

CDP



Research Update -- August 20, 2020

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<https://www.belfercenter.org/publication/modern-warfare-destroys-brains>

Modern Warfare Destroys Brains.

Warren Stewart, Kevin Trujillo

Harvard Kennedy School
Belfer Center for Science and International Affairs
July 2020

“Operator Syndrome,” especially blast TBI (bTBI) and PTSD, are destroying the lives of special operators at an alarming rate. For the purposes of this paper, operators are Green Berets, SEALs, MARSOC Raiders, Combat Controllers, Pararescue, Explosive Ordnance Disposal Technicians, Special Mission Units or those that may accompany special operations forces regularly in training or on missions. The USSOCOM must continue to aggressively address bTBI. The authors acknowledge that the Nation and the command have invested heavily in developing strategies to address this issue; however, thus far, the efforts seem disjointed and have failed to mitigate the impact on

special operators. These well-intentioned programs, policies, and research efforts are not making it to the team rooms or the ready rooms of our Ranger Platoons, Green Beret “A-Teams,” SEAL Platoons, Marine Special Operations Teams or other special mission units. There is no time to waste—senior leaders, policy makers and researchers must translate the current knowledge into actionable programs. There is no doubt that if provided the right tools, equipment and education, the senior non-commissioned officers will undoubtedly alter training protocols, inform their teammates and force positive change.

This paper has two primary objectives. First, it will support the argument that blast related TBI is uniquely different from the more recognized brain injury known as chronic traumatic encephalopathy (CTE) injury associated with impact trauma and therefore requires a different approach to both diagnosis and treatment. Second, it will provide recommendations for mitigating the effects of bTBI on the readiness and long-term health of special operators.

Key recommendations will include identifying blast pressure thresholds, developing imaging technology, and blood markers to diagnose bTBI. It calls for the DoD to institute and sustain “baseline” health surveillance to detect patterns of injury and health distress early, promote awareness for the Center for Neuroscience and Regenerative Medicine Brain Donation Awareness Program, and to establish an active Cross-Functional Brain Consortium. An additional recommendation will include changes to training plans that continue to prepare operators for combat but reduce their exposure to blast trauma.

<https://link.springer.com/article/10.1007/s40737-020-00187-4>

Changes in Physical Activity and Sleep Among Veterans Using a Service Dog as a Rehabilitation Modality for Post-traumatic Stress Disorder: An Open-Label Single-Arm Exploratory Trial Using Actigraphy-Based Measures.

Geneviève Lessard, Dany H. Gagnon, Claude Vincent & Members of the PTSD-Service Dog Research Team

Journal of Psychosocial Rehabilitation and Mental Health

Published 12 August 2020

<https://doi.org/10.1007/s40737-020-00187-4>

Little is known about the changes occurring after acquiring a service dog (SDPTSD) trained for the management of post-traumatic stress disorder (PTSD) symptoms on physical activity and sleep among veterans. To quantify, using actigraphy measures, changes in physical activity and sleep before and after acquiring a SDPTSD. A total of 18 veterans with chronic PTSD wore an actigraph wGT3X-BT during 7 days, 3 months before (T-3) and 9 months after (T+9) acquiring their SDPTSD. They also completed online questionnaires at both measuring times: Life Space Assessment, Pittsburgh Sleep Quality Index, Post-traumatic Stress Disorder Checklist-Military version and Beck Depression Inventory II. Non-parametric statistics compared results between T-3 and T+9 and Cohen's d effect sizes (E.S.) determined the magnitude of changes. Veterans remained sedentary during most of their awake time at T+9 ($p = 0.173$; E.S. = 0.249), whereas the percentage of time dedicated to moderate physical activity ($p = 0.038$, E.S. = 0.38) and the number of steps/day ($p = 0.008$; E.S. = 0.49) increased. These changes were accompanied by expanded mobility patterns into their neighborhood ($p = 0.002$; E.S. = 0.52) and outside of town ($p = 0.03$, E.S. = 0.36). Actigraphy measures showed no change in sleep parameters despite reported improvements in sleep efficiency ($p = 0.006$; E.S. = 0.45), quality ($p = 0.04$, E.S. = 0.35), and disturbances ($p = 0.001$; E.S. = 0.55). Decreased PTSD ($p \leq 0.001$; E.S. = 0.60) and depressive ($p \leq 0.001$; E.S. = 0.60) symptoms were reported. Acquiring a SDPTSD represents a promising rehabilitation intervention for veterans with PTSD that improves moderate physical activity and the number of steps/day while reportedly triggering positive changes on mobility patterns, sleep quality, and psychiatric symptoms. The present exploratory trial provides the rationale for studying larger groups of participants in controlled studies over longer periods of time.

