



CDP Research Update -- July 13, 2017

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https://www.ptsd.va.gov/professional/newsletters/ctu-online/ctu_v11n3.pdf

Clinician's Trauma Update Online (CTU-Online)

June 2017 Issue: Vol. 11(3)

National Center for PTSD

CTU-Online includes brief updates on the latest clinically relevant research. Content on treatment and assessment is emphasized. Publications on other topics are included if the content has significant clinical implications.

<http://www.dartmouth.edu/~ajordan/papers/Wortmann%20et%20al.%20-%20Spiritual%20Features%20of%20Moral%20Injury.pdf>

Spiritual Features of War-Related Moral Injury: A Primer for Clinicians

Jennifer H. Wortmann, Ethan Eisen, Carol Hundert, Alexander H. Jordan, Mark W. Smith, William P. Nash, Brett T. Litz

Warzone experiences that violate deeply held moral beliefs and expectations may lead to moral injury and associated spiritual distress (Litz et al., 2009). Helping morally injured war Veterans who are grappling with spiritual or religious issues is part of multicultural competence (Vieten et al. 2013) and falls within the scope of practice of mental health clinicians. Moreover, practicing clinicians report that they lack adequate knowledge of the diverse spiritual and religious backgrounds of their clients and when to seek consultation from and collaborate with spiritual/religious teachers (Vieten et al., 2016). We argue that optimal assessment and treatment of psychically traumatized military personnel and Veterans requires an understanding of the idioms and perspectives of various spiritual (religious and philosophical) traditions on transgression and their recommendations for forgiveness and healing. To this end, we: (1) provide an overview of the source of moral codes associated with various traditions; (2) discuss aspects of warzone events that may violate those moral codes and spiritual reactions to those violations; (3) describe spiritual traditions' approaches to making amends for transgressions; and (4) provide brief case scenarios that illustrate spiritual features of moral injury and point to circumstances in which collaboration with chaplains or clergy may be helpful for addressing aspects of moral injury.

<https://www.cambridge.org/core/journals/behavioural-and-cognitive-psychotherapy/article/predictors-of-treatment-discontinuation-during-prolonged-exposure-for-ptsd/CA0BD7CF7B653A54D28307294B49D0DAA>

Predictors of Treatment Discontinuation During Prolonged Exposure for PTSD.

Gros, D., Allan, N., Lancaster, C., Szafranski, D., & Acierno, R.

Behavioural and Cognitive Psychotherapy

Published online: 03 July 2017

doi:10.1017/S135246581700039X

Background:

Post-traumatic stress disorder (PTSD) is a highly prevalent and impairing condition for which there are several evidence-based psychotherapies. However, a significant proportion of patients fail to complete a 'sufficient dose' of psychotherapy, potentially limiting treatment gains.

Aims:

The present study investigated predictors of premature treatment discontinuation during a trial of prolonged exposure (PE) therapy for PTSD.

Method:

Combat veterans with PTSD were recruited to participate in a randomized clinical trial of PE delivered in person or via telehealth technologies. Of the 150 initial participants, 61 participants discontinued the trial before the completion of eight sessions (of an 8–12 session protocol). Treatment condition (telehealth or in person) and factors identified by prior research (age, combat theatre, social support, PTSD symptoms) were tested as predictors of treatment discontinuation.

Results:

A Cox proportional hazards model (a subtype of survival analysis) was used to evaluate predictors of treatment discontinuation. Disability status and treatment condition were identified as significant predictors of discontinuation, with a noted disability and use of telehealth demonstrating higher risk.

Conclusions:

The present findings highlight the influence of telehealth and disability status on treatment discontinuation, while minimizing the role of the previously identified variables from studies with less sensitive analyses.

[http://www.drugandalcoholdependence.com/article/S0376-8716\(17\)30303-4/abstract](http://www.drugandalcoholdependence.com/article/S0376-8716(17)30303-4/abstract)

Are brief alcohol interventions targeting alcohol use efficacious in military and veteran populations? A meta-analysis.

A.M. Doherty, C. Mason, N.T. Fear, R. Rona, N. Greenberg, L. Goodwin

Drug & Alcohol Dependence

DOI: <http://dx.doi.org/10.1016/j.drugalcdep.2017.05.029>

Background

Rates of hazardous and harm-related drinking are higher in the military and veteran populations compared to the general population. Brief alcohol interventions (BAIs) targeting alcohol use appear to reduce harmful drinking in the general population.

However, less is known about the efficacy of BAIs targeting alcohol in military and veteran populations.

Methods

A systematic review and meta-analysis was conducted to assess the type and efficacy of BAIs used to reduce alcohol use in military and veteran populations conducted from 2000 onwards. The meta-analysis was conducted using a standardised outcome measure of change in average weekly drinks (AWDs) from baseline to follow-up.

