CDP Research Update -- July 27, 2017

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- Links of Interest
- Resource of the Week: VA/DOD Clinical Practice Guideline for Opioid Therapy for Chronic Pain (Version 3.0 – 2017)

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https://content.govdelivery.com/accounts/USVHA/bulletins/1abae94

PTSD Monthly Update -- New Guidelines for Managing PTSD

National Center for PTSD
July 2017

A panel of experts from VA and the Department of Defense developed the latest guideline for managing PTSD and acute stress disorder.
The 2017 Clinical Practice Guideline (PDF) includes the most effective treatments for PTSD, rated both for the quality of the clinical studies and the strength of the recommendations.

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http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.201700070

Discontinuing Psychiatric Medications: A Survey of Long-Term Users.

Laysha Ostrow, Ph.D., M.P.P., Lauren Jessell, L.M.S.W., Manton Hurd, M.S.N., P.M.H.N.P., Sabrina M. Darrow, Ph.D., David Cohen, Ph.D., M.S.W.

Psychiatric Services
Published online: July 17, 2017
https://doi.org/10.1176/appi.ps.201700070

Objective:
Individuals undergoing long-term psychiatric treatment frequently choose to stop taking psychiatric medications. To enhance service user choice and prevent undesirable outcomes, this first U.S. survey of a large sample of longer-term users sought to increase knowledge about users' experience of medication discontinuation.

Methods:
A sample of 250 U.S. adults with a diagnosis of serious mental illness and a recent goal to stop up to two prescribed psychiatric medications, which they had taken for at least nine months, completed a web-based survey about experiences, strategies, and supports during discontinuation.

Results:
About half (54%) met their goal of completely discontinuing one or more medications; 46% reported another outcome (use was reduced, use increased, or use stayed the same). Concerns about medications' effects (for example, long-term effects and side effects) prompted the decision to discontinue for 74% of respondents. They used various strategies to cope with withdrawal symptoms, which 54% rated as severe. Self-education and contact with friends and with others who had discontinued or reduced medications were most frequently cited as helpful. Although more than half rated the initial medication decision with prescribers as largely collaborative, only 45% rated prescribers as helpful during discontinuation. Of respondents who completely discontinued, 82% were satisfied with their decision.

Conclusions:
Discontinuing psychiatric medication appears to be a complicated and difficult process, although most respondents reported satisfaction with their decision. Future research should guide health care systems and providers to better support patient choice and self-determination regarding the use and discontinuation of psychiatric medication.

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http://onlinelibrary.wiley.com/doi/10.1111/cpsp.12206/abstract

Reducing the Stigma of Mental Illness: Current Approaches and Future Directions.

Ava T. Casados

Clinical Psychology: Science and Practice
First published: 18 July 2017
DOI: 10.1111/cpsp.12206

The stigma of mental illness hinders treatment use and may exacerbate the already sizable social and psychological burden imposed by mental illness symptoms. Despite continuous efforts to reduce mental illness stigma, negative attitudes have persisted or worsened in the last few decades. Past reviews have already evaluated the many methodological limitations that may be dampening progress in this area. In this work, additional issues related to costly stigma-reduction approaches, heterogeneous constructs, and overly narrow research questions are discussed. Specific recommendations are then provided for refocusing this area of work by expanding research questions, establishing clearer constructs, and including some neglected but crucial study populations. Addressing the conceptual challenges in mental illness stigma research can help to improve interventions and better serve persons suffering from psychological distress.

See also: Making the Most of Contact to Erase Stigma (Corrigan)

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http://onlinelibrary.wiley.com/doi/10.1111/cpsp.12202/abstract

Posttraumatic Stress Disorder: An Integrated Overview of the Neurobiological Rationale for Pharmacology.

Benjamin Kelmendi, Thomas G. Adams, Steven Southwick, Chadi G. Abdallah, John H. Krystal

Clinical Psychology: Science and Practice
First published: 18 July 2017
DOI: 10.1111/cpsp.12202

Thirty years of research on the biology of posttraumatic stress disorder now provides a foundation for hypotheses related to the mechanisms underlying the pharmacotherapy of this disorder. Only two medications, sertraline and paroxetine, are approved by the U.S. Food and Drug Administration for the treatment of PTSD. Although these medications are somewhat effective, other treatment mechanisms must be explored to address the unmet need for effective treatment. This article provides a concise

summary of advances in our understanding of the neurobiology of PTSD and novel approaches to pharmacotherapy.

See also: Translating Neurobiological Findings Into Improved Combined Pharmacological and Psychotherapeutic Interventions for Posttraumatic Stress Disorder. (Maples-Keller and Rauch)

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http://online.liebertpub.com/doi/abs/10.1089/tmj.2016.0208

"Go! to Sleep": A Web-Based Therapy for Insomnia.

