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Uniformed Services University

Research Update -- April 17, 2025

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- Links of Interest
- Resource of the Week: Military Suicide Prevention and Response (Congressional Research Service

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Anger in social anxiety disorder.

Roni Oren-Yagoda, Gal Werber & Idan M. Aderka

Cognitive Behaviour Therapy
Volume 54, 2025 - Issue 3

The present study focused on the emotional experience of anger among individuals with and without social anxiety disorder (SAD). Eighty-eight participants took part in the study, half (n = 44) met diagnostic criteria for SAD and half (n = 44) did not meet criteria for SAD. Participants completed a 21-day experience sampling measurement (ESM) in which they reported on daily social interactions and emotions. Using multilevel linear modeling we found that individuals with SAD experienced more anger compared to individuals without SAD. We also found a Diagnosis × Social Context interaction such that interactions with distant others were associated with elevated anger compared to interactions with close others for individuals with SAD but not for individuals without SAD. Finally, we found that for individuals with SAD (but not those without SAD) anger on a given day (day t) was associated with elevated anxiety on the following day (day t + 1), above and beyond previous anxiety, sadness and guilt (i.e. anxiety, sadness and guilt reported on day t). This suggests that anger may play a unique role in maintaining

or exacerbating anxiety among individuals with SAD. Additional implications of our findings for models of psychopathology and for treatment of SAD are discussed.

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Transitioning into trauma-focused evidence-based psychotherapy for posttraumatic stress disorder from other treatments: a qualitative investigation.

Holder, N., Ranney, R. M., Delgado, A. K., Purcell, N., Iwamasa, G. Y., Batten, A., … Maguen, S.

Cognitive Behaviour Therapy
Volume 54, 2025 - Issue 3

Although trauma-focused evidence-based psychotherapy (TF-EBP) is recommended for posttraumatic stress disorder (PTSD), rates of TF-EBP initiation among veterans is very low. Service delivery research has shown that other treatments are commonly provided to veterans diagnosed with PTSD, including stabilization treatments. As little is known about how veterans experience the transition to TF-EBP, we conducted a qualitative examination of veterans' perspectives on transitions in PTSD treatment. We recruited a diverse sample of veterans (n = 30) who recently initiated TF-EBP to complete semi-structured qualitative interviews focusing on six domains (PTSD treatment options, cultural sensitivity of treatment, PTSD treatment selection, transition criteria, beliefs about stabilization treatment, treatment needs/preferences). Rapid qualitative analysis procedures were used to identify themes. Themes included: (1) wanting to learn about TF-EBP earlier; (2) perceived risks of transition; (3) relationships with non-TF-EBP providers as transition barriers; (4) high symptoms and poor interpersonal functioning as transition facilitators; (5) benefits of treatment planning and handoffs; (6) prior therapy best when aligned with TF-EBP; (7) socialization as a key benefit of prior therapy; and (8) medications supporting TF-EBP. Results highlight the importance of introducing TF-EBP early to veterans, establishing and communicating a comprehensive care plan, and anchoring stabilization treatment in TF-EBP concepts.

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Effectiveness of written exposure therapy for Korean patients with post-traumatic stress disorder: non-randomized treatment-as-usual waitlist-controlled study.

Yun, J. A., Lee, C. H., Jeong, S. H., Yu, J. C., & Choi, K. S.

Cognitive Behaviour Therapy
Volume 54, 2025 - Issue 3

Written exposure therapy (WET) is a five-session exposure-based protocol for treating post-traumatic stress disorder (PTSD). The brevity and tolerability of WET present the potential to overcome barriers in implementing evidence-based therapy for PTSD within the Korean mental healthcare system. This study investigated the effectiveness of WET in Korean patients with PTSD through a waitlist-controlled trial (KCT0008112). A total of 57 patients with PTSD were allocated non-randomly to either WET (n = 27) or treatment-as-usual waitlist groups (n = 30). Both groups were followed up until the twenty-fourth week after the initial session. Primary outcomes assessed included PTSD symptoms, depressive symptoms, and general function. In the WET group, significant improvements were observed in PTSD symptoms, depressive symptoms, and general function compared to the control group. After the waiting period, the waitlist group also participated in WET, and exhibited significant improvement in all scores. The between- and within-group effect sizes were large. The dropout rate in both groups was 10.9%, and the mean satisfaction ratings were 28.24 ± 3.33 (range 22–32; scale range 8–32). The present study provides evidence of WET successfully reducing PTSD and depressive symptoms and improving general function among Korean patients with PTSD. Moreover, WET was well tolerated and received by Korean patients with PTSD.

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Reasons for E-cigarette Use and Their Associations with Frequency, Dependence, and Quit Intentions: Findings from a Youth and Young Adult Sample.

Elizabeth K. Do, Kristiann Koris, Tyler Minter, Suad Esayed, Elizabeth C. Hair

American Journal of Preventive Medicine
Available online 3 April 2025

Introduction
The purpose of this study is to examine associations between reasons for e-cigarette use and e-cigarette use frequency, dependence, and quit intentions.

