CDP Research Update -- November 1, 2012

What's here:

- What are the effects of having an illness or injury whilst deployed on post deployment mental health? A population based record linkage study of UK Army personnel who have served in Iraq or Afghanistan.
- Ten Things You Should Know About Today's Student Veteran
- Sexual Dysfunction among Male Veterans Returning from Iraq and Afghanistan: Prevalence and Correlates.
- Using Cognitive Processing Therapy–Cognitive in a Residential Treatment Setting With an OEF/OIF Veteran With PTSD and a History of Severe Traumatic Brain Injury: A Case Study.
- Poor sleep quality as a risk factor for lapse following a cannabis quit attempt.
- Health surveillance of deployed military personnel occasionally leads to unexpected findings.
- Answering the Joining Forces Call: Integrating Woman Veteran Care Into Nursing Simulations.
- Where Did You Serve? Veteran Identity, Representative Bureaucracy, and Vocational Rehabilitation.
- Teleconcussion: An Innovative Approach to Screening, Diagnosis, and Management of Mild Traumatic Brain Injury.
- Kids at the VA? A Call for Evidence-Based Parenting Interventions for Returning Veterans.
- Psychiatric comorbidity in veterans with psychogenic seizures.
- Mild traumatic brain injury and posttraumatic stress disorder: Investigation of visual attention in Operation Iraqi Freedom/Operation Enduring Freedom veterans.
- Relationship of screen-based symptoms for mild traumatic brain injury and mental health problems in Iraq and Afghanistan veterans: Distinct or overlapping symptoms?
- Mortality and Suicide Risk in Treatment-Resistant Depression: An Observational Study of the Long-Term Impact of Intervention.

- Reducing Suicidal Ideation: Cost-Effectiveness Analysis of a Randomized Controlled Trial of Unguided Web-Based Self-help.
- Mood, Anxiety, and Substance-Use Disorders and Suicide Risk in a Military Population Cohort.
- PTSD Among Our Returning Veterans.
- Primary Care–Mental Health Integration Programs in the Veterans Affairs Health System Serve a Different Patient Population Than Specialty Mental Health Clinics.
- Gender, trauma type, and PTSD prevalence: a re-analysis of 18 nordic convenience samples.
- Impact of sleep disturbance on patients in treatment for mental disorders.
- Insomnia.
- Are you under stress in EMS. Understanding the slippery slope of burnout and PTSD.
- Traumatic brain injury and sleep disorders.
- Evidence-based guidelines for the management of traumatic brain injury.
- Psychiatric disorders and sleep.
- Sleep-related headaches.
- Neuropsychiatric Symptoms and the Use of Complementary and Alternative Medicine.
- The Effect of Draft DSM-V Criteria on Posttraumatic Stress Disorder Prevalence.
- Sex differences in fear conditioning in posttraumatic stress disorder.
- Manualized Therapy for PTSD: Flexing the Structure of Cognitive Processing Therapy.
- The effects of positive patient testimonials on PTSD treatment choice.
- Impact of panic disorder on quality of life among veterans in a primary care pilot study.
- What is the Role of Eye Movements in Eye Movement Desensitization and Reprocessing (EMDR) for Post-Traumatic Stress Disorder (PTSD)? A Review.
- Individual augmentee deployment and newly reported mental health morbidity.
- Self-harm and attempted suicide among UK armed forces personnel: results of a cross-sectional survey.

- Effectiveness of Abbreviated CBT for Insomnia in Psychiatric Outpatients: Sleep and Depression Outcomes.
- Links of Interest
- Research Tip of the Week: CDC Disaster Mental Health

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http://www.biomedcentral.com/content/pdf/1471-244X-12-178.pdf

What are the effects of having an illness or injury whilst deployed on post deployment mental health? A population based record linkage study of UK Army personnel who have served in Iraq or Afghanistan.

Harriet J Forbes, Norman Jones, Charlotte Woodhead, Neil Greenberg, Kate Harrison, Sandra White, Simon Wessely, Nicola T Fear

BMC Psychiatry 2012, 12:178

Background
The negative impact of sustaining an injury on a military deployment on subsequent mental health is well-documented, however, the relationship between having an illness on a military operation and subsequent mental health is unknown.

Methods
Population based study, linking routinely collected data of attendances at emergency departments in military hospitals in Iraq and Afghanistan [Operational Emergency Department Attendance Register (OpEDAR)], with data on 3896 UK Army personnel who participated in a military health study between 2007 and 2009 and deployed to Iraq or Afghanistan between 2003 to 2009.

Results
In total, 13.8% (531/3896) of participants had an event recorded on OpEDAR during deployment; 2.3% (89/3884) were medically evacuated. As expected, those medically evacuated for an injury were at increased risk of post deployment probable PTSD (odds ratio 4.25, 95% confidence interval 1.81 to 9.99). Less expected was that being medically evacuated for an illness was also associated with a similarly increased risk of probable PTSD (4.43, 1.61 to 12.16) and common mental disorders (2.82, 1.43 to 5.56). There was no association between having an OpEDAR event and alcohol misuse. Having an injury caused by hostile action was associated with increased risk of probable PTSD compared to those with a non-hostile injury (3.88, 1.15 to 13.06).

Conclusions
Personnel sustaining illnesses on deployment are just as, if not more, at risk of having subsequent

mental health problems as personnel who have sustained an injury. Monitoring of mental health problems should consider those with illnesses as well as physical injuries.

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http://www.nea.org/assets/docs/HE/2012-TA-Lighthall.pdf

Ten Things You Should Know About Today's Student Veteran

Alison Lighthall

Thought & Action (National Education Association)

Fall 2012

You may not realize how many student veterans are on campuses these days. According to Completing The Mission: A Pilot Study of Veteran Student Progress Toward Degree Attainment in the Post 9/11 Era, by 2011, more than 924,000 veterans had used the benefits offered through the Post-9/11 G.I. Bill.

The report, prepared by the Pat Tillman Foundation and Operation College Promise, goes on to say that the number is rising as more troops are discharged into a dismal job market.

At George Mason University in northern Virginia, for instance, the number of student veterans has soared from 840 in 2009 to 1,575 in early 2011.

At Wayne State University in Detroit, the administration expects these numbers to double in the next year, from approximately 500 to 1,000.

Getting through the dizzying, sometimes maddening maze of Veterans Affairs paperwork may be the biggest obstacle that student veterans face in getting a higher education, but it is certainly not the only one. Issues like blast-related reading and hearing impairments, or feelings of intense discomfort when a well-meaning professor puts them on the spot to discuss his/her world views, or their struggles to manage intrusive memories of deployment while sitting still in a windowless classroom, can be incredibly challenging and fatiguing to these men and women. Making it worse, they persistently resist asking for help to retain their self-belief of being "bullet-proof."

In my eight years of working with our military citizens, and having been one myself, I've found that when college faculty and staff understand a few core principles about student veterans, the experience is much more positive for everybody in the classroom. Here, in David Letterman style, is my top-ten list of principles for working with student veterans…

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http://onlinelibrary.wiley.com/doi/10.1111/j.1743-6109.2012.02978.x/abstract

Sexual Dysfunction among Male Veterans Returning from Iraq and Afghanistan: Prevalence and Correlates.

Hosain, G.M. M., Latini, D. M., Kauth, M., Goltz, H. H. and Helmer, D. A.

Journal of Sexual Medicine

Article first published online: 22 OCT 2012

ABSTRACT

Introduction.
Sexual dysfunction (SD) is not well described in the Iraq/Afghanistan veteran population despite high prevalence of multiple risk factors for this issue.

Aim.
To estimate the prevalence and examine the association of various sociodemographic, mental health, comorbid conditions and life style factors with sexual dysfunction in Iraq/Afghanistan veterans.

Methods.
This exploratory cross-sectional study was conducted using data from the VA administrative database. A total of 4,755 Iraq/Afghanistan veterans were identified who sought treatment from the Michael E. DeBakey Veterans Affairs Medical Center inpatient and outpatient clinic between September 2007 and August 2009.

