

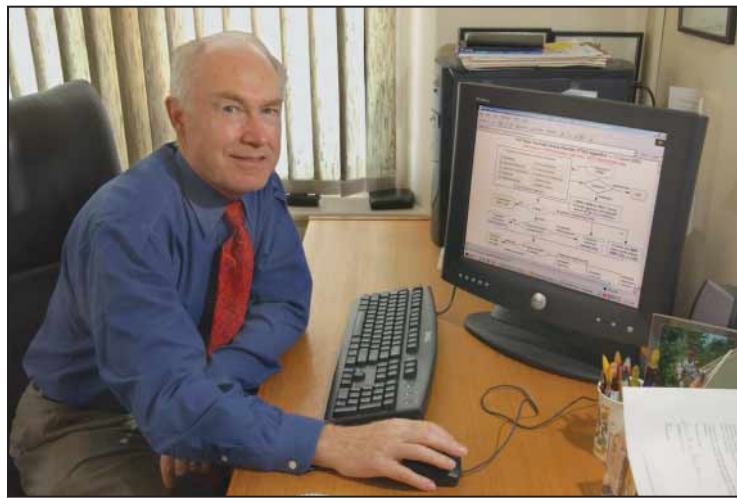
Online PTSD Treatment Algorithm Makes Debut

BY MICHELE G. SULLIVAN
Mid-Atlantic Bureau

An interactive, online treatment algorithm provides a decision tree complete with graded supporting evidence and special clinical considerations for patients with posttraumatic stress disorder.

The new tool is a product of the International Psychopharmacology Algorithm Project, said Jonathan Davidson, M.D., chairman of the IPAP PTSD algorithm faculty. Last year, the group launched its online, interactive algorithm for diagnosing and treating schizophrenia. Both are free to registered users at www.ipap.com.

"We hope the PTSD algorithm will be used both in the United States and internationally as a readily available" guide, Dr. Davidson said. "It presents clinicians with the types of problems they are likely to encounter with these patients and helps them identify where to start treatment and where to go next if treatment fails or if the patient is only partially responsive. It also lays out the evidence for those decisions."



The online PTSD treatment tool has the fluidity to respond quickly to new research or drug options, Dr. Jonathan Davidson says.

The algorithm is intended for use by mental health clinicians and primary care physicians who might be the first to suspect and diagnose PTSD in their patients. "It's very much aimed at people who are going to encounter these patients in general practice, and that includes all primary care physicians," said Dr. Davidson, professor of psychiatry and behavioral science at Duke University, Durham, N.C.

The document exists online, so it has the fluidity to respond quickly to any research or new

drug options that could alter treatment protocol, he added. As cochair of the committee that examined PTSD criteria for DSM-IV, Dr. Davidson appreciates that kind of flexibility. "You don't have to wait 2 years for a committee's suggestions to go through the bureaucracy."

The algorithm begins with the initial decision after a diagnosis of PTSD—whether to offer psychosocial therapy, pharmacotherapy, or both. Psychosocial factors, such as the presence of suicidality, psychoses, night-

mares, sleep disorder, and compliance, affect that decision.

It then explores initial medication choices along with appropriate dosages, calling for a minimum 4- to 6-week trial of a selective serotonin reuptake inhibitor or a selective norepinephrine reuptake inhibitor, or a tricyclic antidepressant if those choices are unavailable.

The algorithm really proves its usefulness after this node, he said, as it considers those patients who fail to respond or have only a partial response. "The question then is where to go. What do you do if, for example, the patients have continued nightmares?" Choices include increasing the dose or adding additional medications. If after several medication adjustments, there is still not adequate repose, the algorithm suggests reevaluating for another disorder and adding psychosocial therapy, as appropriate.

A click on any node in the algorithm takes the reader to notes containing literature references and grading the level of evidence upon which the decision node is based. Since it's also intended for use outside the U.S., all pharmacotherapy suggestions include al-

ternative drugs that may be more available in other countries.

The algorithm is being translated into Spanish, Chinese, Japanese, and Thai. In fact, Dr. Davidson and coauthor Kathryn Connor, M.D., are preparing to visit Thailand to help train 100 physicians to recognize and treat PTSD, with the algorithm playing an important part.

Areas of Thailand that were hit by the tsunami are experiencing high rates of PTSD, Dr. Davidson said. "In the United States, the prevalence is about 6%, and that has stayed relatively stable for years. The prevalence is obviously tied up with prevalence of trauma in a community and whether there is support for the survivors and preservation of the community, both of which are important determinants."

