

Research Article

Accelerated Resolution Therapy for Women Veterans Experiencing Military Sexual Trauma Related Post-Traumatic Stress Disorder

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• Women; Military; PTSD; Military sexual trauma; Accelerated resolution therapy

Abstract

Purpose: To examine the use of Accelerated Resolution Therapy (ART) as an emerging, brief, non-invasive treatment for Military Sexual Assault-related Post-Traumatic Stress Disorder (MST-PTSD) including potential minimal dropout.

Design: This was a feasibility study utilizing an evidence-based, best practice intervention for PTSD. The aim was to examine treatment success in relation to reductions of PTSD symptomology, psychological distress, sleep dysfunction, depression, anxiety, and guilt hopelessness.

Method: Pre and post treatment surveys were used to evaluate ART as a treatment modality for reducing MST-PTSD.

Findings: After delivery of ART, both statistically and clinically significant improvements were reported for symptoms of MST-PTSD including psychological trauma, psychological distress, sleep, depression, anxiety, and guilt hopelessness.

Conclusions: Results from this feasibility study indicate that ART is a viable treatment option for women with MTS-PTSD.

Clinical Relevance: MST is the leading cause of PTSD in women veterans. With upwards of 6,083 military cases of sexual assault reported in fiscal year 2015, women in the military experiencing sexual harassment and/or sexual assault suffer from multiple physical and psychological health comorbidities. We contend that ART may potentially be more cost effective, decrease wait time to care, and decrease the stigma associated with mental health services by providing an effective therapeutic option that is less invasive and of shorter duration than current established therapies.

INTRODUCTION

Since the terrorist attacks on September 11, 2001, 2.6 million servicemen and women have deployed, often multiple times, in support of Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) [1]. The effects of fourteen years of sustained war have led to staggering statistics in regards to the mental health consequences experienced by our servicemen and women, and our active duty, veteran, and civilian healthcare systems are ill prepared to meet this crisis. The Institute of Medicine (IOM) estimates that approximately 20%, or roughly 520,000, of the veterans who have served in OEF/OIF/OND may suffer from Post Traumatic Stress Disorder (PTSD) [2]. This is more than ten times the number of physically wounded veterans and is thought to be a conservative estimate. Other sources estimate the number as high as 37% of returning veterans from the wars in Iraq and Afghanistan have been diagnosed with a mental health condition, primarily PTSD and depression [3].

Post—Traumatic Stress Disorder and Military Sexual Trauma

PTSD is an anxiety disorder that is preceded by a frightening or horrific event. Military personnel are subjected to multiple events that can lead to PTSD—combat, wounding or loss of life of a fellow service member, or experiencing physical or sexual trauma to name a few. PTSD can affect both men and women at any age. Psychological co-morbidities secondary to PTSD include sleep disorders, anger management problems, paranoia, depression, and anxiety, and can lead to behaviors such as substance abuse, marital or relationship issues, domestic violence, homicide, and suicide. While combat is the most common cause of PTSD in males, Military Sexual Trauma (MST) is the leading cause of PTSD in women veterans [4].

The Veterans Administration (VA) defines MST as “psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which

occurred while the veteran was serving on active duty or active duty for training” [5]. According to the DoD Annual Report on Sexual Assault in the Military, 6,083 cases of sexual assault were reported in fiscal year 2015 (Sexual Assault Prevention and Response [6]. Of the 6,083 victims who reported sexual assault, only 5,240 victims were service members and the other 843 were U.S. civilians, foreign nationals, and individuals who were not considered to be on Active Duty status in the U.S. Armed Forces [6]. Furthermore, while females (80%) comprised the majority of the reports, approximately 19% of the reports were made by male service members [6]. These numbers have steadily increased over the last five years from 3,327 to 3,393, 3,604, 5,518, and 6,131 in fiscal years 2010 to 2014 respectively indicating a significant increase in reports of sexual assault in a five year period [6]. Due to the fact that many women who experience MST never tell, it is estimated that the number of sexual assaults are six times higher—that approximately 36,498 sexual assaults occurred in fiscal year 2015 [4].

