CDP

Uniformed Services University

Research Update – November 2, 2017

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- Resource of the Week: An Evaluation of U.S. Military Non-Medical Counseling Programs (RAND Corporation)

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https://content.govdelivery.com/accounts/USVHA/bulletins/1c12cf0

Managing Stress after Trauma, PTSD Monthly Update - October 2017

National Center for PTSD

The devastation of hurricanes Harvey, Irma, and Maria; the fires in California; and the tragic events in Las Vegas have deeply affected people across the nation.

Learn about the common reactions to disaster and mass violence, and how to manage stress reactions.

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https://jamanetwork.com/journals/jama/fullarticle/2658302

New Data on Suicide Risk Among Military Veterans.

Jeff Lyon

JAMA
2017;318(16):1531
doi:10.1001/jama.2017.15982

The suicide rate among female US military veterans has shown a dramatic increase, the Department of Veterans Affairs reported last month in a deeper analysis of data from its 2016 report showing that 20 US veterans take their own lives each day.

The further analysis of the 2016 report, which was based on data covering the years 2001-2014 and highlighted in a fact sheet, showed that the suicide rate among female veterans in 2014 was 19 per 100 000, a 62.4% increase since 2001. The figure is roughly 2.5 times higher than the rate among nonveteran US women (7.2 per 100 000). By contrast, among male US veterans, the 2014 suicide rate was 37.2 per 100 000, a 29.7% increase since 2001. The rate is 19% higher than that among US nonveteran males (25 per 100 000). But even though the gap between male and female veterans is closing slightly, men are still nearly twice as likely to take their own lives as women.

In addition, the new report revealed that in 2014, veterans accounted for 18% of all deaths by suicide among US adults, while representing only 8.5% of the US population. Six of every 20 veterans who died by suicide, less than a third, were receiving VA health

services at the time. Age is a major factor, with 65% of all veterans who died by suicide aged 50 years or older.

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https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2652967

National Trends in Suicide Attempts Among Adults in the United States.

Mark Olfson, MD, MPH; Carlos Blanco, MD, PhD; Melanie Wall, PhD; et al.

JAMA Psychiatry
2017;74(11):1095-1103
doi:10.1001/jamapsychiatry.2017.2582

Key Points

Questions
Has a national increase in suicide attempts occurred in the United States in the decade since wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions?

Finding
In this national epidemiologic survey of 69 341 US adults, the percentage making a recent suicide attempt increased from 0.62% in 2004 through 2005 to 0.79% in 2012 through 2013. The adjusted risk differences for suicide attempts were significantly larger among adults aged 21 to 34 years than among adults aged 65 years or older; adults with no more than a high school education than among college graduates; and adults with antisocial personality disorder, a history of violent behavior, anxiety disorders, or depressive disorders than among adults without these conditions.

Meaning
A recent overall increase in suicide attempts among US adults has disproportionately affected younger adults with less formal education and those with antisocial personality disorder, anxiety disorders, depressive disorders, and a history of violence.

Abstract

Importance
A recent increase in suicide in the United States has raised public and clinical interest in determining whether a coincident national increase in suicide attempts has occurred

and in characterizing trends in suicide attempts among sociodemographic and clinical groups.

Objective
To describe trends in recent suicide attempts in the United States.

Design, Setting, and Participants
Data came from the 2004-2005 wave 2 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) and the 2012-2013 NESARC-III. These nationally representative surveys asked identical questions to 69 341 adults, 21 years and older, concerning the occurrence and timing of suicide attempts. Risk differences adjusted for age, sex, and race/ethnicity (ARDs) assessed trends from the 2004-2005 to 2012-2013 surveys in suicide attempts across sociodemographic and psychiatric disorder strata. Additive interactions tests compared the magnitude of trends in prevalence of suicide attempts across levels of sociodemographic and psychiatric disorder groups. The analyses were performed from February 8, 2017, through May 31, 2017.

Main Outcomes and Measures
Self-reported attempted suicide in the 3 years before the interview.

Results
With use of data from the 69 341 participants (42.8% men and 57.2% women; mean [SD] age, 48.1 [17.2] years), the weighted percentage of US adults making a recent suicide attempt increased from 0.62% in 2004-2005 (221 of 34 629) to 0.79% in 2012-2013 (305 of 34 712; ARD, 0.17%; 95% CI, 0.01%-0.33%; P = .04). In both surveys, most adults with recent suicide attempts were female (2004-2005, 60.17%; 2012-2013, 60.94%) and younger than 50 years (2004-2005, 84.75%; 2012-2013, 80.38%). The ARD for suicide attempts was significantly larger among adults aged 21 to 34 years (0.48%; 95% CI, 0.09% to 0.87%) than among adults 65 years and older (0.06%; 95% CI, −0.02% to 0.14%; interaction P = .04). The ARD for suicide attempts was also significantly larger among adults with no more than a high school education (0.49%; 95% CI, 0.18% to 0.80%) than among college graduates (0.03%; 95% CI, −0.17% to 0.23%; interaction P = .003); the ARD was also significantly larger among adults with antisocial personality disorder (2.16% [95% CI, 0.61% to 3.71%] vs 0.07% [95% CI, −0.09% to 0.23%]; interaction P = .01), a history of violent behavior (1.04% [95% CI, 0.35% to 1.73%] vs 0.00% [95% CI, −0.12% to 0.12%]; interaction P = .003), or a history of anxiety (1.43% [95% CI, 0.47% to 2.39%] vs 0.18% [95% CI, 0.04% to 0.32%]; interaction P = .01) or depressive (0.99% [95% CI, −0.09% to 2.07%] vs −0.08% [95% CI, −0.20% to 0.04%]; interaction P = .05) disorders than among adults without these conditions.

Conclusions and Relevance
A recent overall increase in suicide attempts among adults in the United States has disproportionately affected younger adults with less formal education and those with antisocial personality disorder, anxiety disorders, depressive disorders, and a history of violence.

See also: Suicide and Attempted Suicide in the United States During the 21st Century. (editorial)

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https://mhealth.jmir.org/2017/10/e156/

Posttraumatic Stress Disorder and Mobile Health: App Investigation and Scoping Literature Review.