Bernstein Adam M., Allexandre Didier, Bena James, Doyle Jonathan, Gendy Gina, Wang Lu, Fay Susan, Mehra Reena, Moul Douglas, Foldvary-Schaefer Nancy, Roizen Michael F., and Drerup Michelle

Telemedicine and e-Health
July 2017, 23(7): 590-599
https://doi.org/10.1089/tmj.2016.0208

Background:
Insomnia is a common complaint of individuals presenting to healthcare providers and is associated with decreased quality of life and higher healthcare utilization. In-person cognitive behavioral therapy (CBT) is an effective treatment for insomnia but is hindered by cost and limited access to treatment. Initial research suggests that Web-based CBT may mitigate these obstacles.

Introduction:
This study tests the effectiveness of a Web-based program for insomnia based on principles of CBT and stress management.

Materials and Methods:
We conducted a randomized trial with wait-list controls among adults with primary insomnia (n = 88). Two hundred sixty-three adults with comorbid insomnia were also included and analyzed separately. The intervention was a 6-week online program, and effectiveness was measured via the Insomnia Severity Index (ISI).

Results:
Baseline ISI score for the intervention group (n = 43) was 17.0; 16.6 for the control

group (n = 45). At first follow-up, the intervention group (n = 25) had a mean change from baseline of −7.3 (95% CI: −9.0, −5.6), sustained through second follow-up, while the control group (n = 35) had a change of −1.3 (−2.7, 0.1). The between-group difference was statistically significant (p < 0.001). Participants in the comorbid insomnia group had a baseline ISI score of 16.7 with improvement similar to the primary insomnia group (−6.9; −7.6, −6.2).

Discussion:
We observed clinically meaningful improvements in insomnia severity in adults with primary or comorbid insomnia. Sustained improvement over 4 months underscores the effectiveness of a well-constructed online CBT for insomnia program.

Conclusions:
Go! to Sleep© offers a potentially effective treatment option for adults with insomnia by eliminating geographical barriers to care.

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http://focus.psychiatryonline.org/doi/abs/10.1176/appi.focus.20170010

Evidence-Based Psychotherapy in Primary Care.

Craig N. Sawchuk, Ph.D., A.B.P.P., and Julia R. Craner, Ph.D.

Focus: Journal of Lifelong Learning in Psychiatry
Published online: July 18, 2017
https://doi.org/10.1176/appi.focus.20170010

The functional and financial effects of untreated psychiatric disorders within primary care have led to the development of novel service delivery models to improve access to high-quality, evidence-based mental health treatments. Cognitive-behavioral therapy (CBT) is an efficacious and effective psychotherapeutic approach for treating a broad range of mental health conditions. CBT is a practical, skill-building approach that emphasizes self-efficacy and self-management of symptoms while working toward defined and measurable treatment goals. Although significant barriers to the full dissemination of CBT remain, collaborative care and integrated behavioral health programs embedded within primary care clinics can enhance treatment outcomes by using CBT. Identifying core CBT principles used in the treatment of anxiety (e.g., exposure), depression (e.g., behavioral activation), and insomnia (e.g., stimulus control) is an important step toward improving the quality of care for these conditions. High-

impact, low-intensity CBT programs hold promise in improving access to this evidence-based treatment across a broader population.

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http://onlinelibrary.wiley.com/doi/10.1111/jmft.12252/full

Army Soldiers and Suicidal Thoughts: The Impact of Negative Relationship Dynamics Moderated by the Dissolution of Romantic Relationships.

Heather A. Love, Jared A. Durtschi, Lauren M. Ruhlmann, Briana S. Nelson Goff

Journal of Marital and Family Therapy
First published: 18 July 2017
https://doi.org/10.1111/jmft.12252

Suicide among United States active-duty Army soldiers rapidly increased over the past two decades. Using a sample of 322 soldiers from the Army STARRS study, the researchers examined if romantic relationship factors (i.e., hostile disagreements and relationship distress) were linked with suicidal thoughts in Army soldiers, and if these associations were moderated by a recent separation or divorce. Hostile disagreements and relational distress were both significantly associated with higher rates of suicidal ideation. These associations were significantly amplified in magnitude when in the context of a recent separation or divorce. Implications include novel assessment, prevention, and treatment efforts focused on romantic relationships that may reduce the likelihood of soldiers experiencing thoughts of suicide.

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http://jamanetwork.com/journals/jamaneurology/article-abstract/2618936

Early Clinical Predictors of 5-Year Outcome After Concussive Blast Traumatic Brain Injury.