Women with histories of MST may experience a myriad of symptoms including irritability, intense emotions, hyper vigilance, emotional numbing, difficulty falling or staying asleep, nightmares and bad dreams, difficulty experiencing emotions such as love and happiness, trust and sexual/intimacy issues, difficulty focusing, and isolation and disconnection from others which leads to anger, depression, and sleep disturbances [7,8]. Women who have experienced MST face many barriers when seeking mental health care—lack of mental health services, inability to complete courses of the psychological treatments currently available, stigma surrounding seeking mental health services, emotional trauma of reliving the assault, and fear of repercussions secondary to disclosure of sexual assaults and subsequent treatment, such as retaliation, loss of security clearance, and threats to career progression. Women who experience sexual assault in the military often equate the experience to incest—the perpetrator is not an enemy or an unknown entity; rather, the perpetrator is a fellow soldier or “brother in arms”. Furthermore, victims who disclose their sexual assault or turn the perpetrator in often do not receive support from their fellow soldiers or their chain of command leading to the “ultimate betrayal” by a system that is known for loyalty and integrity. Despite numerous campaigns focused at breaking the barriers regarding seeking treatment for mental health issues, patients (veterans) still feel the stigma of a mental health diagnosis and view treatment as a sign of weakness and a potential threat to their military career.

Treatment Options for Post-Traumatic Stress Disorder and Military Sexual Trauma

In 2010, in response to the increasing incidence of PTSD among active duty military and veterans, Congress requested that the DoD and the VA conduct a review of PTSD programs in both agencies. At the request of the Pentagon, the IOM convened a fourteen-member panel of experts to address the issues surrounding the treatment of PTSD. The panel made recommendations in five areas—analyze the effectiveness of PTSD treatment through data collection; implement annual PTSD screening at every visit with a primary care provider; conduct more innovative research on PTSD treatments including emerging

treatments; overcome barriers to awareness, accessibility, availability, acceptability, and adherence; and integrate PTSD screening, diagnosis, and treatment into a variety of clinical settings as well as treatment of PTSD with patients experiencing comorbid conditions such as Traumatic Brain Injury (TBI) and MST [9]. In light of the issues facing the VA to keep up with the staggering numbers of veterans requiring mental health services, as well as the need to reduce the multiple barriers faced by veterans, the IOM committee recommended that the VA support researchers outside the VA system who are developing therapies that provide effective treatment with minimal invasiveness, rapid results, and maximum benefits.

Acceleration Resolution Therapy (ART) is an example of an emerging and innovative treatment for PTSD that would meet the IOM criteria. ART was developed in 2008 and is an emerging psychotherapy used to treat the symptoms of psychological and emotional traumas. ART is a trauma-focused therapy with some similarities to Eye Movement Desensitization and Reprocessing (EMDR) which is one of several A-level trauma-focused psychotherapies accepted as standard of care [10, 11]. It is postulated that ART, much like EMDR, allows an individual to effectively process traumatic memories and physiological sensations that are linked to the traumas. Unlike EMDR, ART utilizes a direct versus passive approach to eye movement therapy and utilizes two primary components—Imaginal Exposure (IE) and Imagery Rescripting (IR) to resolve the symptoms of psychological trauma [10, 11]. Clinicians wishing to use ART in practice must be trained on how to use ART by the developer of the therapy and training includes the use of a standard training protocol and training manual [12]. Patients typically receive one 45 to 60 minute treatment per week of between one to five sessions [12]. The majority of patients see significant reductions in PTSD symptomology in less than four sessions with a dropout rate of less than 10% [12].

Specifically, through the use of IE, the patient either verbally or nonverbally re-imagines the traumatic event. The patient recalls the event from start to finish, during which time the patient may typically experience heightened physiological arousal and sensations, such as an increased heart rate, palpitations, chest pain, and/or sweating. To reduce, or eliminate, these physical symptoms, the therapist directs the patient to perform left to right eye movements by following their oscillating hand during the re-imagining phase [12, 13]. The therapist then utilizes IR which is based on the process of memory reconsolidation and directs the patient to replace (rescript) the negative, painful images by re-envisioning a new, positive way to remember the experience [13].