Results

The search revealed 10 papers that met the search criteria, and that reported data on 11 interventions included in the systematic review. 8 papers (reporting on 9 different interventions) were included in the meta-analysis after 2 papers were excluded for which the relevant outcome data were not available. There was no overall effect of BAIs; a non-significant weekly drink reduction of 0.95 drinks was found (95% CI, -0.17 to 2.07). This lack of efficacy persisted regardless of military group (conscripts, serving or veterans) and method of delivery (i.e., face-to-face, web-based or written information). Furthermore, sensitivity analyses revealed this small drink reduction was driven mainly by a single study.

Conclusions

Based on these findings, existing BAIs do not seem to be efficacious in reducing alcohol use in military populations, despite some encouraging results from one electronic intervention which was of extensive duration.

<http://militarymedicine.amsus.org/doi/abs/10.7205/MILMED-D-16-00269>

Embedded Mental Health: Promotion of Psychological Hygiene Within a Submarine Squadron.

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Military Medicine

Volume 182 Issue 7, July 2017, pp. E1675-e1680

<https://doi.org/10.7205/MILMED-D-16-00269>

Introduction:

Psychological fitness is an important component to operational unit readiness and success. Embedding behavioral health providers can reduce unplanned personnel losses (UPL) as a result of psychological stress. The U.S. Submarine Forces implemented the Submarine Squadron 6 (CSS-6) Embedded Mental Health Pilot (EMHP) Program to address this type of UPL, which is classified as a Code 2 loss. The aim of the study is to evaluate the effectiveness of the EMHP Program at reducing UPL by improving psychological readiness through expedited access to care. Materials and

Methods:

Using data from the CSS-6 EMHP Program, we identified the cohort of patients who were evaluated and received a full course of treatment from August 1, 2013, to April 30, 2015, and examined their final dispositions. A comparative review of Code 2 losses between 2012 and 2014 was performed to assess for any reduction in the annual incidence of Code 2 losses with EMHP. The Outcome Questionnaire (OQ-45) survey was used to determine the quantitative impact of EMHP on patient psychological readiness. We performed multiple regression analysis to identify any significant correlation between all independent variables and improvement in final OQ-45 scores. We performed logistic regression analysis to assess the logistic score as a function of predicting patient probability of returning vice not returning to duty. The logistic score is a by-product of the end results data and was not an original metric when the program was started. The Clinical Investigations Department at Naval Medical Center, Portsmouth waived this study from institutional review board review. Authorization was obtained from the U.S. Submarine Forces Command Public Affairs Office to publish the contents of this study.

Results:

EMHP providers conducted a total of 878 patient sessions for 183 sailors over a 21-month period. There were eight fewer Code 2 losses after 2014, the first full calendar year with EMHP. This decrease in the number of Code 2 losses was in fact statistically significant, given $p < 0.001$. EMHP providers saw a 200% increase in patient volume and contributed to a 12% decrease in the annual incidence of Code 2 losses in 2014. Seventy patients returning to duty demonstrated clinically and statistically significant improvements in OQ-45 scores at the end of treatment. Only the initial symptomatic distress score on the OQ-45 survey demonstrated any statistical significance of predicting an improvement in OQ-45 composite scores by the end of treatment, given $p < 0.01$. A negative logistic score was significantly associated with not returning to duty (odds ratio, 16.0; 95% confidence interval, 5.22–49.02; $\chi^2 = 30.63$; $p < 0.001$).

Conclusion:

The EMHP Program reduced Code 2 losses and positively promoted psychological hygiene for submariners. With the establishment of embedded programs at other squadrons, we can develop a longitudinal study that provides a more inclusive assessment of this model. A future study may be warranted to evaluate the validity of the logistic score as a metric to determine further fitness for submarine duty.

<http://militarymedicine.amsus.org/doi/abs/10.7205/MILMED-D-16-00382>

The Reasons for Living Scale—Military Version: Assessing Protective Factors Against Suicide in a Military Sample.

Anne-Marie Deutsch, PhD; R. Gregory Lande, DO

Military Medicine

Volume 182 Issue 7, July 2017, pp. E1681-e1686

<https://doi.org/10.7205/MILMED-D-16-00382>

Introduction:

Military suicide rates have been rising over the past decade and continue to challenge military treatment facilities. Assessing suicide risk and improving treatments are a large part of the mission for clinicians who work with uniformed service members. This study attempts to expand the toolkit of military suicide prevention by focusing on protective factors over risk factors. In 1983, Marsha Linehan published a checklist called the Reasons for Living Scale, which asked subjects to check the reasons they choose to continue living, rather than choosing suicide. The authors of this article hypothesized that military service members may have different or additional reasons to live which may relate to their military service. They created a new version of Linehan's inventory by adding protective factors related to military life. The purpose of these additions was to make the inventory more acceptable and relevant to the military population, as well as to identify whether these items constitute a separate subscale as distinguished from previously identified factors.