Mac Donald CL, Barber J, Jordan M, Johnson AM, Dikmen S, Fann JR, Temkin N

JAMA Neurology
2017;74(7):821-829
doi:10.1001/jamaneurol.2017.0143

Importance
The long-term clinical effects of wartime traumatic brain injuries (TBIs), most of which are mild, remain incompletely described. Current medical disability cost estimates from world conflicts continually surpass projections. Additional information regarding long-term functional trajectory is needed to reduce this extensive public health burden.

Objectives
To examine 5-year clinical outcomes leveraging existing clinical data collected at 1 year after injury in the same patients and to identify early risk factors for long-term disability.

Design, Setting, and Participants
This prospective, longitudinal study enrolled active-duty US military after concussive blast injury (n = 50) in the acute to subacute stage and combat-deployed control individuals (n = 44) in Afghanistan or after medical evacuation to Germany from November 1, 2008, through July 1, 2013. One- and 5-year clinical evaluations were completed in the United States. All concussive blast injuries met the Department of Defense definition of mild, uncomplicated TBI. In-person clinical evaluations included standardized evaluations for neurobehavior, neuropsychological performance, and mental health burden that were essentially identical to the evaluations completed at 1-year follow-up. Data were analyzed from October 1 through November 30, 2016.

Main Outcomes and Measures
Changes in the in-person standardized evaluations for neurobehavior, neuropsychological performance, and mental health burden from the 1- to 5-year follow-up. Predictive modeling was used to identify early risk factors for long-term disability.

Results
Among the 94 participants (87 men [93%] and 7 women [7%]; mean [SD] age, 34 [8] years), global disability, satisfaction with life, neurobehavioral symptom severity, psychiatric symptom severity, and sleep impairment were significantly worse in patients with concussive blast TBI compared with combat-deployed controls, whereas performance on cognitive measures was no different between groups at the 5-year evaluation. Logistic regression on the dichotomized Extended Glasgow Outcome Scale (GOS-E) at 5 years as a measure of overall disability identified brain injury diagnosis, preinjury intelligence, motor strength, verbal fluency, and neurobehavioral symptom severity at 1 year as risk factors for a poor outcome at 5 years, with an area under the curve of 0.92 indicating excellent prediction strength. Thirty-six of 50 patients with concussive blast TBI (72%) had a decline in the GOS-E from the 1- to 5-year evaluations, in contrast with only 5 of 44 combat-deployed controls (11%). Worsening of symptoms in concussive blast TBI was also observed on measures of posttraumatic

stress disorder and depression. Service members with concussive blast TBI experienced evolution, not resolution, of symptoms from the 1- to 5-year outcomes.

Conclusions and Relevance
Considerable decline was observed in military service members with concussive blast TBI when comparing 1- and 5-year clinical outcomes. These results advocate for new treatment strategies to combat the long-term and extremely costly effect of these wartime injuries.

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http://www.sciencedirect.com/science/article/pii/S0278262617300891

Neural activity and emotional processing following military deployment: Effects of mild traumatic brain injury and posttraumatic stress disorder.

Daniel V. Zuj, Kim L. Felmingham, Matthew A. Palmer, Ellie Lawrence-Wood, Miranda Van Hooff, Andrew J. Lawrence, Richard A. Bryant, Alexander C. McFarlane

Brain and Cognition
Volume 118, November 2017, Pages 19-26
https://doi.org/10.1016/j.bandc.2017.07.001

Posttraumatic Stress Disorder (PTSD) and mild traumatic brain injury (mTBI) are common comorbidities during military deployment that affect emotional brain processing, yet few studies have examined the independent effects of mTBI and PTSD. The purpose of this study was to examine distinct differences in neural responses to emotional faces in mTBI and PTSD. Twenty-one soldiers reporting high PTSD symptoms were compared to 21 soldiers with low symptoms, and 16 soldiers who reported mTBI-consistent injury and symptoms were compared with 16 soldiers who did not sustain an mTBI. Participants viewed emotional face expressions while their neural activity was recorded (via event-related potentials) prior to and following deployment. The high-PTSD group displayed increased P1 and P2 amplitudes to threatening faces at post-deployment compared to the low-PTSD group. In contrast, the mTBI group displayed reduced face-specific processing (N170 amplitude) to all facial expressions compared to the no-mTBI group. Here, we identified distinctive neural patterns of emotional face processing, with attentional biases towards threatening faces in PTSD, and reduced emotional face processing in mTBI.

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http://www.sciencedirect.com/science/article/pii/S0278584617303524

Sleep, chronic pain, and opioid risk for apnea.