Methods
Data were obtained from the Truth Longitudinal Cohort (TLC), a national probability-based online survey of United States youth and young adults (aged 15-24 years, collected from October 2022 to December 2023). The analytic sample (N=815) included participants who reported current e-cigarette use and their most important reason for e-cigarette use (selected from a list of responses, regrouped into categories), use frequency (number of days used in the past 30 days), dependence (E-cigarette Dependence Scale), and quit intentions (any vs. none). Linear and logistic regression models were applied to aggregated cross-sectional data, adjusted for age, gender identity, race and ethnicity, perceived financial situation, past 30-day use of other combustible tobacco products, and e-cigarette device type.

Results
The most endorsed reason for using e-cigarettes was coping with mental health challenges (39.6%), followed by sensation seeking (20.4%), lower perceived harms (14.7%), social status/acceptability (10.9%), ease of use/access (10.1%), and peer/family influence (4.3%). All reasons for e-cigarette use were associated with e-cigarette use frequency and dependence. Using e-cigarettes as a means of coping with mental health challenges and social status/acceptability were also associated with greater odds of expressing any quit intentions.

Conclusions
Reasons for e-cigarette use were differentially associated with e-cigarette use behavior outcomes. Findings suggest a need to address mental health challenges and reduce access and appeal of e-cigarettes among young people to facilitate reductions in e-cigarette use.

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Effective Components of Collaborative Care for Depression in Primary Care: An Individual Participant Data Meta-Analysis.

Schillok, H., Gensichen, J., Panagioti, M., Gunn, J., Junker, L., Lukaschek, K., Jung-Sievers, C., Sterner, P., Kaupe, L., Dreischulte, T., Ali, M. K., Aragonès, E., Bekelman, D. B., Herbeck Belnap, B., Carney, R. M., Chwastiak, L. A., Coventry, P. A., Davidson, K. W., Ekstrand, M. L., Flehr, A., … POKAL Group

JAMA Psychiatry
March 26, 2025

Importance:
Collaborative care is a multicomponent intervention for patients with chronic disease in primary care. Previous meta-analyses have proven the effectiveness of collaborative care for depression; however, individual participant data (IPD) are needed to identify which components of the intervention are the principal drivers of this effect.

Objective:
To assess which components of collaborative care are the biggest drivers of its effectiveness in reducing symptoms of depression in primary care.

Data sources:
Data were obtained from MEDLINE, Embase, Cochrane Library, PubMed, and PsycInfo as well as references of relevant systematic reviews. Searches were conducted in December 2023, and eligible data were collected until March 14, 2024.

Study selection:
Two reviewers assessed for eligibility. Randomized clinical trials comparing the effect of collaborative care and usual care among adult patients with depression in primary care were included.

Data extraction and synthesis:
The study was conducted according to the IPD guidance of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses reporting guideline. IPD were collected for demographic characteristics and depression outcomes measured at baseline and follow-ups from the authors of all eligible trials. Using IPD, linear mixed models with random nested effects were calculated.

Main outcomes and measures:
Continuous measure of depression severity was assessed via validated self-report instruments at 4 to 6 months and was standardized using the instrument's cutoff value for mild depression.

Results:
A total of 35 datasets with 38 comparisons were analyzed (N = 20 046 participants [57.3% of all eligible, with minimal differences in baseline characteristics compared with nonretrieved data]; 13 709 [68.4%] female; mean [SD] age, 50.8 [16.5] years). A significant interaction effect with the largest effect size was found between the depression outcome and the collaborative care component therapeutic treatment strategy (-0.07; P < .001). This indicates that this component, including its key elements manual-based psychotherapy and family involvement, was the most effective component of the intervention. Significant interactions were found for all other components, but with smaller effect sizes.

Conclusions and relevance:
Components of collaborative care most associated with improved effectiveness in reducing depressive symptoms were identified. To optimize treatment effectiveness and resource allocation, a therapeutic treatment strategy, such as manual-based psychotherapy or family integration, may be prioritized when implementing a collaborative care intervention.

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The Growing Conservatism of White Veterans Since the 1970s.

MacLean, A., & Cassidy, S. P.

Armed Forces & Society
First published online March 31, 2025

In this article, we assess how the political attitudes of veterans compared to those of nonveterans have changed historically. We draw hypotheses from research and theory suggesting that veterans are relatively conservative due to either selection or socialization. We use General Social Survey data from 1974-1985 and 2010s, which include questions about service length, conservative identity, party affiliation, and beliefs about government spending. The analyses show differences across eras, with data from more recent years showing that veterans are generally more conservative than nonveterans. These differences may stem from selection—specifically, the transition from the draft era, when between a quarter and more than half of eligible men served, to a volunteer force, when only a much smaller share do so. The article also presents

evidence consistent with socialization: veterans who served for longer periods tend to be more conservative than both nonveterans and those who served for shorter periods.

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Clinician Suicide Risk Assessment for Prediction of Suicide Attempt in a Large Health Care System.

Bentley, K. H., Kennedy, C. J., Khadse, P. N., Brooks Stephens, J. R., Madsen, E. M., Flics, M. J., Lee, H., Smoller, J. W., & Burke, T. A.

JAMA Psychiatry
April 9, 2025

Key Points
Question
How accurate are clinician assessments for risk stratification of future suicide attempt?