<https://www.sciencedirect.com/science/article/abs/pii/S0005789419301376>

Predictors of Dropout in Cognitive Processing Therapy for PTSD: An Examination of Trauma Narrative Content.

Elizabeth Alpert, Adele M. Hayes, J. Ben Barnes, Denise M. Sloan

Behavior Therapy

Volume 51, Issue 5, September 2020, Pages 774-788

<https://doi.org/10.1016/j.beth.2019.11.003>

Highlights

- Dropout rates in gold-standard PTSD treatments are high.

- We examined dropout predictors in trauma narratives from cognitive processing therapy.
- More negative emotion and ruminative processing predicted lower dropout.
- Physiological trauma responses and overgeneralization predicted higher dropout.
- Narratives can provide useful information for clinicians to maximize engagement.

Abstract

Dropout rates in trauma-focused treatments for adult posttraumatic stress disorder (PTSD) are high. Most research has focused on demographic and pretreatment predictors of dropout, but findings have been inconsistent. We examined predictors of dropout in cognitive processing therapy (CPT) by coding the content of trauma narratives written in early sessions of CPT. Data are from a randomized controlled noninferiority trial of CPT and written exposure therapy (WET) in which CPT showed significantly higher dropout rates than WET (39.7% CPT vs. 6.4% WET). Participants were 51 adults with a primary diagnosis of PTSD who were receiving CPT and completed at least one of three narratives in the early sessions of CPT. Sixteen (31%) in this subsample were classified as dropouts and 35 as completers. An additional 9 participants dropped out but could not be included because they did not complete any narratives. Of the 11 participants who provided a reason for dropout, 82% reported that CPT was too distressing. The CHANGE coding system was used to code narratives for pathological trauma responses (cognitions, emotions, physiological responses) and maladaptive modes of processing (avoidance, ruminative processing, overgeneralization), each on a scale from 0 (absent) to 3 (high). Binary logistic regressions showed that, averaging across all available narratives, more negative emotions described during or around the time of the trauma predicted less dropout. More ruminative processing in the present time frame predicted lower rates of dropout, whereas more overgeneralized beliefs predicted higher rates. In the first impact statement alone, more negative emotions in the present time frame predicted lower dropout rates, but when emotional reactions had a physiological impact, dropout was higher. These findings suggest clinicians might attend to clients' written trauma narratives in CPT in order to identify indicators of dropout risk and to help increase engagement.

<https://www.tandfonline.com/doi/abs/10.1080/21635781.2020.1803162>

Distress, Grief, and Functionality following Military Unit Suicide Exposure.

Kyna Pak , Su Yeon Lee-Tauler , Kelly E. Ferreira , Kanchana Perera & Marjan Ghahramanlou-Holloway

Military Behavioral Health

Published online: 11 Aug 2020

<https://doi.org/10.1080/21635781.2020.1803162>

Given the high prevalence of suicide within the military context, there is a need to understand the impact of suicide within the military unit and assess factors that mitigate unfavorable outcomes. The aim of this study was to describe characteristics of military service members exposed to unit suicide and to examine demographic and psychosocial factors associated with military suicide exposure. Demographic, psychosocial, and exposure data were collected from 1,555 service members and veterans using an online survey. Additional data on exposure to trauma, closeness to the decedent, and unit social support were collected and analyzed as potential factors influencing grief, psychological distress, and functioning in those exposed to suicide. Service members and veterans who lost more than three unit members to suicide experienced significantly greater psychological distress than participants who lost one unit member to suicide. Lifetime trauma exposure was significantly related to greater distress and functional impairment. Perceived closeness was significantly related to greater grief, while increased unit social support was significantly related to less functional impairment. These findings suggest that suicide postvention efforts should focus on unit members most at risk for negative psychological and functional outcomes.

