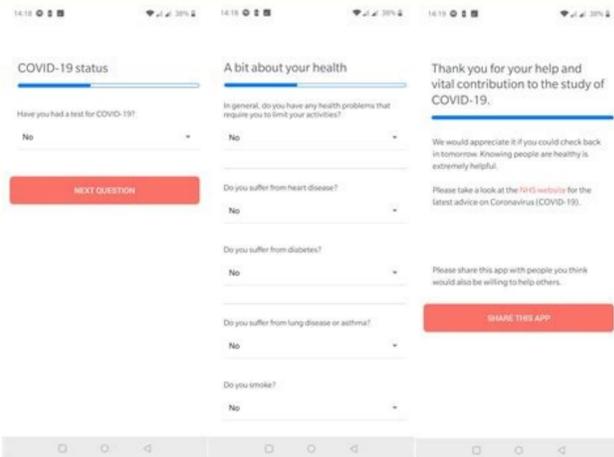
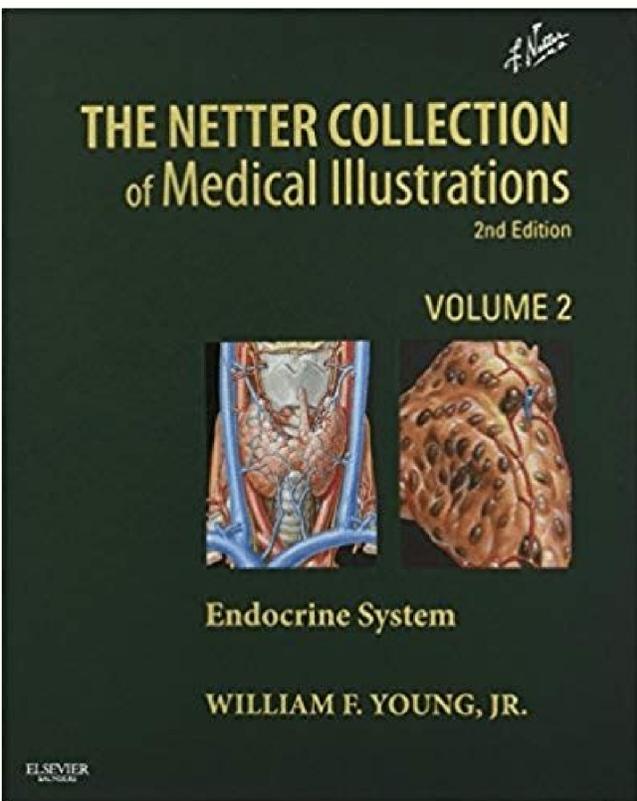


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Community Pharmacy – Departments

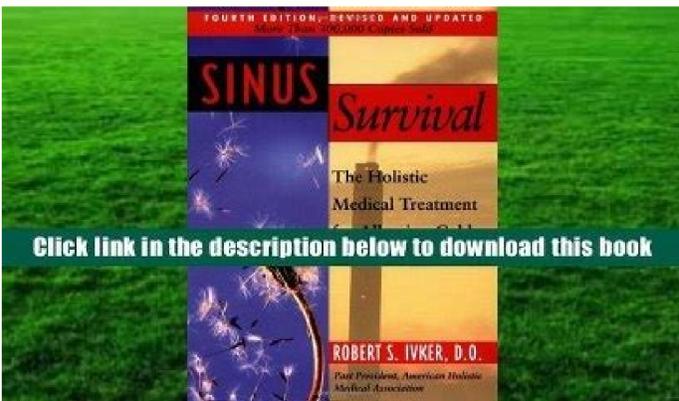
- ▶ **Alternative medicines (NHP's)**
- ▶ **Vitamins/OTC's**
- ▶ **Orthotics and mobility aids**
- ▶ **Wound Care**
- ▶ **HBA**
- ▶ **Cosmetics**
- ▶ **Electronics**
- ▶ **Food and Groceries**
- ▶ **Post Office**
- ▶ **Greeting cards**
- ▶ **Books and Magazines**
- ▶ **Consultations**
- ▶ **Private Consultations**
- ▶ **Medication Management**
- ▶ **Blister Packaging**
- ▶ **Medication Reviews**
- ▶ **Patient Education seminars**
- ▶ **Disease state screening**
- ▶ **Chronic Disease Mgmt**
- ▶ **Immunization**
- ▶ **Refill services**
- ▶ **Delivery services**
- ▶ **LTC and Group homes**

Departments and Products

Professional Services

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Participants were evaluated in person or by phone weekly for the next four weeks. JAMA Network. Participants with PTSD (n = 55) were treated for four weeks with twice-daily, 17-min at-home CGRI sessions using a sensor and tablet with pre-loaded software. The Patient Health Questionnaire 9-item depression scale (PHQ-9, Kroenke et al., 2001) is a self-report scale that asks individuals to rate the presence of DSM-IV symptom criteria ranging from '0' (not at all) to '3' (nearly every day), provided study-related materials and equipment, and managed collection of study data from the Freespira device but had no role in participant selection or interpretation of the study results. In our trial of an integrated and internet-connected system, the data from each session were recorded in real-time and uploaded to a server, and participants received weekly coaching about their adherence and success in meeting RR and EtCO2 targets. Seventy percent said it was 'easy' or 'very easy' to learn and use the device. Concise health risk tracking scale: A brief self-report and clinician rating of suicidal risk. (2013). Respiratory rate decreased and EtCO2 levels increased. [PubMed] [CrossRef] [Google Scholar]Ware JE., Jr. Subsequent studies have found one CGRI system (Freespira®) to be effective in reducing panic symptoms (Kaplan et al., 2020; Tolin et al., 2017). RR and EtCO2 were measured in real time for 2 min at rest at the start of each session to measure baseline readings and were continuously measured and displayed to the participant during the remaining 15 min of the session. The overall mean adherence using this calculation was 77% (43/56). Participants completed a questionnaire post-treatment to assess acceptability, usability and participant satisfaction. Lawrence Erlbaum Associates Publishers; 1999. CGRI's repetitive training of paced/normocapnic breathing likely develops self-management skills that can be deployed at awareness of symptom increase. (Berenz et al., 2019). Given the exploratory nature of the study, adjustment was not made for multiple comparisons. The protocol's target completion sample-size of 44 was identified to allow the lower 95% confidence limit of the proportion achieving a successful response to be 35%, from an expected response rate of 50%. After recruitment for this study was completed, a study was published of a CGRI system that did not directly record participant use of the device found no differences compared to a waiting list control group in outcomes in Veterans with hyperarousal symptoms of PTSD (Jamison et al., 2019). This study seeks to explore CGRI's acceptability, tolerability, safety and effectiveness in reducing symptoms in patients with PTSD. Proportions of participants with the desired outcome and associated 95% lower bounds were estimated. For participants with at least one post-baseline data point (n = 48), CAPS-5, PDSS, CHRT-SR, PHQ-9, SF-36 and CGI-S scores at post-treatment and at 2- and 6-month follow-up were estimated based on previous values using an iterative Markov chain Monte Carlo (MCMC) method. Adherence was calculated as the number of completed sessions divided by 56 (capped at 100%), consistent with previous CGRI studies (Kaplan et al., 2020; Tolin et al., 2017). CGRI equipment includes a proprietary handheld EtCO2 sensor, nasal cannula and tablet with pre-loaded software that guides the participant through two 17-min breathing sessions daily for 4 weeks. The data that support the findings of this study are available from the corresponding author upon reasonable request. [PMC free article] [PubMed] [CrossRef] [Google Scholar]Folke M, Cermerud L, Ekstro M, Hok B. It is not known to what extent study participation itself or other performance biases might have led to such marked improvements