Serguei Marshansky, Pierre Mayer, Dorrie Rizzo, Marc Baltzan, Ronald Denis, Gilles J. Lavigne

Progress in Neuro-Psychopharmacology and Biological Psychiatry
Available online 19 July 2017
https://doi.org/10.1016/j.pnpbp.2017.07.014

Pain is an unwelcome sleep partner. Pain tends to erode sleep quality and alter the sleep restorative process in vulnerable patients. It can contribute to next-day sleepiness and fatigue, affecting cognitive function.

Chronic pain and the use of opioid medications can also complicate the management of sleep disorders such as insomnia (difficulty falling and/or staying asleep) and sleep-disordered breathing (sleep apnea). Sleep problems can be related to various types of pain, including sleep headache (hypnic headache, cluster headache, migraine) and morning headache (transient tension type secondary to sleep apnea or to sleep bruxism or tooth grinding) as well as periodic limb movements (leg and arm dysesthesia with pain).

Pain and sleep management strategies should be personalized to reflect the patient's history and ongoing complaints. Understanding the pain–sleep interaction requires assessments of: i) sleep quality, ii) potential contributions to fatigue, mood, and/or wake time functioning; iii) potential concomitant sleep-disordered breathing (SDB); and more importantly; iv) opioid use, as central apnea may occur in at-risk patients. Treatments include sleep hygiene advice, cognitive behavioral therapy, physical therapy, breathing devices (continuous positive airway pressure – CPAP, or oral appliance) and medications (sleep facilitators, e.g., zolpidem; or antidepressants, e.g., trazodone, duloxetine, or neuroleptics, e.g., pregabalin). In the presence of opioid-exacerbated SDB, if the dose cannot be reduced and normal breathing restored, servo-ventilation is a promising avenue that nevertheless requires close medical supervision.

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http://onlinelibrary.wiley.com/doi/10.1002/jts.22209/abstract

Increased Mindfulness Skills as Predictors of Reduced Trauma-Related Guilt in Treatment-Seeking Veterans.

Philip Held, Gina P. Owens, J. Richard Monroe, Kathleen M. Chard

Journal of Traumatic Stress
First published: 25 July 2017
DOI: 10.1002/jts.22209

The present study examined the predictive role of increased self-reported mindfulness skills on reduced trauma-related guilt in a sample of veterans over the course of residential treatment for posttraumatic stress disorder (PTSD; N = 128). The residential treatment consisted of seven weeks of intensive cognitive processing therapy (CPT) for PTSD, as well as additional psychoeducational groups, including seven sessions on mindfulness skills. Increased mindfulness skills describing, acting with awareness, and accepting without judgment were significantly associated with reductions in trauma-related guilt over the course of treatment. Increases in the ability to act with awareness and accept without judgment were significantly associated with reductions in global guilt, R2 = .26, guilt distress, R2= .23, guilt cognitions, R2= .23, and lack of justification, R2= .11. An increase in the ability to accept without judgment was the only self-reported mindfulness skill that was associated with reductions in hindsight bias, β = −.34 and wrongdoing, β = −.44. Increases in self-reported mindfulness skills explained 15.1 to 24.1% of the variance in reductions in trauma-related guilt, suggesting that mindfulness skills may play a key role in reducing the experience of trauma-related guilt during psychotherapy. Our results provide preliminary support for the use of mindfulness groups as an adjunct to traditional evidence-based treatments aimed at reducing trauma-related guilt, though this claim needs to be tested further using experimental designs.

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http://onlinelibrary.wiley.com/doi/10.1002/jts.22210/abstract

Gender Differences in Machine Learning Models of Trauma and Suicidal Ideation in Veterans of the Iraq and Afghanistan Wars.

Jaimie L. Gradus, Matthew W. King, Isaac Galatzer-Levy, Amy E. Street

Journal of Traumatic Stress
First published: 25 July 2017
DOI: 10.1002/jts.22210

Suicide rates among recent veterans have led to interest in risk identification. Evidence of gender-and trauma-specific predictors of suicidal ideation necessitates the use of advanced computational methods capable of elucidating these important and complex associations. In this study, we used machine learning to examine gender-specific associations between predeployment and military factors, traumatic deployment experiences, and psychopathology and suicidal ideation (SI) in a national sample of veterans deployed during the Iraq and Afghanistan conflicts (n = 2,244). Classification, regression tree analyses, and random forests were used to identify associations with SI and determine their classification accuracy. Findings converged on several associations for men that included depression, posttraumatic stress disorder (PTSD), and somatic complaints. Sexual harassment during deployment emerged as a key factor that interacted with PTSD and depression and demonstrated a stronger association with SI among women. Classification accuracy for SI presence or absence was good based on the receiver operating characteristic area under the curve, men = .91, women = .92. The risk for SI was classifiable with good accuracy, with associations that varied by gender. The use of machine learning analyses allowed for the discovery of rich, nuanced results that should be replicated in other samples and may eventually be a basis for the development of gender-specific actuarial tools to assess SI risk among veterans.

