TIER 2 DAY 1

Center for Deployment Psychology

Uniformed Services University of the Health Sciences

CENTER FOR DEPLOYMENT PSYCHOLOGY

Preparing Professionals to Support Warriors and Families

Sleep Disorders: An Overview of Sleep Disorders Common in Military Members

Center for Deployment Psychology
Uniformed Services University of the Health Sciences

Disclaimer

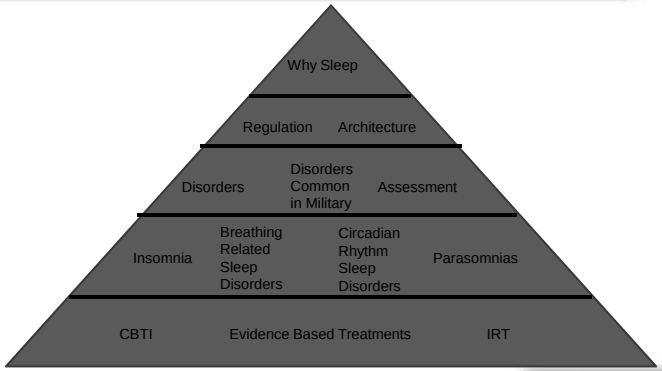
The views expressed are those of the presenters and do not necessarily reflect the opinions of the Uniformed Services University of the Health Sciences, the Department of Defense, or the U.S. Government.

Learning Objectives

1. Discuss sleep disturbances and disorders common to the military population.
2. Summarize the goals and strategies of a thorough assessment for sleep disorders.
3. Identify appropriate treatments for sleep disorders common to the military population.

Introduction to Ramos Family

Understanding Sleep



Brim, 2013

Sleep
What is it good for?

"I'll sleep when I'm dead"
-Warren Zevon

Inactivity Theory

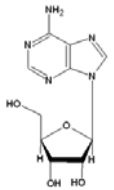
- Also called an adaptive or evolutionary theory
- Sleep serves a survival function and has developed through natural selection
- Animals that were able to stay out of harm's way by being still and quiet during times of vulnerability, usually at night…survived.

Energy Conservation

- Related to inactivity theory
- Suggests primary function of sleep is to reduce energy demand and expenditure
- Research has shown that energy metabolism is significantly reduced during sleep

Restorative

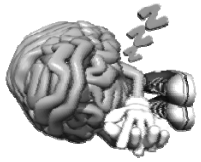
- Sleep provides an opportunity for the body to repair and rejuvenate
- Major restorative functions such as muscle growth, tissue repair, protein synthesis and growth hormone release occur mostly or exclusively during sleep



- Adenosine builds up while we are awake (and promotes a drive to sleep) and is cleared from the system while we sleep.

Brain Plasticity

- One of the most recent theories is based on findings that sleep is correlated to changes in the structure and organization of the brain.

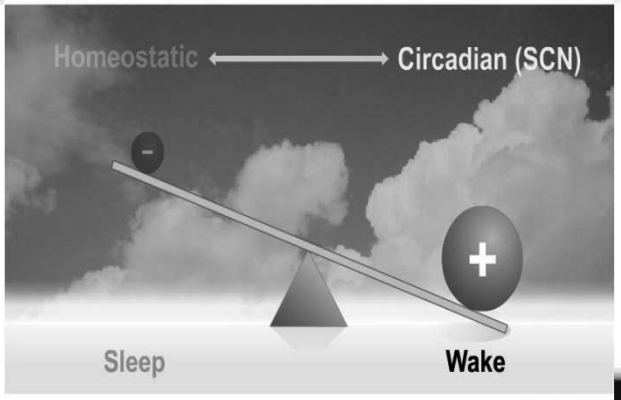


- Sleep plays a critical role in brain development with infants and children spending 12-14 hours a day sleep and a link to adult brain plasticity is becoming clear as well

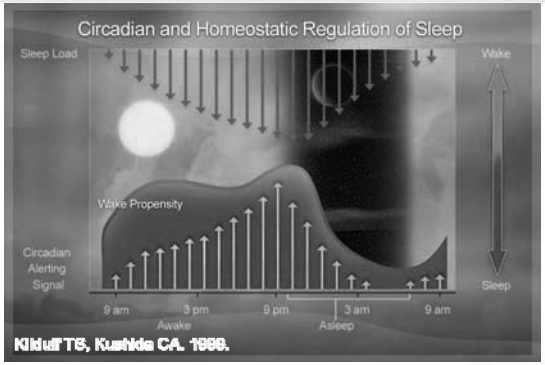
How is sleep regulated?

- Early scientists believed that gases rising from the stomach during digestion brought on the transition to sleep.

Aristotle (c350 B.C.) “We awaken when the digestive process is complete”

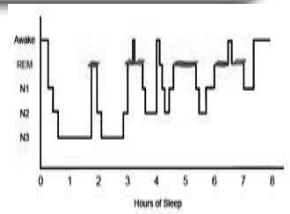


How is sleep regulated?



Sleep architecture

- N1 or Stage 1 (5%)
  - 5 mins; transitional phase
  - Low arousal threshold
- N2 or Stage 2 (50-55%)
  - 10-15 mins;
- N3 or Stage 3 & 4 (20%)
  - Lasts 20-40 mins; “delta” “slow-wave sleep”
- REM (20%)
  - Tonic (hypotonic muscles) and Phasic (eye movement) stages



Sleep-Wake Disorders

Disorders

- The International Classification of Sleep Disorders-2 lists more than 80 distinct sleep disorders in 8 categories
- The DSM-5 Classification of Sleep Wake Disorders includes:
  - Insomnia
  - Narcolepsy
  - Breathing Related Sleep Disorders
  - Circadian Rhythm Sleep Disorders
  - Parasomnias

APA, 2013

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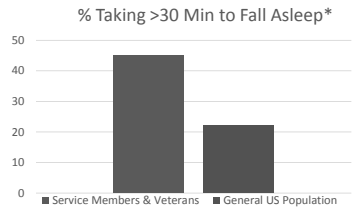
Disorders Common in the Military

- The most common complaint of military members returning from deployment is about sleep



* Plumb, Peachey, & Zelman, 2014; NSF Sleep in America Poll, 2005

Disorders Common in the Military

- There has been a rise in the number of service members receiving treatment for:
  - Insomnia
  - Obstructive Sleep Apnea
  - Circadian Rhythm Sleep Disorders
    - Delayed Sleep Phase
    - Shift work type
  - Nightmares

Assessment Goals

- Differential Diagnosis
  - Insomnia vs other sleep disorders
- Is referral to a sleep specialist or primary care provider needed
  - Obstructive Sleep Apnea
  - Restless Leg Syndrome
  - Other medical or psychiatric condition

Assessment of Sleep Disturbance

Assessment Measures

- Retrospective
  - Clinical Interview
  - Epworth Sleepiness Scale
  - Morning and Eveningness Questionnaire
  - Dysfunctional Beliefs and Attitudes Scale
  - Insomnia Severity Index
  - STOP
  - RLS
- Prospective
  - Sleep Diary

ESS

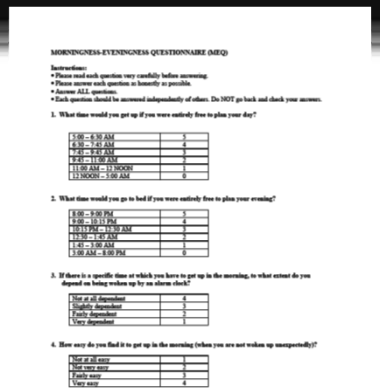
- How Sleepy <u>in the recent past</u>: Epworth Sleepiness Scale

  0= no chance of dozing 1= slight 2= moderate 3= high

Situation:

- Sitting and reading
- Watching TV
- Sitting, inactive in a public place (e.g. a theater or meeting)
- As a passenger in car for an hour without a break
- Lying down to rest in the afternoon when circumstances permit
- Sitting and talking to someone
- Sitting quietly after lunch without alcohol
- In a car, while stopped for a few minutes in traffic

MEQ



MORNINGNESS-EVENINGNESS QUESTIONNAIRE (MEQ)

Instructions:
- Please read each question very carefully before answering.
- Please answer each question as honestly as possible.
- Answer ALL questions.
- Each question should be answered independently of others. Do NOT go back and check your answers.

1. What time would you get up if you were entirely free to plan your day?

5:00 – 6:30 AM	5
6:30 – 7:45 AM	4
7:45 – 9:45 AM	3
9:45 – 11:00 AM	2
11:00 AM – 12 NOON	1
12 NOON – 5:00 AM	0

2. What time would you go to bed if you were entirely free to plan your evening?

8:00 – 9:00 PM	5
9:00 – 10:15 PM	4
10:15 PM – 12:30 AM	3
12:30 – 1:45 AM	2
1:45 – 3:00 AM	1
3:00 AM – 8:00 PM	0

3. If there is a specific time at which you have to get up in the morning, to what extent do you depend on being woken up by an alarm clock?

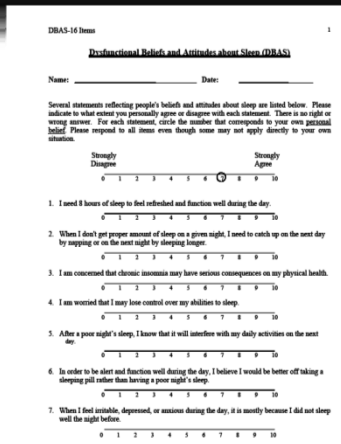
Not at all dependent	4
Slightly dependent	3
Fairly dependent	2
Very dependent	1

4. How easy do you find it to get up in the morning (when you are not woken up unexpectedly)?

Not at all easy	1
Not very easy	2
Fairly easy	3
Very easy	4

Horne & Ostberg (1976).

DBAS



DBAS-16 Items 1

Dysfunctional Beliefs and Attitudes about Sleep (DBAS)

Name: _____ Date: _____

Several statements reflecting people's beliefs and attitudes about sleep are listed below. Please indicate to what extent you personally agree or disagree with each statement. There is no right or wrong answer. For each statement, circle the number that corresponds to your own personal belief. Please respond to all items even though some may not apply directly to your own situation.

Strongly Disagree — Strongly Agree

0 1 2 3 4 5 6 7 8 9 10

1. I need 8 hours of sleep to feel refreshed and function well during the day.
2. When I don't get proper amount of sleep on a given night, I need to catch up on the next day by napping or on the next night by sleeping longer.
3. I am concerned that chronic insomnia may have serious consequences on my physical health.
4. I am worried that I may lose control over my abilities to sleep.
5. After a poor night's sleep, I know that it will interfere with my daily activities on the next day.
6. In order to be alert and function well during the day, I believe I would be better off taking a sleeping pill rather than having a poor night's sleep.
7. When I feel irritable, depressed, or anxious during the day, it is mostly because I did not sleep well the night before.

Espie, Inglis, Harvey, & Tessier (2000).

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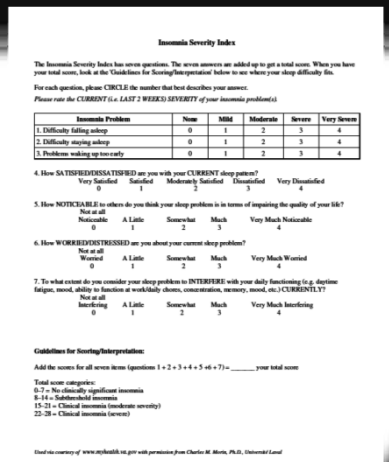


Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.

Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?
Very Satisfied 0 — Satisfied 1 — Moderately Satisfied 2 — Dissatisfied 3 — Very Dissatisfied 4

5. How NOTICIABLE to others do you think your sleep problem is in terms of impairing the quality of your life?
Not at all Noticeable 0 — A Little 1 — Somewhat 2 — Much 3 — Very Much Noticeable 4

6. How WORRIED/DISTRESSED are you about your current sleep problems?
Not at all Worried 0 — A Little 1 — Somewhat 2 — Much 3 — Very Much Worried 4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?
Not at all Interfering 0 — A Little 1 — Somewhat 2 — Much 3 — Very Much Interfering 4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7)= _____ your total score

Total score categories:
0-7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)

Used via courtesy of www.myhealth.ul.gov with permission from Charles M. Morin, Ph.D., Université Laval

Bastien, Vallières, & Morin, (2001).

STOP

- Quick screen for Obstructive Sleep Apnea
  - Snoring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
  - Tired: Do you often feel tired, fatigued, or sleepy during the daytime?
  - Observed
  - Blood Pressure

RLS

Restless Legs Syndrome (RLS) Rating Scale

Restless leg syndrome (RLS) is a sensation in the legs, and sometimes arms, that makes one have to move to get comfortable. It comes on at rest, is worse in the evening. It get better with movement or tensing of the muscles. It may cause difficulty falling asleep.

Please rate your symptoms for the following ten questions.

In the past week . . . . .

(1) Overall, how would you rate the RLS discomfort in your legs or arms?
- ___ (4) Very severe
- ___ (3) Severe
- ___ (2) Moderate
- ___ (1) Mild
- ___ (0) None

(2) Overall, how would you rate the need to move around because of your RLS symptoms?
- ___ (4) Very severe
- ___ (3) Severe
- ___ (2) Moderate
- ___ (1) Mild
- ___ (0) None

(3) Overall, how much relief of your RLS arm or leg discomfort did you get from moving around?
- ___ (4) No relief
- ___ (3) Mild relief
- ___ (2) Moderate relief
- ___ (1) Either complete or almost complete relief
- ___ (0) No RLS symptoms to be relieved

(4) How severe was your sleep disturbance due to your RLS symptoms?
- ___ (4) Very severe
- ___ (3) Severe
- ___ (2) Moderate
- ___ (1) Mild
- ___ (0) None

(5) How severe was your tiredness or sleepiness during the day due to your RLS symptoms?
- ___ (4) Very severe
- ___ (3) Severe
- ___ (2) Moderate
- ___ (1) Mild
- ___ (0) None

(6) How severe was your RLS as a whole?
- ___ (4) Very severe
- ___ (3) Severe
- ___ (2) Moderate
- ___ (1) Mild
- ___ (0) None

International Restless Legs Syndrome Study Group

Sleep Diary

TWO WEEK SLEEP DIARY

INSTRUCTIONS:
1. Write the date, day of the week, and type of day: Work, School, Day Off, or Vacation.
2. Put the letter "C" in the box when you have coffee, cola or tea. Put "M" when you take any medicine. Put "A" when you drink alcohol. Put "E" when you exercise.
3. Put a line (|) to show when you go to bed. Shade in the box that shows when you think you fell asleep.
4. Shade in all the boxes that show when you are asleep at night or when you take a nap during the day.
5. Leave boxes unshaded to show when you wake up at night and when you are awake during the day.

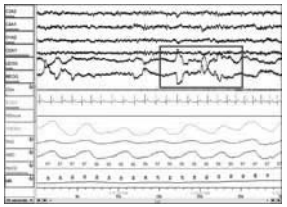
SAMPLE ENTRY BELOW: On a Monday when I worked, I jogged on my lunch break at 1 PM, had a glass of wine with dinner at 6 PM, fell asleep watching TV from 7 to 8 PM, went to bed at 10:30 PM, fell asleep around Midnight, woke up and couldn't get back to sleep at about 4 AM, went back to sleep from 5 to 7 AM, and had coffee and medicine at 7:00 in the morning.

Today's Date	Day of the week	Type of Day (Work, School, Off, Vacation)	Noon	1PM	2	3	4	5	6PM	7	8	9	10	11PM	Midnight	1AM	2	3	4	5	6AM	7	8	9	10	11AM
sample	Mon.	Work		E						A				I								M C				

week 1

week 2

Objective Measures of Sleep



- Polysomnography – (PSG) overnight sleep study
- Multiple Sleep Latency Test (MSLT) – measure of daytime wakefulness
- Actigraphy – monitors human movement cycles
- There's an app for that

Sleep Interview

- A complete assessment of sleep disorders will include an interview that includes:
  - Sleep history
  - Functional analysis (antecedents, consequences, etc.)
  - Dietary, substance use, and exercise habits
  - Bedroom environment including bed partner habits
  - Beliefs and attitudes about sleep
  - Medical history
  - Medication use
  - Psychological screening

Case Study: Assessment of Changes in Sleep, Concentration, and Memory

Case Study: Assessment of Re-experiencing and Avoidance Symptoms

Bedroom Environment

- Sleeping with bed partner
- Mattress
- Quiet
- Stereo/radio bedroom
- Desk in bedroom/Computer
- Exercise in bedroom
- TV
- Read
- Snack
- Temperature

Symptoms of Sleep Problems

- RLS
  - Crawling or aching feeling in legs
  - An inability to keep legs still
- PLMS
  - Leg twitches or jerks during the night
  - Waking up with cramps in legs
  - Bed partner report
  - Find covers all kicked off

Symptoms of Sleep Problems

- OSA
  - Snoring
  - Pauses in your breathing at night
  - Choking at night
  - Gasping for air during the night
  - Morning headaches, chest pain, or dry mouth
  - Partner report

Symptoms of Sleep Problems

- Nightmares
- Dream-like images (hallucinations) in am
- Awakening from sleep screaming and confused
- Sleepwalking
- Narcolepsy
  - Sudden “attacks” of sleep during the day
  - Sudden muscular weakness in situations of high stress

Insomnia

Harvard University Sleep Lab Website

http://healthysleep.med.harvard.edu/

//healthysleep.med.harvard.edu/interactive/sleep_lab

DSM-5 – Insomnia Disorder 780.52

- A predominant complaint of dissatisfaction with sleep quantity or quality, associated with one (or more) of the following symptoms – difficulty initiating sleep, difficulty maintaining sleep, early morning awakening
- Sleep complaint is accompanied by significant distress or impairment in social, occupational or other important area of functions by presence of at least one of the following
- 3 nights per week
- Present for 3 months
- Occurs despite adequate opportunity for sleep
- Insomnia is not better explained by and does not occur exclusively during the course of another sleep wake disorder
- Not attributable to substances
- Coexisting mental disorders and medical conditions do not adequately explain the insomnia

APA, 2013

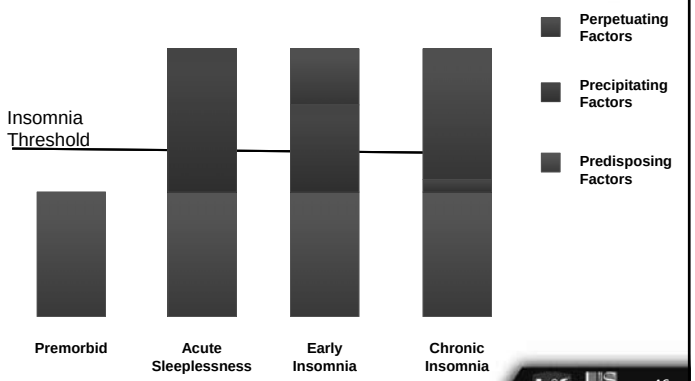
DSM-5 Insomnia Disorder

- Episodic – Symptoms last at least 1 month but less than 3 months
- Persistent – Symptoms last 3 months or longer
- Recurrent – Two or more episodes within the space of 1 year

Factors Involved in Insomnia: Behavioral Model of Insomnia

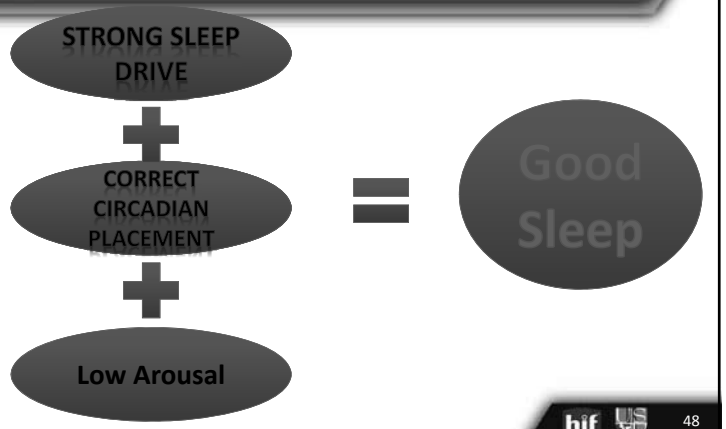
- Predisposing Factors
  - Arousal level
  - Genetics
  - Worry or rumination tendency
  - Previous Episodes
  - Sleep schedule
- Precipitating Factors
  - Situational Stressors
    - Illness or injury
    - Acute stress reactions
    - Environmental Changes
  - Sustained/Continuous Ops?
- Perpetuating Factors
  - Maladaptive Habits
  - Dysfunctional Cognitions

Evolution from Sleep Disturbance to Insomnia



Chronic insomnia is a major public health problem affecting millions of individuals, along with their families and communities. Evidence supports the efficacy of cognitive-behavioral therapy and benzodiazepine receptor agonists* in the treatment of this disorder, at least in the short term. Very little evidence supports the efficacy of other treatments, despite their widespread use.