<https://www.jmir.org/2020/8/e15506/>

Mobile App for Mental Health Monitoring and Clinical Outreach in Veterans: Mixed Methods Feasibility and Acceptability Study.

Betthausen LM, Stearns-Yoder KA, McGarity S, Smith V, Place S, Brenner LA

Journal of Medical Internet Research

Vol 22, No 8 (2020): August

<https://www.doi.org/10.2196/15506>

Background:

Advances in mobile health (mHealth) technology have made it possible for patients and health care providers to monitor and track behavioral health symptoms in real time.

Ideally, mHealth apps include both passive and interactive monitoring and demonstrate high levels of patient engagement. Digital phenotyping, the measurement of individual technology usage, provides insight into individual behaviors associated with mental health.

Objective:

Researchers at a Veterans Affairs Medical Center and Cogito Corporation sought to explore the feasibility and acceptability of an mHealth app, the Cogito Companion.

Methods:

A mixed methodological approach was used to investigate the feasibility and acceptability of the app. Veterans completed clinical interviews and self-report measures, at baseline and at a 3-month follow-up. During the data collection period, participants were provided access to the Cogito Companion smartphone app. The mobile app gathered passive and active behavioral health indicators. Data collected (eg, vocal features and digital phenotyping of everyday social signals) are analyzed in real time. Passive data collected include location via global positioning system (GPS), phone calls, and SMS text message metadata. Four primary model scores were identified as being predictive of the presence or absence of depression or posttraumatic stress disorder (PTSD). Veterans Affairs clinicians monitored a provider dashboard and conducted clinical outreach when indicated.

Results:

Findings suggest that use of the Cogito Companion app was feasible and acceptable. Veterans (n=83) were interested in and used the app; however, active use declined over time. Nonetheless, data were passively collected, and outreach occurred throughout the study period. On the Client Satisfaction Questionnaire–8, 79% (53/67) of the sample reported scores demonstrating acceptability of the app (mean 26.2, SD 4.3). Many veterans reported liking specific app features (day-to-day monitoring) and the sense of connection they felt with the study clinicians who conducted outreach. Only a small percentage (4/67, 6%) reported concerns regarding personal privacy.

Conclusions:

Feasibility and acceptability of the Cogito Corporation platform to monitor mental health symptoms, behaviors, and facilitate follow-up in a sample of veterans were supported. Clinically, platforms such as the Cogito Companion system may serve as useful methods to promote monitoring, thereby facilitating early identification of risk and mitigating negative psychiatric outcomes, such as suicide.

https://pubs.asha.org/doi/abs/10.1044/2020_PERSP-20-00011

Updating and Refining Prevalence Rates of Traumatic Brain Injury–Related Communication Disorders Among Post-9/11 Veterans: A Chronic Effects of Neurotrauma Consortium Study.

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Perspectives of the ASHA Special Interest Groups

11 Aug 2020

https://doi.org/10.1044/2020_PERSP-20-00011

Purpose

To describe the prevalence of communication disorders in a cohort of 84,377 deployed post-9/11 veterans stratified by blast traumatic brain injury (TBI) exposure. Secondary aim was to evaluate the association between postconcussion symptoms, such as posttraumatic stress disorder, depression, anxiety, insomnia, pain, headache, substance use disorder, and auditory problems, among veterans with and without a communication disorder diagnosis.

Method

This is a retrospective study of the prevalence of aphasia, apraxia of speech and dysarthria, cognitive-communication disorder, fluency, and voice disorders among veterans, stratified by TBI severity and blast status. Data were obtained from the national Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn roster file provided by the Department of Veterans Affairs Office of Public Health and the Veterans Affairs' TBI screening and subsequent comprehensive TBI evaluation.

Results

Cognitive-communication disorder was the most prevalent diagnosis, comprising 57.1% of all communication disorder diagnoses, followed by voice disorder (19%) and aphasia (16%). Increased age was significantly associated with higher rates of aphasia, apraxia of speech/dysarthria, and voice disorder.