Main Outcome Measures.
Sexual dysfunction was determined by ICD9-CM codes related to sexual health issues and/or by specific medications, primarily phosphodiesterase-5 inhibitors (PDE5i), prescribed for erectile dysfunction.

Results.
The overall prevalence of sexual dysfunction was 5.5% (N = 265). By age category, it was 3.6% (N = 145) for Iraq/Afghanistan veterans aged 18–40 years and 15.7% (N = 120) for Iraq/Afghanistan veterans aged > 40 years, respectively. A multivariate logistic-regression model revealed that annual income, marital status, post-traumatic stress disorder, and hypertension were significant risk factors of SD (all $P < 0.05$) among younger Iraq/Afghanistan veterans, whereas among the older Iraq/Afghanistan veterans, being African American and having PTSD and hypertension were significant risk factors of SD (all $P < 0.05$). There was marked discrepancy between documented erectile dysfunction and prescription of a PDE5i.

Conclusions.
These data demonstrate that a significant proportion of Iraq/Afghanistan veterans have SD and that the risk factors differ between younger and older veterans. Our findings also suggest that SD is likely under-coded. To better identify the scope of the problem, systematic screening for sexual dysfunction may be appropriate perhaps as part of an initial post-deployment health evaluation.

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http://www.sciencedirect.com/science/article/pii/S1077722912001095

Using Cognitive Processing Therapy–Cognitive in a Residential Treatment Setting With an OEF/OIF Veteran With PTSD and a History of Severe Traumatic Brain Injury: A Case Study.

Susan M. McIlvaina, Kristen H. Waltera, Kathleen M. Charda

Cognitive and Behavioral Practice

Available online 22 October 2012

The co-occurrence of posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI) is common among military personnel returning from deployments in Iraq and Afghanistan. Despite the prevalence, scant evidence exists to inform clinicians as how to best treat these individuals, particularly for individuals with PTSD and a history of severe TBI. This case study presents the course of treatment in a VA residential PTSD/TBI program for an Operation Iraqi Freedom Veteran with PTSD, a history of severe TBI, and other psychiatric comorbidities. Cognitive Processing Therapy–Cognitive (CPT-C) was utilized as the primary PTSD treatment in conjunction with ancillary treatment. Data obtained during and following treatment suggest that CPT-C, without modifications to the protocol, offered within a residential treatment program may be an effective treatment for veterans with PTSD and a history of severe TBI.

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http://www.sciencedirect.com/science/article/pii/S0740547212003777

Poor sleep quality as a risk factor for lapse following a cannabis quit attempt.

Kimberly A. Babson, Matthew Tyler Boden, Alex H. Harris, Timothy R. Stickle, Marcel O. Bonn-Miller

Journal of Substance Abuse Treatment

Available online 23 October 2012

Treatments for cannabis dependence are associated with high rates of lapse/relapse, underscoring the importance of identifying malleable risk factors that are associated with quit failure. Whereas research has demonstrated that poor sleep quality following cannabis discontinuation is related to subsequent use, there has yet to be an examination of whether poor sleep quality prior to a quit attempt results in a similar pattern of lapse. The present study addressed this gap by examining the role of pre-quit sleep quality on early lapse to cannabis use following a self-guided quit attempt, among 55 cannabis dependent military veterans. Results indicated that participants who experienced poor pre-quit sleep quality had greater risk for lapse within the first 2 days (out of 7) following their quit attempt. Findings are discussed in terms of improving treatments for individuals who report poor sleep quality prior to a cannabis quit attempt.

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http://www.biomedcentral.com/1741-7015/10/126/abstract

Health surveillance of deployed military personnel occasionally leads to unexpected findings.

Alexander C McFarlane

BMC Medicine

Published: 24 October 2012

Post-traumatic stress disorder (PTSD) can be caused by life threatening illness, such as cancer and coronary events. The study by Forbes et al. made the unexpected finding that military personnel evacuation with medical illness have similar rates of PTSD to those evacuated with combat injuries. It may be that the illness acts as a nonspecific stressor that interacts with combat exposures to increase the risk of PTSD. Conversely, the inflammatory consequence of systemic illness may augment the effects to traumatic stress and facilitate the immunological abnormalities that are now being associated with PTSD and depression. The impact of the stress on cytokine systems and their role in the onset of PTSD demands further investigation. Military personnel evacuated due to physical illness require similar screening and monitoring for the risk of PTSD to those injured who are already known to be at high risk. Please see related article: http://www.biomedcentral.com/1471-244X/12/178 .

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http://journals.lww.com/nurseeducatoronline/Abstract/2012/11000/Answering_the_Joining_Forces_Call__Integrating.8.aspx

Answering the Joining Forces Call: Integrating Woman Veteran Care Into Nursing Simulations.

McKay Harmer, Bonnie PhD, MSN, MSEd, RN; Huffman, Jaime MSN, RN

Nurse Educator

November/December 2012 - Volume 37 - Issue 6 - p 237–241

Joining Forces is a national undertaking asking for a commitment from nurses to serve military members, veterans, and their family members. However, given the content saturation concerns so common in nursing curricula, how can educators ensure this content is in their curricula without overburdening their faculty or students? The authors provide suggestions on how to modify existing simulations to incorporate veteran care. These suggestions can easily be incorporated into simulations for nursing schools, hospitals, or outpatient care settings.

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http://jpart.oxfordjournals.org/content/early/2012/10/12/jopart.mus030.abstract

Where Did You Serve? Veteran Identity, Representative Bureaucracy, and Vocational Rehabilitation.

Daniel M. Gade and Vicky M. Wilkins

J Public Adm Res Theory first published online October 22, 2012

The research on representative bureaucracy investigates whether higher levels of representation within public agencies affect policy outcomes. We expand this line of inquiry by examining the effect of symbolic representation on the clients' perceptions of the vocational rehabilitation program administered by the Department of Veterans Affairs. We test the link between passive representation and symbolic representation for Veteran identity. This is one of the first studies to investigate an identity not associated with immutable characteristics. We question how an identity related to a profession that an individual selects into, like Veteran status, can influence a client's relationship with a government program. We find that Veteran clients of the vocational rehabilitation system perceive substantial differences in the behaviors of their counselor and report significantly higher levels of overall satisfaction with the program when they know or believe their counselor is also a Veteran.

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http://online.liebertpub.com/doi/abs/10.1089/tmj.2012.0118

Teleconcussion: An Innovative Approach to Screening, Diagnosis, and Management of Mild Traumatic Brain Injury.

Bert B. Vargas, Dwight D. Channer, David W. Dodick, and Bart M. Demaerschalk

Telemedicine and e-Health

Online Ahead of Print: October 26, 2012

Concussion awareness and management in sports have gained a great deal of attention in light of research illustrating the potentially devastating consequences of repeated traumatic brain injuries. In order to address this public health crisis, numerous states have passed legislation that mandates medical clearance before being eligible to return to play of concussed athletes by a qualified healthcare provider. As the number of qualified healthcare providers with expertise in the diagnosis and management of concussions remains very small, patient safety and the ability to fulfill these legislative return-to-play requirements present unique problems to rural communities without easy access to subspecialty care. Telemedicine is a possible means by which to address the needs of the rural student-athlete.

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http://psycnet.apa.org/psycinfo/2012-28379-001/

Kids at the VA? A Call for Evidence-Based Parenting Interventions for Returning Veterans.

Pemberton, Joy R.; Kramer, Teresa L.; Borrego Jr., Joaquin; Owen, Richard R.