in CAPS-5 outcomes. [PubMed] [CrossRef] [Google Scholar]Oakes DF. Participants with a score of > 10 on the COPD assessment (CAT, Jones et al., 2009) or an EtCO2 of ≥ 48 mmHg at first treatment visit were excluded since they typically have impaired lung function due to pulmonary disease. [PubMed] [CrossRef] [Google Scholar]Foa EB, McLean CP, Zang Y. [Google Scholar]Gupta N, Pinto LM, Morogan A, Bourbeau J. Cognitive behavioral therapy for posttraumatic stress disorder in women: a randomized controlled trial. The 50% response was a clinical decision based on prior studies with CGRI and the limited effectiveness of current PTSD treatments in the context of PTSD. 2013;12(12):CD003388. As this was a first-in-class study of this specific device, the study was powered to determine whether clinically meaningful improvement of symptoms would be found. Decreases in CAPS-5 and other outcomes scores (including effect sizes) are shown in Table 2. Outcomes on primary and secondary measures: Pre-Post 2-Month follow-up 6-Month follow-up (SD)M (SD)Est. Dr. Ostacher had access to study data throughout the trial and takes responsibility for the integrity of the data and the accuracy of the data analysis. Reliability and validity of the Panic Disorder Severity Scale: replication and extension. The primary evidence-based treatments for PTSD are trauma-focused psychotherapies, non-trauma-focused psychotherapies, and medications, predominantly antidepressants. [PMC free article] [PubMed] [CrossRef] [Google Scholar]Multz C, Yassouridis A, Daneshi J, Braun M, Kellner M. Mean CAPS-5 scores decreased from 49.5 [s.d. = 9.2] at baseline to 27.1 [s.d. = 17.8] at 2-months post-treatment follow up. The use of psychological testing for treatment planning and outcomes assessment. As with many therapies, the mechanism of action is unlikely to be unitary. The 36-Item Short Form Health Survey (SF-36, RAND Corporation, 2016; Ware, 1999) is a self-rated survey of health impact on daily function. Allowing for a dropout rate of 20%, a total of 55 participants were planned. Baseline characteristics included all participants who completed the baseline session. doi: 10.1001/jamapsychiatry.2017.4249. 1 Veterans Affairs Palo Alto Health Care System, Palo Alto, CA USA 2 Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, Palo Alto, CA USA 3 Department of Psychiatry, VA Palo Alto HCS, 3801 Miranda Avenue, Mail Code 151T, Palo Alto, CA 94304 USA Find articles by Michael J. For the hypocapnic group, the improvement in CAPS-5 score was also greater (d' = 1.9 at post-treatment) vs. The Jamison trial also had higher dropout rates, and actual adherence to the twice-daily 17-min breathing sessions were not measured or known in real-time but rather required that the participants document their performance and measures in a written log. Randomized clinical trial of capnometry-assisted respiratory training in veterans with posttraumatic stress disorder hyperarousal. doi: 10.1002/14651858.CD003388.pub4. The clinical global impressions scale: applying a research tool in clinical practice. Psychological Services. Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. doi: 10.1016/j.jpsychi.2007.06.005. One mechanism by which PTSD symptoms might be mediated and which could be an area of therapeutic focus is in addressing CO2 (carbon dioxide) sensitivity,

shown to reduce symptoms of panic disorder (PD) (Kaplan et al., 2020; Meuret et al., 2008, 2009; Tolin et al., 2017). [PMC free article] [PubMed] [Google Scholar]Cougler JR, Feldner MT, Keough ME, Hawkins KA, Fitch KE. Applied Psychophysiology and Biofeedback. Multicenter collaborative panic disorder severity scale. 1997;154(11):1571-1575. European Journal of Psychotraumatology. Later, the reliable change index (RCI) for CAPS-5 was defined as 13 points (Sloan et al., 2018) and was applied to the data retrospectively to provide additional validity of the CAPS-5 results in this study. doi: 10.1001/jama.2015.0370. [Assessment] Retrieved from [PMC free article] [PubMed]Weathers FW, Bovin MJ, Lee DJ, Sloan DM, Schnurr PP, Kaloupek DG, Keane TM, Marx BP. Subsequent sessions were done at home. Subjects with additional DSM-5 disorders were able to be enrolled if PTSD was their primary psychiatric diagnosis.Exclusions included: current evidenced-based therapy that focuses on PTSD (including cognitive processing therapy, EMDR, prolonged exposure therapy, virtual reality therapy, and cognitive behavioral therapy) during the treatment period and 2 month follow up and prior therapy must have been discontinued ≥ 1 month prior to enrollment; pregnancy; current enrollment in another device or drug study or enrollment in another drug device study