Psychosocial Rehabilitation After Moral Injury and Loss With Adaptive Disclosure

National Clinical Trial Number: NCT03056157

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OBJECTIVES

The overarching goal of this study is to conduct a multi-site randomized control trial comparing Adaptive Disclosure-Moral Injury and Loss (AD-MIL), a new combat-specific psychotherapy for PTSD stemming from military trauma, to Present Centered Therapy (PCT; Frost et al., 2014), in terms of its impact on psychosocial functioning. We have seven hypotheses, grouped into (A) functional change and (B) mental health change.

A: Functional and behavioral change hypotheses:

A.1. Immediately post-treatment, 3-, and 6-months post-treatment, veterans with PTSD randomized to AD-MIL will have greater reductions in social, educational, and occupational disability

A.2. COVID-19 aim. In the extended time period for the trial, at the post-treatment, or post-treatment and 3-months post-treatment intervals (depending on when the participant was randomized), veterans with PTSD randomized to AD-MIL will have greater reductions in social, educational and occupational disability

B: Mental health change hypotheses:

B.4. Veterans randomized to AD-MIL will have greater reductions in PTSD symptom severity and a smaller percentage of PTSD cases
B.5. Veterans randomized to AD-MIL will have greater reductions in depressive symptoms
B.6. Veterans randomized to AD-MIL will have greater reductions in shame and guilt
B.7. Veterans randomized to AD-MIL will have greater reductions in psychological distress

We will also explore the impact of treatment on anger and aggressive behaviors, suicidal ideation, alcohol abuse, compassion towards self and others, and social connectedness.

BACKGROUND

Posttraumatic stress disorder (PTSD) is a highly prevalent and disabling condition among military veterans, posing a significant public health burden. Depending on the degree and type of exposure to military stressors, approximately 20% of the 2.5 million service members who served in Iraq and Afghanistan have or will develop clinically significant PTSD (Hoge et al., 2004; Milliken et al., 2007; Litz & Schlenger, 2009). PTSD causes private suffering and has a uniquely damaging ripple effect on family members, friends, co-workers, productivity, and healthcare costs. Veterans with PTSD suffer from a variety of co-morbid mental and physical health conditions (Buckley et al., 2004; Kulka et al., 1990) and are heavy service-utilizers (e.g., Calhoun et al., 2002). They also have extensive functional impairments, such as occupational problems (Hoge et al., 2005; Savoca & Rosenheck, 2000), family and relationship difficulties (e.g. Riggs et al., 1998), aggressive and risky behaviors (e.g. McFall et al., 1999), and reduced quality of life (e.g., Buckley et al., 2004). Unfortunately, although considerable gains have been made in the VA's dissemination of PTSD treatments that are highly effective with civilian trauma, these therapies have been shown to work considerably less well for war trauma (Steenkamp & Litz, 2013). We have argued that this is partly due to a lack of attention to the military culture and ethos and the heterogeneous harms of war trauma, including life threat, moral injury (MI) and traumatic loss (TL). In addition, VA treatments have failed to demonstrate an impact on functioning and quality of life, problems that are no less impacted by the military trauma being targeted in treatment. Instead, symptom change is typically the sole metric of success, and functional deficits are rarely taken into account. We argue that PTSD symptoms should be conceptualized and targeted as part of the fabric of the whole veteran and his or her context. Consequently, the overarching goal of this proposed study is to fill a substantial care-gap in the VA by

creating an evidence-based treatment for military-related PTSD focusing on improving psychosocial functioning. We have modified and extended Adaptive Disclosure (AD; Litz et al., 2015) by building in skills training and behavioral contracting to improve functioning and reducing behavioral obstacles to positive and potentially habilitative engagements in occupational, relationship, and family roles. If found to be effective, AD-MIL will fill a care-gap in the VA, reduce PTSD patients' suffering, and help veterans reclaim or establish positive relationships, work roles, and self-care routines.

METHOD

Overview

We plan to conduct a multi-site randomized controlled trial of AD-MIL, comparing it to PCT (Frost et al., 2014). Study recruitment and treatment will occur off-site at four VA partnering sites: Minneapolis, MN, San Diego, CA (Oceanside CBOC), San Francisco, CA, and Waco, TX (Center for Returning Veterans Center of Excellence at the Central Texas Veterans Healthcare System; CTVHCS). VA Boston's research roles are to: (1) conduct weekly and PRN oversight and supervision meetings to problem-solve recruitment, treatment delivery, patient compliance, and data collection issues; (2) conduct blinded phone interviews to diagnose PTSD using the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) before treatment and at three time points after treatment; (3) manage and analyze de-identified data sets; and (4) help prepare manuscripts and reports.

The trial will follow the consensus recommendations for clinical trials in the VA (VA-ORD, 2008): (1) clearly defined target symptoms: Functional and clinical outcomes will be operationalized; (2) reliable and valid measures: Assessment tools are selected for their content relevance and psychometric properties; (3) use of blind evaluators of outcome: The evaluator will be independent and blind to treatment condition. The assessor will remind participants to help maintain their blind; (4) assessor training: The independent evaluator (IE) will be carefully trained to criteria and monitored on an ongoing basis; (5) manualized, replicable, specific treatment programs; (6) unbiased assignment to treatment arms and (7) treatment adherence: Sessions will be recorded, and a random percentage will be used to assess treatment integrity. Adherence to the therapy manuals will be monitored by senior supervisors. We will follow the CONSORT guidelines for randomization and participant tracking.

Participants

Participants will comprise a sample of 148 veterans (including women and members of diverse ethnic and racial groups) with PTSD as a result of military trauma.

To power the COVID-19 aim, we require 74 veterans (including women and members of diverse ethnic and racial groups) with PTSD as a result of military trauma.

Inclusionary Criteria:
1. Age 18 or older
2. Served in an active-duty role within the military since September 2001 (Veterans may be eligible whether or not they were deployed to a warzone)
3. Meet the DSM-5 diagnostic criteria for PTSD as a result of military trauma (per Clinician Administered PTSD Scale for DSM-5 [CAPS-5]) and report non-negligible levels of associated functional impairment (Sheehan Disability Scale [SDS] score ≥ 10)
4. Prospective enrollees must be willing to commit to 12 consecutive weekly therapy sessions lasting up to 90 minutes in duration and to complete assessment materials.

Exclusionary Criteria:
1. Bipolar or psychotic disorders

2. Current drug or alcohol dependence (other than caffeine or tobacco dependence). Prospective enrollees who have maintained sobriety for at least 6 weeks immediately prior to the time of enrollment may be eligible.
3. Evidence of traumatic brain injury severe enough to influence the ability to understand and respond to study procedures
4. Suicidal or homicidal ideation severe enough to warrant immediate attention
5. Concurrent enrollment in any treatment that involves: (1) systematic disclosure of troubling trauma-related memories or (2) present-focused psychosocial skills training for PTSD or (3) supportive therapy/case management on a > monthly basis or (4) any individual therapy or (5) newly (< 6 weeks) prescribed pharmacological treatment.