Psychological Services, Oct 22 , 2012

Veterans of the current and recent U.S. military conflicts are at risk for negative physical, psychological, and family functioning outcomes. Children of veterans are also at risk for developing mental and behavioral difficulties. Furthermore, the parent–child relationship can be negatively affected by deployment-related problems. These child and family functioning difficulties can result in less positive outcomes for the veteran. Therefore, treatments targeting family and parent–child functioning have the potential to promote veterans' recovery. This article reviews literature related to child mental health, parenting, and veteran outcomes and calls for research regarding the implementation of parenting interventions at facilities which provide mental health care to veterans, such as VA medical centers. Using an example treatment, Parent-Child Interaction Therapy (PCIT), the authors outline the components needed to make a parenting intervention most useful to veterans. Challenges to implementation are outlined, including policy, resource, and population-specific factors. Research directions related to each challenge are also discussed, emphasizing the ability of interventions such as PCIT to adapt to serve new populations, and the ability of the VA to adapt to provide ideal services to veterans. (PsycINFO Database Record (c) 2012 APA, all rights reserved)

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http://www.sciencedirect.com/science/article/pii/S152550501200488X

Psychiatric comorbidity in veterans with psychogenic seizures.

Martin Salinskya, Collette Evrarda, Daniel Storzbacha, Mary Jo Pugh

Epilepsy & Behavior

Volume 25, Issue 3, November 2012, Pages 345–349

Psychogenic non-epileptic seizures (PNES) are frequently encountered in epilepsy monitoring units (EMU) at Veterans Affairs Medical Centers (VAMCs) and cause significant long-term disability. An understanding of psychiatric factors associated with PNES could aid in earlier diagnosis and treatment. We studied 50 consecutive veterans diagnosed with PNES and 37 veterans diagnosed with epileptic seizures (ES), evaluated at a VAMC EMU. We reviewed all available mental health evaluations prior to EMU evaluation. Univariate comparisons included axis I diagnoses, axis II diagnoses, and psychiatric hospitalizations. Predictive models of seizure classification were evaluated by logistic regression. A diagnosis of post-traumatic stress disorder (PTSD) preceded the diagnosis of PNES in 58% of patients and the diagnosis of ES in 13.5% ($p < 0.001$). On logistic regression, PTSD was the only significant psychiatric diagnosis (odds ratio 9.2). Major depression and alcohol abuse were common diagnoses but did not differentiate PNES and ES groups.

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http://www.rehab.research.va.gov/jour/2012/497/pdf/ogden497.pdf

Mild traumatic brain injury and posttraumatic stress disorder: Investigation of visual attention in Operation Iraqi Freedom/Operation Enduring Freedom veterans.

Kristen Barlow-Ogden, MA; William Poynter, PhD

J Rehabil Res Dev. 2012;49(7):1101–14.

Mild traumatic brain injury (mTBI) and posttraumatic stress disorder (PTSD) are prevalent dual impairments in veterans returning from the wars in Iraq and Afghanistan. Attention problems are a common self-reported complaint of veterans with mTBI, but relatively few studies have investigated the types and levels of behavioral attentional deficits present in veterans with mTBI and PTSD. The purpose of this study was to compare visual attentional performance between samples of veterans with both mTBI and PTSD (mTBI+PTSD), PTSD only, and a control group. Overall, the attentional responses of the mTBI+PTSD group were slower than those of the PTSD and control groups. The response times were also more variable, suggesting difficulty with attentional vigilance. Additionally, we found evidence of hemispheric asymmetries in attentional performance. Participants with mTBI+PTSD were less efficient in orienting visual attention to stimuli flashed to the left visual field (LVF), suggesting a right hemisphere deficit. Overall, we found that veterans who had sustained an mTBI and had a coexisting PTSD diagnosis displayed longer response times and were less accurate than the PTSD and control groups, especially when cues were presented to the LVF.

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http://www.rehab.research.va.gov/jour/2012/497/maguen497.html

Relationship of screen-based symptoms for mild traumatic brain injury and mental health problems in Iraq and Afghanistan veterans: Distinct or overlapping symptoms?

Shira Maguen, PhD; Karen M. Lau, MA; Erin Madden, MPH; Karen Seal, MD, MPH

J Rehabil Res Dev. 2012;49(7):1115-26.

This study used factor analytic techniques to differentiate distinct from overlapping screen-based symptoms of traumatic brain injury (TBI), posttraumatic stress disorder (PTSD), and depression in Iraq and Afghanistan veterans. These symptoms were derived from screen results of 1,549 veterans undergoing Department of Veterans Affairs postdeployment screening between April 2007 and January 2010. Veterans with positive TBI screens were approximately twice as likely to also screen positive for depression and PTSD (adjusted relative risks = 1.9 and 2.1, respectively). Irritability was a shared symptom between TBI and PTSD, and emotional numbing was a shared symptom between PTSD and depression. Symptoms unique to TBI included dizziness, headaches, memory problems, and light sensitivity. Four separate constructs emerged: TBI, PTSD, depression, and a fourth construct consisting of hypervigilance and sleep problems. These findings illuminate areas of overlap between TBI and common postdeployment mental health problems. Discriminating symptoms of TBI from mental health problems may facilitate diagnosis, triage to specialty care, and targeted symptom management. The emergence of a fourth factor consisting of sleep problems and hypervigilance highlights the need to attend to specific symptoms in the postdeployment screening process.

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http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0048002

Mortality and Suicide Risk in Treatment-Resistant Depression: An Observational Study of the Long-Term Impact of Intervention.

Olin B, Jayewardene AK, Bunker M, Moreno F

PLoS ONE 7(10): e48002

Major depressive disorder is a common global disease that causes a significant societal burden. Most interventional studies of depression provide a limited assessment of the interventions on mortality and suicide risks. This study utilizes data from an observational registry of patients with major depressive disorder to determine the impact of intervention (vagus nerve stimulation or standard pharmacological/non-pharmacological therapy) and a latent factor, patient trajectory toward response, on mortality, suicide and suicidal ideation. A total of 636 patients were available for an intent-to-treat analysis of all-cause mortality, suicide and suicidal ideation. Patients treated with vagus nerve stimulation in addition to standard therapies experienced lower, but not statistically significant, all-cause mortality (vagus nerve stimulation 4.93 per 1,000 person-years vs. 10.02 per 1,000 patient years for treatment as usual) and suicide rates (vagus nerve stimulation 0.88 per 1,000 person-years vs. 1.61 per 1,000 patient years for treatment as usual). Treatment with vagus nerve stimulation produced a statistically lower relative risk of suicidal ideation 0.80, 95% confidence interval (0.68,0.95). Further, patients that responded to either treatment saw a 51% reduction in relative risk of suicidal behavior; relative risk and 95% confidence interval of 0.49 (0.41,0.58). In summary, we find that treatment with adjunctive vagus nerve stimulation can potentially lower the risk of all-cause mortality, suicide and suicide attempts.

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http://www.jmir.org/2012/5/e141/

Reducing Suicidal Ideation: Cost-Effectiveness Analysis of a Randomized Controlled Trial of Unguided Web-Based Self-help.

van Spijker BA, Majo MC, Smit F, van Straten A, Kerkhof AJ

J Med Internet Res 2012;14(5):e141

Background:
Suicidal ideation is highly prevalent, but often remains untreated. The Internet can be used to provide accessible interventions.

Objective:
To evaluate the cost-effectiveness of an online, unguided, self-help intervention for reducing suicidal ideation.

Methods:
A total of 236 adults with mild to moderate suicidal thoughts, defined as scores between 1-26 on the Beck Scale for Suicide Ideation (BSS), were recruited in the general population and randomized to the intervention (n = 116) or to a waitlist, information-only, control group (n = 120). The intervention aimed to decrease the frequency and intensity of suicidal ideation and consisted of 6 modules based on cognitive behavioral techniques. Participants in both groups had unrestricted access to care as usual. Assessments took place at baseline and 6 weeks later (post-test). All questionnaires were self-report and administered via the Internet. Treatment response was defined as a clinically significant decrease in suicidal ideation on the BSS. Total per-participant costs encompassed costs of health service uptake, participants' out-of-pocket expenses, costs stemming from production losses, and intervention costs. These were expressed in Euros (€) for the reference year 2009.

