



# Communiqué

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## Cognitive Processing Therapy (CPT)

By Catherine E. Hansen, Ph.D., Clinical Psychologist, Alexandria VA of Louisiana and Kathleen M. Chard, Ph.D., CPT Implementation Team

Cognitive Processing Therapy (CPT) is a 12-session (usually once or twice weekly) trauma-focused, manualized cognitive-behavioral therapy for PTSD and other corollary symptoms of trauma (Chard, 2005; Resick et al., 2002, 2008; Resick & Schnicke, 1992, 1993). CPT is a recommended evidence-based therapy in the VA's clinical practice guidelines for PTSD and the National Center for PTSD due to its effectiveness for treating combat trauma (Monson et al., 2006). It is effective for several patient populations, including civilian and military rape victims, childhood sexual abuse survivors, and combat Veterans. Research is ongoing for the effectiveness of CPT in residential treatment programs and in conjunction with other treatments.

CPT is administered in individual, group, or combined group/individual formats for patients with a range of traumatic experiences. Support for the effectiveness of CPT as an evidence-based treatment for trauma derives from

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## Results of the SC MIRECC Recruitment Strategies Survey

By Ellen P. Fischer, PhD, P. Adam Kelly, PhD, and Dana Perry, MA  
for the MIDAS Team

### Background

With the application of HIPAA in the research arena, it has become much more challenging to find ways to make initial contact with potential study participants that will be both effective and acceptable to local institutional review boards (IRBs). There is a dearth of literature on recruitment strategies, especially in the Veteran population. In addition, it is becoming clear that the acceptability of various recruitment strategies to local IRBs changes over time and varies from facility to facility; effective strategies that are acceptable to one IRB may be vetoed by another.

As an outgrowth of the 2010 SC MIRECC Leadership Retreat, the MIRECC Implementation, Design and Analysis Support team (MIDAS) was asked to survey SC MIRECC-affiliated investigators involved in human-participants research about the effectiveness of various strategies they have

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## CPT (continued from page 1)

nearly 20 years of research and clinical work. Underlying assumptions for CPT include: 1) the theory that PTSD represents a failure to recover from the traumatic experience and 2) findings that people naturally recovering from trauma pursue an active cognitive process of understanding and insight. CPT assists patients in activating this process. Conceptual formulation also emanates from Beck & Emery (1985) regarding cognitive therapy utilizing cognitive restructuring.

CPT targets trauma-associated memories and feelings, as well as the disruption of beliefs about self, others, and the world. Providers use a Socratic style of therapy to modify clients' extreme beliefs, which allows clients to challenge their self-statements and to create a more balanced worldview. CPT treatment sessions typically begin by focusing on blame and undoing the traumatic event. Treatment progresses systematically through the most common areas of cognitive disruption: safety, trust, power/control, esteem, and intimacy.

The VA will likely monitor the number of evidence-based treatment providers on staff at medical centers nationwide, with the goal of ensuring that evidence-based treatments are available to Veterans. Providing these effective treatments will enable the VA to work through backlogs of patients requiring these services. This is particularly relevant for two reasons: 1) we are experiencing a much higher rate of combat survival in the current wars and 2) many soldiers with multiple lengthy deployments return in need of mental health services. The more trauma these soldiers sustain, the more difficult it is for them to experience spontaneous remission of symptoms. Evidence-based treatments such as CPT are more efficient in assisting greater numbers of Veterans because these are effective in group and residential formats.

Currently, the VA is implementing a national CPT training initiative targeting providers, including psychologists, licensed counselors, social workers, physicians, nurse practitioners, and clinical nurse specialists, who regularly provide psychotherapy to Veterans with PTSD. Regional training is also available to students and non-permanent hires (e.g., practicum students, psychology interns, postdoctoral fellows), as well as new staff working with PTSD. Licensed or license-eligible clinicians can also participate in these trainings. The CPT implementation team provides comprehensive training consisting of didactics and experience-based case consultation. Trainees must attend a three-day basic and group CPT workshop (two-day review workshops are also available) followed by weekly group phone consultation for six months to discuss active CPT cases

and share training experiences. Program completion consists of at least two individual or one group therapy session using the CPT implementation team approved model.

