Tier 2 Day 1
December 6, 2016

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

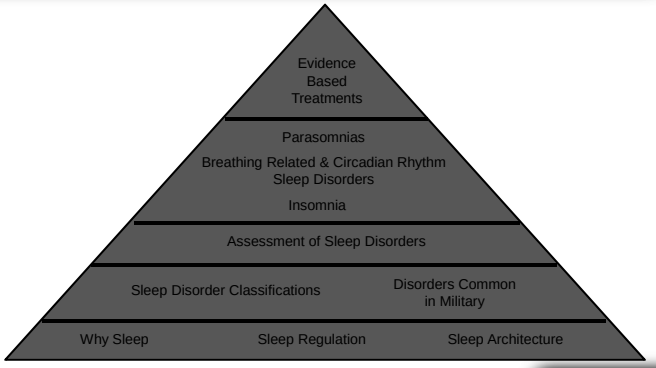
The views expressed are those of the presenters and do not necessarily reflect the opinions of the Uniformed Services University of the Health Sciences, the Department of Defense, or the U.S. Government.

Learning Objectives

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

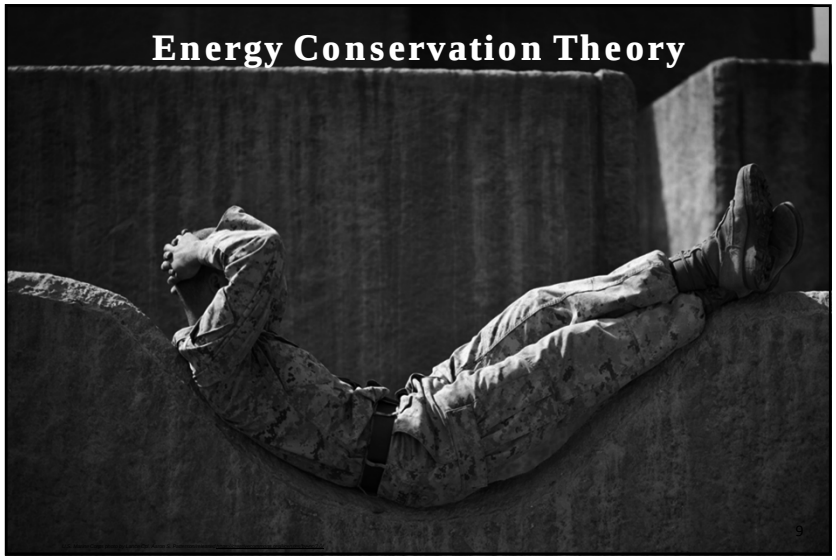
Introduction to Ramos Family

Understanding Sleep



Inactivity Theory

Energy Conservation Theory



Restorative Theory

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.

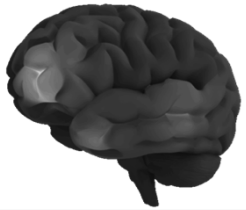


Photo by Michael "Mike" L. Baird, https://flickr.com/, https://creativecommons.org/licenses/by/2.0/

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

Why do we sleep?

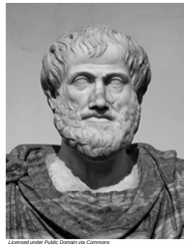
- **Inactivity Theory**
  - Also called an adaptive or evolutionary theory
  - Sleep serves a survival function and has developed through natural selection
  - Animals that were able to stay out of harm's way by being still and quiet during times of vulnerability—usually at night—survived
- **Energy 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
- **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 asleep, and a link to adult brain plasticity is becoming clear as well

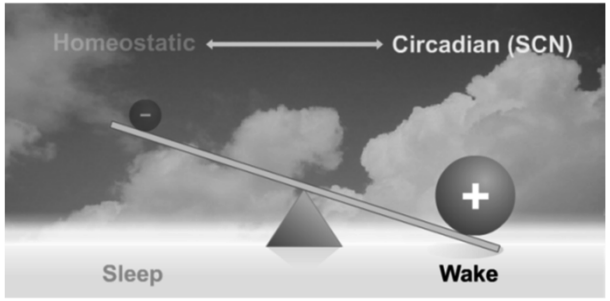
How is sleep regulated?

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

"We awaken when the digestive process is complete"

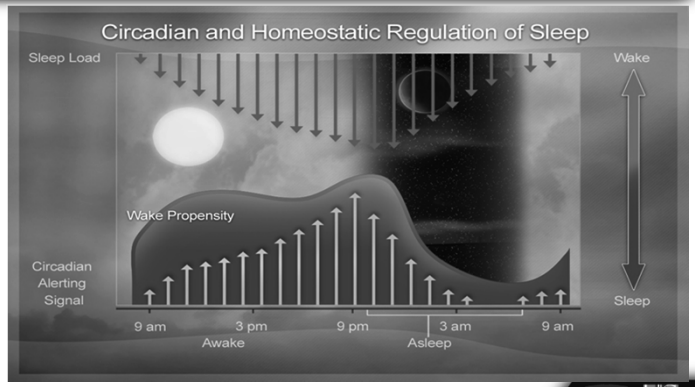
Aristotle (c350 B.C.)





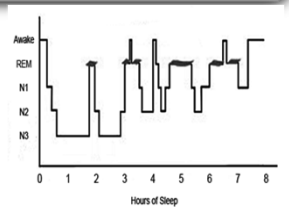
Kilduff & Kushida (1999)

How is sleep regulated?



Kilduff & Kushida (1999)

Sleep architecture



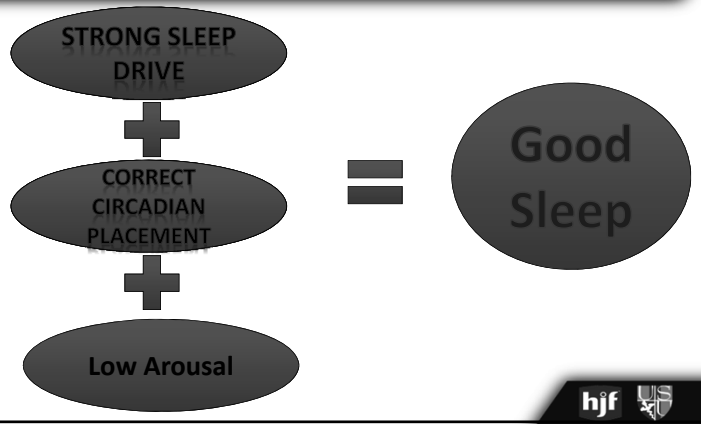
- N1 or Stage 1 (5%)
  - 5 mins; transitional phase
  - Low arousal threshold
- N2 or Stage 2 (50-55%)
  - 10-15 mins;
- N3 or Stage 3 & 4 (20%)
  - Lasts 20-40 mins; "delta" "slow-wave sleep"
- REM (20%)
  - Tonic (hypotonic muscles) and Phasic (eye movement) stages

Harvard University Sleep Lab Website

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

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

Components for Good Sleep



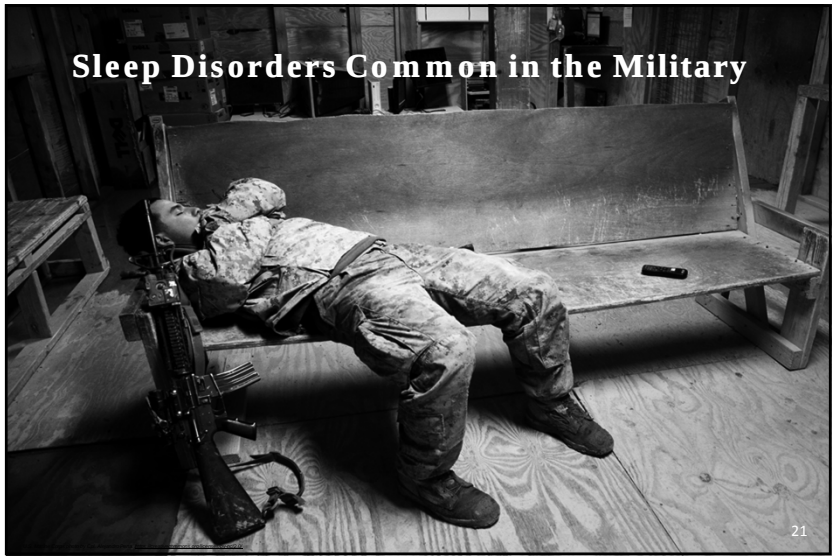
Brim (2013)