Sample Size

Power calculations were based on a two-sided, two-sample t-test to compare the differences in mean change. Effect sizes were selected based on a trial comparing Acceptance and Commitment Therapy with PCT in veterans with mental health diagnoses, using the SDS (Lang et al., 2016), which showed a large effect size for reduction in disability ($d \approx .60$), a change of 1.2 points. Lang et al.'s (2016) follow-up interval was 3 months. These correspond to 3-month changes of 1.2 points assuming a standard deviation for the change of 2.1 points as per Lang and colleagues. These power calculations inflate the variance to account for clustering of scores (sites by therapists), with an ICC = .02. To partially offset possible losses to follow-up, we will follow the Benjamini-Hochberg testing procedure, which is less conservative than the Bonferroni rule (Benjamini & Hochberg, 1995). Each hypothesis is powered to compare outcome at 3 months. Analyses up to 6-months post-treatment are exploratory. Testing five hypotheses, each with Type I error of 1% =5%/5, then with 93 participants per arm, a two-sample t-test, comparing the difference between the 3-month changes, has 90% power to detect an absolute difference of .50 or larger assuming an effect size of .56. To have 80% power with 93 participants per arm requires an effect size of .50.

Note: In consultation with RR&D, we recalculated the number of participants to power the original trial at .8 (vs. .9) and this resulted in a new target N of 148 (74 per arm).

COVID-19 Aim: We used the AD grant's power framework to estimate the N required to test our hypothesis that AD would lead to better functional changes relative to PCT in COVID-19 stressed veterans with PTSD. We used the same parameters for mean change and the SD for change in Sheehan scores from the grant and a revised differential effect size prediction of .8. We reasoned that we would expect a larger differential effect size for this sub-study because AD can not only help veterans whose existing PTSD symptoms and impairments are exacerbated by COVID-19 stressors but also because AD includes change agents that can help reduce distress and impairment associated with the day to day demands and stressors of living in the time of COVID-19 (mindfulness, loving kindness meditation, letter-writing, behavioral assignments). With these parameters, we need 74 veterans (37 per arm) to power the aim (at a power of 0.90; one-tailed).

Procedures

NOTE - PANDEMIC-RELATED CHANGES: As of August 2020, the entire AD-MIL study is being conducted virtually due to the COVID-19 pandemic. We have provided more information on how we are adapting to these times.

Recruitment

Veterans will be recruited and treated at VA sites in Minneapolis, MN, San Diego, CA (Oceanside CBOC), San Francisco, CA, and Waco, TX (CTVHCS). Co-Investigators (Co-Is) at these study sites have successfully resolved operational obstacles and challenges to implementing clinical trials in their respective settings. Referrals for clinical studies have been nurtured through each Co-I's role as a clinician and PTSD expert. Co-Is will (a) provide materials describing the nature of the study and the target populations sought, distributing said materials via formal (e.g., staff meetings) and informal (e.g., bulletin boards) channels; (b) attend clinical staff meetings; (c) give talks to describe various treatments in staff grand rounds and other contexts (e.g., to trainees); (d) provide feedback to staff about referred patients.

COVID-19 changes: There will be no face-to-face recruitment. Instead, sites will recruit at Virtual Clinic Staff meetings rather than in person.

Consent and Pre-Eligibility Screening

A trained research assistant (RA) at each treatment site will pre-screen interested veterans for basic eligibility requirements (see above for inclusion criteria and exclusion criteria) and schedule consent and eligibility/baseline assessment appointments with site RA and an independent evaluator (IE). Research personnel at the coordinating site (i.e., Boston) and all study sites (i.e., Minneapolis, San Diego, San Francisco, and Central Texas) will serve as IEs. However, to assure independence, in the case of dual roles (IE and study therapist), IEs will not perform any assessments with veterans who they will treat or have treated. At the consent and eligibility/baseline visit, the RA will first obtain in-person, written informed consent and HIPAA authorization for study participation and recording of assessments and treatment sessions, and collect demographic information. Veterans will be informed about all potential study risks during the informed consent process, including limits to confidentiality. They will be informed that they can refuse to answer any question or terminate their assessments at any time if they so desire.

Also at the eligibility/baseline visit, Veterans will complete the PTSD diagnostic assessment by telephone with the IE. The study site RA will ask the veteran to read the IE site's informed consent form for the telephone evaluation while the IE is called on the telephone. The IE will verbally instruct participant to confirm that the participant has signed, initialed, and dated in the appropriate places in the written informed consent for the IE's site and in the HIPPA authorization form. The IE will ask whether the veteran agrees to be audio recorded. If the veteran consents, the IE will start the audio recorder and complete a telephone consent form that confirms oral consent of participant. If the veteran consents, the IE will sign and date a telephone consent form stating that the IE received verbal consent for evaluation and recording.

The IE will administer the LEC to measure exposure to various traumatic events; veterans will also be asked to clarify whether each event that they endorse happened during military service, civilian life, or both. Next, the IE will begin the CAPS-5 assessment by asking veterans to report their worst or most currently distressing military related experience. To account for trauma-types in post-hoc analyses, we will use a procedure to type index events that are used in the STRONG STAR consortium and the Consortium to Alleviate PTSD (CAP; Dr. Litz is the assessment core director of each). This entails patients indicating whether any of the following applies to the event: (1) during the event they thought they or someone else could be seriously injured or killed (threat-based); (2) the event entailed the loss of a friend or unit member (loss); (3) they experienced the sights, sounds, and smells of dead or badly wounded people (the grotesque aftermath of battle, an MI); or (4) the event entailed something the veteran did or failed to do or entailed something that someone else did or failed to do (MI). The participant is then asked to indicate which one of these aspects was the worst part of the event. If the participant is unable to choose only one of these, s/he will be asked to rank the worst parts of the event from most to least distressing. The IE will then continue the assessment with the CAPS-5, select modules of the MINI, and the Mental Health Service History form.

The site RAs will emphasize to veterans that their therapists will not see the CAPS-5 results. As with any psychotherapy, increased distress is expected in response to discussing symptoms during assessment and therapy procedures. During evaluation and treatment, participants will have the support of experienced clinicians and be provided with emergency contact information.

Following the phone call with the IE, the site RA will administer all self-report measures. Baseline measures will be completed the same day as screening/eligibility regardless of whether the individual is preliminarily eligible based on screening. If a participant waits for a month or more before starting therapy after the baseline session, the baseline measures will be re-administered.

COVID-19 Changes: All communication with participants is being conducted either via a HIPAA-compliant videoconferencing platform or over the phone.

Follow-Up Assessments

Follow-up assessments will be completed 3 months, 6 months, and 9 months after the first treatment session, or, if no treatment sessions were attended or a participant terminated therapy early, 3 months, 6 months and 9 months after the baseline assessment. As part of these follow-up assessments, all participants will complete CAPS-5 assessments by phone with an IE. In most instances, these calls will occur while the participant is in person at their local VA (i.e., Minneapolis, San Diego, San Francisco, or Central Texas). In cases where a participant is unable to attend a follow-up assessment at their local VA in person, we will offer participants the opportunity to complete the CAPS-5 assessment by phone from their home or another non-VA location. In instances where the participant is not at their local VA, IEs will conduct a thorough risk assessment during the call, and follow thoroughly defined procedures for risk management and safety planning when indicated (see "Follow-up Risk Assessment Phone Script" attached).