Rodriguez-Paras C, Tippey K, Brown E, Sasangohar F, Creech S, Kum HC, Lawley M, Benzer JK

JMIR Mhealth Uhealth
2017;5(10):e156
DOI: 10.2196/mhealth.7318

Background:
Posttraumatic stress disorder (PTSD) is a prevalent mental health issue among veterans. Access to PTSD treatment is influenced by geographic (ie, travel distance to facilities), temporal (ie, time delay between services), financial (ie, eligibility and cost of services), and cultural (ie, social stigma) barriers.

Objective:
The emergence of mobile health (mHealth) apps has the potential to bridge many of these access gaps by providing remote resources and monitoring that can offer discrete assistance to trauma survivors with PTSD and enhance patient-clinician relationships. In this study, we investigate the current mHealth capabilities relevant to PTSD.

Methods:
This study consists of two parts: (1) a review of publicly available PTSD apps designed to determine the availability of PTSD apps, which includes more detailed information about three dominant apps and (2) a scoping literature review performed using a

systematic method to determine app usage and efforts toward validation of such mHealth apps. App usage relates to how the end users (eg, clinicians and patients) are interacting with the app, whereas validation is testing performed to ensure the app's purpose and specifications are met.

Results:
The results suggest that though numerous apps have been developed to aid in the diagnosis and treatment of PTSD symptoms, few apps were designed to be integrated with clinical PTSD treatment, and minimal efforts have been made toward enhancing the usability and validation of PTSD apps.

Conclusions:
These findings expose the need for studies relating to the human factors evaluation of such tools, with the ultimate goal of increasing access to treatment and widening the app adoption rate for patients with PTSD.

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https://link.springer.com/article/10.1007/s40501-017-0130-0

Management of Treatment-Resistant Posttraumatic Stress Disorder.

Jonathan A. Starke, Dan J. Stein

Current Treatment Options in Psychiatry
First Online: 28 October 2017
https://doi.org/10.1007/s40501-017-0130-0

Purpose of review
The management of treatment-resistant posttraumatic stress disorder (TRPTSD) is a complex clinical challenge, and many patients may continue to endure a heavy symptom burden, even despite the best available treatments. We review the recent literature to provide an update on the evidence base and offer guidance to clinicians on available approaches, including a number of novel and emerging options.

Recent findings
If adequate trials of treatment with first-line antidepressants (SSRIs or venlafaxine) or trauma-focused psychotherapy have failed, dosage increase, switching to an alternative first-line option, or combining medication and psychotherapy are reasonable initial approaches. If these remain insufficient, augmentation strategies should be offered, including addition of second-generation antipsychotics (such as risperidone) or the

adrenergic antagonist prazosin (especially if sleep disturbance or nightmares are problematic). Further options include the use of other antidepressants (most notably mirtazapine, duloxetine, and trazodone), and the anticonvulsants topiramate or lamotrigine, though the evidence for these is relatively weak. Having tried all these possibilities, the clinician may wish to suggest complementary approaches such as yoga, mindfulness meditation, or acupuncture for symptom reduction and overall well-being. Emerging alternatives, if available, could also be considered, such as augmentation of exposure therapy with d-cycloserine or MDMA, or the use of device-based brain stimulation (such as transcranial magnetic stimulation), though the evidence for these is still preliminary.

Summary
Comprehensive assessment of TRPTSD, including a thorough evaluation of associated comorbidity, should inform individualized care, incorporating a process of shared decision-making. Despite the complex clinical challenge of TRPTSD, clinicians should remain hopeful however, that translational neuroscience and clinical trials of emerging approaches will allow progressively better treatment alternatives to be established.

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http://psycnet.apa.org/record/2017-46640-006

A longitudinal investigation of the impact of psychotherapist training: Does training improve client outcomes?

Erekson, D. M., Janis, R., Bailey, R. J., Cattani, K., & Pedersen, T. R.

Journal of Counseling Psychology
64(5), 514-524
http://dx.doi.org/10.1037/cou0000252

This study is a longitudinal examination of the impact of therapist stage of training on client outcomes in psychotherapy. The study included 22 PhD-level psychologists who work in a university counseling center (8 female, 14 male) who had completed at least 2 training periods in the center where data were gathered. Therapists worked with 4,047 clients, and 40,271 sessions were included in our analyses. Clients were given the Outcome Questionnaire-45 (OQ-45) on a session-by-session basis, tracking treatment response. The effect of stage of training on both the magnitude and speed of OQ-45 change was examined through hierarchical linear modeling. Therapists were found to achieve the same amount of change or less change on average in their later stages of

training. Therapists were also found, on average, to achieve the same rate of change or a slower rate of change in later stages of training. Findings suggest that as therapists progress through formal stages of training, they do not improve in their ability to effect change in their clients. Given these findings, a better understanding of expertise in psychotherapy practice and how to develop it may be an important area for future theory development, research, and training program development. We call for further work examining if and how an individual therapist can become more effective with time.

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http://ebmh.bmj.com/content/20/4/102

The promise of digital mood tracking technologies: are we heading on the right track?

Gin S Malhi, Amber Hamilton, Grace Morris, Zola Mannie, Pritha Das, Tim Outhred

Evidence-Based Mental Health
2017;20:102-107
http://dx.doi.org/10.1136/eb-2017-102757

The growing understanding that mood disorders are dynamic in nature and fluctuate over variable epochs of time has compelled researchers to develop innovative methods of monitoring mood. Technological advancement now allows for the detection of minute-to-minute changes while also capturing a longitudinal perspective of an individual's illness. Traditionally, assessments of mood have been conducted by means of clinical interviews and paper surveys. However, these methods are often inaccurate due to recall bias and compliance issues, and are limited in their capacity to collect and process data over long periods of time. The increased capability, availability and affordability of digital technologies in recent decades has offered a novel, non-invasive alternative to monitoring mood and emotion in daily life. This paper reviews the emerging literature addressing the use of digital mood tracking technologies, primarily focusing on the strengths and inherent limitations of using these new methods including electronic self-report, behavioural data collection and wearable physiological biosensors. This developing field holds great promise in generating novel insights into the mechanistic processes of mood disorders and improving personalised clinical care. However, further research is needed to validate many of these novel approaches to ensure that these devices are indeed achieving their purpose of capturing changes in mood.

