



CDP Research Update -- July 14, 2016

What's Here:

- Transformation of Mental Health Care for U.S. Soldiers and Families During the Iraq and Afghanistan Wars: Where Science and Politics Intersect.
- Are you in the mood? Therapist affect and psychotherapy process.
- Effects of hardiness and years of military service on posttraumatic stress symptoms in U.S. Army medics.
- Unit cohesion, resilience, and mental health of soldiers in basic combat training.
- Williams, Jason; Brown, Janice M.; Bray, Robert M.; Anderson Goodell, Erin M.; Rae Olmsted, Kristine; Adler, Amy B.
- The Role and Functions of Embedded Behavioral Health Providers in VA Primary Care-Mental Health Integration: Current Evidence and Future Directions for Research (white paper)
- The association between post-traumatic stress disorder and lifetime DSM-5 psychiatric disorders among veterans: Data from the National Epidemiologic Survey on Alcohol and Related Conditions-III (NESARC-III).
- Alcohol-Focused Behavioral Couple Therapy.
- Technology-enhanced suicide prevention interventions: A systematic review of the current state of the science.
- Post-traumatic Stress Disorder and Magnetic Resonance Imaging.
- Posttraumatic Stress Disorder, Overweight, and Obesity: A Systematic Review and Meta-analysis.
- Selective prevention of combat-related post-traumatic stress disorder using attention bias modification training: a randomized controlled trial.
- A Description of Suicides in the Army National Guard During 2007–2014 and Associated Risk Factors.

- Shame, Dissociation, and Complex PTSD Symptoms in Traumatized Psychiatric and Control Groups: Direct and Indirect Associations With Relationship Distress.
- Links of Interest
- Resource of the Week: Facts about Veteran Suicide (July 2016)

<http://www.ncbi.nlm.nih.gov/pubmed/26552941>

Am J Psychiatry. 2016 Apr 1;173(4):334-43. doi: 10.1176/appi.ajp.2015.15040553. Epub 2015 Nov 10.

Transformation of Mental Health Care for U.S. Soldiers and Families During the Iraq and Afghanistan Wars: Where Science and Politics Intersect.

Hoge CW, Ivany CG, Brusher EA, Brown MD 3rd, Shero JC, Adler AB, Warner CH, Orman DT

The cumulative strain of 14 years of war on service members, veterans, and their families, together with continuing global threats and the unique stresses of military service, are likely to be felt for years to come. Scientific as well as political factors have influenced how the military has addressed the mental health needs resulting from these wars. Two important differences between mental health care delivered during the Iraq and Afghanistan wars and previous wars are the degree to which research has directly informed care and the consolidated management of services. The U.S. Army Medical Command implemented programmatic changes to ensure delivery of high-quality standardized mental health services, including centralized workload management; consolidation of psychiatry, psychology, psychiatric nursing, and social work services under integrated behavioral health departments; creation of satellite mental health clinics embedded within brigade work areas; incorporation of mental health providers into primary care; routine mental health screening throughout soldiers' careers; standardization of clinical outcome measures; and improved services for family members. This transformation has been accompanied by reduction in psychiatric hospitalizations and improved continuity of care. Challenges remain, however, including continued underutilization of services by those most in need, problems with treatment of substance use disorders, overuse of opioid medications, concerns with the structure of care for chronic postdeployment (including postconcussion) symptoms, and ongoing questions concerning the causes of historically high suicide rates, efficacy of resilience training initiatives, and research priorities. It is critical to ensure that remaining gaps are addressed and that knowledge gained during these wars is retained and further evolved.

<http://psycnet.apa.org/journals/cou/63/4/405>

Are you in the mood? Therapist affect and psychotherapy process.

Chui, Harold; Hill, Clara E.; Kline, Kathryn; Kuo, Patty; Mohr, Jonathan J.

Journal of Counseling Psychology
Vol 63(4), Jul 2016, 405-418
<http://dx.doi.org/10.1037/cou0000155>

Studies on therapist factors have mostly focused on therapist traits rather than states such as affect. Research related to therapist affect has often looked at therapist baseline well-being or therapist reactions, but not both. Fifteen therapists and 51 clients rated pre- and postsession affect, as well as postsession working alliance and session quality, for 1,172 sessions of individual psychotherapy at a community clinic. Therapists' affect became more positive when clients were initially positive and when clients became more positive over the session, and became more negative when clients were initially negative and when clients became more negative over the session.