Classification of Disorders

- DSM-5 Classification of Sleep-Wake Disorders:
  - Insomnia
  - Narcolepsy
  - Breathing Related Sleep Disorders
  - Circadian Rhythm Sleep Disorders
  - Parasomnias
  - Restless Leg Syndrome

APA (2013)

APA (2013)



Disorders Common in the Military

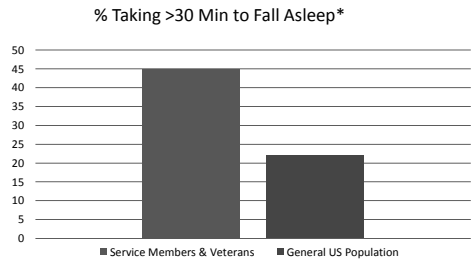
Rise in treatment seeking for:

- Insomnia
- Obstructive Sleep Apnea
- Circadian Rhythm Sleep Disorders
  - Delayed Sleep Phase
  - Shift work type
- Nightmares

Armed Forces Health Surveillance Center (2010); Troxel et al. (2015)

Disorders Common in the Military

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



* Plumb, Peachey, & Zelman, (2014); National Sleep Foundation, (2005)

"A wake up call"

- Air Force PDHRA (n > 86,000)
  - 33% report problems sleeping or still feeling tired after sleeping
  - #1 deployment related concern or condition
- Armed Forces (n > 327,000)
  - 46.8% complaints were related to sleep disturbance

AFCHIPS & Update: Deployment Health Assessments, U.S. Armed Forces

Sleep-Wake Disorders

Assessment Goals

- Differential Diagnosis
  - Symptom of psychiatric condition vs separate diagnosis
  - Insomnia vs other sleep disorders
- Sleep specialist or primary care provider referral
  - Obstructive Sleep Apnea
  - Narcolepsy
  - Rapid Eye Movement Sleep Disorder
  - Circadian Rhythm Disorders
  - Restless Leg Syndrome
  - Other medical or psychiatric conditions

Case Study: Changes in Sleep, Concentration, & Memory

Subjective Measures of Sleep

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

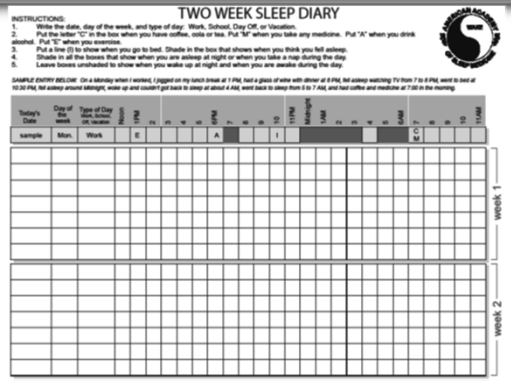
Sleep Interview

- A thorough interview for sleep-wake disorders covers:
  - 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

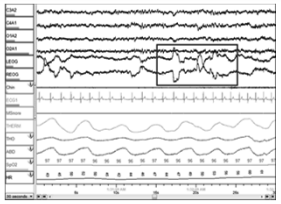
Bedroom Environment

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

Sleep Diary



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

Insomnia

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 with inability to return to sleep
- 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

APA (2013)

DSM-5
Insomnia Disorder 780.52

- 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 Specifiers

- **With non–sleep disorder mental comorbidity,** including substance use disorders
- **With other medical comorbidity**
- **With other sleep disorder**

- **Episodic:** Symptoms last at least 1 month but less than 3 months.
- **Persistent:** Symptoms last 3 months or longer.
- **Recurrent:** 2 (or more) episodes within the space of 1 year.

APA (2013)

Insomnia Severity Index (ISI)

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 NOTICEABLE 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 problem?
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.va.gov with permission from Charles M. Morin, Ph.D., Université Laval

Bastien, Vallières, & Morin, (2001); Polyhart (2005)

Dysfunctional Beliefs About Sleep Scale (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 0 1 2 3 4 5 6 7 8 9 10 Strongly Agree

1. I need 8 hours of sleep to feel refreshed and function well during the day.
0 1 2 3 4 5 6 7 8 9 10
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.
0 1 2 3 4 5 6 7 8 9 10
3. I am concerned that chronic insomnia may have serious consequences on my physical health.
0 1 2 3 4 5 6 7 8 9 10
4. I am worried that I may lose control over my abilities to sleep.
0 1 2 3 4 5 6 7 8 9 10
5. After a poor night's sleep, I know that it will interfere with my daily activities on the next day.
0 1 2 3 4 5 6 7 8 9 10
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.
0 1 2 3 4 5 6 7 8 9 10
7. When I feel irritable, depressed, or anxious during the day, it is mostly because I did not sleep well the night before.
0 1 2 3 4 5 6 7 8 9 10

Espie, Inglis, Harvey, & Tessier (2000)

Epworth Sleepiness Scale (ESS)

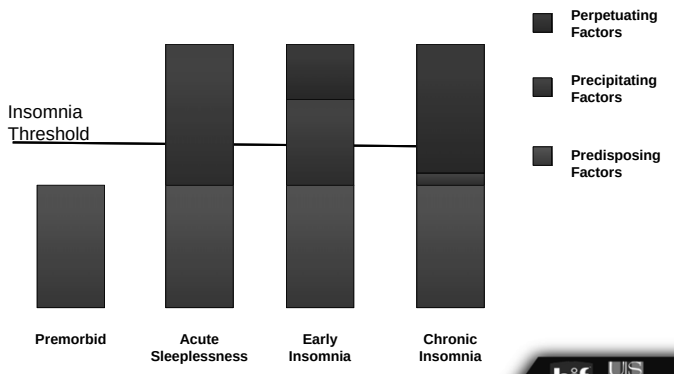
- How sleepy <u>in the recent past</u>: Epworth Sleepiness Scale
  0= no chance of dozing 1= slight 2= moderate 3= high

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

Johns (1991)

Evolution from Sleep Disturbance to Insomnia



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

Spielman et al (1987)

Insomnia Treatment

- Efficacious psychological treatments include:
  - Cognitive-behavioral therapy
  - Multicomponent therapy
  - Biofeedback therapy
- Psychological or behavioral interventions are recommended prior to use of medication
- Combined therapy shows no consistent advantage over CBT-I alone

NIH (2005); Schutte-Rodin et al. (2008); Trauer et al. (2015)

CBT-I 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
Circadian Rhythm Entrainment	Shift or strengthen the circadian sleep wake rhythm
Cognitive Restructuring	Address thoughts and beliefs that interfere with sleep and adherence

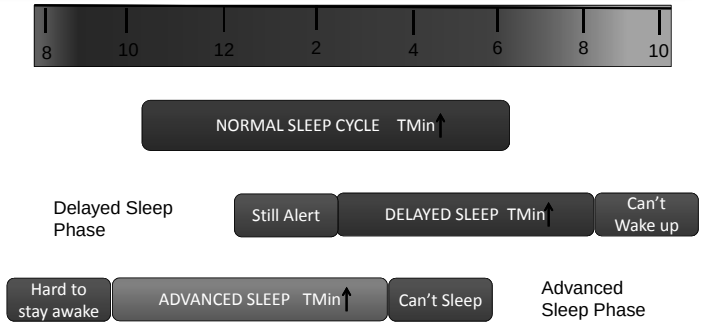
Circadian Rhythm Sleep Disorders

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



Morningness - Eveningness Questionnaire (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 – 12:00NOON	1
12:00NOON – 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 PM – 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)

Treatments

- Melatonin Therapy
- Light Therapy

- Environmental Entrainment
- Consistent Bed-Wake Time

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

Symptoms of OSA

- Nocturnal Breathing Disturbances
  - Snoring
  - Pauses in your breathing at night
  - Choking at night
  - Gasping for air during the night
- Daytime sleepiness/fatigue
- Morning headaches, chest pain, or dry mouth

