Research relating to Counselling Military Service Personnel

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Overview

The mental or psychological health of military personnel has received considerable recent attention in parliamentary questions and also in the press. A useful, but somewhat dated overview to the area has been provided by the Mental Health Foundation http://www.mentalhealth.org.uk/information/mental-health-a-z/military-and-mental-health/

The majority of research evidence in this area focuses on the prevalence of psychological disorders on return from combat or duty oversees, most recently from Iraq and Afghanistan. Although not directly focussing on counselling research, some key references have been included below to provide a context of the current debates and evidence. There is considerable debate surrounding the existence and prevalence of psychological disorders in military personnel, in both the UK and particularly US literature. A limited number of references have been included below to provide some context to the counselling research.

The majority of relevant evidence in relation to the psychological treatment of military personnel focuses on the treatment of PTSD – and this is the main focus of this bulletin. However, the most recent research (Iverson et al, 2009) has suggested that the most common mental disorders amongst the military are alcohol abuse and neurotic disorders. Counselling research on these topic areas will also be of use, but are not covered here.

Abstracts of each article have been provided, in some cases there is a link to full text of the article via the Internet. To obtain full text of remaining articles, please contact your local NHS or academic library if you qualify for their use. Some journals provide free access to limited content, and check with the journal website for more details.

It should be noted that the information given below has not been critically appraised to assure its quality.

Prevalence

The KING'S CENTRE FOR MILITARY HEALTH RESEARCH (KCMHR) is a joint initiative of the Institute of Psychiatry and the Department of War Studies at King's College London. A number of their publications focus on mental health issues in the UK armed forces and can be located via their website. http://www.kcl.ac.uk/kcmhr/

Gould, M., J. Sharpley, et al. (2008). "Patient characteristics and clinical activities at a British military department of community mental health." Psychiatric Bulletin 32(3): 99-102.

Aims and Methods: To describe patient characteristics and clinical activities at a British military department of community mental health (DCMH). Data were drawn from a clinical database over a 1-year period (n=409). Result: Mean age was 29 years, 50% were single and 76% were from the junior ranks. Women were over-represented compared with the wider military population. Mean length of service prior to presentation was 5 years. The main presenting problem was alcohol misuse (33%) followed by depression (19%).Twenty-five per cent were referred for psychotherapy and 68% returned to full employment after treatment. Clinical Implications: Patient characteristics of those treated at a DCMH differ from those in the wider military. An out-patient occupational mental health service returns a substantial number of patients to occupational fitness within the Armed Forces. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Hooper, R., R. J. Rona, et al. (2008). "Cigarette and alcohol use in the UK Armed Forces, and their association with combat exposures: a prospective study." Addict Behav 33(8): 1067-71.

Retrospective studies of military personnel and survivors of community disasters suggest a link between traumatic exposure and substance use. This is the first study to investigate this association prospectively in a military population. A representative cohort of members of the UK Armed Forces was recruited into a longitudinal study, with 1382 people surveyed at baseline, and 941 followed up around three years later. Alcohol and cigarette use were assessed on both occasions, and combat exposures during this time were assessed at follow-up. Alcohol consumption and the prevalence of binge-drinking increased over the course of the study. The increase in alcohol consumption was greater in those subjects who had been deployed, in particular in those who thought they might be killed (p=.010), or who experienced hostility from civilians while on deployment (p=.010). The effects of these combat exposures were strongest in those most recently deployed. In contrast, cigarette smoking declined during the three years of the study.

Horn, O., L. Hull, et al. (2006). "Is there an Iraq war syndrome? Comparison of the health of UK service personnel after the Gulf and Iraq wars." Lancet 367(9524): 1742-6.

BACKGROUND: UK armed forces personnel who took part in the 1991 Gulf war experienced an increase in symptomatic ill health, colloquially known as Gulf war syndrome. Speculation about an Iraq war syndrome has already started. METHODS: We compared the health of male regular UK armed forces personnel deployed to Iraq during the 2003 war (n=3642) with that of their colleagues who were not deployed (n=4295), and compared these findings with those from our previous survey after the 1991 war. Data were obtained by questionnaire. FINDINGS: Graphs comparing frequencies of 50 non-specific symptoms in the past month in deployed and non-deployed groups did not show an increase in prevalence of symptoms equivalent to that observed after the Gulf war. For the Iraq war survey, odds ratios (ORs) for self-reported symptoms ranged from 0.8 to 1.3. Five symptoms were significantly increased, and two decreased, in deployed individuals, whereas prevalence greatly increased

for all symptoms in the Gulf war study (ORs 1.9-3.9). Fatigue was not increased after the 2003 Iraq war (OR 1.08; 95% CI 0.98-1.19) but was greatly increased after the 1991 Gulf war (3.39; 3.00-3.83). Personnel deployed to the Gulf war were more likely (2.00, 1.70-2.35) than those not deployed to report their health as fair or poor; no such effect was found for the Iraq war (0.94, 0.82-1.09). INTERPRETATION: Increases in common symptoms in the 2003 Iraq war group were slight, and no pattern suggestive of a new syndrome was present. We consider several explanations for these differences.

Iverson AC et al (2009) The prevalence of common mental disorders and PTSD in the UK military: using data from a clinical interview-based study
BMC Psychiatry 2009, **9**:68 (open access article)
http://www.biomedcentral.com/1471-244X/9/68
Background: The mental health of the Armed Forces is an important issue of both academic and public interest. The aims of this study are to: a) assess the prevalence and risk factors for common mental disorders and post traumatic stress disorder (PTSD) symptoms, during the main fighting period of the Iraq War (TELIC 1) and later deployments to Iraq or elsewhere and enlistment status (regular or reserve), and b) compare the prevalence of depression, PTSD symptoms and suicidal ideation in regular and reserve UK Army personnel who deployed to Iraq with their US counterparts.
Methods: Participants were drawn from a large UK military health study using a standard two phase survey technique stratified by deployment status and engagement type. Participants undertook a structured telephone interview including the Patient Health Questionnaire (PHQ) and a short measure of PTSD (Primary Care PTSD, PC-PTSD). The response rate was 76% (821 participants).
Results: The weighted prevalence of common mental disorders and PTSD symptoms was 27.2% and 4.8%, respectively. The most common diagnoses were alcohol abuse (18.0%) and neurotic disorders (13.5%). There was no health effect of deploying for regular personnel, but an increased risk of PTSD for reservists who deployed to Iraq and other recent deployments compared to reservists who did not deploy. The prevalence of depression, PTSD symptoms and subjective poor health were similar between regular US and UK Iraq combatants.
Conclusions: The most common mental disorders in the UK military are alcohol abuse and neurotic disorders. The prevalence of PTSD symptoms remains low in the UK military, but reservists are at greater risk of psychiatric injury than regular personnel.

Iversen, A., C. Dyson, et al. (2005). "'Goodbye and good luck': the mental health needs and treatment experiences of British ex-service personnel." Br J Psychiatry 186: 480-6.

BACKGROUND: Little is known about the psychological health or treatment experiences of those who have left the British armed forces. AIMS: To describe the frequency and associations of common mental disorders and help-seeking behaviours in a representative sample of UK veterans at high risk of mental health problems. METHOD: A cross-sectional telephone survey of 496 'vulnerable' ex-service personnel selected from an existing epidemiological military cohort. RESULTS: The response rate was 64%; 44% of these had a psychiatric diagnosis, most commonly depression. Those with a diagnosis were more likely to be of lower rank and divorced or separated. Just over half of those with self-reported mental health problems were currently seeking help, most from their general practitioners. Most help-seekers received treatment, usually medication; 28% were in touch with a service charity and 4% were receiving cognitive-behavioural therapy. CONCLUSIONS: Depression is more common than post-traumatic stress disorder in UK ex-service personnel. Only about half of those who have a diagnosis are seeking help currently, and few see specialists.

Sundin, J., N. T. Fear, et al. (2009). "PTSD after deployment to Iraq: conflicting rates, conflicting claims." Psychol Med: 1-16.

BACKGROUND: Post-traumatic stress disorder (PTSD) has been called one of the signature injuries of the Iraq War. In this review prevalence estimates of PTSD are summarized and discrepancies are discussed in relation to methodological differences between studies. Method: We searched for population-based studies with a minimum sample size of 300. Studies based on help-seeking samples were excluded. We identified 60 possible papers, of which 19 fulfilled the inclusion criteria. Prevalence estimates and study characteristics were examined graphically with forest plots, but because of high levels of heterogeneity between studies, overall estimates of PTSD prevalence were not discussed. RESULTS: The prevalence of PTSD in personnel deployed to Iraq varied between 1.4% and 31%. Stratifying studies by PTSD measure only slightly reduced the variability in prevalence. Anonymous surveys of line infantry units reported higher levels of PTSD compared to studies that are representative of the entire deployed population. UK studies tend to report lower prevalence of PTSD compared with many US studies; however, when comparisons are restricted to studies with random samples, prevalences are similar. US studies that have assessed personnel more than once since return from deployment have shown that PTSD prevalence increases over the 12 months following deployment. CONCLUSIONS: Differences in methodologies and samples used should be considered when making comparisons of PTSD prevalence between studies. Further studies based on longitudinal samples are needed to understand how the prevalence of PTSD changes over time.

Stigma and Barriers to seeking treatment

A number of studies have reported that military service personnel do not seek treatment due to the stigma associated with psychological problems. Furthermore, a number of studies report barriers to accessing services.

Britt, Thomas W. Greene-Shortridge Tiffany M. Brink Sarah et al (2008)"Perceived stigma and barriers to care for psychological treatment: Implications for reactions to stressors in different contexts." Journal of Social and Clinical Psychology, 27(4),2008, 317-335

Informed by data on the dose-response effect, the authors assessed use of psychotherapy in the Veterans Health Administration (VA). The authors identified 410,923 patients with newly diagnosed depression, anxiety, or posttraumatic stress disorder using VA databases (October 2003 through September 2004). Psychotherapy encounters were identified by Current Procedural Terminology codes for the 12 months following patients' initial diagnosis. Psychotherapy was examined for session exposure received within the 12-month follow-up period and time (in days) between diagnosis and treatment. Of the cohort, 22% received at least one session of psychotherapy; 7.9% received four or more sessions; 4.2% received eight or more sessions; and 2.4% received 13 or more sessions. Delays between initial mental health diagnosis and initiation of care averaged 57 days. Patient variables including age, marital status, income, travel distance, psychiatric diagnosis, and medical-illness burden were significantly related to receipt of psychotherapy. Treatment delays and general underuse of psychotherapy services are potential missed opportunities for higher-quality psychotherapeutic care in integrated health care settings. (PsycINFO Database Record (c) 2009 APA, all rights reserved) Unique Identifier 2008-16478-002

French, C., R. J. Rona, et al. (2004). "Screening for physical and psychological illness in the British Armed Forces: II: Barriers to screening--learning from the opinions of Service personnel." J Med Screen 11(3): 153-7.

