









at the 6-month follow-up. Bupropion SR was generally well-tolerated in combination with other psychotropic medications. Bupropion SR may be effective in helping patients who desire to quit smoking and who also have a concomitant anxiety disorder, such as PTSD.

KESSLER, R.C., SONNEGA, A., BROMET, E., HUGHES, M., & NELSON, C.B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, 52, 1048-1060. Data from a representative national sample of 5877 persons aged 15 to 54 years were used to examine the general population epidemiology of DSM-III-R PTSD, including information on estimated lifetime prevalence, the kinds of traumas most often associated with PTSD, sociodemographic correlates, the comorbidity of PTSD with other lifetime psychiatric disorders, and the duration of an index episode. Modified versions of the DSM-III-R PTSD module from the Diagnostic Interview Schedule and of the Composite International Diagnostic Interview were administered to a part II subsample of the National Comorbidity Survey. The estimated lifetime prevalence of PTSD is 7.8%. Prevalence is elevated among women and the previously married. The traumas most commonly associated with PTSD are combat exposure and witnessing among men and rape and sexual molestation among women. PTSD is strongly comorbid with other lifetime DSM-III-R disorders. Survival analysis shows that more than one third of people with an index episode of PTSD fail to recover even after many years. PTSD is more prevalent than previously believed, and is often persistent. [adapted from abstract]

KOENEN, K.C., HITSMAN, B., LYONS, M.J., NIAURA, R., McCAFFERY, J., GOLDBERG, J., et al. (2005). A twin registry study of the relationship between posttraumatic stress disorder and nicotine dependence in men. *Archives of General Psychiatry*, 62, 1258-1265. To test competing explanations for the association between PTSD and nicotine dependence (ND), data were analyzed on 6744 members of the Vietnam Era Twin Registry, a national registry of all male-male twin pairs who served in the military during the Vietnam era interviewed in 1991-1992. The prevalence of ND was elevated among trauma-exposed individuals (52.0%) and those with PTSD (71.7%) compared with unexposed individuals (40.5%). This association was significant for ND and for trauma without PTSD and was not entirely explained by shared risk factors. Shared genetic effects explained 63% of the PTSD-ND association; the remaining covariance was explained by individual-specific environmental effects. Using survival analysis with time-dependent covariates, ND was associated with a substantially increased risk of PTSD among trauma-exposed men. Trauma and PTSD were less strongly but significantly associated with increased risk of ND onset after controlling for shared risk factors. Most of the PTSD-ND association is explained by shared genetic effects. However, there is a substantial, robust PTSD-ND association not explained by shared risk factors. Multiple explanations for the association were supported; however, the strongest association was consistent with preexisting ND increasing the risk of PTSD onset. These data suggest that male veterans with a history of ND may be at increased risk for PTSD. [adapted from abstract]

KULKA, R.A., SCHLENGER, W.E., FAIRBANK, J.A., HOUGH, R.L., JORDAN, B.K., MARMAR, C.R., & WEISS, D.S. (1990). Trauma and the Vietnam War generation: Report of findings from the National Vietnam Veterans Readjustment Study. New York: Brunner/Mazel. This overview is offered to provide access to a more general, thematic perspective of the study. [Text, p. 265] Topics addressed include an overview of findings keyed to specific issues of Public Law 98-160 (the prevalence of PTSD among Vietnam veterans; the prevalence of other postwar psychological problems among Vietnam veterans; the relationship between PTSD and other postwar psychological problems; the relationship

between service-connected disabilities and postwar psychological problems; the relationship between alcohol and drug abuse and postwar psychological problems).

LASSER, K., BOYD, J.W., WOOLHANDLER, S., HIMMELSTEIN, D.U., McCORMICK, D., & BOR, D.H. (2000). Smoking and mental illness: A population-based prevalence study. *Journal of the American Medical Association*, 284, 2606-2610. Studies of selected groups of persons with mental illness have reported rates of smoking to be higher than in persons without mental illness. However, recent population-based, nationally representative data are lacking. To assess rates of smoking and tobacco cessation in adults with and without mental illness, data were analyzed on 4411 respondents aged 15 to 54 years from the National Comorbidity Survey. Current smoking rates for respondents with no mental illness, lifetime mental illness, and past-month mental illness were 22.5%, 34.8%, and 41.0%, respectively. Lifetime smoking rates were 39.1%, 55.3%, and 59.0%, respectively. Smokers with any history of mental illness had a self-reported quit rate of 37.1%, and smokers with past-month mental illness had a self-reported quit rate of 30.5% compared with smokers without mental illness (42.5%). Persons with mental illness are about twice as likely to smoke as other persons but have substantial quit rates. [adapted from abstract]