ART is typically delivered in two to five sessions of approximately 60 minutes each without the requirement for additional homework, medications, or the patient to verbalize the traumatic experience during the sessions. In published reports, most patients experience significant reductions in symptoms in approximately 3-4 sessions [12]. Alexithymia is a term used to describe an individual’s difficulty with identifying and describing emotions associated with trauma. Women who have experienced sexual trauma often have difficulty with telling those in authority about their sexual trauma as well as

discussing details of the assault [14]. A hallmark of ART, and what makes it appreciably different from other psychotherapies including Cognitive Behavioral Therapy (CBT) and Prolonged Exposure Therapy (PE), is that the individual does not need to verbalize the details of their trauma in order to participate in the therapy. A recent study conducted by Suris, Holder, Holliday, and Morris (2016) [15] indicated that potential participants in their PTSD study preferred less time-intensive treatments such as pharmacological treatments over psychotherapy, and that stigma associated with MST treatment continues to be a barrier. Therefore, development of a treatment option that reduces the stresses and emotional distress women veterans experience while receiving treatment for PTSD secondary to MST, and one that achieves a relatively quick decrease in symptomatology, would yield significant clinical benefits. ART, a new treatment for PTSD, indicates promise in providing these benefits.

METHODS

This was a feasibility study utilizing an evidence-based, best practice intervention for PTSD. PTSD symptomology was assessed utilizing reliable and valid pre and post treatment surveys—PTSD Checklist-Military (PCL-M, DSM-IV), Brief Symptom Inventory (BSI), Pittsburgh Sleep Quality Index (PSQI), Center for Epidemiological Studies Depression Scale (CES-D), State-Trait Inventory for Cognitive and Somatic Anxiety (STICSA), and Trauma Related Guilt Index (TRGI) to assess treatment success in terms of reductions of PTSD symptomology, psychological distress, sleep dysfunction, depression, anxiety, and guilt hopelessness (Table 1). Participants received a \$75 gift card after completing the above questionnaires pre-ART treatment.

The PCL-M Checklist (DSM-IV) is a self-administered 17-item scale that corresponds to key symptoms of PTSD [16]. The PCL has been validated in both civilians and veterans [16]. The 18-item Brief Symptom Inventory (BSI) is designed to measure clinically relevant psychological distress [17,18]. The 22-item Trauma Related Guilt Inventory (TRGI) assesses event-focused, trauma-related guilt. The inventory has high internal consistency and adequate temporal stability, and its scales and subscales significantly correlate with measures of guilt and PTSD, depression, and adjustment [19]. The 20-item Centers for Epidemiological Studies Depression Scale (CES-D) is a widely used self-report scale that measures current level of depressive symptomatology with an emphasis on depressed mood during the past week [20]. The 125-item Psychiatric Diagnostic Screening Questionnaire (PDSQ) is used to screen for Axis I disorders and provide a global assessment of psychopathology [21].

To be included in this feasibility study, female veterans were required to report symptoms indicative of PTSD. This included a score of ≥ 40 on the PCL-M Checklist, or in the absence of a score ≥ 40 , therapist assessment of symptoms of PTSD, as determined from the Checklist for ART Standard Protocol and corresponding information on the PTSD subscale of the PDSQ. Individuals with previous treatment for psychological trauma, yet with residual symptoms, were eligible for this feasibility study, but could not be experiencing suicidal ideation or intent, homicidal ideation or intent, and also indicate no evidence of psychotic behavior or being in psychological crisis, as screened by use of the PDSQ [22].

ETHICAL CONSIDERATIONS

Institutional review board approval was obtained from the IRB committee at the University of South Florida.

Statistical Methods

Continuous variables are presented as mean and standard deviation; categorical variables are presented as percentages. Recognizing small sample size, treatment response of PTSD-related symptoms was evaluated by use of paired *t* tests with a *p*-value of 0.05 used to define statistical significance.

RESULTS

Sample

A total of nine women veterans expressed interest in the study, of whom, six met inclusion criteria and were found to be clinically eligible for enrollment. Of the six who were enrolled, five completed the study with one dropping out of the study (16.6% dropout rate) due to transportation issues and lack of time in her schedule due to a multitude of VA appointments. Two participants received five ART sessions, one participant received four ART sessions, and two participants received three ART sessions.