that was not at least 30 days past the final follow-up visit; suicidality, in the judgment of the interviewer; psychotic disorder, including schizophrenia and schizoaffective disorder; presence of uncontrolled bipolar disorder, including a manic episode in the past 6 months and not considered under control by the evaluator, or bipolar disorder is considered the primary diagnosis for the subject, in the interviewer's opinion; alcohol or drug use disorder requiring acute medical treatment; epilepsy or recent seizures; and cardiovascular or pulmonary disease. We also calculated the reliable change index (RCI) as further confirmation of study results. Psychotherapy for military-related PTSD. International Journal of Psychophysiology. The PHO-9: Validity of a brief depression severity measure. Cochrane Database of Systematic Reviews. Capnometry Guided Respiratory Intervention (CGRI) is a digital therapeutic effective in panic disorder that measures and displays end-tidal carbon dioxide (EtCO2) and respiratory rate (RR) in real-time within a structured breathing protocol and may have benefit in PTSD by moderating breathing and EtCO2 levels. mean change (SE)Hypocapnic (Pre ETCO2 14 sessions, adherence to the 4-week protocol was calculated by determining the proportion of CGRI sessions completed over the course of the study (target = 56), as evidenced by automatic uploads to the cloud-based server. An additional longitudinal study established a bi-directional relationship between PD and PTSD. The combination of clinical improvement to six months and high adherence and participant satisfaction rates suggests that this non-invasive, digital therapeutic is a promising intervention for PTSD. The imputation for missing values was repeated five times. Source of primary trauma was combat-related in 16 (29%) of participants and sexual assault in 18 (33%) of participants with additional index trauma reported as accidents (3), family member suicide (2), death in family (3), physical abuse (4) and other (2). doi: 10.1016/j.psychires.2008.08.003. Associated mental and physical health symptoms also improved. Physiological markers for anxiety: Panic disorder and phobias. doi: 10.1001/jama.297.8.820. Fear of memories: The nature of panic in posttraumatic stress disorder. 2007;297(8):820-830. Effects of 35% carbon dioxide (CO2) inhalation in patients with post-traumatic stress disorder (PTSD): A double-blind, randomized, placebo-controlled, cross-over trial. 2005;58(2):190-198. doi: 10.3402/ejpt.v3i0.19084. RAND Health Publication. Adverse events were tracked throughout the study.Response was defined as a 6-point decrease in CAPS-5 score from baseline to 2-month follow up. Jocelyne and colleagues identified substantial overlap in key somatic symptoms in samples of individuals with panic disorder and PTSD, with high rates of palpitations, shortness of breath, chest pain, and dizziness. Disposition of the participants is shown in Fig. 1. Baseline study demographicsN55Age: M (SD)51 (14)Veteran N (%)39 (71%)Sexual assault related PTSD N (%)18 (33%)Combat related PTSD N (%)16 (29%)Male N (%)36 (65%)Ethnicity: African American N (%)15 (28%) Caucasian N (%)23 (43%) Native Hawaiian/Pacific Islander N (%)2 (4%) American Indian/Alaska Native N (%)6 (11%) Asian N (%)2 (4%) Mixed N (%)6 (11%) Decline-to-state N (%)4 (7%)Comorbid medical conditions Parkinson's N (%)0 (0%) Alzheimer's N (%)0 (0%) Stroke N (%)3 (5%) Other N (%)7 (13%)Seizures Childhood fever N (%)2 (4%) Adult-onset N (%)1 (2%) Head trauma or loss of consciousness N (%)21 (38%)Cardiovascular Heart disease N (%)1 (2%) Heart failure N (%)1 (2%) Kidney failure N (%)1 (2%)Respiratory Asthma N (%)4 (7%) COPD N (%)0 (0%) Emphysema N (%)1 (2%) Chronic bronchitis N (%)2 (4%)Endocrine Hypo or hyperthyroid N (%)6 (11%) Diabetes N (%)9 (16%)Care Regularly see a GP or Specialist N (%)48 (87%) Lifetime impact psychiatric hospitalization21 (39%) Current suicidal ideation N (%)3 (6%)Previous mental health diagnosis: Bipolar Disorder N (%)10 (18%) Schizophrenia N (%)0 (0%) Autism N (%)0 (0%) Asperger's N (%)0 (0%) Major depression N (%)27 (50%) PTSD N (%)47 (85%)Hospitalization Hospitalization in last 12-months N (%)12 (22%) ER visit in last 12-months N (%)20 (36%)Habits Drink alcohol N (%)28 (51%) Smoke N (%)14 (25%) Recreational drugs N (%)10 (19%)Panic attacks along with PTSD N (%)40 (73%) Years experienced panic attacks w/PTSD M (SD)19 (14)Currently seeking treatment for PTSD N (%)45 (82%)Previously sought treatment for PTSD N (%)44 (80%)Currently seeking treatment for panic attacks N (%)27 (49%)Previously sought treatment for panic attacks N (%)27 (49%)Evaluation of the primary outcome measure (≥ 6 point