OBJECTIVE: To identify any potential barriers to the effectiveness of a military health screening programme based on the beliefs of British Service personnel. METHODS: As part of a pilot evaluation of the suitability of a new health screening questionnaire for the British Armed Forces, 73 men and women from the three Services, of various ranks and age, underwent a semi-structured interview after completing a screening questionnaire. Participants were asked about the veracity of their answers and their views regarding a screening questionnaire. Afterwards questionnaires were sent to 4496 randomly selected personnel from the three Services, which validated the main emerging themes. A constant comparative method of analysis was used to identify and categorise all ideas presented. RESULTS: The main barriers to health screening were lack of trust, perceived low quality of healthcare, and perceived lack of concern within the institution about work environments and home life. The central issue was 'confidence' in military health care provision. Screening was considered worthwhile, but many confided that they would not honestly answer some items in the questionnaire. Lack of trust in medical confidentiality, stigmatisation and fears that the process would jeopardise career prospects were stressed. Many Service personnel admitted to seeking medical help outside the Armed Forces. CONCLUSIONS: Concerns raised by Service personnel may endanger the value of a screening programme and the provision of health services. Greater emphasis needs to be placed upon gaining the confidence of those targeted for health screening.

Gould, M., N. Greenberg, et al. (2007) Stigma and the military: evaluation of a PTSD psychoeducational program. Journal of Traumatic Stress 505-15

Trauma risk management (TRiM) is an intensive posttraumatic stress disorder (PTSD) psychoeducational management strategy based on peer-group risk assessment developed by

the UK Royal Navy (RN). TRiM seeks to modify attitudes about PTSD, stress, and help-seeking and trains military personnel to identify at-risk individuals and refer them for early intervention. This quasiexperimental study found that TRiM training significantly improved attitudes about PTSD, stress, and help-seeking from TRiM-trained personnel. There was a nonsignificant effect on attitudes to seeking help from normal military support networks and on general health. Within both the military and civilian populations, stigma is a serious issue preventing help-seeking and reducing quality of life. The results suggest that TRiM is a promising antistigma program within organizational settings.

Mahadevan, D. "Review of War and health: Lessons from the Gulf War." (2009). International Journal of Geriatric Psychiatry; 1099-1166

Fifty female veterans of the wars in Iraq and Afghanistan completed an Internet survey related to their mental health needs, service utilization, and barriers to seeking mental health care within the Veterans Administration (VA) system. Veterans completed several self-report measures including the PTSD Checklist; Military, Center for Epidemiologic Scales; Depression, and Hopkins Symptom Checklist. The most frequently reported concerns for which participants indicated they needed counseling were depression, relationship issues, anxiety, and anger management. Although 78% of respondents reported that they felt they needed treatment in the past year, 42% of these individuals indicated that they did not seek counseling. Two commonly reported barriers to seeking mental health services in the VA were long waiting periods for appointments and prior bad experiences. Mental health concerns and symptoms of returning female veterans indicate the need for treatment, but a significant gap remains in the self-reported need for assistance and seeking of services. (PsycINFO Database Record (c) 2009 APA, all rights reserved) Unique Identifier 2009-10667-005

McFall, M., C. Malte, et al. (2000) Effects of an outreach intervention on use of mental health services by veterans with posttraumatic stress disorder. Psychiatric services (Washington, D.C.) 369-74

OBJECTIVE: The study examined the effectiveness of an outreach intervention designed to increase access to mental health treatment among veterans disabled by chronic posttraumatic stress disorder (PTSD) and identified patient-reported barriers to care associated with failure to seek the treatment offered. METHODS: Participants were 594 male Vietnam veterans who were not enrolled in mental health care at a Department of Veterans Affairs (VA) medical center but who were receiving VA disability benefits for PTSD. Half the sample was randomly assigned to an outreach intervention, and the other half was assigned to a control group. Veterans in the intervention group received a mailing that included a brochure describing PTSD treatment available at an urban VA medical center, along with a letter informing them about how to access care. Participants in the intervention group were subsequently telephoned by a study coordinator who encouraged them to enroll in PTSD treatment and who administered a survey assessing barriers to care. RESULTS: Veterans in the intervention group were significantly more likely than those in the control group to schedule an intake appointment (28 percent versus 7 percent), attend the intake (23 percent versus 7 percent), and enroll in treatment (19 percent versus 6 percent). Several patient-identified barriers were associated with failure to seek VA mental health care, such as personal obligations that prevented clinic attendance, inconvenient clinic hours, and current receipt of mental health treatment from a non-VA provider. CONCLUSIONS: Utilization of mental health services among underserved veterans with PTSD can be increased by an inexpensive outreach intervention, which may be useful with other chronically mentally ill populations.

Rona, R. J., M. Jones, et al. (2004). "Screening for physical and psychological illness in the British Armed Forces: I: The acceptability of the programme." J Med Screen 11(3): 148-52.

OBJECTIVES: To assess the response to a self-administered questionnaire and attendance of a medical centre for physical and psychological health screening. METHODS: 4500 men and women from the three services were randomly selected to receive either a full or abridged screening questionnaire. The full questionnaire included the General Health Questionnaire-12 (GHQ-12) and Post-traumatic Stress Disorder (PTSD) checklist, 15 symptoms, a self-assessed health status question and three questions on alcohol behaviour (WHO Audit). The abridged questionnaire included GHQ-4, a slightly shortened PTSD checklist and five symptoms, but excluded questions on alcohol behaviour. All 'screen-positive' and a random 'screen-negative' sample were invited to attend a medical centre. RESULTS: 67.1% of the servicemen completed a questionnaire; slightly but significantly more the abridged than the full questionnaire (4.9%, 95% confidence interval 2.3-7.4%). Of those receiving a full or abridged questionnaire, 32% and 22.5% respectively were 'screen-positives', most of the difference (7.5%) attributable to alcohol behaviour. Less than 30% of the servicemen invited to attend a medical centre accepted the invitation, even fewer during the preparation for deployment to Iraq. Those who fulfilled the criteria for PTSD, alcohol behaviour or multi-criteria 'screen-positive' were more reluctant than controls to attend. CONCLUSIONS: Screening for psychological illness has little support among servicemen, perhaps because they may not wish to share concerns with a military doctor. Avoidance behaviour among those with a psychological condition may also selectively reduce willingness to attend a medical centre. Screening during pre-deployment periods has even less support than at other times.

Seal, K. H., D. Bertenthal, et al. (2008). "Getting beyond "Don't ask; don't tell": an evaluation of US Veterans Administration postdeployment mental health screening of veterans returning from Iraq and Afghanistan." Am J Public Health 98(4): 714-20.

OBJECTIVES: We sought to evaluate outcomes of the Veterans Administration (VA) Afghan and Iraq Post-Deployment Screen for mental health symptoms. METHODS: Veterans Administration clinicians were encouraged to refer Iraq or Afghanistan veterans who screened positive for posttraumatic stress disorder, depression, or high-risk alcohol use to a VA mental health clinic. Multivariate methods were used to determine predictors of screening, the proportions who screened positive for particular mental health problems, and predictors of VA mental health clinic attendance. RESULTS: Among 750 Iraq and Afghanistan veterans who were referred to a VA medical center and 5 associated community clinics, 338 underwent postdeployment screening; 233 (69%) screened positive for mental health problems. Having been seen in primary care (adjusted odd ratio [AOR]=13.3; 95% confidence interval [CI]=8.31, 21.3) and at a VA community clinic (AOR=3.28; 95% CI=2.03, 5.28) predicted screening. African American veterans were less likely to have been screened than were White veterans (AOR=0.45; 95% CI=0.22, 0.91). Of 233 veterans who screened positive, 170 (73%) completed a mental health follow-up visit. CONCLUSIONS: A substantial proportion of veterans met screening criteria for co-occurring mental health problems, suggesting that the VA screens may help overcome a "don't ask, don't tell" climate that surrounds stigmatized mental illness. Based on data from 1 VA facility, VA postdeployment screening increases mental health clinic attendance among Iraq and Afghanistan veterans.

Service Delivery

Batten, Sonja V. Pollack Stacey J. (2008) "Integrative outpatient treatment for returning service members." Journal of Clinical Psychology; 1097-4679

To date, more than 1.3 million service members have served in the Global War on Terrorism. These men and women and their families face a range of stressful situations and must navigate many important tasks after a deployment. This article outlines four of the tasks of reintegration: redefining roles, expectations, and division of labor; managing strong emotions; abandoning emotional constriction and creating intimacy in relationships; and creating shared meaning. For each task, potential challenges are discussed and suggestions for how psychologists can support families are described. In addition, potential red flags and indicators that more intensive services may be warranted are reviewed. (PsycINFO Database Record (c) 2009 APA, all rights reserved) Unique Identifier 2008-10899-010

Cully, J. A., L. Tolpin, et al. (2008). "Psychotherapy in the veterans health administration: Missed opportunities?" Psychological Services 5(4): 320-331.

Informed by data on the dose-response effect, the authors assessed use of psychotherapy in the Veterans Health Administration (VA). The authors identified 410,923 patients with newly diagnosed depression, anxiety, or posttraumatic stress disorder using VA databases (October 2003 through September 2004). Psychotherapy encounters were identified by Current Procedural Terminology codes for the 12 months following patients' initial diagnosis. Psychotherapy was examined for session exposure received within the 12-month follow-up period and time (in days) between diagnosis and treatment. Of the cohort, 22% received at least one session of psychotherapy; 7.9% received four or more sessions; 4.2% received eight or more sessions; and 2.4% received 13 or more sessions. Delays between initial mental health diagnosis and initiation of care averaged 57 days. Patient variables including age, marital status, income, travel distance, psychiatric diagnosis, and medical-illness burden were significantly related to receipt of psychotherapy. Treatment delays and general underuse of psychotherapy services are potential missed opportunities for higher-quality psychotherapeutic care in integrated health care settings. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Dobscha, S. K., K. Corson, et al. (2007). "Depression treatment preferences of VA primary care patients." Psychosomatics: Journal of Consultation Liaison Psychiatry 48(6): 482-488.

The authors identified veterans' depression treatment preferences and explored relationships between preferences, process of care, and clinical outcomes. Patients entering a collaborative depression intervention trial in primary care completed an assessment of treatment preferences. Medical record review was used to identify treatments offered and received over a 12-month period. Of 314 patients, 32% preferred antidepressants; 19%, individual counseling; 18%, antidepressants plus counseling; 7%, group counseling; and 25%, "watchful waiting." Although the treatment that was offered was associated with treatment preferences, being offered preferred treatment was not associated with receiving treatment or with changes in depression severity or satisfaction over time. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Engel, C. C., T. Oxman, et al. (2008). "RESPECT-Mil: feasibility of a systems-level collaborative care approach to depression and post-traumatic stress disorder in military primary care." Mil Med 173(10): 935-40.