- 2005 NIH State of the Science Conference on Manifestations and Management of Chronic Insomnia in Adults



Brim, 2013

CBTI Targets

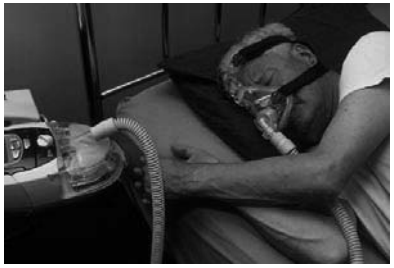
- Behaviors
  - Increase sleep drive
  - Optimize congruency between circadian clock and placement of sleep opportunity (time in bed)
  - Strengthen the signals from the circadian clock
  - Strengthen the bed as cue for sleep (conditional insomnia)
  - Reduce physiological arousal
- Cognitions
  - Reduce sleep effort
  - Reduce cognitive arousal
  - Address dysfunctional beliefs about sleep
  - Address obstacles in adherence

CBTI Components

Technique	Goal
Stimulus Control	Strengthen bed & bedtime as sleep cues
Sleep Restriction	Restrict time in bed to increase sleep drive and consolidate sleep
Relaxation, buffer, worry time	Arousal reduction
Sleep Hygiene	Address substances, exercise, eating and environment
Cognitive Restructuring	Address thoughts and beliefs that interfere with sleep and adherence
Circadian Rhythm Entrainment	Shift or strengthen the circadian sleep wake rhythm

Brim, 2013

Breathing Related Sleep Disorders



Breathing Related Sleep Disorders

- Obstructive Sleep Apnea
- Central Sleep Apnea
  - Idiopathic central sleep apnea
  - Cheyne-Stokes breathing
  - Central sleep apnea comorbid with opioid use
- Sleep Related Hypoventilation
  - Idiopathic hypoventilation
  - Congenital central alveolar hypoventilation
  - Comorbid sleep-related hypoventilation

Sleep Apnea

Treatment

- Constant Positive Airway Pressure (CPAP)
- Bilevel Positive Airway Pressure (BPAP)
- Surgery (uvulopalatopharyngoplasty – UPPP)
- Mouthpiece

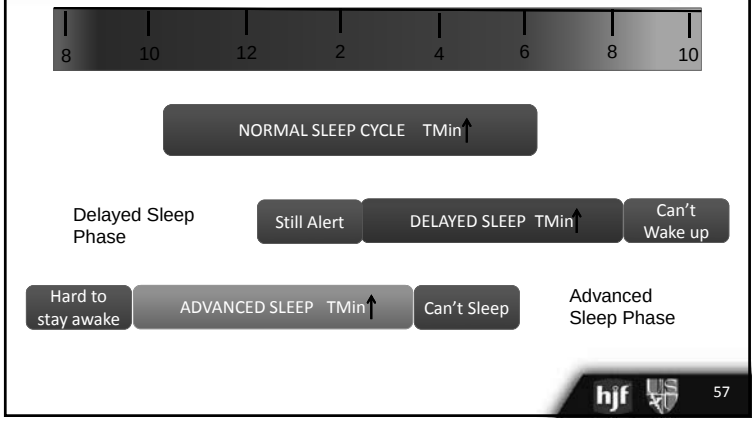
Circadian Rhythm Sleep Disorders

Circadian Rhythm Sleep Disorders

- Circadian rhythm sleep disorders
  - –Delayed sleep phase type
  - –Advanced sleep phase type
  - –Irregular sleep-wake type
  - –Non-24 hour sleep wake type
  - –Shift work type
  - –Unspecified
  - –Jet lag type - removed

APA, 2013

Circadian Rhythm Alignment



Treatments

- Melatonin Therapy
- Light Therapy
- Environmental Entrainment
- Consistent Bed-Wake Time

Parasomnias

Parasomnias

- Non-Rapid Eye Movement
  - –Sleepwalking type
  - –Sleep terror type
- Nightmares
- REM Sleep Behavior Disorder
- Restless Legs Syndrome

Somnambulism

•Up to 15 percent of adults occasionally get up and amble around the house in their sleep.

•Close relatives of sleepwalkers are 10 times more likely to sleepwalk than the general population.

•One study published in 2003 in the journal Molecular Psychiatry found that 19 percent of adult sleepwalkers had been hurt during their nocturnal forays.

•Treatment options

- •Time
- •Short-term benzodiazepine

Nightmare Disorder

A. Repeated awakenings from the major sleep period or naps with detailed recall of extended and extremely dysphoric dreams, usually involving active efforts to avoid threats to survival, security, or physical integrity. The awakenings generally occur during the second half of the sleep period.

B. On awakening from the dysphoric dreams, the person rapidly becomes oriented and alert (in contrast to the confusion and disorientation seen in Sleep Terror Disorder and some forms of epilepsy).

C. The dream experience, or the sleep disturbance resulting from the awakening, causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The nightmares do not occur exclusively during the course of another mental disorder (e.g., a delirium, Posttraumatic Stress Disorder) and are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

APA, 2013

Discerning Between Sleep Events

- **Bad dreams** – relatively common, negative affect, person does not awaken from sleep
- **Night terrors** – individual is difficult to awaken, confused upon awakening, often inconsolable, partial-full lack of recall of event (often related to stress, medical problems)

Discerning Between Sleep Events

- **Idiopathic nightmares** – awaken oriented, full recall of event, distressed, difficult to resume sleep
- **Post-trauma nightmares** – clear precipitating event, awaken oriented, usually terrified, often vivid recall of event (not always), difficult to resume sleep, often include gross body movements

Nightmare Assessment Questions

- Did you have nightmares before the trauma?
- Did the nightmare awaken service member?
- How frequent are nightmares? Weekly?
- Which negative affect? Fear or anxiety?
  - Disgust, anger, sadness, guilt, frustration
- How severe are the nightmares?
- Have your nightmares changed over time?

O'Reilly, 2009

How are PTSD nightmares different?

- Likely to be a replay of the traumatic event
- May occur earlier in the evening
- More likely to occur with gross body movements

Nightmare Treatment Options

- There are several protocols for imagery rehearsal and/or rescripting therapies for trauma nightmares
  - Exposure, Relaxation and Rescripting Therapy
  - Imagery Rehearsal Therapy
  - Imagery Rehearsal and Exposure Therapy

Rationale

- Nightmares are a learned behavior
- With repetition, nightmares become automatic involuntary behaviors
- Nightmares can be reduced by replacing them with a more desirable behavior

Main Components

- Brief protocol
- Psychoeducation
- Relaxation training
- Nightmare narrative (exposure)
- Restructure of nightmare
- Rehearse rescripted nightmare

Imagery Rehearsal Therapies

- Empirically supported for sexual assault survivors with PTSD (Hoge et al, 2004)
- Improve nightmare frequency in US Army Veterans (Mustafa et al, 2005)
- Meta-analysis confirmed that IRT improves nightmare frequency and sleep quality in a variety of trauma-related study samples and protocols (Casement & Swanson, 2012).
- Vietnam era veterans did not find IRT to be effective compared to an active control condition (Cook et al., 2010)
- The efficacy of IRT in Veterans with PTSD is still not fully determined.
- Use of Prazosin in conjunction with IRT

Recommended Reading

- Belenky G, Wesensten NJ, Thorne DR, et al. Patterns of performance degradation and restoration during sleep restriction and subsequent recovery: a sleep dose-response study. J Sleep Res 2003; 12:1–13.
- Perlis, M et al. Cognitive behavioral therapy for insomnia: A session by session guide. 2008. Springer Press
- Morin, C Insomnia: A Clinician's Guide to Assessment and Treatment. 2003. Springer Press
- Davis, J.L. (2009). Treating Post-Trauma Nightmares: A cognitive-behavioral approach. New York, New York: Springer Publishing Company.
- Thompson, K. E., Hamilton, M., & West, J. A. (1995). Group Treatment For Nightmares In Veterans With Combat-Related PTSD. National Center for PTSD Clinical Quarterly 5(4).

CDP Website: Deploymentpsych.org

Features include:

- Descriptions and schedules of upcoming training events
- Blog updated daily with a range of relevant content
- Articles by subject matter experts related to deployment psychology, including PTSD, mTBI, depression, and insomnia
- Other resources and information for behavioral health providers
- Links to CDP's Facebook page and Twitter feed

Online Learning

The following online courses are located on the CDP website at:
http://www.deploymentpsych.org/content/online-courses
NOTE: All of these courses can be take for free or for CE Credits for a fee

- Cognitive Processing Therapy (CPT) for PTSD in Veterans and Military Personnel (1.25 CE Credits)
- Prolonged Exposure Therapy for PTSD in Veterans and Military Personnel (1.25 CE Credits)
- Epidemiology of PTSD in Veterans: Working with Service Members and Veterans with PTSD (1.5 CE Credits)
- Provider Resiliency and Self-Care: An Ethical Issue (1 CE Credit)
- Military Cultural Competence (1.25 CE Credits)
- The Impact of Deployment and Combat Stress on Families and Children, Part 1 (2.25 CE Credits)
- The Impact of Deployment and Combat Stress on Families and Children, Part 2 (1.75 CE Credits)
- The Fundamentals of Traumatic Brain Injury (TBI) (1.5 CE Credits)
- Identification, Prevention, & Treatment of Suicidal Behavior in Service Members & Veterans (2.25 CE Credits)
- Depression in Service Members and Veterans (1.25 CE Credits)

All of these courses and several others are contained in the Serving Our Veterans Behavioral Health Certificate program, which also includes 20+ hours of Continuing Education Credits for $350.

Provider Support

CDP's "Provider Portal" is exclusively for individuals trained by the CDP in evidence-based psychotherapies (e.g., CPT, PE, and CBT-I)

Features include:

- Consultation message boards
- Hosted consultation calls
- Printable fact sheets, manuals, handouts, and other materials
- FAQs and one-on-one interaction with answers from SMEs
- Videos, webinars, and other multimedia training aids

Participants in CDP's evidence-based training will automatically receive an email instructing them how to activate their user name and access the "Provider Portal" section at Deploymentpsych.org.

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Sleep Hygiene Guidelines

Sleep only as much as needed to feel refreshed the following day

Restricting time in bed helps consolidate and deepen sleep. Spending excessive time in bed can lead to fragmented and shallow sleep.

Have a routine wake up time, seven days a week

A regular wake up time in the morning will help set your "biological clock" and leads to regular sleep onset.

Your bedroom should be comfortable and free from light and noise

A comfortable bed and bedroom environment will reduce the likelihood that you will wake up during the night. Excessively warm or cold rooms can disrupt sleep as well. A quiet environment is more sleep promoting than a noisy one. Noises can be masked with background white noise (such as the noise of a fan) or with earplugs. Bedrooms may be darkened with black-out shades or sleep masks can be worn. Position clocks out-of-sight since clock-watching can increase anxiety about lack of sleep.

Caffeine: Avoid Caffeine 4 - 6 Hours Before Bedtime

Caffeine disturbs sleep, even in people who do not subjectively experience such an effect. Individuals with insomnia are often more sensitive to mild stimulants than are normal sleepers. Caffeine is found in items such as coffee, tea, soda, chocolate, and many over-the-counter medications (e.g., Excedrin).

Nicotine: Avoid Nicotine Before Bedtime

Although some smokers claim that smoking helps them relax, nicotine is a stimulant. Thus, smoking, dipping, or chewing tobacco should be avoided near bedtime and during the night.

Alcohol: Avoid Alcohol After Dinner

A small amount of alcohol often promotes the onset of sleep, but as alcohol is metabolized sleep becomes disturbed and fragmented. Thus, alcohol is a poor sleep aid.

Sleeping Pills: Sleep Medications are Effective Only Temporarily

Scientists have shown that sleep medications lose their effectiveness in about 2 - 4 weeks when taken regularly. Despite advertisements to the contrary, over-the-counter sleeping aids have little impact on sleep beyond the placebo effect. Over time, sleeping pills actually can make sleep problems worse. When sleeping pills have been used for a

long period, withdrawal from the medication can lead to an insomnia rebound. Thus, many individuals incorrectly conclude that they "need" sleeping pills in order to sleep normally.

Exercise/Hot Bath: Avoid Vigorous Exercise Within 2 Hours of Bedtime

Regular exercise in the late afternoon or early evening seems to aid sleep, although the positive effect often takes several weeks to become noticeable. Exercising sporadically is not likely to improve sleep and exercise within 2 hours of bedtime may elevate nervous system activity and interfere with sleep onset. Spending 20 minutes in a tub of hot water an hour or two prior to bedtime may also promote sleep.

Napping: Avoid Daytime Napping

Many individuals with insomnia "pay" for daytime naps with more sleeplessness at night. Thus, it is best to avoid daytime napping. If you do nap, be sure to schedule naps before 3:00pm.

Eating: A Light Snack at Bedtime May be Sleep Promoting

A light bedtime snack, such a glass of warm milk, cheese, or a bowl of cereal can promote sleep. You should avoid the following foods at bedtime: any caffeinated foods (e.g., chocolate), peanuts, beans, most raw fruits and vegetables (since they may cause gas), and high-fat foods such as potato or corn chips. Avoid snacks in the middle of the nights since awakening may become associated with hunger.

Avoid Excessive liquids in the evening

Reducing liquid intake will decrease the need for nighttime trips to the bathroom.

Do not try to fall asleep

If you are unable to fall sleep within a reasonable time (15-20 minutes) or when you notice that you are beginning to worry about falling asleep, get out of bed. Leave the bedroom and engage in a quiet activity such as reading. Return to bed only when you are sleepy.

Don't have worry time in bed

Plan time earlier in the evening to review the day, plan the next day or deal with any problems. Worrying in bed can interfere with sleep onset and cause you to have a shallow sleep.

Sleep Disorders Interview

Name: Gender: M F Marital Status: M Sep Single D W

Day Phone: Date of Birth: ___/___/___ Education (Yrs):
Yr Mth Day

Referral Source: Interviewer:

Nature of Sleep-Wake Problem

In a typical week… *(Ideally focus on the last week, if the last week was not typical, focus on the most recent typical week).*

Do you have a problem with falling asleep?	No	Mild	Moderate	Severe
Do you have a problem with staying asleep?	No	Mild	Moderate	Severe
Do you have a problem with waking up too early in the morning?	No	Mild	Moderate	Severe
Do you have a problem with staying awake during the day?	No	Mild	Moderate	Severe

Many people that we see with similar problems report that their difficulty sleeping not only affects them at night but also during the day, have you found this to be true for you as well?

After a poor night's sleep, which of the following problems do you experience on the next day?

Daytime fatigue: ____ Low physical energy ____ Low mental energy _____ Exhausted _____

Sleepiness: ____ Propensity to fall asleep ____ Heavy eyes _____ Difficulty staying awake

Difficulty functioning: ____ Performance impairment ____ Poor concentration _____ Memory problems

Mood Problems: ____ Irritable ____ Tense ____ Nervous ____ Depressed ____ Angry

Physical Symptoms: ____ Muscle Aches/Pains ____ Headache ____ Heartburn ____ Light-headed

After a stressful or bad day, have you found that your sleep is worse or better?

Because problems sleeping affect us not only at night but also during the day, we have found that it is helpful to talk not only about your sleep at night but also to discuss the impact of a bad night sleep on the next day and the impact of a stressful day on your sleep at night. One of the most effective ways I have found to get a good understanding of all the factors that may be playing a role in your insomnia is to have you walk me through the 24 hours of a typical work day. So lets start with what time you intend to wake up on a typical work day…

At what time do you last awaken in the morning (wake up)? _____ o'clock
How do you usually wake up? Alarm, automatically, child/pet other environmental?

What is your usual arising time on weekdays (get up)? _____ o'clock

What do you typically have for breakfast?
When do you have your first caffeinated beverage?
How much caffeine do you drink on a typical day?

Do you take any medications or vitamins?
What time do you typically leave for work and how is your commute; do you find yourself dozing off?

Describe a typical morning at work. How is your job, what do you do, is your job sedentary or pretty physical, what is the likelihood that you would nod off in the morning at work?

Tell me about breaks at work; do you take breaks? How often and how long? What do you do on breaks?

Do you use tobacco? About how much tobacco do you use in a typical day?

Do you eat lunch at work? What is your typical lunch and how much time do you have? Do you ever nap or unintentionally nod off during lunch?

Describe a typical afternoon at work. Is there a time in the afternoon when you seem most likely to nod off? In what setting?

How many caffeinated beverages do you typically drink in the afternoon?

How is your commute home? Have you ever dozed off or felt very groggy driving home?

How often do you exercise? What type of exercise do you do? What time of day do you typically exercise?

How often do you intentionally nap? Where do you usually nap and for how long?

When do you typically eat dinner?

How stressful is your typical evening at home?

How many alcoholic beverages do you drink on a typical night? Have you noticed any changes in your alcohol consumption since your sleep problems began?

What is your typical nighttime routine? What do you do (watch tv, read, play videogames, work/play on the computer)? Who is around with you?

How likely are you to doze or unintentionally nod off during the evening? Where and when does this happen?

When is your last caffeinated beverage?

When do you use tobacco for the last time each night?

How do you decide when to go to bed for the night? Do you have a bed time or do you typically go to bed just whenever you feel sleepy? Do you fall asleep outside of your bed, before deciding to go to bed?

Let's talk about your bed room environment, imagine standing in the doorway to your bedroom, let's talk about what you see and how it makes you feel.

Do you have a television in your room?
Do you have exercise equipment in your room?
Do you have a TV, radio, or phone in your bedroom?
Is there a desk with paperwork to be done in your bedroom?
Is your bedroom quiet?
Is your mattress comfortable?

How is your room temperature?
Are you sleeping with a bed partner?
What is your bed partners sleep like?
What do you do in your bedroom besides sleep?
Do you have conversations with your partner in the bedroom or bed?
How do you feel in your bedroom? (anxious, frustrated, sad, restful, calm)

Now let's talk about your bedtime routine. What do you usually do in the 30-60 minutes leading up to your bedtime?

What do you typically do in bed prior to sleeping (tv, read etc)

How long, once you turn out the lights with the intention of falling asleep does it usually take you to fall asleep?

What sort of things seem to interfere with your ability to fall asleep?

Once you fall asleep do you wake up during the night?

What sort of things seem to wake you in the middle of the night?

How often do you wake during the night?

How long are you awake in the middle of the night?

In a moment I am going to ask you some more specific questions about things that might happen during the course of your sleep, however is there anything that comes to mind now about your typical day, the impact of sleep problems, things that interfere with your sleep or the impact of sleep on your daily functioning?

Now can you tell me how your schedule changes on days that you do not work?

Do your bed and wake times differ? If so, how does your sleep quality change with the different amount or hours of sleep?

How does your bedtime routine differ on nights before your days off?

Are you more or less likely to nap on days off?

How is your daytime functioning and mood different on your days off?

Sleeping Aids

So let me just clarify a few things we covered in reviewing your typical day…

In the past 4 weeks have you used sleeping medication?

If yes, which drugs?

Prescribed, over-the-counter, or both?

How many nights/week do you use the medication?

If no, have you ever used sleeping medication?

When did you *first* use sleep medication?

When did you *last* use sleep medication?

In the past 4 weeks, have you used alcohol as a sleep aid? Yes No

If yes, what type and how many ounces?

How many nights/week?

If no, have you ever used alcohol as a sleep aid?

Sleep Problem History

How long have you been suffering from insomnia? ____ years ____ months

Were there any stressful life events related to its onset?

Gradual or sudden onset?

What have been the course of your insomnia problem since its onset (e.g., persistent, episodic, seasonal, etc.)?

What do you do when you can't fall asleep or return to sleep?

Is your sleep better/worse/same when you go away from home?

What types of factors make your sleep problem worse (e.g., stress at work, travel plans, emotional tension)?

What types of factors improve your sleep (e.g., vacation, sex, distractions)?

How concerned are you about sleep/insomnia?

What impact does insomnia have on your mood?

What impact does insomnia have on your alertness?

What impact does insomnia have on your performance?

How do you cope with these daytime sequelae?

Have you stopped doing anything (other than sleeping) because of insomnia?

How would your life be different if you didn't have insomnia (e.g., work harder, take care of children)?
Have you received treatment in the past for insomnia (other than medication)?

What prompted you to seek insomnia treatment at this time?

Symptoms of Other Sleep Disorders

Have you or your bed partner ever noticed one of the following, and if so, how often in a typical week would you estimate you experience these symptoms?

A. *Restless legs*: Crawling or aching feelings in your legs (calves) and inability to keep legs still?

B. *Periodic limb movements*: Leg twitches or jerks during the night, waking up with cramps in your legs?

C. *Apnea*: Snoring, pauses in breathing at night, shortness of breath, choking at night, morning headaches, chest pain, dry mouth?

D. *Narcolepsy*: Sleep attacks, sleep paralysis, hypnagogic hallucinations, cataplexy?

E. *Gastro-esophageal reflux*: Sour taste in mouth, heartburn, reflux?

F. *Parasomnias*: Nightmares, night terrors, sleepwalking/talking, bruxism?

G. *Sleep-wake schedule disorder*: Rotating shift or night shift work?

Medical History/Medication Use

Current medical problems:

Current medications: Name Amount Frequency Taken Purpose

Hospitalizations/Surgery:

Height: Weight (lbs): Recent Weight Gain/Loss?

History of Psychopathology/Mental Health Treatment *(modified SCID)*

Are you currently receiving psychological or psychiatric treatment for emotional or mental health problems?	Yes	No
Have you or anyone in your family ever been treated for emotional or mental health problems in the past?	Yes	No
Have you or anyone in your family ever been a patient in a psychiatric hospital?	Yes	No
Has alcohol or any drug ever caused a problem for you?	Yes	No
Have you ever been treated for alcohol/substance abuse problems?	Yes	No
Has anything happened lately that has been especially hard for you?	Yes	No
What about difficulties at work or with your family?	Yes	No

Scale for below ? = Inadequate information 1 = Absent or false 2 = Subthreshold 3 = Present

In the last month, has there been a period of time when you were feeling depressed or down most of the day nearly every day?	?	1	2	3
What about being a lot less interested in most things or unable to enjoy the things you used to enjoy? If yes, was it nearly every day?	?	1	2	3
For the past couple of years, have you been bothered by depressed mood most of the day, more days than not? More than half the time?	?	1	2	3
Have your ever had a panic attack, when you suddenly felt frightened, anxious or extremely uncomfortable? If yes, 4 attacks within 1 month?	?	1	2	3
Have you ever been afraid of going out of the house alone, being in crowds, standing in a line, or traveling on buses or trains?	?	1	2	3
Have you ever been bothered by thoughts that didn't make any sense and kept coming back to you even when you tried not to have them?	?	1	2	3
In the last 6 months, have you been particularly nervous or anxious?	?	1	2	3
Do you worry a lot about terrible things that might happen?	?	1	2	3
During the last 6 months, would you say that you have been worrying most of the time (more days than not)?	?	1	2	3

If psychopathology is present, evaluate its onset and temporal course in relation to the sleep disturbance.