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http://onlinelibrary.wiley.com/wol1/doi/10.1002/jts.22221/abstract

Coping Strategies as Moderators of the Association Between Combat Exposure and Posttraumatic Stress Disorder Symptoms.

Britt, T. W., Adler, A. B., Sawhney, G. and Bliese, P. D.

Journal of Traumatic Stress
Volume 30, Issue 5, pages 491–501, October 2017
DOI: 10.1002/jts.22221

The present research examined selected coping strategies as moderators of the relationship between combat exposure and posttraumatic stress disorder (PTSD) symptoms among service members who were deployed to Iraq (N = 2,023) and Afghanistan (N = 1,023). A three-factor model of coping was confirmed for both military operations: positive emotion-focused, self-blame, and prayer/spirituality. Positive emotion-focused coping was inversely associated with PTSD symptoms (r = −.14) and buffered service members from the negative effects of combat exposure in both Iraq (r2 = .01) and Afghanistan (r2 = .02). Self-blame coping was positively associated with PTSD symptoms in both samples (Iraq, r = .36; Afghanistan, r = .29) but only magnified the relationship between combat exposure and PTSD symptoms among service members in Iraq (r2 = .01) . These findings were replicated when controlling for unit cohesion and symptoms of depression. Prayer/spirituality coping was not significantly associated with PTSD symptoms, regardless of combat exposure. Discussion focuses on how specific positive emotion-focused coping strategies may be helpful for military personnel in combat operations given the uncontrollable and chaotic nature of the environment. Implications include providing training for deploying personnel that covers the use of these positive emotion-focused coping strategies and the potential problems with self-blame. Such training may also be suitable for other high-risk occupations in which employees face uncontrollable situations.

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http://onlinelibrary.wiley.com/wol1/doi/10.1002/jts.22214/abstract

Patterns of Smoking and Unhealthy Alcohol Use Following Sexual Trauma Among U.S. Service Members.

Seelig, A. D., Rivera, A. C., Powell, T. M., Williams, E. C., Peterson, A. V., Littman, A. J., Maynard, C., Street, A. E., Bricker, J. B. and Boyko, E. J.

Journal of Traumatic Stress
Volume 30, Issue 5, pages 502–511, October 2017
DOI: 10.1002/jts.22214

In the first known longitudinal study of the topic, we examined whether experiencing sexual assault or sexual harassment while in the military was associated with increased risk for subsequent unhealthy alcohol use and smoking among U.S. service members in the Millennium Cohort Study (2001–2012). Adjusted complementary log–log models were fit to estimate the relative risk of (a) smoking relapse among former smokers (men: n = 4,610; women: n = 1,453); (b) initiation of unhealthy alcohol use (problem drinking and/or drinking over recommended limits) among those with no known history of unhealthy alcohol use (men: n = 8,459; women: n = 4,816); and (c) relapse among those previously reporting unhealthy alcohol use (men: n = 3,487; women: n = 1,318). Men who reported experiencing sexual assault while in the military had sixfold higher risk for smoking relapse: relative risk (RR) = 6.62; 95% confidence interval (CI) [2.34, 18.73], than men who did not. Women who reported experiencing sexual assault while in the military had almost twice the risk for alcohol relapse: RR = 1.73; 95% CI [1.06, 2.83]. There were no other significant associations. These findings suggest that men and women may respond differently following sexual trauma, and support future concerted policy efforts by military leadership to prevent, detect, and intervene on sexual assault.

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http://onlinelibrary.wiley.com/wol1/doi/10.1002/jts.22223/abstract

The Association Between PTSD and Functional Outcome Is Mediated by Perception of Cognitive Problems Rather Than Objective Neuropsychological Test Performance.

Samuelson, K. W., Abadjian, L., Jordan, J. T., Bartel, A., Vasterling, J. and Seal, K.

Journal of Traumatic Stress
Volume 30, Issue 5, pages 521–530, October 2017
DOI: 10.1002/jts.22223

Posttraumatic stress disorder (PTSD) has been consistently linked to poorer functional outcomes, including quality of life, health problems, and social and occupational functioning. Less is known about the potential mechanisms by which PTSD leads to poorer functional outcomes. We hypothesized that neurocognitive functioning and perception of cognitive problems would both mediate the relationship between PTSD diagnosis and functioning. In a sample of 140 veterans of the recent wars and conflicts in Iraq and Afghanistan, we assessed PTSD symptoms, history of traumatic brain injury (TBI), depression, self-report measures of quality of life, social and occupational functioning, and reintegration to civilian life, as well as perception of cognitive problems. Veterans also completed a comprehensive neuropsychological battery of tests. Structural equation modeling revealed that perception of cognitive problems, but not objective neuropsychological performance, mediated the relationship between PTSD diagnosis and functional outcomes after controlling for TBI, depression, education, and a premorbid IQ estimate, b = −6.29, 95% bias-corrected bootstrapped confidence interval [−11.03, −2.88], showing a large effect size. These results highlight the importance of addressing appraisals of posttrauma cognitive functioning in treatment as a means of improving functional outcomes.

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http://onlinelibrary.wiley.com/wol1/doi/10.1002/jts.22226/abstract

Emotion Dysregulation and Social Support in PTSD and Depression: A Study of Trauma-Exposed Veterans.

Cox, D. W., Bakker, A. M. and Naifeh, J. A.