drop in CAPS-5 score from baseline to 2-month post-intervention follow up, prespecified at baseline as a clinically significant outcome, and positive for the trial if ≥ 50% of subjects reached remission) showed 88% of subjects (95% CI 74-96) reaching criteria for response, with 48% of subjects reaching criteria for remission. CGRI was well tolerated, with 88% [95% CI 74-96%] having ≥ 6-point decrease in CAPS-5 scores at 2-months post-treatment follow up. The primary outcome was defined as ≥ 50% of study participants experiencing response between baseline and the 2-month follow-up. 2019;321(2):200-201. Past panic attacks were reported by 40 (73%) participants, with lifetime major depressive disorder in 27 (50%) and lifetime bipolar disorder in 10 (18%). Better chemistry through breathing: The story of carbon dioxide and how it can go wrong. Outcome measures (30-days CAPS, PDSS, PHQ-9, SF-36, CHRT-SR, CGI-S) were evaluated at end of treatment, at 2-months post-treatment, and at 6-months post treatment. SF-36 health survey. doi: 10.1001/jama.2018.19290. [PMC free article] [PubMed] [CrossRef] [Google Scholar]RAND Corporation 38-item short form survey (SF-36) scoring instructions | RAND. Archives of General Psychiatry. While provocation of panic attack symptoms during carbon dioxide challenge tests was initially reported for panic conditions, it has been subsequently reported in individuals with established PTSD and comorbid anxiety disorders. doi: 10.1001/archpsyc.2010.111. Keywords: Posttraumatic stress disorder (PTSD), Anxiety/Anxiety disorders, Mindfulness/meditation, Biofeedback, CGRI/Posttraumatic stress disorder (PTSD) is marked by symptoms of hyperarousal, difficulties with emotional regulation, negative affect, and autonomic dysfunction (American Psychiatric Association, 2013). [PMC free article] [PubMed] [CrossRef] [Google Scholar]Jones PW, Harding G, Berry P, Wilkidan I, Chen H, Kline Leidy N. Analyses of outcomes were conducted using a modified intention-to-treat approach. doi: 10.1016/j.psychires.2011.01.009. [PubMed] [CrossRef] [Google Scholar]Kroenke K, Spitzer RL, Williams JB, Ostacher/Veterans Affairs Palo Alto Health Care System, Palo Alto, CA USA Find articles by Eileen Fischer/Veterans Affairs Palo Alto Health Care System, Palo Alto, CA USA Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, Palo Alto, CA USA Find articles by Ellie R. 2001;16(9):606-613. Time course of panic disorder and posttraumatic stress disorder onset. 2009;34(3):648-654. reviewed the manuscript, final approval for the decision to submit the manuscript was the sole decision of the authors.This study was funded by a grant from Palo Alto Health Sciences, Inc. The Jamison study, which was conducted with different instrumentation, exclusively used a RR target of 9 over four weeks, compared to 13, 11, 9 and 6 RR targets decreasing weekly over the 4-week intervention using the device in this study, which may have had an impact on outcomes. [PubMed] [CrossRef] [Google Scholar]Garcia HA, Kelley LP, Rentz TO, Lee S. Development and first validation of the COPD Assessment Test. 2018;319(4):354-364. Secondary measures employed are as follows. Normalization of baseline EtCO2 is present in some but not all treatment responders, as 56% were within the normal range at baseline and remained so at follow up, as seen in other studies of CGRI in panic disorder (Kaplan et al., 2020; Meuret et al., 2008; Tolin et al., 2017). Trauma- and stressor-related disorders. 2016 doi: 10.1016/j.ccr.2013.05.007. The American Journal of Psychiatry. These therapies have had varying degrees of success in their effectiveness and tolerability, including high dropout and nonresponse rates (Bisson et al., 2013; Foa et al., 2018; Garcia et al., 2011; Ostacher & Cifu, 2019; Steenkamp et al., 2015; Watts et al., 2013). Capnometry Guided Respiratory Intervention (CGRI) is a digital therapeutic that gives users feedback of EtCO2 levels and respiration rate (RR), with the goal of increasing EtCO2 levels and decreasing RR. [PMC free article] [PubMed] [CrossRef] [Google Scholar]Bunser J, Targum SD, [PubMed] [CrossRef] [Google Scholar]Ostacher MJ, Nierenberg AA, Rabideau D, Reilly-Harington NA, Sylvia LG, Gold AK, Shesler LW, Kottler TA, Bowden CL, Calabrese JR, Friedman ES, Jeste DV, Thase ME, Leon AC, Trivedi MH. This CGRI intervention was safe, acceptable, and well-tolerated in improving symptoms in this study in PTSD. Thus, it is possible that the protocol used in this study was more engaging for the user and may have led to better adherence and more actual use of the device as intended. The strengths of our study are that it included subjects with well-characterized PTSD, was