COVID-19 aim: Participants randomized between 12/31/2020 and 5/31/2021 will complete follow-up assessments 3 months and 6 months after the first treatment session, or, if no treatment sessions were attended or a participant terminated therapy early, 3 months and 6 months after the baseline assessment. Participants randomized between 6/1/2020 and 8/31/2021 will complete a follow-up assessment 3 months after the first treatment session, or, if no treatment sessions were attended or a participant terminated therapy early, 3 months after the baseline assessment.

COVID-19 Changes: All communication with participants is being conducted either via a HIPAA-compliant videoconferencing platform or over the phone.

Data Storage and Transmission

A VA intranet SharePoint site will be used to facilitate coordination across the multiple study sites. The SharePoint site will be used, in part, to store consent forms. Informed consent forms, HIPAA Authorization forms, and HIPAA supplement forms will be securely faxed and uploaded to SharePoint for storage and reference by both the Boston and local sites. Regarding data transmission, participants and study assessors will complete clinical measures on teleforms. The data from these forms will be securely transported to Boston through a fax machine, which will upload the data from the forms into a restricted access database on a secure network server inside the VA firewall. Hard copies of data files and consent forms will be maintained in secure, locked cabinets at the site in which they are collected.

Assessor Training and Adherence

A co-investigator, Dr. Matt Gray (University of Wyoming) will train the assessors prior to beginning enrollment. Training will include reading and viewing training materials, observation of CAPS administration, and supervised administration of at least three CAPS. Dr. Gray has expertise in the conduct of CAPS assessment and has past experience performing training and fidelity monitoring for use of CAPS assessment in clinical trials. Each assessor will be considered trained on CAPS when he or she "matches" Dr. Gray on three interviews. To establish matching, Dr. Gray will co-rate an interview conducted by the assessor. A match occurs when the assessor and Dr. Gray agree on the diagnosis and are within 2 points of severity on all of the symptom clusters (PTSD criteria B, C, D, and E). If the assessor does not match on three interviews after five attempts, Dr. Gray will determine whether additional training is necessary or if the assessor needs to be replaced.

All assessments will be audiotaped to ensure that a standardized approach is being used across patients (provided that the participant consents). Dr. Gray will review audio recordings of 10% of the assessments, selected randomly. Dr. Gray can at his discretion increase the proportion reviewed for difficult patients or assessors needing additional monitoring. Assessors will be provided with feedback about their performance. All recordings will be stored on a restricted-access directory (i.e., only lab personnel with personal usernames expressly granted access may access the directory containing the folder of recordings, and they must log in with their personal username and password to do so) in a locked office maintained at the Boston VA Healthcare System, Jamaica Plain campus. Selected sessions (recordings and interviewer-scored assessments sheets) will be securely transferred to Dr. Gray via encrypted email (see attached Data Use Agreement).

Assessors are permitted to do baseline assessments and follow-ups from their home in order to reduce patient and assessor burden. Written consent is obtained at the remote performance sites and any emergency and duty to warn issues are also handled in real time at the respective performance site's VAs (patients are physically at the respective VAs when interviewed remotely by Boston and research staff are present during the interview time).

Random Assignment

Veterans will be randomly assigned to PCT or AD-MIL. The Boston site will generate a randomized permuted block scheme to randomly assign patients to blocks by gender and minority status. Block size for gender and minority status will be based on the distribution of these variables at each site. Blocking by gender and minority status will ensure appropriate accrual rates for participants with lower base-rate characteristics. The Boston site will use constrained randomization (i.e., biased coin design; Cook & DeMets, 2008) if unexpected imbalance arises in gender and minority distribution across treatment groups.

Treatment Arms

AD-MIL is a modification and extension of Adaptive Disclosure (AD; Litz et al., 2015) which utilizes existing change agents in AD to address self-blame and guilt associated with trauma in several ways. In-session dialogue about traumatic events helps veterans understand and make sense out of their various shame- and guilt-related concerns. In addition, AD-MIL extends these change agents by also including session content focused on building in skills training and behavioral contracting to improve functioning, and targeting trauma-related psychological and behavioral obstacles to positive and potentially habilitative engagements in occupational, relationship, and family roles. Homework assignments to be completed between therapy sessions are generated collaboratively in session. For MI, homework activities may entail increased reparative time spent volunteering or with other veterans, family, and friends, and engaging in meaningful activities and/or spiritual practices, to counteract self-or other-condemnation. For TL, homework may entail restoring attachments and engaging in positive and wellness-promoting behaviors. For life-threat traumas, homework may include engaging in valued activities and relationships to counteract fear-driven avoidance. The AD-MIL manual adheres to consensus guidelines for replicable and functionally viable treatment manuals, including: (1) specific and operationalized procedures for goal-setting, target-selection, and monitoring process and outcome; (2) detailed session-by-

session instructions and content with examples and vignettes; and (3) supervisor instructions for bolstering competence and maintaining adherence (Carroll & Nuro, 2002).

PCT is a manualized evidenced-based PTSD treatment (Frost et al., 2014) used in several large-scale PTSD trials (e.g., Schnurr et al., 2007). It incorporates the essential therapeutic elements common to different types of psychotherapies, including supportive empathic listening and unconditional positive regard. The therapist plays an active role but does not impart any systematic training. The focus is to create an understanding of how the symptoms of PTSD are related to day-to-day difficulties and to help patients develop new, more adaptive responses to these stressors with a problem-focused and problem-solving approach. PCT includes weekly homework assignments. These include reading psychoeducational handouts and self-monitoring problems and stressors in a daily diary, which are then problem-solved in session. In prior trials, PCT showed equivalent change to active therapies at the last follow-up. The VA offers PCT as an evidence-based therapy for PTSD. So, this design element represents a conservative test of the superiority of AD-MIL.

Participants in both treatment arms will receive 12 weekly 90-minute sessions of individual psychotherapy.

Treatment Training, Supervision, and Fidelity Monitoring
Therapists with Ph.D.s in clinical or counseling psychology and VA internship experiences treating veterans with PTSD will be trained to deliver AD-MIL or PCT (not both).

Training and supervision of AD-MIL and PCT trial cases will be provided by Drs. Brett Litz and Candice Presseau. Dr. Litz developed AD for the Marine Corps trial and has spearheaded the extension of AD principles in the development of AD-MIL. Dr. Presseau has extensive expertise in the conduct of PCT. Training will involve a review of the respective manuals and supporting materials, intensive supervision of trial cases, and weekly group and one-on-one phone supervision with Dr. Litz for AD-MIL and Dr. Candice Presseau for PCT). Drs. Litz and Presseau will review audio recording of treatment sessions (all treatment session will be audiotaped) as needed to facilitate their supervisory roles. Selected sessions will be securely transferred to an approved and secure drive within the VA firewall to Drs. Litz and Presseau.

Treatment fidelity monitoring will be conducted by Drs. Matt Gray and Melissa Wattenberg. Dr. Gray was instrumental in the development of AD for the Marine Corps trial and has served as a consultant in the extension of AD principles in the development of AD-MIL. Dr. Wattenberg has extensive expertise in the conduct of PCT. Fidelity monitoring will be executed via the following procedure: 100% of a patient's first two sessions will be selected for review, 50% of next two, 20% of next five and 10% thereafter. After ten subjects, the therapist will discuss with the site RA which sessions to send for review to total 10% of caseload. Selected sessions will be securely transferred to an approved and secure drive within the VA firewall to Dr. Wattenberg. Selected sessions will be securely transferred to Dr. Gray via encrypted email (see attached Data Use Agreement).