Materials and Methods:

A commonly used assessment tool, the Reasons for Living Inventory (RFL) designed by Marsha Linehan, was expanded to offer items geared to the military population. The RFL presents users with a list of items which may be reasons to not commit suicide (e.g., "I have a responsibility and commitment to my family"). The authors used focus

groups of staff and patients in a military psychiatric partial hospitalization program to identify military-centric reasons to live. This process yielded 20 distinct items which were added to Linehan's original list of 48. This expanded list became the Reasons for Living—Military Version. A sample of 200 patients in the military partial hospitalization program completed the inventory at time of or close to admission. This study was approved by the Institutional Review Board at Walter Reed National Military Center for adhering to ethical principles related to pursuing research with human subjects.

Results:

The rotated factor matrix revealed six factors that have been labeled as follows: Survival and Coping Beliefs, Military Values, Responsibility to Family, Fear of Suicide/Disability/Unknown, Moral Objections and Child-Related Concerns. The subscale of Military Values is a new factor reflecting the addition of military items to the original RFL.

Conclusions:

Results suggest that formally assessing protective factors in a military psychiatric population has potential as a useful tool in the prevention of military suicide and therefore warrants further research. The latent factor we have entitled “Military Values” may help identify those service members for whom military training or “esprit de corps” is a reason for living. Further research can focus on further validation, pre/post-treatment effects on scores, expanded clinical use to stimulate increased will to live, or evaluation of whether scores on this scale, or the subscale of Military Values, can predict future suicidal behavior by service members. Finally, a larger sample size may produce more robust results to support these findings.

<http://militarymedicine.amsus.org/doi/abs/10.7205/MILMED-D-16-00360>

Association Between Alcohol Craving and Health-Related Quality of Life Among Veterans With Co-occurring Conditions.

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Military Medicine

182(7), pp. e1712–e1717

Published online: July 5, 2017

<https://doi.org/10.7205/MILMED-D-16-00360>

Background:

Probable alcohol use disorder (AUD), mental health disorders (MHDs), and mild traumatic brain injury (mTBI) are endemic among U.S. Veterans of the recent conflicts in Iraq and Afghanistan. Previous research demonstrates that recent Veterans with AUD and MHD both with and without mTBI (MHD \pm mTBI) self-report higher alcohol craving levels relative to Veterans with AUD only. Since it is unknown if alcohol craving negatively impacts health-related quality of life (HRQOL), the purpose of this study is to identify and describe the relationship between alcohol craving and HRQOL for recent Veterans with AUD alone and those with AUD and co-occurring conditions.

Methods:

This cross-sectional study included Penn Alcohol Craving Scale (PACS) and Veterans RAND 36 Item Health Survey mental and physical component score data collected among recent Veterans with AUD (N = 29, n = 27 males): 14 combat controls, 15 MHD \pm mTBI. The Alcohol Use Disorder Identification Test, consumption questions determined AUD classification. That is only Veterans scoring a 4 or above for males and a 3 or above for females on the Alcohol Use Disorder Identification Test, consumption questions were included in this study. Associations between alcohol craving and HRQOL were examined using correlations and regression models.

Results:

There was a significant negative linear relationship between PACS and mental component score ($p < 0.05$) that did not significantly differ between groups. There was a significant negative curvilinear relationship between PACS and physical component score with a significant group effect.

Discussion:

Greater alcohol craving was associated with poorer mental HRQOL. Physical HRQOL was also significantly associated with alcohol craving. These relationships have important implications for clinical assessment and treatment among people with AUD. These findings suggest that alcohol craving is an important symptom of AUD for clinicians to assess and focus their treatment upon because it may negatively impact HRQOL.

<http://militarymedicine.amsus.org/doi/abs/10.7205/MILMED-D-16-00378>

Self-Management Strategies for Stress and Anxiety Used by Nontreatment Seeking Veteran Primary Care Patients.

Robyn L. Shepardson; Jennie Tapio; Jennifer S. Funderburk

Military Medicine

182(7), pp. e1747–e1754

Published online: July 5, 2017

<https://doi.org/10.7205/MILMED-D-16-00378>

Introduction:

One of the most common reasons individuals do not seek mental health treatment is a preference to manage emotional concerns on their own. Self-management refers to the strategies that individuals use on their own (i.e., without professional guidance) to manage symptoms. Little research has examined self-management for anxiety despite its potential utility as the first step in a stepped care approach to primary care. The objectives of this study were to describe patients' anxiety self-management strategies, identify which types were perceived to be effective, and explore potential correlates.