Providers will receive many benefits from completing the training, including access to education and referral resources, such as the CPT Provider SharePoint website and the VA CPT Provider membership list. VA Central Office, the Office of Mental Health Services, and regional/local VA mental health leadership will also recognize providers. Furthermore, CPT providers will be among a large and growing community of clinicians able to make a difference in the lives of Veterans through their commitment to providing evidence-based treatments for PTSD.

Patients will also benefit from receiving CPT from a trained provider. They can expect recovery from PTSD, which many believe will never happen. They will be able to let go of prior maladaptive thoughts and behaviors that keep them stuck in unhealthy relationships. Veterans begin to live much fuller lives; socializing more, often enjoying activities not pursued since before the traumatic event, and developing more depth in their relationships. Finally, they will learn that PTSD is not who they are.

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used in contacting potential participants. In spring 2011, MIDAS sent a brief electronic questionnaire to SC MIRECC investigators involved in research with human participants. Respondents who were principal investigators on more than one study could complete a separate questionnaire for each of those studies.

We received responses from 27 separate investigators who reported on 39 unique studies. Four of the studies were secondary data analyses that did not involve participant recruitment, so no additional information was collected on them. The majority of the remaining 35 studies (21/35; 60.0%) were experimental; 37.1% (13/35) were observational; no design was specified for one study (2.9%).

### What strategies were used?

We asked respondents to indicate which of seven common strategies they had used in the study they were reporting on. The strategies listed were (1) posting flyers at clinical sites, (2) posting flyers in community sites, (3) requesting that clinicians refer potentially eligible Veterans, (4) requesting Veterans already participating in the study to refer other eligible Veterans, (5) identifying potential participants through registries, (6) contacting Veterans through the mail using opt-in letters, and (7) contacting Veterans through the mail using opt-out letters. Opt-in letters state that a Veteran will be contacted by study personnel only if he/she responds to the initial letter (usually via post-card or telephone) stating that he/she is interested in the study; opt-out letters state that the Veteran will be contacted unless he/she responds to the initial letter within a specified period stating that he/she does not want to be contacted by study personnel. Because many studies use multiple strategies concurrently or sequentially to contact potential participants, respondents were asked to indicate all strategies used, including those not on our list.

The strategies used most frequently were clinician referral (62% of studies), flyers posted in clinical sites (49%), opt-out letters (36%), and participant referral (23%). In addition to the common strategies we asked

about, investigators reported doing community outreach through educational presentations (n=2), approaching potential participants during clinical visits (n=2), placing recruitment ads in local military newspapers (n=1), and being approached by a chapter of the National Association of Veterans' Research and Education Foundations (NAVREF), a VA-affiliated non-profit group that had learned about the study on ClinicalTrials.gov and was interested in making its membership aware of the study (n=1).

***The Recruitment Strategies Survey was designed to gather evidence to help investigators select effective and efficient recruitment strategies and to justify their choice of strategies to funding agencies and IRBs. SC MIRECC investigators highlighted the difficulty in recruiting Veterans, particularly OEF/OIF/OND service-era Veterans. Respondents most often found opt-out letters and registries to be the most effective strategies they had tried, and least often reported community flyers, opt-in letters and flyers at clinical sites to be the most effective.***

### Which strategies were rated most effective?

Respondents were asked to rate the effectiveness of strategies in both absolute and relative terms. They were first asked to rate the effectiveness of each of the strategies they had used or to indicate that it was still too early in the study to assess a strategy's effectiveness. Most strategies were considered effective by at least 50% of those who responded to the question and did not indicate that it was too early to tell. However, only 25% of respondents rated flyers posted at community sites effective and only 21% rated flyers posted at clinical sites effective.

Each respondent was also asked to indicate which of the strategies had been most effective for the study being reported on. By definition, if a single strategy had been used, it was the most effective one for that study. In that context, we were most interested in the ratings of respondents who had used multiple strategies in a single study. Twenty-three studies had used multiple strategies. In these studies, the three strategies most often ranked "most effective" by those who had used them were other (70%), opt-out letters (50%),

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and registries (50%). The three strategies least likely to be ranked “most effective” by those who had used them were community flyers (0%), opt-in letters (0%), and flyers in clinical sites (10%).