Data Safety Monitoring Board (DSMB), Adverse Events (AE), Unanticipated Problems Involving Risk (UPR), and Protocol Deviations

Data Safety Monitoring Board (DSMB): A DSMB has been created for the study, including Drs. Denise Sloan, Brian Marx, and Kelly Harrington at the VA Boston Healthcare System. The DSMB is tasked with independently ensuring the safety of study participants and scientific goals. The DSMB will review the initial protocol and any proposed amendments, meet and complete reports bi-yearly, perform expedited monitoring of all serious adverse events, perform ongoing monitoring of drop-outs and non-serious adverse events, determine whether study procedures should be changed or the study should be halted for reasons related to the safety of study subjects, and perform periodic review of the completeness and validity of data to be used for analysis of safety and efficacy. The DSMB will also ensure subject privacy and research data confidentiality. A statistical

penalty will not be assessed for the ongoing unblended review of safety by the DSMB. Unblinded data will not be released to investigators unless necessary for safety reasons. Suspected information security and privacy incidents will be reported within one hour to the Information Security and Privacy Officers and Research Administration.

Adverse Event (AE): An adverse event (AE) is any untoward physical or psychological occurrence directly or indirectly affecting a human subject participating in research.

Adverse Event is a broad term covering physical, psychological, social, legal or economic occurrence directly or indirectly affecting a human subject participating in research. An AE can be any unfavorable or unintended event including abnormal laboratory finding, symptom or disease associated with the research or the use of a medical investigational test article (includes drug, biologic, or device). An AE may or may not have a causal relationship with the research, or any risk associated with the research or the research intervention, or the assessment. Adverse events involve participants only.

Negative events that are **unanticipated and unrelated** (by reasonable judgment) will be logged and tracked over the course of the study and reported in a summary of their occurrence at DSMB bi-yearly meetings, as well as for continuing reviews and at end of study. Examples might include medical problems, legal problems, homelessness, or traumatic events.

The therapist will query about adverse events (AEs) at every session by asking about any notable events since the last visit. These will be reviewed in a timely manner with the supervisor.

Serious Adverse Event (SAE): A SAE occurring in a patient or subject enrolled in a research study is serious if it results in any of the following outcomes: death, a life-threatening adverse drug experience, inpatient hospitalization or prolongation of existing hospitalization, a persistent or significant disability/incapacity, or is a congenital anomaly/birth defect. This will be reported to the IRB within 5 business days, as stated in reporting requirements. The only exception is death, which requires immediate reporting.

Unanticipated Problems Involving Risk (UPR): Defined as being (1) unexpected given the research procedures and characteristics of the population, (2) related (or possibly related) to participation in the research and (3) indicative that the research may place the subject or others at a greater risk of harm than was previously known. UPRs require notifying the IRB immediately.

Examples of possible UPRs for psychotherapeutic interventions:

1. Psychosis or mania

2. New onset or clinically significant exacerbation of a psychiatric disorder

3. Suicide and suicide attempts

An incident, experience, or outcome that meets UPR criteria generally will warrant consideration of substantive changes in the research protocol or informed consent process/document or other corrective actions in order to protect the safety, welfare, or rights of subjects or others. Examples of corrective actions or substantive changes that might need to be considered in response to an unanticipated problem include:

* modification of inclusion or exclusion criteria to mitigate the newly identified risks;
* implementation of additional procedures for monitoring subjects;
* suspension of enrollment of new subjects;

* suspension of research procedures in currently enrolled subjects;
* modification of informed consent documents to include a description of newly recognized risks; and
* provision of additional information about newly recognized risks to previously enrolled subjects.

Reporting Requirements:

UPR: Immediately notify IRB

SAE: Report to IRB within 5 business days

AE that is **unanticipated and unrelated**: Track in AE Log (summary will be reported quarterly to DSMB and as needed)

All other AEs: Report to IRB within 10 business days

To report to the IRB, an AE form, SAE form, and/or UPR form will be completed, the site PI's signature will be obtained, and the form will be submitted to the local IRB. The form (with encryption) will be emailed to the Study Coordinator. The Coordinator will forward each completed AE/SAE/UPR form to Data Safety Monitoring Board as soon as possible and will maintain a record of all AEs/SAEs/UPRs (see AE Log) to report to the Boston IRB in summary or table form at the time of annual Continuing Review. In the case that a Boston IE learns of an AE/SAE/UPR during the course of a telephone contact, the IE will initiate the AE/SAE/UPR Form and email (with encryption) to the local PI at the site where the participant was recruited (i.e., Dr. Tasha Nienow: Minneapolis, Dr. Ariel Lang: San Diego, Dr. Shira Maguen: San Francisco, or Dr. Sheila Frankfurt: Central Texas) for signature and submission to the local IRB (i.e., the site at which the participant was seen). The Study Coordinator will notify RR&D of any UPR, AE, or SAE promptly via encrypted email.

Protocol Deviation/Violation

A protocol deviation or violation is any change, divergence, or departure from the study design or procedures of a research protocol. Investigators are required to conduct their research according to the plans reviewed and approved by the IRB. Instances where this does not occur, either inadvertently due to circumstances beyond the investigator's control, or due to errors of omission or commission by research project staff, must be reported.

Reporting Requirement: Fill out a Protocol Deviation/Violation form, and submit to local IRB within 3 days of the occurrence (one day if there was harm to the participant). Also email the form (with encryption) to the PI and Study Coordinator, who will maintain a record of all Protocol Deviations/Violations to report to the Boston IRB at the time of annual Continuing Review.

Measures

Eligibility will be determined by scores on the CAPS-5 (Weathers et al, 2013) and select modules of the Mini International Neuropsychiatric Interview (e.g., Manic and Hypomanic Episodes, Alcohol Use Disorder, Substance Use Disorder, Psychotic Disorders and Mood Disorder with Psychotic Features, Suicidality, Homicidality; MINI; Sheehan et al, 2015). In addition, potential participants will be queried about current mental health treatment (i.e. Mental Health Service History form) to determine eligibility.
The **Moral Injury Events Scale** (**MIES**; Nash et al., 2013) is an 9-item scale that evaluates various military-related potential moral transgressions by self or others. The MIES has good internal and temporal consistency, and good discriminant and concurrent validity (Nash et al., 2013).

The **Working Alliance Inventory** (**WAI**; Horvath & Greenberg, 1989) assesses the quality of the working relationship between therapist and client. This working relationship, or alliance, is comprised of three components: the bond between therapist and client, shared goals, and engagement in relevant tasks in sessions. The WAI can be completed by both the therapist and the client. The original version contained 36 items, but a 12-item short-form was developed (WAI-S; Tracey & Kototovic, 1989), which displayed similarly good psychometric properties as the full-length WAI (Busseri & Tyler, 2003). The WAI-S is used in the current study.