Conclusions

The current study shows that, while the overall total number of communication disorder diagnoses was higher in the blast groups than in the nonblast groups, TBI severity was a more significant risk factor for a diagnosis, with veterans in the more severe groups at

a higher risk of being diagnosed with a communication disorder when compared to those with mild TBI and no blast exposure. In order to better inform rehabilitation and clinical management of communication conditions, it is critical to examine the influence of blast and postconcussive symptoms in post-9/11 veterans.

<https://academic.oup.com/alcalc/advance-article/doi/10.1093/alcalc/agaa075/5882174>

Early Adolescent Binge Drinking Increases Risk of Psychopathology in Post-9/11 Veterans and Mild Traumatic Brain Injury Exacerbates Symptom Severity.

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Alcohol and Alcoholism

Published: 10 August 2020

<https://doi.org/10.1093/alcalc/agaa075>

Aims

To demonstrate that early adolescent binge drinking (BD) increases the risk for and/or severity of psychopathology in post-9/11 Veterans and determine if mild traumatic brain injury (mTBI) modifies risk.

Methods

Post-9/11 Veterans (n = 375) were classified into two groups: 57 Veterans with a history of early adolescent BD (E-BD; age of onset <15) and 318 who did not BD until age 15 or older (late-BD or L-BD; age of onset ≥15). History of military mTBI and mental health disorders were also assessed following military service.

Results

Logistic regression and analysis of variance (ANOVA) analyses revealed that the E-BD's had significantly higher prevalence of alcohol use disorders (AUDs) and more severe symptoms of AUD, substance use disorder (SUD), depression and stress. Two-way ANOVAs showed that history of military mTBI was differentially associated with posttraumatic stress disorder (PTSD) incidence and severity among Veterans who had engaged in early adolescent BD. Specifically, Veterans with a history of both early adolescent BD and military mTBI were at greater risk for a PTSD diagnosis and had more severe symptoms of PTSD than those with only a history of adolescent BD. The

greater PTSD symptom severity in the comorbid group was driven by hyperarousal symptoms.

Conclusions

A history of BD during early adolescence is prevalent among Veterans and is related to higher risk for AUD and more severe AUD, SUD, mood and stress symptoms later in life. Veterans with early BD and military mTBI showed greater incidence and severity of PTSD, indicating that mTBI, a common comorbidity among post-9/11 Veterans, exacerbates risk.

<https://focus.psychiatryonline.org/doi/abs/10.1176/appi.focus.20200009>

Toward Optimizing Mental Health Care for Sexual and Gender Minority Veterans.

William Byne, M.D., Ph.D., and Joseph Wise, M.D.

Focus

Published Online: 11 Aug 2020

<https://doi.org/10.1176/appi.focus.20200009>

Studies examining physicians' knowledge, attitudes, and perceptions of their clinical competence have revealed that many are, or perceive themselves to be, poorly prepared to address the needs of sexual and gender minority (SGM) patients as well as military veterans. In this article, the authors examine these findings as they pertain to mental health care and identify the areas of cultural and clinical competence necessary for psychiatrists and other mental health professionals to provide high-quality care for SGM veterans.

<https://jamanetwork.com/journals/jamapediatrics/article-abstract/2769286>

The Need for Clinicians to Recognize Military-Connected Children. (Viewpoint)

Gewirtz AH, Cozza SJ, Kizer KW

JAMA Pediatrics

Published online August 10, 2020

<https://www.doi.org/10.1001/jamapediatrics.2020.2548>

The United States has been continuously at war for nearly 2 decades, during which time some 2.7 million Americans have answered the call to arms. Such prolonged conflict is unprecedented in US history. Also unprecedented is the number of service members of the National Guard and military Reserve forces who have left their families to deploy to the battlefields of southwest Asia. As a result of these circumstances, more than 2 million military-connected children have experienced the deployment of one or both parents, with some of these children subsequently facing the challenges of their parents returning with service-connected injuries or illnesses or not returning at all. But how many among the 99% of Americans who have not served in the military understand the challenges faced by these children? How effectively are health care professionals responding to their needs? Are these military-connected children even recognized by clinicians?