STOP

<u>Quick screen for Obstructive Sleep Apnea</u>

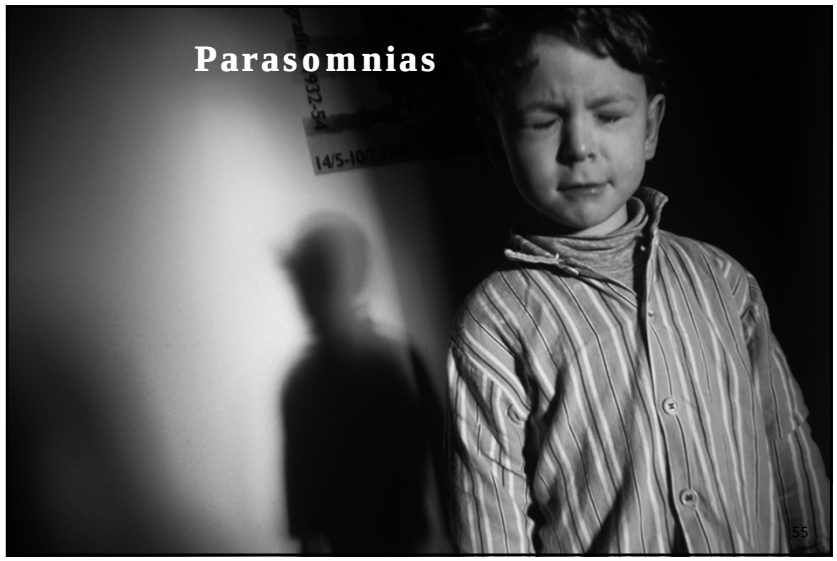
- Snoring: Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
- Tired: Do you often feel tired, fatigued, or sleepy during the daytime?
- Observed
- Blood Pressure

Chung et al (2008)

Sleep Apnea

Treatment

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



Parasomnias

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

Nightmare Disorder

DSM-5 CRITERIA

A. Repeated awakenings from the major sleep period or naps with detailed recall of extended and extremely dysphoric dreams

B. On awakening from the dysphoric dreams, the person rapidly becomes oriented and alert

C. Causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. Not a result of substance use

E. Not a result of another mental health disorder or 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

- May have a clear etiology in stress, illness or sleep deprivation
- Content is typically bizarre and includes efforts to escape
- Tend to occur in the second half of the sleep period
- Awaken alert and oriented

Trauma Nightmares

- Have a clear precipitating event – the trauma
- Content is typically related to the trauma (reenactment or emotion)
- Tend to happen in the first third of the night
- Awakened disoriented and confused

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?

Evidence-Based Treatments Non-Pharmocological

- Cognitive behavioral therapy (CBT)
  - Image rehearsal therapy (IRT) is recommended for treatment of nightmare disorder. **(Level A)**
  - Lucid dreaming therapy (LDT) may be considered for treatment for nightmare disorder. **(Level C)**
  - Exposure, relaxation and rescripting therapy (ERRT) may be considered for treatment of PTSD-associated nightmares.**(Level C)**
  - Sleep dynamic therapy may be considered for treatment of PTSD-associated nightmares. **(Level C)**
  - Self-exposure therapy may be considered for treatment of nightmare disorder. **(Level C)**
  - Systematic desensitization is suggested for treatment of idiopathic nightmares. **(Level B)**

Aurora et al. (2010)

Evidence-Based Treatments Non-Pharmocological (cont.)

- Progressive deep muscle relaxation training is suggested for treatment of idiopathic nightmares. **(Level B)**
- Hypnosis may be considered for treatment of PTSD-associated nightmares. **(Level C)**
- Eye movement desensitization and reprocessing (EMDR) may be considered for treatment of PTSD-associated nightmares.**(Level C)**
- The testimony method may be considered for treatment of PTSD-associated nightmares. **(Level C)**
- No recommendation is made regarding individual psychotherapy because of sparse data.

Aurora et al. (2010)

Differences between IRT and ERRT

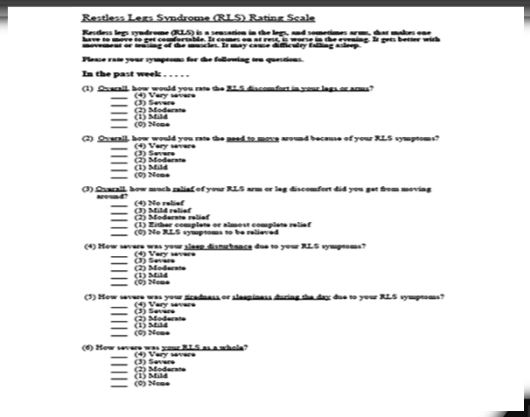
- Selection of nightmare
- Use of relaxation skills
- Use of exposure
- Guidance on changing the nightmare narrative

Krakow & Zadra (2006), Davis (2009)

RLS and PLMD

- Restless Leg Syndrome (RLS)
  - Crawling or aching feeling in legs
  - An inability to keep legs still
- Periodic Limb Movement Disorder (PLMD)
  - Leg twitches or jerks during the night
  - Waking up with cramps in legs
  - Bed partner report
  - Find covers all kicked off

Restless Legs Syndrome (RLS)



Restless Legs Syndrome (RLS) Rating Scale

Restless legs 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 gets better with movement or rubbing 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

Treatment for RLS & PLMD

Medications

- Pramipexole (Mirapex): 0.125-.5mg - 1x daily 2-3 hours before bed
- Ropinirole (Requip): 0.25-4mg – 1x daily 1-3 hours before bed

Other Interventions

- Moderate exercise (3x a week 30 minutes)
- Address any iron/vitamin deficiencies
- Avoid use of certain medications (i.e., neuroleptics, antiemetics, antihistamines, SSRIs)
- Treat comorbid conditions like insomnia with CBT-I
- Sleep hygiene (no alcohol, caffeine, or nicotine)

Aurora et al. (2012); Piegeon & Yurcheshen, (2009)

Recommended Reading

- Davis, J.L. (2009). Treating Post-Trauma Nightmares: A cognitive-behavioral approach. New York, New York: Springer Publishing Company.
- Krakow, B., &Zadra, A. (2006). Clinical management of nightmares: Imagery rehearsal therapy. *Behavioral Sleep Medicine*, *4*, 45-70.
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QUESTIONS?

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.

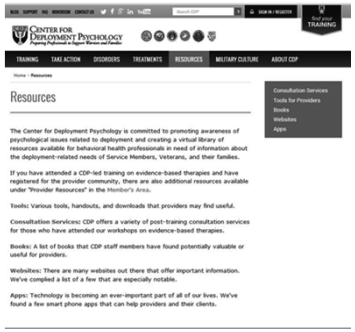
Provider Support

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 Disorders: An Overview of Sleep Disorders Common in Military Members