Findings
In this electronic health record–based, prognostic study, clinicians' overall single-item risk estimates predicted 90- and 180-day suicide attempt at significantly above chance levels. Incorporating all suicide risk assessment items via machine learning significantly increased predictive accuracy.

Meaning
Clinicians stratify patients for suicide risk at significantly above chance levels; however, predictive accuracy is significantly enhanced by statistically incorporating information about recent suicidal thoughts and behaviors and other risk and protective factors routinely assessed during suicide risk assessment.

Abstract
Importance
Clinical practice guidelines recommend suicide risk screening and assessment across behavioral health settings. The predictive accuracy of real-world clinician assessments for stratifying patients by risk of future suicidal behavior, however, remains understudied.

Objective
To evaluate routine clinical suicide risk assessment for prospectively predicting suicide attempt.

Design, Setting, and Participants This electronic health record–based, prognostic study included 89 957 patients (≥5 years of age) with a structured suicide risk assessment (based on the Suicide Assessment Five-step Evaluation and Triage framework) that was documented by 2577 clinicians during outpatient, inpatient, and emergency department encounters at 12 hospitals in the Mass General Brigham health system between July 2019 and February 2023.

Main Outcomes and Measures
The primary outcome was an emergency department visit with a suicide attempt code recorded in the electronic health record within 90 days or 180 days of the index suicide risk assessment. The predictive performance of suicide risk assessments was evaluated on a temporal test set first using stratified prevalence (clinicians' overall risk estimates from a single suicide risk assessment item indicating minimal, low, moderate, or high risk) and then using machine learning models (incorporating all suicide risk assessment items).

Results
Of the 812 114 analyzed suicide risk assessments from the electronic health record, 58.81% were with female patients and 3.27% were with patients who were Asian, 5.26% were Black, 3.02% were Hispanic, 77.44% were White, and 11.00% were of Other or Unknown race. After suicide risk assessments were conducted during outpatient encounters, the suicide attempt rate was 0.12% within 90 days and 0.22% within 180 days; for inpatient encounters, the rate was 0.79% within 90 days and 1.29% within 180 days; and for emergency department encounters, the rate was 2.40% within 90 days and 3.70% within 180 days. Among patients evaluated during outpatient encounters, clinicians' overall single-item risk estimates had an area under the curve (AUC) value of 0.77 (95% CI, 0.72-0.81) for 90-day suicide attempt prediction; among patients evaluated during inpatient encounters, the AUC was 0.64 (95% CI, 0.59-0.69); and among patients evaluated during emergency department encounters, the AUC was 0.60 (95% CI, 0.55-0.64). Incorporating all clinician-documented suicide risk assessment items (87 predictors) via machine learning significantly increased the AUC for 90-day risk prediction to 0.87 (95% CI, 0.83-0.90) among patients evaluated during outpatient encounters, 0.79 (95% CI, 0.74-0.84) among patients evaluated during inpatient encounters, and 0.76 (95% CI, 0.72-0.80) among patients evaluated during emergency department encounters. Performance was similar for 180-day suicide risk prediction. The positive predictive values for the best-performing machine learning

models (with 95% specificity) ranged from 3.6 to 10.1 times the prevalence for suicide attempt.

Conclusions and Relevance
Clinicians stratify patients for suicide risk at levels significantly above chance. However, the predictive accuracy improves significantly by statistically incorporating information about recent suicidal thoughts and behaviors and other factors routinely assessed during clinical suicide risk assessment.

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https://doi.org/10.1001/jamanetworkopen.2025.4026

Psychological Therapy Outcomes and Engagement in People of Different Religions.

Shafan-Azhar, Z., Suh, J. W., Delamain, H., Arundell, L. L., Naqvi, S. A., Knight, T., Ellard, S., Pilling, S., Saunders, R., & Buckman, J. E. J.

JAMA Network Open
April 8, 2025

Key Points
Question
Are there inequalities in psychological therapy outcomes by self-identified religion, and if so, what are the contributing factors?

Findings
In this cohort study of 70 098 individuals in England, UK, Muslim patients were less likely to recover following psychological therapy than patients of all other religions or none after adjusting for sociodemographic, treatment-related, and clinical characteristics. Muslim patients of White or other ethnicities had worse outcomes than Asian, Black, and mixed race Muslim patients and patients of those ethnicities with other religious identities.

Meaning
These findings suggest cultural adaptations at the organizational, therapist, and therapy levels should be considered to reduce inequalities in psychological therapy outcomes, particularly for Muslim patients of White or other ethnic backgrounds.

Abstract

Importance

Identifying whether people of minoritized religious identities are less likely to benefit from psychological therapy is key to tackling inequalities in mental health treatment.

Objective

To assess inequalities in the effectiveness of routinely delivered psychological therapy across religious groups and by the intersections with ethnicity.

Design, Setting, and Participants

Retrospective cohort study including all patients who completed a course of treatment at 5 London-based National Health Service Talking Therapies for anxiety and depression (NHS TTad) services between 2011 and 2020. Individuals reported their religion using routine patient records collected by the services. Data were analyzed from September 2023 to October 2024.