Materials and Methods:

This was an exploratory descriptive study (N = 182) of nontreatment seeking Veterans Health Administration primary care patients (M = 58.3 years of age, SD = 14.9) who reported current anxiety symptoms (≥ 8 on Generalized Anxiety Disorder-7). The Institutional Review Board approved the study, and all participants provided informed consent. We assessed self-management strategies, anxiety and depression symptoms, and past-year treatment via telephone. Two independent raters coded strategies into 1 of 7 categories ($\kappa = 0.85$) and 23 subcategories ($\kappa M = 0.82$, SD = 0.16).

Results:

Participants reported nearly universal (98%) use of self-management, with an average of 2.96 (SD = 1.2) strategies used in the past 3 months, and 91% of all strategies perceived as effective. Self-care (37.0%), cognitive (15.8%), and avoidance (15.1%) strategies were reported most commonly; the most prevalent subcategories were exercise (11.0% of all strategies), redirecting thoughts (9.1%), and family/friends (8.1%). Age and depression screen status were associated with self-management strategy use.

Conclusion:

Our results demonstrate the ubiquity and high perceived effectiveness of self-management for anxiety among Veteran primary care patients. Although avoidance strategies were fairly common, self-care strategies, particularly exercising, and cognitive strategies, such as redirecting thoughts, were most prevalent in this sample. Strengths of the study include its novelty, our sample of non-treatment seeking Veteran primary

care patients with current symptoms, and the open-ended format of the strategies questions. Limitations include reliance on self-report data, dichotomous response options for the perceived effectiveness item, limited number of potential correlates, and sampling from a single medical center. Overall, this research highlights the opportunity that health care providers have to engage primary care patients around self-management to determine what strategies they are using and how effective those strategies may be. Future directions include identification of the most effective and feasible self-management strategies for anxiety to facilitate promotion of evidence-based self-management among primary care patients.

<http://www.sciencedirect.com/science/article/pii/S0165032717302549>

A comparison of ICD-11 and DSM criteria for posttraumatic stress disorder in two national samples of U.S. military veterans.

Blair E. Wisco, Brian P. Marx

Journal of Affective Disorders

Available online 6 July 2017

<https://doi.org/10.1016/j.jad.2017.07.006>

Background

The proposed ICD-11 criteria for posttraumatic stress disorder (PTSD) differ substantially from the DSM-5. ICD-11 eliminated several PTSD symptoms thought to be nonspecific, with the goal of reducing psychiatric comorbidities. However, this change also results in a narrower PTSD definition that may fail to capture individuals with clinically significant PTSD. The purpose of the current study was to compare prevalence and psychiatric comorbidities of DSM (IV/5) and ICD-11 PTSD.

Methods

We evaluated concordance between DSM (IV/5) and ICD-11 PTSD diagnoses in a web survey of two nationally representative samples of U.S. military veterans (ns = 3517 and 1484). Lifetime and past-month PTSD symptoms were assessed with the DSM-IV-based PTSD Checklist-Specific Stressor version and the DSM-5-based PTSD Checklist-5. Psychiatric comorbidities were assessed using MINI Neuropsychiatric Interview modules.

Results

A significantly greater proportion of veterans met criteria for lifetime and past-month PTSD under DSM-IV/5 than under ICD-11. 21.8–35.9% of those who met criteria under DSM IV/5 did not meet under ICD-11, whereas only 2.4–7.1% of those who met under ICD-11 did not meet under DSM-IV/5. Psychiatric comorbidities did not significantly differ between DSM-IV/5 and ICD-11.

Limitations

This study relied upon self-report measures of PTSD, distress/impairment, and psychiatric comorbidities.

Conclusions

The proposed ICD-11 criteria identify fewer PTSD cases than DSM-IV/5 without reducing psychiatric comorbidities. Veterans with clinically significant PTSD symptoms may not meet ICD-11 PTSD criteria, possibly affecting eligibility for healthcare, disability, and other services. The ICD-11 criteria could be revised to capture more PTSD cases before ICD-11 is published in 2018.

<http://www.sciencedirect.com/science/article/pii/S0005796717301353>

Effects of psychotherapies for posttraumatic stress disorder on sleep disturbances: Results from a randomized clinical trial.