The **Deployment Risk and Resiliency Inventory-2 (DRRI-2**; Vogt et al., 2013) **Combat Experiences and Aftermath of Battle** subscales, military service and **demographics** questionnaires, and the **DVBIC TBI Screening Instrument, and Montreal Cognitive Assessment (MoCA; Nasreddine, 2017)** will be administered at baseline only.

A. Functional and behavioral change hypotheses

Hypothesis A.1.

> **Sheehan Disability Scale** (**SDS; Sheehan, 1983; Sheehan et al., 1996).** The SDS will be our primary functional outcome measure. Respondents indicate the degree to which symptoms disrupted work/school, social life, and family life/responsibilities on an 11-point scale ranging from "Not at all" to "Extremely," and list the number of lost and unproductive work or school days. For this study, we will have participants' index impairment caused by *PTSD symptoms* in the last month. The SDS is widely used to track disability in clinical trials and has demonstrated very good criterion (change from treatment) validity (Sheehan & Sheehan, 2008). We will use a prorated total mean score for the dimensional ratings such that only social and family ratings will be included for veterans who were not employed or attending school.

Hypothesis A.2.

> **Brief Inventory of Psychosocial Functioning (B-IPF; Marx 2013).** Overall psychosocial functioning will also be assessed with this 7-item scale indexing overall level of functioning in seven life domains: romantic relationship, relationship with children, family relationships, friendships and socializing, work, training and education, and activities of daily living. Respondents indicate the degree to which they had trouble in the last 30 days in each area on a 7-point scale ranging from "Not at all" to "Very much." The B-IPF has demonstrated concurrent validity, and the full 80-item IPF from which it was created has strong test-retest reliability and internal consistency (Marx, 2013). This scale is regularly used in PTSD clinical team settings in the VA.
>
> **DRRI-2 (Vogt et al., 2013).** The **Post-Deployment Social Support** subscale of the DRRI will be used to assess social support resources. This subscale has excellent psychometric properties.

Hypothesis A.3.

The CAIR Pandemic Impact Questionnaire (C-PIQ; MacLean & Cloitre, 2020). We will measure COVID-related stress with the C-PIQ, a 19-item scale that measures COVID-19 exposure and the psychological impact of the pandemic. The C-PIQ has good psychometric properties (Lang, 2020, adapted form MacLean & Cloitre, 2020).

B. Mental health change hypotheses

Hypothesis B.4.

Clinician-Administered PTSD Scale for DSM-5 (CAPS-5; Weathers et al., 2013a). The CAPS-5 will be used to diagnose PTSD and index PTSD symptom severity. This version of the CAPS 5 also contains a separate Criterion A assessment procedure. The CAPS-5 is closely modeled on the CAPS-IV, a structured diagnostic interview and gold standard for assessing PTSD. The CAPS-IV has excellent psychometric properties and diagnostic efficiency (Weathers, Keane, & Davidson, 2001). The CAPS-5 uses a single 4-point ordinal rating scale to measure symptom severity. These ratings combine information about symptom frequency and intensity obtained by the interviewer. CAPS-5 scores range from 0 to 80, with higher scores indicating greater PTSD symptom severity. A PTSD case will entail a rating of >2 (moderate/threshold) for the requisite DSM-5 criteria. The CAPS-5 will be administered by telephone; we have determined that distance evaluations of PTSD are reliable and valid (Litwack et al., 2014).

Life Events Checklist (LEC; Gray, Litz, Hsu, & Lombardo, 2004): The LEC will be used to assess exposure to potentially traumatic events and will be employed in this trial to inform assessment of Criterion A for PTSD using the CAPS (described above). The LEC will be administered as an interview by the IE during the baseline assessment. The measure enquires about exposure to 17 potentially traumatic experiences (e.g., natural disasters, accidents, assaults, war zone experiences, captivity, human suffering, death, etc.) and asks participants to state whether or not they have been exposed to each event, either through directly experiencing it, witnessing it, or learning about it happening to someone close to them. In this study, participants will also be asked to clarify whether each event that they endorse happened during military service, civilian life, or both. The LEC has excellent psychometric properties (Gray, Litz, Hsu, & Lombardo, 2004).

PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013b). The PCL-5 will also be used to examine PTSD symptom burden. At the pre-eligibility screening, site RAs will ask veterans to write a one-sentence description of their worst and most currently distressing warzone experience on the top of the PTSD Checklist for DSM-5 (PCL-5) page and to rate symptoms referencing this event on the PCL-5. The PCL-5 will also be administered each week during therapy to track progress, capture adverse outcome, and model within-treatment change. The PCL-5 is similar to the PTSD Checklist (PCL) based on the DSM-IV. The PCL-IV has excellent psychometric characteristics (McDonald & Calhoun, 2010). The PCL-5 has 20-items which are scored in the past month on a scale from "0 = not at all" to "4 = extremely."

Hypothesis B.5.

Patient Health Questionnaire (PHQ-9). This widely used and well-validated (Kroenke et al., 2001) measure will be used to measure depression. It has high internal consistency (e.g., Cameron et al., 2008) and correlates strongly with other measures of depression (Kroenke et al., 2001);

Hypothesis B.6.

Trauma-Related Guilt Inventory (TRGI; Kubany et al., 1996). The TRGI assesses guilty feelings and attitudes about a specific warzone event. It is scored into three scales (Global Guilt, Distress Scale, and Guilt Cognitions) and 3 subscales (Hindsight-Bias/Responsibility, Wrongdoing, and Lack of Justification).

Trauma-Related Shame Inventory –Internal Shame Subscale (TRSI; Øktedalen **et al., 2014)**. The TRSI internal shame subscale is a 12-item self-report instrument designed to assess individuals' negative self-evaluations in the context of their traumatic experiences. The measure has good construct validity (Øktedalen et al., 2014).

Hypothesis B.7.

The Schwartz Outcome Scale-10 (SOS-10; Blais et al., 1999). Psychological health and distress will be measured using the SOS-10, a 10-item general mental health outcome measure. The SOS-10 has demonstrated good psychometric properties.

C. Exploratory Hypotheses.

Dimensions of Anger Scale (DAR-5; Forbes et al., 2014). Anger and aggression will be measured using the DAR-5, a 5-item measure of the frequency and intensity of anger in the past month. The DAR-5 has strong internal reliability and concurrent validity with the STAXI-2 (Forbes et al, 2014).

Revised Conflict Tactics Scale; Physical Assault and Psychological Aggression subscales (CTS2; Straus & Douglas, 2004) The CTS was designed to assess the use of reasoning, verbal aggression, and violence within the family (Straus, 1979), and over time has become the most widely used instrument to assess intimate aggressive behavior and violence (Straus & Douglas, 2004; Straus et al., 1996). The CTS2 poses 20 questions to assess five tactics used when there is conflict in the relationships of dating, cohabitating, or married couples (i.e., Assault, Psychological Aggression, Negotiation, Injury, and Sexual Coercion), and has been used to assess interpersonal conflict among friends, colleagues, and acquaintances, as well as within the family. Various versions of the CTS have been used in other studies of military personnel (Adler et al, 2008; Taft et al., 2007).

