Treating the trauma of war in women vets

Veterans of World War I and II, all of them men, experienced aftereffects of combat known then as "shell shock." In the wake of the Vietnam conflict, the condition acquired a new name—post-traumatic stress disorder (PTSD)—but most of its victims were still men. In today's military, however, women as well as men suffer psychological effects related to the trauma of combat.

Dartmouth psychiatry researcher Paula Schnurr, Ph.D., is determined to help the women who are serving on the front lines in Afghanistan and Iraq and thus are returning home in need of treatment for PTSD. She is leading the the first Veterans Affairs study to focus exclusively on female GIs and PTSD; it is also the largest individual psychotherapy trial ever done on PTSD.

PTSD is an anxiety disorder that develops after a traumatic event, whether it be engaging in combat, surviving a natural disaster, or experiencing sexual assault. Its symptoms can include nightmares, depression, emotional numbness, outbursts of anger, and feelings of intense guilt. By testing two forms of cognitive behavioral therapy, Schnurr and her colleagues hope to determine the most effective, lasting treatment for women, as well as men, at VAs across the country.

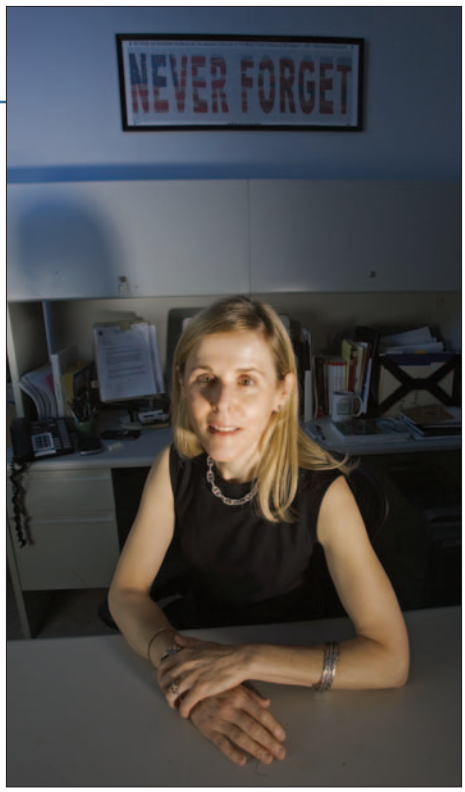
Schnurr, one of the study's principal investigators, is deputy executive director of the VA National Center for PTSD in White River Junction, Vt. Her team plans to start analyzing the data in November 2005 and to publish the results in February 2006.

The study has enrolled 283 women diagnosed with PTSD—aged 22 to 78, both active-duty personnel and veterans—from 12 sites: nine VA hospitals, two community VA centers, and Walter Reed Army Medical Center in Washington, D.C. While only a handful of the subjects have served in Iraq or Afghanistan (most enrolled in the study in 2002, before many troops started returning), of the 283 women, 198 (70%) have experienced sexual trauma, either in childhood, in the military, or since their discharge. "Although there are unique experiences for the women currently in Iraq, especially the exposure to hostile fire and use of weapons in ways that many women in the military—even in a war zone—haven't experienced, many other issues are quite similar. The event that we are really focusing on in the treatment [in this trial] is sexual trauma, and you don't have to be in a war zone, unfortunately, to experience that," says Schnurr.

Grand opera: The study employs nearly 120 people—therapists, supervisors, monitors, and investigators at the 12 participating sites, plus data analysts and a biostatistician at a data-coordinating center in Palo Alto, Calif. "This is the grand opera of treatment research," says Schnurr's DMS colleague and coprincipal investigator, Matthew Friedman, M.D., Ph.D. "We've been very fortunate having some excellent people working with us to coordinate all this."

The women in the trial were split into two groups. Half are being treated with exposure therapy and half with present-centered therapy. In exposure therapy, the premise is that reliving a traumatic experience "can help reduce the fears, the emotional distress associated with that experience," says Schnurr. "You're trying to allow them to remember without being overwhelmed by the pain." Patients relive the trauma through imaginary formats in therapy, as well as by going into real situations they may be avoiding because of their fears. "The goal is to uncouple the memory itself—which is never going to disappear—from all of the emotional baggage," adds Friedman. In present-centered therapy, patients talk about current problems in their daily lives—how the disorder affects their relationships, children, jobs, and so on—rather than about the past trauma.

Schnurr and Friedman believe both therapies will do well in the trial but that exposure therapy may do better, in part because the therapists are very enthusiastic about it.



CHRIS MILLMAN

Schnurr is heading the largest individual psychotherapy trial ever done on post-traumatic stress disorder; the poster behind her commemorates the trauma of 9/11.

Most had to be trained in the technique for the trial, which was a good simulation of how it would work in a real VA setting. The team chose exposure therapy because data suggested it would work in a wide range of patients—women and men, young and old.

"If the hypothesis is that the active ingredient, the thing that makes exposure therapy so effective, is the confrontation with the traumatic material in the safety of a therapist's office, then the comparison [present-centered] therapy has to be absolutely without that ingredient," says Friedman.

Role: But present-centered therapy may have a role as well. "It has all the non-specific components of trust, of therapeutic relationships . . . that any good psychotherapy consists of, so if the prolonged exposure beats it in this horse race, it will really be good evidence that it's the ingredient of the exposure itself that is the crucial difference," says Friedman.

Once the researchers know which therapy is more effective, they'll start implementing it in the VA system. MATTHEW C. WIENCKE