Care must be taken in interpreting the high ranking for “other” strategies. These were used in very few studies and information on effectiveness was provided only for community outreach and for one of the two studies that approached potential participants in clinical settings. The latter is also of limited relevance as approaching Veterans in clinical settings is not an option for non-clinician investigators.

### Strategies not approved by IRBs

Several investigators reported having had an IRB disapprove a proposed recruitment strategy. The Oklahoma City VAMC does not allow research recruitment flyers to be posted at the VAMC, although this is one of the most commonly used approaches elsewhere. The opt-out letter strategy was originally disapproved by the CAVHS (Little Rock) IRB although they have subsequently allowed it. Two investigators noted that they would have liked to have directly contacted potential participants in the waiting room/clinic without a previous opt-in or opt-out letter. One investigator would have liked to use e-mail to contact potential participants.

### Investigators’ comments re lessons learned

We asked investigators what lessons they had learned about recruitment strategies that they would like to share with others. Their three main themes are outlined below with illustrative comments.

#### *You are right – recruiting, especially recruiting OEF/OIF/OND Veterans, is hard*

- “Recruiting patients with schizophrenia in the VA is very difficult ...”
- “It’s hard & takes perseverance & connections.”
- “It was more difficult to recruit OEF/OIF Veterans who were not in care than we thought. That was even with the PI participating in drill weekend activities for the National Guard.”

- “We tried to use an incentive (offering to donate a teddy bear to the local National Guard for each survey returned) to motivate our vets to return a 1-page (short & easy!!) survey. We gave postage paid envelopes & all. However, even with doing this at 2 sites, we got ZERO returned. Very discouraging & frustrating.”
- “Despite ours being an interview-only study (no treatment involved), OEF/OIF Veterans with PTSD are proving to be the hardest group of Veterans I have ever tried to recruit.”

#### *If you can only use one approach, make it the opt-out letter and try to avoid having to go through providers for permission to contact their patients*

- “Opt-out recruitment is critical to success. We had five sites in this study. One site did not allow opt-out and that site’s recruitment was dismal.”
- “We’ve tried a lot of things on other smaller studies but the opt-out letter has worked the best so far. We’re also lucky that we do psycho-oncology and so we have the luxury of pulling names from the VA cancer registry to identify cases.”
- “For prior studies, we used opt out, but we [had to get] permission from Veterans’ primary care providers to contact them and [then]sent [the] letter [out] from the provider. For this study, IRB approved for us to use VA administrative databases to get addresses of patients with dementia and send them letters directly without going through their providers. I am certain this will decrease our costs and improve recruitment.”

#### *Active clinician buy-in is hard to get, especially if you’re not a clinician, but it is invaluable if you can really get it*

- “It is very difficult to get direct referrals from providers given the multiple demands on their time.”
- “Recruiting patients with schizophrenia in the VA is very difficult - especially if you do not work (treat patients) in the clinic.”
- “[You] have to be very assertive; have a real presence with other treatment teams – attend team meetings regularly, be willing to take their “hard” cases and provide training to staff on [your] interventions to motivate them.”

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- “Referrals from clinicians really seem to be most effective. Having working relationships with the clinicians seems to really help.” “This is a two-site study; at the site with clinicians leading recruitment, we had much better success in attracting participants.”
- “Relationships with clinicians who can refer can make or break your study.”

## Discussion

While recruitment clearly remains a challenge, several effective approaches can be identified: opt-out letters, registries, and clinician referral. Registries may or may not require an additional contact mechanism such as opt-in or opt-out letters. Registries of Veterans who have agreed to be contacted for future research are an efficient as well as effective strategy; unfortunately, there are few such registries. Registries that are solely lists of Veterans with a given diagnostic or other characteristic (e.g., OEF/OIF) allow for efficient identification of potential participants but do not obviate the need for approval of an additional contact strategy. Clinician referral appears to be most effective when the PI is also a practicing clinician who has good relations with referring clinicians and can offer something other than gratitude in exchange.