Furthermore, when therapists were initially positive in affect and when therapists became more positive over the session, clients rated the session quality to be high. Conversely, when therapists were initially negative in affect and when therapists became more negative over the session, clients rated the session quality and working alliance low. On open-ended questions, therapists reported mood shifts in 67% of sessions (63% positive, 50% negative). Positive affect change was attributed to collaborating with the client, perceiving the client to be engaged, or being a good therapist. Negative affect change was attributed to having a difficult client, perceiving the client to be in distress, or being a poor therapist. Thus, therapist state affect at presession and change in affect across a session may independently contribute to the process and outcome of therapy sessions. The examination of within-therapist variables over the course of therapy may further our understanding of therapist factors.

(PsycINFO Database Record (c) 2016 APA, all rights reserved)

<http://psycnet.apa.org/journals/mil/28/4/278>

Effects of hardiness and years of military service on posttraumatic stress symptoms in U.S. Army medics.

Pitts, Barbara L.; Safer, Martin A.; Russell, Dale W.; Castro-Chapman, Paula L.

Military Psychology

Vol 28(4), Jul 2016, 278-284

<http://dx.doi.org/10.1037/mil0000106>

We examined the effects of hardiness on symptoms of posttraumatic stress (PTS) in postdeployed U.S. Army medics (N = 322). Medics endure a high level of work-related stress on and off the battlefield. Hardiness correlated negatively with reports of PTS symptoms and moderated the cumulative effects of years of military service on PTS symptoms. After controlling for socially desirable responding, PTS symptoms increased with years of military service for those with low levels of hardiness and decreased with years of military service for those with very high levels of hardiness. The military's current resiliency training programs would likely benefit from incorporating hardiness measures and principles into its curriculum. (PsycINFO Database Record (c) 2016 APA, all rights reserved)

[Correction Notice: An Erratum for this article was reported in Vol 28(4) of Military Psychology (see record 2016-32104-001). In the article the last two authors were inadvertently omitted from the advance online version. Also, the author note was revised to include a disclaimer of government interest and to acknowledge funding and support. The second sentence in the first paragraph should read as follows: "Psychological hardiness, a personality factor that describes individual differences in commitment, control, and challenge (Kobasa, 1979), may serve to protect some service members from physical and behavioral health problems. Indeed, Escolas, Pitts, Safer, and Bartone (2013) found a positive relationship between years of military service and posttraumatic stress (PTS) symptoms only among those who self-reported hardiness." In the second-to-last paragraph of the introduction, the citation "(Crum- Cianflone, Powell, LeardMann, Russell, & Boyko, 2016)" was added to the end of the following sentence: "In fact, military service in general is associated with greater risk of physical health problems, such as hypertension, hypercholesterolemia, and back pain (O'Toole, Catts, Outram, Pierse, & Cockburn, 2009), and behavioral health problems, such as alcohol use, depression, and PTS." Finally, the following reference was added to the References section: "Crum-Cianflone, N. F., Powell, T. M., LeardMann, C. A., Russell, D. W., & Boyko, E. J. (2016). Mental health and comorbidities in U.S. military members. Military Medicine, 181, 537–545. <http://dx.doi.org/10.7205/MILMED-D-15-00187>." All versions of this article have been corrected.]

<http://psycnet.apa.org/journals/mil/28/4/241>

Unit cohesion, resilience, and mental health of soldiers in basic combat training.
Williams, Jason; Brown, Janice M.; Bray, Robert M.; Anderson Goodell, Erin M.;
Rae Olmsted, Kristine; Adler, Amy B.