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http://www.aasmnet.org/jcsm/ViewAbstract.aspx?pid=31051

Characterization of Patients Who Present With Insomnia: Is There Room for a Symptom Cluster-Based Approach?

Crawford MR, Chirinos DA, Iurcotta T, Edinger JD, Wyatt JK, Manber R, Ong JC

Journal of Clinical Sleep Medicine
2017;13(7):911–921
http://dx.doi.org/10.5664/jcsm.6666

Study Objectives
This study examined empirically derived symptom cluster profiles among patients who present with insomnia using clinical data and polysomnography.

Methods
Latent profile analysis was used to identify symptom cluster profiles of 175 individuals (63% female) with insomnia disorder based on total scores on validated self-report instruments of daytime and nighttime symptoms (Insomnia Severity Index, Glasgow Sleep Effort Scale, Fatigue Severity Scale, Beliefs and Attitudes about Sleep, Epworth Sleepiness Scale, Pre-Sleep Arousal Scale), mean values from a 7-day sleep diary (sleep onset latency, wake after sleep onset, and sleep efficiency), and total sleep time derived from an in-laboratory PSG.

Results
The best-fitting model had three symptom cluster profiles: “High Subjective Wakefulness” (HSW), “Mild Insomnia” (MI) and “Insomnia-Related Distress” (IRD). The HSW symptom cluster profile (26.3% of the sample) reported high wake after sleep onset, high sleep onset latency, and low sleep efficiency. Despite relatively comparable PSG-derived total sleep time, they reported greater levels of daytime sleepiness. The MI symptom cluster profile (45.1%) reported the least disturbance in the sleep diary and questionnaires and had the highest sleep efficiency. The IRD symptom cluster profile (28.6%) reported the highest mean scores on the insomnia-related distress measures (eg, sleep effort and arousal) and waking correlates (fatigue). Covariates associated with symptom cluster membership were older age for the HSW profile, greater obstructive sleep apnea severity for the MI profile, and, when adjusting for obstructive sleep apnea severity, being overweight/obese for the IRD profile.

Conclusions
The heterogeneous nature of insomnia disorder is captured by this data-driven approach to identify symptom cluster profiles. The adaptation of a symptom cluster-based approach could guide tailored patient-centered management of patients presenting with insomnia, and enhance patient care.

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http://psycnet.apa.org/record/2017-04560-001

Modeling the indirect association of combat exposure with anger and aggression during combat deployment: The moderating role of perceived unit morale.

Dyches, K. D., Saboe, K. N., Anderson, J. A., Wilk, J. E., Hinman, S. J., Sipos, M. L., & Quartana, P. J.

Military Psychology
29(4), 260-270
http://dx.doi.org/10.1037/mil0000165

OBJECTIVE:
We evaluated the efficacy of the Strength at Home Men's Program (SAH-M), a trauma-informed group intervention based on a social information processing model to end intimate partner violence (IPV) use in a sample of veterans/service members and their partners. To date, no randomized controlled trial has supported the efficacy of an IPV intervention in this population.

METHOD:
Participants included 135 male veterans/service members and 111 female partners. Recruitment was conducted from February 2010 through August 2013, and participation occurred within 2 Department of Veterans Affairs hospitals. Male participants completed an initial assessment that included diagnostic interviews and measures of physical and psychological IPV using the Revised Conflict Tactics Scales and were randomly assigned to an enhanced treatment as usual (ETAU) condition or SAH-M. Those randomized to SAH-M were enrolled in this 12-week group immediately after baseline. Those randomized to ETAU received clinical referrals and resources for mental health treatment and IPV services. All male participants were reassessed 3 and 6 months after baseline. Female partners completed phone assessments at the same intervals that were focused both on IPV and on the provision of safety information and clinical referrals.

RESULTS:
Primary analyses using hierarchical linear modeling indicated significant time-by-condition effects such that SAH-M participants compared with ETAU participants evidenced greater reductions in physical and psychological IPV use (β = -0.135 [SE = 0.061], P = .029; β = -0.304 [SE = 0.135], P = .026; respectively). Additional analyses of a measure that disaggregated forms of psychological IPV showed that SAH-M, relative to ETAU, reduced controlling behaviors involving isolation and monitoring of the partner (β = -0.072 [SE = 0.027], P = .010).