BACKGROUND: U.S. military ground forces report high rates of war-related traumatic stressors, posttraumatic stress disorder (PTSD), and depression following deployment in support of recent armed conflicts in Iraq and Afghanistan. Affected service

members do not receive needed mental health services in most cases, and they frequently report stigma and significant structural barriers to mental health services. Improvements in primary care may help address these issues, and evidence supports the effectiveness of a systems-level collaborative care approach. OBJECTIVE: To test the feasibility of systems-level collaborative care for PTSD and depression in military primary care. We named our collaborative care model "Re-Engineering Systems of Primary Care for PTSD and Depression in the Military" (RESPECT-Mil). METHODS: Key elements of RESPECT-Mil care include universal primary care screening for PTSD and depression, brief standardized primary care diagnostic assessment for those who screen positive, and use of a nurse "care facilitator" to ensure continuity of care for those with unmet depression and PTSD treatment needs. The care facilitator assists primary care providers with follow-up, symptom monitoring, and treatment adjustment and enhances the primary care interface with specialty mental health services. We report assessments of feasibility of RESPECT-Mil implementation in a busy primary care clinic supporting Army units undergoing frequent Iraq, Afghanistan, and other deployments. RESULTS: Thirty primary care providers (family physicians, physician assistants, and nurse practitioners) were trained in the model and in the care of depression and PTSD. The clinic screened 4,159 primary care active duty patient visits: 404 screens (9.7%) were positive for depression, PTSD, or both. Sixty-nine patients participated in collaborative care for 6 weeks or longer, and the majority of these patients experienced clinically important improvement in PTSD and depression. Even although RESPECT-Mil participation was voluntary for providers, only one refused participation. No serious adverse events were noted. CONCLUSIONS: Collaborative care is an evidence-based approach to improving the quality of primary care treatment of anxiety and depression. Our version of collaborative care for PTSD and depression, RESPECT-Mil, is feasible, safe, and acceptable to military primary care providers and patients, and participating patients frequently showed clinical improvements. Efforts to implement and evaluate collaborative care approaches for mental disorders in populations at high risk for psychiatric complications of military service are warranted.

French, C., R. J. Rona, et al. (2004). "Screening for physical and psychological illness in the British Armed Forces: II: Barriers to screening--learning from the opinions of Service personnel." J Med Screen 11(3): 153-7.

OBJECTIVE: To identify any potential barriers to the effectiveness of a military health screening programme based on the beliefs of British Service personnel. METHODS: As part of a pilot evaluation of the suitability of a new health screening questionnaire for the British Armed Forces, 73 men and women from the three Services, of various ranks and age, underwent a semi-structured interview after completing a screening questionnaire. Participants were asked about the veracity of their answers and their views regarding a screening questionnaire. Afterwards questionnaires were sent to 4496 randomly selected personnel from the three Services, which validated the main emerging themes. A constant comparative method of analysis was used to identify and categorise all ideas presented. RESULTS: The main barriers to health screening were lack of trust, perceived low quality of healthcare, and perceived lack of concern within the institution about work environments and home life. The central issue was 'confidence' in military health care provision. Screening was considered worthwhile, but many confided that they would not honestly answer some items in the questionnaire. Lack of trust in medical confidentiality, stigmatisation and fears that the process would jeopardise career prospects were stressed. Many Service personnel admitted to seeking medical help outside the Armed Forces. CONCLUSIONS: Concerns raised by Service personnel may endanger the value of a screening programme and the provision of health services. Greater emphasis needs to be placed upon gaining the confidence of those targeted for health screening.

Frueh, B. Christopher Grubaugh Anouk L. Yeager Derik E. Magruder Kathryn M (2009) "Delayed-onset post-traumatic stress disorder among war veterans in primary care clinics. Publication Date Jun 2009." British Journal of Psychiatry; 1472-1465
Background: Trauma Risk Management (TRiM) is a post-traumatic psychological management model utilizing peer support/assessment, developed by the UK military. Following September 11th, 2001, the UK Foreign & Commonwealth Office (FCO) deployed TRiM personnel to New York. Aims: This report describes the use of TRiM by the FCO in New York and examines the correlation validity of the TRiM assessments. Method: Assessments were conducted among personnel shortly after the event and again after a further month. The initial and follow-up scores on the 10-item TRiM Risk Assessment Tool (RAT) and the Impact of Events Scale (IES) were compared. Results: Twenty-eight people were assessed using the RAT; 20 also completed the IES. The IES identified 19 cases at initial assessment compared to 5 using the RAT. At follow up, the IES identified 10 cases compared to two using the RAT. Initial RAT and IES scores were not correlated however the follow-up scores (Pearson?s r = 0.79, p < 0.001) and the change in scores were (Pearson?s r = 0.56, p = 0.02). Conclusion: Results suggest the TRiM process was well received and the RAT appears to measure a similar change in post traumatic distress as the well validated IES. Further research will determine the efficacy of this system. (PsycINFO Database Record (c) 2009 APA, all rights reserved) Unique Identifier 2009-06980-004

Kutter, C. J., E. J. Wolf, et al. (2004). "Predictors of Veterans' Participation in Cognitive-Behavioral Group Treatment for PTSD." Journal of Traumatic Stress 17(2): 157-162.

Increasingly effective treatments for posttraumatic stress disorder (PTSD) have led to dramatic improvements in the lives of many trauma survivors; however, a significant subgroup of individuals with PTSD avoids mental health treatment. Little is known about the features distinguishing those who participate in treatment from those who do not. We analyzed archival clinical data from 197 male veterans who were evaluated in a Veterans Affairs Medical Center PTSD clinic. We found greater PTSD severity associated with initial enrollment and continued participation in a PTSD group treatment program, and we noted few differences on other background and symptom measures. These preliminary findings suggest possible directions for future research in this area, which may have implications for enhancing service delivery to individuals with PTSD. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

McFall, M., C. Malte, et al. (2000) Effects of an outreach intervention on use of mental health services by veterans with posttraumatic stress disorder. Psychiatric services (Washington, D.C.) 369-74

OBJECTIVE: The study examined the effectiveness of an outreach intervention designed to increase access to mental health treatment among veterans disabled by chronic posttraumatic stress disorder (PTSD) and identified patient-reported barriers to care associated with failure to seek the treatment offered. METHODS: Participants were 594 male Vietnam veterans who were not enrolled in mental health care at a Department of Veterans Affairs (VA) medical center but who were receiving VA disability benefits for PTSD. Half the sample was randomly assigned to an outreach intervention, and the other half was assigned to a control group. Veterans in the intervention group received a mailing that included a brochure describing PTSD treatment available at an urban VA medical center, along with a letter informing them about how to access care. Participants in the intervention group were subsequently telephoned by a study coordinator who encouraged them to enroll in PTSD treatment and who administered a survey assessing barriers to care. RESULTS: Veterans in the intervention group were significantly more likely than those in the control group to schedule an intake appointment (28 percent versus 7 percent), attend the intake (23

percent versus 7 percent), and enroll in treatment (19 percent versus 6 percent). Several patient-identified barriers were associated with failure to seek VA mental health care, such as personal obligations that prevented clinic attendance, inconvenient clinic hours, and current receipt of mental health treatment from a non-VA provider. CONCLUSIONS: Utilization of mental health services among underserved veterans with PTSD can be increased by an inexpensive outreach intervention, which may be useful with other chronically mentally ill populations.

Sammons, M. T. and S. V. Batten (2008). "Psychological services for returning veterans and their families: evolving conceptualizations of the sequelae of war-zone experiences." J Clin Psychol 64(8): 921-7.

The provision of effective and timely behavioral health care for veterans returning from the conflicts in Iraq and Afghanistan has become the focus of national attention. In this special issue, attempts to provide psychological care for service members and their families are examined in light of three key constructs. First, it is contended that at no other time in history has more attention been paid to the psychological consequences of engaging in combat. Second, for the first time in recorded warfare, psychological morbidity is likely to far outstrip physical injury associated with combat. Finally, although posttraumatic stress disorder and traumatic brain injury are serious concerns, most service members return without significant physical or psychological injury and will be able to return to functioning without notable problems. Accurate diagnosis, a focus on resilience, and the expectation of readjustment are essential precepts that should guide clinical efforts and resource allocation.

PTSD

There are a number of studies relating to PTSD and its treatment, this includes 4 high quality systematic reviews. These are listed below and followed by a wide range of studies of varying treatments.

Bisson, J. and M. Andrew (2007) Psychological treatment of post-traumatic stress disorder (PTSD). Cochrane Database of Systematic Reviews DOI: 10.1002/14651858.CD003388.pub3

http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003388/frame.html

This review concerns the efficacy of psychological treatment in the treatment of PTSD. There is evidence that individual trauma focused cognitive-behavioural therapy (TFCBT), eye movement desensitisation and reprocessing (EMDR), stress management and group TFCBT are effective in the treatment o PTSD. Other non-trauma focused psychological treatments did not reduce PTSD symptoms as significantly. There is some evidence that individual TFCBT and EMDR are superior to stress management in the treatment of PTSD at between 2 and 5 months following treatment, and also that TFCBT, EMDR and stress management are more effective than other therapies. There is insufficient evidence to show whether or not psychological treatment is harmful. Trauma focused cognitive behavioural therapy or eye movement desensitisation and reprocessing should be considered in individuals with PTSD. Psychological treatments can reduce symptoms of post traumatic stress disorder (PTSD). Trauma focused treatments are more effective than non-trauma focused treatments.

Parslow, R., R. Purcell, et al. (2008) Combined pharmacotherapy and psychological therapies for post traumatic stress disorder (PTSD). Cochrane Database of Systematic Reviews DOI: 10.1002/14651858.CD007316
http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD007316/frame.html

This is the protocol for a review which is currently being undertaken, to date, results of the review have not been published. The objectives are as follows: The purpose of this review is to assess whether the combination of psychological therapy and pharmacotherapy provides a more efficacious treatment for PTSD than either of these interventions delivered separately, and whether combination treatment is tolerable to patients with diagnosed PTSD.