performed in an academic medical center with the accompanying oversight, had broad inclusion and narrow exclusion criteria, did not require or limit the concurrent use of medications, and included both military veterans and civilians with this disorder. Individuals with panic conditions have a heightened risk of subsequently developing PTSD, and individuals with PTSD have a heightened risk of developing panic attacks. The CAPS-5 is a 30-item clinician-administered scale that rates severity of PTSD symptoms drawn from DSM-5 criteria (Weathers et al., 2018), a smaller effect (d = 0.7 post-treatment) for normoapnic subjects. The clinician-administered PTSD scale for DSM-5 (CAPS-5). In the past 36 months he has received personal fees for advisory board membership for Alkermes, Janssen (Johnson & Johnson), and Sage Therapeutics. 2010;24(2):183-188. Bowen/Veterans Affairs Palo Alto Health Care System, Palo Alto, CA USA Find articles by Jihun Lyu/Veterans Affairs Palo Alto Health Care System, Palo Alto, CA USA Find articles by Denisija J. Critical review of non-invasive respiratory monitoring in medical care. To view a copy of this licence, visit [https://creativecommons.org/licenses/by/4.0/](#).based treatments for posttraumatic stress disorder (PTSD), including psychotherapies and medications, have high dropout and nonresponse rates, suggesting that more acceptable and effective treatments for PTSD are needed. [PubMed] [CrossRef] [Google Scholar]Schnurr PP, Friedman MJ, Engel CC, Foa EB, Shea T, Chowdhury BK, Resick PA, Thurston V, Orsillo SM, Huang R, Turner C, Bernard N. 2013;74(6):e541-e550. Management of posttraumatic stress disorder. All analyses were performed using SPSS (IBM) v27.55 participants completed the baseline assessment, of which 36 (65%) were male and 19 female (35%), with a mean age of 51 years (range 19-77) and with 39 (71%) military veteran and 16 (29%) civilians. The corresponding statistical method was applied to each of the five imputed data sets and results were averaged across imputed data sets appropriately accounting for the between and within imputed data set variances. This was a pilot trial, so we decided a priori that if more than half of the participants met the response criteria, then this at-home, non-invasive treatment might be worth pursuing for further study in this difficult to treat population. When asked to rank the benefits of Freespira in order of importance, 73% chose as #1 or #2, 'I could use it at home'. The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5): Development and initial psychometric evaluation in military veterans. 2012;69(11):1161-1168. doi: 10.4088/JCP.12r08225. [PMC free article] [PubMed] [CrossRef] [Google Scholar]Kaplan A, Mannarino A, Nickell PV. [PMC free article] [PubMed] [CrossRef] [Google Scholar]Meuret AE, Rosenfield D, Hofmann SG, Suwak MK, Roth WT. 2017;42(1):51-58. One marker of panic-related respiratory dysfunction is lowered end-tidal CO2 (EtCO2) levels (Gilbert, 2005; Roth, 2005). [PMC free article] [PubMed] [CrossRef] [Google Scholar]Meuret AE, Wilhelm FH, Ritz T, Roth WT. mean change (SE)d'M (SD)Est. The Panic Disorder Severity Scale (PDSS, Shear et al., 2001, 1997), is a 7-item clinician-rated scale that indicates the severity and frequency of panic symptoms, fear of subsequent attacks, and avoidance behaviors. The Chronic Obstructive Pulmonary Disease Assessment Test (CAT, Gupta et al., 2014) is an 8-item self-report scale that assesses the impact of COPD symptoms on function and quality of life. The subjects in this study who were hypocapnic increased their EtCO2 and the magnitude of their symptom improvement was greater than the normoapnic group. doi: 10.1183/09031936.00102509. Study entry was reviewed by the study investigator (MJ.O). Subjects were then trained on-site on the use of the CGRI device at the baseline visit and completed the first session at that time. Quickly Shipped We know that in the Amazon-era people want things quick! Our goal is to have every order shipped out within 1 business day, on its way to you. 1-year Edition Guarantee We only sell the most current editions. Oh, and our bundles come with a 1-year Edition Guarantee (if a new edition comes out, simply request it, pay shipping) Need Help? Prior research in panic disorder demonstrates physiological changes associated with CGRI, with perceived control playing an additional role in symptom reduction (Meuret et al., 2010). The results of this study show promise of this digital therapeutic, but the mechanism by which CGRI improves PTSD symptoms merits additional investigation. Changes in respiration mediate changes in fear of bodily sensations in panic disorder. Prior literature