For non-clinicians, registries of Veterans willing to be contacted for research offer an ideal strategy. When such registries are not available, requesting approval to use opt-out letters as an initial strategy seems indicated. In the past IRBs have often required evidence of the failure of other approaches before approving use of opt-out letters. Results of this survey may be useful in convincing IRBs to approve them as an initial strategy. One of us (EF) can attest that when we were able to use opt-out letters, our monthly recruitment rate for female OEF/OIF/OND Veterans with PTSD was four times what we had been able to achieve recruiting via clinician referral, self-referral, community outreach and flyers.

The lack of effectiveness of three common strategies (opt-in letters, and flyers placed in either community or clinical settings) is also noteworthy. IRBs may be less likely to require an opt-in letter attempt if they are made aware of accumulating evidence of their ineffectiveness.

*SC MIRECC and MIDAS want to thank each of you who took the time to respond to the Recruitment Strategies Survey, with special thanks to those who responded about multiple projects. This project was only possible because of you!!! ♦*

## ATTRIBUTION: ACKNOWLEDGEMENT OF MIRECC RESEARCH SUPPORT/EMPLOYMENT

SC MIRECC researchers and educators have a responsibility to ensure that the SC MIRECC receives proper credit for SC MIRECC-supported studies or projects in articles, presentations, interviews, and other professional activities in which the results of those projects are publicized or recognized. All investigators should credit the SC MIRECC if they receive either direct or indirect support from the SC MIRECC. For example, "This work was supported in part by the VA South Central (VISN 16) Mental Illness Research, Education, and Clinical Center." If you receive salary support from the SC MIRECC, you should list the SC MIRECC as an affiliation.

# NEW CLINICAL EDUCATOR PRODUCTS AVAILABLE

## After the Dust Settles: Assessing Mild Traumatic Brain Injury in the Combat Veteran

Developed by Nicholas Pastorek, Ph.D., ABPP, David Graham, M.D., and Kim Arlinghaus, M.D.

The prevalence rate of mild traumatic brain injury is believed to range from 15% to 30% in Veterans who engaged in active combat in the Iraq and Afghanistan theatres. Furthermore, a small but significant minority of returning Veterans may experience the long-term persistence of cognitive, emotional, or somatic problems related to their history of mild traumatic brain injury. This condition is known as postconcussive syndrome. While the VA has thoughtfully developed a vast polytrauma system of care to provide specialized assessment and rehabilitative services to these Veterans, it can be expected that many Veterans may seek care at VA facilities where specialized mild traumatic brain injury services are not immediately available. “After the Dust Settles: Assessing Mild Traumatic Brain Injury in the Combat Veteran” is an instructional video designed to enhance care for Veterans with a history of mild traumatic brain injury by providing guidance to clinicians with limited experience working with this unique population.

This 55-minute instructional video is intended for clinicians working with OEF/OIF/OND Veterans with a history of mild traumatic brain injury in rural areas or areas where Veterans may otherwise have difficulty accessing specialized care for mild traumatic brain injury. The video includes a brief introduction and three mock interview modules. The introduction details the scope and potential consequences of mild traumatic brain injury in returning Veterans. The interview modules are intended to demonstrate basic techniques that will help clinicians to recognize a history of combat-related mild traumatic brain injury, assess current symptoms, and provide basic feedback to the Veteran regarding the results of the assessment. The mock interview is punctuated by teaching moments highlighting challenges that frequently arise during these evaluations. The teaching moments also provide potential solutions for successfully navigating these challenges, which are then demonstrated in the mock interview. While the clinical history reviewed during the mock interview does not represent the actual experience of any single Veteran, care was taken in development of the mock interview to create a realistic representation of the experience of combat-deployed Veterans. This realism will help clinicians translate skills learned during the mock interview directly to their clinical practice.