Roberts Neil, P., J. Kitchiner Neil, et al. (2009) Multiple session early psychological interventions for the prevention of post-traumatic stress disorder. Cochrane Database of Systematic Reviews DOI: 10.1002/14651858.CD006869.pub2
http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD006869/frame.html

Traumatic events can have a significant impact on individuals', families' and communities' abilities to cope. In the past, single session interventions such as psychological debriefing were widely used with the aim of preventing continuing psychological difficulties. However, previous reviews have found that single session individual interventions have not been effective at preventing post -traumatic stress disorder (PTSD). A range of other forms of intervention have been developed to try to prevent individuals exposed to trauma developing PTSD. This review evaluated the results of 11 studies that tested a diverse range of psychological interventions aimed at preventing PTSD. The results did not find any evidence to support the use of an intervention offered to everyone. There was some evidence that multiple session interventions may result in worse outcome than no intervention for some individuals. Further research is required to evaluate the most effective ways of providing psychological help in the early stages after a traumatic event.

Rose Suzanna, C., J. Bisson, et al. (2002) Psychological debriefing for preventing post traumatic stress disorder (PTSD). Cochrane Database of Systematic Reviews DOI: 10.1002/14651858.CD000560
http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000560/frame.html

This review concerns the efficacy of single session psychological "debriefing" in reducing psychological distress and preventing the development of post traumatic stress disorder (PTSD) after traumatic events. Psychological debriefing is either equivalent to, or worse than, control or educational interventions in preventing or reducing the severity of PTSD, depression, anxiety and general psychological morbidity. There is some suggestion that it may increase the risk of PTSD and depression. The routine use of single session debriefing given to non selected trauma victims is not supported. No evidence has been found that this procedure is effective.

Creamer, M. and D. Forbes (2004). "Treatment of Posttraumatic Stress Disorder in Military and Veteran Populations." Psychotherapy: Theory, Research, Practice, Training 41(4): 388-398.

While concerns about the psychological effects of war are not new, only recently has systematic attention been paid to such problems among past and present military personnel. There is increasing recognition that mental health has serious implications for operational performance, retention, and compensation. Although little controlled research exists with this population, preliminary evidence suggests that psychological treatments for posttraumatic stress disorder may be beneficial, albeit less so than for civilian populations. This article reviews evidence for each of several psychological treatment stages: stabilization and engagement, psychoeducation, symptom management, prolonged exposure, cognitive restructuring, and relapse prevention, with particular reference to the clinical issues raised by

military personnel. Possible explanations for reduced treatment effects in this population compared with civilians are discussed. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Forbes, D., V. Lewis, et al. (2008). "Naturalistic comparison of models of programmatic interventions for combat-related post-traumatic stress disorder." Australian and New Zealand Journal of Psychiatry 42(12): 1051-1059.

Objectives: Post-traumatic stress disorder (PTSD) is a difficult-to-treat sequel of combat. Data on effectiveness of alternate treatment structures are important for planning veterans' psychiatric services. The present study compared clinical presentations and treatment outcomes for Australian veterans with PTSD who participated in a range of models of group-based treatment. Method: Participants consisted of 4339 veterans with combat-related PTSD who participated in one of five types of group-based cognitive behavioural programmes of different intensities and settings. Data were gathered at baseline (intake), as well as at 3 and 9 month follow up, on measures of PTSD, anxiety, depression and alcohol misuse. Analyses of variance and effect size analyses were used to investigate differences at intake and over time by programme type. Results: Small baseline differences by programme intensity were identified. Although significant improvements in symptoms were evident over time for each programme type, no significant differences in outcome were evident between programmes. When PTSD severity was considered, veterans with severe PTSD performed less well in the low-intensity programmes than in the moderate- or high-intensity programmes. Veterans with mild PTSD improved less in high-intensity programmes than in moderate- or low-intensity programmes. Conclusion: Comparable outcomes are evident across programme types. Outcomes may be maximized when veterans participate in programme intensity types that match their level of PTSD severity. When such matching is not feasible, moderate-intensity programmes appear to offer the most consistent outcomes. For regionally based veterans, delivering treatment in their local environment does not detract from, and may even enhance, outcomes. These findings have implications for. the planning and purchasing of mental health services for sufferers of PTSD, particularly for veterans of more recent combat or peacekeeping deployments. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Monson, C. M., S. J. Fredman, et al. (2008). "Cognitive-behavioral conjoint therapy for posttraumatic stress disorder: Application to Operation Enduring and Iraqi Freedom veterans." Journal of Clinical Psychology 64(8): 958-971.

As the newest generation of veterans returns home from their duties abroad, many face the individual and interpersonal aftereffects of duty-related traumatic experiences. Despite the established association between posttraumatic stress disorder (PTSD) and relationship problems, there is a lack of evidence-based conjoint treatments that target both PTSD and relationship distress. Cognitive-behavioral conjoint therapy (CBCT) for PTSD was developed to address this need. The authors summarize knowledge on the association between PTSD and relationship functioning, as well as recent research on veterans and their partners. Following an overview of CBCT for PTSD, the authors present a case study to illustrate the application of CBCT to an Operation Enduring and Iraqi Freedom couple. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Monson, C. M., P. P. Schnurr, et al. (2006). "Cognitive processing therapy for veterans with military-related posttraumatic stress disorder." J Consult Clin Psychol 74(5): 898-907.

Sixty veterans (54 men, 6 women) with chronic military-related posttraumatic stress disorder (PTSD) participated in a wait-list controlled trial of cognitive processing therapy (CPT). The overall dropout rate was 16.6% (20% from CPT, 13% from waiting list). Random regression analyses of the intention-to-treat sample revealed significant improvements in PTSD and comorbid symptoms in the CPT condition compared with the wait-list condition. Forty percent of the intention-to-treat sample receiving CPT did not meet criteria for a PTSD diagnosis, and 50% had a reliable change in their PTSD symptoms at posttreatment assessment. There was no relationship between PTSD disability status and outcomes. This trial provides some of the most encouraging results of PTSD treatment for veterans with chronic PTSD and supports increased use of cognitive- behavioral treatments in this population.

Moon, P. K. (2006). Sand Play Therapy With U.S. Soldiers Diagnosed With PTSD and Their Families. Vistas: Compelling perspectives on counseling 2006., Alexandria, VA, US: American Counseling Association: 63-66.

War is good for one thing: giving hundreds of thousands of American soldiers PTSD. PTSD, or posttraumatic stress disorder, is a psychiatric disorder that results from experiencing or witnessing events that are extremely traumatic or life threatening. Soldiers in Iraq, who experience firsthand military combat and terrorist threats, are especially at risk for developing this disorder. According to a study published in the New England Journal of Medicine (Hoge et al., 2004), 15% to 17% of returning veterans are suffering from posttraumatic stress disorder. This means that literally thousands of American soldiers are returning to the United States with a serious mental disorder that not only affects the soldier, but his or her family system as well. Now more than ever, counselors need to educate themselves about PTSD treatment and be prepared to offer innovative individual and family therapy to military families. One treatment option that shows particular promise in the treatment of PTSD is sand tray therapy. This is discussed in this article. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Pantalon, M. V. and R. W. Motta (1998) Effectiveness of anxiety management training in the treatment of posttraumatic stress disorder: a preliminary report. Journal of behavior therapy and experimental psychiatry 21-9

This preliminary study investigated the effectiveness of anxiety management training (AMT), a coping skills treatment similar to systematic desensitization, in comparison to implosive therapy (IT), an exposure-based treatment, for treating six Vietnam combat veterans with posttraumatic stress disorder (PTSD). The Clinician Administered PTSD Interview Scale (CAPS; Blake et al. (1988), The Behaviour Therapist, 18, 187-188) and a self-monitoring measure (Weathers et al., 1991) were used as dependent measures. A single-subject, multiple-baseline, crossover design (ABC/ACB) was employed. A new statistic for such designs (Mueser et al. (1991), Behaviour Modification, 15, 134-155), based on classical test theory, was used to assess treatment effects on intrusive war memories and avoidance of stimuli reminiscent of war. Within-subject results indicated that AMT and IT were similarly effective in reducing the frequency and intensity of intrusions and avoidance. This preliminary report therefore suggests that it may be productive to investigate multidimensional approaches (combining coping skills, exposure-based, and other approaches) to the treatment of combat-related PTSD as Foa et al. (1991), Journal of Consulting and Clinical Psychology, 59, 715-723 and Nishith et al. (1995), Behaviour Therapy, 26, 319-335 have for rape-related PTSD.

Pitman, R. K., S. P. Orr, et al. (1996) Emotional processing during eye movement desensitization and reprocessing therapy of Vietnam veterans with chronic posttraumatic stress disorder. Comprehensive psychiatry 419-29

This study examined emotional processing and outcome in 17 Vietnam veterans with chronic posttraumatic stress disorder (PTSD) who underwent eye movement desensitization and reprocessing (EMDR) therapy, with and without the eye movement component, in a crossover design. Results supported the occurrence of partial emotional processing, but there were no differences in its extent in the eye-movement versus eyes-fixed conditions. Therapy produced a modest to moderate overall improvement, mostly on the impact of Event Scale. There was slightly more improvement in the eyes-fixed than eye-movement condition. There was little association between the extent of emotional processing and therapeutic outcome. In our hands, EMDR was at least as efficacious for combat-related PTSD as imaginal flooding proved to be in a previous study, and was better tolerated by subjects. However, results suggest that eye movements do not play a significant role in processing of traumatic information in EMDR and that factors other than eye movements are responsible for EMDR's therapeutic effect.

Ragsdale, K. G., R. D. Cox, et al. (1996) Effectiveness of short-term specialized inpatient treatment for war-related posttraumatic stress disorder: a role for adventure-based counseling and psychodrama. Journal of Traumatic Stress 269-83

Psychological tests were administered to 24 participants of an inpatient posttraumatic stress disorder (PTSD) treatment program both immediately before and following completion of treatment. Responses were compared to a treatment/wait list comparison group composed of 24 subjects awaiting entry into the program. All treatment/wait list comparison group subjects received weekly PTSD outpatient group therapy. Significant improvements were found in the inpatient treatment group in areas of hopelessness, feelings of guilt and shame, loneliness, and emotional expressiveness. Other indices of psychological functional, including interpersonal skills, gender role stress, anxiety, anger, and PTSD symptomatology did not change significantly in response to treatment. No positive changes in any area of psychological function occurred in the treatment/wait list comparison group. Implications for PTSD and areas of future research are discussed.

Rauch, S. A., E. Defever, et al. (2009). "Prolonged exposure for PTSD in a Veterans Health Administration PTSD clinic." J Trauma Stress 22(1): 60-4.