Elizabeth Woodward, Ann Hackmann, Jennifer Wild, Nick Grey, David M. Clark, Anke Ehlers

Behaviour Research and Therapy

Available online 8 July 2017

<https://doi.org/10.1016/j.brat.2017.07.001>

The effectiveness and mechanisms of psychotherapies for PTSD in treating sleep problems is of interest. This study compared the effects of a trauma-focused and a non-trauma-focused psychotherapy on sleep, to investigate 1) whether sleep improves with psychotherapy for PTSD; 2) whether the degree of sleep improvement depends on whether the intervention is trauma or nontrauma-focused, 3) whether the memory-updating procedure in CT-PTSD was associated with sleep improvements; 4) the effect of initial sleep duration on PTSD treatment outcome was also investigated; and 5) symptoms associated with sleep duration improvements. Self-reported sleep was

assessed during a randomized controlled trial (Ehlers et al., 2014) comparing cognitive therapy for PTSD (CT-PTSD, delivered weekly or intensively over 7-days) with emotion-focused supportive therapy, and a waitlist. Sleep duration was reported daily in sleep diaries during intensive CT-PTSD. CT-PTSD led to greater increases in sleep duration (55.2 min) and reductions in insomnia symptoms and nightmares than supportive therapy and the waitlist. In intensive CT-PTSD, sleep duration improved within 7 days, and sleep diaries indicated a 40-min sleep duration increase after updating trauma memories. Initial sleep duration was not related to CT-PTSD treatment outcome when initial PTSD symptom severity was controlled. The results suggest that trauma-focused psychotherapy for PTSD is more effective than nontrauma-focused therapy in improving self-reported sleep, and that CT-PTSD can still be effective in the presence of reduced sleep duration.

<http://psycnet.apa.org/journals/mil/29/4/260/>

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

Dyches, Karmon D.; Saboe, Kristin N.; Anderson, James A.; Wilk, Joshua E.; Hinman, Sarah J.; Sipo, Maurice L.; Quartana, Phillip J.

Military Psychology

Vol 29(4), Jul 2017, 260-270

<http://dx.doi.org/10.1037/mil0000165>

Anger and aggression are common combat-related behavioral health problems. The impact of combat on anger and aggression appears to be largely attributable to symptoms of posttraumatic stress disorder (PTSD). Factors that moderate the purported pathway from combat to anger and aggression are poorly understood. We examined the conditional direct and indirect associations of combat exposure with self-reported anger and aggression using survey data collected from 592 U.S. Soldiers during a combat deployment in Afghanistan. Unit morale was examined as a moderator between combat exposure and PTSD symptoms, as well as the indirect association of combat exposure with anger and aggression via PTSD symptoms, controlling for depression symptoms. Results indicated that unit morale was negatively correlated with PTSD symptoms and self-reported anger and aggressive behaviors. Perceptions of unit morale moderated the direct association of combat exposure with PTSD symptoms. Unit morale also moderated the indirect association of combat exposure with anger and aggression

through PTSD symptoms. Unit morale moderated the association of combat exposure with anger and aggression during combat operations by putatively mitigating the deleterious effect of combat on stress-related symptoms. The impact of policy and leadership on soldier and unit morale should be carefully considered given its protective role during combat operations. (PsycINFO Database Record (c) 2017 APA, all rights reserved)

<http://psycnet.apa.org/journals/mil/29/4/294/>

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

Aronson, Keith R.; Kyler, Sandee J.; Morgan, Nicole R.; Perkins, Daniel F.; Love, Linda

Military Psychology

Vol 29(4), Jul 2017, 294-306

<http://dx.doi.org/10.1037/mil0000156>

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

<http://psycnet.apa.org/journals/mil/29/4/283/>

Associations between participant ratings of PREP for strong bonds and marital outcomes 1 year postintervention.

Allen, Elizabeth S.; Post, Kristina M.; Markman, Howard J.; Rhoades, Galena K.; Stanley, Scott M.

Military Psychology

Vol 29(4), Jul 2017, 283-293

<http://dx.doi.org/10.1037/mil0000155>

After completing a relationship education program, collecting participant evaluations of the program is common practice. These are generally used as an index of “consumer satisfaction” with the program, with implications for feasibility and quality. Rarely have these ratings been used as predictors of changes in marital quality, although such feedback may be the only data providers collect or have immediate access to when considering the success of their efforts. To better understand the utility of such ratings to predict outcomes, we evaluated links between participant ratings and changes in self-reported marital satisfaction and communication scores 1 year later for a sample of 191 Army couples who had participated in a relationship education program delivered by Army chaplains (PREP for Strong Bonds). Overall ratings of general satisfaction with the program and the leader did not predict changes in marital outcomes 1 year later, whereas higher ratings of how much was learned, program helpfulness, increased similarity in outlook regarding Army life, and helpfulness of communication skills training predicted greater change in communication skills 1 year later. Higher ratings of items reflecting intent to invest more time in the relationship, and increased confidence in constructive communication and working as a team with the spouse predicted greater increases in both marital satisfaction and communication skills 1 year later. The constructs of intention and confidence (akin to perceived behavioral control) suggest that the Theory of Planned Behavior may be particularly useful when considering which Army couples will show ongoing benefit after relationship education. (PsycINFO Database Record (c) 2017 APA, all rights reserved)

<http://onlinelibrary.wiley.com/doi/10.1111/sltb.12368/full>

On the Iatrogenic Risk of Assessing Suicidality: A Meta-Analysis.