Does insomnia occur exclusively during the course of worry/depression episodes? Yes No

TWO WEEK SLEEP DIARY

Sleep Handout 3

INSTRUCTIONS:

1. Write the date, day or the week and type of day: (W)ork, (S)chool, (O)ff or (V)acation.
2. Put the letter "C" in the box when you have any caffeinated beverage or supplement that includes caffeine. Put "M" when you take ANY Medication. Put "A" when you drink alcohol. Put "E" when you exercise.
3. Put a line (I) to show when you get in bed. Shade in the box that shows when you think you fell asleep.
4. Shade in all the boxes that show when you are asleep include all naps.

SAMPLE ENTRY: *On Monday when I worked, I jogged on my lunch break at 1 PM, had a glass of wine with dinner at 6 PM, fell asleep Watching TV from 7-8 PM, went to bed at 10:30 pm, fell asleep around midnight, woke up and couldn't get back to sleep until about 5 am, slept from 5-7 am, got out of bed at 7:30 am and had coffee and medicine before going to work.*

Today's Date	Day of the week	Type of Day	Noon	1PM	2	3	4	5	6PM	7	8	9	10	11PM	Midnight	1AM	2	3	4	5	6AM	7	8	9	10	11AM
Sample	Mon	W		E					A				I									I	C M			

WEEK ONE

WEEK TWO

SLEEP DIARY

Name: _____

Week:_____ to _____
(Beginning date) (Ending date)

	Example ↓ Mon.							
1. I napped from ____ to ____ (note times of all naps).	2:00 to 2:45 pm							
2. I took ____ mg of sleep medication as a sleep aid.	Ambien 5 mg							
3. I took ____ oz. of alcohol as a sleep aid.	Beer 12 oz.							
4. I went to bed at ____ o'clock.	10:30							
5. I turned the lights out at ____ o'clock.	11:15							
6. I plan to awaken at ____ o'clock.	6:15							
7. After turning the lights out, I fell asleep in ____ minutes.	45							
8. My sleep was interrupted ____ times (specify number of nighttime awakenings).	3							
9. My sleep was interrupted for ____ minutes (specify duration of each awakening).	20 30 15							
10. I woke up at ____ o'clock (note time of last awakening).	6:15							
11. I got out of bed at ____ o'clock (specify the time).	6:40							
12. When I got up this morning I felt ____ . (**1** = Exhausted, **2** = Tired, **3** = Average, **4** = Rather Refreshed, **5** = Very Refreshed)	2							
13. Overall, my sleep last night was ____ . (**1** = Very Restless, **2** = Restless, **3** = Average, **4** = Sound, **5** = Very Sound)	1							

Fill in the Day of the Week above each column

NOTES:

Sleep Diary Instructions

In order to better understand your sleep problem and to assess your progress during treatment, we'd like you to collect some important information about your sleep habits.

- ***Before you go to sleep at night***, please answer Questions 1 - 6.
- After you get up in the morning, please answer the remaining questions, Questions 7 - 13.

It is very important that you complete the diary every evening and morning!!! Please don't attempt to complete the diary later. If you have any difficulties completing the diary, please contact one of the BHP staff members at (210) 670-5968 and we'll be glad to assist you.

It's often difficult to estimate how long you take to fall asleep or how long you're awake at night. Keep in mind that we simply want your best estimates.

If any unusual events occur on a given night (e.g., emergencies, phone calls) please make a note of it on the diary (at the bottom of the sheet).

Below are some guidelines to help you complete the Sleep Diary.

1. *Napping*: Please include **all** times you slept during the day, even if you didn't intend to fall asleep. For example, if you fell asleep for 10 minutes during a movie, please write this down. Remember to specify a.m. or p.m., or use military time.
2. *Sleep Medication*: Include both prescribed and over-the-counter medications. Only include medications used as a sleep aid.
3. *Alcohol as a sleep aid:* Only include alcohol that you used as a sleep aid.
4. *Bedtime*: This is the time you physically got into bed, with the intention of going to sleep. For example, if you went to bed at 10:45 p.m. but turned the lights off to go to sleep at 11:15 p.m., write down 10:45 p.m.
5. *Lights-Out Time:* This is the time you actually turned the lights out to go to sleep.
6. *Time Planned to Awaken:* This is the time you plan to get up the following morning.

7. *Sleep-Onset Latency*: Provide your best estimate of how long it took you to fall asleep after you turned the lights off to go to sleep.
8. *Number of Awakenings*: This is the number of times you remember waking up during the night.
9. *Duration of Awakenings*: Please estimate how many minutes you spent awake for each awakening. If this proves impossible, then estimate the number of minutes you spent awake for all awakenings combined. Don't include your very last awakening in the morning, as this will be logged in number 10.
10. *Morning Awakening*: This is the very last time you woke up in the morning. If you woke up at 4:00 a.m. and never went back to sleep, this is the time you write down. However, if you woke up at 4:00 a.m. but went back to sleep for a brief time (for example, from 5:00 a.m. to 5:15 a.m.), then your last awakening would be 5:15 a.m.
11. *Out-of-Bed Time*: This is the time you actually got out of bed for the day.
12. *Restedness upon Arising*: Rate your restedness using the scale on the diary sheet.
13. *Sleep Quality*: Rate the quality of your sleep using the scale on the diary sheet.

CENTER FOR DEPLOYMENT PSYCHOLOGY

Preparing Professionals to Support Warriors and Families

Overview of Traumatic Brain Injury (TBI) in the Military

Center for Deployment Psychology
Uniformed Services University of the Health Sciences

Disclaimer

The views expressed are those of the presenters and do not necessarily reflect the opinions of the Uniformed Services University of the Health Sciences, the Department of Defense, or the U.S. Government.

Acknowledgements

This talk is based on the joint collaborative efforts of DVBIC and CDP

Learning Objectives

1. Define and differentiate between different types of traumatic brain injuries.
2. Identify the mechanisms of brain injury common in a military population.
3. Discuss traumatic brain injury resources for military clients, families, and providers.

Case Study Refresher: The Ramos Family

What is Traumatic Brain Injury (TBI)?

Definition of TBI

Any injury to the head that results in:

- Loss of consciousness for any period of time
- Loss of memory immediately before or after injury
- Alteration of mental state
- Focal neurological deficits transient or non-transient in nature

American Congress of Rehabilitation Medicine, (1993).

Case Study: Assessing for Exposure to Blasts

Case Study: Assessing for Loss of Consciousness or Alteration in Consciousness

Neurocognitive Disorder: DSM-5

A: Decline in one or more cognitive domains:

- Complex attention
- Executive functioning
- Learning and memory
- Perceptual-motor
- Social cognition

Neurocognitive Disorder: DSM-5

- Major Neurocognitive Disorder, Criteria A
  - Concern of the individual, a knowledgeable informant, or the clinician that there has been a ***significant*** decline in cognitive functioning
  - A ***substantial*** impairment in cognitive performance, preferably documented by standardized neuropsychological testing

Neurocognitive Disorder: DSM-5

- Mild Neurocognitive Disorder, Criteria A
  - Concern of the individual, a knowledgeable informant, or the clinician that there has been a ***mild*** decline in cognitive functioning
  - A ***moderate*** impairment in cognitive performance, preferably documented by standardized neuropsychological testing

Neurocognitive Disorder: DSM-5

B: Capacity for independence in everyday activities

- The degree to which the neurocognitive deficits affect the individual's capacity for independent activities differentiates between ***Major*** and ***Mild*** Neurocognitive Disorder

Neurocognitive Disorder: DSM-5

- Major Neurocognitive Disorder, Criteria B
  - ***Interferes*** with independence
  - Requiring ***assistance*** with complex instrumental activities (paying bills or managing medications)
- Mild Neurocognitive Disorder, Criteria B
  - ***Does not interfere*** with independence
  - ***Greater effort***, compensatory strategies or accommodation may be required

Neurocognitive Disorder: DSM-5

C: Deficits do not occur exclusively in the context of delirium

D: Not better explained by another mental disorder

Neurocognitive Disorder due to TBI

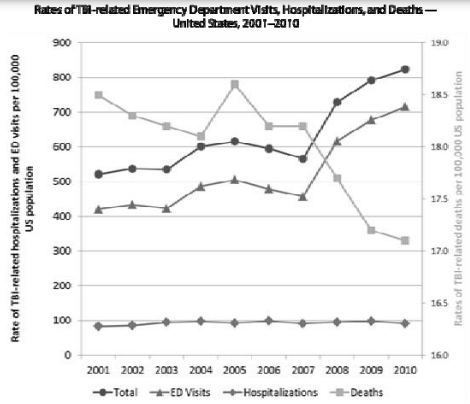
A: Criteria met for Neurocognitive Disorder
B: Evidence of a TBI with ***one or more*** of the following:

1. Loss of consciousness
2. Posttraumatic amnesia
3. Disorientation and confusion
4. Neurological signs

Neurocognitive Disorder due to TBI

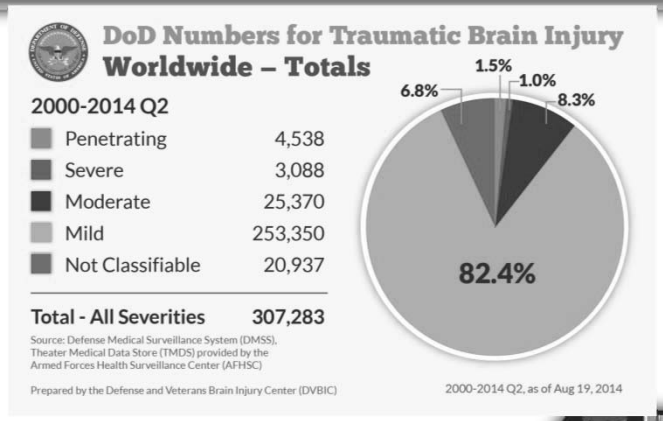
C: The neurocognitive disorder presents immediately after the occurrence of the TBI or immediately after recovery of consciousness, and persists past the acute post-injury period.

Emergency Department Visits, Hospitalizations and Deaths Related to TBI 2001-2010 (per 100,000)

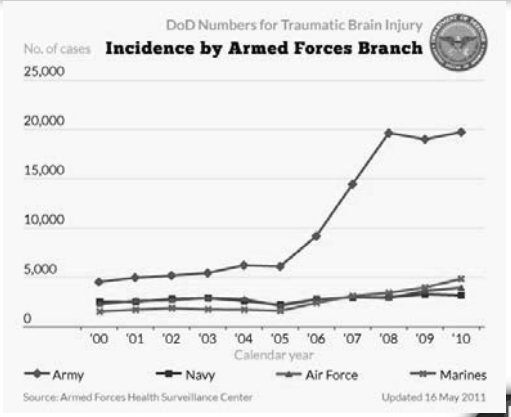


Centers for Disease Control and Prevention (2014)

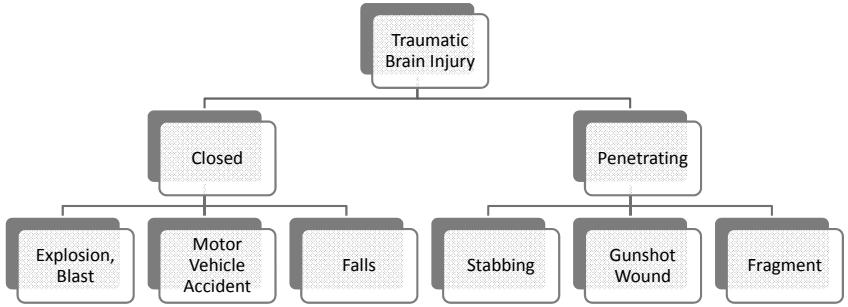
All Armed Forces – TBI 2000 – 2014 Q2



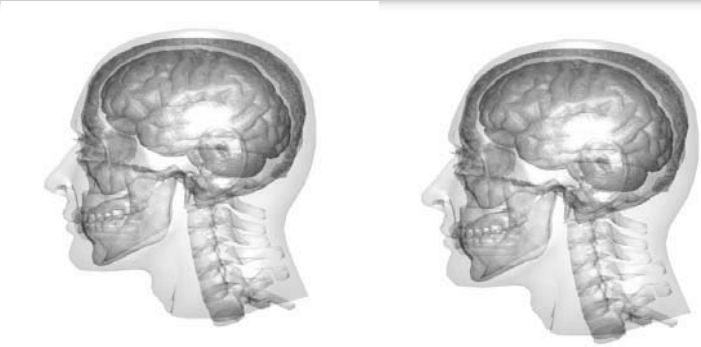
TBI Incidents by Branch of Service 2000 – 2010



Mechanisms of Injury



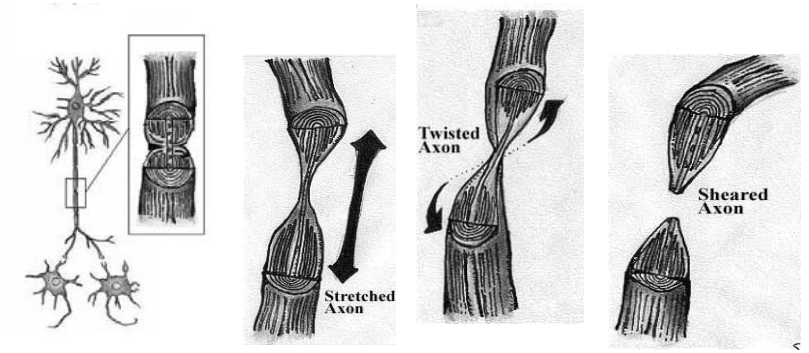
Closed Brain Injury



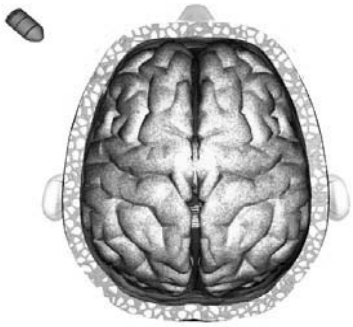
Diffuse Axonal Injury

Contra Coup

Diffuse Axonal Injury (DAI)



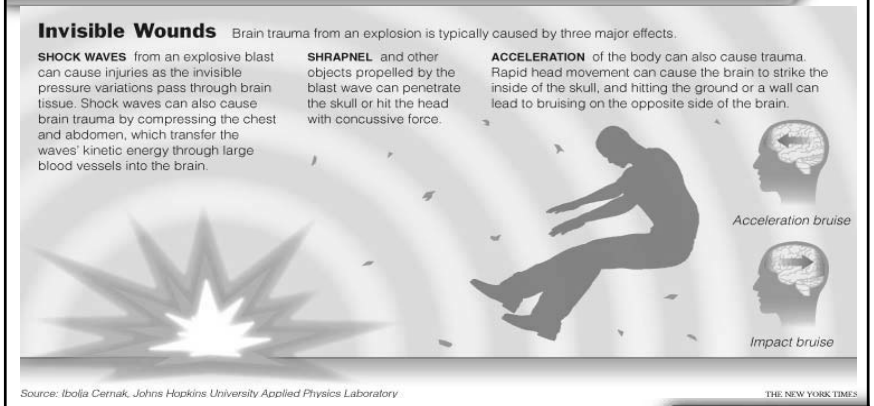
Penetrating Brain Injury



Mechanisms of Blast Injuries

- Primary
- Secondary
- Tertiary
- Quaternary

Blast Mechanism Overview



Primary Blast

- Enormous Over-Pressurization Wave:
  - Axonal Damage
  - Changes in Cell Metabolism
- Primary Blast Injuries Examples:
  - Ear/Auditory/Vestibular
  - Lung
  - Abdomen

Primary Blast

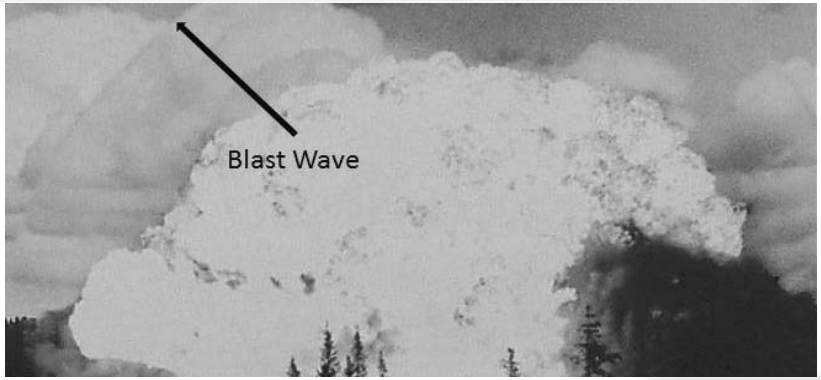


Photo Credit: D.R. Richmond, US Army

Blast Wave

http://youtu.be/2imofil5GbM

Secondary Blast Injury: Flying Debris

Objects propelled by blast wind

- Small missiles accelerated to 50 ft/sec cause skin laceration
- Speeds of 400 ft/sec associated with body cavity penetration

Secondary Blast Injury: Fragment and Shrapnel Wounds

Figure 11. Multiple fragment wounds from blast injury.

Photo courtesy of Professor Zvi Gimmon, MD.

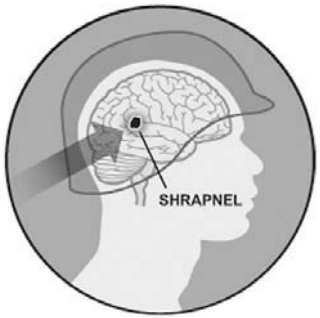


Image: Al Granberg/ProPublica

Tertiary Blast Injuries

- Body Displacement by:
  - Overpressure
  - Shockwave
- Close to explosion
- Multiple Fractures
- Head Injuries
- Amputations

Photo Credit: Sgt. Anthony L. Ortiz, USMC

Quaternary or Miscellaneous Blast Injuries

- Collapsed Structures
- Displaced Heavy Objects
- Smoke Inhalation
- Burn Injuries
- Complications from Existing Conditions

Photo Credit: US Department of Defense

Concussion/mTBI Assessment: Principle Goals

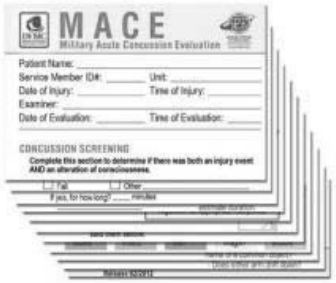
- **Identify** patients who have experienced risk for mTBI
- **Minimize** impact of secondary effects
- **Improve** treatment outcome
- **Optimize** mTBI care
- **Reduce** disability

Predisposing TBI Risk Factors

- Psychiatric Conditions
- Personality Traits
- Medical Conditions
- Intelligence Level
- Demographic Characteristics
- Coping Abilities

Concussion Screening

- Military Acute Concussion Evaluation (MACE)
- Screening Protocols in Theater, Landstuhl, MTFs
- PDHA, PDHRA
- VA 4 Questions



Pre-Deployment Testing: ANAM

- Automated Neuropsychological Assessment Metrics (ANAM)
- Establishes an accurate baseline of cognitive performance

Photo Credit: US Department of Defense

Accurate Diagnostic Factors

- Screening Checklists
- Records Review
- COC Input
- Family/Patient Interview
- Concussion History
- Potential Missed & Misdiagnoses Issues

Lessons Learned: YouTube Meet David

http://youtube/txqiwrbYGrs

TBI Assessment Domains

Severity	Glasgow Coma Score (GCS)	Alteration in consciousness (AOC)	Loss of consciousness (LOC)	Post traumatic amnesia (PTA)
Mild	13 – 15	≤ 24 hrs	0 – 30 min	≤ 24 hrs
Moderate	9 – 12	> 24 hrs	> 30 min < 24 hrs	> 24 hrs < 7 days
Severe	3 – 8	> 24 hrs	≥ 24 hrs	≤ 7 days

- Consider imaging results when determining level of severity
- Positive Imaging = at least a moderate TBI rating
- GCS not as useful given complications of theater setting
- Use of AOC in DoD severity rating

TBI "Red Flags"

a) Altered consciousness
b) Progressively declining neurological exam
c) Pupillary asymmetry
d) Seizures
e) Repeated vomiting
f) Double vision
g) Worsening headache
h) Cannot recognize people or is disoriented to place
i) Behaves unusually or seems confused and irritable
j) Slurred speech
k) Unsteady on feet
l) Weakness or numbness in arms/legs

Identified as Positive for Concussion

- Evaluate and treat symptoms
- Assess for non-TBI factors contributing to presentation
- Assess cognitive complaints through formal testing, if appropriate
- Educate about recovery appropriately depending on severity of injury and time since injury

Concussion Education

- Early intervention with TBI education and positive expectations have a direct effect on recovery
  - Patients, families, providers, military command, employers
  - Reduces patient and family anxiety
- Prevent re-injury while recovering
- Address specific symptoms (e.g., headaches, sleep problems) with strategies or referrals

Concussion Brain Injury Clinical Course

Expected Outcomes

- Full recovery (vast majority)
  - Rapid recovery (days to weeks) with minimal intervention
  - Longer recovery (3 months – 12 months)
- Persisting symptoms (minority; years)
  - Sometimes referred to as post-concussive syndrome (PCS) but controversial and not in DSM-5

Concussion Brain Injury Clinical Course

- Second impact syndrome (repeated mild concussion before full recovery) ->possible [rare] fatality (synergistic effects)
- Multiple concussions (>2) over time – more morbidity/slower recovery
- "Invisible Injury"
  - Can adversely impact interpersonal relationships
  - Symptoms can be missed due to more apparent physical injuries
  - Co-morbid emotional distress

What are common changes following a concussion?