With the move toward dissemination of empirically supported treatments in the Veterans Health Administration (VHA), dissemination of additional data concerning the effectiveness of prolonged exposure (PE) among veterans is important. The authors present clinical treatment data from veterans with chronic posttraumatic stress disorder (PTSD) treated in a VHA PTSD clinic (N = 10). Veterans demonstrated significant reductions in total PTSD symptoms from pre- to posttreatment. Returning veterans from the conflicts in Afghanistan and Iraq and other era veterans (Vietnam Veterans and military sexual trauma veterans) demonstrated significant reductions in PTSD. In addition, veterans demonstrated significant reductions in depression from pre- to posttreatment. In conclusion, PE is effective in reducing the symptoms of PTSD in veterans.

Ready, D. J., K. R. Thomas, et al. (2008). "A field test of group based exposure therapy with 102 veterans with war-related posttraumatic stress disorder." Journal of Traumatic Stress 21(2): 150-157.

Group-based exposure therapy (GBET) was field-tested with 102 veterans with war-related posttraumatic stress disorder (PTSD). Nine to 11 patients attended 3 hours of group therapy per day twice weekly for 16-18 weeks. Stress management and a minimum of 60 hours of exposure was included (3 hours of within-group war-trauma presentations per

patient, 30 hours of listening to recordings of patient's own war-trauma presentations and 27 hours of hearing other patients' war-trauma presentations). Analysis of assessments conducted by treating clinicians pre-, post- and 6-month posttreatment suggests that GBET produced clinically significant and lasting reductions in PTSD symptoms for most patients on both clinician symptoms ratings (6-month posttreatment effect size d = 1.22) and self-report measures with only three dropouts. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Rizzo, A., J. Pair, et al. (2005). "Development of a VR therapy application for Iraq war military personnel with PTSD." Stud Health Technol Inform 111: 407-13.

Post Traumatic Stress Disorder (PTSD) is reported to be caused by traumatic events that are outside the range of usual human experiences including (but not limited to) military combat, violent personal assault, being kidnapped or taken hostage and terrorist attacks. Initial data suggests that 1 out of 6 returning Iraq War military personnel are exhibiting symptoms of depression, anxiety and PTSD. Virtual Reality (VR) exposure therapy has been used in previous treatments of PTSD patients with reports of positive outcomes. The aim of the current paper is to specify the rationale, design and development of an Iraq War PTSD VR application that is being created from the virtual assets that were initially developed for theX-Box game entitled Full Spectrum Warrior which was inspired by a combat tactical training simulation, Full Spectrum Command.

Rizzo, A. A., K. Graap, et al. (2008). "Virtual Iraq: initial results from a VR exposure therapy application for combat-related PTSD." Stud Health Technol Inform 132: 420-5.

Post Traumatic Stress Disorder (PTSD) is reported to be caused by traumatic events that are outside the range of usual human experience including (but not limited to) military combat, violent personal assault, being kidnapped or taken hostage and terrorist attacks. Initial data suggests that at least 1 out of 6 Iraq War veterans are exhibiting symptoms of depression, anxiety and PTSD. Virtual Reality (VR) delivered exposure therapy for PTSD has been used with reports of positive outcomes. The aim of the current paper is to present the rationale and brief description of a Virtual Iraq PTSD VR therapy application and present initial findings from its use with PTSD patients. Thus far, Virtual Iraq consists of a series of customizable virtual scenarios designed to represent relevant Middle Eastern VR contexts for exposure therapy, including a city and desert road convoy environment. User-centered design feedback needed to iteratively evolve the system was gathered from returning Iraq War veterans in the USA and from a system deployed in Iraq and tested by an Army Combat Stress Control Team. Clinical trials are currently underway at Ft. Lewis, Camp Pendleton, Emory University, Weill Cornell Medical College, Walter Reed Army Medical Center, San Diego Naval Medical Center and 12 other sites.

Rogers, S., S. M. Silver, et al. (1999) A single session, group study of exposure and Eye Movement Desensitization and Reprocessing in treating Posttraumatic Stress Disorder among Vietnam War veterans: preliminary data. Journal of anxiety disorders 119-30

This report summarizes data gathered thus far from an ongoing study. Two groups (total N = 12) of Vietnam War veterans diagnosed with Posttraumatic Stress Disorder (PTSD) received a single session of exposure or Eye Movement Desensitization and Reprocessing (EMDR) focusing on the veterans' most distressing war experience. Group assignment was random, treatment providers were blind to assessment data, and the pre- and posttreatment assessor was blind to treatment assignment. Both groups showed improvement on the Impact of Event Scale. EMDR treatment resulted in greater positive changes in within-session Subjective Units of Discomfort levels and on self-monitored severity of intrusive recollection. A trend toward decreased heart rate reactivity was observed in both groups. Results must be considered carefully due to the small number of subjects used in the study.

Rona, R. J., M. Jones, et al. (2009). "The impact of posttraumatic stress disorder on impairment in the UK military at the time of the Iraq war." J Psychiatr Res 43(6): 649-55.

The aims of this study were to assess: (1) the relationship between PTSD and impairment, (2) whether there is a threshold in the association of PTSD score and impairment, and (3) whether any of the PTSD criteria are more strongly associated with impairment. We studied 10,069 service personnel from a representative sample of the British Armed Forces to assess the effects of the Iraq war. Participants completed the PTSD checklist (PCL), the general health questionnaire-12 (GHQ-12), the alcohol use disorder identification test (AUDIT) and five questions to assess impairment. 78% of those with a PCL-score of 50 or more endorsed at least one impairment item in comparison to 27% of those with a score below 50. The odds ratio (OR) of impairment in the PCL group with a score of 50 or more was 16.7 (95% CI 12.9-21.6). There was an increasing risk of impairment with an increasing category of PCL-score without a noticeable threshold. For each PTSD subscale: intrusiveness, avoidance/numbing and hyper-arousal, divided into four score categories, there was an increased association with impairment, but the association of avoidance/numbing with impairment was the greatest and independent of the other two criteria (OR 7.2 (95% CI 4.8-10.9). Having a good relationship with a partner had minimal effect on the level of association between PTSD and impairment. Functional impairment is a serious problem for those with PTSD. The impairment is not confined to those with the highest PCL-score. Avoidance/numbing is the criterion which makes the greatest independent contribution to impairment.

Russell, M. C. (2008). "Treating traumatic amputation-related phantom limb pain: A case study utilizing eye movement desensitization and reprocessing within the armed services." Clinical Case Studies 7(2): 136-153.

Since September 2006, more than 725 service members from the global war on terrorism have survived combat-related traumatic amputations that often result in phantom limb pain (PLP) syndrome. Combat amputees are also at high risk of developing chronic mental health conditions such as posttraumatic stress disorder (PTSD) and clinical depression as they deal with wartime experiences, rehabilitation, and postrehabilitation adjustments. One active-duty patient was referred to a military outpatient clinic for treatment of PLP and PTSD following a traumatic leg amputation from a noncombat-related motor vehicle accident. Four sessions of eye movement desensitization and reprocessing (EMDR) led to elimination of PLP and a significant reduction in PTSD, depression, and phantom limb tingling sensations. A detailed account of this treatment, as well as a review of the benefits of EMDR research and treatment in the military, is provided. The results are promising but in need of further research. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Russell, M. C. Friedberg. F. (2009) "Training, treatment access, and research on trauma intervention in the armed services." Journal of EMDR Practice and Research, 3(1),24-31.

In a large posttraumatic stress disorder (PTSD) and depression treatment outcome study, thorough diagnostic assessments of veterans at pretreatment, posttreatment, and 3 follow-up times were completed. The research team that reviewed these assessments encountered several challenges in the differential diagnosis of PTSD because of high comorbidity and symptoms shared with or resembling other disorders. For example, how do mental health professionals distinguish symptoms of agoraphobia from avoidance and hypervigilance symptoms of PTSD? When are hallucinations symptomatic of PTSD (e.g., flashbacks) versus a nonpsychotic near-death experience or an independent psychotic disorder? How do mental health professionals differentiate overlapping symptoms of PTSD and depressive disorders? To help make reliable diagnoses, the team developed clarifying questions and diagnostic guidelines, which may prove useful to other clinicians and

researchers working with PTSD populations. (PsycINFO Database Record (c) 2009 APA, all rights reserved) Unique Identifier 2009-01453-006

Saldanha, D. (2002). "Family intervention in the treatment of post-traumatic stress disorders." Journal of Projective Psychology & Mental Health 9(1): 57-61.

Details the cases of 6 military personnel (aged 17-38 yrs) who, after sustaining various traumas, met criteria for posttraumatic stress disorder (PTSD). A treatment protocol was used that incorporated family members whenever possible. Five families actively cooperated in a trauma-based cognitive framework and insight-oriented psychotherapy to effect on attitudinal change. Five out of the 6 PTSD cases showed significant improvement with the intervention of family members. The 6th case illustrates how incorporating a family member in treatment could have helped prevent chronicity of PTSD. Finally, the significance of the role of families in the care of the mentally ill is discussed. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Schnurr, P. P., M. J. Friedman, et al. (2007). "Cognitive behavioral therapy for posttraumatic stress disorder in women: a randomized controlled trial." JAMA 297(8): 820-30.

CONTEXT: The prevalence of posttraumatic stress disorder (PTSD) is elevated among women who have served in the military, but no prior study has evaluated treatment for PTSD in this population. Prior research suggests that cognitive behavioral therapy is a particularly effective treatment for PTSD. OBJECTIVE: To compare prolonged exposure, a type of cognitive behavioral therapy, with present-centered therapy, a supportive intervention, for the treatment of PTSD. DESIGN, SETTING, AND PARTICIPANTS: A randomized controlled trial of female veterans (n=277) and active-duty personnel (n=7) with PTSD recruited from 9 VA medical centers, 2 VA readjustment counseling centers, and 1 military hospital from August 2002 through October 2005. INTERVENTION: Participants were randomly assigned to receive prolonged exposure (n = 141) or present-centered therapy (n = 143), delivered according to standard protocols in 10 weekly 90-minute sessions. MAIN OUTCOME MEASURES: Posttraumatic stress disorder symptom severity was the primary outcome. Comorbid symptoms, functioning, and quality of life were secondary outcomes. Blinded assessors collected data before and after treatment and at 3- and 6-month follow-up. RESULTS: Women who received prolonged exposure experienced greater reduction of PTSD symptoms relative to women who received present-centered therapy (effect size, 0.27; P = .03). The prolonged exposure group was more likely than the present-centered therapy group to no longer meet PTSD diagnostic criteria (41.0% vs 27.8%; odds ratio, 1.80; 95% confidence interval, 1.10-2.96; P = .01) and achieve total remission (15.2% vs 6.9%; odds ratio, 2.43; 95% confidence interval, 1.10-5.37; P = .01). Effects were consistent over time in longitudinal analyses, although in cross-sectional analyses most differences occurred immediately after treatment. CONCLUSIONS: Prolonged exposure is an effective treatment for PTSD in female veterans and active-duty military personnel. It is feasible to implement prolonged exposure across a range of clinical settings.