CONCLUSIONS:
Results provide support for the efficacy of SAH-M in reducing and ending IPV in male veterans and service members.

TRIAL REGISTRATION:
ClinicalTrials.gov Identifier: NCT01435512

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http://psycnet.apa.org/record/2017-05748-001

The impact of aggression on the relationship between betrayal and belongingness among U.S. military personnel.

Martin, R. L., Houtsma, C., Bryan, A. O., Bryan, C. J., Green, B. A., & Anestis, M. D.

Military Psychology
29(4), 271-282
http://dx.doi.org/10.1037/mil0000160

The suicide rate among U.S. military personnel, particularly within the Army National Guard, is significantly higher than the rate found among the general population. To better understand why the Army National Guard has elevated rates of suicide, the current study examined how deployment-related moral injury interacts with interpersonal factors to predict suicide risk. Specifically, this study hypothesized that deployment-related betrayal, a facet of the Moral Injury Events Scale, would predict thwarted belongingness and that this relationship would be moderated by several types of aggression (physical aggression, verbal aggression, hostility, and anger). The current sample comprised 562 military personnel who had experienced at least 1 previous deployment. Results revealed that betrayal predicted thwarted belongingness in the presence of high but not low or mean levels of aggression among military personnel. This indicates that aggressive individuals who experience perceived betrayal while deployed may be at high risk for development of thwarted belongingness, an important risk factor for suicide. These results suggest the need for better assessment and treatment of betrayal among military personnel, as well as the need for programs to help soldiers manage aggression. (PsycINFO Database Record (c) 2017 APA, all rights reserved)

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http://psycnet.apa.org/record/2017-09877-001

Spouse and family functioning before and after a Marine's suicide: Comparisons to deaths by accident and in combat.

Aronson, K. R., Kyler, S. J., Morgan, N. R., Perkins, D. F., & Love, L.

Military Psychology
29(4), 294-306
http://dx.doi.org/10.1037/mil0000156

he impact of service member suicides on families is not well understood. Civilian studies have demonstrated that family survivors of suicide deaths experience complicated grief, feel guilt and shame, and often do not receive sufficient social support. In this exploratory study, spouse survivors of Marines who died by suicide (N = 17), accident (N = 19), and in combat (N = 34) retrospectively reported on their immediate pre- and postmortem and current personal and family functioning. Nonparametric analyses revealed that several between-group differences existed. Observation of the means suggested that the spouses and families of Marines who died by suicide exhibited significantly poorer pre- and postmortem functioning compared with those whose spouses died in combat. Specific challenges included low family cohesion, high family conflict, perceived stigma, and shame. There were no differences in current spouse or family functioning, and there was weak evidence for posttraumatic growth among surviving spouses of those dying by suicide. These results should be considered preliminary and interpreted with caution given several methodological challenges. (PsycINFO Database Record (c) 2017 APA, all rights reserved)

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http://psycnet.apa.org/record/2017-11087-001

Childhood sexual assault, quality of life, and psychiatric comorbidity in veterans with military and civilian sexual trauma.

Williams, R. C., Holliday, R., Holder, N., & Surís, A.

Military Psychology
29(4), 307-315
http://dx.doi.org/10.1037/mil0000166

Veterans with military sexual trauma (MST) are at risk for a variety of psychiatric conditions, including posttraumatic stress disorder (PTSD) and depression. Survivors of MST are also likely to experience diminished quality of life (QoL). Individuals with higher lifetime incidence of sexual trauma may also be at increased risk for poorer outcomes in QoL and psychiatric symptomatology. The differences in psychological sequelae among those who have experienced sexual trauma as children, and those whose sexual

trauma exposure is limited to adulthood are relatively understudied. The majority of sexual trauma literature has focused primarily on civilian trauma, and comparatively few studies have specifically examined psychosocial sequelae (e.g., QoL) in veterans with MST. This study examined how childhood sexual abuse (CSA) affects overall QoL as well as severity of PTSD and depressive symptoms. Veterans who reported CSA had significantly greater depression symptom severity than veterans who did not. No significant differences in PTSD symptom severity or QoL were found between veterans who did and did not report CSA. Results highlight the need for further examination of the relationship between CSA and depression in veterans with MST-related PTSD who also report CSA.

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http://psycnet.apa.org/record/2017-15224-001

The performance of the AUDIT-C and the examination of risks associated with postdeployment alcohol misuse in Air Force Medical Service personnel.

Tvaryanas, A. P., Maupin, G. M., White, E. D., Schroeder, V. M., & Mahaney, H. J.