Christopher R. DeCou MS, Matthew E. Schumann MA

Suicide and Life-Threatening Behavior

First published: 5 July 2017

DOI: 10.1111/sltb.12368

Previous studies have failed to detect an iatrogenic effect of assessing suicidality. However, the perception that asking about suicide may induce suicidality persists. This meta-analysis quantitatively synthesized research concerning the iatrogenic risks of assessing suicidality. This review included studies that explicitly evaluated the iatrogenic effects of assessing suicidality via prospective research methods. Thirteen articles were identified that met inclusion criteria. Evaluation of the pooled effect of assessing suicidality with regard to negative outcomes did not demonstrate significant iatrogenic effects. Our findings support the appropriateness of universal screening for suicidality, and should allay fears that assessing suicidality is harmful.

<http://www.sciencedirect.com/science/article/pii/S0165032717304482>

Comparing brief interventions for suicidal individuals not engaged in treatment: A randomized clinical trial.

Erin F. Ward-Ciesielski, Julia A. Tidik, Amanda J. Edwards, Marsha M. Linehan

Journal of Affective Disorders

Volume 222, November 2017, Pages 153-161

<https://doi.org/10.1016/j.jad.2017.07.011>

Background

Non-treatment-engaged individuals experiencing suicidal thoughts have been largely overlooked in the intervention literature, despite reviews suggesting most individuals who die by suicide were not in treatment immediately prior to their death. Most intervention studies recruit individuals from treatment providers, potentially neglecting those individuals who are not already engaged in services. These individuals clearly represent a group in need of additional empirical attention.

Methods

A randomized clinical trial was conducted to compare a single-session dialectical behavior therapy skills-based intervention to a relaxation training control condition.

Ninety-three non-treatment-engaged subjects participated in a single in-person assessment, received one of the intervention protocols, and completed follow-up phone interviews for three months including measures of suicidal ideation, emotion dysregulation, and coping skills, as well as other relevant assessments.

Results

Both conditions reported significantly reduced levels of suicidal ideation, depression, and anxiety; however, analyses revealed no significant differences between conditions on the main outcome measures of suicidal ideation, emotion dysregulation, skills use, depression, or anxiety.

Limitations

The two interventions may have been too similar to permit detection of differential effects with this sample size. Specifically, the control condition may have been too active and there may have been stylistic overlap by providers who delivered both interventions.

Conclusions

Encouragingly, half of subjects contacted other mental health services during the follow-up period. Although the two interventions under investigation did not yield differential results, the significant changes in important domains across interventions suggest that brief interventions may hold promise for this difficult-to-reach population.

<http://jech.bmj.com/content/early/2017/07/05/jech-2016-207731>

Smoking and suicide: biological and social evidence and causal mechanisms.

Margaret Green, Sarah Turner, Jitender Sareen

Journal of Epidemiology & Community Health

Published Online First: 05 July 2017

doi: 10.1136/jech-2016-207731

Smoking as a risk factor for death by suicide has been a controversial area of inquiry. Over the last 20 years, there has been an expanding body of literature demonstrating that smokers have an increased risk of death by suicide. In this editorial, we highlight some of the key studies providing support for the relationship between smoking and

suicide. Next, we discuss some of the key biopsychosocial mechanisms that may explain the link between smoking and suicide.

<http://psycnet.apa.org/journals/mil/29/4/307/>

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

Williams, Rush C.; Holliday, Ryan; Holder, Nicholas; Surís, Alina

Military Psychology

Vol 29(4), Jul 2017, 307-315

<http://dx.doi.org/10.1037/mil0000166>

Veterans with military sexual trauma (MST) are at risk for a variety of psychiatric conditions, including posttraumatic stress disorder (PTSD) and depression. Survivors of MST are also likely to experience diminished quality of life (QoL). Individuals with higher lifetime incidence of sexual trauma may also be at increased risk for poorer outcomes in QoL and psychiatric symptomatology. The differences in psychological sequelae among those who have experienced sexual trauma as children, and those whose sexual trauma exposure is limited to adulthood are relatively understudied. The majority of sexual trauma literature has focused primarily on civilian trauma, and comparatively few studies have specifically examined psychosocial sequelae (e.g., QoL) in veterans with MST. This study examined how childhood sexual abuse (CSA) affects overall QoL as well as severity of PTSD and depressive symptoms. Veterans who reported CSA had significantly greater depression symptom severity than veterans who did not. No significant differences in PTSD symptom severity or QoL were found between veterans who did and did not report CSA. Results highlight the need for further examination of the relationship between CSA and depression in veterans with MST-related PTSD who also report CSA. (PsycINFO Database Record (c) 2017 APA, all rights reserved)

<http://www.sciencedirect.com/science/article/pii/S000578941730076X>

Economic Impact of 'Third-Wave' Cognitive Behavioral Therapies: A Systematic Review and Quality Assessment of Economic Evaluations in Randomized Controlled Trials.