Schnurr, P. P., M. J. Friedman, et al. (2003). "Randomized trial of trauma-focused group therapy for posttraumatic stress disorder: Results from a Department of Veterans Affairs cooperative study." Archives of General Psychiatry 60(5): 481-489.

Department of Veterans Affairs Cooperative Study 420 is a randomized clinical trial of 2 methods of group psychotherapy for treating posttraumatic stress disorder (PTSD) in male Vietnam veterans. 360 veterans were randomly assigned to receive trauma-focused group psychotherapy or a present-centered comparison treatment that avoided trauma focus. Treatment was provided weekly to groups of 6 members for 30 wks, followed by 5 monthly booster sessions. Severity of PTSD was the primary outcome. Additional measures were other

psychiatric symptoms, functional status, quality of life, physical health, and service utilization. Follow-up assessments were conducted at the end of treatment (7 mo) and at the end of the booster sessions (12 mo); 325 individuals participated in 1 or both assessments. Additional follow-up for PTSD severity was performed in a subset of participants at 18 and 24 mo. Although posttreatment assessments of PTSD severity and other measures were significantly improved from baseline, intention-to-treat analyses found no overall differences between therapy groups on any outcome. Analyses of data from participants who received an adequate dose of treatment suggested that trauma-focused group therapy reduced avoidance and numbing and, possibly, PTSD symptoms.... (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Strauss, J. L., P. S. Calhoun, et al. (2009). Guided imagery as a therapeutic tool in post-traumatic stress disorder. Post-traumatic stress disorder: Basic science and clinical practice., Totowa, NJ, US: Humana Press: 363-373.

Guided imagery is a behavioral technique used to direct individuals to effectively create and manipulate mental representations to produce therapeutic changes. A growing empirical literature supports the use of these techniques in a variety of physical and emotional conditions. The focus of our research program is on applying these techniques to the treatment of post-traumatic stress disorder (PTSD). We have developed and piloted a clinician-facilitated, self-management intervention for PTSD called guided imagery for trauma (GIFT). We describe the rationale for this approach, its conceptual framework, and the treatment protocol. We present preliminary findings in a sample of women with PTSD related to military sexual trauma, which demonstrate feasibility, tolerability, and a large effect on PTSD symptoms. We also describe our current research efforts, including a randomized controlled trial of the GIFT intervention in women survivors of military sexual trauma, and the extension of this intervention to the treatment of combat-related PTSD. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Teng, E. J., S. D. Bailey, et al. (2008). "Treating comorbid panic disorder in veterans with posttraumatic stress disorder." Journal of Consulting and Clinical Psychology 76(4): 704-710.

This study compares the effectiveness of panic control treatment (PCT) with that of a psychoeducational supportive treatment (PE-SUP) in treating panic disorder among a veteran sample with a primary diagnosis of chronic posttraumatic stress disorder (PTSD). Thirty-five patients randomized to receive 10 individual sessions of either PCT or PE-SUP underwent assessments at pretreatment, at 1-week posttreatment, and at a 3-month follow-up. Intent-to-treat analyses of covariance showed that PCT participants significantly improved on panic severity at posttreatment and panic fear at the 3-month follow-up. The PCT group also showed significant reductions in anxiety sensitivity at posttreatment and follow-up compared with that of the PE-SUP group. A significantly higher proportion of persons (63%) in the PCT group was panic free by the follow-up period compared with that of the PE-SUP group (19%). Patient self-report and clinician ratings showed no changes in general anxiety, depression, and PTSD symptoms in either group. These findings indicated that PCT was superior to an active control therapy in reducing the frequency, severity, and distress associated with panic disorder and suggested that brief cognitive-behavioral therapy for panic is effective for persons with chronic PTSD. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

SUICIDE

Brenner, L. A., P. M. Gutierrez, et al. (2008). "A Qualitative study of potential suicide risk factors in returning combat veterans." Journal of Mental Health Counseling 30(3): 211-225.

According to the interpersonal-psychological theory of attempted and completed suicide (Joiner, 2005) suicide-related behavior is contingent upon three factors: acquired ability, burdensomeness, and failed belongingness. Qualitative research methodology was employed to explore these concepts among a group of returning Operation Enduring Freedom (OEF)ZOperation Iraqi Freedom (OIF) combat veterans. A sample of 16 individuals participated in interviews. Themes emerged regarding combat as a context for exposure to pain, subsequent coping strategies, and perceptions of burdensomeness, failed belongingness, and increased pain tolerance. Suicidal behavior was also articulated as a means of coping with risk factors outlined by Joiner. These results highlight the potential utility of this theory for OEF/OIF veterans. Interventions aimed at decreasing emotional dysregulation, and lessening perceptions of burdensomeness and failed belongingness may reduce risk for suicidal behavior. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Matthieu, M. M., W. Cross, et al. (2008). "Evaluation of gatekeeper training for suicide prevention in veterans." Archives of Suicide Research 12(2): 148-154.

Clinical providers and "front line" nonclinical staff who work with veterans, families, and communities are natural gatekeepers to identify and to refer veterans at risk for suicide. A national cohort (n = 602) of community based counseling center staff from the U.S. Department of Veterans Affairs (VA) participated in an evaluation of a brief standardized gatekeeper training program and a scripted behavioral rehearsal practice session. A significant difference in knowledge and self efficacy was observed from pre to post ($p < .0001$) with the nonclinicians showing larger effect sizes for knowledge (0.96 vs. 0.42) and self efficacy (0.89 vs. 0.41). Gatekeeper training for suicide prevention shows promise for increasing the capacity of VA staff to work with at risk veterans. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Smoking

Severson, H. H., A. L. Peterson, et al. (2009). "Smokeless tobacco cessation in military personnel: a randomized controlled trial." Nicotine Tob Res 11(6): 730-8.

INTRODUCTION: Military personnel are twice as likely as civilians to use smokeless tobacco (ST). This study evaluated the efficacy of a minimal-contact ST cessation program in military personnel. METHODS: Participants were recruited from 24 military dental clinics across the United States during annual dental examinations. Participants were 785 active-duty military personnel who were randomly assigned to receive a minimal-contact behavioral treatment (n = 392) or usual care (n = 393). The behavioral treatment included an ST cessation manual, a videotape cessation guide tailored for military personnel, and three 15-min telephone counseling sessions using motivational interviewing methods. Usual care consisted of standard procedures that are part of the annual dental examination, including recommendations to quit using ST and referral to extant local tobacco cessation programs. Participants were assessed at 3 and 6 months after enrollment. RESULTS: Participants in the ST cessation program were significantly more likely to be abstinent from all tobacco, as assessed by repeated point prevalence at both 3 and 6 months (25.0%), and were significantly more likely to be abstinent from ST use for 6 months, as assessed by prolonged abstinence (16.8%), compared with participants in usual care (7.6% and 6.4%, respectively). DISCUSSION: These results indicate that a minimal-contact behavioral treatment can significantly reduce ST use in military personnel and has the potential for widespread dissemination. If ST users were identified in dental visits and routinely referred to telephone counseling, this could have a substantial benefit for the health and well-being of military personnel.

Various Psychological Treatments

A range of other studies provide limited evidence different types of psychological treatments

Krieshok, T. S., S. Hastings, et al. (1999). "Telling a good story: Using narratives in vocational rehabilitation with veterans." The Career Development Quarterly 47(3): 204-214.

Because of the high chronicity of work-related problems in the Veterans Administration Medical Center (VAMC) population, many of the traditional methods of career assessment, counseling, and placement have proven ineffectual. This article details the development of a vocational intervention based on narrative or storytelling principles. Ss were 14 veterans (13 males and 1 female; ages 26â€“62 yrs) seeking assistance from a VAMC vocational rehabilitation program. Seven Ss had medical problems, 10 had mental health diagnoses, and several had combinations of the two. Ss were asked to narrate a story of their desired future (i.e., 1 yr hence), being as specific as possible regarding their living and work situations as well as other factors. Stories were subjected to a qualitative analysis and counselors rated the stories on several factors including overall goodness (i.e., how well the client's story might act as a usable roadmap for goals in the coming year). Client's whose stories had higher overall goodness ratings tended to have better vocational outcomes. The usefulness of stories as an organizing principle for counselors and clients is discussed, and suggestions are offered for further uses of storytelling interventions. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Lanza, M. L., J. Anderson, et al. (2002). "Assaultive behavior intervention in the Veterans Administration: Psychodynamic group psychotherapy compared to cognitive behavior therapy." Perspectives in Psychiatric Care 38(3): 89-97.

Compared the efficacy of a psychodynamic psychotherapy group (PPG) and a cognitive-behavior group (CBG) for 27 male veterans with a history of assault. Data collected included the Addiction Severity Index, the Overt Aggression Scale, and the State-Trait Anger Expression Inventory. Analyses included an overall comparison of the groups as well as repeated-measures analyses and adjustments for covariates. The PPG showed a trend toward improvement of overt aggression and significant improvement of trait aggression compared with CBG. There were no differences in state aggression or efforts to control aggression. Results suggest that both the PPG and CBG are effective treatments for aggression. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Larsson, G., P.-O. Michel, et al. (2000). "Systematic assessment of mental health following various types of posttrauma support." Military Psychology 12(2): 121-135.

Evaluated the influence of different forms of support (peer support, ventilation or defusing led by the ordinary group leader, and more formal debriefing sessions led by an external counselor) on mental health following traumatic experiences, using a prospective study design. The sample consisted of a 510 members of a Swedish batallion in Bosnia (20â€“53 yrs of age), who was part of NATO's implementation force in 1996. Preservice assessment was made of personality, sense of coherence, and mental health. One-third of the soldiers experienced traumatic situations during their service. Results showed that poor mental health after service was related more to preservice mental health and sense of coherence than to trauma exposure and posttrauma support. Peer support followed by a defusing session had a positive effect on postservice mental health, although this did not apply to the individuals with the worst preservice mental health. The value of formal debriefings could not be evaluated due to insufficient data. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Peters, L., E. P. Simon, et al. (2000). "The COPE program: treatment efficacy and medical utilization outcome of a chronic pain management program at a major military hospital." Mil Med 165(12): 954-60.

This study presents a treatment efficacy and medical utilization evaluation of a cognitive-behavioral, outpatient, chronic pain management program in a military hospital setting. A total of 61 nonmalignant chronic pain patients with heterogeneous pain syndromes who participated in sequential group programs were included in the study. Comprehensive and multi-dimensional outcome criteria were used, including pain ratings, relaxation skills, quality of life, satisfaction ratings, and medical utilization. The findings demonstrated improvements on all general indices. Military status had no effect on any of the outcome measures. Most significant was an 87% reduction in outpatient clinic visits in the first 3 months after treatment. This reduction amounts to a projected net annual saving of $78,960 in the first year after behavioral medicine intervention. In light of the increasing cost of health care for chronic pain patients, psychological approaches as an adjunct to traditional medical care seem to present a sound solution for cost savings. This study also supports the notion that a strategic biopsychosocial pain program, which targets the multiple dimensions of persistent pain, provides effective treatment and increases patient satisfaction.

