phyllis R. Freeman, Ph.D., of the Institute for Disaster Mental Health and the department of psychology, State University of New York in New Paltz.

“This suggests that practitioners in our sample do not think it is important for them or for colleagues to use techniques recommended as best practice,” he said.

About half (51%) of the respondents had treated active military personnel and veterans in the past, and 22.5% were doing so at present. In addition, 43% previously had treated military family members, and 26% were currently doing so.

The sample was made up of clinical psychologists (15%), counseling psychologists (13%), psychiatrists (2%), mental health counselors (14%), marriage and family therapists (3%), creative arts therapists (2%), spiritual care providers (9%), social workers (40%), and nurses (2%). They had a mean of 14 years of experience (range, 0-45 years).

The second study used an hour-long focus session with 10 community mental health professionals to evaluate gaps in the research literature. Their responses clustered around six metathemes: assessment and treatment; specific symptoms in military personnel such as suicide and violence; effects of military culture such as redeployment and resistance to entering treatment; community and ecological factors including support for socially isolated military personnel; professional training opportunities; and the impact of military service and related symptoms on children and families.

Participants pointed out the importance of preventive interventions before deployment and also suggested interventions for families to prepare them for a soldier’s deployment, Dr. Halpern said.

Participants used several information sources to stay current on research, with most receiving their information from professional conferences and continuing education.

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