Albert Feliu-Soler, Ausiàs Cebolla, Lance M. McCracken, Francesco D'Amico, Martin Knapp, Alba López-Montoyo, Javier García-Campayo, Joaquim Soler, Rosa M. Baños, Adrián Pérez-Aranda, Laura Andrés-Rodríguez, María Rubio-Valera, Juan V. Luciano

Behavior Therapy

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The term third-wave cognitive behavioural therapy (CBT) encompasses new forms of CBT that both extend and innovate within CBT. Most third-wave therapies have been subject to RCTs focused on clinical effectiveness, however the number and quality of economic evaluations in these RCTs has been unknown and may be few. Evidence about efficiency of these therapies may help support decisions on efficient allocation of resources in health policies. The main aim of this study was to systematically review the economic impact of third-wave therapies in the treatment of patients with physical or mental conditions. We conducted a systematic literature search in PubMed, PsycINFO, EMBASE, and CINALH to identify economic evaluations of third-wave therapies. Quality and Risk of Bias (RoB) assessment of economic evaluations was also made using the Drummond 35-item checklist and the Cochrane Collaboration's tool for assessing risk of bias, respectively. Eleven RCTs were included in this systematic review. Mindfulness-Based Cognitive Therapy (MBCT), Mindfulness-Based Stress Reduction (MBSR), Acceptance and Commitment Therapy (ACT), Dialectical Behavior Therapy (DBT), and extended Behaviour Activation (eBA) showed acceptable cost-effectiveness and cost-utility ratios. No study employed a time horizon of more than 3 years. Quality and RoB assessments highlight some limitations that temper the findings. There is some evidence that MBCT, MBSR, ACT, DBT, and eBA are efficient from a societal or a third-party payer perspective. No economic analysis was found for many third-wave therapies. Therefore, more economic evaluations with high methodological quality are needed.

[http://www.jpain.org/article/S1526-5900\(17\)30557-6/fulltext](http://www.jpain.org/article/S1526-5900(17)30557-6/fulltext)

Predictors of Treatment Outcome in Contextual Cognitive and Behavioral Therapies for Chronic Pain: A Systematic Review.

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There is increasing evidence that contextual forms of cognitive-behavioral therapy (CBT) are effective in the management of chronic pain, yet little is understood about the factors that moderate or predict outcomes in these treatments. This systematic review aimed to identify pretreatment participant characteristics associated with positive treatment responses in contextual CBT for chronic pain. Medline, EMBASE, PsychINFO, and CENTRAL were searched to identify eligible studies. Studies were included if the participants were adults with chronic pain, designs were longitudinal, treatments focused on psychological flexibility or mindfulness, and reported results allowed for examination of moderators or predictors of standard treatment outcomes. Of 991 records initially identified, 20 were eligible for inclusion in the review. Some evidence suggested that baseline emotional functioning predicts treatment response, but the direction of this association varied between studies. Substantive findings were inconsistent and inconclusive, however, methodological limitations were consistent. These included treatment heterogeneity, and a lack of theoretical, a priori guidance in examining potential predictors. Future research should adopt a theoretically based approach to examining moderators in relation to specific treatment methods and therapeutic processes. Considering moderation without first considering mediation is probably a limited strategy.

Links of Interest

How the Death of a Muslim Recruit Revealed a Culture of Brutality in the Marines

<https://www.nytimes.com/2017/07/06/magazine/how-the-death-of-a-muslim-recruit-revealed-a-culture-of-brutality-in-the-marines.html>

Opioid prescriptions down, but numbers still dramatically high in some places, CDC says

<https://www.usatoday.com/story/news/2017/07/06/opioid-prescriptions-down/456064001/>

Treating Post-Traumatic Headache After Concussion

<http://www.neurologyadvisor.com/migraine-and-headache/post-traumatic-headache-treatment-after-concussion/article/673201/>

Traumatic brain injury in veterans: Differences from civilians may affect long-term care
<https://www.sciencedaily.com/releases/2017/07/170706155930.htm>

Home-front help: 14 tips for dealing with deployment, from spouses who've been there
<http://www.militarytimes.com/articles/home-front-help-14-tips-for-dealing-with-deployment-from-spouses-whove-been-there>