Schmidt, N. B., J. P. Staab, et al. (1997). "Efficacy of a brief psychosocial treatment for panic disorder in an active duty sample: implications for military readiness." Mil Med 162(2): 123-9.

OBJECTIVE: The efficacy of a brief cognitive-behavioral treatment for panic in military personnel was evaluated. Method: Active duty military patients (N = 37) presenting at outpatient psychiatry and psychology clinics were randomly assigned to immediate or delayed treatment conditions. All patients met Diagnostic and Statistical Manual of Mental Disorders criteria for a primary diagnosis of panic disorder with or without agoraphobia. RESULTS: At posttreatment, 80% of the immediate treatment group, compared to 0% of the delayed treatment group, met recovery criteria on all major clinical facets of panic disorder (i.e., panic attacks, panic-related worry, phobic avoidance). At follow-up, 75% of the treated group continued to meet recovery criteria, suggesting maintenance of treatment gains. A majority of those patients (58%) taking benzodiazepines at the start of treatment were successfully discontinued by posttreatment. CONCLUSIONS: Brief, skill-based treatments for panic disorder are effective for a majority of active duty personnel. These treatments may also improve military readiness by facilitating benzodiazepine discontinuation.

Sharpley, J. G., N. T. Fear, et al. (2008). "Pre-deployment stress briefing: does it have an effect?" Occup Med (Lond) 58(1): 30-4.

BACKGROUND: The role of giving information about stress and stress reactions to people about to be exposed to hazardous situations remains unclear. Such information might improve coping and hence resilience. Alternatively, it might increase the expectancy of experiencing adverse psychological consequences following exposure to a hazard. AIM: To determine the effect of a pre-operational stress briefing on health and occupational indices among Naval and Marine personnel who were subsequently deployed to the 2003 Iraq War. METHOD: Controlled, non-randomized, parallel group study. Mental health outcomes post-deployment were compared between those who received a pre-operational stress briefing and those who did not receive such a briefing. RESULTS: Stress briefing attendees were slightly younger, more likely to be marines and to have been exposed to traumatic events than non-attendees. There were no significant differences between the two groups for the health outcomes of common mental health disorders, post-traumatic stress disorder or alcohol misuse. Attendees reported higher morale/cohesion but these differences disappeared

following adjustment for demographic and military factors. No differences between the two groups were apparent for experiencing problems during or post-deployment or for marital satisfaction. CONCLUSIONS: We found no evidence that a pre-deployment stress briefing reduced subsequent medium-term psychological distress. On the other hand, we found no evidence of harm either. While only a randomized trial can give genuinely unbiased results, at present stress debriefing must be regarded as an unproven intervention, and it remains a matter of judgement as to whether or not it is indicated.

EMDR

Carlson, J. G., C. M. Chemtob, et al. (1998) Eye movement desensitization and reprocessing (EDMR) treatment for combat-related posttraumatic stress disorder. Journal of Traumatic Stress 3-24

Despite the clinical and social impact of posttraumatic stress disorder (PTSD), there are few controlled studies investigating its treatment. In this investigation, the effectiveness of two psychotherapeutic interventions for PTSD were compared using a randomized controlled outcome group design. Thirty five combat veterans diagnosed with combat-related PTSD were treated with either (a) 12 sessions of eye movement desensitization and reprocessing, EMDR (n = 10), (b) 12 sessions of biofeedback-assisted relaxation (n = 13), or (c) routine clinical care, serving as a control (n = 12). Compared with the other conditions, significant treatment effects in the EMDR condition were obtained at posttreatment on a number of self-report, psychometric, and standardized interview measures. Relative to the other treatment group, these effects were generally maintained at 3-month follow-up. Psychophysiological measures reflected an apparent habituation effect from pretreatment to posttreatment but were not differentially affected by treatment condition.

Pitman, R. K., S. P. Orr, et al. (1996) Emotional processing during eye movement desensitization and reprocessing therapy of Vietnam veterans with chronic posttraumatic stress disorder. Comprehensive psychiatry 419-29

This study examined emotional processing and outcome in 17 Vietnam veterans with chronic posttraumatic stress disorder (PTSD) who underwent eye movement desensitization and reprocessing (EMDR) therapy, with and without the eye movement component, in a crossover design. Results supported the occurrence of partial emotional processing, but there were no differences in its extent in the eye-movement versus eyes-fixed conditions. Therapy produced a modest to moderate overall improvement, mostly on the impact of Event Scale. There was slightly more improvement in the eyes-fixed than eye-movement condition. There was little association between the extent of emotional processing and therapeutic outcome. In our hands, EMDR was at least as efficacious for combat-related PTSD as imaginal flooding proved to be in a previous study, and was better tolerated by subjects. However, results suggest that eye movements do not play a significant role in processing of traumatic information in EMDR and that factors other than eye movements are responsible for EMDR's therapeutic effect.

Rogers, S., S. M. Silver, et al. (1999) A single session, group study of exposure and Eye Movement Desensitization and Reprocessing in treating Posttraumatic Stress Disorder among Vietnam War veterans: preliminary data. Journal of anxiety disorders 119-30

This report summarizes data gathered thus far from an ongoing study. Two groups (total N = 12) of Vietnam War veterans diagnosed with Posttraumatic Stress Disorder (PTSD) received a single session of exposure or Eye Movement Desensitization and Reprocessing (EMDR) focusing on the veterans' most distressing war experience. Group assignment was random, treatment providers were blind to assessment data, and the pre- and posttreatment assessor was blind to treatment assignment. Both groups showed improvement on the Impact of Event Scale. EMDR treatment resulted in greater positive changes in within-session Subjective Units of Discomfort levels and on self-monitored severity of intrusive recollection. A trend toward decreased heart rate reactivity was observed in both groups. Results must be considered carefully due to the small number of subjects used in the study.

Russell, M. C. (2006). "Treating combat-related stress disorders: A multiple case study utilizing eye movement desensitization and reprocessing (EMDR) with battlefield casualties from the Iraqi War." Military Psychology 18(1): 1-18.

Casualties from the Iraqi War were evacuated to a field hospital in Rota, Spain, and were screened for combat-related stress conditions. Four combat veterans requested immediate relief of their posttraumatic symptoms prior to returning to the United States. A single session of Eye Movement Desensitization and Reprocessing (EMDR) led to significant improvement in their acute stress disorder and posttraumatic stress disorder symptoms. A detailed account of those treatment sessions, as well as the proposed alterations of standard protocols for time-limited fleldwork, is presented. Compared to other early interventions, EMDR may be better suited for combat veterans. The results are promising but in need of further research. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Russell, M. C. (2008). "Treating traumatic amputation-related phantom limb pain: A case study utilizing eye movement desensitization and reprocessing within the armed services." Clinical Case Studies 7(2): 136-153.

Since September 2006, more than 725 service members from the global war on terrorism have survived combat-related traumatic amputations that often result in phantom limb pain (PLP) syndrome. Combat amputees are also at high risk of developing chronic mental health conditions such as posttraumatic stress disorder (PTSD) and clinical depression as they deal with wartime experiences, rehabilitation, and postrehabilitation adjustments. One active-duty patient was referred to a military outpatient clinic for treatment of PLP and PTSD following a traumatic leg amputation from a noncombat-related motor vehicle accident. Four sessions of eye movement desensitization and reprocessing (EMDR) led to elimination of PLP and a significant reduction in PTSD, depression, and phantom limb tingling sensations. A detailed account of this treatment, as well as a review of the benefits of EMDR research and treatment in the military, is provided. The results are promising but in need of further research. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Russell, M. C., S. M. Silver, et al. (2007). "Responding to an identified need: A joint department of defense/department of veterans affairs training program in eye movement desensitization and reprocessing (EMDR) for clinicians providing trauma services." International Journal of Stress Management 14(1): 61-71.

An earlier study of federal Department of Defense mental health professionals found relatively few trained in the psychotherapies for posttraumatic stress disorder previously identified as effective by both this department and the federal Department of Veterans Affairs. In response to that need, a training program for one of the psychotherapies, eye movement desensitization and reprocessing (EMDR), was implemented utilizing personnel from these federal departments with assistance from a nonprofit agency. This article presents an evaluation of that program with rating data gathered from participants as well as treatment outcome data from the application of the training to patients. The program was highly rated by the participants and the impact of EMDR treatment was significant. Suggestions for similar programs and for further research are offered. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Silver, S. M., A. Brooks, et al. (1995) Treatment of Vietnam War veterans with PTSD: a comparison of eye movement desensitization and reprocessing, biofeedback, and relaxation training. Journal of Traumatic Stress 337-42

Analyses of scaled self-report data from Vietnam War veterans receiving inpatient treatment for Post-Traumatic Stress Disorder drawn during a program evaluation study suggested inpatient treatment as provided by the program resulted in significant improvement in the areas of Anxiety, Anger, Depression, Isolation, Intrusive Thoughts (of combat experiences), Flashbacks, Nightmares (of combat experiences), and Relationship Problems. Comparing the relative effects of the incremental addition of Eye Movement Desensitization and Reprocessing (EMDR), Relaxation Training, and Biofeedback found that EMDR was for most problems the most effective extra treatment, greatly increasing the positive impact of the treatment program.

CBT

Schmidt, N. B., J. P. Staab, et al. (1997). "Efficacy of a brief psychosocial treatment for panic disorder in an active duty sample: implications for military readiness." Mil Med 162(2): 123-9.

OBJECTIVE: The efficacy of a brief cognitive-behavioral treatment for panic in military personnel was evaluated. Method: Active duty military patients (N = 37) presenting at outpatient psychiatry and psychology clinics were randomly assigned to immediate or delayed treatment conditions. All patients met Diagnostic and Statistical Manual of Mental Disorders criteria for a primary diagnosis of panic disorder with or without agoraphobia. RESULTS: At posttreatment, 80% of the immediate treatment group, compared to 0% of the delayed treatment group, met recovery criteria on all major clinical facets of panic disorder (i.e., panic attacks, panic-related worry, phobic avoidance). At follow-up, 75% of the treated group continued to meet recovery criteria, suggesting maintenance of treatment gains. A majority of those patients (58%) taking benzodiazepines at the start of treatment were successfully discontinued by posttreatment. CONCLUSIONS: Brief, skill-based treatments for panic disorder are effective for a majority of active duty personnel. These treatments may also improve military readiness by facilitating benzodiazepine discontinuation.