Depressive Symptoms Index – Suicidality Subscale (DSI-SS; Metalsky & Joiner, 1997). We will measure suicidal ideation with the DSI-SS which is a 4-item scale that focuses on ideation, plans, perceived control over ideation, and impulses for suicide. It is being used as a core measure in the Military Suicide Research Consortium. A review of measures of suicidal ideation and behaviors found that the DSI-SS had excellent internal consistency and concurrent validity (Batterham et al., 2014)

Quick Drinking Screen (QDS; Sobell et al., 2003). Alcohol use, alcohol abuse will be evaluated with the QDS which is a 4-item probe of frequency and quantity of alcohol consumption in the last month. The QDS has very good psychometric characteristics (Sobell et al., 2003).

The Self Compassion Scale (SCS; Neff, 2003). The 26-item Self-Compassion Scale includes 6 subscales (including Self-Kindness, Self-Judgment, Common Humanity, Isolation, Mindfulness, and Over-Identification) and measures overall self-compassion. The SCS has shown good internal consistency reliability as well as good test–retest reliability (Neff, 2003).

The Santa Clara Brief Compassion Scale (SBSC; Hwang, Plante, & Lackey, 2008). Compassion for humanity will be evaluated with the SBSC, a 5-item short form of the Compassionate Love Scale for Humanity (CLS). This scale has good reliability and is highly correlated with the original version (Hwang, Plante, & Lackey, 2008).

The Social Connectedness Scale (SoCS; Lee and Robbins, 1995). We will measure interpersonal closeness with the SCS, an 8-item scale that focuses on individual experiences in a social world (i.e, with peers, friends, and society) and the degree of difficulty in maintaining a sense of closeness. This

measure is being used as a core measure in the Military Suicide Research Consortium. The SCS has good psychometric properties (Lee and Robbins, 1995).

D. Acceptability, tolerability, and feedback about AD-MIL.

At the end of the study, we will ask veterans about their satisfaction with AD-MIL, the components that were most helpful, and the acceptability and tolerability of targeting military trauma with this treatment. We will incorporate the modal feedback into a final AD-MIL manual.

ANALYSES

Inferential analyses. The longitudinal and clustered nature of the design produces a multilevel or nested data structure (Raudenbush & Bryk, 2002), with a likelihood of between-subject variability in treatment trajectory over time (e.g. random slopes). In this study, veterans and therapists are nested (clustered) within performance sites. The lower level (level-1) data consists of the repeated measures for each individual at each assessment. Level-1 data is nested within upper level (level-2) person-level variables (e.g., study site).

Using the most up to date statistical software such as SAS 9.4 and R/R Studio, we will explore the change trajectory of endpoints over the course of pre-treatment, during-treatment, and post-treatment time intervals. Specifically, we will use the linear mixed model regression framework to assess the differential treatment effects of endpoint symptom burden over time. We will examine observed measurement scores and specify linear mixed models that best fit the time-change trends (e.g. linear, piecewise). We will test for the presence of random variation, such as between-site cluster effects and between-subject random slopes of treatment effect. We will determine the best fit linear mixed effects model as a combination of most appropriate representation of time and empirically-evidenced random and fixed effects.

The linear mixed effects models will incorporate clinically relevant time-invariant and time-varying predictors and will use Maximum Likelihood Estimation to produce estimates that are unbiased in the presence of random missingness and dropout. They will provide an Intent-To-Treat (ITT) analysis that will incorporate all available data. Per-protocol and "completer" subset analyses will be performed under the same paradigm. Additionally, a subset of subjects whom began therapy during the COVID-19 pandemic will be identified and analyzed separately; they comprise subjects which began therapy following December 31st, 2020. The tenability of the "At-Random" missingness assumption will be assessed and a sensitivity analysis of the results will be conducted to determine robustness of the inferences.

Aim I: Randomized controlled trial of AD-E, comparing it to PCT:

Hypotheses 1 and 2: Veterans in the AD-E arm will have a steeper downward slope in SDS (primary endpoint). Identical calculations will be performed with the B-IPF and DRRI-2 Post-Deployment Social Support measure.

Hypotheses 3-6: Veterans in AD-E will have: (3) steeper downward PTSD symptom severity slopes (CAPS-5 and PCL-5) and lower incidence of PTSD cases (tested with Chi-square); (4) steeper slopes in depressive symptoms (PHQ-9); and (5) steeper slopes in shame and guilt (TRSI and TRGI); (6) steeper slopes in overall psychological distress (SOS)Separate models will be tested for each outcome. These models will be structured the same as the model used to test Hypotheses 1 and 2, with the above continuous measure scores designated as the outcome variables in separate analyses.

Exploratory analyses: Will AD-E be associated with steeper downward slopes in anger and aggressive behaviors (DAR-5, CTS2), suicidal ideation (DSI-SS), and alcohol abuse (QDS) as compared to PCT? Will AD-E be associated with steeper upward slopes in compassion towards self (SCS), compassion towards others (SBCS), and social connectedness (SoCS) as compared to PCT? The models used to evaluate these questions will be structured the same as the models above. We will be especially circumspect about statistically significant findings for these variables.

Clinical significance: Clinical significance will be calculated by the Jacobson-Truax (1991) method (e.g., Bauer, Lambert, & Neilson, 2004). This method suggests a two-step criterion. First, a reasonable cutoff between the dysfunctional and functional populations is established. Because normative data for veterans on the SDS does not yet exist, Jacobson and Truax's (1991) suggested cutoff A, defined as the point 2 *SD*s beyond the range of the pre-therapy mean (cutoff A = *M*clinical - 2 *SD*clinical) will be used. Next, a reliable change index (RC) for each participant will be calculated to ensure that changes are not due to an artifact of measurement error. The RC is computed according to the following: RC = (x2 – x1)/Sdiff where x1 represents the participant's pre-treatment SDS total score, x2 represents the participant's post-treatment or follow-up total score, and Sdiff is the standard error of difference between the two test scores. Sdiff will be calculated from the internal consistency of the measure at each time point. An RC larger than 1.96 reflects real change. Based on the two-step criterion, individuals will be classified as recovered (passed both cutoff A and RC criteria), improved (pass RC criterion but not cutoff A), unchanged (passed neither criteria), or deteriorated (passed RC criterion but symptom scores increased) for each follow-up interval. Chi-square analyses will be used to compare proportions per arm at each follow-up.

IMPLICATIONS

This study will develop and test strategies to target PTSD-related social reintegration difficulties and obstacles to meaningful employment. AD-MIL supports social and occupational rehabilitation by providing veterans with a psychological and behavioral foundation to improve relationships and encourage progress toward meaningful social and work goals. AD-MIL is designed to restore social and occupational functioning that has been diminished due to PTSD. Functional rehabilitation and reintegration of veterans with PTSD is unlikely to occur with interventions that are chiefly designed to treat PTSD as a fear- and victim-based phenomenon and with treatments that focus solely on PTSD symptom reduction. This study is consistent with calls to make psychosocial rehabilitation central to PTSD treatment (Glynn et al., 2009). This trial will advance knowledge in rehabilitation research by testing the first therapy specifically designed for veterans targeting military-related trauma and psychosocial functioning. This study may improve the quality of services provided by the VA by offering an ecologically sound treatment targeting experiences that are uniquely impactful for military veterans. This benefits clinicians seeking help for MI in particular; our research team has received many requests for the AD manual and AD training, motivated by the relative vacuum that exists to target MI and TL. If AD-MIL is found to be efficacious, it will fill a void in VA care-providers' toolkit of strategies to help veterans heal and recover from military-related psychological, behavioral, and social difficulties. This research also benefits veterans by redressing the unique phenomenology of MI and TL. If we can show that AD-MIL improves functional and psychological outcomes implicated by transgression and loss, then AD-MIL can be disseminated as an individualized, evidence-based, psychosocial rehabilitation strategy to reduce suffering and reestablish veterans' confidence, competence, motivation, and functioning. Addressing issues of self-forgiveness and morally injurious events of the past can also arguably assist veterans in reconnecting with family and communities, including spiritual communities that they may be avoiding due to their difficult experiences in war. Finally, through family (or friend) engagement, we can provide education about MI and loss early in the process, involve them in the course of recovery, and enlist them in helping with future-oriented healing and goals set by the veteran.