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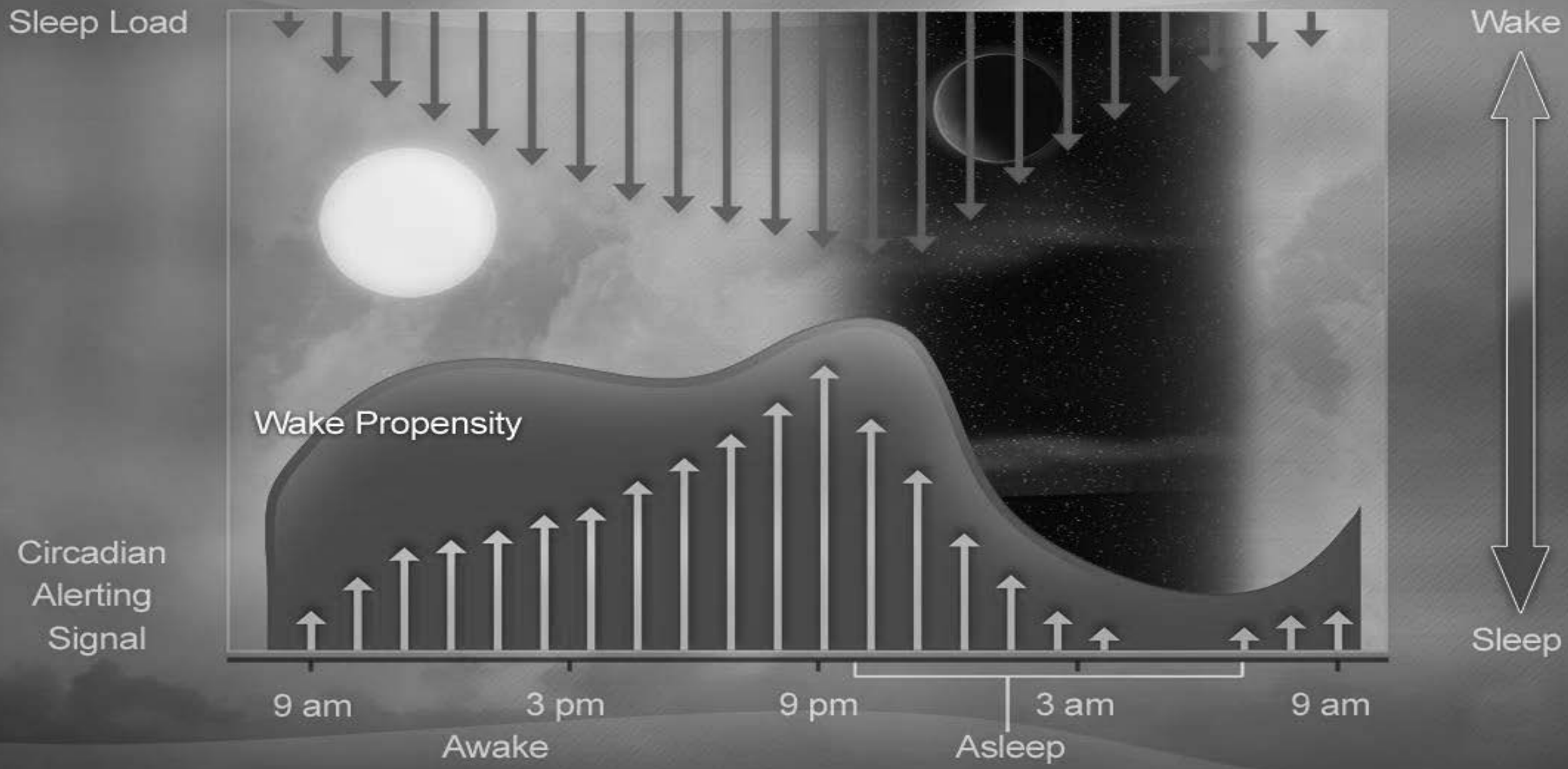
Circadian and Homeostatic Regulation of Sleep



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SLEEP QUESTIONNAIRE

Date: _____

This form asks questions about your sleep and factors associated with sleep problems, such as diet and stress. Please complete each question as accurately as possible. If you have any concerns about a question, make a note on this questionnaire beside the question and we will be sure to address your concern. If you are not requesting help from our service for a sleep problem, please do not complete this questionnaire and contact one of our personnel immediately. Thank you.

Section 1: Identifying Information

1. Name:_____
Last First Middle

2. Home Phone: _____ **2b. Address:** _____

3. Gender: ___Male ___Female _____

4. Date of Birth:_____ **5. SSN** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

6. Marital Status:
___Single
___Married
___Separated
___Divorced

7. Education:
___Less Than High School Diploma
___High School Diploma (or GED)
___Some College (no degree)
___Two Year Degree (e.g. A.S.)
___College Degree (4+ years)
___Some graduate work, no degree
___Advanced Degree (e.g., M.S., Ph.D)

8. Military Status:
___Active Duty
___Retired From Active Duty
___Dependent of Active Duty
___Dependent of Retired Member
___Other

9. Branch of Service:
___Air Force
___Army
___Navy
___Marines
___Other

10. Name of Spouse:_____ **10a. Age of Spouse:**_____

10b. Occupation of Spouse:_____ **10c. Date of Marriage:**_____

11. In the space below, list your children's names, ages, and sex

12. Active Duty Military Only: 12a. Rank: _____ **12b. Date of Separation:** _____

12c. Years of Service: ____ **12.d. Flight Status** ___**Yes** ___**No** **12e. SCI/PRP:** ___**Yes** ___**No**

12f. Present Duty Assignment:_____

12g. Organization:_____ **12h. Duty Phone:**_____

Section 2: In your own words, describe the problem(s) which brings you to our service:

_____

_____

_____

Section 3: Nature of Your Sleep-Wake Problem

1. Please rate the current severity of your sleep problem(s):

1a. Difficulty Falling Asleep	___No	___Mild	___Moderate	___Severe	___Very Severe
1b. Difficulty Staying Asleep	___No	___Mild	___Moderate	___Severe	___Very Severe
1c. Difficulty Waking Up Too Early	___No	___Mild	___Moderate	___Severe	___Very Severe

For questions 2 to 6, circle the number which corresponds to the answer you feel best fits your current sleep problem.

2. How satisfied/dissatisfied are you with your current sleep pattern?

Very Satisfied		Moderately Satisfied		Very Dissatisfied
1	2	3	4	5

3. To what extent do you consider your sleep problem to INTERFERE with your daily functions (e.g., daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)

Not At All	A Little	Somewhat	Much	Very Much
1	2	3	4	5

4. How NOTICEABLE to others do you think your sleeping problem is in terms of impairing the quality of your life?

Not At All	A Little	Somewhat	Much	Very Much
1	2	3	4	5

5. How CONCERNED are you about your current sleep problem?

Not At All	A Little	Somewhat	Much	Very Much
1	2	3	4	5

6. To what extent do you believe the following factors are contributing to your sleep problem?

	None		Some		Much
Cognitive disturbances (racing thoughts at night):	1	2	3	4	5
Somatic disturbances (muscular tension, pain):	1	2	3	4	5
Bad sleeping habits:	1	2	3	4	5
Natural aging process:	1	2	3	4	5

7. After a poor night's sleep, which of the following problems do you experience on the next day. Check all those that apply

Daytime fatigue: ___Tired ___Exhausted ___Washed out ___Sleepy

Difficulty functioning: ___Performance impairment at work/daily chores
___Difficulty concentrating, ___Memory difficulty

Mood problems: ___Irritable ___Tense ___Nervous ___Groggy ___Depressed
___Anxious ___Grouchy ___Hostile ___Angry ___Confused

Physical Symptoms: ___Muscle aches/pains ___Light-headed ___Headache
___Heartburn ___Muscle tension

8. How many nights each week do you have a problem with falling asleep? _____ nights

9. How many nights each week do you have a problem with staying asleep? _____ nights

10. On a typical night (over the past month), how long does it take you to fall asleep after you go to bed and turn the lights off? ____ hours ____ minutes

11. On a typical night, how long do you spend awake in the middle of the night? (total for all awakenings) ____ hours ____ minutes

12. What wakes you up at night? (check all that apply) ___Pain ___Child ___Lights
___Spouse ___Hunger ___Worries
___Noise ___Dreams ___Temperature
___Going to Bathroom ___Unknown

Section 4: Your Current Sleep-Wake Schedule

1. What is your usual bedtime on weekdays? _____ o'clock PM AM (circle PM or AM)
2. At what time do you last wake up in the morning? _____ o'clock PM AM (circle PM or AM)
3. When do you actually get out of bed on weekdays? _____ o'clock PM AM (circle PM or AM)
4. Do you have the same sleep-wake schedule on weekends? ___Yes ___No
5. If your sleep schedule changes on weekends, describe the changes: _____

_____

6. How often do you take naps (including unintentional naps)? _____ days/week
7. Do you ever fall asleep in inappropriate places? ___Yes ___No

   7a. If yes to above, where? (check all that apply): ___Work ___Driving ___Class ___Interesting TV ___Movies ___Church/Synagogue

8. How many hours of sleep per night do you usually get? ____ hours ____ minutes

Section 5: Medication Use, Diet, Exercise

1. In the past 4 weeks have you used *any* sleeping medication? ___Yes ___No
   1a. If yes, which medications? _____
   1b. Was this medication prescribed, over-the-counter, or both? _____
   1c. How many nights each week do you use the medication? _____nights
   1d. When did you *first* use sleep medication? _____
   1e. When did you *last* use sleep medication? _____
2. If you do not currently use sleep medication, have you ever used sleeping medication? ___Yes ___No
3. In the past 4 weeks, have you used alcohol as a sleep aid? ___Yes ___No
   3a. If yes, what type and how many ounces? Type: _____Amount: _____
   3b. How many nights each week? _____nights
4. Have you ever (at any time) used alcohol as a sleep aid? ___Yes ___No
5. How many alcoholic beverages to you drink each day? _____beverages
   5a. If you drink alcohol, what do you typically drink? _____