Military Psychology
29(4), 327-335
http://dx.doi.org/10.1037/mil0000167

This study assessed the performance of the Alcohol Use Disorder Identification Test-Consumption (AUDIT-C) in diagnosing a postdeployment alcohol disorder in a cohort of Air Force Medical Services personnel (N = 13,353). The prevalence of alcohol disorders in this population of previously deployed military healthcare personnel was 1.26% based on medical record data. Assessing the AUDIT-C as a screening tool, the following characteristics were found: sensitivity was 23.81%, specificity was 91.48%, positive predictive value was 3.44%, and negative predictive value was 98.95%. The positive and negative likelihood ratios were 2.80 and 0.83, respectively. Classification accuracy of the AUDIT-C was improved by accounting for officer status and female gender. The area under the receiver operating characteristic curve was 0.69 for the multivariable model, indicating poor to fair classification accuracy. However, this model was significantly improved over the univariate model. Thus, taking rank and gender into account when conducting screening may improve the utility of the AUDIT-C. (PsycINFO Database Record (c) 2017 APA, all rights reserved)

Links of Interest

Tricare expands mental health, substance abuse, opioid treatment options
http://www.militarytimes.com/military-benefits/health-care/2017/07/21/tricare-now-covers-more-treatment-options-for-mental-health-substance-abuse-such-as-opioid-addiction/

No urinals on the new Navy aircraft carrier
http://www.navytimes.com/news/your-navy/2017/07/21/no-urinals-on-the-new-navy-aircraft-carrier/

Vets Are Using Transcendental Meditation to Treat PTSD—With the Pentagon's Support
And some help from "Twin Peaks" director David Lynch.
http://www.motherjones.com/politics/2017/07/vets-are-using-transcendental-meditation-to-treat-ptsd-with-the-pentagons-support/

Brain Patterns May Predict Psychotherapy Response in PTSD
http://www.medscape.com/viewarticle/883255

PTSD disability claims by vets tripled in the last decade
http://www.militarytimes.com/news/pentagon-congress/2017/07/25/ptsd-disability-claims-by-vets-tripled-in-the-last-decade/

Trump says transgender troops can't serve in the military
http://www.militarytimes.com/news/pentagon-congress/2017/07/26/trump-says-transgender-troops-cant-serve-in-the-military/

The military spends more on giving retirees erections than on transgender troops
http://www.militarytimes.com/news/2017/07/26/the-military-spends-more-on-giving-retirees-erections-than-on-transgender-troops/

Leave transgender military healthcare alone, ex-Joint Chiefs chairman urges
http://www.militarytimes.com/news/your-military/2017/07/26/leave-transgender-militaryspan-span-healthcare-alone-ex-joint-chiefs-chairman-urgesbr/

Transgender airman: 'I would like to see them try to kick me out of my military'
http://www.airforcetimes.com/news/your-air-force/2017/07/26/transgender-airman-i-would-like-to-see-them-try-to-kick-me-out-of-my-military/

Lawmakers condemn Trump for transgender military policy change
http://www.militarytimes.com/news/pentagon-congress/2017/07/26/lawmakers-condemn-trump-for-transgender-military-policy-change/