Military Psychology

Vol 28(4), Jul 2016, 241-250

<http://dx.doi.org/10.1037/mil0000120>

Military unit cohesion has been shown to correlate with physical and psychological outcomes. However, little is known about the development of cohesion in the early days of military service during Basic Combat Training (BCT) and how it relates to positive support and the negative stressors of training. The current study assessed the development of unit cohesion across the 10-week BCT period ($N = 1,939$), and the relation of cohesion to stress, resilience, mental health measures, and BCT outcomes (graduation, passing the Army Physical Fitness Test, and final Basic Rifle Marksmanship scores). The sample was primarily male (62%), under age 25 (88%), and unmarried (88%). All putative mediators showed significant change over time. Unit cohesion increased over time (slope 0.22; $p < .001$), and these increases were associated with decreases in psychological distress ($p < .001$), sleep problems ($p < .001$), and tolerance of BCT stressors ($p < .001$), as well as increases in resilience ($p < .001$), confidence managing stress reactions ($p < .001$), and positive states of mind ($p < .001$). Unit cohesion was indirectly associated with successful graduation and passing the Army Physical Fitness Test through cohesion-related improvement in psychological distress, resilience, and confidence managing reactions to stress. Sleep problems also mediated BCT graduation. Cohesion effects on the Basic Rifle Marksmanship scores were mediated by psychological distress and tolerance of BCT stressors only. These results suggest that unit cohesion may play a key role in the development of psychological health among new soldiers. (PsycINFO Database Record (c) 2016 APA, all rights reserved)

<http://www.mirecc.va.gov/cih-visn2/Documents/Research/White%20Paper%20.pdf>

The Role and Functions of Embedded Behavioral Health Providers in VA Primary Care-Mental Health Integration: Current Evidence and Future Directions for Research

VA Center for Integrated Healthcare
White Paper
FY2015

Since the 2008 release of the Uniform Mental Health Services Handbook (UMHSH), the Veterans Health Administration (VHA) has required all VA Medical Centers (VAMCs) and specified* Community Based Outpatient Clinics (CBOCs) to implement Primary Care-Mental Health Integration (PC-MHI) programs. The UMHSH stipulates that these programs include two key functions: care management (CM) and co-located collaborative care (CCC). Both these components are required with the aims of improving the quality of and access to mental health services in primary care. At the time, the CM component had been relatively widely researched (particularly as applied to depression CM) and had been shown to address these aims.¹ Conversely, other models of integration, including CCC, had received less formal study, and in many cases had been developed through clinical innovations as various sites (both internal and external to VHA) seeking to integrate mental health care into primary care.

...

This white paper consists of four major sections. The first section provides general background about PC-MHI in VHA in order to provide the reader with a context to understand the expected roles of MH LIPs in VA PC-MHI Programs. The next two sections of this document provide summaries of two different literature reviews. The second section is focused on program- and provider-level processes. It provides a focused literature review on programmatic and patient outcomes of the PC-MHI program that incorporate the CCC function and on MH LIP practice behaviors and fidelity to the core components of CCC. The third section focuses on the intervention research. It provides an overview of a comprehensive literature review of BIs that are feasible for delivery in PC. The fourth and final section concludes with recommendations for future research that will lay groundwork for evidence-based CCC clinical practice.

<http://www.sciencedirect.com/science/article/pii/S0022395616301315>

The association between post-traumatic stress disorder and lifetime DSM-5 psychiatric disorders among veterans: Data from the National Epidemiologic Survey on Alcohol and Related Conditions-III (NESARC-III).

Sharon M. Smith, Rise B. Goldstein, Bridget F. Grant

This study examined the prevalence, correlates and psychiatric comorbidity of Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) posttraumatic stress disorder (PTSD) in a nationally representative sample of U.S. veterans using data from the National Epidemiologic Survey on Alcohol and Related Conditions-III (n = 3119 veteran respondents). The overall prevalence of lifetime PTSD was 6.9%. Lifetime PTSD prevalence was higher among veterans who were female (13.2%), aged 18–29 years (15.3%), Native American (24.1%) or Black (11.0%), previously or never married (9.6% and 11.2, respectively), had incomes less than \$70,000 (7.2%–10.1%) and had >2 traumatic events (5.2%–14.7%). After adjusting for sociodemographic characteristics, comorbidity between lifetime PTSD and other psychiatric disorders was highest for any personality disorder (adjusted odds ratio [AOR] = 11.1, 95% confidence interval [CI], 5.7, 21.5), any mood disorder (AOR = 9.7, 95% CI, 4.6, 20.4) and any anxiety disorder (AOR = 9.6, 95% CI, 5.1, 17.7), followed by nicotine, drug, and alcohol use disorders (AOR = 3.4, 95% CI, 1.8, 6.5; AOR = 3.1, 95% CI, 2.0, 5.9; 2.1, 95% CI, 1.5, 3.1, respectively). Associations remained with any mood, anxiety, and personality disorders after controlling for other psychiatric disorders (AOR = 3.7, 95% CI, 1.2, 10.9; AOR = 3.5, 95% CI, 1.6, 7.4; AOR = 4.5, 95% CI, 2.3, 8.7, respectively). Veterans who sought treatment for PTSD had more comorbid conditions, although treatment was only associated with comorbid drug use disorder (AOR = 2.4, 95% CI, 1.0, 5.7). In U.S. veterans, PTSD is highly comorbid with other psychiatric disorders. Although many veterans remain untreated, comorbidity may influence treatment seeking.