The PTSD algorithm was supported by grants from the Dean Foundation, a not-for-profit entity. The Dean Foundation accepts funds from pharmaceutical companies, including AstraZeneca, Bristol-Myers Squibb, Eli Lilly, Janssen, Johnson & Johnson, Novartis, Pfizer, Forest, Glaxo-SmithKline, UCB Pharma, and Wyeth-Ayerst. ■

PTSD Seen in Deployed Medical Personnel

BY DIANA MAHONEY
New England Bureau

ATLANTA— Medical personnel returning from combat deployment experience rates of posttraumatic stress disorder only slightly below those of returning soldiers, a study has shown.

Nearly 16% of medical personnel from one U.S. military hospital who had been deployed to the setting of large-scale, ongoing, armed conflict reported symptoms consistent with posttraumatic stress disorder (PTSD) in a voluntary, anonymous survey, said Tonya T. Kolkow, M.D., of Naval Medical Center San Diego. Whether a consequence of their exposure to battle scenes and wounded soldiers or a concern for their own safety and potential injury, "these individuals experience rates of PTSD somewhat comparable with that of returning soldiers who have engaged in battle," she said. Previous studies have estimated that 15%-20% of combat troops returning from war experience PTSD.

"Medical personnel who provide care in the field and in field hospitals comprise a unique group of individuals with their own distinct trauma exposure," Dr. Kolkow said in a poster presentation at the annual meeting of the American Psychiatric Association.

"Their training and experience with combat situations is likely to be more limited than that of military operational personnel, while their experience with

exposure to illness, trauma, and death may be more extensive," she noted.

To better understand the effects of war on medical personnel, including physicians, nurses, enlisted medical technicians, and other health care workers, who are assigned within the combat theater, Dr. Kolkow and her colleagues provided a voluntary, anonymous, Internet-based questionnaire to the medical staff of a major U.S. military hospital that has deployed a high number of personnel to support U.S. military efforts in Iraq and Afghanistan. Staff members were asked to participate regardless of whether they had been deployed to a combat zone.

The survey included questions about demographics, prior trauma experience, traumatic exposure, and emotional reactions during deployment, and rates of mental health care use before and after deployment. A total of 310 surveys were completed, including 102 from individuals who were deployed the previous year.

The investigators used the 17-item National Center for PTSD Checklist of the Department of Veterans Affairs (PCL-17) to detect PTSD symptoms and the depression scale of the Patient Health Questionnaire-9 to assess the presence of depressive symptoms.

In their PTSD assessments, "we used two case definitions—a broad screening definition in which respondents were scored as positive for PTSD if they endorsed DSM-IV criteria and a strict screening definition that required the

same distribution of symptoms along with a PCL-17 symptom severity score of 50 or higher, indicating a significant level of distress," Dr. Kolkow noted.

Of those who had been deployed to combat areas within the previous year, 15.7% met the broad PTSD criteria, 8.8% met the more conservative criteria, and 4.9% met criteria for probable depression.

While there was no association between combat deployment and presence of depression, deployment to a combat zone was significantly associated with the presence of both the broad and strict PTSD criteria after controlling for demographic variables," Dr. Kolkow said.

Individuals at greatest risk for developing PTSD included those who were directly exposed to combat; those who were fired upon by opposition forces; and those who reported experiencing significant fear for their own safety, anxiety, and helplessness during deployment, Dr. Kolkow said.

In the sample as a whole, ages younger than 35 years and the absence of a college degree were significant risk factors for the presence of PTSD. Those findings probably are likely reflective of the fact that the younger, less educated health care providers typically had more combat exposure, she said.

More research is needed to evaluate the psychological impact of combat deployment on medical personnel and to provide direction in addressing their mental health needs, Dr. Kolkow said. ■

Treat War Victims' Fears, Helplessness

Contrary to popular opinion, posttraumatic stress disorder and depression in war survivors appear to develop independently of a perceived lack of redress for trauma, according to a study conducted in three former Yugoslav republics.

Impunity for those responsible for trauma is widely believed to aggravate psychological problems in survivors of war.

But a cross-sectional survey of more than 1,300 war survivors in four areas of the former Yugoslavia suggests that a general fear-induced helplessness—rather than emotional responses to impunity specifically—is the most important mediating factor in PTSD and depression, said Metin Basoglu, M.D., of the Institute of Psychiatry at King's College in London, and associates (*JAMA* 2005;294:580-90).

Survivors had stronger emotional responses to impunity than did individuals who did not directly experience the trauma of war (the controls)—in addition to higher rates of PTSD and depression—but they also had greater fear and loss of control over life. It was these latter factors that played the biggest role, they said.

The findings might have "important implications for reconciliation efforts in post-war countries and effective interventions for traumatized war survivors," the investigators said.

—Christine Kilgore