   _____

   5b. If you drink alcohol, how many drinks do you have after dinner? _____drinks

6. How many caffeinated beverages do you drink per day? _____beverages
7. What caffeinated beverages do you drink?

_____

8. Do you ever eat/snack after awakening during the night? ___Yes ___No
9. Do you smoke cigarettes? ___Yes ___No

9a. If Yes, how many cigarettes do you smoke after dinner? _____cigarettes

10. List all of the medications you currently take, the amount you take, and why you take them (list both prescribed and over-the-counter medications): _____

_____

_____

_____

11. How many times each week do you exercise, on average? _____times

11a. How long do you exercise at each occasion, on average? _____hours _____minutes

11b. What exercises do you typically do? _____

11c. Do you sometimes exercise close to bedtime? ___Yes ___No

Section 6: Your Bedroom Environment

1. Are you sleeping with a bed partner? ___Yes ___No
2. Is your mattress comfortable? ___Yes ___No
3. Is your bedroom quiet? ___Yes ___No
4. Do you have a TV in your bedroom? ___Yes ___No
5. Do you have a stereo or radio in your bedroom? ___Yes ___No
6. Is there a desk with paperwork to be done in your bedroom? ___Yes ___No
7. Do you have a computer in your bedroom? ___Yes ___No
8. Do you have exercise equipment in your bedroom? ___Yes ___No
9. Do you ever eat/snack in your bedroom? ___Yes ___No
10. Do you read in bed before bedtime? ___Yes ___No
11. What is your bed room temperature at night? ___Cool/Cold ___Warm/Hot ___Just Right/Comfortable

Section 7: Symptoms of Sleep Problems

During the past month, have you or your spouse ever noticed one of the following:

1. Crawling or aching feelings in your legs (calves) ___Yes ___No
2. An inability to keep your legs still ___Yes ___No

3. Leg twitches or jerks during the night ___Yes ___No
4. Waking up with cramps in your legs ___Yes ___No
5. Snoring ___Yes ___No
6. Pauses in your breathing at night ___Yes ___No
7. Choking at night ___Yes ___No
8. Gasping for air during the night ___Yes ___No
9. Morning headaches, chest pain, or dry mouth ___Yes ___No
10. Nightmares ___Yes ___No
11. Dream-like images (hallucinations) when awakening in the morning ___Yes ___No
12. Awakening from sleep screaming and confused ___Yes ___No
13. Sleepwalking ___Yes ___No
14. Sudden “attacks” of sleep during the day ___Yes ___No
15. Sudden muscular weakness in situations of strong emotions ___Yes ___No
16. Sour taste in mouth (heartburn or reflux) ___Yes ___No
17. Grinding your teeth at night ___Yes ___No
18. Rotating shift or night shift work ___Yes ___No
19. Feeling “panicked” during the night (heart pounding, anxious) ___Yes ___No
20. Nose blocking up (allergies, infections) at night ___Yes ___No

Section 8: Medical History

1. Please describe any medical problems you currently have (other than your sleep problem):

_____

_____

2. Have you had any recent hospitalizations or surgery? ___Yes ___No
3. Have you had any significant, recent weight gain or loss? ___Yes ___No
4. Are you currently being treated for a mental health problem? ___Yes ___No
5. Have you ever been treated for a mental health problem? ___Yes ___No
6. Have you ever been treated for an alcohol/substance abuse problem? ___Yes ___No
7. Has alcohol or any drug ever caused a problem for you? ___Yes ___No
8. What are the current stressors in your life? _____

_____

_____

TWO WEEK SLEEP DIARY

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)

Fill in the Day of the Week above each column

	Example ↓ M*on.*							
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							

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.

What is Traumatic Brain Injury (TBI)?

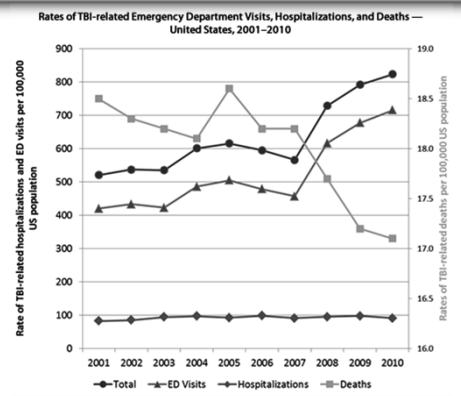
Definition of TBI

Any injury to the head that results in ***one or more*** of the following symptoms:

- 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

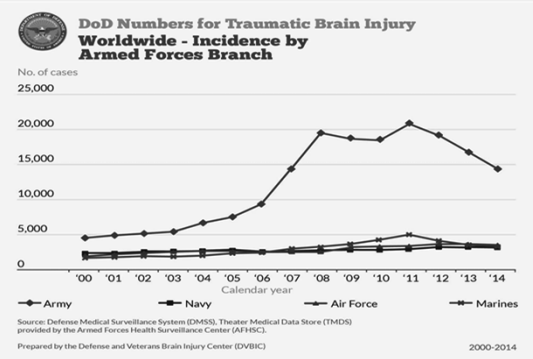
American Congress of Rehabilitation Medicine, (1993).

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

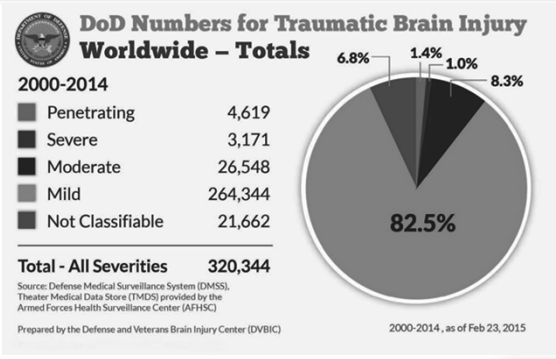


Centers for Disease Control and Prevention (2014)

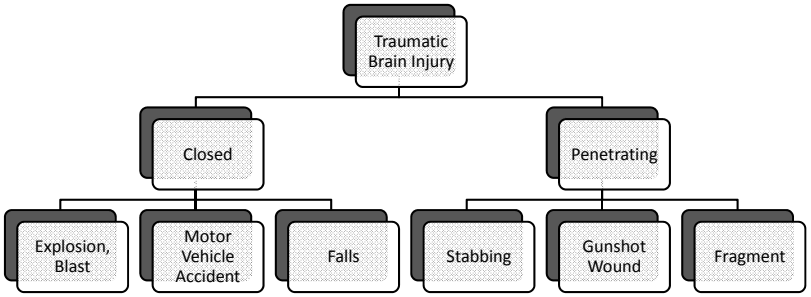
TBI Incidents by Branch of Service 2000 – 2014



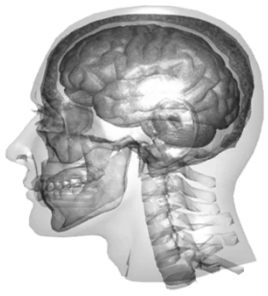
All Armed Forces – TBI 2000 – 2014



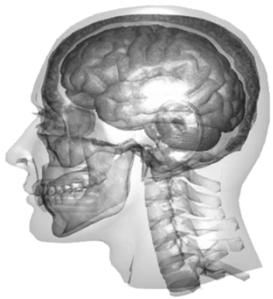
Mechanisms of Injury



Closed Brain Injury

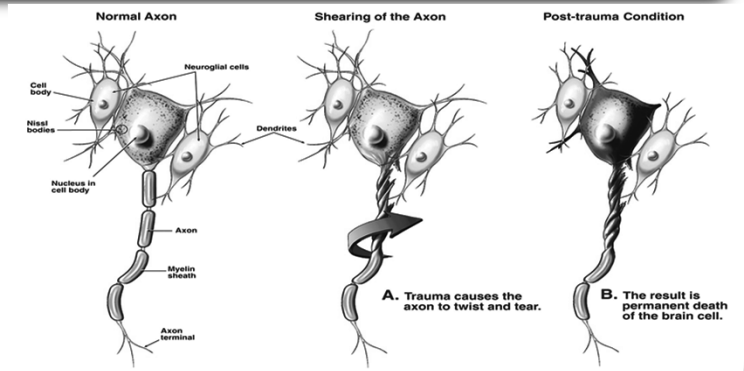


Diffuse Axonal Injury

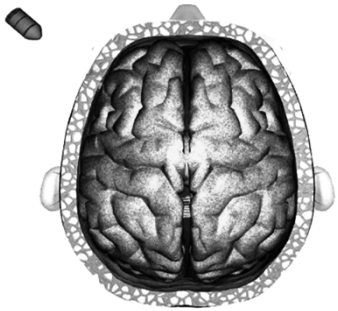


Contra Coup

Diffuse Axonal Injury (DAI)