<https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2769486>

Efficacy of Yoga vs Cognitive Behavioral Therapy vs Stress Education for the Treatment of Generalized Anxiety Disorder: A Randomized Clinical Trial.

Simon NM, Hofmann SG, Rosenfield D, et al.

JAMA Psychiatry

Published online August 12, 2020

<https://www.doi.org/10.1001/jamapsychiatry.2020.2496>

Key Points

Questions

Are yoga and cognitive behavioral therapy (CBT) each more efficacious than a psychological control condition, and is yoga noninferior to CBT for the treatment of generalized anxiety disorder?

Findings

In this randomized clinical trial of 226 adults with generalized anxiety disorder, 12-week group treatment with either Kundalini yoga or CBT was more effective than the stress

education control condition, but the noninferiority test did not find Kundalini yoga to be as effective as CBT.

Meaning

Kundalini yoga can reduce anxiety for adults with generalized anxiety disorder, but study results support CBT remaining first-line treatment.

Abstract

Importance

Generalized anxiety disorder (GAD) is common, impairing, and undertreated. Although many patients with GAD seek complementary and alternative interventions, including yoga, data supporting yoga's efficacy or how it compares to first-line treatments are lacking.

Objectives

To assess whether yoga (Kundalini yoga) and cognitive behavioral therapy (CBT) for GAD are each more effective than a control condition (stress education) and whether yoga is noninferior to CBT for the treatment of GAD.

Design, Setting, and Participants

For this randomized, 3-arm, controlled, single-blind (masked independent raters) clinical trial, participants were recruited from 2 specialty academic centers starting December 1, 2013, with assessment ending October 25, 2019. Primary analyses, completed by February 12, 2020, included superiority testing of Kundalini yoga and CBT vs stress education and noninferiority testing of Kundalini yoga vs CBT.

Interventions

Participants were randomized to Kundalini yoga (n = 93), CBT for GAD (n = 90), or stress education (n = 43), which were each delivered to groups of 4 to 6 participants by 2 instructors during twelve 120-minute sessions with 20 minutes of daily homework.

Main Outcomes and Measures

The primary intention-to-treat outcome was acute GAD response (Clinical Global Impression–Improvement Scale score of much or very much improved) after 12 weeks as assessed by trained independent raters.

Results

Of 538 participants who provided consent and were evaluated, 226 (mean [SD] age, 33.4 [13.5] years; 158 [69.9%] female) with a primary diagnosis of GAD were included in the trial. A total of 155 participants (68.6%) completed the posttreatment assessment.

Completion rates did not differ (Kundalini yoga, 60 [64.5%]; CBT, 67 [74.4%]; and stress education, 28 [65.1%]; $\chi^2 = 2.39$, $df = 2$, $P = .30$). Response rates were higher in the Kundalini yoga group (54.2%) than in the stress education group (33.%) (odds ratio [OR], 2.46 [95% CI, 1.12-5.42]; $P = .03$; number needed to treat, 4.59 [95% CI, 2.52-46.19]) and in the CBT group (70.8%) compared with the stress education group (33.0%) (OR, 5.00 [95% CI, 2.12-11.82]; $P < .001$; number needed to treat, 2.62 [95% CI, 1.91-5.68]). However, the noninferiority test did not find Kundalini yoga to be as effective as CBT (difference, 16.6%; $P = .42$ for noninferiority).

Conclusions and Relevance

In this trial, Kundalini yoga was efficacious for GAD, but the results support CBT remaining first-line treatment.

<https://www.tandfonline.com/doi/abs/10.1080/21635781.2020.1803163>

“Postconcussive” Symptoms Explained by PTSD Symptom Severity in U.S. National Guard Personnel.