<http://onlinelibrary.wiley.com/doi/10.1111/famp.12231/abstract>

Alcohol-Focused Behavioral Couple Therapy.

McCrady, B. S., Wilson, A. D., Muñoz, R. E., Fink, B. C., Fokas, K. and Borders, A.

Family Process

Version of Record online: 2 JUL 2016

DOI: 10.1111/famp.12231

Alcohol Behavioral Couple Therapy (ABCT) has emerged over the last 30 years as a highly efficacious treatment for those with alcohol use disorders. This review highlights

the historical and conceptual underpinnings of ABCT, as well as the specific treatment elements and structure. Proposed active ingredients, moderators, and mediators of treatment outcome are discussed. Efficacy is evaluated for reductions in identified patient drinking, improved relationship functioning, and reductions in intimate partner violence. Adaptations of ABCT for substances other than alcohol are described. Other adaptations, including brief interventions, interventions addressing PTSD and TBI along with alcohol use, and interventions deliverable via technology platforms are described. Additional cost-benefit and cost-effectiveness findings supporting the economic value of ABCT are noted. Future directions for research in this area include possible adaptations for female identified patients, nontraditional couples, LGBT partners and dyads involving nonintimate partner relationships. The development of more flexible models and enhanced dissemination strategies may improve clinical uptake and utility as well as increasing the feasibility of this treatment for integrated healthcare settings.

<http://jtt.sagepub.com/content/early/2016/07/01/1357633X16657928.abstract>

Technology-enhanced suicide prevention interventions: A systematic review of the current state of the science.

Elizabeth Kreuze, Carolyn Jenkins, Mathew Gregoski, Janet York, Martina Mueller, Dorian A Lamis, and Kenneth J Ruggiero

Journal of Telemedicine and Telecare

July 3, 2016

doi:10.1177/1357633X16657928

Objective

Suicide prevention is a high priority. Scalable and sustainable interventions for suicide prevention are needed to set the stage for population-level impact. This systematic review explores how technology-enhanced interventions target suicide risk and protective factors, using the Centers for Disease Control and Prevention (CDC, 2015) Risk and Protective Factors Ecological Model.

Methods

Information databases (PsycINFO, PubMed and CINAHL) were systematically searched and records including technology-enhanced interventions for suicide prevention (n = 3764) were reviewed. Records with varying technologies and diverse methodologies were integrated into the search.

Results

Review of the records resulted in the inclusion of 16 studies that utilized technology-enhanced interventions to address determinants of suicidal behaviour. This includes the use of standalone or, in most cases, adjunct technology-enhanced interventions for suicide prevention delivered by mobile phone application, text message, telephone, computer, web, CD-ROM and video.

Conclusion

Intervention effectiveness was variable, but several technology-enhanced interventions have demonstrated effectiveness in reducing suicidal ideation and mental health co-morbidities. Large-scale research and evaluation initiatives are needed to evaluate the costs and long-term population-level impact of these interventions.

<http://www.radiologictechnology.org/content/87/6/649.short>

Post-traumatic Stress Disorder and Magnetic Resonance Imaging.

Amanda Moyer, BSRS, R.T.(R)

Radiologic Technology

July/August 2016, vol. 87 no. 6; 649-667

Although post-traumatic stress disorder (PTSD) is not fully understood, considerable research has gone into studying anatomical changes in the brain that take place with this condition. Magnetic resonance (MR) imaging can demonstrate changes in the volume of numerous brain regions, and functional MR imaging shows changes in activation when subjects are exposed to trauma-related stimuli. This article reviews current research findings on PTSD-associated brain changes and behavioral effects and discusses how PTSD affects patients of different ages.

http://journals.lww.com/hrpjournal/Abstract/2016/07000/Posttraumatic_Stress_Disorder_Overweight_and.3.aspx

Posttraumatic Stress Disorder, Overweight, and Obesity: A Systematic Review and Meta-analysis.