Results:
At post-test, treatment response was 35.3% and 20.8% in the experimental and control conditions, respectively. The incremental effectiveness was 0.35 − 0.21 = 0.15 (SE 0.06, P = .01). The annualized incremental costs were −€5039 per participant. Therefore, the mean incremental cost-effectiveness ratio (ICER) was estimated to be −€5039/0.15 = −€34,727 after rounding (US −$41,325) for an additional treatment response, indicating annual cost savings per treatment responder.

Conclusions:
This is the first trial to indicate that online self-help to reduce suicidal ideation is feasible, effective, and cost saving. Limitations included reliance on self-report and a short timeframe (6 weeks). Therefore, replication with a longer follow-up period is recommended.

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http://onlinelibrary.wiley.com/doi/10.1111/j.1943-278X.2012.00125.x/abstract

Mood, Anxiety, and Substance-Use Disorders and Suicide Risk in a Military Population Cohort.

Conner, K. R., McCarthy, M. D., Bajorska, A., Caine, E. D., Tu, X. M. and Knox, K. L.

Suicide and Life-Threatening Behavior

Article first published online: 24 OCT 2012

There are meager prospective data from nonclinical samples on the link between anxiety disorders and suicide or the extent to which the association varies over time. We examined these issues in a cohort of 309,861 U.S. Air Force service members, with 227 suicides over follow-up. Mental disorder diagnoses including anxiety, mood, and substance-use disorders (SUD) were based on treatment encounters. Risk for suicide associated with anxiety disorders were lower compared with mood disorders and similar to SUD. Moreover, the associations between mood and anxiety disorders with suicide were greatest within a year of treatment presentation.

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http://journals.lww.com/ajnonline/Fulltext/2012/11000/PTSD_Among_Our_Returning_Veterans.25.aspx

PTSD Among Our Returning Veterans.

Sabella, Donna MEd, MSN, PhD, RN

AJN, American Journal of Nursing

November 2012 - Volume 112 - Issue 11 - p 48–52

Last April, while attending a U.S. Department of Justice–sponsored symposium on human trafficking, I had the pleasure of being invited to lunch with Cindy McCain, wife of Arizona senator and former presidential candidate John McCain. The small group lunch was organized to discuss current initiatives with Mrs. McCain, who was also attending the symposium. However, before that conversation began, a different subject arose: veterans and their mental health needs, especially those suffering from posttraumatic stress disorder (PTSD). Mrs. McCain's son had recently returned from duty and we found ourselves talking about returning veterans and some of the challenges they face, including PTSD. I was struck by the fact that in spite of her “celebrity,” Mrs. McCain sounded like any other mother who had concerns about her child after his return from combat; she was well aware that the scars can be emotional as well as physical.

Indeed, awareness of PTSD is growing; it appears that Americans are finally recognizing the urgent demand for more effective treatment. Recent government efforts highlight this need. The Office of Inspector General of the U.S. Department of Health and Human Services found that in 2011, 36% of veterans had to wait more than two weeks to access Veterans Administration (VA) care for mental health concerns (two weeks is considered a timely wait period). This prompted a commitment by the Under Secretary for Health to “act rapidly on all findings that may improve Veterans’ access to mental health care.”1 And, last April, First Lady Michelle Obama and Dr. Jill Biden visited the University of Pennsylvania to announce the creation of Joining Forces, a White House initiative to support veterans and military families. This initiative will train nurses working with veterans and create “more resources for veterans dealing with post-traumatic stress disorder.”

While these are promising steps, only the universal efforts of all health care providers can help to ensure that those who serve get the help they deserve once they return home. Unfortunately, veterans don't always receive the treatment they're due. Many avoid seeking care because of the stigma associated with mental health disorders.4 Some live in areas that lack trained clinicians and thus may receive an improper diagnosis—or even none at all. With more publicity and public discourse, hopefully this situation will improve. Since many returning soldiers seek medical treatment outside the VA system, it's important for nurses everywhere to be able to recognize PTSD and to inform veterans and their families about resources available in their communities.

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http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3466035/

Primary Care–Mental Health Integration Programs in the Veterans Affairs Health System Serve a Different Patient Population Than Specialty Mental Health Clinics.

Vicki D. Johnson-Lawrence, PhD, Benjamin R. Szymanski, MPH, Kara Zivin, PhD, John F. McCarthy, PhD, Marcia Valenstein, MD, and Paul N. Pfeiffer, MD

Prim Care Companion CNS Disord. 2012; 14(3)

Objective:
To assess whether Primary Care–Mental Health Integration (PC-MHI) programs within the Veterans Affairs (VA) health system provide services to patient subgroups that may be underrepresented in specialty mental health care, including older patients and women, and to explore whether PC-MHI served individuals with less severe mental health disorders compared to specialty mental health clinics.

Method:
Data were obtained from the VA National Patient Care Database for a random sample of VA patients, and primary care patients with an ICD-9-CM mental health diagnosis (N = 243,806) in 2009 were identified. Demographic and clinical characteristics between patients who received mental health treatment exclusively in a specialty mental health clinic (n = 128,248) or exclusively in a PC-MHI setting (n = 8,485) were then compared. Characteristics of patients who used both types of services were also explored.

Results:
Compared to patients treated in specialty mental health clinics, PC-MHI service users were more likely to be aged 65 years or older (26.4% vs 17.9%, P < .001) and female (8.6% vs 7.7%, P = .003). PC-MHI patients were more likely than specialty mental health clinic patients to be diagnosed with a depressive disorder other than major depression, an unspecified anxiety disorder, or an adjustment disorder (P < .001) and less likely to be diagnosed with more severe disorders, including bipolar disorder, posttraumatic stress disorder, psychotic disorders, and alcohol or substance dependence (P < .001).

Conclusions:
Primary Care–Mental Health Integration within the VA health system reaches demographic subgroups that are traditionally less likely to use specialty mental health care. By treating patients with less severe mental health disorders, PC-MHI appears to expand upon, rather than duplicate, specialty care services.

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http://www.annals-general-psychiatry.com/content/11/1/26/abstract

Gender, trauma type, and PTSD prevalence: a re-analysis of 18 nordic convenience samples.

Daniel N Ditlevsen and Ask Elklit

Annals of General Psychiatry 2012, 11:26

Background
The aim of the study was to examine a possible trauma type related variance in the gender difference of posttraumatic stress disorder (PTSD) prevalence.

Methods
An analysis was conducted on 18 convenience sample studies including data from a total of 5220 participants. The studies all applied the Harvard Trauma Questionnaire -- part IV to assess PTSD. Cohen's d was used to measure variance in gender differences. Trauma types included disasters and accidents, violence, loss, chronic disease and non-malignant diseases.

Results
The results showed an overall gender difference in PTSD prevalence similar to previous findings. Thus, women had a two-fold higher prevalence of PTSD than men. Besides categorical analyses, dimensional analyses of PTSD severity were also performed; the latter were associated with twice as large effect sizes. Females were more vulnerable to PTSD after disasters and accidents, followed by loss and non-malignant diseases. In violence and chronic disease, the gender differences were smallest.

Conclusions
The findings support the existence of a trauma type related variance in gender differences in PTSD prevalence.

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http://www.biomedcentral.com/1471-244X/12/179/abstract

Impact of sleep disturbance on patients in treatment for mental disorders.

Håvard Kallestad, Bjarne Hansen, Knut Langsrud, Torleif Ruud, Gunnar Morken, Tore C Stiles and Rolf W Gråwe

BMC Psychiatry 2012, 12:179

Published: 29 October 2012

Background
In clinical practice, sleep disturbance is often regarded as an epiphenomenon of the primary mental disorder. The aim of this study was to test if sleep disturbance, independently of primary mental disorders, is associated with current clinical state and benefit from treatment in a sample representative of public mental health care clinics.

Method
2246 patients receiving treatment for mental disorders in eight public mental health care centers in Norway were evaluated in a cross-sectional study using patient and clinician reported measures. Patients reported quality of life, symptom severity, and benefit from treatment. Clinicians reported

disorder severity, level of functioning, symptom severity and benefit from treatment. The hypothesis was tested using multiple hierarchical regression analyses.