Journal of Traumatic Stress
Volume 30, Issue 5, pages 545–549, October 2017
DOI: 10.1002/jts.22226

Emotion dysregulation has been associated with impaired interpersonal functioning and increased risk of posttraumatic psychopathology. Given that social support is a robust predictor of psychiatric morbidity following trauma exposure, we examined whether emotion dysregulation was associated with posttraumatic psychopathology through its negative effect on social support. Using self-report data from 90 military veterans (89.9% men) enrolled in an outpatient psychotherapy program for posttraumatic stress disorder (PTSD), we found that social support partially mediated the effect of emotion dysregulation on PTSD (PM = .10) and depression symptoms (PM = .14). When source of support was considered, friend (PM = .08) and significant other support (PM = .06)

were greater mediators of the effect of emotion dysregulation on depression symptoms than family support (PM = .01). There were no differential mediating effects for support providers on PTSD symptoms. Our findings indicate that social support is a statistically significant yet clinically limited mechanism through which emotion dysregulation is linked with psychiatric symptoms. Implications for these limitations and alternative potentially relevant interpersonal mechanisms are discussed.

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http://onlinelibrary.wiley.com/doi/10.1111/bjc.12163/full

A relative weights comparison of trauma-related shame and guilt as predictors of DSM-5 posttraumatic stress disorder symptom severity among US veterans and military members.

Cunningham, K. C., Davis, J. L., Wilson, S. M. and Resick, P. A.

British Journal of Clinical Psychology
First published: 23 October 2017
DOI: 10.1111/bjc.12163

Objectives
Veterans and military service members have increased risk for post-traumatic stress disorder (PTSD) and consequent problems with health, psychosocial functioning, and quality of life. In this population and others, shame and guilt have emerged as contributors to PTSD, but there is a considerable need for research that precisely demonstrates how shame and guilt are associated with PTSD. This study examined whether a) trauma-related shame predicts PTSD severity beyond the effects of trauma-related guilt and b) shame accounts for a greater proportion of variance in PTSD symptoms than guilt.

Design
We collected cross-sectional self-report data on measures of PTSD symptom severity based on Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria, trauma-related shame, and trauma-related guilt via online survey.

Method
Participants included 61 US veterans and active duty service members. Hierarchical multiple regression and relative weights analysis were used to test hypotheses.

Results
In step 1 of regression analysis, guilt was significantly associated with PTSD. However, when shame was added to the model, the effect of guilt became non-significant, and only shame significant predicted PTSD. Results from relative weights analysis indicated that both shame and guilt predicted PTSD, jointly accounting for 46% of the variance in PTSD. Compared to guilt, trauma-related shame accounted for significantly more explained variance in PTSD.

Conclusions
This study provided evidence that among US veterans and service members, trauma-related shame and guilt differ in their association with PTSD and that trauma-related shame, in particular, is associated with the severity of PTSD.

Practitioner points

- Trauma-related shame and guilt explained almost half of the observed variance in PTSD symptom severity among this sample of US military veterans and service members.
- Trauma-related shame and guilt each made a unique contribution to PTSD severity after accounting for the similarity between these two emotions; however, shame was particularly associated with increased PTSD severity.
- These results highlight the importance of assessing and addressing trauma-related shame and guilt in PTSD treatment among military populations. We suggest that emotion- and compassion-focused techniques may be particularly relevant for addressing trauma-related shame and guilt.

Limitations of the study

- Cross-sectional data does not allow for determination of causal relationships.
- Although sufficiently powered, the sample size is small.
- The present sample self-selected to participate in a study about stress and emotions.

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http://www.openaccessjournals.com/scholarly-articles/a-suicide-assessment-of-elderly-military-veterans-best-practice-guidelines-inlongterm-care-2471-9846-1000150.pdf

A Suicide Assessment of Elderly Military Veterans: Best Practice Guidelines in Long-Term Care.

Yvette M Rose

Journal of Community Public Health Nursing
3:150
doi:10.4172/2471-9846.1000150

Suicide in the United States continues to be a pervasive problem with military veterans. Sadly, effects of previous military service continue to plague many elderly military veterans decades after the war. Many years after the war, some aging elderly veterans, age 65 years of age or older, find themselves fighting a new battle. Suicide is a major cause of mortality worldwide, and research indicates that the rate of suicide is increasing among the military population. Suicidal ideation is more dangerous in war veterans in comparison to the general population because they know how to use firearms and they often own them. Little research has examined the sensitive phenomena of elderly military veterans and the risk of suicide many years after the war. This document serves as a guideline for assessing suicide in elderly military veterans in long-term care, taking in account the available evidence.

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http://onlinelibrary.wiley.com/doi/10.1002/sem3.20111/full

In and Out: Veterans in Transition and Higher Education.

Barbara Bell

Strategic Enrollment Management Quarterly
First published: 4 October 2017
DOI: 10.1002/sem3.20111

The U.S. Department of Veterans Affairs (VA) spends nearly $12 billion annually on education benefits (VA, 2016). Veterans are showing up on campus in ever increasing numbers. While recruiting veterans makes sense from an enrollment management perspective, as most veterans come to campus with financial aid, how well prepared is higher education to receive them? Given the investment the government, taxpayers, and individual veterans are making, colleges and universities would be well served to understand these students. This article explores how veterans have changed the landscape of higher education, delves into the culture of the military and its impact on veterans, examines the challenges many veterans face as they transition out of the

military, and concludes with a discussion of ways in which higher education institutions might thoughtfully and intentionally assist veterans' transition into life as successful college students.

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https://jamanetwork.com/journals/jama/fullarticle/2659566

Clinical Management of Insomnia Disorder.

Daniel J. Buysse, MD; A. John Rush, MD; Charles F. Reynolds III, MD

JAMA.
Published online October 23, 2017
doi:10.1001/jama.2017.15683

The central feature of insomnia disorder is dissatisfaction with sleep quantity or quality, associated with difficulty falling asleep, maintaining sleep, or early morning awakening.1 Insomnia disorder causes clinically significant distress or impairment in important areas of functioning. Sleep difficulties occur at least 3 nights per week for at least 3 months, and are not better explained by use of substances, medications, or by another disorder. Insomnia is diagnosed only when an individual has adequate opportunity for sleep; this distinguishes insomnia from sleep deprivation, which has different causes and consequences. Insomnia disorder is often comorbid with other sleep-wake, mental, or medical disorders that require separate management. Increased neural, physiological, and psychological arousal, together with perpetuating behavioral factors (such as excessive time in bed) are thought to underlie most cases of chronic insomnia. Acute insomnia, which meets all diagnostic criteria as chronic insomnia except in duration, may have different causes and specific treatment implications.