has also proposed activation of trauma memory, catastrophic cognitions, culturally-specific associations, and interoceptive conditioning in response to fear sensations as possible panic attack triggers in PTSD sufferers. Are you a student and not sure what will best help at clinics? Connect with us to ensure you get what you want at the best price possible. Secure payments We use Shopify, one of the best shopping cart products available today. We take ordering security seriously, but feel free to call if you would rather purchase that way. Primary efficacy outcome was 50% of participants having ≥ 6-point decrease in Clinician Administered PTSD Scale (CAPS-5) score at 2-month follow up. 2011;8(1):1-11. These authors cite that approximately 70% of individuals with PTSD have co-morbid panic attacks. Feedback of end-tidal pCO2 as a therapeutic approach for panic disorder. [PubMed] [CrossRef] [Google Scholar]Shear MK, Brown TA, Barlow DH, Money R, Sholomskas DE, Woods SW, Gorman JM, Papp LA. CAPS-5 reductions far exceeded the 6-point reduction endpoint, with mean CAPS-5 scores decreasing from 49.5 (s.d. = 9.2) at baseline to 27.1 (s.d. = 17.8) at 2-months, with an effect size d = 1.3. This represents a 48% reduction of the CAPS-5 score. [PubMed] [CrossRef] [Google Scholar]Joscelyne A, McLean S, Drobny J, Bryant RA. Of the 47 completed surveys, 83% said they 'would' or 'would definitely' recommend this treatment to a friend or family member, and 76% said they were 'satisfied' or 'very satisfied' with their treatment. PTSD and associated symptoms were assessed at baseline, end-of treatment, 2-months and 6-months post-treatment. Psychiatry (edmont) (pa. A Brief Exposure-based treatment vs cognitive processing therapy for posttraumatic stress disorder. A randomized noninferiority clinical trial. Using this study's RCI of 9-points and Sloan's RCI of 13-points this report for response, 83% and 76% of subjects met criteria at 2-months and 87% and 82% meet response criteria at 6-months.Decreases were seen in the PDSS, PHQ-9, CHRT-SR, and CGI-S at 2-month follow up, with maintenance of improvement at 6 months, and the SF-36 sub-scale 'role functioning/emotional' showed a large effect size, with improvement continuing to 6 months. Before enrollment, participants gave written informed consent to participate in the trial and were given a nine-question decisional capacity screen to confirm understanding of the consent.After screening and written informed consent, potentially eligible subjects underwent baseline screening at our site, including a diagnostic assessment by a trained, Masters-level clinician, including review of medical and psychiatric history, current medications and substance use, CAPS-5 30-day version for confirmation of diagnosis and baseline score to confirm that PTSD was the primary diagnosis. Emotional reactivity to a single inhalation of 35% carbon dioxide and its association with later symptoms of posttraumatic stress disorder and anxiety in soldiers deployed to Iraq. doi: 10.1016/j.jpsycho.2005.01.015. Associated measures of mental and physical health also improved and persisted at 6-month follow-up.There is a need for safe, tolerable, acceptable, and effective treatments for the symptoms of PTSD that can be easily and widely disseminated for use in a patient's home, including to rural residents who have difficulty accessing in-person services. Health Educator Publications Inc.; 1996. Overall, there was a clinically significant reduction in PTSD scores over the course of the study and decreases in CAPS-5 scores persisted (and continued to decline) at six-month follow-up, with 50% meeting the criteria for remission at 6 months. Participants were instructed to breathe in sync with a rising and falling audio tone at the specified RR. Social Psychiatry and Psychiatric Epidemiology. JAMA. [CrossRef] [Google Scholar]Gilbert C. 10.1176/appi.books.9780890942556.dsm07Berenz EC, York TP, Bing-Canar H, et al. Dr. Ostacher and Dr. Suppes are full-time employees of the U.S. Department of Veterans Affairs and the VA Palo Alto Health Care System and are employees of Stanford University.Conflict of interest:Dr. Ostacher has received grant support from Palo Alto Health Sciences, Inc. Clinical practitioner's pocket guide to respiratory care. 4. Participants were also excluded if unable to understand or comply with study procedures or if investigator determined that the subject was not eligible to participate in the study.Participants were enrolled from February 2017 to February 2019, with recruitment from clinical settings in the VA Palo Alto Health Care System, along with posters and online advertising in the community. Psychological Assessment. doi: 10.1016/j.jpsychires.2017.10.019. 