McFALL, M.E., ATKINS, D.C., YOSHIMOTO, D., THOMPSON, C.E., KANTER, E., MALTE, C.A., et al. (2006). Integrating tobacco cessation treatment into mental health care for patients with posttraumatic stress disorder. *American Journal on Addictions*, 15, 336-344. The integration of tobacco cessation treatment into mental health care for posttraumatic stress disorder (PTSD), known as Integrated Care (IC), was evaluated in an uncontrolled feasibility and effectiveness study. Veterans (N = 107) in PTSD treatment at two outpatient clinics received IC delivered by mental health practitioners. Outcomes were seven-day point prevalence abstinence measured at two, four, six, and nine months post-enrollment and repeated seven-day point prevalence abstinence (RPPA) obtained across three consecutive assessment intervals (four, six, and nine months). Abstinence rates at the four assessment intervals were 28%, 23%, 25%, and 18%, respectively, and RPPA was 15%. The number of IC sessions and a previous quit history greater than six months predicted RPPA. Stopping smoking was not associated with worsening PTSD or depression.

McFALL, M.E., SAXON, A.J., THOMPSON, C.E., YOSHIMOTO, D., MALTE, C., STRAITS-TROSTER, K., et al. (2005). Improving the rates of quitting smoking for veterans with posttraumatic stress disorder. *American Journal of Psychiatry* 162,1311-1319. Smoking is highly prevalent and refractory among people with PTSD. This study aimed to improve the rate of quitting smoking for veterans with PTSD by integrating treatment for nicotine dependence into mental health care. Smokers undergoing treatment for PTSD (n = 66) were randomly assigned to (1) tobacco use treatment delivered by mental health providers and integrated with psychiatric care (integrated care) versus (2) cessation treatment delivered separately from PTSD care by smoking-cessation specialists (usual standard of care). 7-day point prevalence abstinence was the primary outcome, measured at 2, 4, 6, and 9 months after random assignment. Data were analyzed by using a generalized estimating equations approach following the intent-to-treat principle. Subjects assigned to integrated care were 5 times more likely than subjects undergoing the usual standard of care to abstain from smoking across follow-up assessment intervals. Subjects in the integrated care condition were significantly more likely than subjects in the usual standard of care to receive transdermal nicotine and nicotine gum. They also received a greater number of smoking-cessation counseling sessions. Integrating cessation treatment into psychiatric care may have the potential for improving smoking quit rates in other populations of chronically mentally ill smokers. [adapted from abstract]



Combat veterans with PTSD reported significantly greater occurrence of violent behaviors over the past year than veterans without PTSD. Among veterans with PTSD, lower socioeconomic status increased aggressive responding, and increased PTSD severity was related to interpersonal violence.

CHILCOAT, H.D., & MENARD, C. (2003). Epidemiological investigations: Comorbidity of posttraumatic stress disorder and substance use disorder. In P. Ouimette & P.J. Brown (Eds.), *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders* (pp. 9-28). Washington, DC: American Psychological Association.

The authors reviewed epidemiological evidence of the association between PTSD and substance use disorders, explored potential causal relationships between them, and proposed future directions for research in this area.

FLEGAL, K.M., CARROLL, M.D., OGDEN, C.L., & JOHNSON, C.L. (2002). Prevalence and trends in obesity among US adults, 1999-2000. *Journal of the American Medical Association*, 288, 1723-1727.

The authors used data from the National Health and Nutrition Examination Survey (NHANES) to estimate age-adjusted prevalence of obesity in the U.S. The age-adjusted prevalence of obesity was 30.5% in 1999-2000 compared with 22.9% in 1988-1994. Results are presented by gender and ethnicity as well as for the total population.

FREEMAN, T.W., & ROCA, V. (2001). Gun use, attitudes toward violence, and aggression among combat veterans with chronic posttraumatic stress disorder. *Journal of Nervous and Mental Disease*, 189, 317-320.

Veterans with chronic PTSD reported different attitudes toward violent crime, higher levels of aggression, and more potentially dangerous firearm-related behaviors than did non-PTSD veterans with equivalent histories of substance abuse.

JACOBSEN, L.K., SOUTHWICK, S.M., & KOSTEN, T.R. (2001). Substance use disorders in patients with posttraumatic stress disorder: A review of the literature. *American Journal of Psychiatry*, 158, 1184-1190.