Individuals with insomnia disorder typically experience multiple sleep symptoms over time. Nevertheless, specific sleep symptoms may aid differential diagnosis. Difficulty falling asleep may signal delayed sleep phase syndrome, restless legs syndrome, or anxiety. Difficulty maintaining sleep can result from sleep apnea, nocturia, or pain. Early morning awakening is associated with advanced sleep phase syndrome and depression.

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http://onlinelibrary.wiley.com/doi/10.1002/jcop.21909/full

A longitudinal investigation of the psychological health of United States Air Force base communities.

Michael F. Lorber, Richard E. Heyman, Amy M. Smith Slep

Journal of Community Psychology
First published: 23 October 2017
DOI: 10.1002/jcop.21909

The longitudinal course of the psychological health (PH) of United States Air Force (USAF) base communities in relation to risk and demographic factors was studied over a 5-year period. PH (clinically significant hazardous drinking, prescription drug misuse, depressive symptoms, suicidal thoughts and behaviors, intimate partner violence [IPV] and child abuse) and risk (personal and family adjustment, workplace adjustment, broader community adjustment) and demographic factors (age and gender distribution) were operationalized at the aggregate level for bases (N = 77) as measured in three large scale surveys of USAF active duty members. Bases whose members collectively exhibited greater levels of risk collectively experienced greater initial problems with alcohol and drug use, depression, suicidality, and physical IPV. Hazardous drinking more quickly increased at bases whose members were younger and more male, and at those with poorer initial aggregate personal adjustment and workplace adjustment. The challenges of studying the community-level course of PH are highlighted.

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https://link.springer.com/chapter/10.1007/978-3-319-62887-5_4

Young Children in Military Families.

Culler E., Saathoff-Wells T.

In: Szente J. (eds) Assisting Young Children Caught in Disasters. Educating the Young Child (Advances in Theory and Research, Implications for Practice), vol 13. Springer, Cham (2018)

https://doi.org/10.1007/978-3-319-62887-5_4

Young children in military families face some distinctive family supports and risks due to one or more parents' military service. These features of military life offer unique opportunities to promote resilience or create stress for young children. Repeated parental absence and risk of a parent's injury or death are central challenges in military families and can create chronic disruptions in parent-child relationships. These early family experiences can affect the development of secure and healthy attachment relationships and, in turn school readiness. The purpose of this chapter is to convey typical and extraordinary family and community contexts that influence the development and school readiness of young military-connected children in the United States. Early childhood professionals can play important roles in the lives of young military children. This includes becoming an important and observant caregiver, creating a safe and supportive environment for a child to explore and learn, and becoming a skilled communicator and advocate. Additional recommendations and implications are provided for early childhood teachers and related professionals who work with children living in military families.

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http://commons.pacificu.edu/spp/1264/

The Effectiveness of Prolonged Exposure Treatment for Posttraumatic Stress Disorder: A Meta-Analytic Review.

Lombardi, Anthony

Doctoral dissertation, Pacific University, 2017

Posttraumatic stress disorder is a multifaceted and widespread anxiety-related disorder associated with significant distress and functional impairment. Evidence has also revealed associations between PTSD and an increased risk for physical health problems, and PTSD has been considered the costliest anxiety-related disorder—largely due to non-psychiatric services such as emergency room visits. To mitigate the impacts of PTSD, decades of research has yielded efficacious treatments; in specific, prolonged exposure (PE)—a cognitive-behavioral treatment for PTSD—has the strongest body of empirical evidence, although is markedly underutilized in routine practice settings for both civilian and military populations. Given that the efficacy of PE is well-established, efforts should be focused on developing solutions to overcome barriers to its dissemination. To aid dissemination efforts, we conducted a meta-analytic review of effectiveness studies (N = 40) that examined the use of PE to treat PTSD within the context of a naturalistic setting. Results suggest that the mean effect size for

reduction in PTSD symptoms at posttreatment across studies was large (Cohen's d = 1.51; SE = .06) and significant (z = 24.83, p < .001). The mean effect size for reduction in comorbid depressive symptoms at posttreatment across studies (n = 28) was also large (Cohen's d = 1.03; SE = .05) and significant (z = 19.17, p < .001). Altogether, the results of this systematic review found that PE—when administered within the context of a naturalistic setting—had a large and positive effect for decreasing self-reported symptoms of PTSD and comorbid depression. Furthermore, results from moderator analyses revealed that PE may yield smaller effects for reductions in (a) depressive symptoms for White patients and (b) PTSD symptoms for older patients. Results also indicated that the presence of a comorbid traumatic brain injury (TBI) may predict a larger decrease in PTSD symptoms at posttreatment when compared to those without a comorbid TBI. In general, results of this review suggested that PE was effective despite variations in study characteristics (e.g., use of five-session, 30 min session PE protocol), thereby suggesting that it is likely effective across patient populations, treatment adaptations, and study designs.

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https://link.springer.com/article/10.1007/s40675-017-0096-x

Next Steps for Patients Who Fail to Respond to Cognitive Behavioral Therapy for Insomnia (CBT-I): the Perspective from Behavioral Sleep Medicine Psychologists.

Kelly Glazer Baron, Stephanie Hooker

Current Sleep Medicine Reports
First Online: 26 October 2017
https://doi.org/10.1007/s40675-017-0096-x

Purpose of Review
Cognitive behavioral therapy for insomnia (CBT-I) is a brief and effective non-pharmacologic treatment for insomnia that is recommended as the first-line treatment for chronic insomnia. Despite the benefits for many patients, 25–40% of patients do not have remission of their insomnia disorder. In this article, we discuss predictors of suboptimal response and a framework for assessing and mitigating factors that may interfere with treatment.