Sample Characteristics

The women ranged in age from 22 to 51 years of age with a mean age of 36.4(SD +/- 12.1). Eighty percent of participants identified themselves as white (n=4) and non-Hispanic (n=4). Of interest was the marital status of the group—80% (n=4) reported they were never married, 20% (n=1) reported they were divorced, and none of the participants (n=0) reported being married. This was a well-educated group with 60% (n=3) stating they had at least sixteen years of education or greater and 40% (n=2) stating they had eighteen years of education or greater. However, only 20% (n=1) were employed full-time with 20% (n=1) reporting they were employed part-time, 20% (n=1) were unemployed or disabled, and 40% (n=2) were students.

In terms of military status, 80% (n=4) were veterans and 20% (n=1) were reservists with 20% (n=1) serving in the Army, 20% (n=1) serving in the Navy, 0% (n=0) serving in the Air Force, 40% (n=2) serving in the Coast Guard, and 20% (n=1) serving in the National Guard. Twenty percent (n=1) were officers and 80% (n=4) were enlisted. Forty percent of participants (n=2) had deployed. During their tour of duty, and per the inclusion criteria, 100% (n=5) of participants stated that they had experienced uninvited or unwanted sexual attention and 60% (n=3) stated that during their tour of duty someone had used force or threat of force to have sexual contact with them against their will. These incidences occurred with 60% (n=3) of participants at a rank of E-4 or lower, 20% (n=1) at E-5 to E-9, and 20% (n=1) were O-4 to O-6 (Table 2).

Summary of Treatment Findings

As seen in Figure (1), mean score on the PCL-M (PTSD checklist) dropped from 62.2 pre-treatment to 33.8 after treatment ($p=0.007$), and all 5 veterans reported a reduction in symptoms. Statistically significant treatment-related reductions were also reported for on the Brief Symptom Inventory ($p=0.046$)

Self-Report Measures	Instrument
PTSD symptomatology	PTSD Checklist-Military (PCL-Military)
Psychological distress	Brief Symptom Inventory (BSI)
Trauma-related guilt	Trauma-Related Guilt Inventory (TRGI)
Depressive symptoms	Center for Epidemiological Studies Depression Scale (CES-D)
Sleep quality and patterns	The Pittsburgh Sleep Quality Index (PSQI)
Anxiety	State-Trait Inventory for Cognitive and Somatic Anxiety (STICSA)

CHARACTERISTICS	ALL (n=5)
Age (Mean+/- SD)	36.40 +/-12.075
Female (%)	100
Race (%)	
White	80
Black	20
Other	0
Hispanic Ethnicity (%)	20
Marital Status (%)	
Married	0
Divorced	20
Never married	80
Employed—Full or Part Time (%)	40
Education	
16 years	3
18 years	2
Current Military Status (%)	
Reservist	20
Discharged/Veteran	80
Rank (%)	
Officer	20
Enlisted	80
Branch of Military (%)	
Army	20
Navy	20
Air Force	0
Coast Guard	40
National Guard	20
Deployed (%)	40
Experienced uninvited or unwanted sexual attention (%)	100
Use of force or threat of force to have sexual contact with you against your will (%)	60
Average number of ART treatments	4
Dropout rate (among 6 consenting participants)	16.7

and Trauma Related Guilt Inventory ($p=0.024$) (Figures 2, 3). In addition, although not statically significant, clinical improvement was noted across participants in regards to sleep, depression, and anxiety. Three of five participants had improvements in sleep with participants scores post ART changing three to nineteen points. Three of five participants had a drop in CES-D scores which ranged between five and twenty three points. Finally, STICSA scores dropped between five and thirty five points post

ART with four of the five participants showing a decrease in anxiety. Per veteran treatment response across the symptoms measures are depicted in Figures (4-6).

Strengths of the Study

Strengths of the study include use of a standardized ART treatment protocol that has been implemented with prior ART studies conducted at the College of Nursing. The use of a single highly trained therapist in ART who has worked on other ART studies is also considered strength and therefore there was no variation in regards to incorporating the treatment protocol

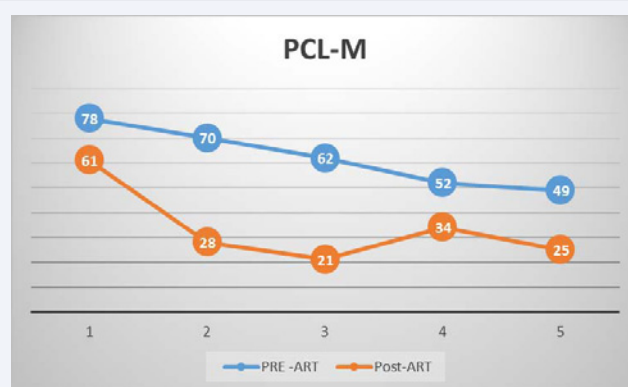


Figure 1 PCL-M.