The authors reviewed studies pertaining to the epidemiology, phenomenology, and pathophysiology of comorbid PTSD and substance use disorders. They concluded that PTSD and substance use disorders are functionally related and advocated for the inclusion of patients with comorbid PTSD and substance use disorders in neurobiologic research and in clinical trials.

McFALL, M.E., FONTANA, A., RASKIND, M.A., & ROSENHECK, R. (1999). Analysis of violent behavior in Vietnam combat veteran psychiatric inpatients with posttraumatic stress disorder. *Journal of Traumatic Stress*, 12, 501-517.

In a study comparing male Vietnam veterans seeking inpatient treatment for PTSD, male psychiatric inpatients without PTSD, and a community sample of Vietnam veterans with PTSD not undergoing inpatient treatment, PTSD inpatients engaged in more types of violent behavior than both comparison conditions. Correlates of violence among PTSD inpatients included PTSD symptom severity and substance abuse.

McFALL, M.E., MACKAY, P.W., & DONOVAN, D.M. (1992). Combat-related posttraumatic stress disorder and severity of substance abuse in Vietnam veterans. *Journal of Studies on Alcohol*, 53, 357-363.

Vietnam-theater veterans with PTSD experienced more severe drug and alcohol-abuse problems than did theater veterans without PTSD and were at greater risk for having both forms of substance abuse. PTSD was significantly related to some dimensions of drug- and alcohol-abuse problems but not to other

dimensions. These findings indicate that PTSD, rather than combat stress per se, is linked to severity of substance abuse.

OUIMETTE, P., MOOS, R.H., & BROWN, P.J. (2003). Substance use disorder—posttraumatic stress disorder comorbidity: A survey of treatments and proposed practice guidelines. In P. Ouimette & P.J. Brown (Eds.), *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders* (pp. 91-110). Washington, DC: American Psychological Association.

The authors reviewed research on the treatment course of substance use disorder-PTSD comorbidity and advocated for the development of a set of evidence-based practice guidelines specific to the treatment of SUD-PTSD comorbidity. [Text, p. 91]

READ, J.P., BROWN, P.J., KAHLER, C.W. (2004). Substance use and posttraumatic stress disorders: Symptom interplay and effects on outcome. *Addictive Behaviors*, 29, 1665-1672.

The authors examined concurrent and prospective associations between substance use disorder (SUD) and PTSD diagnosis and symptoms and mechanisms underlying these associations in a sample of persons receiving inpatient SUD treatment. Patients differed by baseline PTSD status on psychiatric comorbidity and substance use history. Baseline PTSD status did not predict substance use outcome. However, change in PTSD status over follow-up predicted substance use outcomes; those with unremitted PTSD demonstrated poorer SUD outcome than those with remitted PTSD.

SCHNURR, P., & JANKOWSKI, M.K. (1999). Physical health and post-traumatic stress disorder: Review and synthesis. *Seminars in Clinical Neuropsychiatry*, 4, 95-304.

The authors reviewed the empirical evidence showing that PTSD is associated with poor self-reported health and increased utilization of medical services. Possible psychological, behavioral, and biological mechanisms are discussed, and a model integrating these mechanisms is presented.

STEWART, S.H. (1996). Alcohol abuse in individuals exposed to trauma: A critical review. *Psychological Bulletin*, 120, 83-112.

The author reviewed studies on the relationship between exposure to trauma, PTSD, and alcohol abuse, discussed various mechanisms to account for these associations, drew implications for assessment and treatment, and made suggestions for methodological improvements in future research.

STEWART, S.H., & CONROD P.J. (2003). Psychosocial models of functional associations between posttraumatic stress disorder and substance use disorder. In P. Ouimette & P.J. Brown (Eds.), *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders* (pp. 29-55). Washington, DC: American Psychological Association.

The authors reviewed studies that have used varying types of psychosocial research methodologies to investigate potential causal-maintenance relations between PTSD and substance use among victims of various types of trauma. [Text, pp. 30-31]

VIEWIG, W.V.R., JULIUS, D.A., FERNANDEZ, A., TASSONE, D.M., NARLA, S.N., & PANDURANGI, A.K. (2006b). Posttraumatic stress disorder in male military veterans with comorbid overweight and obesity: Psychotropic, antihypertensive, and metabolic medications. *Primary Care Companion Journal of Clinical Psychiatry*, 8, 25-31.

The authors retrospectively examined PTSD program data to assess the prevalence and severity of comorbid overweight and obesity. Overweight and obese and dyslipidemia correlated significantly with Body Mass Index. The authors concluded that obesity probably worsened the chronic conditions and necessitated more aggressive treatment.