Suliman, Sharain PhD; Anthonissen, Lise MA; Carr, Jonathan MD, FCP; du Plessis, Stefan MD; Emsley, Robin MD, PhD; Hemmings, Sian M. J. PhD; Lochner, Christine PhD; McGregor, Nathaniel PhD; van den Heuvel, Leigh MD, MMed; Seedat, Soraya MD, PhD

Harvard Review of Psychiatry:

July/August 2016 - Volume 24 - Issue 4 - p 271–293

doi: 10.1097/HRP.000000000000106

Previous reports have suggested a high prevalence of overweight and obesity among individuals with posttraumatic stress disorder (PTSD). Few studies, however, systematically analyze the relationship between PTSD and body mass index (BMI). We conducted a systematic review and meta-analysis aimed at estimating the association between PTSD and BMI. Fifty-four articles were reviewed, 30 of which (with 191,948 individuals with PTSD and 418,690 trauma-exposed individuals or healthy controls) were eligible for inclusion in the meta-analysis. The pooled standard mean difference, based on a random-effects model, was 0.41 (95% confidence interval, 0.28–0.54; $z = 6.26$; $p < .001$). Statistical heterogeneity between the included studies was high ($p < .001$; $I^2 = 99\%$). Despite limitations, the findings of this systematic review and meta-analysis suggest an association between PTSD and BMI. Furthermore, longitudinal studies tentatively indicate that PTSD may lead to an increase in BMI and, as such, to the development of overweight/obesity, particularly in women. Further prospective studies and research elaborating the nature and etiology of the association are required.

[http://journals.cambridge.org/action/displayAbstract?
fromPage=online&aid=10398644&fileId=S0033291716000945](http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=10398644&fileId=S0033291716000945)

Selective prevention of combat-related post-traumatic stress disorder using attention bias modification training: a randomized controlled trial.

I. Wald, E. Fruchter, K. Ginat, E. Stolin, D. Dagan, P. D. Bliese, P. J. Quartana, M. L. Sipos, D. S. Pine and Y. Bar-Haim. Selective prevention of combat-related post-traumatic stress disorder using attention bias modification training: a randomized controlled trial.

Psychological Medicine

Published online: 05 July 2016

doi:10.1017/S0033291716000945

Background

Efficacy of pre-trauma prevention for post-traumatic stress disorder (PTSD) has not yet been established in a randomized controlled trial. Attention bias modification training (ABMT), a computerized intervention, is thought to mitigate stress-related symptoms by targeting disruptions in threat monitoring. We examined the efficacy of ABMT delivered before combat in mitigating risk for PTSD following combat.

Method

We conducted a double-blind, four-arm randomized controlled trial of 719 infantry soldiers to compare the efficacy of eight sessions of ABMT ($n = 179$), four sessions of ABMT ($n = 184$), four sessions of attention control training (ACT; $n = 180$), or no-training control ($n = 176$). Outcome symptoms were measured at baseline, 6-month follow-up, 10 days following combat exposure, and 4 months following combat. Primary outcome was PTSD prevalence 4 months post-combat determined in a clinical interview using the Clinician-Administered PTSD Scale. Secondary outcomes were self-reported PTSD and depression symptoms, collected at all four assessments.

Results

PTSD prevalence 4 months post-combat was 7.8% in the no-training control group, 6.7% with eight-session ABMT, 2.6% with four-session ABMT, and 5% with ACT. Four sessions of ABMT reduced risk for PTSD relative to the no-training condition (odds ratio 3.13, 95% confidence interval 1.01–9.22, $p < 0.05$, number needed to treat = 19.2). No other between-group differences were found. The results were consistent across a variety of analytic techniques and data imputation approaches.

Conclusions

Four sessions of ABMT, delivered prior to combat deployment, mitigated PTSD risk following combat exposure. Given its low cost and high scalability potential, and observed number needed to treat, research into larger-scale applications is warranted. The ClinicalTrials.gov identifier is NCT01723215.

<http://onlinelibrary.wiley.com/doi/10.1111/sltb.12275/abstract>

A Description of Suicides in the Army National Guard During 2007–2014 and Associated Risk Factors.