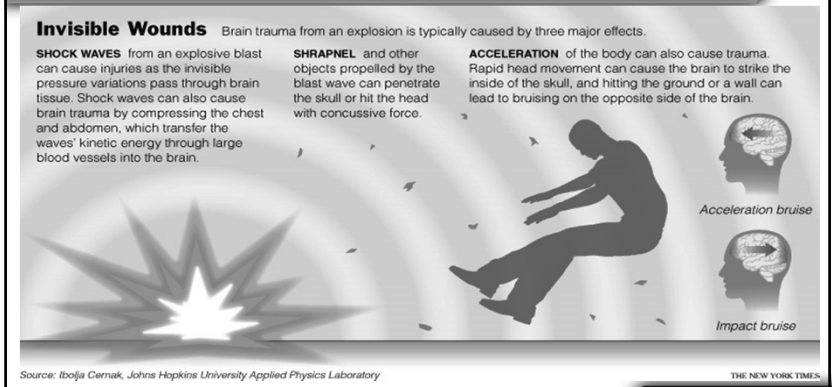
Penetrating Brain Injury



Mechanisms of Blast Injuries

- Primary
- Secondary
- Tertiary
- Quaternary

Blast Mechanism Overview



Primary Blast Injury

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

Primary Blast

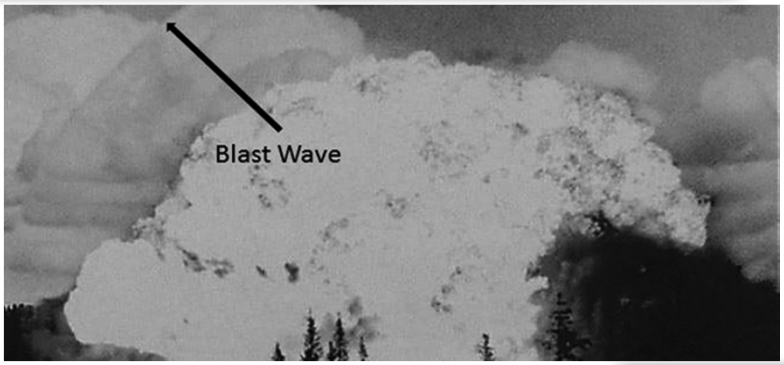


Photo by D.R. Richmond, US Army.
Public domain image: http://commons.wikimedia.org/wiki/File:Explosion-blast_wave.JPG

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

U.S. Marine Corps photo by Sgt. Bobby J. Yarbrough [illegible]

Tertiary Blast Injuries

- Body displacement by:
  - Overpressure
  - Shockwave
- Close to explosion
- Multiple fractures
- Head injuries
- Amputations

Quaternary or Miscellaneous Blast Injuries

- Collapsed structures
- Displaced heavy objects
- Smoke inhalation
- Burn injuries
- Complications from existing conditions

Neurocognitive Disorder: DSM-5

A: Decline in one or more cognitive domains:

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

The severity of cognitive deficits helps differentiate between ***Major*** and ***Mild*** Neurocognitive Disorder

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

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

D: Not better explained by another mental disorder

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

- 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 due to TBI

A: Criteria met for Neurocognitive Disorder

B: Evidence of a 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.

Predisposing NCD Risk Factors

- Psychiatric conditions
- Personality traits
- Medical conditions
- Intelligence level
- Demographic characteristics
- Coping abilities

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

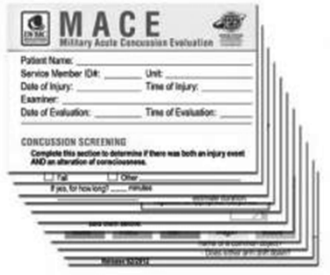
TBI Assessment Domains

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

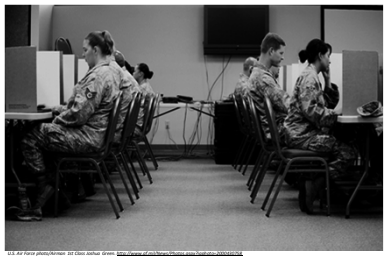
- Consider imaging results when determining level of severity
- Positive Imaging = at least a moderate TBI rating
- GCS not as useful given complications of theater setting
- Use of AOC in DoD severity rating

Concussion Screening

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



Pre-Deployment Testing: ANAM



U.S. Air Force photo/Airman 1st Class Joshua Green. http://www.af.mil/News/Photos.aspx?galleryid=2000419254

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

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

Lessons Learned: YouTube Meet David

http://youtube/txqiwrbYGrs

Accurate Diagnostic Factors

- Screening checklists
- Records review
- COC input
- Family/patient interview
- Concussion history
- Potential missed & misdiagnoses issues

Case Study Refresher: The Ramos Family

Case Study: Assessing for Exposure to Blasts and TBI-Related Symptoms

Intervention following 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
- Make referrals, as necessary

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, anger) 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

Complications with Clinical Course

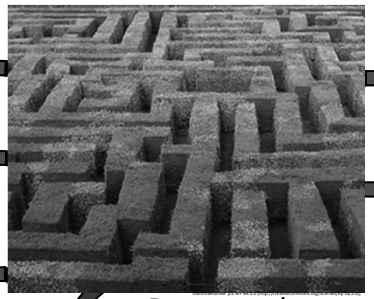
- Second impact syndrome (repeated mild concussion before full recovery)
- Multiple concussions (>2) over time → more morbidity and slower recovery
- "Invisible Injury"
  - Can adversely impact interpersonal relationships
  - Symptoms can be missed due to more apparent physical injuries
  - Comorbid emotional distress

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

What are common changes following a concussion?

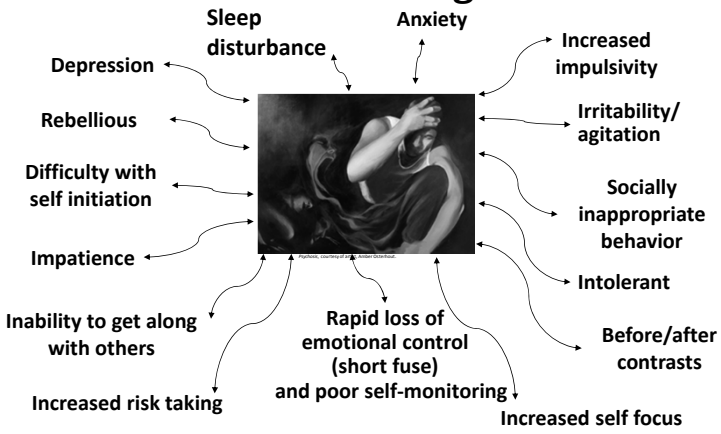
Thinking Changes in "Executive Functioning"



Thinking Changes

- Learning & memory
- Attention
- Processing speed
- Communication

Emotional, Behavioral, and Social Changes



Long Term Challenges Post TBI

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

TBI and DoD

Some controversies include:

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

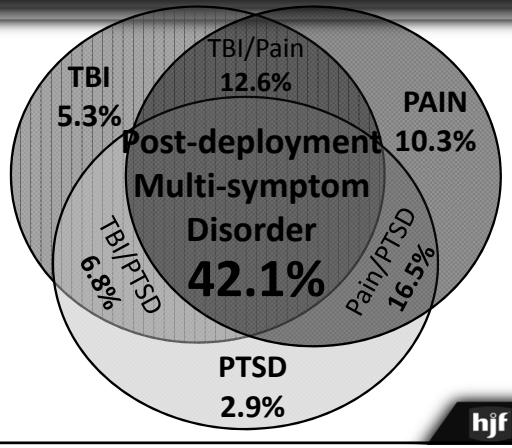
Hoge et al (2009), Coldren et al (2012), Roebuck-Spencer et al (2012)