Case Study: Changes Since the Blasts

Case Study: Allison Discusses Changes She Notices in James' Memory

Thinking Changes in "Executive Functioning"

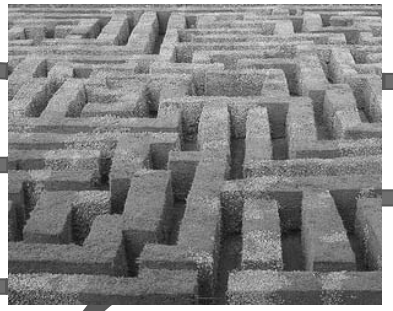
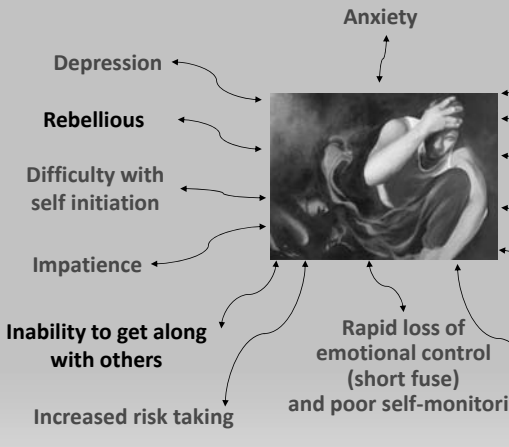


Photo Credit: marsroverdriver

Thinking Changes

- Learning & Memory
- Attention
- Processing Speed
- Communication

Emotional, Behavioral, and Social Changes



Psychosis, courtesy of artist, Amber Osterhout.

Long Term Challenges Post TBI

- Vocational and/or school failure
- Family life/social relationships collapse
- Increased financial burden on families and social service systems
- Alcohol and drug abuse
- Chronic depression/anxiety

TBI and DoD

Some controversies include:

- Diagnosis of mTBI
- Effectiveness of cognitive rehabilitation
- Utility of ANAM

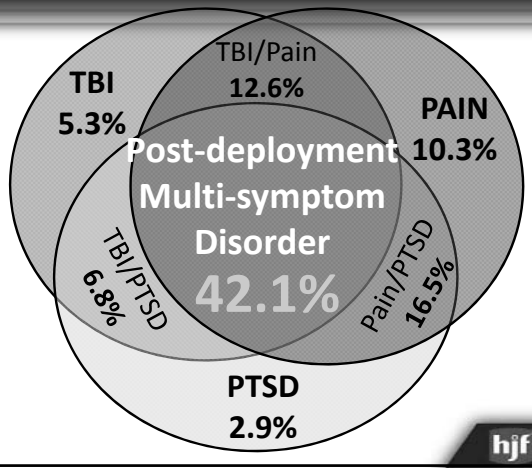
Hoge et al (2009), Coldren et al (2012), Roebuck-Spencer et al (2012)

Comorbid Conditions & TBI Overview

- Risk of psychiatric conditions increase with TBI
- Assessment difficulties due to similar symptoms
- Psychiatric conditions and cognitive compromise

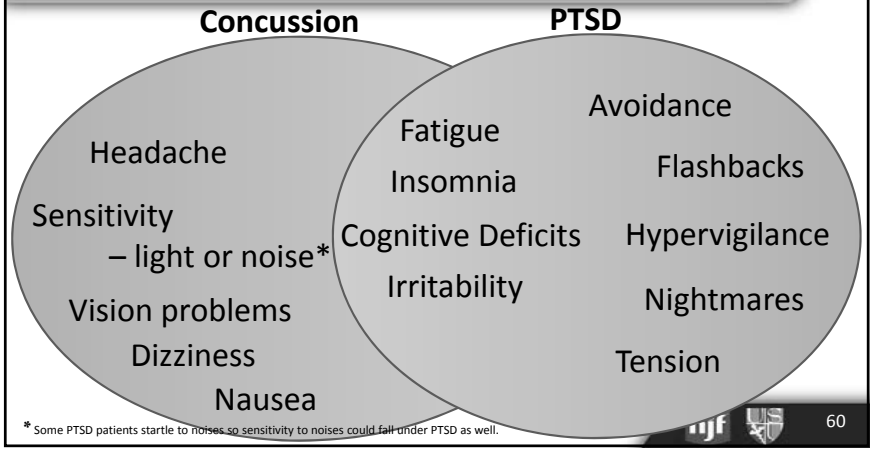
Post-Deployment Disorders

Sample = 340 OEF/OIF outpatients at Boston VA



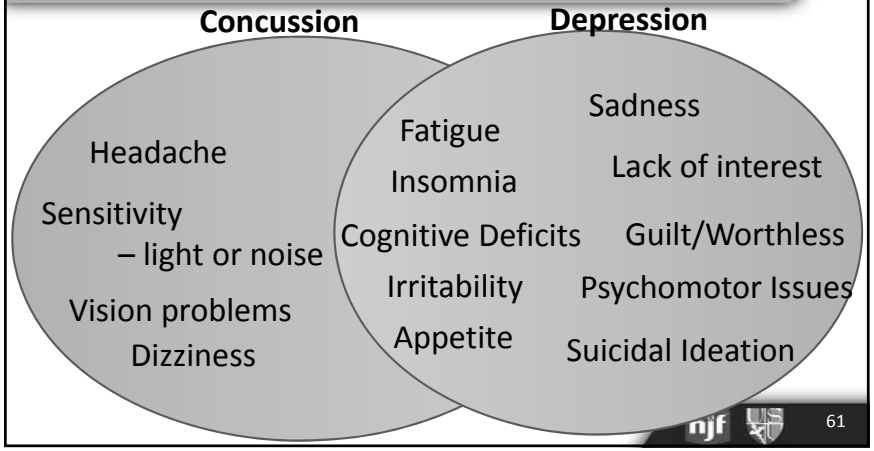
Clark (2009)

Concussion and PTSD Overlap



* Some PTSD patients startle to noises so sensitivity to noises could fall under PTSD as well.

Concussion and Depression Overlap



Factors Affecting Outcome after Concussion

- Physical injury in theater
- Pre-injury and demographic variables
- Family/social/unit/command support
- Compensation/secondary gain
- Additional behavioral health conditions
- Course of medical care

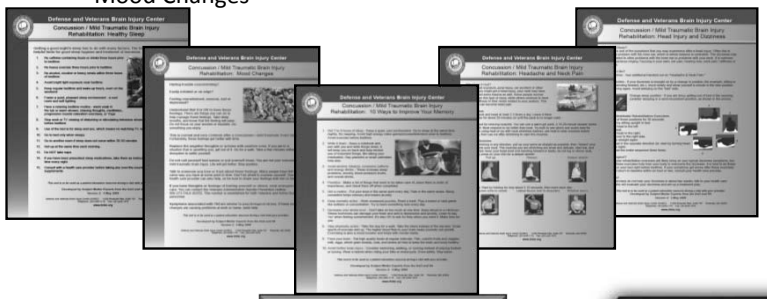
TBI Resources for

Patients, Families & Providers

Resources

Concussion Symptom Management Patient Handouts

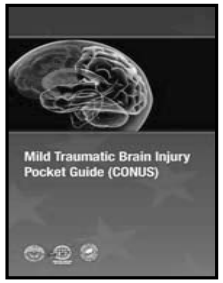
- Improving Memory
- Healthy Sleep
- Mood Changes
- Headache Management
- Head Injury and Dizziness

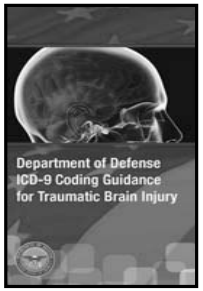


info@DVBIC.org

Products & Tools Available From DVBIC

- **mTBI Pocket Guide**
- **Clinician Resources & Tools Binder**
- **DoD ICD-9 Coding Guidance**





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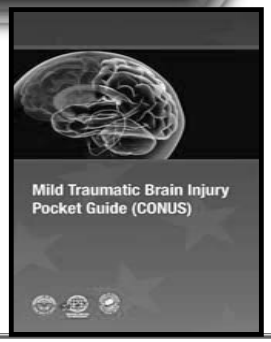
Mild TBI Pocket Guide

Contents Include

- Summary of VA/DoD Clinical Practice Guideline (2009) and DoD mTBI Updated Clinical Guidance (2008)
- Assessment, referral and treatment for common symptoms associated with mTBI
- ICD-9 coding guidance
- Summary of cognitive rehabilitation clinical recommendations
- Clinical recommendations on driving after mTBI
- Patient education materials
- Clinical tools and resources



To request copies, please contact info@dvbic.org or call 1-800-870-9244

Purpose: Quick reference, all encompassing resource on the treatment and management of patients with mTBI and related symptoms

Web Based TBI Education & Resources

www.dvbic.org

www.dcoe.health.mil

www.traumaticbraininjuryatoz.org

www.brainline.org

TBI Clinical Practice Guidelines

- Acute/Subacute
  - Evaluation & Management of Concussion in Deployed Setting (DVBIC, 2008)
  - Evaluation & Management of Concussion in CONUS (DVBIC, 2008)
- Chronic
  - VA/DoD Evidence Based Guideline for Management of Concussion / mTBI (DVA/DoD, 2009)

Rapid TBI Consultation

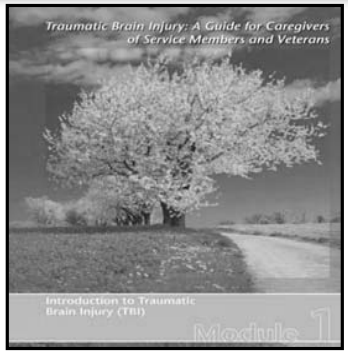
Providers, SMs & Families

- **DVBIC**
  - Info@DVBIC.org
  - 1-800-870-9244
- **DCoE 24/7 Outreach Center**
  - 1-866-966-1020
  - resources@dcoeoutreach.org
  - Live Chat
- **Military One Source**
  - 1-800-342-9647
  - wwrc@militaryonesource.com

Providers Only

- **TBI.consult**
  - For Deployed Providers
  - Feedback Within 12 Hours
  - 38 TBI Specialists
  - 14 Clinical Disciplines
- **ANAM Baselines**
  - anam.baselines@amedd.army.mil

Traumatic Brain Injury:



A Guide for Caregivers of Service Members and Veterans

DVBIC

http://www.dvbic.org/Families---Friends/Family-Caregiver-Curriculum.aspx
http://www.traumaticbraininjuryatoz.org/Caregivers-Journey/Caregiver-Guides.aspx

CDP Website: Deploymentpsych.org

Features include:

- Descriptions and schedules of upcoming training events
- Blog updated daily with a range of relevant content
- Articles by subject matter experts related to deployment psychology, including PTSD, mTBI, depression, and insomnia
- Other resources and information for behavioral health providers
- Links to CDP's Facebook page and Twitter feed

Online Learning

The following online courses are located on the CDP's website at:
Deploymentpsych.org/training/online-courses

NOTE: All of these courses can be take for free or for CE Credits for a fee

- Cognitive Processing Therapy (CPT) for PTSD in Veterans and Military Personnel (1.25 CE Credits)
- Prolonged Exposure Therapy for PTSD in Veterans and Military Personnel (1.25 CE Credits)
- Epidemiology of PTSD in Veterans: Working with Service Members and Veterans with PTSD (1.5 CE Credits)
- Provider Resiliency and Self-Care: An Ethical Issue (1 CE Credit)
- Military Cultural Competence (1.25 CE Credits)
- The Impact of Deployment and Combat Stress on Families and Children, Part 1 (2.25 CE Credits)
- The Impact of Deployment and Combat Stress on Families and Children, Part 2 (1.75 CE Credits)
- The Fundamentals of Traumatic Brain Injury (TBI) (1.5 CE Credits)
- Identification, Prevention, & Treatment of Suicidal Behavior in Service Members & Veterans (2.25 CE Credits)
- Depression in Service Members and Veterans (1.25 CE Credits)

All of these courses and several others are contained in the Serving Our Veterans Behavioral Health Certificate program, which also includes 20+ hours of Continuing Education Credits for $350.

Provider Support

CDP's "Provider Portal" is exclusively for individuals trained by the CDP in evidence-based psychotherapies (e.g. CPT, PE, and CBT-I)

Features cover topics including:

- Consultation message boards
- Hosted consultation calls
- Printable fact-sheets, manuals, handouts, and other materials
- FAQs and one-on-one interaction with answers from SMEs
- Videos, webinars, and other multimedia training aids

Participants in CDP's evidence-based training will automatically receive an email instructing them how to activate their user name and access the "Provider Portal" section at Deploymentpsych.org.

How to Contact Us

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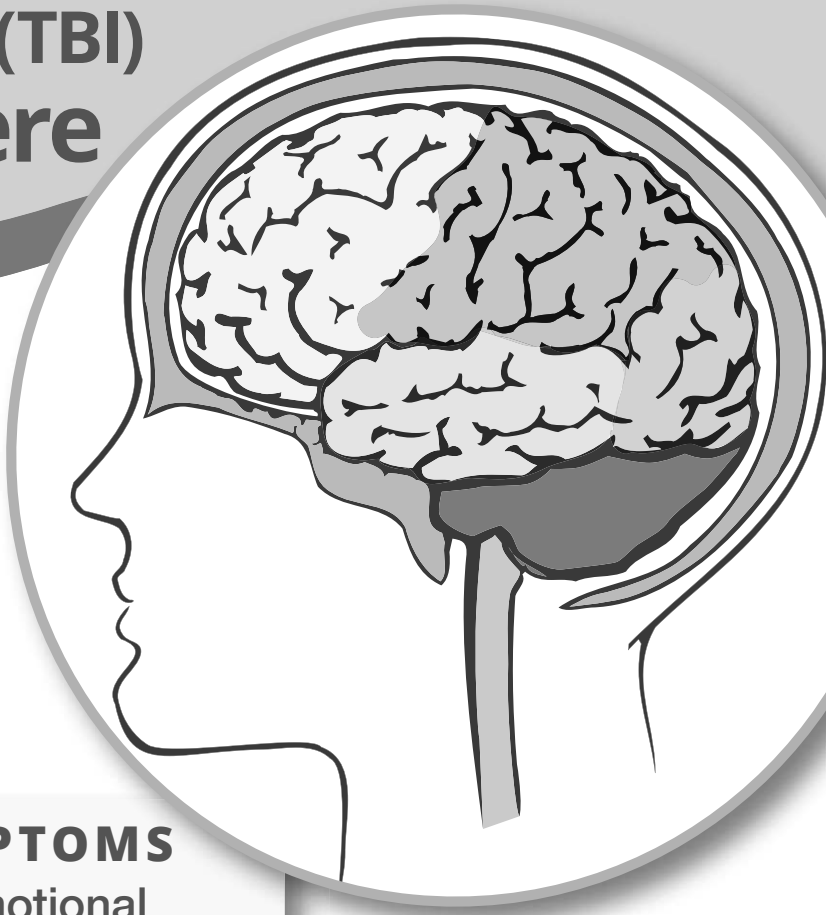
Traumatic Brain Injury (TBI)
Moderate or Severe



DEFINITION

A TBI is classified as moderate or severe when a patient experiences any of the following:

- Is knocked out or blacks out for more than 30 minutes
- Has memory loss or is confused for hours, days or weeks
- Has an abnormal brain scan (CT or MRI)

COMMON SIGNS AND SYMPTOMS

Physical

Headaches
Changes in sleep
Dizziness
Balance problems
Fatigue
Sexual dysfunction
Seizures
Sensory changes
Loss of strength

Cognitive

Confusion/Agitation
Attention problems
Memory problems
Difficulty with decision making
Difficulty with speech
Slowed thinking

Emotional

Depression
Anxiety
Irritability
Impulsivity
Mood swings
Inappropriate behavior
Acting out of character

DID YOU KNOW?

There are two types of TBIs:

Closed Head Injury
Caused by a blow or jolt to the head that does not penetrate the skull

Penetrating Head Injury
Occurs when an object goes through the skull and enters the brain

RELATED INJURIES

- **Skull fracture:** a break in the bones that surround the brain
- **Cerebral edema:** swelling of the brain
- **Hematoma or hemorrhage:** bleeding in or around the brain
- **Contusion:** bruising of the brain
- **Hypoxia or anoxia:** lack of oxygen to the brain
- **Diffuse Axonal Injury:** twisting and/or tearing of the connections between brain cells

Traumatic Brain Injury (TBI)
Moderate or Severe

Photo Credit:
www.gettyimages.com

STAGES OF TREATMENT

Inpatient care requires an overnight stay at a medical center.

Acute/critical care is inpatient treatment that often begins in an intensive care unit. This can last from a few days to several weeks depending on how serious the injury is.

Outpatient care occurs after a patient is released from a medical center.

Outpatient care may include appointments or therapy at a hospital, doctor's office or other rehabilitation center. No overnight stay is required.

RECOVERY TIPS:

- Stay organized by following routines.
- Get seven to eight hours of sleep.
- Avoid overdoing mental and physical activities.
- Avoid smoking.
- Avoid drinking alcoholic or energy drinks.
- Do not isolate yourself — stay in touch with friends and family.
- Keep appointments and take an active role in your therapy sessions.

AND REMEMBER...

- There is no "normal" time frame for recovery.
- Recovery depends on how serious the injury is and what areas of the brain are affected. Other injuries to the body also can affect recovery.
- The most rapid recovery will happen in the first six months following the injury, although recovery may continue for years.
- Most patients will learn useful ways to work around the new challenges from their injury.

For more information on the Family Caregiver Guide, for families of patients with moderate or severe TBI, contact **info@DVBIC.org** or visit **www.DVBIC.org.**

DVBIC
Defense and Veterans Brain Injury Center

20 Years of Service ★ 1992-2012 ★

DVBIC
Defense and Veterans Brain Injury Center

Signs and Symptoms

Concussion/Mild Traumatic Brain Injury

DEFINITION:

A traumatic brain injury (TBI) is a blow or jolt to the head that disrupts the normal function of the brain. The severity of the TBI is determined at the time of the injury and may be classified as: mild, moderate or severe.

COMMON SIGNS AND SYMPTOMS:

Physical

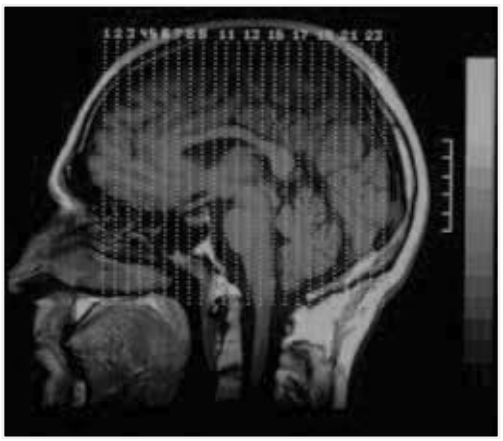
Headache
Sleep disturbances
Dizziness
Balance problems
Nausea/vomiting
Fatigue
Visual disturbances
Light sensitivity
Ringing in ears

Cognitive

Slowed thinking
Poor concentration
Memory problems
Difficulty finding words

Emotional

Anxiety
Depression
Irritability
Mood swings



Did you know?

Concussion – another word for a mild TBI – is the most common form of TBI in the military. Symptoms of concussion often resolve within days or weeks.

PATIENTS

COPING TIPS:

- Write things down.
- Store important items like keys in a designated place to keep from losing them.
- Pace yourself and take breaks as needed.
- Focus on one thing at a time.
- Allow time for your brain to heal. It's the most important thing you can do.

RECOVERY TIPS:

- Avoid smoking or drinking.
- Sit out of contact sports.
- Get enough sleep — 7 to 8 hours a night.
- Take medications as instructed.
- Avoid overexerting yourself physically or mentally.
- If you're concerned about your symptoms or if they're not improving, see your provider.
- Stay engaged with your family and provider as your symptoms improve.

FIND A DVBIC SITE NEAR YOU:

- Camp Lejeune, N.C.
- Camp Pendleton, Calif.
- Fort Bragg, N,C.
- Fort Carson, Colo.
- Fort Hood, Texas
- Landstuhl Regional Medical Center, Germany
- NMC San Diego
- San Antonio Military Medical Center, Texas
- Joint Base Elmendorf-Richardson, Alaska
- Fort Belvoir, Va.
- Walter Reed National Military Medical Center, Md.
- VA Boston
- VA Minneapolis
- VA Palo Alto, Calif.
- VA Richmond, Va.
- VA Tampa, Fla.

Recovery is different for every person and depends on the nature of the injury.

CENTER FOR DEPLOYMENT PSYCHOLOGY

Preparing Professionals to Support Warriors and Families

Alcohol and Drug Use in Military Veterans

Center for Deployment Psychology
Uniformed Services University of the Health Sciences

Disclaimer

The views expressed are those of the presenters and do not necessarily reflect the opinions of the Uniformed Services University of the Health Sciences, the Department of Defense, or the U.S. Government.