Recent Findings
For patients with a suboptimal response to CBT-I, there is no established protocol to follow because of having no published studies of non-pharmacologic treatments directly

targeting CBT-I non-responders. We present evidence-based treatments beyond CBT-I that may benefit patients who are suboptimal CBT-I responders including techniques for promoting adherence and other non-pharmacologic treatments including CBT to address psychiatric symptoms, mindfulness, exercise, bright light, and melatonin treatments. We also discuss the importance of assessment of comorbid sleep disorders and the potential use of hypnotic medications.

Summary
There are other potential non-pharmacologic treatment that may be beneficial to patients with suboptimal response to CBT-I. However, further research is needed to guide treatment algorithms for patients who have suboptimal response to CBT-I in order to inform treatment decision making.

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https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2653443

Adherence to Depression Treatment in Primary Care: A Randomized Clinical Trial.

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JAMA Psychiatry
2017;74(11):1129-1135
doi:10.1001/jamapsychiatry.2017.3047

Key Points

Question
Can a brief psychosocial intervention (ie, Treatment Initiation and Participation Program) targeting medication barriers improve antidepressant adherence among middle-aged and older adults with a newly initiated depression treatment by primary care physicians?

Findings
In this randomized clinical trial, the Treatment Initiation and Participation Program participants were 3 times more likely to be at least 80% adherent to their antidepressant pharmacotherapy at both 6 and 12 weeks. The Treatment Initiation and Participation Program did not have a sustained effect on depression; however, participants who reported 80% adherence at both 6 and 12 weeks showed greater improvement in depression severity by 24 weeks.

Meaning
The Treatment Initiation and Participation Program improved early adherence at weeks 6 and 12 combined and participants showed an early reduction in depressive symptoms at 6 weeks; participants in the Treatment Initiation and Participation Program and treatment as usual groups who were adherent at weeks 6 and 12 had a greater improvement in depressive symptoms.

Abstract

Importance
Nonadherence to antidepressant medication is common and leads to poor outcomes. Early nonadherence is especially problematic.

Objective
To test the effectiveness of a psychosocial intervention to improve early adherence among older patients whose primary care physician newly initiated an antidepressant for depression.

Design, Setting, and Participants
The Treatment Initiation and Participation Program (TIP) was offered in a 2-site randomized clinical effectiveness study between January 2011 and December 2014 at primary care practices in New York, New York, and Ann Arbor, Michigan. Analyses began in February 2016. All participants were middle-aged and older adults (aged ≥55 years) who received newly initiated depression treatment by their primary care physician and recruited within 10 days of their prescription. Analyses were intention-to-treat.

Interventions
Participants were randomly assigned to the intervention (TIP) or treatment as usual. Participants in the TIP group identified and addressed barriers to adherence, including stigma, misconceptions, and fears about treatment, before developing a personalized adherence strategy. The Treatment Initiation and Participation Program was delivered in three 30-minute contacts scheduled during a 6-week period just after the antidepressant was prescribed.

Main Outcomes and Measures
The primary outcome was self-reported adherence on the Brief Medication Questionnaire, with adequate early adherence defined as taking 80% or more of the prescribed doses at 6 and 12 weeks. The secondary outcome was depression severity.

Results
In total, 231 middle-aged and older adults (167 women [72.3%] and 64 men [27.7%]) without significant cognitive impairment were randomly assigned to the TIP intervention (n = 115) or treatment as usual (n = 116). Participants had a mean (SD) age of 67.3 (8.4) years. Participants in the TIP group were 5 times more likely to be adherent at 6 weeks (odds ratio, 5.54; 95% CI, 2.57 to 11.96; $\chi 21 = 19.05$; $P < .001$) and 3 times more likely to be adherent at both 6 and 12 weeks (odds ratio, 3.27; 95% CI, 1.73 to 6.17; $\chi 21 = 13.34$; $P < .001$). Participants in the TIP group showed a significant earlier reduction (24.9%) in depressive symptoms (95% CI, 13.9 to 35.9; $t337 = 4.46$; adjusted $P < .001$). In both groups, participants who were 80% adherent at weeks 6 and 12 had a 15% greater improvement in depressive symptoms from baseline over the course of treatment (95% CI, −0.2 to −30; $t369 = 1.93$; $P = .051$).

Conclusions and Relevance
The Treatment Initiation and Participation Program is an effective intervention to improve early adherence to pharmacotherapy. Improved adherence can promote improvement in depression.

Trial Registration clinicaltrials.gov Identifier: NCT01301859

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https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2648693

Polygenic Scores for Major Depressive Disorder and Risk of Alcohol Dependence.

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JAMA Psychiatry
2017;74(11):1153-1160
doi:10.1001/jamapsychiatry.2017.2269

Key Points

Question
Do major depressive disorder and alcohol dependence share common genetic risk variants?

Findings
In this cohort study of 4 independent samples of 3871 individuals with alcohol dependence and 3347 individuals serving as controls, elevated polygenic risk for major depressive disorder also conveyed a significant increase in risk for alcohol dependence.

Meaning
Common polygenic risk contributes to susceptibility to both major depressive disorder and alcohol dependence.

Abstract

Importance
Major depressive disorder (MDD) and alcohol dependence (AD) are heritable disorders with significant public health burdens, and they are frequently comorbid. Common genetic factors that influence the co-occurrence of MDD and AD have been sought in family, twin, and adoption studies, and results to date have been promising but inconclusive.

Objective
To examine whether AD and MDD overlap genetically, using a polygenic score approach.

Design, Settings, and Participants
Association analyses were conducted between MDD polygenic risk score (PRS) and AD case-control status in European ancestry samples from 4 independent genome-wide association study (GWAS) data sets: the Collaborative Study on the Genetics of Alcoholism (COGA); the Study of Addiction, Genetics, and Environment (SAGE); the Yale-Penn genetic study of substance dependence; and the National Health and Resilience in Veterans Study (NHRVS). Results from a meta-analysis of MDD (9240 patients with MDD and 9519 controls) from the Psychiatric Genomics Consortium were applied to calculate PRS at thresholds from $P < .05$ to $P \leq .99$ in each AD GWAS data set.

Main Outcomes and Measures
Association between MDD PRS and AD.