Exposures

Self-identified religion was categorized into (1) no religion, (2) Christian, (3) Muslim, and (4) other (which was further categorized into Buddhist, Hindu, Jewish, Sikh, and any other in a sensitivity analysis). Ethnicity was conceptualized as a potential confounder and separately as an effect modifier. Self-reported ethnicity was categorized based on UK Census codes into Asian, Black, mixed race, White, and other ethnic groups.

Main Outcomes and Measures

Psychological treatment outcomes used to assess NHS TTad services nationally, including reliable recovery, recovery, and reliable deterioration. Dropout from treatment was also examined. These outcomes were defined based on pre-post treatment changes in depression and anxiety symptom measures according to national guidelines.

Results

A total of 70 098 patients with data on self-reported religion were included in the study (mean [SD] age at referral, 39.2 [14.1] years; 47 797 [68.2%] female). After adjusting for sociodemographic, treatment-related, and clinical characteristics, the odds of reliable recovery were higher in patients who did not have any religious belief (odds ratio [OR], 1.34; 95% CI, 1.26-1.42) or self-reported Christian (OR, 1.39; 95% CI, 1.31-1.48) and other religion (OR, 1.25; 95% CI, 1.17-1.34) compared with Muslim patients. While treatment outcomes improved each year in all groups, Muslim patients remained least likely to improve and more likely to deteriorate. There were interactions between religion and ethnicity; in particular, Muslim patients of White or other ethnic backgrounds had

worse outcomes than Muslim patients of Asian, Black, or mixed race ethnic backgrounds and compared with non-Muslim patients of those ethnicities.

Conclusions and Relevance
In England, patients who identified as Muslim, and particularly those of White or other ethnicities, had poorer outcomes from psychological therapies for depression and anxiety disorders than patients who reported no religion or any other religion. This may be partly due to unmeasured characteristics that warrant further investigation (eg, nationality and asylum-seeking or refugee status). Best practice guidelines on working with people of minoritized ethnicities may inform some of the changes needed to reduce inequalities, but must address religious identity separate from ethnicity, as well as their intersections.

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https://doi.org/10.1001/jamanetworkopen.2025.3721

Zero Suicide Model Implementation and Suicide Attempt Rates in Outpatient Mental Health Care.

Ahmedani, B. K., Penfold, R. B., Frank, C., Richards, J. E., Stewart, C., Boggs, J. M., Coleman, K. J., Sterling, S., Yarborough, B. J. H., Clarke, G., Schoenbaum, M., Aguirre-Miyamoto, E. M., Barton, L. J., Yeh, H. H., Westphal, J., McDonald, S., Beck, A., Beidas, R. S., Richardson, L., Ryan, J. M., … Simon, G. E.

JAMA Network Open
April 7, 2025

Key Points
Question
Is implementation of the Zero Suicide model in outpatient mental health care associated with reductions in suicide attempts?

Findings
This quality improvement study of 55 354 to 451 837 individuals per month aged 13 years or older found that implementation of the Zero Suicide model was associated with a reduction in suicide attempt rates in 3 of 4 health systems, while the fourth system experienced a lower sustained rate. Two systems that implemented the model before the observation period maintained low or declining rates.

Meaning
Findings from this study support implementation of the Zero Suicide model in outpatient mental health care.

Abstract
Importance
Suicide is a major public health concern, and as most individuals have contact with health care practitioners before suicide, health systems are essential for suicide prevention. The Zero Suicide (ZS) model is the recommended approach for suicide prevention in health systems, but more evidence is needed to support its widespread adoption.

Objective
To examine suicide attempt rates associated with implementation of the ZS model in outpatient mental health care within 6 US health systems.

Design, Setting, and Participants
This quality improvement study with an interrupted time series design used data collected from January 2012 through December 2019, from patients aged 13 years or older who received mental health care at outpatient mental health specialty settings within 6 US health systems located in 5 states: California, Oregon, Washington, Colorado, and Michigan. Analyses were conducted from January through December 2024.

Exposure
The ZS model was implemented in 4 health systems at different points during the observation period (2012-2019) and compared with health systems that implemented the model before the observation period (postimplementation). Implementation included suicide risk screening, assessment, brief intervention (safety plan, means safety protocol), and behavioral health treatment.

Main Outcomes and Measures
The primary outcome was a measure of standardized monthly suicide attempt rates captured using health system records and government mortality records. Suicide death rates were also measured as a secondary outcome.

Results
There was a median of 309 107 (range, 55 354-451 837) unique patients per month. In 2017, there were 317 939 eligible individuals (63.2% female). Baseline suicide attempt rates were at least 30 to 40 per 100 000 individuals at each implementation site and

decreased to less than 30 per 100 000 individuals at 3 sites by 2019. Decreases in suicide attempt rates were observed at 3 intervention health systems after site-specific implementation: health systems A and B had decreases of 0.7 per 100 000 individuals per month and C, 0.1 per 100 000 individuals per month. System D evidenced a similar suicide attempt rate after implementation (before implementation: median rate: 35.0 [range, 11.0-50.3] per 100 000 patients per month; after implementation: median rate: 34.3 [range, 18.5-42.0] per 100 000 patients per month). The 2 postimplementation health systems maintained low or declining suicide attempt rates throughout the observation period. The rate at system Y decreased by 0.3 per 100 000 individuals per month across the observation period. The rate at system Z began at 11 per 100 000 individuals per month and declined by 0.03 per 100 000 individuals per month during the observation period. Two systems evidenced reductions in the suicide death rate after implementation: system B declined by 0.2 per 100 000 individuals per month and system C by 0.1 per 100 000 individuals per month.