Comorbid Conditions & TBI Overview

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

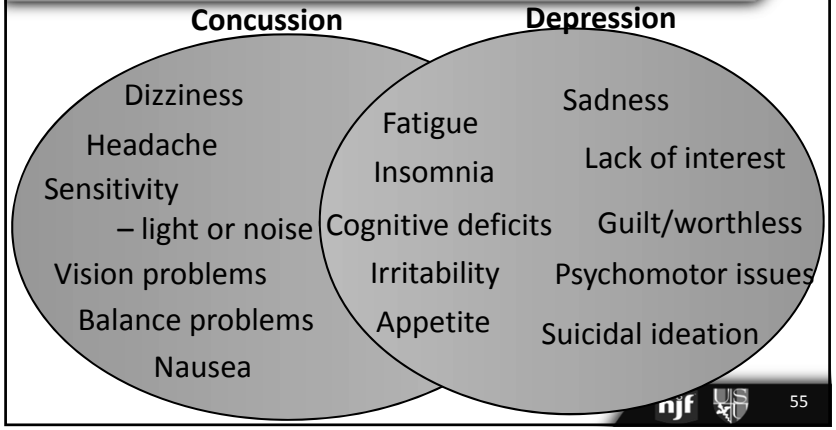
Post-Deployment Disorders

Sample = 340 OEF/OIF outpatients at Boston VA

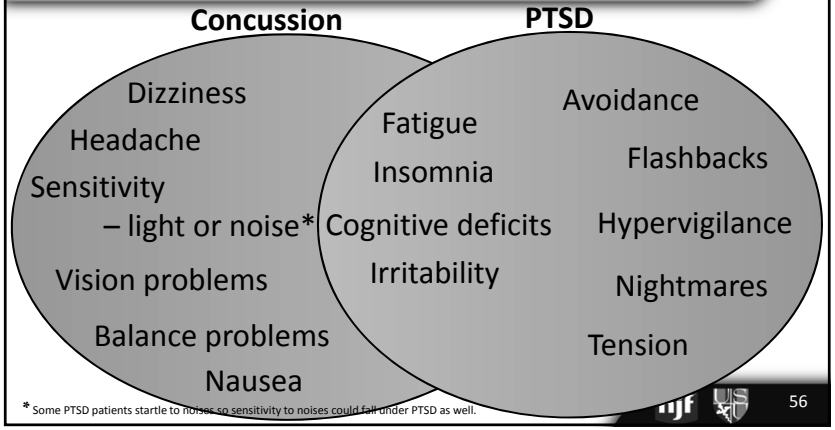


Clark (2009)

Concussion and Depression Overlap

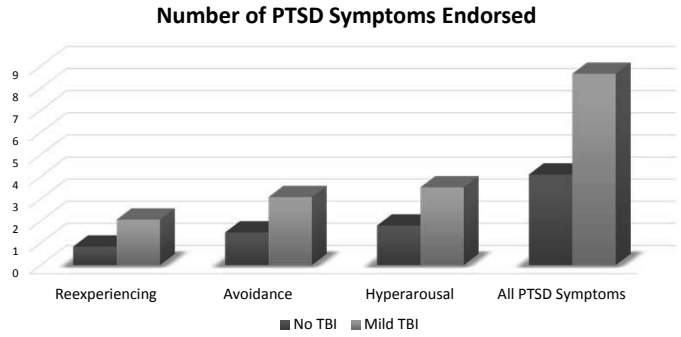


Concussion and PTSD Overlap



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

Concussion and Comorbid PTSD in OEF/OIF Veterans



Miles, Graham, & Teng (2015)

Concussion and Comorbid AUD in OEF/OIF Veterans

- Concussion diagnosis did not predict alcohol use disorder in men or women
- PTSD diagnosis predicted alcohol use disorder for men, but not for women

Miles, Graham, & Teng (2015)

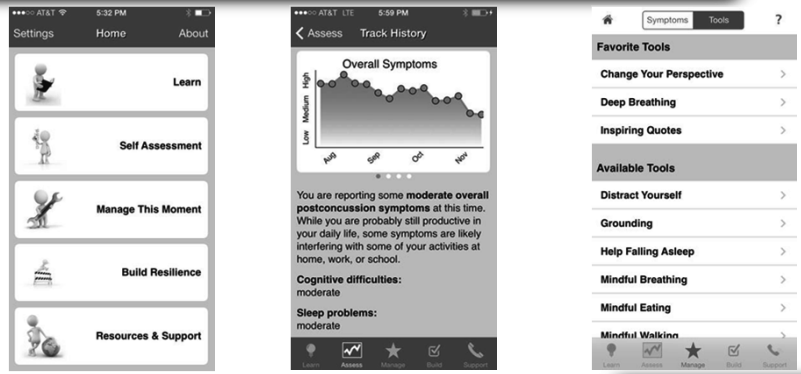
TBI Resources for

Patients, Families & Providers

Concussion Coach

- Mobile app for Veterans, Service members, and others
- For mild-to-moderate TBI
- Joint effort between
  - VA Rehabilitation and Prosthetic Services
  - VA National Center for PTSD
  - DCoE National Center for Telehealth & Technology (T2)

Concussion Coach

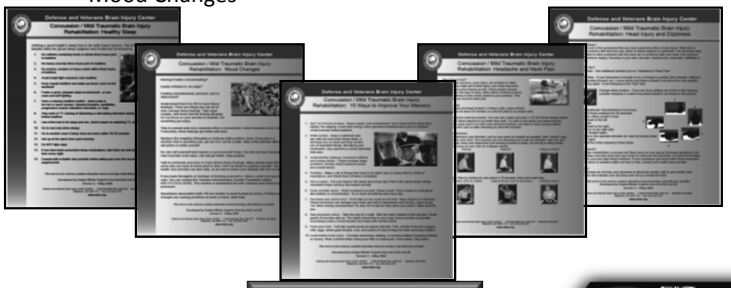


Available for download at: http://t2health.dcoe.mil/apps/ConcussionCoach

Resources

Concussion Symptom Management Patient Handouts

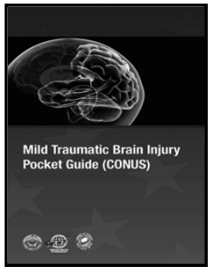
- Improving Memory
- Healthy Sleep
- Mood Changes
- Headache Management
- Head Injury and Dizziness

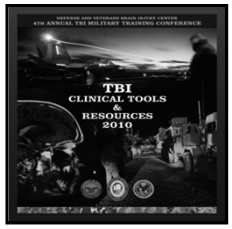


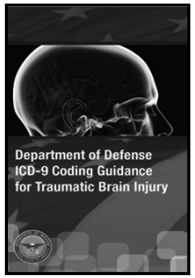
info@DVBIC.org

Products & Tools Available From DVBIC

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







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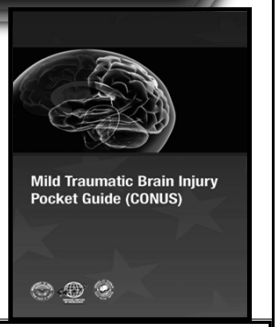
Mild TBI Pocket Guide

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

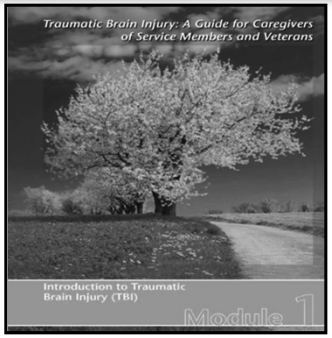
Providers, SMs & Families

- **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/The-Caregivers-Journey/Caregivers-Program-Introduction

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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Uniformed Services University of the Health Sciences
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Website: DeploymentPsych.org
Facebook: http://www.facebook.com/DeploymentPsych
Twitter: @DeploymentPsych