Results
Participants analyzed included 788 cases (548 [69.5%] men; mean [SD] age, 38.2 [10.8] years) and 522 controls (151 [28.9.%] men; age [SD], 43.9 [11.6] years) from COGA; 631 cases (333 [52.8%] men; age [SD], 35.0 [7.7] years) and 756 controls (260

[34.4%] male; age [SD] 36.1 [7.7] years) from SAGE; 2135 cases (1375 [64.4%] men; age [SD], 39.4 [11.5] years) and 350 controls (126 [36.0%] men; age [SD], 43.5 [13.9] years) from Yale-Penn; and 317 cases (295 [93.1%] men; age [SD], 59.1 [13.1] years) and 1719 controls (1545 [89.9%] men; age [SD], 64.5 [13.3] years) from NHRVS. Higher MDD PRS was associated with a significantly increased risk of AD in all samples (COGA: best P = 1.7 × 10−6, R2 = 0.026; SAGE: best P = .001, R2 = 0.01; Yale-Penn: best P = .035, R2 = 0.0018; and NHRVS: best P = .004, R2 = 0.0074), with stronger evidence for association after meta-analysis of the 4 samples (best P = 3.3 × 10−9). In analyses adjusted for MDD status in 3 AD GWAS data sets, similar patterns of association were observed (COGA: best P = 7.6 × 10−6, R2 = 0.023; Yale-Penn: best P = .08, R2 = 0.0013; and NHRVS: best P = .006, R2 = 0.0072). After recalculating MDD PRS using MDD GWAS data sets without comorbid MDD-AD cases, significant evidence was observed for an association between the MDD PRS and AD in the meta-analysis of 3 GWAS AD samples without MDD cases (best P = .007).

Conclusions and Relevance
These results suggest that shared genetic susceptibility contributes modestly to MDD and AD comorbidity. Individuals with elevated polygenic risk for MDD may also be at risk for AD.

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http://jcsm.aasm.org/ViewAbstract.aspx?pid=31104

Improving PTSD Symptoms and Preventing Progression of Subclinical PTSD to an Overt Disorder by Treating Comorbid OSA With CPAP.

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Journal of Clinical Sleep Medicine
2017;13(10):1191–1198

Study Objectives
Obstructive sleep apnea (OSA) and posttraumatic stress disorder (PTSD) are common in United States veterans. These conditions often coexist and symptoms overlap. Previous studies reported improvement in PTSD symptoms with continuous positive airway pressure (CPAP) therapy for comorbid OSA but its effect has not been assessed in a non-PTSD cohort. We have prospectively assessed the effect of CPAP therapy on clinical symptom improvement as a function of CPAP compliance levels among PTSD

and non-PTSD veterans.

Methods
Veterans in whom OSA was newly diagnosed were enrolled in our study (n = 192). Assignment to PTSD and non-PTSD cohorts was determined by chart review. Each patient completed the military version of the PTSD Checklist (PCL), Epworth Sleepiness Scale (ESS), and reported nightmare frequency (NMF) at baseline and 6 months after CPAP therapy. CPAP adherence was objectively documented from machine compliance data.

Results
We had complete data for 177 veterans (PTSD n = 59, non-PTSD n = 118) for analysis. The mean ages were 51.24 years in the PTSD cohort and 52.36 years in the non-PTSD cohort (P = .30). In the PTSD cohort, the mean total PCL score (baseline = 66.06, post-CPAP = 61.27, P = .004, d = −0.34) and NMF (baseline = 4.61, post-CPAP = 1.49, P = .0001, d = −0.51) decreased after 6 months of CPAP treatment. Linear regression analysis showed that the CPAP compliance was the only significant predictor for these changes among veterans with PTSD (PCL score: P = .033, R2 = .65; NMF; P = .03, R2 = .61). Further analysis by CPAP compliance quartiles in this cohort (Q1 = 0% to 25%, Q2 = 26% to 50%, Q3 = 51% to 75%, Q4 > 75%) revealed that mean total PCL score declined in Q2 (change = −3.91, P = .045, d = 0.43), Q3 (change = −6.6, P = .002, d = 0.59), and Q4 (change = −7.94, P = .037, d = 0.49). In the non-PTSD cohort, the PCL score increased despite CPAP therapy in lower CPAP compliance quartiles Q1 (change = 8.71, P = .0001, d = 0.46) and Q2 (change = 4.51, P = .046, d = 0.27). With higher CPAP compliance (in Q3 and Q4) in this cohort, the mean total PCL scores slightly improved with CPAP but they were not statistically significant (P > .05).

Conclusions
CPAP treatment reduces total PCL score and NMF in veterans with PTSD and OSA. Those with overt PTSD respond to even lower CPAP compliance, whereas non-PTSD patients require higher compliance to achieve any symptom improvement. Poor CPAP compliance results in increased PCL score in non-PTSD veterans and may lead to overt PTSD if the OSA remains undertreated.

Links of Interest

Beat Depression: How to Support Women You Know
https://www.dcoe.mil/news/17-10-27/beat-depression-how-support-women-you-know

Dems press VA for in-depth medical marijuana research
https://www.militarytimes.com/veterans/2017/10/26/democrats-push-for-va-to-start-in-depth-medical-marijuana-research/

Survey: 58 percent of IAVA members have lost a veteran to suicide
https://www.militarytimes.com/veterans/2017/10/26/survey-58-percent-of-iava-members-have-lost-a-veteran-to-suicide/

The Secrets of Sleep: Why do we need it, and are we getting enough?
https://www.newyorker.com/magazine/2017/10/23/the-secrets-of-sleep

The Army is buying a device that can quickly assess traumatic brain injury on the battlefield
https://www.armytimes.com/news/your-army/2017/10/29/the-army-is-buying-a-device-that-can-quickly-assess-traumatic-brain-injury-on-the-battlefield/

Air Force colonel appeals discipline for same-sex marriage discrimination
https://www.airforcetimes.com/news/your-air-force/2017/10/28/air-force-colonel-appeals-discipline-for-same-sex-marriage-discrimination/