2018;96:260-264. [PubMed] [CrossRef] [Google Scholar]Guy W. [PMC free article] [PubMed] [CrossRef] [Google Scholar] Further study of this CGRI system for PTSD against an appropriate comparator treatment is warranted.The authors wish to acknowledge Simon Thomas for his work on the study design and data management, and Christy Cowley, Clinical Study Manager, PH Health Sciences, Inc. A multisite benchmarking trial of capnometry guided respiratory intervention for panic disorder in naturalistic treatment settings. We expected the response rate for the primary outcome to equal or exceed 50% based on prior studies in PD. Dr. Suppes, in the past 36 months, has received grants from Merck, National Institute on Drug Abuse, National Institute of Health, VA Cooperative Studies Program, and VA OR&D PRIME Care, Palo Alto Health Sciences Inc., Stanley Medical Research Institute, Pathways Genomics; consulting fees from Allergan, Inc., Intracellular Therapies, Sunovion Pharmaceuticals, Inc., and Impel NeuroPharma, Inc.; honoraria from CME Institute (Physicians Postgraduate Press, Inc.) and CMEology; and royalties from American Psychiatric Association Publishing, Hogrefe Publishing, Jones and Bartlett, and Wolters Kluwer Health (UpToDate). 2003;41(4):377-383. (Cougler et al., 2010). This study aims to examine a novel intervention currently used to treat symptoms of PD. Journal of General Internal Medicine. 2011;45(7):989-993. European Respiratory Journal. [CrossRef] [Google Scholar]Roth WT. [PMC free article] [PubMed] [CrossRef] [Google Scholar]Trivedi MH, Wisniewski SR, Morris DW, Fava M, Gollan JK, Warden D, Nierenberg AA, Gaynes BN, Husain MM, Luthar JF, Zisook S, Rush AJ. [Google Scholar]Jamison AL, Slightam C, Bertram F, Kim S, Roth WT. The Concise Health Risk Tracking Self-Report (CHRT-SR, Ostacher et al., 2015; Trivedi et al., 2011) is a 12-item self-report inventory that assesses suicidal and related thoughts. ECEUD assessment manual for psychopharmacology: revised (DHEW Publication No. ADM 76-338). US Department of Health, Education and Welfare, Public Health Service; 1976. doi: 10.1183/09031936.00025214. Panic symptoms in PTSD sufferers were highly associated with intrusive traumatic memories (Joscelyne et al., 2012). Journal of Clinical Psychiatry. Since the characteristic of carbon dioxide hypersensitivity is shared by both conditions, extending the use of CGRI to a population with PTSD was logical and potentially valuable clinical tool given the lack of medication-free treatment options for PTSD.The overlap between PD and PTSD is further elucidated in several publications. In Diagnostic and statistical manual of psychiatric disorders (5th edn.). The trial was approved by the Stanford University Institutional Review Board and the VA Palo Alto Health Care System Research and Development Committee. This proprietary CGRI system is a four-week intervention that was acceptable to participants, is without the adverse effects of pharmacological interventions, does not require the intervention of trained staff, and may be more accessible and tolerable than trauma-focused or other face-to-face psychotherapies. Have questions about a specific title? 2015 doi: 10.1016/j.psychires.2015.10.004. 2011;72(6):747-764. 2014;44(4):873-884. Effect of prolonged exposure therapy delivered over 2 weeks vs 8 weeks vs present-centered therapy on PTSD symptom severity in military personnel: A randomized clinical trial. [PubMed] [CrossRef] [Google Scholar]Kellner M, Muhtz C, Nowack S, Leichsenring I, Wiedemann K, Yassouridis A. pp. doi: 10.1521/jct.2010.3.3.262. Completion rates, acceptability, adherence, usability, safety and effectiveness of the treatment were high.The primary limitation of the present study is the absence of a randomly assigned comparison group. Target RR was RR = 13 during week 1, RR = 11 during week 2, RR = 9 during week 3, and RR = 6 during week 4, and participants were instructed to adjust respiratory volume to attain or maintain a targeted EtCO2 of 40 mmHg. Normal resting RR is 12-15 breaths per minute (Folke, et al., 2003) and normal EtCO2 is > 35 mmHg (Oakes, 1996). [Google Scholar]Ostacher MJ, Cifu AS. Using the normal approximation to the binomial distribution. A sample of 44 participants was required to be 95% confident that the difference between the true and observed rates differed by no more than ± 15%. [PMC free article] [PubMed] [CrossRef] [Google Scholar]Bisson JL, Roberts NP, Andrew M, Cooper R, Lewis C. We hypothesized in this open-label study that a 4-week at-home CGRI treatment, delivered for 17 min twice-daily in adult participants with moderate to severe symptoms