Conclusions and Relevance
In this quality improvement study, ZS model implementation was associated with a reduction in suicide attempt rates among patients accessing outpatient mental health care at most study sites, which supports widespread efforts to implement the ZS model in these settings within US health systems.

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https://doi.org/10.1080/08995605.2025.2486242

Exploring Moral Injury and Reintegration Challenges Among Post-9/11 U.S. Veterans: A Qualitative Study.

Danson, L., Spontak, K., Do, A. N., Taylor, N., Stapleton, M., & Rattray, N.

Military Psychology
Published online: 01 Apr 2025

Military Veterans face many barriers when reintegrating into civilian society. A growing body of evidence shows that Veterans may experience identity confusion, social isolation, and moral pain during Veteran reintegration. These issues might compound with exposure to traumatic events, leading to the development of moral injury (MI). This study utilizes an exploratory, qualitative approach to look at the relationship between MI and Veteran reintegration to better understand their impact on each other. Twelve Veterans who endorsed experiences of MI completed a cognitive interview utilizing two

existing measures of MI. MI and Veteran reintegration appeared to have a dynamic relationship that significantly impacted Veteran's experiences of moral emotions, their ability to trust others, disclose potentially morally injurious experiences, and make meaning of their service. Mental health practitioners may need to be especially attuned to and assess for MI in reintegrating Veterans, particularly as onset of MI may occur during reintegration as Veterans reflect on their military experiences and come to new moral conclusions. Clinicians and researchers must also foster a significant degree of trust to facilitate disclosure of potentially morally injurious experiences (PMIEs).

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https://www.health.mil/News/Articles/2025/03/01/MSMR-Suicide-Risk

Non-Medical Risk Factors Influencing Health and Association with Suicidal Ideation or Attempt, U.S. Active Component, 2018–2022.

Evan Finlay DO, MPH; Saixia Ying, PhD; Sithembile L. Mabila, PhD, MPH; Shauna L. Stahlman, PhD, MPH

Medical Surveillance Monthly Report
3/1/2025

This study reports the prevalence of non-medical risk factors, also known as social determinants of health, among active component service members and assesses the relationship between these factors and suicide ideation or attempts between 2018 and 2022. This analysis was performed to determine if there is opportunity to prevent suicide ideation or attempt among service members indicated for these non-medical risk factors. The findings reveal differences between demographic variables, emphasizing the disproportionate impacts of non-medical risk factors within the military population. For example, non-Hispanic Black service members had higher frequencies of diagnoses for all factors. After controlling for age, sex, service branch, race, and year of entry into military service, odds of suicidal ideation or attempt were elevated for service members with a recent diagnosis for factors related to abuse (odds ratio [OR] 13.7), family upbringing (OR 10.9), other psychosocial issues (OR 7.5), social environment (OR 7.4), lifestyle (OR 5.4), and life management (OR 5.3). This finding persisted even after excluding individuals with any prior mental health diagnosis. The results of this study suggest a need for a more comprehensive understanding of non-medical risk factors in shaping health outcomes and informing interventions to mitigate their effects.

What are the new findings?
This study documents, for the first time, the frequency of diagnosis for non-medical risk factors influencing health among U.S. active component service members. An association is identified between non-medical risk factors and suicide ideation or attempt within one year following diagnosis of the risk factor.

What is the impact on readiness and force health protection?
Suicide prevention is an aim of each military service. This study emphasizes the need for targeted interventions that address non-medical risk factors affecting health, to reduce mental health issues and suicide rates among service members. Improving access to resources and strengthening social support networks, to address issues related to abuse as well as economics, may enhance overall well-being and military readiness.

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https://doi.org/10.1093/milmed/usaf044

Travel Health Needs of Children in U.S. Military Families Stationed Abroad.

Mauro, A. P., Davis, A. M., Lee, E. H., & Hickey, P. W.

Military Medicine
Published: 09 April 2025

Introduction
While the U.S. DoD mandates preventive health measures for service members overseas, the health needs of their accompanying children are poorly described. This study aims to quantify and characterize the recommended travel health preventive services, with attention to malaria, dengue, yellow fever, Japanese encephalitis, tick-borne encephalitis (TBE), typhoid, and rabies, in military-connected expatriate children.

Materials and Methods
The registered country of residence of active duty service members and their families in December 2022 as reported by the Defense Manpower Data Center was assessed to quantify military-connected children living abroad. Data were sorted by age group and geographic Combatant Command. Country-level populations were mapped against CDC Yellow Book Health Information for International Travel country guidelines and Shoreland Travax recommendations.