Erika M. Roberge, Shelby Baker, Dillon Ely, AnnaBelle O. Bryan, Craig J. Bryan & David C. Rozek

Military Behavioral Health

Published online: 13 Aug 2020

<https://doi.org/10.1080/21635781.2020.1803163>

The aim of the present study was to evaluate the unique associations between self-report history of mild traumatic brain injury (mTBI) and posttraumatic stress disorder (PTSD) symptoms on functional outcomes years after head injury. National Guard personnel ($n = 608$) from the mountain west who denied history of head injury ($n = 342$, 56.3%) and with history of mTBI ($n = 266$, 43.7%) were included in the present analyses. Participants completed self-report study measures of emotional (i.e., depression, PTSD symptoms), social (i.e., relationship satisfaction and perceived social support), and other general (i.e., concentration difficulties and sleep disturbance) functioning through an online survey. PTSD symptoms explained unique variance in emotional, social, and general functioning above and beyond history of mTBI. After controlling for PTSD symptoms, mTBI was not associated with current depression symptoms, relationship satisfaction, social support, concentration, or sleep difficulties. Self-report of PTSD symptoms account for emotional, social, and general functioning

impairments often attributed to mTBI and labeled postconcussive syndrome. Symptoms often described as postconcussive syndrome in patients with mild traumatic brain injury may be better explained from a psychological standpoint. Patients with history of mTBI and persistent complaints should be screened for mental health conditions. If mental health concerns are present, treatment of that disorder may be indicated.

<https://militaryhealth.bmj.com/content/early/2020/07/20/bmjilitary-2020-001518.abstract>

Illicit drug use and self-reported vision loss among military service members or veterans.

McDaniel JT, Jenkins WD, Albright DL, et al

BMJ Military Health

Published Online First: 13 August 2020

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Introduction

Little is known about differences in vision loss prevalence among service members or veterans (SMVs) and civilians; further, no study has compared vision loss risk factors in these two populations. As such, we seek to fill this gap in the literature.

Methods

In this cross sectional study, we obtained data on 106 SMVs and 1572 civilians from the 2013–2018 National Health and Nutrition Examination Surveys. We compared the prevalence of or mean values of vision loss risk factors between SMVs and civilians using the Wald χ^2 statistic or Kruskal-Wallis test. Further, we examined the relative strength of 17 vision loss risk factors in predicting self-reported vision loss via Firth's logistic regression.

Results

SMVs had a significantly higher prevalence of illicit drug use (20.75% vs 13.62%) and HIV (1.89% vs 0.41%), while civilians had a higher prevalence of poor dietary habits (7.61% vs 13.21%). SMVs also had higher mean values of systolic blood pressure (125.85 vs 122.53 mmHg), pack years of cigarette smoking (8.29 vs 4.25), and sedentary minutes per day (379.15 vs 337.07 min). More SMVs (8.49%) self-reported

vision loss than civilians (4.48%). After adjustment for covariates, illicit drug use (adjusted β coefficient=0.72, $p=0.02$) was associated with self-reported vision loss.

Conclusions

This study indicates that self-reported vision loss among SMVs is more prevalent than among civilians, and vision loss in SMVs is associated with severe or prolonged illicit drug use.

<https://econtent.hogrefe.com/doi/abs/10.1027/0227-5910/a000703?journalCode=crit>

Evaluating a Recovery-Oriented Intensive Outpatient Program for Veterans at Risk for Suicide.

Jared F. Roush, Karen M. O'Brien, and Allyson L. Ruha

Crisis

Published online: August 12, 2020

<https://doi.org/10.1027/0227-5910/a000703>

Background:

Suicide is the 10th leading cause of death in the United States and suicide risk is elevated among military veterans. Risk for suicide is inherently transdiagnostic, complex, and multifaceted, which means a comprehensive psychotherapeutic approach to risk mitigation is required.

Aims:

Our aims were to summarize findings from an evaluation of an interdisciplinary, recovery-oriented intensive outpatient program (IR-IOP) that includes evidence-based suicide prevention strategies for veterans with varying psychiatric diagnoses who are at risk for suicide.

Method:

Veterans completed the Patient Health Questionnaire-9 and the Beck Scale for Suicide Ideation prior to and following their participation in the IR-IOP. Results: A significant decrease in the severity of suicide ideation was found between pre- and posttreatment. Limitations: This program evaluation utilized archival data and, as such, there was not a control group and posttreatment follow-up data were not collected.