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1. OVERVIEW OF THE RESEARCH STUDY:

We are asking you to be in a research study that is being supported by the Office of Research and Development at the VA Boston Healthcare System. Before you decide to take part, you should know why the study is being done and what it will involve. This form tells you what to expect if you agree to be in the study. Taking part in this study is completely voluntary; it is your decision whether or not to participate in the study.

We are doing the research to compare the effectiveness of two different therapeutic treatments for military-related distress (such as PTSD, moral injury, and traumatic grief and loss). If you agree, you will participate in an audio-recorded interview today to find out whether the treatments used in this study are a good fit for you. If they are, you will participate in weekly treatment sessions as well as follow-up interviews at the end of treatment and, if enrolled before June 1st, 2021 3 months after treatment ends. You will be in the study for either 3 or 6 months if you decide to stay for the whole study. We will describe your involvement in more detail later in this form.

There are no known direct benefits to you for being in this study.

You may choose not to volunteer to be in the study if you do not want to participate in interviews about or treatments focused on distressing events that happened to you while in the military. You will find more information about these risks later in this form.

If you choose not to participate in this study, you will receive standard medical treatment, decided on by your doctor and you, which may or may not include treatments that are a part of the planned research study. You will find more information about alternate treatment/procedures later in this form.

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any services, benefits or rights you would normally have if you choose not to volunteer.

2. WHAT IS THE PURPOSE OF THIS STUDY?

This is a research study to test the effectiveness of two treatments for military-related PTSD and other types of distress. The treatments are called Adaptive Disclosure for Moral Injury and Loss, and Present Centered Therapy. We hope to learn whether Adaptive Disclosure could be helpful to service members who have experienced distressing events. A total of 148 veterans from Veteran Affairs (VA) hospitals in San Diego, San Francisco, Minneapolis, and Central Texas are expected to take part in this study. In order to participate in the treatments, you must first be interviewed.

3. HOW LONG WILL I BE IN THE STUDY? WHAT WILL HAPPEN AND WHAT CAN I EXPECT IF I TAKE PART IN THIS STUDY?

You will be involved in the study starting today if you choose to participate in an interview. During this interview, you will be asked questions about your general mental health, such as symptoms or problems that you may be experiencing. This interview will be audio recorded unless you do not consent to audio recording. You will also be asked questions about symptoms and problems that you may be having related to stressful or difficult experiences that you had while deployed. This interview will take about 45-60 minutes to complete. After today's interview, if you are eligible, you will be randomized to one of the treatments. You will attend weekly sessions (for about 1 hour per week) where you will work one on one with a therapist. You will also complete an interview lasting 45-60 minutes again at the end of treatment, and, if enrolled before June 1st, 2021 3 months after treatment ends. You will be in the study for either approximately 3 or 6 months.

4. WHAT POSSIBLE RISKS OR DISCOMFORTS MIGHT I HAVE IF I TAKE PART IN THIS STUDY?

You may feel some discomfort or distress from the discussion of personal or emotional topics. It may also feel a little strange or impersonal to talk about some of these things on the phone with someone you don't know. Your confidentiality will be protected to the extent permitted by law; however, there is always a risk of breach of confidentiality. If you are a risk to yourself, study staff will take steps to protect you, which may include disclosing your intentions to another healthcare professional or to another person who could help keep you safe. In addition to the risks described above, you may experience a previously unknown risk or side effect.

5. WHAT ARE THE POSSIBLE BENEFITS OF THIS STUDY?

There are no known direct benefits to you for being in this study.

6. DO I HAVE TO TAKE PART IN THE STUDY?

You may decide to stop today's interview and stop being in the study at any time by letting the study researcher or staff person know. Withdrawal at any time will not have any adverse effects or impact future treatment at the Boston VA Healthcare System or other VA facilities.

You may stop attending therapy without withdrawing your consent for continued study participation. In this case, please let your therapist know. You and your therapist will complete a form called the Therapy Drop-out/Completion Form and indicate why you are ending your participation in treatment.

Likewise, you may withdraw from participating in the study while continuing to participate in treatment. In this case, please let your therapist know. You and your therapist will complete a form called the Study Drop-out Record and indicate why you no longer want to participate in the study.
You may also stop participating in treatment *and* the study. Please let your therapist know. You and your therapist will complete the Study Drop-out/Completion and Therapy Drop-out/Completion forms.

For data already collected prior to your withdrawal, the investigator may continue to review the data already collected for the study but will not collect further information. Data you provide us with prior to your withdrawal will continue to be used and cannot be withdrawn from the study record.

7. WHAT OTHER CHOICES DO I HAVE IF I DO NOT WANT TO JOIN THIS STUDY?

Other treatment to that described above may include PTSD treatments at your local VA (such as Prolonged Exposure or Cognitive Processing Therapy) and will be under the supervision of your doctor or caregiver.

8. RIGHT OF INVESTIGATOR TO TERMINATE MY PARTICIPATION

Your participation in treatment may be terminated without your consent if:

- The researcher believes that it is not in your best interest to stay in the study.
- You become ineligible to participate.
- Your condition changes and you need treatment that is not allowed while you are taking part in the study.
- You do not follow instructions from the researchers.
- The study is stopped.

9. HOW WILL MY PRIVATE INFORMATION BE PROTECTED?

Information collected for the purpose of this research study will be kept confidential as required by law. The results of this study may be published for scientific purposes, but your records or identity will not be revealed unless required by law.

If you are a risk to others, study staff will take steps to protect the other person(s), which includes disclosing your intentions to law enforcement. Study staff will also report child abuse and elder adult physical abuse to appropriate authorities.

Information about you is protected in the following way: We will store your information in ways we think are secure. Full measures will be taken to ensure the confidentiality of the data we collect. All data that are gathered during the study (including audio recordings) will be kept strictly confidential. It will be done in line with the law and will be coded without the use of your name or social security number. Only research staff will have access to the data. All original hard copies of consent forms and surveys will be locked in a cabinet that is locked in a room. Electronic files with identifying information in them will be password-protected.

If data from this study are published or shown at scientific meetings, your name and other personal information will not be used.

Your research records will be kept indefinitely or until the law allows their destruction in accordance with the VA Record Control Schedule (www1.va.gov/VHAPUBLICATIONS/RCS10/rcs10-1.pdf). Records will be destroyed, when allowed, in the following manner.