Results
In 2022, there were 63,592 children of active duty service members living abroad. The largest populations were in Indo-Pacific Command (INDOPACOM) and European Command regions, reflecting long-standing bases in the regions. Of all conditions studied, Japanese encephalitis posed risk to the largest number of military children. Within INDOPACOM, 25,161 had regional to widespread endemic risk, while 357 children lived in countries with rare/focal risk for transmission. Relatively few children lived in areas with endemic risk for the other studied mosquito-borne illnesses, malaria (7454), dengue (3377), and yellow fever (533). With the emergence of TBE in much of Europe, 29,752 children were living in regions with some TBE risk. Only 1609 children lived in regions with both wildlife and domestic canine transmission cycles of rabies established. Typhoid risk for 13,607 children, largely in INDOPACOM, was sufficiently high for vaccination to be recommended for long-term travelers by the CDC and Travax.

Conclusions
Military-connected children living abroad have differing preventive health service needs from their counterparts in the United States. With these children living in countries with and without permanent military bases, there is a clear need for further investigation with attention to both uptake of preventive measures and incidence of disease. While risk assessments for any particular travel are unique and very much itinerary- and activity-specific, the risk stratification and terminology applied are both practical and consistent with the guidelines and resources available to clinicians. While for some children, risk may be overestimated because of their specific location within a country, there is also likely underestimation of risk assumed with regional travel to other countries with increased risk profiles. Understanding the utilization of preventive services and associated health outcomes in this population is crucial for their well-being.

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https://doi.org/10.1146/annurev-publhealth-071823-122832

Health Worker Burnout and Moral Injury: Drivers, Effects, and Remedies.

Grumbach, K., & Willard-Grace, R.

Annual Review of Public Health
Vol. 46:447-465 (Volume publication date April 2025)

The prevalence of burnout among health workers is alarmingly high and worsening. Many factors across the domains of culture of wellness, efficiency of practice and work

demands, and personal resilience place workers at risk for burnout. Intervention research has disproportionately studied individually focused interventions to strengthen personal resilience, demonstrating small benefit from such interventions. While coping strategies may have value, we stress the need to focus interventions on mitigating work conditions that breed burnout, such as inadequate levels of staffing, and to rigorously evaluate such interventions. A conceptual framework on burnout must include critical theory interrogating the broader economic, political, and structural forces shaping health care and the relative power of workers. The concept of moral injury may be more apt than burnout for describing the effects on workers' well-being of accelerating health care consolidation by investor-owned organizations, government austerity policies, and the disempowered position of labor.

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https://doi.org/10.1016/j.jpsychires.2025.03.026

Blast injury and chronic psychiatric disability in military personnel: Exploring the association beyond posttraumatic stress disorder.

Epshtein, E., Shraga, S., Radomislensky, I., Martindale, S. L., Bushinsky, S., Benov, A., Almog, O., Tsur, A. M., Talmy, T., & Israel Trauma Group

Journal of Psychiatric Research
Volume 184, April 2025, Pages 515-521

Highlights

- Research on mental health outcomes of blast injuries has focused on PTSD and TBI.
- We evaluated long term non-PTSD psychiatric disability following blast injury.
- Blast injury was associated with a ~2.5-fold increase in psychiatric disability.

Abstract
Introduction
Blast injuries are common among military personnel, yet their long-term psychiatric consequences, beyond posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI), remain underexplored. This study investigates the association between blast injuries and non-PTSD psychiatric conditions, including psychotic, neurocognitive, mood, anxiety, adjustment and personality disorders resulting in functional impairment.

Methods
Data were collected from three cross-referenced registries that span the continuum of trauma care from 2006 to 2021. Demographics, injury mechanisms, and injury settings were sourced from the Israel Defense Forces Trauma Registry; hospitalization data from the Israeli National Trauma Registry and psychiatric-related disability was assessed utilizing long-term disability claims documented by the Israel Ministry of Health Rehabilitation Department. Logistic regression was employed to evaluate the association between blast injuries and psychiatric morbidity, with results presented as adjusted odds ratios (OR) and 95 % confidence intervals (CI).

Results
Among 7646 military personnel (91.3 % male, median age: 20 years), 1503 (19.7 %) sustained blast injuries. Overall, 44 (0.6 %) were diagnosed with non-PTSD psychiatric-related disability. Prevalence was higher among those with blast injuries (1.0 % vs. 0.5 %; p = 0.016). Blast injuries were associated with a more than two-fold increase in odds for psychiatric morbidity (Adjusted OR 2.44, 95 % CI: 1.07–5.59) after adjusting for blast injury severity and presence of head injury.

Conclusions
Blast injury was significantly associated with long-term psychiatric morbidity, independent of head injury and additional confounders. These findings suggest that proactive mental health screening and interventions should be considered for individuals experiencing blast injuries. Future research should explore the mechanisms underlying this association.

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Interventions for Reducing Mental Health-Related Stigma in Emergency Medicine: An Integrative Review.

Van de Glind, G., Galenkamp, N., Schut, B., Schoonhoven, L., Scheepers, F. E., Muir, R., Baden, D., Werner, L., van Veen, M., Crilly, J., & Ham, W. H. W.

Journal of Emergency Nursing
April 10, 2025

Introduction
The prevalence and impact of mental health disorders are increasing worldwide. A

growing number of people with mental health problems require ambulance and emergency department care, many of whom face stigmatization from health care professionals in these environments. Interpersonal stigma comprises insufficient knowledge (ignorance or misinformation), negative attitudes (negative emotional reactions, such as prejudice), and negative behaviors (such as avoidance or rejection).