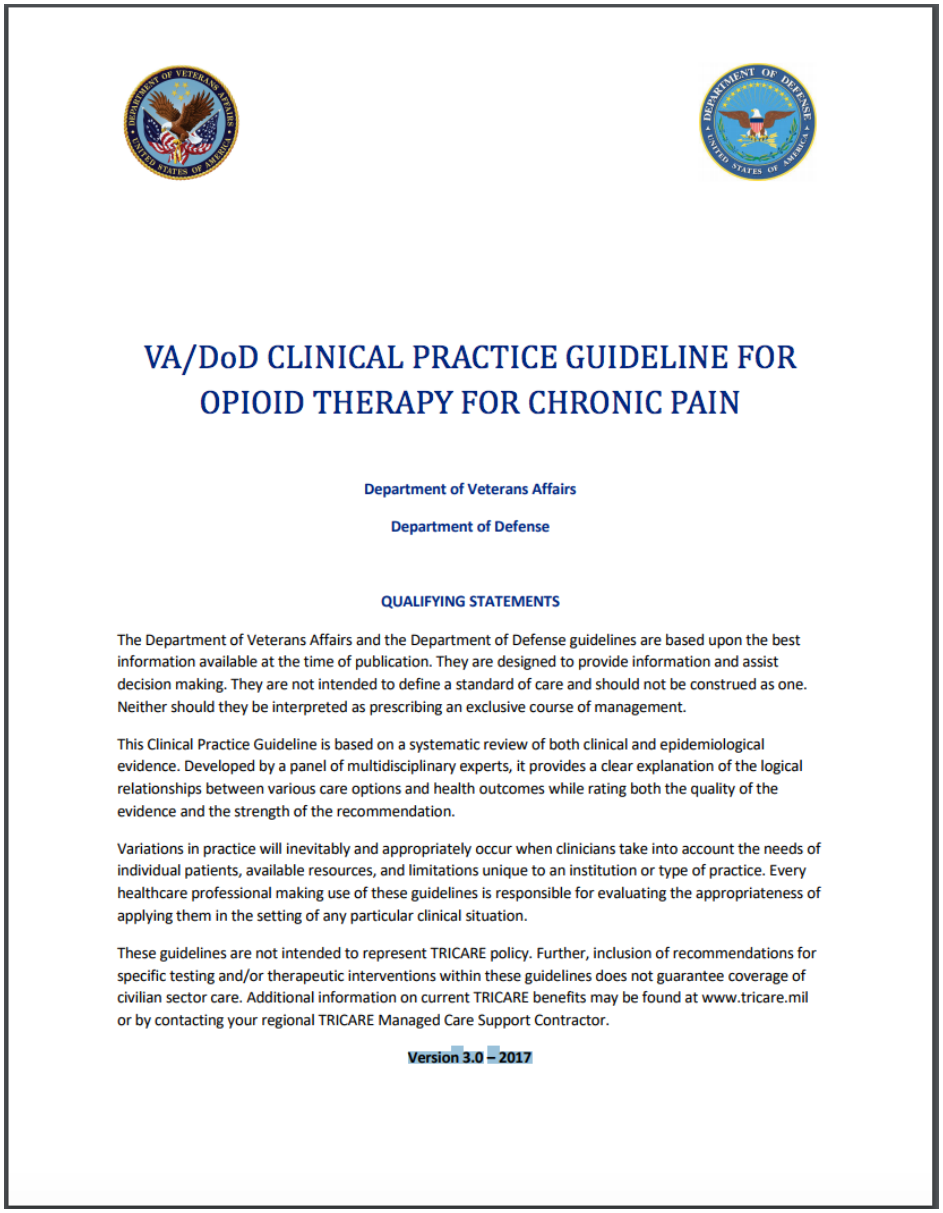
Uncle Sam No Longer Wants You
https://www.nytimes.com/2017/07/27/opinion/donald-trump-transgender-pandering.html

House rejects plan to let VA doctors talk about marijuana
http://www.militarytimes.com/news/pentagon-congress/2017/07/26/house-rejects-plan-to-let-va-doctors-talk-about-marijuana/

Resource of the Week: VA/DOD Clinical Practice Guideline for Opioid Therapy for Chronic Pain (Version 3.0 – 2017)

According to the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE):

> The Departments of Defense and Veterans Affairs (VA) recently updated PDF: clinical guidelines on opioid therapy. These guidelines recommend assessing the risks of using opioid therapy, and address concerns such as managing withdrawal, misuse and overdose in the military.
> …
> The 2017 guidelines offer 18 recommendations for opioid therapy including:
>
> - Know the risks – Before deciding on any form of treatment for chronic pain, patients and providers should discuss the risks of opioid therapy.
> - Discuss alternatives first – Patients and providers should work together and first explore non-pharmacological treatments, or non-opioid medications, especially in cases of mild or moderate pain.
> - Avoid long-term use – Limit treatment to 90 days or less.
> - Begin with the lowest dosage possible.
> - Avoid opioids with patients under 30.
> - Monitor use regularly – Schedule regular check-ins with patients during opioid treatment.
> - Increase the number of check-ins if dosage increases or if the therapy extends beyond 90 days.



VA/DoD CLINICAL PRACTICE GUIDELINE FOR OPIOID THERAPY FOR CHRONIC PAIN

Department of Veterans Affairs

Department of Defense

QUALIFYING STATEMENTS

The Department of Veterans Affairs and the Department of Defense guidelines are based upon the best information available at the time of publication. They are designed to provide information and assist decision making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

This Clinical Practice Guideline is based on a systematic review of both clinical and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.

Variations in practice will inevitably and appropriately occur when clinicians take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation.

These guidelines are not intended to represent TRICARE policy. Further, inclusion of recommendations for specific testing and/or therapeutic interventions within these guidelines does not guarantee coverage of civilian sector care. Additional information on current TRICARE benefits may be found at www.tricare.mil or by contacting your regional TRICARE Managed Care Support Contractor.

Version 3.0 – 2017

Shirl Kennedy
Research Editor
Center for Deployment Psychology
www.deploymentpsych.org
skennedy@deploymentpsych.org
240-535-3901