- Paper records will be shredded
- Electronic records will be destroyed in a manner in which they cannot be retrieved.
- Audio recordings will be destroyed in a manner in which they cannot be retrieved.

Your research records and the information within them will not be used for any purpose other than that described in this study as approved by the IRB. Your information, even if identifiers are removed, will not be used or distributed for future research studies.

While this study is being conducted, you will have access to your research related health records. This will not affect your VA healthcare including your doctor's ability to see your records as part of your normal care.

With your permission, audio recordings will be made of today's and all follow-up interviews. By signing this consent form, you agree to audio recording of the interview. As with all of the data you provide, audio recordings will be kept strictly confidential (see Section 7 for further information).

- Do you consent to being asked questions about your general mental health, such as symptoms or problems that you may be experiencing?
  ☐ If you agree, please initial here _____
- Do you consent to being asked questions about symptoms and problems that you may be having related to stressful or difficult experiences that you had while deployed?
  ☐ If you agree, please initial here _____
- Do you consent to completing an interview lasting 45-60 minutes at the end of treatment and, if enrolled before June 1st, 2021 3 months after treatment ends, if you are eligible for the study?
  ☐ If you agree, please initial here _____
- Do you consent to audio recordings being made of your clinical contacts? As with all of the data you provide, audio recordings will be kept strictly confidential. Audio recordings will be destroyed in a manner in which they cannot be retrieved.
  ☐ If you agree, please initial here _____

To help protect your privacy, we have obtained a Certificate of Confidentiality from the National Institutes or Health. With this Certificate, we cannot be forced, even by a court subpoena from any Federal, state, or local civil, criminal, administrative, legislative, or other proceeding, to disclose information that may identify you. We will use this Certificate to resist any demands for information that would identify you, except as explained below.

The Certificate cannot be used to resist a demand for information from personnel of the United States Government that is used for audting or evaluting Federally funded projects, or for information that must be disclosed to meet the requirements of the Federal Food and Drug Adminsitration (FDA).

You should understand that this Certificate does not prevent you from voluntarily releasing information about you or your involvement in this research. If an insurer, employer, or other person obtains your written consent to receive research information, then the reserachers cannot use the Certificate to withhold that information.

The Certificate does not prevent the researchers from disclosing voluntarily, without your consent, information that would identify you as a reserch participant under the following circumstances: in the event that you report engaging in behavior that constitutes child or elder abuse as defined by the Commonwealth of Massachusetts; or if you are deemed at immediate risk of suicide; or if you are deemed to be at risk of doing bodily harm to a specifically identifiable individual.

Your research records will be kept indefinitely or until the law allows their destruction per the VA Record Control Schedule (www1.va.gov/VHAPUBLICATIONS/RCS10/rcs10-1.pdf). Records will be destroyed, when allowed, in the following manner.

- Paper records will be shredded
- Electronic records will be destroyed in a manner in which they cannot be retrieved.
- Audio recordings will be destroyed in a manner such that they cannot be retrieved.
- Audio/visual recordings and/or printed photographs will be shredded.

Your research records and the information within them will not be used for any purpose other than that described in this study as approved by the IRB.

To comply with laws and regulations, we may need to share safety-related information such as that relating to child abuse or neglect; elder or disabled person abuse; specific reportable diseases; harm to self or others.

An unsigned copy of this consent form will be posted on clinicaltrials.gov or Regulations.gov after all study participants have completed the study.

10. WHO ELSE MIGHT SEE MY DATA?

You consent to the access of your VA research and medical records that may identify you by persons approved for this purpose. Such access may be by the Institutional Review Board and Research & Development Committees of VABHS, the VA, Federal agencies, or national research oversight and accreditation organizations. You may expect the same confidentiality from these persons that is given to you by the Investigator and his/her research staff.

11. WILL I BE TOLD NEW INFORMATION ABOUT THIS STUDY?
You will be told of any significant new findings that come to light during the course of this study and that may relate to your wanting to stay in the study.

12. WHAT ARE THE COSTS TO ME IF I TAKE PART IN THIS STUDY?
A participant will not be required to pay for medical care and services received as a participant in an approved VA research study. Some participants are required to pay co-payments for medical care and services provided by the VA. These co-payment requirements will continue to apply to medical care and services (including, but not limited to, dental services, supplies, medicines, orthopedic and prosthetic appliances, and domiciliary or nursing home care) provided by the VA that are not part of this research study.
You consent to the release of personally identifying information about you including your name, address, and social security number to the VA so that we may provide compensation to you. You can expect to receive a check within 2-6 weeks. The government may garnish the compensation against outstanding debts a veteran has to the federal government.

13. WHAT WILL HAPPEN IF I AM INJURED BECAUSE OF MY BEING IN THE STUDY?

In the event that you are injured as a result of your being in this research study, you will receive medical care, including emergency treatment. This care or treatment is governed by federal law and VA policy. You would also have the right to file any legal action, as in any instance of alleged negligence.

14. WHO COULD PROFIT FROM THE STUDY RESULTS?

No payments are being made to the investigator that could be construed as a potential conflict of interest. Data collected in this study will not be used for commercial profit. A commercial product will not be developed that could be used for commercial profit.

15. WHO DO I CONTACT ABOUT THIS STUDY IF I HAVE QUESTIONS?
I understand that if I have any medical questions or general questions about this research study, I can call **Dr. Brett Litz** at (857) 364-4131 during normal working hours during normal working hours.

I understand that if I have any medical problems that might be related to this study that **during the day** I can call **Dr. Brett Litz** at (857) 364-4131 and **after hours** I can call my local Medical Center operator and ask for the fellow on call for Psychiatry. For participants in San Diego, please call (858)552-8585. For participants in San Francisco, please call (800) 773-0502. For participants in Minneapolis, please call (866) 687-7382. For participants in Central Texas, please call (800) 423-2311.

I understand that, if at any point during or after this study I have any questions about my rights as a research participant or I want to discuss problems, complaints, concerns, and questions about

the research, obtain information, or offer input, I may contact the Research Compliance Officer at (857) 364-4182.

You may also contact the local people listed on the consent form you signed earlier (entitled "VA Research Consent Form"). For participants in San Diego, please call Dr. Ariel Lang at (858) 246-0631. For participants in San Francisco, please call Dr. Shira Maguen at (415) 221-4810. For participants in Minneapolis, please call Dr. Tasha Nienow at (612)-467-1004. For participants in Central Texas, please call Dr. Sheila Frankfurt at (254) 400-6742.

16. AGREEMENT TO PARTICIPATE IN THE RESEARCH STUDY

I have read or have had read to me all of the above. Study staff have explained the study to me and answered all of my questions. I have been told of the discomforts and risks of the study. I have been told of other choices of treatment that I could have.

I understand that my participation in this study is voluntary, that I do not have to take part in this study and that, if I do take part, I may withdraw from the study at any time. I also understand that, if I refuse to take part or if I decide to withdraw, I will not suffer any penalty, loss of rights, or loss of VA or other benefits that I have a right to receive.

I voluntarily consent to be in this study. I will receive a signed copy of this consent form.

Participant's Signature **Month Day Year** **Name (print)**