James Griffith PhD

Suicide and Life-Threatening Behavior
Version of Record online: 7 JUL 2016
DOI: 10.1111/sltb.12275

Suicide, due to its increased occurrence in recent years, has been a chief concern of the U.S. military. While there have been many published studies on the topic, conspicuously absent are studies that have included reserve military personnel. To fill this gap, this study reports descriptive statistics of personnel information and events surrounding 706 Army National Guard suicides that had occurred from 2007 through 2014. Comparative personnel information for random samples of nonsuicides for similar years (8 years, 1,000 cases per year) allowed examining factors associated most with suicide. Findings were very similar to those observed in the active duty Army and civilian populations. Primary risk factors for suicide were as follows: age (young), gender (male), and race/ethnicity (White). Most suicides occurred in nonmilitary status (86%) involving personal firearms (72%). Most frequent events surrounding the suicide were as follows: poor military performance (36% of all suicides), parent–family relationship problems (28%), substance abuse (27%), past behavioral health problem (20%), current behavioral health problems (10%), income problems (22%), and full-time employment problems (18%). Implications of findings for suicide prevention are discussed.

<http://onlinelibrary.wiley.com/doi/10.1002/jclp.22339/abstract>

Shame, Dissociation, and Complex PTSD Symptoms in Traumatized Psychiatric and Control Groups: Direct and Indirect Associations With Relationship Distress.

Dorahy, M. J., Corry, M., Black, R., Matheson, L., Coles, H., Curran, D., Seager, L., Middleton, W. and Dyer, K. F. W.

Journal of Clinical Psychology
Version of Record online: 11 JUL 2016

DOI: 10.1002/jclp.22339

Objectives

Elevated shame and dissociation are common in dissociative identity disorder (DID) and chronic posttraumatic stress disorder (PTSD) and are part of the constellation of symptoms defined as complex PTSD. Previous work examined the relationship between shame, dissociation, and complex PTSD and whether they are associated with intimate

relationship anxiety, relationship depression, and fear of relationships. This study investigated these variables in traumatized clinical samples and a nonclinical community group.

Method

Participants were drawn from the DID (n = 20), conflict-related chronic PTSD (n = 65), and nonclinical (n = 125) populations and completed questionnaires assessing the variables of interest. A model examining the direct impact of shame and dissociation on relationship functioning, and their indirect effect via complex PTSD symptoms, was tested through path analysis.

Results

The DID sample reported significantly higher dissociation, shame, complex PTSD symptom severity, relationship anxiety, relationship depression, and fear of relationships than the other two samples. Support was found for the proposed model, with shame directly affecting relationship anxiety and fear of relationships, and pathological dissociation directly affecting relationship anxiety and relationship depression. The indirect effect of shame and dissociation via complex PTSD symptom severity was evident on all relationship variables.

Conclusion

Shame and pathological dissociation are important for not only the effect they have on the development of other complex PTSD symptoms, but also their direct and indirect effects on distress associated with relationships.

Links of Interest

Killer App for Insomnia Therapy

<http://www.psychiatrictimes.com/bipolar-disorder/killer-app-insomnia-therapy>

DCoE Webinar Rewind: Cognitive Rehabilitation for Mild TBI

<http://www.health.mil/News/Articles/2016/07/08/DCoE-Webinar-Rewind-Cognitive-Rehabilitation-for-Mild-TBI>

Telehealth System Improved Mental Health and Depression in Army Study

<http://medicalresearch.com/author-interviews/telehealth-system-improved-mental-health-and-depression-in-army-study/25743/>

Yale Study: Clinicians Often Overlook Veterans' Mental Health Disorders

<http://www.courant.com/health/hc-yale-veterans-mental-health-0624-20160623-story.html>

Antidepressants: Treatment for bad marriages?

<https://www.sciencedaily.com/releases/2016/07/160707172337.htm>

Resource of the Week: [Facts about Veteran Suicide](#) (July 2016)

This is a just-published suicide prevention fact sheet from the U.S. Department of Veterans Affairs, based on a report about Veteran suicide that is to be released to the public later this month.

VA conducts nation's largest analysis of Veteran suicide



VA has undertaken the most comprehensive analysis of Veteran suicide rates in the U.S., examining over 55 million Veteran records from 1979 to 2014 from every state in the nation. The effort extends VA's knowledge from the previous report issued in 2010, which examined three million Veteran records from 20 states were available. Based on the data from 2010, VA estimated the number of Veteran deaths by suicide averaged 22 per day. The current analysis indicates that in 2014, an average of 20 Veterans a day died from suicide.

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