Conclusion:

Preliminary findings suggest an IR-IOP for veterans with heterogeneous psychiatric diagnoses utilizing a multifaceted psychotherapeutic approach to suicide prevention may be effective in reducing suicide ideation.

<https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.202000109>

Balancing Scientific Evidence, Clinical Expertise, and Patient Preferences: VHA's Suicide Risk Identification Strategy. (Commentary)

Bridget B. Matarazzo, Psy.D., Lisa A. Brenner, Ph.D., A.B.P.P.-R.P., Hal S. Wortzel, M.D., Nazanin H. Bahraini, Ph.D.

Psychiatric Services

Published Online: 12 Aug 2020

<https://doi.org/10.1176/appi.ps.202000109>

As part of a comprehensive effort to prevent veteran suicide, the Veterans Health Administration (VHA) recently implemented Risk ID, a standardized national suicide risk screening and evaluation initiative (1). Fully implemented, this process ensures that nearly every veteran receiving care in the VHA, including those who do not present with a diagnosed mental or behavioral health condition, will be screened and/or evaluated for suicide risk. Veterans with a positive initial screen, determined by response to item nine on the Patient Health Questionnaire-9, complete a second level of screening with the Columbia Suicide Severity Rating Scale (C-SSRS) Screener. The second-level screening comprises between three and eight questions, depending on the veteran's responses. A positive secondary screen triggers the Comprehensive Suicide Risk Evaluation (CSRE). Using the Risk ID process, clinicians and patients can work together to facilitate identification of suicide risk and individualized treatment needs. Veterans at elevated risk may receive additional services, such as suicide prevention team support and evidence-based treatments aimed at addressing drivers of suicide and associated mental health conditions (e.g., depression). During the first year of implementation (October 2018–September 2019), over four million veterans in the VHA were screened in ambulatory care settings, and over 1.9 million screens occurred in the emergency department.

<https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.202000190>

Critical Foundations for Implementing the VA's Public Health Approach to Suicide Prevention. (Commentary)

Lisa K. Kearney, Ph.D., A.B.P.P., Clifford A. Smith, Ph.D., A.B.P.P., Matthew A. Miller, Ph.D., M.P.H.

Psychiatric Services

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<https://doi.org/10.1176/appi.ps.202000190>

Suicide is a national public health concern, with over 45,000 Americans and 6,139 veterans dying by suicide in 2017, according to the 2019 National Veteran Suicide Prevention Annual Report. Providers, community members, and loved ones are vital partners in bringing to fruition the U.S. Department of Veterans Affairs' (VA) National Strategy for Preventing Veteran Suicide by implementing a public health approach combining community-based prevention and clinical intervention strategies. All health care systems are called to implement the Quadruple Aim, focused on provision of care that is cost efficient, produces high-quality outcomes, enhances patient satisfaction, and improves clinical provider experience. In alignment with the Quadruple Aim, Warren and Smithkors's (1) recent critique of suicide prevention in the VA includes critical concerns about clinician burnout, therapeutic alliance, staffing, and open-access. Appropriately implemented staffing and open-access processes are indeed needed to fully implement evidence-based practices, the VA's National Strategy, and the Quadruple Aim. Below, we highlight the important role of fidelity in implementing staffing and access models to ensure the highest-quality suicide prevention programs.

<https://pubmed.ncbi.nlm.nih.gov/32005353/>

Posttraumatic Stress Disorder, Traumatic Brain Injury, Sleep, and Performance in Military Personnel.

Moore BA, Brock MS, Brager A, Collen J, LoPresti M, Mysliwiec V.

Sleep Medicine Clinics

2020 Mar; 15(1): 87-100

<https://doi.org/10.1016/j.jsmc.2019.11.004>

Sleep disturbances, posttraumatic stress disorder, and traumatic brain injury are highly prevalent in military personnel and veterans. These disorders can negatively impact military performance. Although literature evaluating how posttraumatic stress disorder and traumatic brain injury directly impact military performance is limited, there is evidence supporting that these disorders negatively impact cognitive and social functioning. What is not clear is if impaired performance results from these entities individually, or a combination of each. Further research using standardized evaluations for the clinical disorders and metrics of military performance is required to assess the overall performance decrements related to these disorders.