Biomarkers: The Future of PTSD Diagnosis and Treatment Monitoring?
<https://www.pdhealth.mil/news/blog/biomarkers-future-ptsd-diagnosis-and-treatment-monitoring>

'Sexism' in sexual assault research, but this time men are the target
<https://www.sciencedaily.com/releases/2017/07/170710091655.htm>

Purpose in life by day linked to better sleep at night
<https://www.sciencedaily.com/releases/2017/07/170710091734.htm>

Air Force Academy's sexual assault prevention office under investigation
<https://www.airforcetimes.com/articles/air-force-academys-sexual-assault-prevention-office-under-investigation>

What First Responders Should Seek in Mental Health Clinicians
<http://inpublicsafety.com/2017/07/what-first-responders-should-look-for-in-mental-health-clinicians/>

This Robot Therapist Talks to Patients Via Facebook
<https://www.entrepreneur.com/article/296970>

Imaging reveals how well PTSD patients will respond to psychotherapy
<https://medicalxpress.com/news/2017-07-imaging-reveals-ptsd-patients-psychotherapy.html>

Suicide prevention among vets a topic at Bay Pines panel
<http://www.tampabay.com/news/military/veterans/suicide-prevention-among-vets-a-topic-at-bay-pines-panel/2330258>

House reaches deal to greatly expand GI Bill
<https://www.stripes.com/news/veterans/house-reaches-deal-to-greatly-expand-gi-bill-1.477772>

Commentary: Restore GI Bill benefits for veterans with career-ending PTSD
<http://www.militarytimes.com/articles/commentary-restore-gi-bill-benefits-for-veterans-with-career-ending-ptsd>

Resource of the Week: [Updated PTSD Guidelines and Recommendations Released: Learn About the Changes](#)

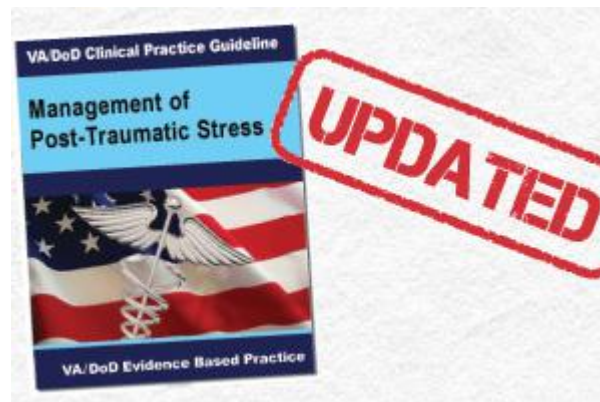
On Monday(July 3), the Department of Veterans Affairs (VA) and Department of Defense (DoD) released an updated version of the [VA/DoD Clinical Practice Guideline \(CPG\) for the `Management of Posttraumatic Stress Disorder \(PTSD\) and Acute Stress Disorder \(ASD\)](#). The new version incorporates research conducted since the last revision in 2010 and covers treatment for both PTSD and ASD. There are several new recommendations, so both seasoned and new mental health practitioners should take time to review it.

Selected recommendations:

- The CPG provides a strong recommendation for the first line of treatment for PTSD: individual, manualized trauma-focused psychotherapy, over use of pharmacologic and non-pharmacologic interventions for primary treatment. Only if the patient prefers not to use this therapy or it is not available, then pharmacotherapy or other specified evidence-based individual non-trauma focused psychotherapy can be used (see CPG for details). However, in an effort to increase access to care, the CPG strongly recommends using those trauma-focused psychotherapies that have demonstrated efficacy using secure video conferencing (VTC).
- The CPG presents a strong recommendation for use of selective serotonin reuptake inhibitors (SSRIs) fluoxetine, paroxetine, or sertraline and serotonin norepinephrine reuptake inhibitor (SNRI) venlafaxine for patients diagnosed with PTSD who choose not to engage in or are unable to access trauma-focused psychotherapy.
- The CPG makes a strong recommendation against treating PTSD with

divalproex, tiagabine, guanfacine, risperidone, benzodiazepines, ketamine, hydrocortisone, or D-cycloserine, as monotherapy due to the lack of strong evidence for their efficacy and/or known adverse effect profiles and associated risks.

- The CPG recommends against using atypical antipsychotics, benzodiazepines, and divalproex as augmentation therapy for the treatment of PTSD due to low quality evidence or the absence of studies and their association with known adverse effects.
- For nightmares associated with PTSD, there is insufficient evidence to recommend for or against the use of prazosin as mono- or augmentation therapy.
- There is insufficient evidence to recommend using any complementary and integrative health (CIH) practices including mindfulness, yoga, meditation, or acupuncture as the primary treatment for PTSD.
- The CPG strongly recommends against using cannabis to treat PTSD because of the lack of evidence for efficacy, known adverse effects, and associated risks.



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