Results
Sleep disturbance was, adjusted for age, gender, time in treatment, type of care, and the presence of any primary mental disorder, associated with lower quality of life, higher symptom severity, higher disorder severity, lower levels of functioning, and less benefit from treatment.

Conclusion
Sleep disturbance ought to be considered a stand-alone therapeutic entity rather than an epiphenomenon of existing diagnoses for patients receiving treatment in mental health care.

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http://www.ncbi.nlm.nih.gov/pubmed/23099129?dopt=Abstract

Neurol Clin. 2012 Nov;30(4):1045-66. doi: 10.1016/j.ncl.2012.08.012.

Insomnia.

Deak MC, Winkelman JW.

Source: Division of Sleep Medicine, Harvard Medical School, Sleep Health Centers, Brigham and Women's Hospital, 1505 Commonwealth Avenue, 5th Floor, Brighton, MA 02135, USA. Electronic address: Maryann_Deak@sleephealth.com.

Abstract

Insomnia is a common disorder, with individual and societal consequences. Advances have been made in the understanding of insomnia and its treatment options. However, cognitive behavioral therapy and Food and Drug Administration-approved pharmacologic therapies have limitations, the former primarily involving access and the latter involving potential side effects. Further research is needed to optimize management strategies.

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http://www.ncbi.nlm.nih.gov/pubmed/23097838?dopt=Abstract

EMS World. 2012 Oct;41(10):47-50, 52-6.

Are you under stress in EMS. Understanding the slippery slope of burnout and PTSD.

Collopy KT, Kivlehan SM, Snyder SR.

Source: Vitalink/Airlink in Wilmington, NC, USA. kcollopy@colgatealumni.org

Abstract

Burnout and PTSD are closely linked and often underreported in EMS. EMS classrooms do little or nothing to prepare providers for the inherent emotional stresses of emergency response and the "thick skin" culture of EMS may make many providers apprehensive about sharing their true feelings. Burnout is triggered by many of the same stresses that lead to the symptoms of PTSD and providers experiencing burnout that doesn't resolve within a few weeks may actually be experiencing PTSD. Be mindful of yourself and your fellow coworkers, particularly after a very traumatic response. And remember traumatic responses don't need to be as dramatic as Sept. 11, New Orleans after Hurricane Katrina or the Aurora, CO shootings to bother an EMS worker. In contrast, these are the calls where providers often receive the most attention. Instead, watch for the new father who just performed CPR on an infant the same age as his own, or the provider who just watched his or her friend die following a motor vehicle collision. Pay attention to yourself and colleagues, and be responsible and honest with yourself and others about when coping strategies are enough, and when they aren't. Finally, don't ever be afraid to seek help.

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http://www.ncbi.nlm.nih.gov/pubmed/23099139?dopt=Abstract

Neurol Clin. 2012 Nov;30(4):1299-312. doi: 10.1016/j.ncl.2012.08.008.

Traumatic brain injury and sleep disorders.

Viola-Saltzman M, Watson NF.

Source: Pritzker School of Medicine, NorthShore University HealthSystem, Department of Neurology, 2650 Ridge Avenue, Evanston, IL 60201, USA.

Abstract

Sleep disturbance is common after traumatic brain injury (TBI). Insomnia, fatigue, and sleepiness are the most frequent post-TBI sleep complaints with narcolepsy (with or without cataplexy), sleep apnea (obstructive or central), periodic limb movement disorder, and parasomnias occurring less commonly. In addition, depression, anxiety, and pain are common TBI comorbidities with substantial influence on sleep quality. Diagnosis of sleep disorders after TBI may involve polysomnography, multiple sleep latency testing, or actigraphy. Treatment is disorder-specific and includes the use of medications, continuous positive airway pressure, or behavioral modifications. Unfortunately, treatment of sleep disorders associated with TBI often does not improve sleepiness or neuropsychologic function.

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http://www.ncbi.nlm.nih.gov/pubmed/23097944?dopt=Abstract

Mo Med. 2012 Sep-Oct;109(5):384-7.

Evidence-based guidelines for the management of traumatic brain injury.

Gianino JW, Afuwape LO.

Source: University of Missouri - Kansas City School of Medicine, USA. john.gianino@tmcmed.org

Abstract

The management of traumatic brain injury has changed as a result of evidence-based treatment guideline first established in 1995. They have promoted standardization of care and as a result improved outcomes. In addition, the guidelines have helped identify gaps in our knowledge-base that can direct future research efforts.

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http://www.ncbi.nlm.nih.gov/pubmed/23099143?dopt=Abstract

Neurol Clin. 2012 Nov;30(4):1389-413. doi: 10.1016/j.ncl.2012.08.018.

Psychiatric disorders and sleep.

Krystal AD.

Source: Sleep Research Laboratory and Insomnia Program, Department of Psychiatry, Duke University Medical Center, Box 3309, Durham, NC 27710, USA. Electronic address: kryst001@mc.duke.edu.

Abstract

There is growing experimental evidence that the relationship between psychiatric disorders and sleep is complex and includes bidirectional causation. This article provides the evidence that supports this point of view, reviewing data on sleep disturbances seen in patients with psychiatric disorders as well as data on the impact of sleep disturbances on psychiatric conditions. Although much has been learned about the psychiatric disorders-sleep relationship, additional research is needed to better understand the relationship. Such work promises to improve comprehension of these phenomena and lead to better treatment for the many patients with sleep disorders and psychiatric disorders.

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http://www.ncbi.nlm.nih.gov/pubmed/23099138?dopt=Abstract

Neurol Clin. 2012 Nov;30(4):1285-98. doi: 10.1016/j.ncl.2012.08.014.

Sleep-related headaches.

Rains JC, Poceta JS.

Source: Center for Sleep Evaluation, Elliot Hospital, 185 Queen City Avenue, Manchester, NH 03102, USA. Electronic address: jrains@elliot-hs.org.

Abstract

Irrespective of diagnosis, chronic daily, morning, or "awakening" headache patterns are soft signs of a sleep disorder. Sleep apnea headache may emerge de novo or may present as an exacerbation of cluster, migraine, tension-type, or other headache. Insomnia is the most prevalent sleep disorder in chronic migraine and tension-type headache, and increases risk for depression and anxiety. Sleep disturbance (eg, sleep loss, oversleeping, schedule shift) is an acute headache trigger for migraine and tension-type headache. Snoring and sleep disturbance are independent risk factors for progression from episodic to chronic headache.

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http://www.ncbi.nlm.nih.gov/pubmed/23098832?dopt=Abstract

PM R. 2012 Oct 23. pii: S1934-1482(12)00330-9. doi: 10.1016/j.pmrj.2012.06.012. [Epub ahead of print]

Neuropsychiatric Symptoms and the Use of Complementary and Alternative Medicine.

Purohit MP, Wells RE, Zafonte RD, Davis RB, Phillips RS.

Source: Spaulding Rehabilitation Hospital, Harvard Medical School, 125 Nashua St, #720, Boston, MA 02114; Massachusetts General Hospital, Harvard Medical School, Boston, MA; and Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, MA(1). Electronic address: mpurohit1@partners.org.

Abstract

OBJECTIVES:
To assess the prevalence of complementary and alternative medicine (CAM) use by U.S. adults reporting neuropsychiatric symptoms and whether this prevalence changes based on the number of symptoms reported. Additional objectives include identifying patterns of CAM use, reasons for use, and disclosure of use with conventional providers in U.S. adults with neuropsychiatric symptoms.

DESIGN:
Secondary database analysis of a prospective survey.

PARTICIPANTS:
A total of 23,393 U.S. adults from the 2007 National Health Interview Survey.