Learning Objectives

1. Describe common trends in alcohol and drug use amongst civilian and military populations.
2. Identify strategies for screening and assessing civilian and military clients for substance use disorders.
3. Discuss evidence-based treatments for substance use disorders.

Presentation Outline

- New Military, DOD, and VA Guidelines (IOM, 2013)
- Prevalence of Substance Use and Problems
- Active Duty Health-Related Behaviors Survey and Use Among Veterans
- DSM-5 SUD Criteria and Symptoms
- Comorbid Conditions with SUDs and Challenges
- Brief Screening Measures and Interventions to Assess SUDs

Presentation Outline (con't)

- Obtaining Accurate Self-Reports
- Using a Motivational Interviewing Style and Motivational Strategies
- General Trends in SUD Treatment and Stepped Care: Adapting Treatment to Problem Intensity
- Evidence-Based Treatments for SUDs
- Managing and Preventing Relapses
- Medications to Assist in Treatment of SUDs
- Additional Resources

New Military, DoD and VA Guidelines (IOM, 2013)

IOM 2013 Report: Far Reaching Committee Charge

- Substantial and expansive charge involving several areas and subpopulations
- Collected information from several sources
- Compared all information with best practices and modern standards of care in scientific literature

Institute of Medicine (2013)

Committee Offered Many Recommendations for DoD, Service Branches, and TRICARE

- Use of **evidence-based practices** in SUD care integral to ensuring that individuals receive effective, high-quality care
- Policies of DoD and individual branches should promote **evidence-based diagnostic and treatment processes**
- Best practices for SUD treatment should include use of agonist and antagonist medications
- DoD should **conduct routine screening** for unhealthy alcohol use, together with brief alcohol education interventions

Institute of Medicine (2013)

Prevalence of Substance Abuse and Problems

Case Study: James' Tobacco Use

What Substances Are Used?

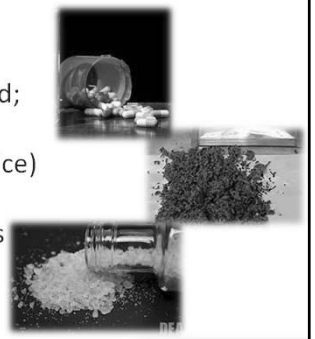
Same as civilians, but military members seem to gravitate more toward:

- **Alcohol**
  Legal (used to self-medicate)
- **Marijuana**
  Most used illicit drug lifetime, past 12 mos., & 30 days
- **Cocaine, other stimulants and synthetic stimulants**
  Can be used to stay alert

National Institute of Drug Abuse

What Substances Are Used?

- **Opiates**
  Vicodin and OxyContin
  Becoming more widespread;
  Used to self-medicate
- **Synthetic Marijuana** (e.g., Spice)
- **Synthetic**
  Cathinones/Amphetamines
  (e.g., Bath Salts)



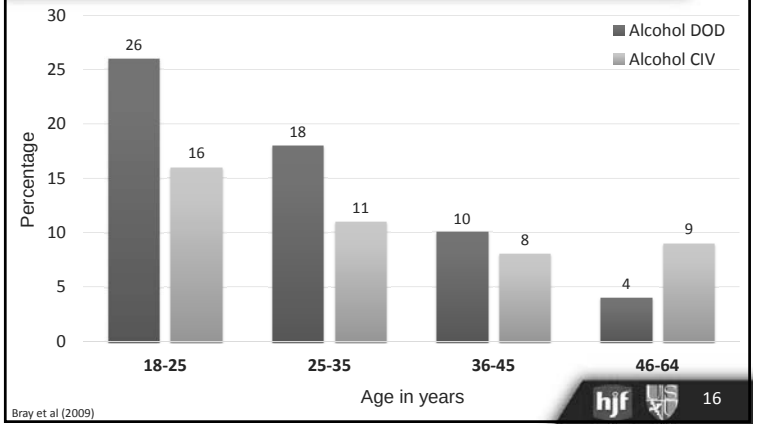
National Institute of Drug Abuse

Case Study: Impact of Smoking

General Population Prevalence of Illicit Drug Use: Ages 12+

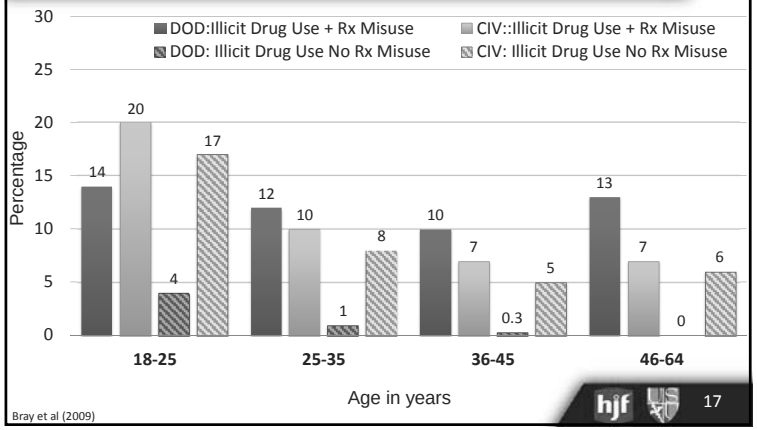
	Lifetime	Past Month
Illicit Drugs (not Marijuana)	29.6%	9.6%
Marijuana	39.8%	14.8%
Cocaine (including Crack)	14.3%	2.4%
Heroin	1.5%	0.3%
Hallucinogens	14.3%	1.0%
Inhalants	9.3%	0.8%
Nonmedical Use of Prescription Drugs	20.3%	7.0%
Methamphetamine	5.8%	0.7%
Crack	3.5%	0.7%

Active Duty (DoD) and Civilians: Heavy Alcohol Use in Past 30-Day by Age Group



Bray et al (2009)

Active Duty (DoD) and Civilians (CIV): Any Illicit Drug Past 30 Days by Age Group



Bray et al (2009)

Substance Use Among Veterans and Comparable Non-veterans

Variable	Veterans	Non-Veterans
Alcohol Use past 30 days	57%*	51%*
Binge Alcohol Use	23%	22%
Heavy Alcohol Use	8%*	7%*
DSM-IV Alcohol Abuse/Dep	6%	6%
DSM-IV Alcohol Dep	3%	3%
Illicit Drug Abuse	2%	1.4%
Substance Use Tx past year	0.8%*	0.5%*

Wagner et al (2007)

Case Study: More about James' Substance Use

Active Duty Health-Related Behaviors Survey and Use Among Veterans

Active Duty: 2011 DOD Health Related Behaviors Survey Definitions

Dept of Defense (2013)

Active Duty: 2011 DOD Health Related Behaviors Anonymous Survey

- 40% of current drinkers reported binge drinking
- 12% active duty had **AUDIT** scores ≥ 8 (suggestive of alcohol problem)
- < 1% reported being in treatment or would seek treatment in next 6 months

Dept of Defense (2013)

Active Duty: 2011 DOD Health Related Behaviors Anonymous Survey (con't)

- **Top 3 reasons for drinking:**
  1. To celebrate (50%)
  2. Enjoy drinking (46%)
  3. To be social (33%)
- Only 11% said they drank to forget problems and 14% when in a bad mood

Dept of Defense (2013)

Active Duty: 2011 DOD Health Related Behaviors Anonymous Survey (con't)

- **Any illicit drug use reported past 30 days:**
  - < 1% past 30 days
  - 1% past year
  - 28% reported use lifetime

Dept of Defense (2013)

Combat Experience

Having combat experience is associated with increased substance abuse problems

Could be related to:

- Coping with stress/trauma
- Loneliness
- Deployment culture
- Lessen fatigue

*Bray et al. (2009); Jacobson et al. (2008); IOM (2013)

Barriers to Treatment

"Service members commonly reported concerns related to stigma as barriers to treatment, particularly concerns related to their military career, functioning, and relationships with command and peers."

Institute of Medicine (2013)

Case Study: James' Drinking

DSM-5 SUD Criteria and Symptoms

DSM-5 SUD Criteria

"A problematic pattern of alcohol or other drug use leading to clinically significant impairment or distress, as manifested by at least 2 of 11 symptoms occurring within a 12-month period."

American Psychiatric Association (2013)

DSM-5 Substance Use Disorder Symptoms

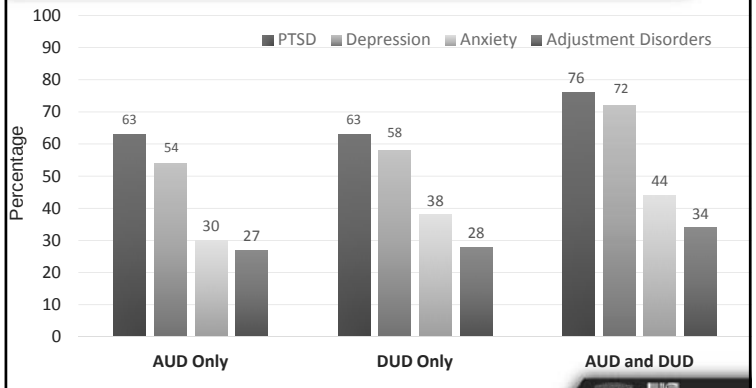
In the past 12 months:
• Have often used in larger amounts or over longer periods of time than intended
• Have often wanted or tried to cut down or control use
• Have spent a lot of time either using, trying to obtain, or recovering from the substance
• Gave up or reduced involvement in important social, occupational, or recreational activities because of substance use
• Continued to use despite knowing it likely caused or made worse psychological or physical problems

DSM-5 Substance Use Disorder Symptoms (con't)

In the past 12 months:
• Had to use greater amounts to get desired effect, or affected less by same amount
• Experienced withdrawal symptoms, or used to avoid or relieve withdrawal symptoms
• Did not fulfill major obligations at work, school, or home due to substance use
• Repeatedly used substance in situations that were physically hazardous
• Experienced strong desires, urges, or cravings to use the substance
• Continued to use despite persistent or recurrent social or interpersonal problems caused by or made worse by use

Comorbid Conditions with SUDs and Challenges

Prevalence of Comorbid Military Service Mental Health Problems Associated with Alcohol (AUD) and Drug (DUD) Use Disorders in Iraq and Afghanistan



Seal et al (2011)

Challenges to Working with SUDs and Other Psychiatric Problems

Three General Treatment Approaches

- **Parallel**: Strong support for concurrent (in ≥ 2 programs, MH & SUDs)
- **Integrated**: Both disorders in one program; difficult to implement - requires staff skilled in both problems
- **Sequential:** In second program after first (SUD then PTSD); issue - can one problem be placed on hold?

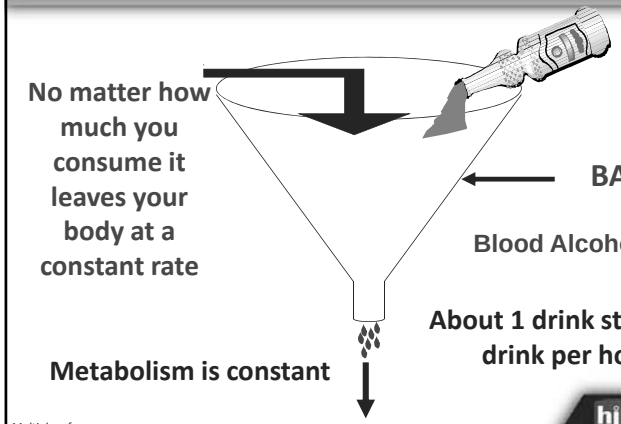
Brief Screening Measures and Brief Interventions to Assess SUDs

% Alcohol Content by Volume 1 Standard Drink =

Alcohol Type	% Alcohol Content	Number Ounces		Total Oz. Alcohol
Beer	5%	x	12	= 0.6 oz.
Wine	12%	x	5	= 0.6 oz.
Hard Liquor (e.g., gin, whiskey)*80 proof	40%	x	1.5	= 0.6 oz.

1 standard drink = 14 gm. absolute ethanol

Alcohol Metabolized at Constant Rate in Healthy Adults



Multiple references

Why Use Brief Screening Measures to Assess Alcohol, Drug, & Nicotine Use?

Most measures …….

- Have been lengthy and time consuming to administer and score; thus, cannot provide immediate feedback to patients
- Not sensitive to the full continuum of those with SUDs (e.g., young problem drinkers)
- Consequently, most substance use assessment measures not well-integrated into standard clinical care

Sobell, Sobell & Robinson (2013); Sobell & Sobell (2003); Maisto, Connors & Dearing (2007); Earlywine (2009)

Brief Alcohol Screening Measures

- Alcohol Use Disorders Identification Test (AUDIT-10)
- AUDIT-C
- Quick Drinking Screen (QDS)
- Single Binge Drinking (SBD) Question

Note: Participants have handouts of all these screens.

Brief Drug Screening Measures

- Drug Abuse Screening Test (DAST-10)
- Opioid Risk Tool (ORT)

Note: Participants have handouts of these 2 screens.

Obtaining Accurate Self Reports

Where Do We Get Most Information About Our Patients?

- **Answer:** Self-reports, regardless of the SUD
- In addictions field, long-standing distrust by many clinicians - that is, you cannot trust SUD patients' self-reports.
- **Question:** Is this accurate? **Answer:** No!
- **How do you know?** 60-plus research studies from '70s on have shown that on a group basis SUD patients report accurately about their alcohol and drug use.
- **So why the distrust?** It might relate to how some practitioners interact with their patients.
- **Accurate information can be obtained from patients when** they're guaranteed confidentiality, substance use free, and when asked in a clinical or research context.

Connors et al (2003); Babor et al (2000); Sobell et al (1992)

Why Don't Substance Abusers Report Accurately Sometimes?

Stigma: Single biggest reason why substance abusers say they avoid or delay entering treatment

- Most individuals with SUDs do not see themselves as severely dependent and they are not
- A motivational approach can be successfully used to help motivate patients to consider changing

IOM (2013); Oleski et al (2010); Klingemann & Sobell (2007)

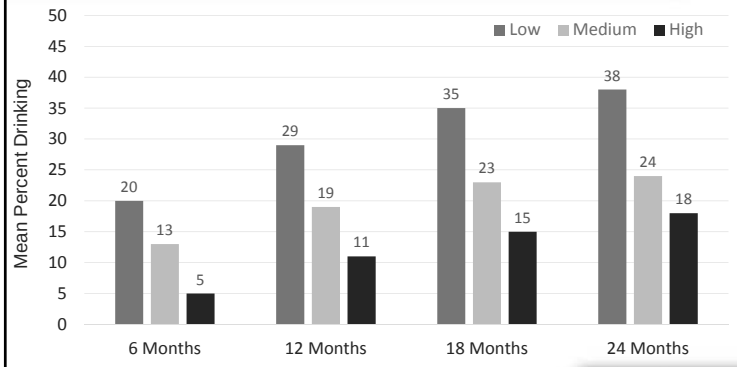
Using a Motivational Interviewing Style and Motivational Strategies

What is Motivational Interviewing?

- Often thought of as an intervention, but it is <u>NOT a treatment</u>
- Communication skills that are motivational rather than judgmental in nature
- Uses principles and techniques based on models of therapy and behavior change techniques
- Designed to help patients explore their ambivalence about changing

Multiple references

Low Therapist Empathy is Toxic



Valle (1981)

Self-Efficacy

- Self-efficacy is positively associated with SUD treatment outcomes.
- For most patients, substance use is situational, and they have low self-efficacy for handling those situations without using substances.
- *Brief Situational Confidence Questionnaire* is a short easy psychometrically sound way to identify high risk situations.

Sobell & Sobell (2011); Witkiewitz & Marlatt (2004); Breslin et al (2000)

Main Types of High-Risk Situations

Typology first developed by Marlatt and now supported by other researchers:

- Unpleasant emotions
- Physical discomfort
- Conflict with others
- Testing control
- Urges and temptations
- Pleasant emotions
- Social pressure
- Pleasant times with others

Breslin, Sobell, Sobell & Agrawal (2000); Connors, Maistro, Donovan (1996); Marlatt & Gordon (1985)

READINESS RULERS
Assess Readiness to Change

Definitely NOT Ready To Change

Definitely Ready To Change

On a scale of 1-10, how ready are you **at the present time** to change?

MI Scaling Tool to Build Self-Efficacy

Multiple references

General Trends in SUD Treatment and Stepped Care: Adapting Treatment to Problem Intensity

General Trends in SUD Treatment

- Use brief interventions, brief assessments, and stepped care approach
- Use outpatient treatments before intensive options
- Use a less confrontational and more empathic motivational style to interact with patients
- Integrate pharmacotherapy with psychotherapy

Multiple references

General Trends in SUD Treatment (con't)

- Provide SUD interventions in primary care
- Combine psychiatric and SUDs treatments
- Quitting smoking now addressed with other SUDs
- Use of web-based social networks and gaming approaches to facilitate engagement

See list for references

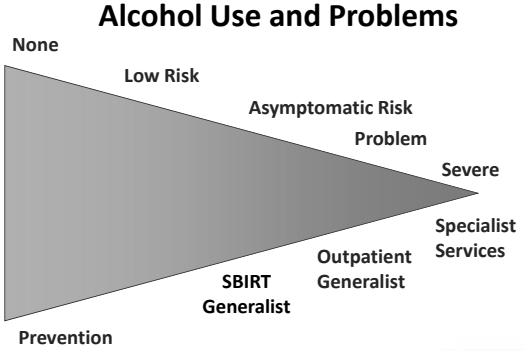
Treatment Needs To Be

- Attractive
- Accessible
- Affordable
- Effective

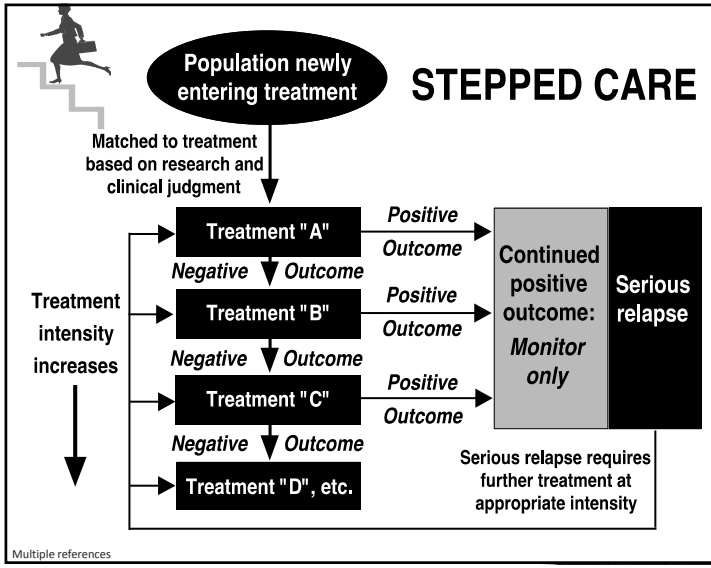
Incorporating *patient preference* and *good customer service* are essential principles for this new system of care.

Multiple references

Services and Alcohol Problem Intensity



Institute of Medicine (1990)



Multiple references

Evidence-Based Treatments for SUDs

Evidence-Based Treatments for SUDs

- Brief and Web-based Social Media Interventions
- Cognitive Behavioral Therapy (CBT)
- Motivational Enhancement (MET)
- 12-Step Facilitation (TST)
- Contingency Management
- Community Reinforcement and Family Training (CRAFT)
- Behavioral Couples Therapy (BCT)
- Family Systems Approach
- Methadone Maintenance

Dept of VA & DoD (2009); Institute of Medicine (2013); Miller & Wilbourne (2002)

Brief Interventions

Not a single treatment but a collection of interventions

- **Primary Goal:** Reduce alcohol and drug use below risk levels
- **Primary Focus:** Increase motivation to change by weighing the pros and cons of the substance use
- **Intervention Time Varies:** Self-change materials, apps, 5-min discussion with a health care practitioner, one or a few outpatient sessions

Multiple references

Web-based Social Media Interventions

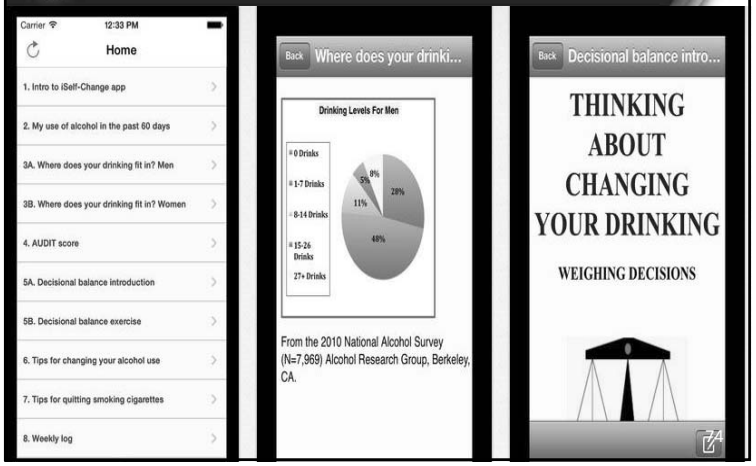
- **iSelfChange App:**

https://itunes.apple.com/us/app/iselfchange/id761033899?ls=1&mt=8

Evidence-based app for problem drinkers (21-35) based on promoting self-change studies.