Copies of the DVD have been distributed to VISN 16 medical centers and community-based outpatient centers. **Dr. Pastorek, the interviewer in the DVD, will be available Tuesday, November 15 at 8:00 a.m. CT and Wednesday, November 16 at 3:00 p.m. CT (1-800-767-1750, access code 32344#) to answer questions about assessing for mild traumatic brain injury (Dr. Pastorek will not address referral and rehabilitation issues).** Additional questions about this product can be forwarded to Michael Kauth, Ph.D., the SC MIRECC Co-Director and Associate Director for Education, at [Michael.Kauth@va.gov](mailto:Michael.Kauth@va.gov).

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## Self-Help STOP WORRY: A Tool for Older Veterans

Developed by Srijana Shrestha, Ph.D. and Melinda Stanley, Ph.D.

“Self-Help STOP WORRY: A Tool for Older Veterans” includes a user-friendly, text-based clinician guide and patient workbook for the treatment of generalized anxiety disorder in Veterans 60 years of age and older who experience high levels of worry and anxiety and the clinicians who work with them. The patient workbook is accompanied by a CD with instructions for diaphragmatic breathing and progressive muscle relaxation to increase comprehension and usability.

These documents are based on treatment materials from a recent clinical trial of cognitive behavioral therapy for late-life generalized anxiety disorder in primary care (STOP WORRY; Stanley et al., 2009) and include helpful hints on tailoring cognitive behavioral therapy techniques to address the needs of older Veterans. The patient workbook can be used independently by Veterans or with minimal direction from mental health providers and includes practice exercise forms to help Veterans monitor their progress.

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These documents are not suitable for use by Veterans with cognitive and visual impairment and those with limited English proficiency. To download the clinician workbook visit [http://www.mirecc.va.gov/VISN16/docs/STOP\\_Worry\\_Clinician\\_Workbook.pdf](http://www.mirecc.va.gov/VISN16/docs/STOP_Worry_Clinician_Workbook.pdf). To download the self-help workbook visit [http://www.mirecc.va.gov/VISN16/docs/STOP\\_Worry\\_Self-Help\\_Workbook.pdf](http://www.mirecc.va.gov/VISN16/docs/STOP_Worry_Self-Help_Workbook.pdf). To request the accompanying CD contact Michael Kauth, Ph.D. at [Michael.Kauth@va.gov](mailto:Michael.Kauth@va.gov).

Reference

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## **VA Doctors Study the Effects of Yoga in Veterans with PTSD**

By Karen Collins

Southeast Louisiana Veterans Health Care System (SLVHCS) mental health practitioners recently completed a study to evaluate the feasibility and effectiveness of a yoga program on reducing PTSD symptoms in Veterans.

SLVHCS doctors at the mental health clinic on Canal Street in New Orleans partnered with yoga instructors to teach simple and gentle exercises, guided relaxation and breathing exercises to a small test group as therapy for one hour, twice a week for six weeks. The results of the preliminary study suggest that this yoga program may be an effective complementary therapy for improving PTSD-related symptoms of increased arousal, such as sleep problems.

“It was a small study, but we’re very excited about the results,” said Dr. Madeline Uddo, PTSD program team leader with SLVHCS. “The Veterans have been extremely responsive and I believe there is justification to test this program with more participants over longer periods of time to determine if we find the same kind of improvements in a larger study.”

The study participants included ten men and two women, aged 58 to 64. Most were Vietnam Veterans. Many of the participants said they were surprised with the mental and spiritual well-being yoga brings them.

A team of VA researchers and local yoga instructors administered the study. Along with Uddo, Dr. Michelle Hamilton and Dr. Julie Staples were investigators for the VA in this study. Three instructors certified by the Krishnamacharya Healing and Yoga Foundation – Libby Levin, Becky Deano and Tiffany Conner – volunteered their time to lead the yoga classes for the participating Veterans. “We’re very interested in the outcome and in helping this population,” Deano said.

For more information about the SLVHCS PTSD program, visit [www.neworleans.va.gov](http://www.neworleans.va.gov), like them on Facebook at [www.facebook.com/VANewOrleans](http://www.facebook.com/VANewOrleans) or follow them on Twitter at [www.twitter.com/vaneworleans](http://www.twitter.com/vaneworleans). ♦

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