METHODS:
We compared CAM use between adults with and without neuropsychiatric symptoms. Symptoms included self-reported anxiety, depression, insomnia, headaches, memory deficits, attention deficits, and excessive sleepiness. CAM use was defined as use of mind-body therapies (eg, meditation), biological therapies (eg, herbs), or manipulation therapies (eg, massage) or alternative medical systems (eg, Ayurveda). Statistical analysis included bivariable comparisons and multivariable logistical regression analyses.

MAIN OUTCOME MEASURES:
The prevalence of CAM use among adults with neuropsychiatric symptoms within the previous 12 months and the comparison of CAM use between those with and without neuropsychiatric symptoms.

RESULTS:
Adults with neuropsychiatric symptoms had a greater prevalence of CAM use compared with adults who did not have neuropsychiatric symptoms (43.8% versus 29.7%, P < .001); this prevalence increased with an increasing number of symptoms (trend, P < .001). Differences in the likelihood of CAM use as determined by the number of symptoms persisted after we adjusted for covariates. Twenty percent of patients used CAM because standard treatments were either too expensive or ineffective, and 25% used CAM because it was recommended by a conventional provider. Adults with at least one neuropsychiatric symptom were more likely to disclose the use of CAM to a conventional provider (47.9% versus 39.0%, P < .001).

CONCLUSION:
More than 40% of adults with neuropsychiatric symptoms commonly observed in many diagnoses use CAM; an increasing number of symptoms was associated with an increased likelihood of CAM use.

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http://www.ncbi.nlm.nih.gov/pubmed/23109002

Depress Anxiety. 2012 Oct 26. doi: 10.1002/da.22012. [Epub ahead of print]

The Effect of Draft DSM-V Criteria on Posttraumatic Stress Disorder Prevalence.

Calhoun PS, Hertzberg JS, Kirby AC, Dennis MF, Hair LP, Dedert EA, Beckham JC.

Source: VISN-6 Mental Illness Research & Education Center, Durham, North Carolina; Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, Durham, North Carolina; Durham Veterans Affairs Medical Center, Durham, North Carolina.

Abstract

BACKGROUND:
This study was designed to examine the concordance of proposed DSM-V posttraumatic stress disorder (PTSD) criteria with DSM-IV classification rules and examine the impact of the proposed DSM-V PTSD criteria on prevalence.

METHOD:
The sample (N = 185) included participants who were recruited for studies focused on trauma and health conducted at an academic medical center and VA medical center in the southeastern United States. The prevalence and concordance between DSM-IV and the proposed DSM-V classifications were calculated based on results from structured clinical interviews. Prevalence rates and diagnostic efficiency indices including sensitivity, specificity, area under the curve (AUC), and Kappa were calculated for each of the possible ways to define DSM-V PTSD.

RESULTS:
Ninety-five percent of the sample reported an event that met both DSM-IV PTSD Criterion A1 and A2, but only 89% reported a trauma that met Criterion A on DSM-V. Results examining concordance between DSM-IV and DSM-V algorithms indicated that several of the algorithms had AUCs above 0.90. The requirement of two symptoms from both Clusters D and E provided strong concordance to DSM-IV (AUC = 0.93; Kappa = 0.86) and a greater balance between sensitivity and specificity than requiring three symptoms in both Clusters D and E.

CONCLUSIONS:
Despite several significant changes to the diagnostic criteria for PTSD for DSM-V, several possible classification rules provided good concordance with DSM-IV. The magnitude of the impact of DSM-V decision rules on prevalence will be largely affected by the DSM-IV PTSD base rate in the population of interest.

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http://www.ncbi.nlm.nih.gov/pubmed/23107307

J Psychiatr Res. 2012 Oct 26. pii: S0022-3956(12)00268-3. doi: 10.1016/j.jpsychires.2012.08.027. [Epub ahead of print]

Sex differences in fear conditioning in posttraumatic stress disorder.

Inslicht SS, Metzler TJ, Garcia NM, Pineles SL, Milad MR, Orr SP, Marmar CR, Neylan TC.

Source: University of California, San Francisco, San Francisco, CA, United States; San Francisco VA Medical Center, San Francisco, CA, United States. Electronic address: Sabra.Inslicht@ucsf.edu.

Abstract

BACKGROUND:
Women are twice as likely as men to develop Posttraumatic Stress Disorder (PTSD). Abnormal acquisition of conditioned fear has been suggested as a mechanism for the development of PTSD. While some studies of healthy humans suggest that women are either no different or express less conditioned fear responses during conditioning relative to men, differences in the acquisition of conditioned fear between men and women diagnosed with PTSD has not been examined.

METHODS:
Thirty-one participants (18 men; 13 women) with full or subsyndromal PTSD completed a fear conditioning task. Participants were shown computer-generated colored circles that were paired (CS+) or unpaired (CS-) with an aversive electrical stimulus and skin conductance levels were assessed throughout the task.

RESULTS:
Repeated measures ANOVA indicated a significant sex by stimulus interaction during acquisition. Women had greater differential conditioned skin conductance responses (CS + trials compared to CS- trials) than did men, suggesting greater acquisition of conditioned fear in women with PTSD.

CONCLUSIONS:
In contrast to studies of healthy individuals, we found enhanced acquisition of conditioned fear in women with PTSD. Greater fear conditioning in women may either be a pre-existing vulnerability trait or an acquired phenomenon that emerges in a sex-dependent manner after the development of PTSD. Characterizing the underlying mechanisms of these differences is needed to clarify sex-related differences in the pathophysiology of PTSD.

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http://www.ncbi.nlm.nih.gov/pubmed/23107002

Ann Gen Psychiatry. 2012 Oct 29;11(1):26. [Epub ahead of print]

Gender, trauma type, and PTSD prevalence: a re-analysis of 18 nordic convenience samples.

Ditlevsen DN, Elklit A.

Abstract

BACKGROUND:
The aim of the study was to examine a possible trauma type related variance in the gender difference of posttraumatic stress disorder (PTSD) prevalence.

METHODS:
An analysis was conducted on 18 convenience sample studies including data from a total of 5220 participants. The studies all applied the Harvard Trauma Questionnaire -- part IV to assess PTSD. Cohen's d was used to measure variance in gender differences. Trauma types included disasters and accidents, violence, loss, chronic disease and non-malignant diseases.

RESULTS:
The results showed an overall gender difference in PTSD prevalence similar to previous findings. Thus, women had a two-fold higher prevalence of PTSD than men. Besides categorical analyses, dimensional analyses of PTSD severity were also performed; the latter were associated with twice as large effect sizes. Females were more vulnerable to PTSD after disasters and accidents, followed by loss and non-malignant diseases. In violence and chronic disease, the gender differences were smallest.

CONCLUSIONS:
The findings support the existence of a trauma type related variance in gender differences in PTSD prevalence.

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http://www.ncbi.nlm.nih.gov/pubmed/23106761

J Consult Clin Psychol. 2012 Oct 29. [Epub ahead of print]

Manualized Therapy for PTSD: Flexing the Structure of Cognitive Processing Therapy.

Galovski TE, Blain LM, Mott JM, Elwood L, Houle T.

Abstract

Objective:
This study tested a modified cognitive processing therapy (MCPT) intervention designed as a more flexible administration of the protocol. Number of sessions was determined by client progress toward a priori defined end-state criteria, "stressor sessions" were inserted when necessary, and therapy was conducted by novice CPT clinicians.

Method:
A randomized, controlled, repeated measures, semicrossover design was utilized (a) to test the relative efficacy of the MCPT intervention compared with a symptom-monitoring delayed treatment (SMDT) condition and (b) to assess within-group variation in change with a sample of 100 male and female interpersonal trauma survivors with posttraumatic stress disorder (PTSD).

Results:
Hierarchical linear modeling analyses revealed that MCPT evidenced greater improvement on all primary (PTSD and depression) and secondary (guilt, quality of life, general mental health, social functioning, and health perceptions) outcomes compared with SMDT. After the conclusion of SMDT,

participants crossed over to MCPT, resulting in a combined MCPT sample (n = 69). Of the 50 participants who completed MCPT, 58% reached end-state criteria prior to the 12th session, 8% at Session 12, and 34% between Sessions 12 and 18. Maintenance of treatment gains was found at the 3-month follow-up, with only 2 of the treated sample meeting criteria for PTSD. Use of stressor sessions did not result in poorer treatment outcomes.