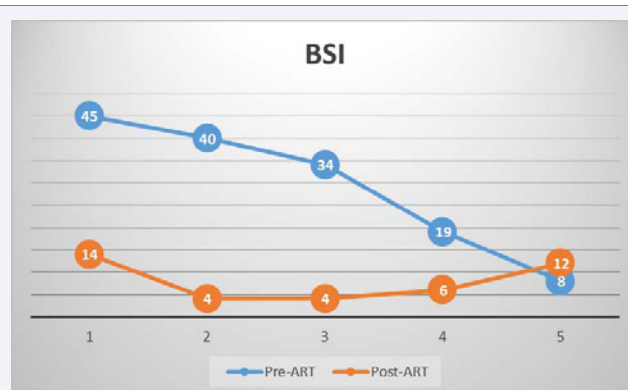


Figure 2 BSI.

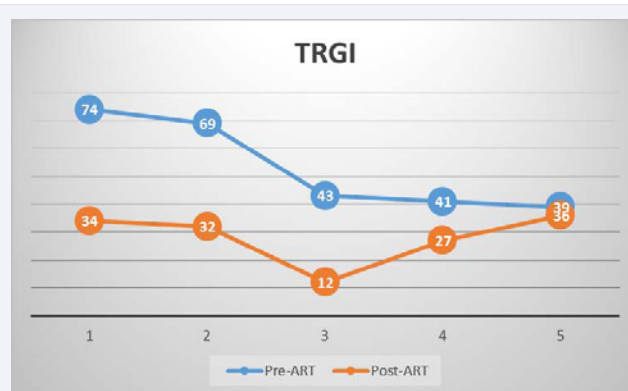


Figure 3 TRGI.

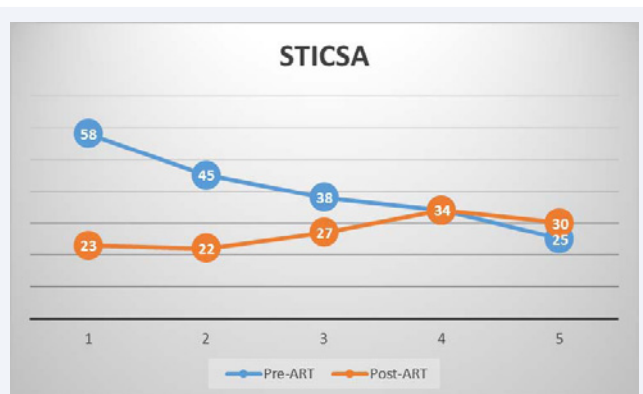


Figure 4 STICSA.

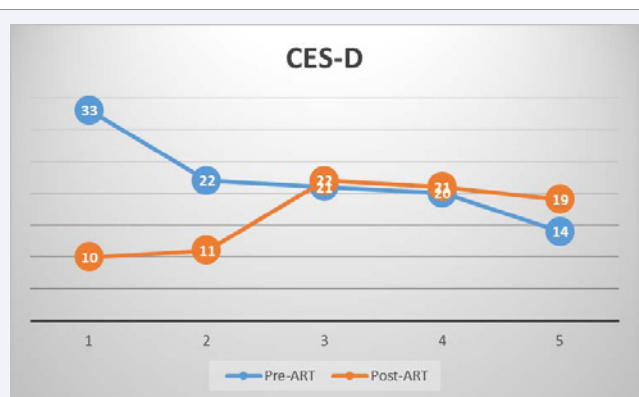


Figure 5 CES-D.