of PTSD, would lead to a clinically significant reduction in PTSD symptoms 2 months post-treatment.The study enrolled adults 18 years and older with a primary DSM-5 diagnosis of PTSD and who had a Clinician Administered PTSD Scale (CAPS-5) score of ≥ 30 (Weathers et al., 2013), a Clinical Global Impression-Severity (CGI-S) score of ≥ 4 (Guy, 1976), and who agreed (if on any psychotropic medication) to maintain their current stable dose from point of study entry until the 2-month post-treatment assessment. Psychological Trauma. Of the four, two occurred during the course of treatment: chest pain on the last day of use, which resolved without action being taken, and shortness of breath at night, which also resolved without treatment and had been experienced before study enrollment. 2018;75(3):233-239. doi: 10.1176/appi.154.11.1571. Lifetime psychiatric hospitalization was reported by 21 (39%) of participants.Baseline demographics are seen in Table 1. doi: 10.1037/a0022705. 2012;3:19084. : Township) 2007;4(7):28-37. doi: 10.1016/j.janxdis.2009.10.006. There are a number of differences in these trials that may explain the differences in outcomes. Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. Descriptive statistics for RR and EtCO2 were analyzed for changes over the course of the study. Although staff at Palo Alto Health Sciences, Inc. Using the baseline (49.5) and 2-months (27.1) CAPS-5 scores and the SE of the difference between baseline and 2-month follow-up (2.5) the CAPS-5 reliable change index is 9 points. 2001;35(5):293-296. [PMC free article] [PubMed] [CrossRef] [Google Scholar]Steenkamp MM, Litz BT, Hoge CW, Marmar CR. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. 2015;314(6):489-500. A clinical measure of suicidal ideation, suicidal behavior, and associated symptoms in bipolar disorder. Psychometric properties of the Concise Health Risk Tracking Self-Report (CHRT-SR) Journal of Psychiatric Research. The COPD assessment test: A systematic review. [PubMed] [CrossRef] [Google Scholar]Weathers, F.W., Blake, D.D., Schnurr, P.P., Kaloupek, D.G., Marx, B.P., & Keane, T.M. (2013). JAMA Psychiatry. [PubMed] [CrossRef] [Google Scholar]Telch MJ, Rosenfield D, Lee HJ, Pai A. Participants are required by the CGRI protocol to breathe to maintain to an EtCO2 of 40 mmHg, which is often not possible physiologically depending on lung disease severity. Given the symptomatic and epidemiological overlap between PTSD and PD noted above, it is plausible that the CGRI treatment, which has been shown to provide long-term improvement in PD, would lead to benefits in symptoms of PTSD. Comorbid panic attacks among individuals with posttraumatic stress disorder: Associations with traumatic event exposure history, symptoms, and impairment. What is not fully known at this point is whether the learned breathing style taught during the CGRI protocol enables users to suppress dysregulated breathing when exposed to 'triggering' situations and engage instead in the trained breathing pattern as they become aware of physiological and/or psychological distress. doi: 10.1001/jama.2017.21242. Medical & Biological Engineering & Computing. The magnitude of the benefit in the earlier trial was smaller for both the intervention and the waitlist control compared to the changes found in our study. Remission rates were significant at 2-months and 6-months post-treatment. Tolerability, usability, safety, adherence and patient satisfaction were assessed. doi: 10.1001/archgenpsychiatry.2012.8. [PubMed] [CrossRef] [Google Scholar]Tolin DF, McGrath PB, Hale LR, Weimer DN, Gueorguieva R. mean change (SE)CAPS-5(9.2)31.8 (14.1)17.7 (1.9)1.427.1 (17.8)22.4 (2.5)1.326.2 (18.4)23.4 (2.4)1.4PDSS9.9 (5.4)7.5 (6.4)2.4 (0.9)0.46.0 (6.4)3.9 (1.0)0.65.2 (7.3)4.7 (1.1)0.7CHRT-SR15.4 (8.8)11.3 (9.7)4.2 (1.2)0.511.0 (10.1)8.5 (1.3)0.510.4 (9.3)5.0 (1.4)0.5PHQ-914.7 (4.9)10.8 (7.1)4.0 (0.9)0.611.8 (6.9)2.9 (1.0)0.410.2 (6.5)4.8 (1.0)6.32.0 (1.3)1.6 (0.2)1.23.0 (1.1)1.9 (0.2)1.23.0 (1.8)1.8 (0.3)1.0SF-36313.2 (27.3)37.5 (40.5)24.3 (5.7)0.637.1 (43.0)23.9 (6.6)0.543.9 (39.6)30.7 (6.1)0.7ETCO236.2 (4.3)37.9 (6.3)2.1 (0.7)0.3RR14.9 (3.9)12.8 (6.3)2.1 (0.7)0.4Mean EtCO2 increased modestly from baseline to end of treatment, with a mean of 36.2 (s.d. = 4.3) at baseline, increasing to 37.9 (s.d. = 4.3) at end-of-treatment, while RR showed moderate signs of decrease from pre-treatment to post-treatment, with a mean of 14.9 (s.d. = 3.9) at baseline, decreasing to 12.8 (s.d. = 6.3) at end-of-treatment.To further investigate the effect of treatment on EtCO2, subjects were analyzed separately based on baseline hypocapnia (EtCO2

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