Conclusions:
Findings suggest that individuals respond at a variable rate to CPT, with significant benefit from additional therapy when indicated and excellent maintenance of gains. Insertion of stressor sessions did not alter the efficacy of the therapy.

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http://www.ncbi.nlm.nih.gov/pubmed/23103234

Behav Res Ther. 2012 Oct 5;50(12):805-813. doi: 10.1016/j.brat.2012.09.007. [Epub ahead of print]

The effects of positive patient testimonials on PTSD treatment choice.

Pruitt LD, Zoellner LA, Feeny NC, Caldwell D, Hanson R.

Source: Department of Psychology, University of Washington, Box 351525, Seattle, WA 98195-1525, USA. Electronic address: Ldpruitt@uw.edu.

Abstract

Despite the existence of effective treatment options for PTSD, these treatments are failing to reach those that stand to benefit from PTSD treatment. Understanding the processes underlying an individual's treatment seeking behavior holds the potential for reducing treatment-seeking barriers. The current study investigates the effects that positive treatment testimonials have on decisions regarding PTSD treatment. An undergraduate (N = 439) and a trauma-exposed community (N = 203) sample were provided with videotaped treatment rationales for prolonged exposure (PE) and sertraline treatments of PTSD. Half of each sample also viewed testimonials, detailing a fictional patient's treatment experience. All participants then chose among treatment options and rated the credibility of - and personal reactions toward - those options. Among treatment naïve undergraduates, testimonials increased the proportion choosing PE alone; and among treatment naïve members of the trauma-exposed community sample, testimonials increased the proportion choosing a combined PE plus sertraline treatment. These effects were not observed for those with prior history of either psychotherapeutic or pharmacological treatment. Major barriers exist that prevent individuals with PTSD from seeking treatment. For a critical unreached treatment sample, those who are treatment naïve, positive patient testimonials offer a mechanism in which to make effective treatments more appealing and accessible.

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http://www.ncbi.nlm.nih.gov/pubmed/23102729

Compr Psychiatry. 2012 Oct 25. pii: S0010-440X(12)00218-0. doi: 10.1016/j.comppsych.2012.09.001. [Epub ahead of print]

Impact of panic disorder on quality of life among veterans in a primary care pilot study.

Barrera TL, Hiatt EL, Dunn NJ, Teng EJ.

Source: Michael E. DeBakey Veterans Affairs (VA) Medical Center, 116 MHCL, Houston, TX 77030, USA; Menninger Department of Psychiatry & Behavioral Sciences, Baylor College of Medicine, Houston, TX, USA; University of Houston, Houston, TX, USA.

Abstract

Panic disorder is a debilitating and costly mental health condition which commonly presents in primary care settings; however, little is known about the impact of panic disorder on quality of life and health utility valuations among Veterans in primary care. A cross-sectional investigation of quality of life was conducted in a sample of 21 Veterans with panic disorder in a VA primary care clinic. Health utilities were determined using an algorithm based upon the Medical Outcomes Study Short-Form 36 Health Survey (SF-36). Veterans in the current sample reported significantly greater impairment on all eight of the SF-36 subscales in comparison to published norms. Veterans with panic and comorbid mood disorders reported significantly greater impairment on the Vitality, Social Functioning, and Mental Health subscales, while Veterans with panic and comorbid anxiety disorders reported significantly greater impairment on the Physical Functioning and Bodily pain subscales. Health utilities for the current sample were comparable to previous reports of Veterans with PTSD and depression, as well as health utilities of persons with chronic pulmonary disease and irritable bowel syndrome. The findings from this study highlight the devastating nature of panic disorder and reflect the need for increased attention to the identification and treatment of panic disorder in VA primary care settings.

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http://www.ncbi.nlm.nih.gov/pubmed/23102050

Behav Cogn Psychother. 2012 Oct 29:1-11. [Epub ahead of print]

What is the Role of Eye Movements in Eye Movement Desensitization and Reprocessing (EMDR) for Post-Traumatic Stress Disorder (PTSD)? A Review.

Jeffries FW, Davis P.

Source: University of Surrey, Guildford, UK.

Abstract

Background: Controversy continues to exist regarding how EMDR works and whether its mechanisms differ from those at work in standard exposure techniques. Aims: To investigate first whether eye movement bilateral stimulation is an essential component of EMDR and, second, the current status of its theoretical basis. Method: A systematic search for relevant articles was conducted in databases using standard methodology. Results: Clinical research evidence is contradictory as to how essential EMs are in PTSD treatment. More positive support is provided by analogue studies. With regards to potential theoretical support, some evidence was found suggesting bilateral stimulation first increases access to episodic memories; and second that it could act on components of working memory which makes focusing on the traumatic memories less unpleasant and thereby improves access to these memories. Conclusions: The results suggest support for the contention that EMs are essential to this therapy and that a theoretical rationale exists for their use. Choice of EMDR over trauma-focused CBT should therefore remain a matter of patient choice and clinician expertise; it is suggested, however, that EMs may be more effective at reducing distress, and thereby allow other components of treatment to take place.

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http://www.ncbi.nlm.nih.gov/pubmed/22547123

J Occup Environ Med. 2012 May;54(5):615-20. doi: 10.1097/JOM.0b013e31824be417.

Individual augmentee deployment and newly reported mental health morbidity.

Granado NS, Zimmermann L, Smith B, Jones KA, Wells TS, Ryan MA, Slymen D, Koffman RL, Smith TC; Millennium Cohort Study Team.

Source: Deployment Health Research Department, Naval Health Research Center, San Diego, CA, USA. nisara.granado@med.navy.mil

Abstract

OBJECTIVE:
To investigate the association between US Navy individual augmentee (IA) deployers, who may lack the protective effects of unit cohesion and social support, and newly reported mental health.

METHODS:
Responses from the Millennium Cohort Study questionnaires were examined for 2086 Navy deployers in this prospective exploratory study. Multivariable logistic regression was used to evaluate IA deployment and newly reported mental health symptoms.

RESULTS:
After adjusting for covariates, IA deployment was not significantly associated with newly reported

posttraumatic stress disorder (odds ratio = 1.02; 95% confidence interval: 0.53-1.95) or mental health symptoms (odds ratio = 1.03; 95% confidence interval: 0.66-1.60) compared with non-IA deployment.

CONCLUSION:
A deployment was not associated with increased risk for posttraumatic stress disorder or mental health symptoms following deployment. It is likely that social isolation was not highly influential among Navy IAs in this study.

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http://www.ncbi.nlm.nih.gov/pubmed/21693487

Int J Soc Psychiatry. 2012 Jul;58(4):433-9. doi: 10.1177/0020764011408534. Epub 2011 Jun 21.

Self-harm and attempted suicide among UK armed forces personnel: results of a cross-sectional survey.

Pinder RJ, Iversen AC, Kapur N, Wessely S, Fear NT.

Source: King's Centre for Military Health Research and Academic Centre for Defence Mental Health, Department of Psychological Medicine, King's College London, UK. richard.pinder@doctors.org.uk

Abstract

AIMS:
Little has been reported on self-harm among the UK Armed Forces, partly due to the difficulties in recording self-harm, within an often-difficult-to-reach population. This study assesses the lifetime prevalence of attempted suicide and self-harm within currently serving and ex-service personnel of the UK Armed Forces.

METHODS:
Telephone interviews were conducted with 821 personnel who had previously participated in the King's Centre for Military Health Research military health study. Within the telephone interview, participants were asked about attempted suicide and episodes of self-harm.