Mirtenbaum et al. (2013)

iSelfChange Screenshots and Menu



Cognitive-Behavioral Therapy (CBT)

- Empirically supported in multiple RCTs and has consistently been superior to most other interventions
- Focuses on modifying thinking and/or behavior for substance use and other areas of life functioning
- Central features
  - Brief time limited
  - Functional analysis of substance use
  - Coping skills training
  - Cognitive restructuring

Multiple references

Motivational Enhancement Therapy (MET)

- Similar to motivational interviewing but with a more directive approach to increase awareness of ambivalence about change, promote commitment, and enhance self-efficacy
- More structured than motivational interviewing

Project MATCH Research Group (1988)

Behavioral Couples Therapy (BCT)

- Focus is on the dyadic relationship
- Goal is to decrease substance use and improve overall marital satisfaction for both partners
- Sobriety Contract is used
- Positive feelings, shared activities, constructive communication are factors conducive to sobriety

Epstein & McCrady (1998); Walitzer & Dermen (2004)

Contingency Management Approach

- Incorporates substance users' social system into the treatment plan
- Uses rewards for specific behavioral recovery goals

- Core of contingency management is reinforcement of abstinence
- Effective with drug abuse to establish early recovery and continuous abstinence

Community Reinforcement And Family Training (CRAFT)

- Goal is to rearrange multiple aspects of one's life so sober lifestyle is more rewarding than one with alcohol and/or drugs
- Focuses on environmental factors that impact and influence patients
- Uses family, social, recreational, and occupational events to support sobriety

Family Systems Approach

- Members are interdependent
- Patterns of interaction in the family influence the behavior of each family member
- Interventions target and provide practical ways to change patterns of interaction
- 8-24 sessions

Earlywine (2009); Kaufman & Kaufmann (1992); Miller et al (2005)

12-Step Facilitation Treatment

Developed for NIAAA's Project MATCH

- Manualized 12 sessions of individual outpatient therapy
- Although based on the 12-Step principles of AA emphasizing surrender and turning oneself over to a higher power, this is a psychotherapy It is not AA.
- Encourages participation in AA and completing the first 4 steps

Project MATCH Research Group (1998)

Managing and Preventing Relapses

Marlatt's Relapse Prevention Model

- Hypothesizes that in presence of high-risk situations, if people don't exercise effective coping response, self-efficacy will be reduced.
- Combined with expectation of short-term positive effects from substance use, this can lead to lapse or slip and becoming a full relapse if patients view a slip as indicating inability to control behavior.

Witkiewitz & Marlatt (2004)

Managing Relapses

- **Stop slip as soon as possible** to minimize consequences and risks
- **View slip as learning experience**; i.e., Why did it occur then? What could be done to avoid a similar slip in the future?
- Do not ruminate. **Take long-term perspective on recovery** and view the slip as a bump in the road rather than the end of the road

Sobell & Sobell (2011)

Harm Reduction Approach with SUDS

- Meet patients where they are; seek to attract patients who otherwise would not get treatment.
- For patients not willing to commit to abstinence, negotiate reduction in use and develop plans to minimize risks.
- Reduced use means reduced risks and helps keep patients in treatment.
- Avoid high risk settings.

Marlatt (1998); Tatarsky & Marlatt (2010)

Medications to Assist in Treatment of SUDs

Role of Medications in Management of SUDs

- Detoxification
- Relapse Prevention
- Maintenance (harm reduction)

Additional Resources

Major Websites

National Institute on Alcohol Abuse and Alcoholism
http://www.niaaa.nih.gov
National Institute on Drug Abuse
http://www.drugabuse.gov
Substance Abuse & Mental Health Services Administration (SAMHSA) http://www.samhsa.gov
Web of Addictions
http://www.well.com/user/woa/
Medline Plus (National Library of Medicine)
http://www.nlm.nih.gov/medlineplus/drugabuse.html
Center for Substance Abuse Research
http://www.cesar.umd.edu/cesar/drug_info.asp
World Health Organization
http://www.who.int/topics/substance_abuse/en

Key Website Publications and Resources

- Institute of Medicine. (2013). Substance Use Disorders in the U.S. Armed Forces. Washington, DC: National Academy of Science (400 page report)
- Southeastern Consortium for Substance Abuse Treatment (SECSAT)

Key Website Publications and Resources

- Allen, J. P., & Wilson, V. (2003). *Assessing alcohol problems (2nd ed.)*. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/index.htm
- **NIAAA:** Resources and publications on alcohol use and alcohol-related problems http://www.niaaa.nih.gov/publications
- **NIDA:** Resources and publications on drug use and drug-related-problems http://www.drugabuse.gov/publications/media-guide/nida-resources

Key Website Publications and Resources

- National SBIRT ATTC Suite of Services http://ireta.org/toolkitforsbirtRethinking
- Rethinking Drinking: Alcohol and Your Health http://rethinkingdrinking.niaaa.nih.gov/
- National Institute on Alcohol Abuse and Alcoholism (NIAAA) Clinician's
- Guide http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm
- SAMHSA publications http://store.samhsa.gov/facet/Substances
- *Invisible Wounds: Mental Health and Cognitive Care Needs of America's Returning Veterans*, by the Rand Corporation, 2008. http://www.rand.org/multi/military/veterans.html

Key SUD Books

- Earlywine, M. (2009). *Substance use problems*. Cambridge, MA: Hogrefe.
- Maisto, S. A., Connors, G. J., Dearing, R. L. (2007). *Alcohol use disorders*. Cambridge, MA: Hogrefe.
- Peterson, A. L., Weg, M. W. V., & Jaén, C. R. (2011). *Nicotine and tobacco dependence*. Cambridge, MA: Hogrefe.
- Shaffer, H., LaPlante, D. A., & Nelson, S. E. (2012). *APA addiction syndrome handbook. Volume 1* (1st ed.). Washington, DC: APA.
- Shaffer, H., LaPlante, D. A., & Nelson, S. E. (2012). *APA addiction syndrome handbook. Volume 2* (1st ed.). Washington, DC: APA.

CDP Website: Deploymentpsych.org

Features include:

- Descriptions and schedules of upcoming training events
- Blog updated daily with a range of relevant content
- Articles by subject matter experts related to deployment psychology, including PTSD, mTBI, depression, and insomnia
- Other resources and information for behavioral health providers
- Links to CDP's Facebook page and Twitter feed

Online Learning

The following online courses are located on the CDP website at:

http://www.deploymentpsych.org/content/online-courses

NOTE: All of these courses can be take for free or for CE Credits for a fee

- Cognitive Processing Therapy (CPT) for PTSD in Veterans and Military Personnel (1.25 CE Credits)
- Prolonged Exposure Therapy for PTSD in Veterans and Military Personnel (1.25 CE Credits)
- Epidemiology of PTSD in Veterans: Working with Service Members and Veterans with PTSD (1.5 CE Credits)
- Provider Resiliency and Self-Care: An Ethical Issue (1 CE Credit)
- Military Cultural Competence (1.25 CE Credits)
- The Impact of Deployment and Combat Stress on Families and Children, Part 1 (2.25 CE Credits)
- The Impact of Deployment and Combat Stress on Families and Children, Part 2 (1.75 CE Credits)
- The Fundamentals of Traumatic Brain Injury (TBI) (1.5 CE Credits)
- Identification, Prevention, & Treatment of Suicidal Behavior in Service Members & Veterans (2.25 CE Credits)
- Depression in Service Members and Veterans (1.25 CE Credits)

All of these courses and several others are contained in the Serving Our Veterans Behavioral Health Certificate program, which also includes 20+ hours of Continuing Education Credits for $350.

Provider Support

CDP's "Provider Portal" is exclusively for individuals trained by the CDP in evidence-based psychotherapies (e.g., CPT, PE, and CBT-I)

Features include:

- Consultation message boards
- Hosted consultation calls
- Printable fact sheets, manuals, handouts, and other materials
- FAQs and one-on-one interaction with answers from SMEs
- Videos, webinars, and other multimedia training aids

Participants in CDP's evidence-based training will automatically receive an email instructing them how to activate their user name and access the "Provider Portal" section at Deploymentpsych.org.

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Alcohol and Drug Use in Military Veterans

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Websites in the Slide Presentation

Association for Cognitive and Behavioral Therapies (ABCT)
http://www.abct.org/home/

Motivational Interviewing
http://motivationalinterviewing.org/

Website for standard drink cards
http://sbirtonline.org/toolkit/
http://rethinkingdrinking.niaaa.nih.gov/WhatCountsDrink/WhatsAstandardDrink.asp

Fagerström Test for Nicotine Dependence
http://www.nova.edu/gsc/nicotine_risk.html

Institute of Medicine. (2013). Substance Use Disorders in the U.S. Armed Forces. Washington, DC: National Academy of Science. 400 page report can be downloaded from the website
www.nap.edu

Drug Abuse Screening Test (DAST-10)
http://www.nova.edu/gsc/online_files.html
http://sbirtonline.org/toolkit/

Opioid Risk Tool (ORT)
http://sbirtonline.org/toolkit/

Quick Drinking Screen (QDS)
http://www.nova.edu/gsc/online_files.html

Single Binge Question (SBD)
http://sbirtonline.org/toolkit/

Decisional Balance Exercise
http://www.nova.edu/gsc/online_files.html

Alcohol Use Disorders Identification Test (AUDIT-10 and AUDIT-3)
http://sbirtonline.org/toolkit/

Where Are You Now Scale
http://www.nova.edu/gsc/online_files.html
http://www.nova.edu/gsc/

Comorbidity in Veterans
http://www.rand.org/content/dam/rand/pubs/research_briefs/2008/RAND_RB9336.pdf
http://www.rand.org/multi/military/veterans.html

Department of Defense (2013). 2011 Department of Defense Health Related Behaviors Survey of Active Duty Military Personnel

http://tricare.mil/tma/dhcape/surveys/coresurveys/surveyhealthrelatedbehaviors/downloads/Final%202011%20HRB%20Active%20Duty%20Survey%20Exec%20Summary.pdf (accessed 11.5.2013)

National Institute of Drug Abuse
Drugs of Abuse
www.drugabuse.gov
http://www.drugabuse.gov/drugs-abuse/emerging-drugs

Division 50, Society of Addiction Psychology, American Psychological Association
http://www.apa.org/about/division/div50.aspx

Size and Gender Differences can be Estimated in Charts at the Following Website
http://www.brad21.org/bac_charts.html

http://www.intox.com/drinkwheel.aspx

http://bloodalcoholcalculator.org/#LinkURL **(also provides information about a person's BAL and laws for determining drunk driving by state)**

Other Resources in Slide Presentation

Rethinking Drinking: Alcohol and Your Health
http://rethinkingdrinking.niaaa.nih.gov/

National Institute on Alcohol Abuse and Alcoholism (NIAAA) Clinician's Guide
http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm

SAMHSA publications
http://store.samhsa.gov/facet/Substances

NIAAA Assessing alcohol problems (Allen, J. P., & Wilson, V. (2003). ***Assessing alcohol problems (2nd ed.)*****. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism**
http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/index.htm

NIAAA: Resources and publications on alcohol use and alcohol-related problems
http://www.niaaa.nih.gov/publications

NIDA: Resources and publications on drug use and drug-related-problems
http://www.drugabuse.gov/publications/media-guide/nida-resources

National SBIRT ATTC Suite of Services
http://ireta.org/toolkitforsbirtRethinking

Southeastern Consortium for Substance Abuse Treatment (SECSAT): Developed many resources to help clinicians assess at risk alcohol and drug users. SECSAT ToolKit has several brief screening measures as well as tools for clinicians to implement the Screening, Brief Intervention and Referral to Treatment (SBIRT) protocols which have been shown to be effective in reducing substance misuse. Descriptions and links to download materials are provided

http://sbirtonline.org/toolkit

Institute of Medicine. (2013). Substance Use Disorders in the U.S. Armed Forces. Washington, DC: National Academy of Science (400 page report)
www.nap.edu

Office of National Drug Control Policy
http://www.whitehouse.gov/ondcp/
http://www.whitehouse.gov/ondcp/ondcp-fact-sheets/synthetic-drugs-k2-spice-bath-salts
http://www.whitehouse.gov/ondcp/prescription-drug-abuse

***Invisible Wounds: Mental Health and Cognitive Care Needs of America's Returning Veterans*, by the Rand Corporation, 2008. Download report**
http://www.rand.org/multi/military/veterans.html

Beck Institute
http://www.beckinstitute.org

Websites Listing Evidenced Based or Empirically Supported Interventions for SUDs
http://nrepp.samhsa.gov/ViewAll.aspx
SAMSA's National Registry of Evidence-based Programs and Practices (NREPP) is a searchable online database of mental health and substance abuse interventions. All interventions in the registry have met NREPP's minimum requirements for review and have been independently assessed and rated for Quality of Research and Readiness for Dissemination.

NREPP is a searchable online registry of more than 310 substance abuse and mental health interventions. NREPP was developed to help the public learn more about evidence-based interventions that are available for implementation. 310 substance abuse and mental health interventions. NREPP was developed to help the public learn more about evidence-based interventions that are available for implementation.

http://www.div12.org/Psychological Treatments/index.html
The purpose of this website is to provide information about effective treatments for psychological disorders. The website is for the general public, practitioners, researchers, and students. Basic descriptions are provided for each psychological disorder and treatment. In addition, for each treatment, the website lists key references, clinical resources, and training opportunities.

Major Addiction Websites

National Institute on Alcohol Abuse and Alcoholism:
http://www.niaaa.nih.gov

National Institute on Drug Abuse:
http://www.drugabuse.gov

Substance Abuse & Mental Health Services Administration (SAMHSA)
http://www.samhsa.gov

Web of Addictions:
http://www.well.com/user/woa/

Medline Plus (National Library of Medicine):
http://www.nlm.nih.gov/medlineplus/drugabuse.html

Center for Substance Abuse Research
http://www.cesar.umd.edu/cesar/drug_info.asp

World Health Organization
http://www.who.int/topics/substance_abuse/en

Active Duty: 2011 DOD Health Related Behaviors Survey Definitions

Type	Number of Drinks	Time Period
Abstainer	<12 drinks in lifetime	0 in past 12 mos
Former Drinker	≥12 drinks in lifetime	0 in past 12 mos
Infrequent/Light Drinker	<4 drinks per week	In past 12 mos
Moderate Drinker	4-14 drinks per week (men) 4-7 drinks per week (women)	In past 12 mos
Heavy Drinker	>14 drinks per week (men) >7 drinks per week (women)	In past 12 mos
Binge Drinker	≥5 drinks (men) ≥4 drinks (women)	At least once in last 30 days

Department of Defense (2013)

AUDIT-10 and AUDIT-C Brief Alcohol Screening Measures

The AUDIT was developed by the World Health Organization to evaluate a person's use of alcohol. An AUDIT score is suggestive of whether a person's drinking should be considered a problem.

SCORING:
AUDIT-C: Each AUDIT-C question is scored 0 to 4 points, resulting in a total score ranging from 0 to 12 points. Sum of scores for the 3 questions results in possible AUDIT-C scores ranging from 0 to 12. **A score of ≥ 4 for men and ≥ 3 for women is suggestive of an alcohol problem**

AUDIT-10: Each AUDIT-C question is scored 0 to 4 points, resulting in a total score ranging from 0 to 40 points. Higher scores typically reflect more serious problems. **A score of ≥ 8 is suggestive of an alcohol problem,**

AUDIT-C

1. How often do you have a drink containing alcohol?
Never (0 points)
Monthly or less (1 points)
Two to four times a month (2 points)
Two to three times a week (3 points)
Four or more times a week (4 points)

2. *How many drinks containing alcohol do you have on a typical day when you are drinking?*

1 or 2 (0 points)
3 or 4 (1 points) 5 or 6 (2 points)
7 to 9 (3 points)
10 or more (4 points)

3. *How often do you have six or more drinks on one occasion?*
Never (0 points)
Less than monthly (1 point)
Monthly (2 points)
Weekly (3 points)
Daily or almost daily (4 points)

Total Score: _____

The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol?

   (0) Never [Skip to Qs 9-10]
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 3 times a week
   (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 9
   (4) 10 or more

3. How often do you have six or more drinks on one occasion?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

   Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

   (0) No
   (2) Yes, but not in the last year
   (4) Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

    (0) No
    (2) Yes, but not in the last year
    (4) Yes, during the last year

Record total of specific items here

Brief Alcohol Screening Questions and Standard Drink Card

Single Binge Drinking (SBD) Question and Quick Drinking Screen (QDS)

The QDS contains four questions about drinking including Question 4, the single binge drinking question

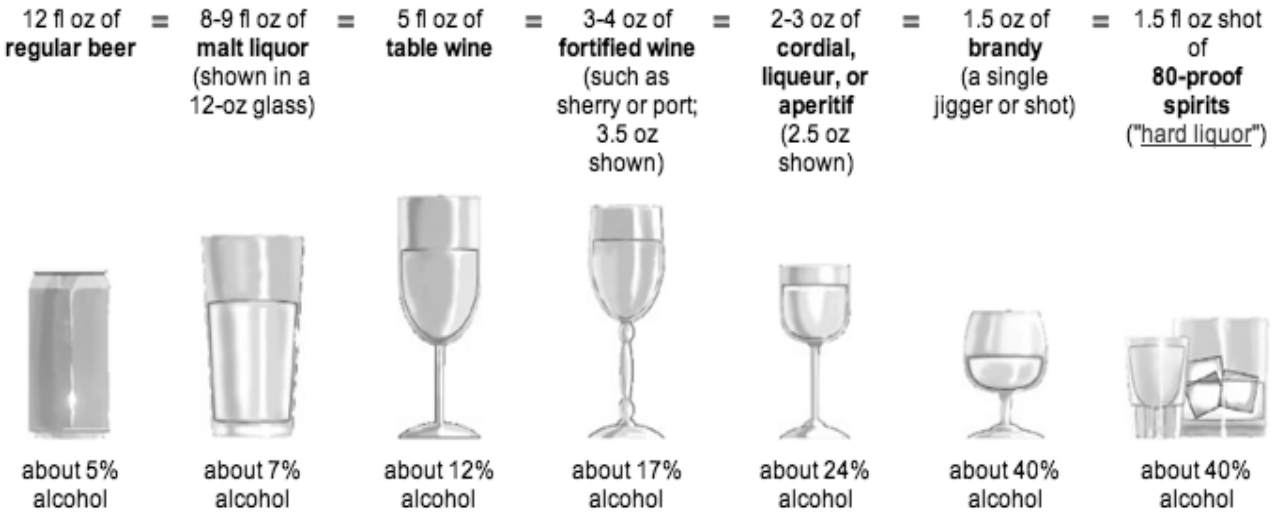
- **Question 1. Number of days drinking per week:** "On average in the past ____ month(s), how many days per week did you drink?" _____
- **Question 2: Number of standard drinks (SDs) per drinking day:** "When you did drink, on average, how many SDs did you have per day?" _____
- **Question 3: Number of drinks per week: Multiply Questions 1 x 2 to get** *"How many SDs consumed on average per week?"* _____
- **Question 4 (Single Binge Drinking question): Number of days drinking ≥ 5 SDs (for men) or ≥ 4 SDs (for women)** "*How many times in the past ___month(s) have you had 5 or more (men) SDs or 4 or more SDs per day?"*

Notes:

1. The temporal interval for these questions can vary depending on the practitioner's needs from the past 30 days (1 month) to the past 12 months
2. Show patients the standard drink card below when asking them about the number of drinks they drink per day.

What's a "standard" drink?

Many people are surprised to learn what counts as a drink. In the United States, a "standard" drink is any drink that contains about 0.6 fluid ounces or 14 grams of "pure" alcohol. Although the drinks below are different sizes, each contains approximately the same amount of alcohol and counts as a single standard drink.



Date: _____ DAST Score: _____

NAME: _____

DRUG USE QUESTIONNAIRE (DAST-10)

The following questions concern information about your potential involvement with drugs excluding alcohol and tobacco during the past 12 months. Carefully read each statement and decide if your answer is "No" or "Yes". Then, fill in the appropriate box beside the question.

When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcohol or tobacco.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months	No	Yes
1. Have you used drugs other than those required for medical reasons?.....	❑	❑
2. Do you abuse more than one drug at a time?.....	❑	❑
3. Are you always able to stop using drugs when you want to?.....	❑	❑
4. Have you had "blackouts" or "flashbacks" as a result of drug use?.....	❑	❑
5. Do you ever feel bad or guilty about your drug use?.....	❑	❑
6. Does your spouse (or parents) ever complain about your involvement with drugs?.....	❑	❑
7. Have you neglected your family because of your use of drugs?.....	❑	❑
8. Have you engaged in illegal activities in order to obtain drugs?.....	❑	❑
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?.....	❑	❑
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	❑	❑

DAST-10 SCORING[1]

SCORE	DEGREE OF PROBLEM RELATED TO DRUG ABUSE
0	**None Reported**
1 – 2	**Low Level**
3 - 5	**Moderate Level**
6 - 8	**Substantial Level**
9 - 10	**Severe Level**

SCORING: For every "YES" answer to Questions 1–2, 4-10 score l point and for Question 3 score l point for a "NO" answer

[1]Skinner, H. A. (1982). The Drug Abuse Screening Test. *Addictive Behaviors*, *7*, 363-371.

Opioid Risk Tool (ORT) Brief Screening Measure

Scoring: The ORT is a 5-item brief screening measure that can be used to predict individuals who may develop aberrant behaviors when prescribed opioids for chronic pain Scores can range from 0 to 13 for men and 0 to 16 for women. **Scores ≥ 8 reflect very high risk of patients who may develop aberrant behaviors.**

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
		TOTAL	———	———

Total Score Risk Category
Low Risk 0 – 3
Moderate Risk 4 – 7
High Risk ≥ 8

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine*. 2005;6(6):432-442. Used with permission.