Links of Interest

Veterans benefits 2020: Largest or most successful state employer of Veterans

<https://www.blogs.va.gov/VAntage/76442/veterans-benefits-2020-largest-successful-state-employer-veterans/>

Veteran guides others with PTSD to avoid suicidal thoughts

<https://www.blogs.va.gov/VAntage/77740/veteran-guides-others-ptsd-avoid-suicidal-thoughts/>

Congress Wants the Pentagon to Expand Coverage for Troops' Eating Disorder Treatments

<https://www.military.com/daily-news/2020/08/12/congress-wants-pentagon-expand-coverage-troops-eating-disorder-treatments.html>

COVID-19 Mental, Economic Stresses Worse for US Public than for Those in Other Wealthy Countries

<https://jamanetwork.com/channels/health-forum/fullarticle/2769483>

ED visits for mental health, substance use doubled in 1 decade

<https://www.mdedge.com/psychiatry/article/226699/addiction-medicine/ed-visits-mental-health-substance-use-doubled-1-decade>

Offering Support and Compassion for a COVID-19 Positive Colleague

<https://www.pdhealth.mil/news/blog/offering-support-and-compassion-covid-19-positive-colleague>

Resource of the Week -- [Military Pay: Key Questions and Answers](#)

Recently updated Congressional Research Service report:

From the earliest days of the republic, the federal government has compensated members of the Armed Forces for their services. While the original pay structure was fairly simple, over time a more complex system of compensation has evolved. The current military compensation system includes cash payments such as basic pay, special and incentive pays, and various allowances. Servicemembers also receive noncash benefits such as health care and access to commissaries and recreational facilities, and may qualify for deferred compensation in the form of retired pay and other retirement benefits. This report provides an overview of military compensation generally, but focuses on cash compensation for current servicemembers.

Table 2. Average Regular Military Compensation for Selected Paygrades
(2020 Data; assumes BAH and BAS instead of government quarters and meals)

Pay Grade	Rank	Average Annual Basic Pay	Average Annual Housing Allowance	Average Annual Subsistence Allowance	Estimated Average Annual Federal Tax Advantage	Average Annual RMC
E-1	Private (Army and Marine Corps) Seaman Recruit (Navy) Airman Basic (Air Force)	\$19,910	\$15,249	\$4,473	\$2,719	\$42,350
E-5	Sergeant (Army and Marine Corps) Petty Officer Second Class (Navy) Staff Sergeant (Air Force)	\$37,157	\$21,111	\$4,473	\$5,108	\$67,848
E-8	Master Sergeant or First Sergeant (Army and Marine Corps) Senior Chief Petty Officer (Navy) Senior Master Sergeant or First Sergeant (Air Force)	\$66,273	\$25,912	\$4,473	\$4,501	\$101,159
O-1	Second Lieutenant (Army, Air Force and Marine Corps) Ensign (Navy)	\$40,711	\$19,238	\$3,080	\$4,526	\$67,555
O-4	Major (Army, Air Force and Marine Corps) Lieutenant Commander (Navy)	\$94,918	\$29,903	\$3,080	\$8,339	\$136,240
O-6	Colonel (Army, Air Force and Marine Corps) Captain (Navy)	\$139,441	\$34,107	\$3,080	\$10,617	\$187,244

Source: Department of Defense, Selected Military Compensation Tables, January 1, 2020, B3, <https://militarypay.defense.gov/Portals/3/Documents/Reports/GreenBook%202020.pdf?ver=2020-05-06-170512-543>. For the E-1 data above, CRS used the "ALL E-1" row of the referenced table; for the O-1 data, CRS used the "O-1" row, which excludes the higher rates for those in paygrade O-1 who formerly served as enlisted personnel. The tax advantage is computed "using the standard deduction and 2018 tax rates, including the earned income tax credit." Actual annual tax advantage of servicemembers will vary based on their unique tax situation. Rows may not sum perfectly in the Annual RMC column due to rounding.

Notes: BAH = Basic Allowance for Housing; BAS = Basic Allowance for Subsistence; RMC = Regular Military Compensation.

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