RESULTS:
A lifetime prevalence of 5.6% for intentional self-harm (self-harm or attempted suicide) was reported. Intentional self-harm was associated with psychological morbidity (in particular, post-traumatic stress disorder) and adverse experiences in childhood. Ex-service personnel reported lifetime prevalence more than double that of serving personnel (10.5% vs 4.2%, respectively). Participants reporting intentional self-harm were younger (34.4 years vs 39.8 years).

CONCLUSION:
A lifetime prevalence of 5.6% for attempted suicide and self-harm is higher than previous research has suggested. Younger service personnel, those who have experienced adversity in childhood, those with other psychological morbidity, and ex-service personnel are more likely to report self-harm behaviours.

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http://www.ncbi.nlm.nih.gov/pubmed/23109266?dopt=Abstract

J Clin Psychol. 2012 Oct 26. doi: 10.1002/jclp.21927. [Epub ahead of print]

Effectiveness of Abbreviated CBT for Insomnia in Psychiatric Outpatients: Sleep and Depression Outcomes.

Wagley JN, Rybarczyk B, Nay WT, Danish S, Lund HG.

Source: University of Virginia.

Abstract

OBJECTIVE:
To test the efficacy of cogntive-behavioral therapy for insomnia (CBT-I) as a supplement treatment for psychiatric outpatients. Comorbid insomnia is prevalent among individuals with varied psychiatric disorders and evidence indicates that CBT-I may be effective for reducing insomnia and other psychiatric symptoms.

METHOD:
The present study randomly assigned 30 psychiatric outpatients (mean duration of treatment = 3.6 years) with low sleep quality and residual depressive symptoms to two sessions of CBT-I or a treatment as usual control group. Assessment included the Pittsburgh Sleep Quality Index (PSQI) for insomnia and the Patient Health Questionnaire (PHQ-9) for depression at pretreatment and 4 and 8 weeks posttreatment.

RESULTS:
Patients who received CBT-I demonstrated within group changes in PSQI and the PHQ-9 scores at both 4 and 8 weeks posttreatment, but did not show between-group differences. Additionally, 38% of the treatment participants achieved normal sleep at follow-up compared with none in the control condition.

CONCLUSIONS:
This study provides preliminary evidence that abbreviated behavioral treatment has beneficial effects on residual insomnia and depression in long-term psychiatric outpatients.

Links of Interest

Military Suicide Research Consortium Newsletter -- October 2012
https://msrc.fsu.edu/members/newsletter/msrc-newsletter-october-2012

DOD Funds Study of Omega 3 Benefit in Reducing Suicides
http://www.defense.gov//News/NewsArticle.aspx?ID=118350

Wrong-Way Navy Crash Suit Survives Dismissal
"...claims that the United States misdiagnosed Sciple and should not have allowed him to be considered 'fit for full duty." It allegedly knew or should have known Sciple has PTSD."
http://www.courthousenews.com/2012/10/26/51716.htm

The Hidden Wounds of War
http://journals.lww.com/ajnonline/Fulltext/2012/11000/The_Hidden_Wounds_of_War.1.aspx

Army expands telebehavioral health care in Afghanistan
http://www.nextgov.com/health/2012/10/army-expands-telebehavioral-health-care-afghanistan/59026/

Boston program helps veterans finally reach home
http://www.army.mil/article/89335/Boston_program_helps_veterans_finally_reach_home/

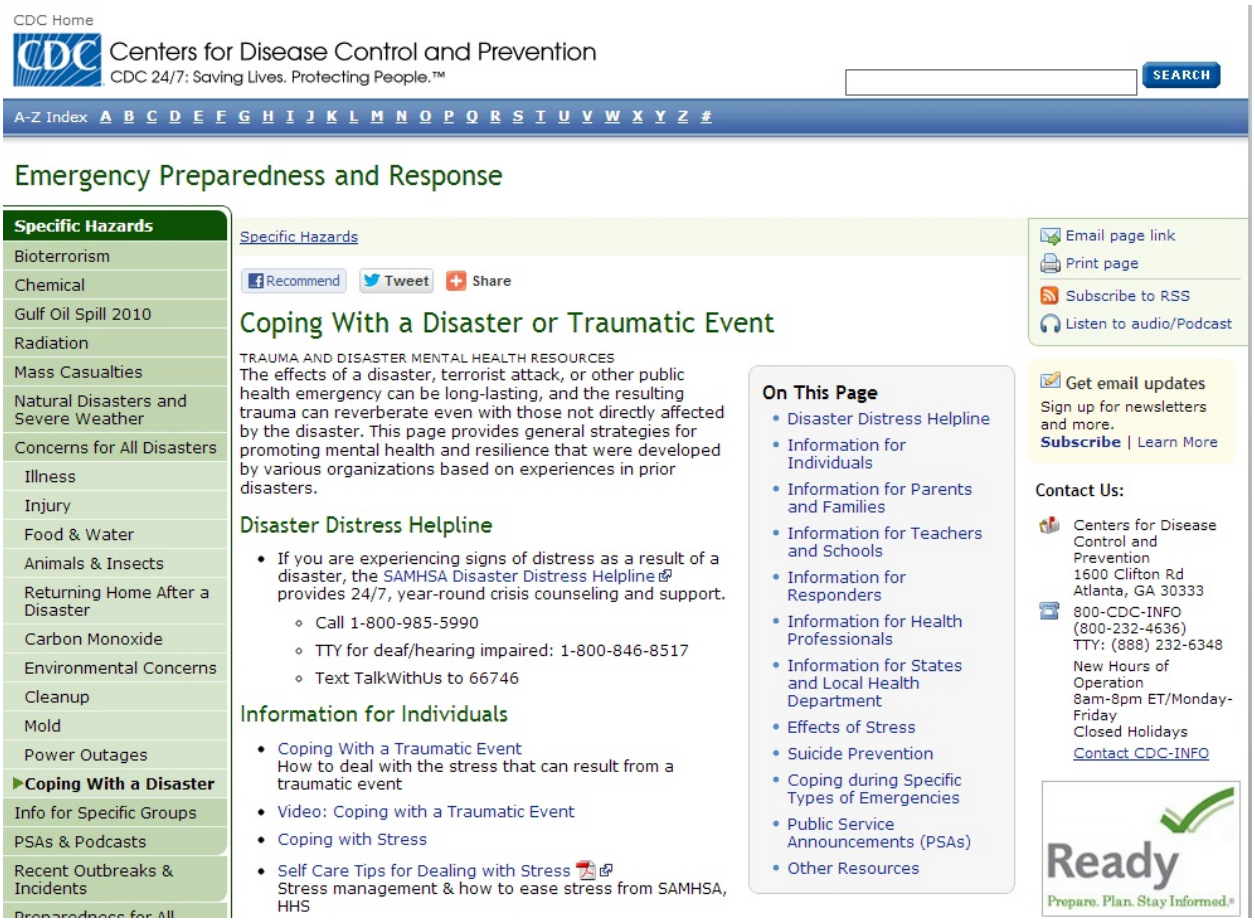
Battling suicidal thoughts: A Soldier's story
http://www.army.mil/article/88002/Battling_suicidal_thoughts__A_Soldier_s_story/

Marine's suicide attempt was a cry for help. Was it also a crime?
http://www.stripes.com/news/special-reports/post-traumatic-stress-disorder-ptsd/marine-s-suicide-attempt-was-a-cry-for-help-was-it-also-a-crime-1.189153

Research Tip of the Week: CDC Disaster Mental Health

The damage from Hurricane Sandy was overwhelming in some densely populated mid-Atlantic locales. As of today, more than 82 people lost their lives because of this storm. But we know there will be far more mental health casualties, as there always are in the wake of a disaster.

This page of resources, curated by the Centers for Disease Control and Prevention, “provides general strategies for promoting mental health and resilience that were developed by various organizations based on experiences in prior disasters.” Included are videos and many brochures in PDF format that can be downloaded, printed and distributed.



Shirl Kennedy
Web Content Strategist
Center for Deployment Psychology
www.deploymentpsych.org
skennedy@deploymentpsych.org
301-816-4749