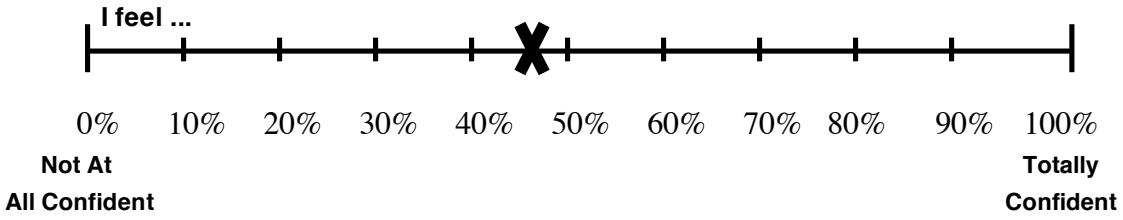
Name: _____ Date: _____

Brief Situational Confidence Questionnaire (SCQ)

The behavior I would like to change is _____

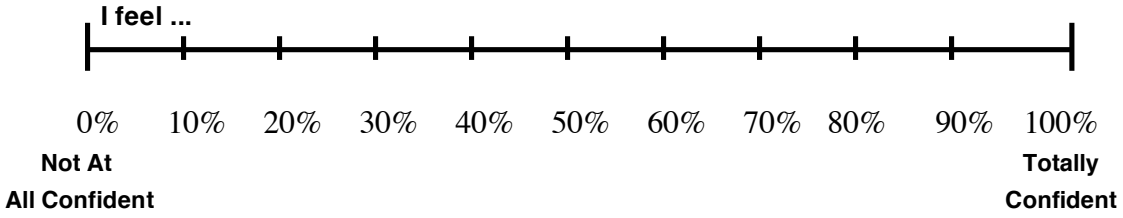
Listed below are 8 types of situations in which some people experience problems. The questions are to be answered in relation to the behavior you would like to change.

Imagine yourself as you are right now in each of the following types of situations. Indicate on each scale how confident you **are right now** that you will be able to resist the urge engage in the behavior you want to change by placing an **"X"** along the line, from **0% "Not At All Confident**" to **100% "Totally Confident",** as in the example below.

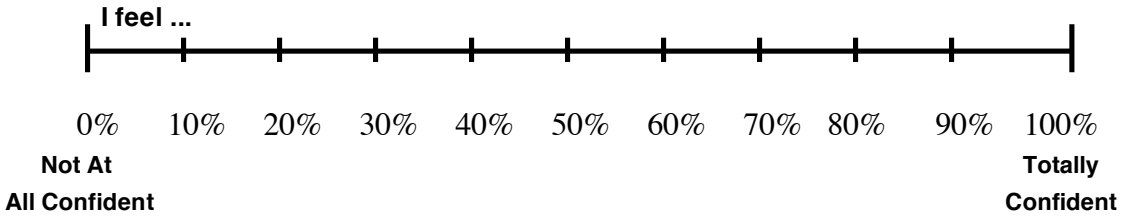


Right now I would be able to resist the urge to engage in the behavior I want to change when I experience…..

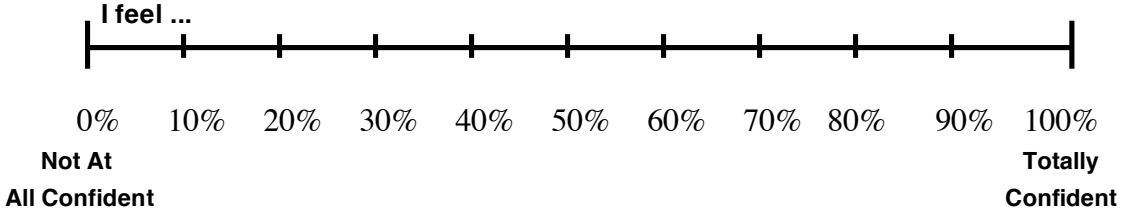
1. **UNPLEASANT EMOTIONS** (e.g., If I were depressed about things in general; If everything was going badly for me).



2. **PHYSICAL DISCOMFORT** (e.g., If I would have trouble sleeping; If I felt jumpy and physically tense).

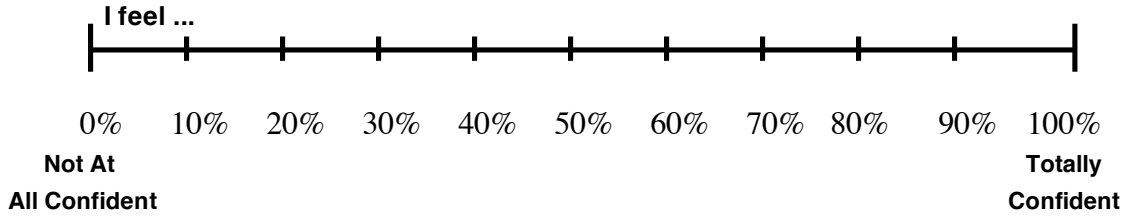


3. **PLEASANT EMOTIONS** (e.g., If something good would happen and I would feel like celebrating; If everything were going well).

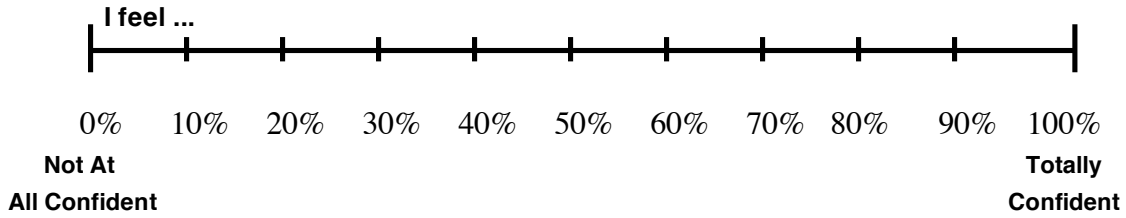


Right now I would be able to resist the urge to engage in the behavior I want to change when I experience…..

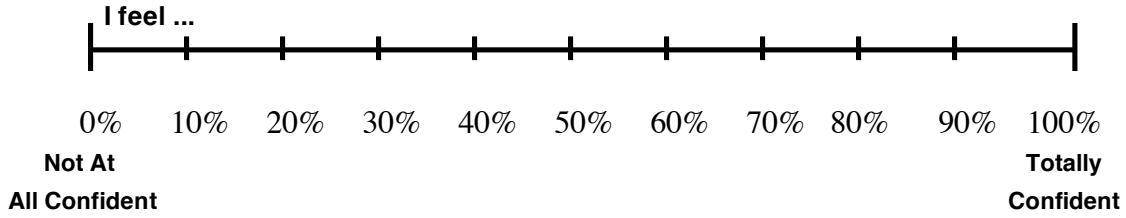
4. **TESTING CONTROL OVER THE BEHAVIOR I WANT TO CHANGE** e.g., If I would start to believe that the behavior is no longer a problem for me; If I would feel confident that I could engage in the behavior without problems).



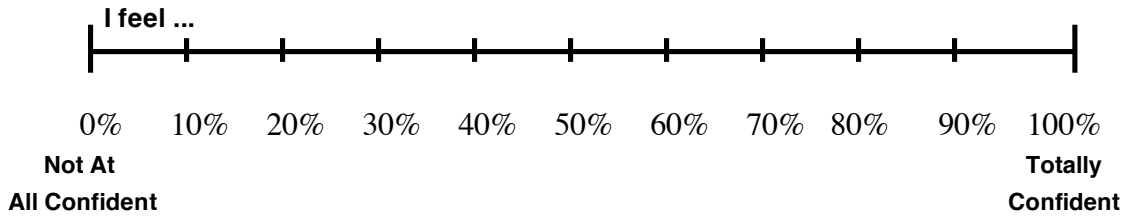
5. **URGES AND TEMPTATIONS** (e.g., If I suddenly had an urge to engage in the behavior I want to change or if I were in a situation where the behavior had occurred; If I began to think of how good it was to engage in the behavior I want to change).



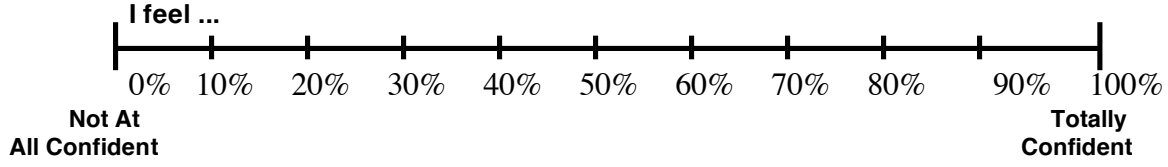
6. **CONFLICT WITH OTHERS** (e.g., If I had an argument with a friend; If I were not getting along well with others at work).



7. **SOCIAL PRESSURE** (e.g., If someone were to pressure me to engage in the behavior I want to change)



8. **PLEASANT TIMES WITH OTHERS** (e.g., If I wanted to celebrate with a friend; If I would be enjoying myself at a party and wanted to feel even better).



MI STRATEGIES CARD

ASK PERMISSION: Do you mind if we talk a bit about your **insert behavior?** (smoking, hypertension, medication use, drinking)

DECISIONAL BALANCING: *Helps people to resolve their ambivalence by evaluating the pros and cons of the behavior they want to change.*

What are some of the **Good Things** about your **insert behavior**?

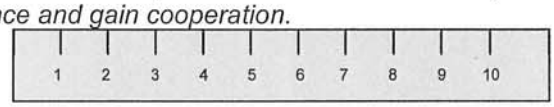
It sounds like there are some good things about **insert behavior** (insert specifics if you want). ***Reflection***

Now what about the **Less Good Things**?

It sounds like there are **ALSO** some less good things about **insert behavior** (insert specifics if you want). ***Reflection***

Taking the good and less good things together, where are you **Now**?

READINESS RULER: *People are at different levels of readiness to change. It helps to know and operate at the level where they are in order to minimize resistance and gain cooperation.*



Definitely NOT Ready to Change — **Definitely Ready to Change**

On a scale from 1 to 10, where **1 is Definitely Not Ready to Change and 10 is Definitely Ready to Change,** what number best reflects how READY you are at the **present time** to change your **insert behavior?**

On this same scale, **where were you 6 months ago**?

How did you go from **(# 6 mo. ago)** to **(# now)?**

What would it take for you to change your **insert behavior**?

What would be the **best outcome** if you do change?

CENTER FOR DEPLOYMENT PSYCHOLOGY

Preparing Professionals to Support Warriors and Families

Sexual Assault in the United States Military

Center for Deployment Psychology
Uniformed Services University of Health Sciences

Disclaimer

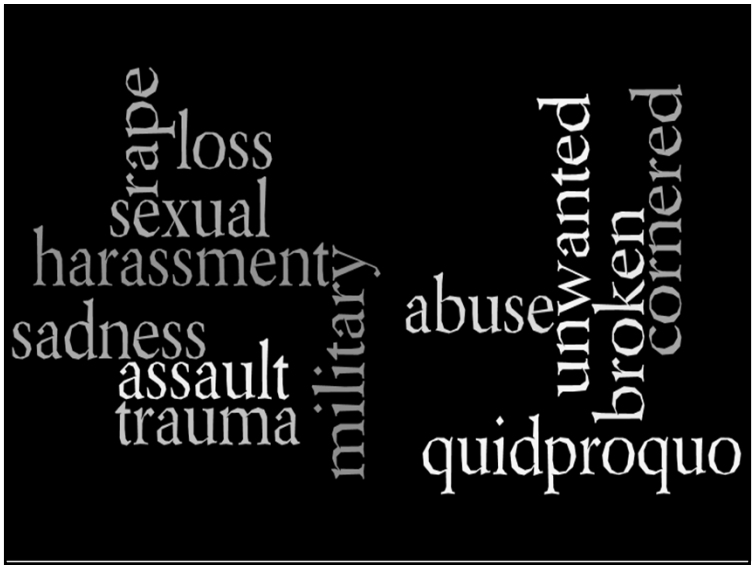
The views expressed are those of the presenters and do not necessarily reflect the opinions of the Uniformed Services University of the Health Sciences, the Department of Defense, or the U.S. Government.

Learning Objectives

1. Discuss military sexual assault and its prevalence in military populations.
2. Identify strategies for conducting an assessment of a military sexual assault client.
3. Review treatment strategies for military sexual assault survivors.

Outline

- Myths and Facts
- Military Sexual Assault (MSA) defined & prevalence
- Context of MSA
- Risk Factors for PTSD
- Clinical Presentation
- Clinical Issues Specific to Male Survivors
- Assessment of MSA
- Overview of Clinical Diagnoses & Treatment
  - PTSD
  - Depression
  - Death by Suicide
- Resources



Common Myths Regarding Sexual Assault

Definition

Military Sexual Assault Defined by DoD 6495.01

Intentional sexual contact characterized by **use of force, threats, intimidation, or abuse of authority** or when the victim **does not or cannot consent.**

Sexual assault includes rape, forcible sodomy (oral or anal sex), and

other **unwanted sexual contact** that is aggravated, abusive, or wrongful (including unwanted and inappropriate sexual contact), or attempts to commit these acts

DoD 6495.01

Military Sexual Trauma

- VHA term (not Department of Defense)
- "Physical assault of a sexual nature, battery of a sexual nature, or sexual harassment" ["repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character"] that occurred while a veteran was serving on active duty or active duty for training.

Title 38 U.S. Code 1720 D

Examples of Military Sexual Assault

- MSA may occur off base, or off duty
- Threatening or unwelcome sexual advances
- Offensive remarks about body or sexual activities
- Cornering with suggestive comments
- Implied or perceived negative consequences for not engaging in sexual behaviors

Examples of Military Sexual Assault

- Violence or threatened use of force to force sexual activity
- Inability to consent to sexual activity due to alcohol/drugs, including being drugged
- Implied better treatment for sexual activities or faster promotions for sexual activities

Restricted Reporting

- A process used by Service members or their adult dependents in certain circumstances* to report or disclose that he or she is the victim of a sexual assault to specified officials on a requested confidential basis.
- Survivor may receive services but assault will NOT be reported and investigation NOT initiated.

*The matter may not fall under the Family Advocacy Program.

Unrestricted Reporting

- A process a Service member uses to disclose, without requesting confidentiality or restricted reporting, that he or she is the victim of a sexual assault.
- Under these circumstances, the victim's report and any details **provided…are reportable to law enforcement and may be used to initiate the official investigative process**

Why Women Choose Not to Report

- Survivors reported
  - Did not want anyone to know
  - Felt uncomfortable making a report
  - Concern that report may not be confidential
  - Concern that nothing would be done about the assault
  - Thought it was not important enough to report
  - Concern of being labeled a troublemaker
  - Fear retaliation
  - Heard of negative experiences of other survivors who made a report
  - Thought no one would believe them

Gender Relations Survey of Active Duty Members, 2012

Why Men Choose Not to Report

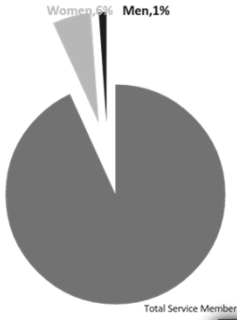
- Survivors reported
  - Concerns that they would get in trouble for infractions (underage drinking)
  - Thought no one would believe them
  - Concern that performance evaluation or chance for promotion would suffer
  - Fear of losing security clearance
  - Heard of negative experiences of other survivors who made a report

Gender Relations Survey of Active Duty Members, 2012

Prevalence Rates

Prevalence - DoD

- Service Members (unwanted sexual contact)
  - 6.1% of Women
  - 1.2% Men



Gender Relations Survey of Active Duty Members, 2012

Prevalence – Lifetime Veterans vs Civilians

Females
- 24.3% veterans
- 19.3% civilians

- Male
  - 1.3% veterans
  - 1.7% civilians

Breidling et al (2014), MST Support Team (2013)

Rates of Military Sexual Harassment (Women)

- 8% of women reported sexual coercion
- 23% of women reported unwanted sexual attention
  - Romantic pursuit
  - Being touched in a way that felt uncomfortable
- 41% reported offensive sexual behaviors
  - Sexual stories
  - Joke
  - Discussions about sex

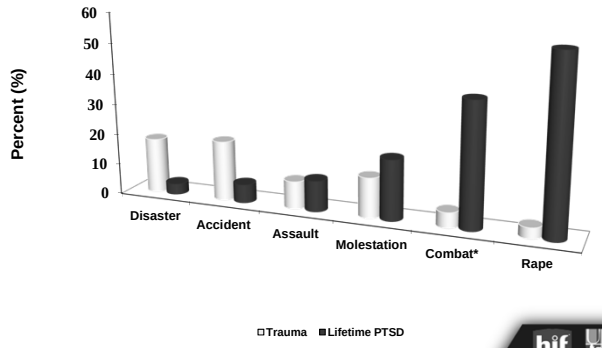
Gender Relations Survey of Active Duty Members 2012

Rates of Military Sexual Harassment (Men)

- 2% of men report some form of sexual coercion for not being sexually cooperative
- 6% of men reported unwanted sexual attention
  - Romantic pursuit
  - Being touched in a way that felt uncomfortable
- 20% reported offensive sexual behaviors
  - Sexual stories
  - Joke
  - Discussions about sex

Gender Relations Survey of Active Duty Members 2012

Rates of PTSD are Influenced by the Nature of the Trauma



Kessler (1995)

Deployment Stressors Compound the Trauma

Deployment Stressors Compound the Trauma

Sexual Trauma in the Military Increases Risk

When sexual trauma is experienced during military service, it is more strongly associated with negative MH outcomes than sexual assault experienced before or after military service.

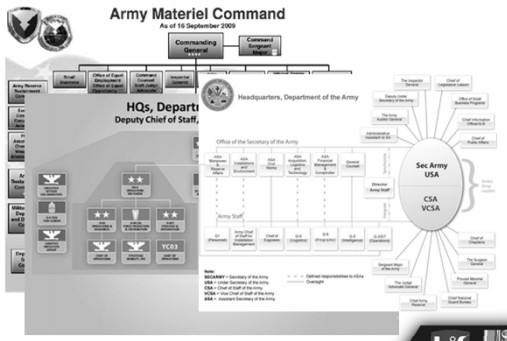
Kimerling et al. (2010)

The Context of Military Culture

Military Values

- Particular aspects of military culture may compound feelings of helplessness, isolation, and betrayal
  - Loyalty and teamwork
    - Being harmed by a fellow Service member may be that much more shocking and incomprehensible to victims
    - Taboo to divulge negative information about peers
  - Strength and self-sufficiency
    - Reduces social support available (particularly if far from home), increases likelihood of invalidating responses
    - Being a "victim" conflicts with desired identity
    - Stigma may be particularly strong for men

The Organization



Constructive Force

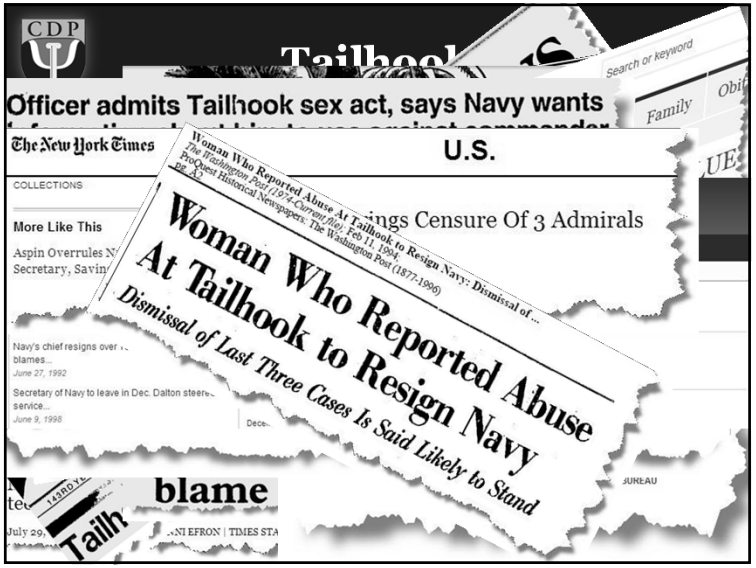
Coercion based on power differential

Murphy (1996)

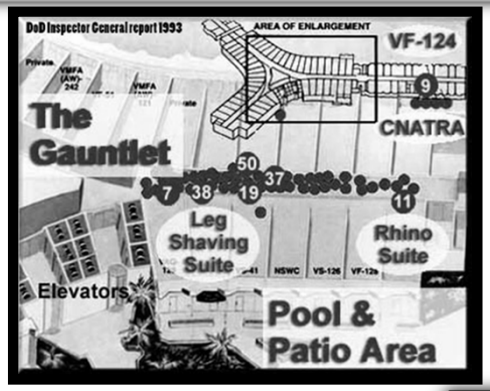
The Nature of Military Sexual Assault

- It's interpersonal
  - The perpetrator is often known to the victim
- The survivor may still work/live with perpetrator in close proximity
- The trauma is often repeated over a period of time
- The environment in which it occurs carries additional risks

Breslau et al. (1999)



Tailhook - 1991



DoD Inspector General Report, 1993

Sexual Trauma, Risk Factors, and PTSD

The Impact of Trauma

- Requires an understanding of:
  - Characteristics of the trauma
  - Characteristics of the individual
  - Context in which the trauma occurs

Context: Sexual Assault in the Military is Unique

- Work/Live/Play in same environment
- Members of military become like family
- Hierarchy is very rigid
- Members of unit should protect each other not hurt each other

Context: Previous Trauma History

- Rates of revictimization are high
  - 16% - 72% of female childhood sexual abuse survivors experience sexual or physical revictimization as adults (Messman & Long, 1996)
  - Sadler and colleagues (2003) found that 37% of women reporting a history of MST had been raped at least twice during their military service
  - Few studies exist for men, but some suggest sexual revictimization rates comparable to those for women

Zinzow et al. (2007)

Context: Previous Trauma History

- Childhood trauma is a known risk factor for sexual assault during adulthood:
  - 30% of all AD women and 6% of all AD men report sexual assault prior to joining the military(WGRA, 2012)
  - Given a history of CSA, risk of sexual revictimization as an adult is at least twice as high and possibly 10x higher than for those without a history of CSA (Messman & Long, 1996)

Zinzow et al. (2007)

Personal Risk Factors

- Female Gender
- Typically Younger in Age
- Prior Trauma
- Domestic Violence

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Kessler et al (1995)

Interpersonal Stressors

- Rigid gender roles
- Lack of positive relationships/social support

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Specialist 2nd Class Jennifer Johnson , DVIDS, is free of known copyright restrictions under US copyright law

Rosen et al (1999), Vogt et al (2005), Brailey et al (2007)

Case Study Discussion

- As a clinician, what stood out for you about Ashley?
- How might she present clinically?