Schnurr, P. P., M. J. Friedman, et al. (2007). "Cognitive behavioral therapy for posttraumatic stress disorder in women: a randomized controlled trial." JAMA 297(8): 820-30.

CONTEXT: The prevalence of posttraumatic stress disorder (PTSD) is elevated among women who have served in the military, but no prior study has evaluated treatment for PTSD in this population. Prior research suggests that cognitive behavioral therapy is a particularly effective treatment for PTSD. OBJECTIVE: To compare prolonged exposure, a type of cognitive behavioral therapy, with present-centered therapy, a supportive intervention, for the treatment of PTSD. DESIGN, SETTING, AND PARTICIPANTS: A randomized controlled trial of female veterans (n=277) and active-duty personnel (n=7) with PTSD recruited from 9 VA medical centers, 2 VA readjustment counseling centers, and 1 military hospital from August 2002 through October 2005. INTERVENTION: Participants were randomly assigned to receive prolonged exposure (n = 141) or present-centered therapy (n = 143), delivered according to standard protocols in 10 weekly 90-minute sessions. MAIN OUTCOME MEASURES: Posttraumatic stress disorder symptom severity was the primary outcome. Comorbid symptoms, functioning, and quality of life were secondary outcomes. Blinded assessors collected data before and after treatment and at 3- and 6-month follow-up. RESULTS: Women who received prolonged exposure experienced greater reduction of PTSD symptoms relative to women who received present-centered therapy (effect size, 0.27; P = .03). The prolonged exposure group was more likely than the present-centered therapy group to no longer meet PTSD diagnostic criteria (41.0% vs 27.8%; odds ratio, 1.80; 95% confidence interval, 1.10-2.96; P = .01) and achieve total remission (15.2% vs 6.9%; odds ratio, 2.43; 95% confidence interval, 1.10-5.37; P = .01). Effects were consistent over time in longitudinal analyses, although in cross-sectional analyses most differences occurred immediately after treatment. CONCLUSIONS: Prolonged exposure is an effective treatment for PTSD in female veterans and active-duty military personnel. It is feasible to implement prolonged exposure across a range of clinical settings. TRIAL REGISTRATION: clinicaltrials.gov Identifier: NCT00032617.

Counselling

Dobson, M., D. A. Grayson, et al. (1996). "The impact of a counseling service program on the psychosocial morbidity of Australian Vietnam Veterans." Evaluation Review 20(6): 670-694.

Evaluated the effectiveness of the Vietnam Veterans Counselling Service (VVCS), a national counseling program for Australian Vietnam veterans. The symptom levels of 146 VVCS clients were compared with those of 546 matched nonclient controls. Health outcomes assessed ranged from depression and posttraumatic stress disorder (PTSD) to alcohol dependence and problems in dyadic adjustment. The positive influence of service-based counseling was most evident in the areas of alcohol dependence and dyadic adjustment. Findings are consistent with the view that the major benefit of treatment programs such as the VVCS is that they facilitate veteran coping responses, thereby enabling them to "live well" with their symptomatology. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Family Therapy

Elmore, D. L.(2009) "Addressing the mental health needs of returning service members. Publication Date Sep, 2009." Monitor on Psychology;Sep, 2009; 40(8) 1529-4978:

The present study examined interest in family involvement in treatment and preferences concerning the focus of family oriented treatment for veterans (N = 114) participating in an outpatient Veterans Affairs outpatient posttraumatic stress disorder (PTSD) program. Most veterans viewed PTSD as a source of family stress (86%) and expressed interest in greater family involvement in their treatment (79%). These results suggest the need to consider increasing family participation in the clinical care of individuals with PTSD and to develop specialized family educational and support services for this population. (PsycINFO Database Record (c) 2009 APA, all rights reserved) Unique Identifier 2009-12007-002

Glynn, S. M., S. Eth, et al. (1999) A test of behavioral family therapy to augment exposure for combat-related posttraumatic stress disorder. Journal of consulting and clinical psychology 243-51

This study tested a family-based skills-building intervention in veterans with chronic combat-related posttraumatic stress disorder (PTSD). Veterans and a family member were randomly assigned to 1 of 3 conditions: (a) waiting list, (b) 18 sessions of twice-weekly exposure therapy, or (c) 18 sessions of twice-weekly exposure therapy followed by 16 sessions of behavioral family therapy (BFT). Participation in exposure therapy reduced PTSD positive symptoms (e.g., reexperiencing and hyperarousal) but not PTSD negative symptoms. Positive symptom gains were maintained at 6-month follow-up. However, participation in BFT had no additional impact on PTSD symptoms.

Leibowitz, R. Q. Jeffreys Matthew D. Copeland Laurel A. Noël Polly H.(2008) "Veterans' disclosure of trauma to healthcare providers." General Hospital Psychiatry, 30(2), 100-103

This study examined problems pertaining to the health and well-being of Army spouses during deployment, comparing those whose experienced extensions of their partners' deployments with those whose partners returned home on time or early. It used data from a 2004 survey of 798 spouses of active duty personnel. Controlling for demographic and deployment characteristics, spouses who experienced extensions fared worse on an array of measures, including mental well-being (e.g., feelings of depression), household strains (e.g., problems with household and car maintenance), and some areas of their jobs (having to stop work or to work fewer hours). There were no statistically significant differences regarding problems pertaining to their overall health, marriage, other work issues, finances, relationships with Army families, or safety. However, spouses who experienced extensions were more likely to perceive the Army negatively during deployment. These findings suggest that deployment extensions may exacerbate certain problems and frustrations for Army spouses. (PsycINFO Database Record (c) 2009 APA, all rights reserved) Unique Identifier 2008-03460-001

Saldanha, D. (2002). "Family intervention in the treatment of post-traumatic stress disorders." Journal of Projective Psychology & Mental Health 9(1): 57-61.

Details the cases of 6 military personnel (aged 17-38 yrs) who, after sustaining various traumas, met criteria for posttraumatic stress disorder (PTSD). A treatment protocol was used that incorporated family members whenever possible. Five families actively cooperated in a trauma-based cognitive framework and insight-oriented psychotherapy to effect on attitudinal change. Five out of the 6 PTSD cases showed significant improvement with the intervention of family members. The 6th case illustrates how incorporating a family member in treatment could have helped prevent chronicity of PTSD. Finally, the significance of the role of families

in the care of the mentally ill is discussed. (PsycINFO Database Record (c) 2009 APA, all rights reserved)

Research Methods

Schnurr, P. P., M. J. Friedman, et al. (2005) Issues in the design of multisite clinical trials of psychotherapy: VA Cooperative Study No. 494 as an example. Contemporary Clinical Trials, 6: 626-36

This article describes issues in the design of an ongoing multisite randomized clinical trial of psychotherapy for treating posttraumatic stress disorder (PTSD) in female veterans and active duty personnel. Research aimed at testing treatments for PTSD in women who have served in the military is especially important due to the high prevalence of PTSD in this population. VA Cooperative Study 494 was designed to enroll 384 participants across 12 sites. Participants are randomly assigned to receive 10 weekly sessions of individual psychotherapy: Prolonged Exposure, a specific cognitive-behavioral therapy protocol for PTSD, or present-centered therapy, a comparison treatment that addresses current interpersonal problems but avoids a trauma focus. PTSD is the primary outcome. Additional outcomes are comorbid problems such as depression and anxiety; psychosocial function and quality of life; physical health status; satisfaction with treatment; and service utilization. Follow-up assessments are conducted at the end of treatment and then 3 and 6 months after treatment. Both treatments are delivered according to a manual. Videotapes of therapy sessions are viewed by experts who provide feedback to therapists throughout the trial to ensure adherence to the treatment manual. Discussion includes issues encountered in multisite psychotherapy trials along with the rationale for our decisions about how we addressed these issues in CSP #494.

Schnurr, P. P., M. J. Friedman, et al. (2001) Design of Department of Veterans Affairs Cooperative Study no. 420: group treatment of posttraumatic stress disorder. Controlled clinical trials 74-88

Posttraumatic stress disorder (PTSD) is a significant problem for a large number of veterans who receive treatment from the Department of Veterans Affairs (VA) health-care system. VA Cooperative Study 420 is a randomized clinical trial of group psychotherapy for treating PTSD among veterans who sought VA care. Participants at ten sites were randomly assigned to receive one of the two treatments: active treatment that embedded exposure therapy in a group context or comparison treatment that avoided trauma focus and instead addressed current interpersonal problems. Treatment was delivered weekly to groups of six participants for 30 weeks, followed by five monthly booster sessions. Follow-up assessments were conducted at the end of treatment (7 months) and the end of boosters (12 months) for all participants. Long-term follow-up data were collected for a subset of participants at 18 and 24 months. The primary outcome is PTSD severity; other symptoms, functional status, quality of life, physical health, and service utilization also were assessed. Data analysis will account for the clustering introduced by the group nature of the intervention. The pivotal comparison was at the end of treatment. Analyses of subsequent outcomes will concentrate on the question of the durability of effects. The study provides an example of how to address the unique challenges posed by multisite trials of group psychotherapy through attention to methodological and statistical issues. This article discusses these challenges and describes the design and methods of the study. Control Clin Trials 2001;22:74-88

Stirman, S. W. (2008) The applicability of randomized controlled trials of psychosocial treatments for PTSD to a veteran population. Journal of psychiatric practice,4: 199-208

The extent to which the results of randomized controlled trials can be expected to generalize to clinical populations has been the subject of much debate. To examine this issue among a population of individuals diagnosed with posttraumatic stress disorder (PTSD), the clinical characteristics of Veterans Affairs (VA) patients with PTSD were compared to the

eligibility criteria for clinical trials of psychosocial treatments for PTSD. Administrative data for 239,668 patients who received a diagnosis of PTSD within the VA healthcare system during the 2003 fiscal year were compared with inclusion and exclusion criteria of 31 clinical trials for PTSD. Based on available data, all patients appeared to be eligible for at least one study, and half (50%) were eligible for between 16 and 21 (50% or more) of the 31 studies examined. The studies for which the most veterans with PTSD would have been eligible targeted combat-related trauma or did not specify type of trauma in their eligibility criteria. Veterans who exhibited psychotic symptoms (3% of the sample) were ineligible for most, but not all, of the studies. However, most veterans with comorbid Axis I conditions, such as depression, anxiety disorders, and substance use disorders, were eligible for multiple studies. These findings, which indicate that the existing literature on the efficacy of psychosocial treatment may inform the treatment of the majority of veterans who present with PTSD, have applications for the design of future clinical trials and for consultation of the literature regarding appropriate treatments for veterans with PTSD.