Methods
An integrative review was conducted to assess the current landscape of interventions aimed at reducing stigmatization among health care professionals in ambulance and emergency department settings.

Results
Of the 18 publications included, 1 targeted stigma reduction. Although 2 additional studies examined interventions not specifically aimed at reducing stigma, these studies have examined the impact of interventions on stigma. The other included studies reported measures of attitudes. One study involved patients evaluating the intervention, whereas the rest relied on assessments by health care professionals. Four studies mentioned patient involvement in the development of interventions. The predominant approach in these studies involved educational and training interventions associated with improvements in knowledge levels and attitudes. However, the direct impact of these changes on reducing stigmatizing behavior remains unclear. It is concerning that national practice guidelines in ambulance and emergency care hardly address mental health–related stigma despite longstanding awareness of this issue.

Discussion
The findings underscore the urgent need for concerted efforts in practice, research, and policy within ambulance and emergency department settings to address and combat stigmatizing behaviors toward patients with mental health challenges by enhancing knowledge and reshaping attitudes.

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http://dx.doi.org/10.15585/mmwr.ss7402a1

Prevalence and Early Identification of Autism Spectrum Disorder Among Children Aged 4 and 8 Years — Autism and Developmental Disabilities Monitoring Network, 16 Sites, United States, 2022.

Shaw KA, Williams S, Patrick ME, et al.

Morbidity and Mortality Weekly Report
Surveillance Summaries
April 17, 2025 / 74(2);1–22

Problem/Condition: Autism spectrum disorder (ASD).

Period Covered: 2022.

Description of System:
The Autism and Developmental Disabilities Monitoring Network is an active surveillance program that estimates prevalence and characteristics of ASD and monitors timing of ASD identification among children aged 4 and 8 years. In 2022, a total of 16 sites (located in Arizona, Arkansas, California, Georgia, Indiana, Maryland, Minnesota, Missouri, New Jersey, Pennsylvania, Puerto Rico, Tennessee, Texas [two sites: Austin and Laredo], Utah, and Wisconsin) conducted surveillance for ASD among children aged 4 and 8 years and suspected ASD among children aged 4 years. Surveillance included children who lived in the surveillance area at any time during 2022. Children were classified as having ASD if they ever received 1) an ASD diagnostic statement in a comprehensive developmental evaluation, 2) autism special education eligibility, or 3) an ASD International Classification of Diseases, Ninth Revision (ICD-9) code in the 299 range or International Classification of Diseases, Tenth Revision (ICD-10) code of F84.0, F84.3, F84.5, F84.8, or F84.9. Children aged 4 years were classified as having suspected ASD if they did not meet the case definition for ASD but had an evaluator's suspicion of ASD documented in a comprehensive developmental evaluation.

Results:
Among children aged 8 years in 2022, ASD prevalence was 32.2 per 1,000 children (one in 31) across the 16 sites, ranging from 9.7 in Texas (Laredo) to 53.1 in California. The overall observed prevalence estimate was similar to estimates calculated using Bayesian hierarchical and random effects models. ASD was 3.4 times as prevalent among boys (49.2) than girls (14.3). Overall, ASD prevalence was lower among non-Hispanic White (White) children (27.7) than among Asian or Pacific Islander (A/PI) (38.2), American Indian or Alaska Native (AI/AN) (37.5), non-Hispanic Black or African American (Black) (36.6), Hispanic or Latino (Hispanic) (33.0), and multiracial children (31.9). No association was observed between ASD prevalence and neighborhood median household income (MHI) at 11 sites; higher ASD prevalence was associated with lower neighborhood MHI at five sites.

Record abstraction was completed for 15 of the 16 sites for 8,613 children aged 8 years who met the ASD case definition. Of these 8,613 children, 68.4% had a documented

diagnostic statement of ASD, 67.3% had a documented autism special education eligibility, and 68.9% had a documented ASD ICD-9 or ICD-10 code. All three elements of the ASD case definition were present for 34.6% of children aged 8 years with ASD.

Among 5,292 (61.4% of 8,613) children aged 8 years with ASD with information on cognitive ability, 39.6% were classified as having an intellectual disability. Intellectual disability was present among 52.8% of Black, 50.0% of AI/AN, 43.9% of A/PI, 38.8% of Hispanic, 32.7% of White, and 31.2% of multiracial children with ASD. The median age of earliest known ASD diagnosis was 47 months and ranged from 36 months in California to 69.5 months in Texas (Laredo).

Cumulative incidence of ASD diagnosis or eligibility by age 48 months was higher among children born in 2018 (aged 4 years in 2022) than children born in 2014 (aged 8 years in 2022) at 13 of the 15 sites that were able to abstract records. Overall cumulative incidence of ASD diagnosis or eligibility by age 48 months was 1.7 times as high among those born in 2018 compared with those born in 2014 and ranged from 1.4 times as high in Arizona and Georgia to 3.1 times as high in Puerto Rico. Among children aged 4 years, for every 10 children meeting the case definition of ASD, one child met the definition of suspected ASD.

Children with ASD who were born in 2018 had more evaluations and identification during ages 0–4 years than children with ASD who were born in 2014 during the 0–4 years age window, with an interruption in the pattern in early 2020 coinciding with onset of the COVID-19 pandemic.