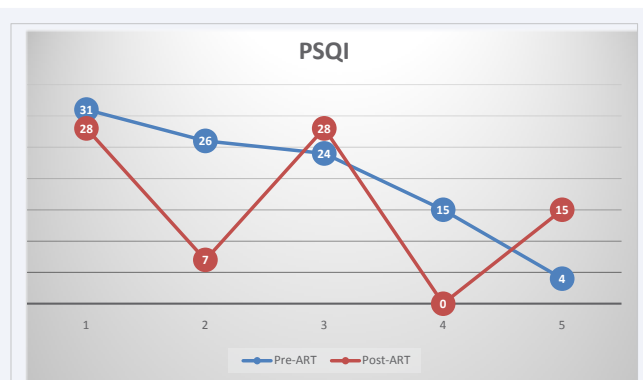


Figure 6 PSQI.

across participants. Because this study utilized blind recruitment process, interaction between participants did not occur and therefore participant interaction did not influence outcomes. All participants had officially separated from the military therefore there were minimal limitations to participation based on military commitments or Uniformed Code of Military Justice restrictions. Finally, the project utilized reliable and valid instruments.

LIMITATIONS OF THE STUDY

Limitations of the project include low numbers of participants which could affect the strength and power of the findings

however statistically significant treatment-related reductions were reported in two of the six factors and clinical improvement was noted across participants in regards to three of the six. Participants were not given a formal diagnosis—they were screened for PTSD utilizing the PCL-M; however four of the five participants had been treated for PTSD prior to participation in this study. During the study, none of the participants indicated inclusion in other treatment programs for MST. Longitudinal data to determine sustainability is indicated.

DISCUSSION

To summarize, this feasibility study suggests that ART is a viable treatment option for women veterans with PTSD secondary to MST, including reductions across a range of symptoms associated with PTSD and secondary to MST. Expansion of this small-scale improvement project appears to be warranted.

Strengths of the study include a standardized ART treatment protocol that has been implemented in prior studies of ART among both civilians and veterans. The use of a highly-trained therapist in ART who has worked on the other ART studies is also considered a strength. Finally, the project utilized reliable and valid symptom-related instruments.

Limitations of the project a small numbers of participants which limits statistical power and ability to make reliable inferences on study results. In addition, participants were not given a formal diagnosis—instead, they were screened for symptoms of PTSD utilizing the PCL-M. Nonetheless, four of the five participants had been treated for PTSD prior to participation in this study. Finally, longitudinal follow-up data is needed to assess sustainability of initial treatment benefits.

Barriers to Recruitment

Barriers to recruitment were experienced despite the rich military environment that included one large military base and two VA hospitals in close geographic proximity. Lack of referrals of veterans from the VA could have occurred secondary to lack of support of the treatment modality used in the project. In regards to active duty referrals, active duty personnel are unable to accept compensation so that may have served as a deterrent to participation or may not have served as an incentive for treatment. In addition, fear of commanders learning of participation in this project and assumption of a mental health diagnosis could have served as a barrier.

CONCLUSIONS

MST has occurred throughout the history of the military with documented cases extending back to the Vietnam War. The impact of ART for widespread treatment of PTSD secondary to MST is potentially far reaching and has the potential to impact outcomes for the estimated 500,000 women who may have experienced MST during their service in the military and who are receiving health care within the DoD and the VA health care systems. Although results presented herein are preliminary, utilization of ART for women veterans could influence the manner in which DoD and the VA health and mental health care providers treat veterans with PTSD secondary to MST.

Notably, the ART protocol has been developed to allow

Table 3: Treatment Results of Study Participants.

Measure of Comorbidity	Pre-ART	Post-ART	Difference	Sig (2 Tailed)	T-Value
PTSD	62.20	33.80	28.40	0.007	5.180
Brief Symptom Inventory	29.20	8.00	21.20	0.046	2.865
Depression	22.00	16.60	5.40	0.354	1.048
Sleep	20.00	15.60	4.40	0.479	0.781
Anxiety	40.00	27.20	12.80	0.157	1.741
Trauma Related Guilt	53.20	28.20	25.00	0.024	3.518

for the provision of an effective treatment option that is less traumatic in its delivery, while providing rapid improvements in symptoms (less than a third of the time of current treatment plans being used by the DoD and the VA). This therapeutic option may potentially be more cost effective, decrease wait time to care and decrease the stigma associated with mental health services by providing an effective therapeutic option that is less invasive and of shorter duration. The incorporation of ART as a treatment option for women veterans in both the DoD and the VA health care systems represents an innovative potential opportunity to positively affect both patients and providers by decreasing session workload, patient attrition, and the physical and psychological comorbidities experienced by women veterans with PTSD secondary to MST.

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