One Other Factor to Consider: An Interpersonal Trauma

- Perpetrated by another human being
  - Often by a friend/intimate partner/coworker
  - Involves a profound violation of boundaries and personal integrity
  - Sends confusing messages about what relationships involve, what is acceptable and expected behavior from a trusted other, what rights/needs the victim has, what is "theirs" versus publicly accessible…
- Has significant implications for survivors' subsequent relationships and understanding of self
  - Particularly true when victim is young and trauma is chronic and/or repeated

Risk Factors for PTSD: Combat versus Interpersonal Violence

Combat trauma	IPV
– Peritraumatic dissociation	– Peritraumatic dissociation
– Perceived life threat	– Perceived life threat
– Perceived [lack of] support	– Prior emotional problems
– Prior trauma	– Family of origin psychopathology
– Family of origin psychopathology	– Prior trauma
– Prior emotional problems	– Perceived [lack of] support

Ozer et al (2003)

Clinical Presentation

Following MSA, Survivors often report…

Self-Blame	Restricted Affect	Trust Issues
Boundary Issues	Substance Use	Sensitive to Power & Control
Over-Eating	Under-Eating	Self-Injurious Behavior

Re-Conceptualizing Symptoms

- Even seemingly purposeless or self-destructive behaviors often turn out to be serving a self-protective function if you look more closely
  - Allowed the victim to survive the event at the time, but have persisted into different, inappropriate contexts

    and/or
  - Represent best efforts to deal with (overwhelming) uncharted territory
- Particularly true in the case of early or complex trauma (and thus often MST) – the trauma occurred before the victim had developed more sophisticated coping strategies

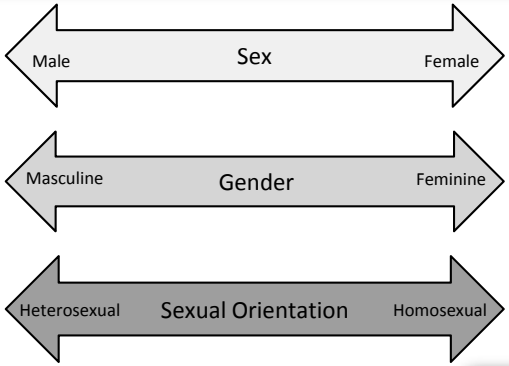
Male Survivors of Sexual Assault (Service Members and Veterans)

Male Rape Myths (all false)

- Real men can defend themselves against rape
- Only gay men rape other men
- Women cannot sexually assault men
- Homosexuals and bisexuals are being punished
- Men raped by men become gay
- A physical response to a rape means the victim "wanted it"

Turchik & Edwards (2012)

Sex vs Gender Identity vs Sexual Orientation



APA Guidelines for Psychological Practice with Lesbian, Gay and Bisexual Clients

When Male Service Members & Veterans Are Assaulted

- Frequent responses include
  - Confusion regarding sexual identity
  - May overcompensate with promiscuity
  - Concerns that no one will believe they have been assaulted

Photo by SGT Ken Scar, DVIDS, is free of known copyright restrictions under US Copyright law

When Male Service Members & Veterans Are Assaulted

- Self-Blame (maladaptive thoughts)
  - "I'm not a real man"
  - "I must give off a 'homosexual vibe'"
  - "I'm damaged" or "Perpetrators must know about my past" (especially for CSA)
- Disruptions in intimate relationships
- Rape myths

Male Service Members & Veterans

- Specific Clinical Issues
  - May avoid group treatment (do not want to be with combat veterans)
  - Higher rates of suicidal behavior
  - Higher rates of depression
  - Fear of being judged by provider
  - Concerns about medical records

Male Service Members & Veterans (Homosexual)

- May feel that the crime is “punishment”
- May worry that sexual orientation may be impacted
- May worry that they were targeted because they were gay which may lead to withdrawal from community
- Disruption in intimate relationships

Working with Male Survivors

- Expect that many will be hesitant to document their sexual assault, may document as “assault”
- Many will expect you NOT to believe them, especially if perpetrator is female
- If assaulted by homosexual male, may have intense anger/hatred towards homosexual males
- May attempt to assault others (male & female), especially when drinking or using substances

Case Study Discussion

- Which issues might you expect to see in treatment?
- What psychoeducation would you provide?

Assessment of Sexual Assault and Basic Tips

Trauma Assessment Tools

Sexual Experiences Questionnaire - DoD

- Sexual Harassment
  - Sexual Experiences Questionnaire – DoD

Fitzgerald, Magley, Drasgow & Vialdo (1999)

Sexual Experiences Survey

- Sexual Assault
  - Forced and coerced behaviors

Koss, Gidycz &Wisniewski (1987)

Trauma Assessment Guidelines

- Begin assessment with presenting problem
- Be direct, empathic and nonjudgmental
- Build rapport before assessment
- Do not display discomfort
- Start broadly and use follow-up questions
- Describe behaviors, not terms
- Repeat assessments as necessary

Sexual Trauma Assessment Questions

- Have you ever received unwanted or threatening sexual attention?
- Have you ever been physically assaulted or attacked?
- Has anyone ever used force to have sexual contact with you against your will?
- Have you ever been forced to touch someone in a sexual way when you did not want to?
- Have you ever had an unwanted sexual experience?

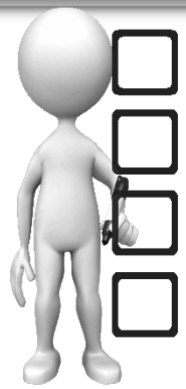
Childhood Trauma Exposure Questions

- When you were a child, what was it like at your house?
- Who did you grow up with?
- Did you see any violence as a child?
- As a child, how were you disciplined? Was it predictable?
- As a child, was anyone abusive to you in any way?
- As a child, did anyone ever do anything sexual to you?

Sexual Trauma Assessment Questions

- If trauma disclosed, follow up with questions regarding
  - Were you injured as a result?
  - Did you require medical attention for these injuries?
  - Are you currently experiencing any medical problems related to your assault?
  - Other medical consequences...pregnancy or STD

Tips for Treatment with Military Sexual Assault Survivors



- Empathy, not sympathy
- Trust is earned, and maintained
- Create structure & boundaries
- Establish treatment plan, use treatments that work!

Tips for Treatment with Military Sexual Assault Survivors

- Believe them! Validate that they were assaulted ***against their will***.
- They are likely to have significant shame, guilt and self-blame
- Men who are sexually harassed are likely to have higher levels of psychological distress than women who are sexually harassed*
- They may be anticipating a negative response from you, the clinician
- Work with prescribing provider to minimize medications that may interfere with CBT

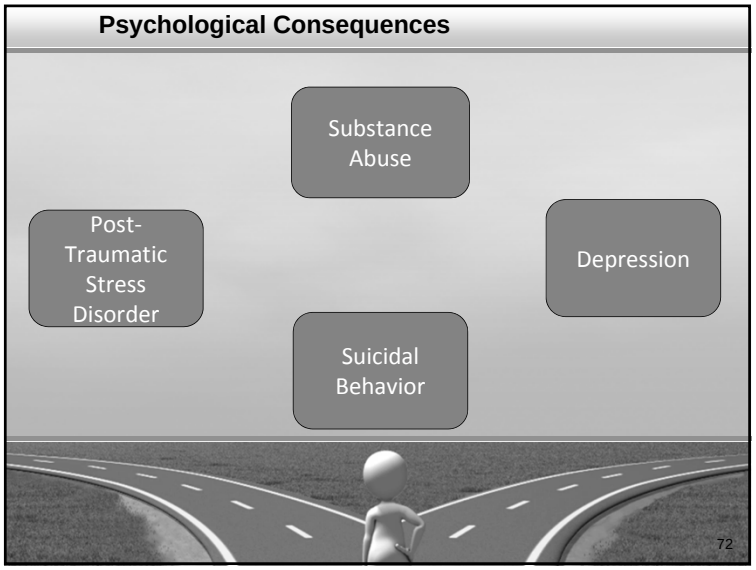
Turchick et al (2013)

Psychological Consequences of Military Sexual Assault and Harassment and Overview of Interventions

Trauma Themes

"I have a hard time setting limits and maintaining boundaries"	Fear	"They kept kicking me and I was thinking…If I could just get up I could hit him in the nose"
Humiliation and shame—related to who you are	Alienation	"I've really lost a piece of myself; I've changed"
"I must be gay if I couldn't keep that asshole from abusing me"	Loss of Self-Worth	Sex with strangers Unsafe sex Gambling Reckless driving

Psychological Consequences



PTSD

DSM-5: Symptom Criteria for PTSD
1+1+2+2 =PTSD

Re-experiencing (B)	Avoidance (C)	Negative Alterations in Cognitions and Mood (D)	Arousal (E)
Intrusive, Distressing Recollections	Avoidance of Internal Reminders (memories, thoughts, feelings)	Traumatic Amnesia	Irritable Behavior and Angry Outbursts
Distressing Dreams	Avoidance of External Reminders (people, places, conversations, activities, objects, situations)	Persistent Negative Beliefs and Expectations	Reckless or Self-Destructive Behavior
Dissociative Reactions (e.g. flashbacks)		Persistent Distorted Blame	Hypervigilance
Psychological Distress to Reminders		Persistent Negative Emotional State	Exaggerated Startle Response
Marked Physiological Reactions to Reminders		Diminished Interest	Concentration Difficulties
		Detachment or Estrangement	Sleep Difficulties
		Persistent Inability to have Positive Emotions	
1	1	2	2

DSM-5 (2013)

PTSD Treatment

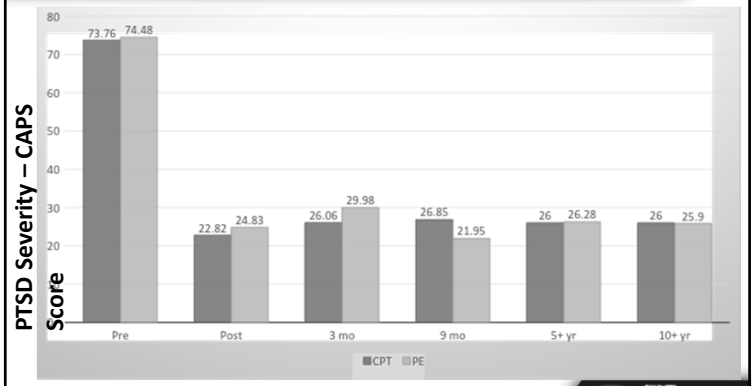
Cognitive Processing Therapy

- Very effective
- Approx 12 sessions
- Provide psychoeducation
- Cognitive Restructuring
- Individual and/or group
- Approved DoD-wide

Prolonged Exposure Therapy

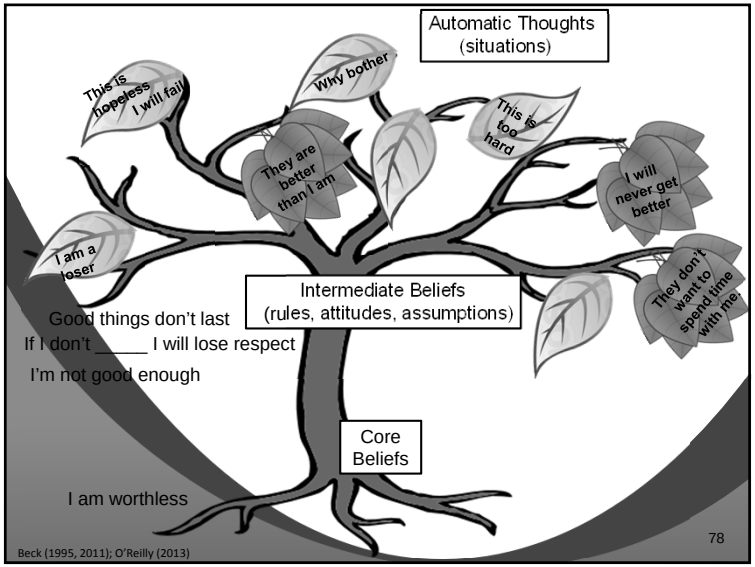
- Very effective
- Approx 10-12 sessions
- Provide psychoeducation
- Exposure and habituation
- Individual format
- Approved DoD-wide

CPT and PE Follow-up



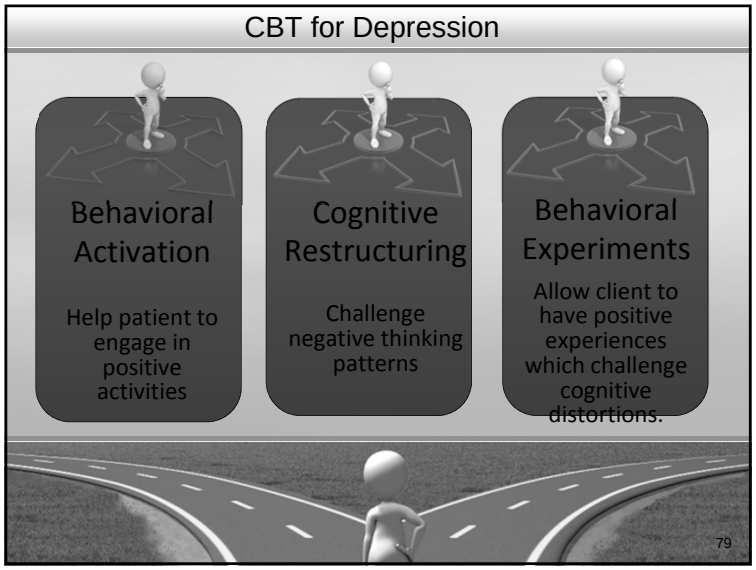
Resick et al (2012)

Depression



Beck (1995, 2011); O'Reilly (2013)

CBT for Depression



Death by Suicide

Death by Suicide

Suicide Risk Factors

*Relationship problems
*Hopelessness/worthlessness
*Alcohol abuse/dependence
*Feelings of disgrace/isolation
*Guilt or shame
*Stressful military life events
*Easy access to firearms
*Unexplained mood change/depression
*Financial, legal or job performance problems
*Medical or administrative discharge processing
*Sleep problems
*Previous suicide attempts **

Warning Signs

*Ideation *Substance Abuse
*Purposelessness *Anxiety * Trapped
*Withdrawn *Anger *Recklessness
*Mood Changes

Rudd et al. (2006c); American Association of Suicidology (2012) Martin et al. (2009); Jones et al. (2012); Ribeiro et al. (2012); Bryan et al. (2013)

Legal Updates & Policy Change

Legal Updates

- National Defense Authorization Act
  - Prohibits recruiting of felons
  - *Separate convicted sex offenders from military*
  - Review of unrestricted reports and service members who separated after making report
  - Options to have military records corrected following assault or harassment

Stars & Stripes (2013)

Resources

- **Veterans Crisis Line 1-800-273-8255 (Press 1)**
- **Rape Abuse and Incest National Network**
  - **https://www.safehelpline.org/**
  - **1-877-995-5247 (DSN users 94+ 10 digit number)**
- **National Sexual Violence Resource Center**
  - **www.nsvrc.org**
- **Overcoming sexual victimization of boys and men**
  - **www.malesurvivor.org**

QUESTIONS?

More Information?

Additional resources
http://www.afterdeployment.org
http://www.dcoe.health.mil
http://maketheconnection.net

For more information on sexual assault:
Trauma & Recovery by Judith Herman
The Invisible War (documentary film)

CDP Website: Deploymentpsych.org

Features include:

- Descriptions and schedules of upcoming training events
- Blog updated daily with a range of relevant content
- Articles by subject matter experts related to deployment psychology, including PTSD, mTBI, depression, and insomnia
- Other resources and information for behavioral health providers
- Links to CDP's Facebook page and Twitter feed

Online Learning

The following online courses are located on the CDP website at:
http://www.deploymentpsych.org/content/online-courses
NOTE: All of these courses can be take for free or for CE Credits for a fee

- Cognitive Processing Therapy (CPT) for PTSD in Veterans and Military Personnel (1.25 CE Credits)
- Prolonged Exposure Therapy for PTSD in Veterans and Military Personnel (1.25 CE Credits)
- Epidemiology of PTSD in Veterans: Working with Service Members and Veterans with PTSD (1.5 CE Credits)
- Provider Resiliency and Self-Care: An Ethical Issue (1 CE Credit)
- Military Cultural Competence (1.25 CE Credits)
- The Impact of Deployment and Combat Stress on Families and Children, Part 1 (2.25 CE Credits)
- The Impact of Deployment and Combat Stress on Families and Children, Part 2 (1.75 CE Credits)
- The Fundamentals of Traumatic Brain Injury (TBI) (1.5 CE Credits)
- Identification, Prevention, & Treatment of Suicidal Behavior in Service Members & Veterans (2.25 CE Credits)
- Depression in Service Members and Veterans (1.25 CE Credits)

All of these courses and several others are contained in the Serving Our Veterans Behavioral Health Certificate program, which also includes 20+ hours of Continuing Education Credits for $350.

Provider Support

CDP's "Provider Portal" is exclusively for individuals trained by the CDP in evidence-based psychotherapies (e.g., CPT, PE, and CBT-I)

Features include:

- Consultation message boards
- Hosted consultation calls
- Printable fact sheets, manuals, handouts, and other materials
- FAQs and one-on-one interaction with answers from SMEs
- Videos, webinars, and other multimedia training aids

Participants in CDP's evidence-based training will automatically receive an email instructing them how to activate their user name and access the "Provider Portal" section at Deploymentpsych.org.

How to Contact Us

Center for Deployment Psychology
Department of Medical & Clinical Psychology
Uniformed Services University of the Health Sciences
4301 Jones Bridge Road, Executive Office: Bldg. 11300-602
Bethesda, MD 20813-4768

Email: General@DeploymentPsych.org
Website: DeploymentPsych.org
Facebook: http://www.facebook.com/DeploymentPsych
Twitter: @DeploymentPsych

DoD
Safe Helpline
Sexual Assault Support for the DoD Community

Live 1-on-1 Help **Confidential** Worldwide 24/7

No one has to know unless YOU want them to!

Safe Helpline offers free confidential and anonymous sexual assault support.

Click www.SafeHelpline.org
Call 877-995-5247
Text* 55-247 (INSIDE THE U.S.)
202-470-5546 (OUTSIDE THE U.S.)
*Text your location for the nearest support resources

Want to go mobile? To download the free DoD Safe Helpline app, visit the App Store or Google Play.

QUESTIONS?

More Information?

Additional resources
http://www.afterdeployment.org
http://www.dcoe.health.mil
http://maketheconnection.net

For more information on sexual assault:
Trauma & Recovery by Judith Herman
The Invisible War (documentary film)

CDP Website: Deploymentpsych.org

Features include:

- Descriptions and schedules of upcoming training events
- Blog updated daily with a range of relevant content
- Articles by subject matter experts related to deployment psychology, including PTSD, mTBI, depression, and insomnia
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Remember:

- Be direct, matter of fact
- Use descriptions of behaviors
- Be empathic and non-judgmental

Normalize the experience by couching questions in the context of common experiences.

- e.g., "Some people have experienced unwanted sexual attention such as comments, questions or jokes that made them uncomfortable. Has this ever happened to you?"

Childhood

When you were a child, what was it like at your house? _____

_____

_____

_____

Who did you grow up with? _____

_____

Do you see any violence as a child? _____

_____

_____

As a child, was anyone abusive to you in anyway? _____

_____

_____

_____

As a child, did anyone ever do anything sexual to you? (Note age and relationship)

_____

_____

_____

Adult

Have you ever been the target of unwelcome or threatening sexual attention, such as comments, questions, jokes, conversations? _____

_____

Have you experienced leering, or repeated requests for dates or other intimate behavior?

_____

_____

Have you experienced "sexting," showing or sending sexual photos or pornography (when it's an unwanted experience)

_____

_____

Have you experienced unwanted touching such as another person bumping, brushing against you, cornering, grabbing, hugging or kissing you?

_____

_____

Has another person flashed you or exposed their private parts to you? _____

_____

_____

Has another person watched you change your clothing or insisted that you remove your clothing? _____

_____

_____

Have you ever been forced to touch someone in a sexual way when you did not want to? _____

_____

_____

During the course of consensual sexual activity, has a partner failed to stop after you said “No” or “Stop”?

_____

_____

Have you ever had an unwanted sexual experience? _____

_____

_____

Have you ever been physically assaulted or attacked? _____

_____

_____

As a result of the experiences we just discussed, were you injured? _____

_____

_____

Did you require medical attention (e.g., stitches, urgent care, hospital)? _____

_____

_____

Are you currently experiencing any medical problems as a result of your assault? _____

_____

_____

Did you have any other consequences of your assault, such as pregnancy or STD? _____

_____

_____

Additional notes about trauma history:

Adapted from Us Government (2003). Military Sexual Trauma: An Independent Study Course.