Overall,
66.5% of children aged 8 years with ASD had a documented autism test. Use of autism tests varied widely across sites: 24.7% (New Jersey) to 93.5% (Puerto Rico) of children aged 8 years with ASD had a documented autism test in their records. The most common tests documented for children aged 8 years were the Autism Diagnostic Observation Schedule, Autism Spectrum Rating Scales, Childhood Autism Rating Scale, Gilliam Autism Rating Scale, and Social Responsiveness Scale.

Interpretation:
Prevalence of ASD among children aged 8 years was higher in 2022 than previous years. ASD prevalence was higher among A/PI, Black, and Hispanic children aged 8 years than White children aged 8 years, continuing a pattern first observed in 2020. A/PI, Black, and Hispanic children aged 8 years with ASD were also more likely than White or multiracial children with ASD to have a co-occurring intellectual disability. Identification by age 48 months was higher among children born in 2018 compared with

children born in 2014, suggesting increased early identification consistent with historical patterns.

Public Health Action:
Increased identification of autism, particularly among very young children and previously underidentified groups, underscores the increased demand and ongoing need for enhanced planning to provide equitable diagnostic, treatment, and support services for all children with ASD. The substantial variability in ASD identification across sites suggests opportunities to identify and implement successful strategies and practices in communities to ensure all children with ASD reach their potential.

Links of Interest

Drug overdoses among military members dropped sharply in recent years, DOD report finds
https://www.stripes.com/theaters/us/2025-04-15/military-drug-overdoses-report-17475148.html

- Fatal Drug Overdoses in Service Members Significantly Below National Average

Thousands of sailors get access to trendy weight-loss app in new deal
https://www.militarytimes.com/news/your-navy/2025/04/01/thousands-of-sailors-get-access-to-trendy-weight-loss-app-in-new-deal/

504 Plan Versus IEP Overview
https://www.militaryonesource.mil/special-needs/educational-needs/iep-vs-504-plan-for-students-with-special-needs/

Suicide prevention: Self-check assessment
https://news.va.gov/139230/suicide-prevention-self-check-assessment/

Why one Veteran's resilience remains unshaken
https://news.va.gov/139093/why-one-veterans-resilience-remains-unshaken/

Staff Perspective: Military Families with Children Who Have Special Needs
https://deploymentpsych.org/blog/staff-perspective-military-families-children-who-have-special-needs

Staff Perspectives: Never Have I Ever…Been a Military Dependent
https://deploymentpsych.org/blog/staff-perspectives-never-have-i-ever%E2%80%A6been-military-dependent

How to Handle Rejection and Take Control of Your Feelings
https://www.prevention.com/health/mental-health/a63189234/how-to-recover-from-rejection/

Battle Buddy: Your direct connection to Veteran resources
https://news.va.gov/139407/battle-buddy-your-direct-connection-resources/

The Impact of Addictions: Improving Access to Care, Education to Return Service Members Back to Duty
https://www.health.mil/News/Dvids-Articles/2025/03/26/news493777

Resource of the Week: Military Suicide Prevention and Response

Updated 3/24/25 by the Congressional Research Service:

> When a servicemember dies by suicide, those close to the member often experience shock, anger, guilt, and sorrow. As such, a servicemember's suicide may adversely impact the wellbeing of his or her family and friends. Further, it may affect the morale and readiness of his or her unit. The military's response to suicidal thoughts (ideation), attempts, and deaths involves coordinated efforts among command and unit leadership, medical professionals, counselors, and others across the military community.
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> …
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> According to the Centers for Disease Control and Prevention (CDC), the suicide mortality rate for the U.S. general population was 14.2 per 100,000 in 2022 (the most recently available data). DOD asserts that between 2011 and 2022, military suicide rates were similar to the U.S. population after accounting for age and sex differences. Direct comparisons between the general civilian population and the military can be deceiving, as the military services are disproportionately comprised of younger individuals

and more males. These sub-populations are generally at higher risk for suicide and may be exposed to military-specific risk factors.

Table 1. Unadjusted Suicide Mortality Rates by Service and Component, CY2018-CY2023
(rate per 100,000 personnel)

Service	2018	2019	2020	2021	2022	2023
Active Total	**24.9**	**26.3**	**28.6**	**24.3**	**25.1**	**28.2**
Army	29.9	30.5	36.2	36.1	28.9	34.8
Marine Corps	30.8	25.3	34.5	23.9	36.0	35.9
Navy	20.7	22.1	19.0	17.0	20.6	21.0
Air Force	18.5	25.1	24.3	15.3	19.0	22.5
Space Force	—	—	nr	nr	nr	nr
Reserve Total	**22.9**	**18.5**	**21.7**	**21.2**	**19.4**	**20.9**
Army Reserve	25.3	19.4	22.2	24.8	20.8	24.9
Air Force, Navy, and Marine Corps Reserve rates are not reported (nr) by DOD when the suicide count is less than 20 due to statistical instability.						
Natl Guard Total	**30.8**	**20.5**	**27.5**	**27.3**	**22.2**	**21.2**
Army Guard	35.6	22.9	31.5	31.2	24.8	23.7
Air Guard	nr	nr	nr	nr	nr	nr

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