Coast Guard Academy Investigating Report of Racially-Charged Incident
https://www.nbcconnecticut.com/news/local/Coast-Guard-Academy-Investigating-Report-of-Racially-Charged-Incident-454011253.html

Commentary: Civilians can thank troops, veterans just by paying attention
https://www.militarytimes.com/military-honor/salute-veterans/2017/10/31/commentary-civilians-can-thank-troops-veterans-just-by-paying-attention/

Life with Lizzy
https://health.mil/News/Articles/2017/11/01/Life-with-Lizzy

Psychiatrist: Bergdahl mental disorder factored in desertion
https://www.armytimes.com/news/your-army/2017/11/01/psychiatrist-bergdahl-mental-disorder-factored-in-desertion/

Resource of the Week: An Evaluation of U.S. Military Non-Medical Counseling Programs (RAND Corporation)

This report evaluates two programs offered by the U.S. Department of Defense (DoD) that provide short-term, solution-focused counseling for common personal and family issues to members of the U.S. military and their families. These counseling services are collectively called non-medical counseling within the DoD and are offered through the Military and Family Life Counseling (MFLC) and Military OneSource programs. RAND's National Defense Research Institute was asked to evaluate these programs to determine whether they are effective in improving outcomes and whether effectiveness varies by problem type and/or population. Two online surveys were provided to program participants — the first two to three weeks after their initial session and the second three months later. Surveys were designed to gain information on 1) problem severity and overall problem resolution, 2) resolution of stress and anxiety, 3) problem interference with work and daily life, 4) connection to other services and referrals, 5) experiences with MFLC and Military OneSource programs, and 6) perceptions of non-medical counselors. The majority of participants experienced a decrease in problem severity and a reduction in reported frequency of feeling stressed or anxious as a result of their problem following counseling. These improvements were sustained or continued to improve in the three months after initiation of counseling. Non-medical counseling was not universally successful, however, and a small minority expressed dissatisfaction with the program or their counselor. Collectively these findings suggest a number of policy implications and programmatic improvements of interest to program leadership in the Office of the Secretary of Defense.

Key Findings

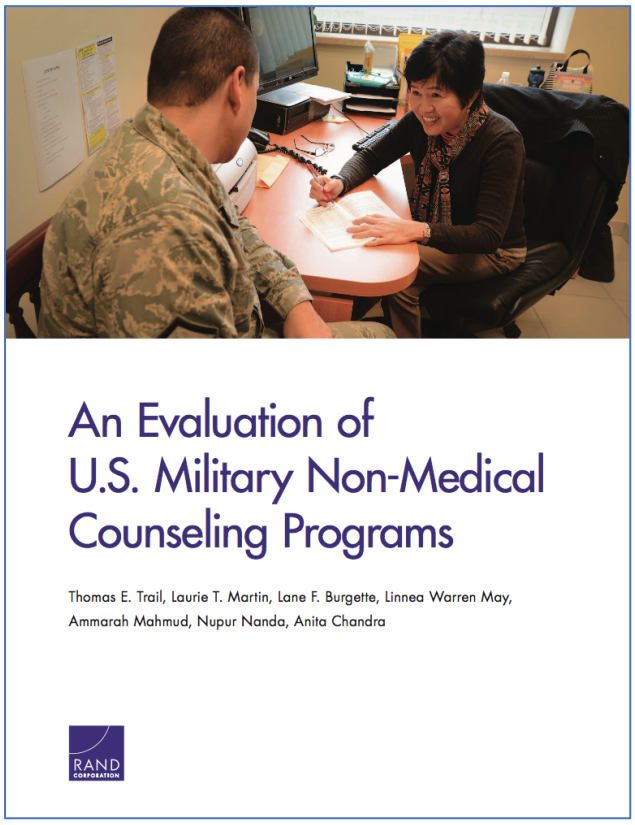
- In general, most people who used non-medical counseling experienced a reduction in problem severity and its impact on their lives over the short and long term.
- There was a statistically significant decrease in the frequency with which a participant's problem interfered with work or daily routines following non-medical counseling, and a decrease in stated difficulty coping with day-to-day demands.
- Most non-medical counseling participants were connected with support and services outside of the program — although not necessarily to support they would not have found on their own.
- Across most measures, over 90 percent of participants reported positive

experiences with non-medical counseling provided through the Military and Family Life Counseling and Military OneSource programs.
- Over 90 percent of participants expressed favorable perceptions of the professionalism and knowledge of non-medical counselors, thought that their counselor listened to them and spent enough time with them, and agreed that their counselor provided the services they needed to address their problem.
- Despite positive perceptions from the majority of participants, between 1 percent and 7 percent of participants reported being dissatisfied or very dissatisfied with non-medical counseling, and about 15 percent continued to rate their problem as severe or very severe, suggesting that there is room for improvement.

Recommendations

- Take steps to increase awareness of the program. Open-ended survey responses by participants noted the awareness of non-medical counseling in the broader military community may be limited, suggesting that more work could be done to disseminate information about the availability of this service.
- Provide opportunities for ongoing support, guidance, and training for counselors. A small minority of participants' dissatisfaction with their counselor suggests that counselors might benefit from more opportunities to receive support and guidance from other non-medical counselors or from supervisors with more experience in the military community. These activities may provide consistent counselor support and supervision and standardize high-quality non-medical counseling approaches and experiences across counselors.
- Strengthen non-medical counseling for parents with child-related concerns. Participants who sought non-medical counseling for child-related problems reported lower levels of problem resolution and lower satisfaction with the continuity of care. Services for this population could potentially be strengthened through warm handoffs to counselors who hold specialized training with children.
- Identify ways to systematically collect counselor-level feedback and incorporate findings into performance review. Both programs may benefit from systematically collecting counselor-level feedback to establish whether identified concerns are more prevalent for a given counselor or location.

- Strengthen continuity of care. Satisfaction with continuity of care varied significantly across respondents. While most participants were satisfied, open-ended comments suggest a need for greater continuity of care.
- Strengthen screening and connections to other services. Survey results and open-ended comments from participants suggest that non-medical counseling could benefit from strengthening connections to other services.



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