Overview of Traumatic Brain Injury (TBI) In the Military

References

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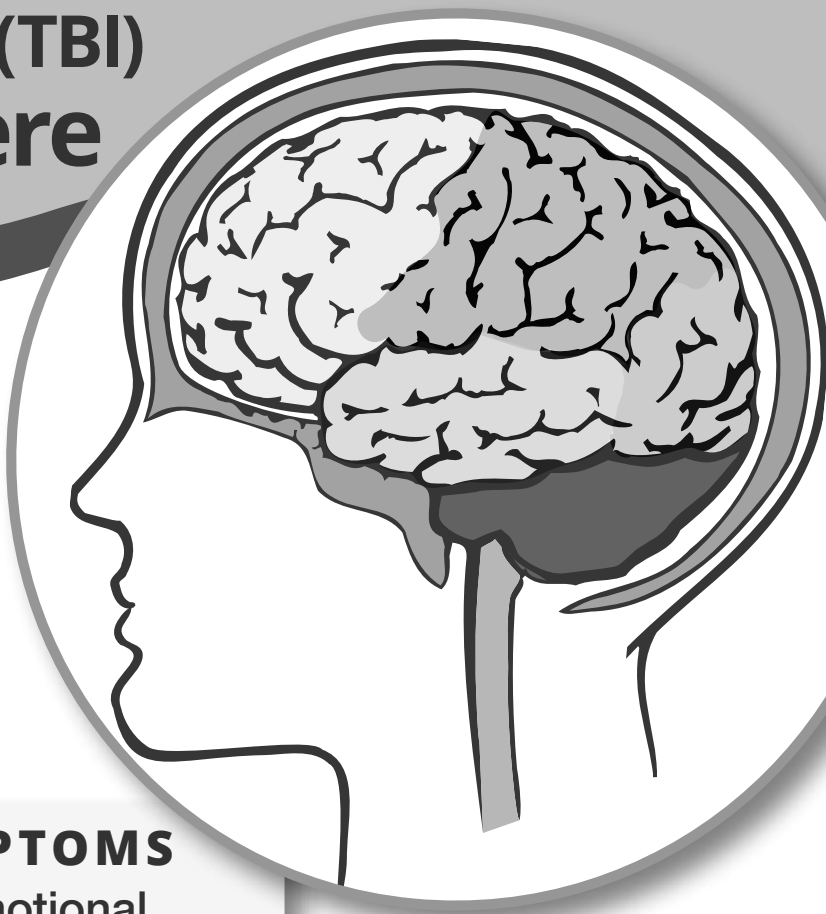
Traumatic Brain Injury (TBI)
Moderate or Severe



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 ★

DEFENSE CENTERS OF EXCELLENCE
For Psychological Health & Traumatic Brain Injury

Signs and Symptoms

Concussion/Mild Traumatic Brain Injury

DVBIC
Defense and Veterans Brain Injury Center

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.

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.

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

Feeling anxious
Feeling depressed
Irritability
Mood swings

U.S. Air Force photo by Airman 1st Class Matthew Flynn

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:

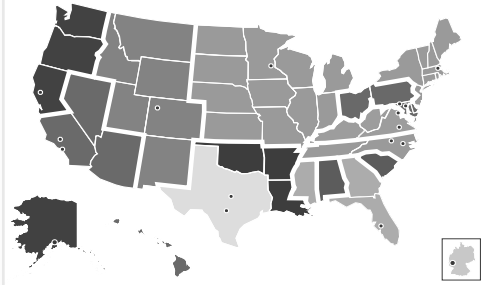
- Avoid smoking.
- Sit out of contact sports.
- Get enough sleep — 7 to 8 hours a night.
- Take medications as instructed.
- Avoid overexerting yourself physically or mentally.
- If you're concerned about your symptoms or if they're not improving, see your provider.
- Stay engaged with your family and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

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

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.

To find a point of contact in your region, please visit the DVBIC website.



DVBIC is proud to partner with the Army, Navy, Air Force, Marine Corps and Coast Guard on this product.

Do you have questions about this fact sheet? Feedback? Email info@dvbic.org.

CENTER FOR DEPLOYMENT PSYCHOLOGY

Preparing Professionals to Support Warriors and Families

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.

Alcohol and Substance Use within the Military Population

Center for Deployment Psychology
Uniformed Services University of the Health Sciences

Learning Objectives

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

Alcohol and Drug Treatment Programs within the Military:

A Historical Perspective

Office of the Under Secretary for Personnel and Readiness Report, rev. 2015

Military Alcohol & Drug Treatment Timeline

- **1960s** • With the Vietnam Era came the recognition of significant marijuana and heroin use among Service members.
- **June 1971** • President Nixon spearheads a military urinalysis program to identify returning Vietnam Veterans in need of rehabilitative services.
- **1972** • The DoD Amnesty Program was established and encouraged Service members to admit to having a drug problem so that they could get help.
- **April 1974** • DoD Directive 1010.1 is issued. This directive establishes random drug testing for active duty personnel. In spite of the instruction, the program does not see a reduction in drug use among Service members.

Military Alcohol & Drug Treatment Timeline (continued)

- **May 1981** • An significant aircraft incident aboard the USS Nimitz brings military drug use to the news headlines and highlights the danger and possible losses caused by off-duty drug abuse.
- **Dec 1981** • Deputy Secretary of Defense mandates punitive recourse, including court martial or administrative separation for military drug use.
- **Dec 1983** • It is found that drug testing procedures are flawed. 10,000+ Service members who were wrongly discharged are offered reparations.

Military Alcohol & Drug Treatment Timeline (continued)

- **1985** • DoD Survey of Health Related Behavior Among Military Personnel revealed that 8.9% of Service members used an illegal drug within the past 30 days.
  • Subsequent DoD HRBAMPs will consistently show a decrease in illicit drug use.
- **Sept 1986** • President Reagan mandates random drug testing for all government employees.
- **Oct 2003** • The DoD Drug Demand Reduction policy implements a “Zero Tolerance” policy for SMs. All prohibited use will result in administrative separation.

Military Alcohol & Drug Treatment: The Beginning

- Vietnam Era and Amnesty Act of 1972
- In 1972, the Dept. of the Navy established the first long-term drug and alcohol treatment program known as SARP (Substance Abuse and Rehabilitation Program)
  - SARP would become the model for the Betty Ford Clinic

About the 2013 IOM Report:

- Reviewed information about substance use disorders in the armed forces
- Populations examined included active-duty, National Guard, Reserves and military dependents
- Compared all information with best practices and modern standards of care in scientific literature

Institute of Medicine (2013)

Committee Offered 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)

Substances Used and Prevalence of Substance Use Problems

What Substances Are Used?

- Alcohol
- Tobacco
- Marijuana
- Opioids
- Stimulants

NIDA (2013)

General Population Prevalence of Substance Use

Type of Substance	Current Use*
Alcohol (Binge Drinking)	56.4% (24.6%)
Any Nicotine (Cigarettes)	25.5% (21.3%)**
Illicit Drugs	9.4%
Prescription Drug Misuse	2.5%
Misuse of Pain Relievers	1.7%

*Current Use: Reflects % of individuals who used substance in past 30 days; individuals included in the sample were 18+ years unless otherwise noted

**Nicotine/Cigarette Current Use Rates: Individuals included in this sample were 12+ years, so these rates likely underestimate adult nicotine/cigarette use rates.

SAMHSA (2014)

Active Duty Prevalence of Substance Use

Type of Substance	Current Use*	Past-Year
Alcohol Use (Binge Drinking)	84.5% (33.3%)	-
Any Nicotine (Cigarettes)	(24%)	49.2%
Illicit Drugs	0.3%	1.4%
Prescription Drug Misuse	-	1.3%
Misuse of Pain Relievers	-	0.8%

*Current Use AD SMs: Used substance in the past 30 days.

"-" designates data not included in the report

Barlas et al. (2013)

Ramos Case Video

Prevalence of SUDs Among Veterans

- 1 in 15 Veterans had a SUD in past year
- Veterans of OEF/OIF
  - 10% Alcohol use disorder
  - 5% Drug use disorder
  - 3% Both
- Up to 40% of OEF/OIF Veterans report alcohol misuse
- Less substance misuse among female veterans

Burnett-Zeigler et al. (2011); Calhoun et al. (2008); Cohen et al. (2015); … References continue in handouts

Military Risk Factors for SUDs

- Combat exposure→ higher alcohol use
- Multiple deployments →
  - binge/heavy drinking
  - alcohol/drug problems
  - start/relapse smoking
  - more behavioral health medications

U.S. Air Force photo by Tech. Sgt. Nadine Barclay (released)

- Reserve component → higher rates of AUDs

Brancu et al. (2011); Cohen et al. (2015); Larson et al. (2012); Ong et al. (2008); Spera et al. (2010)

Alcohol Use in the Military

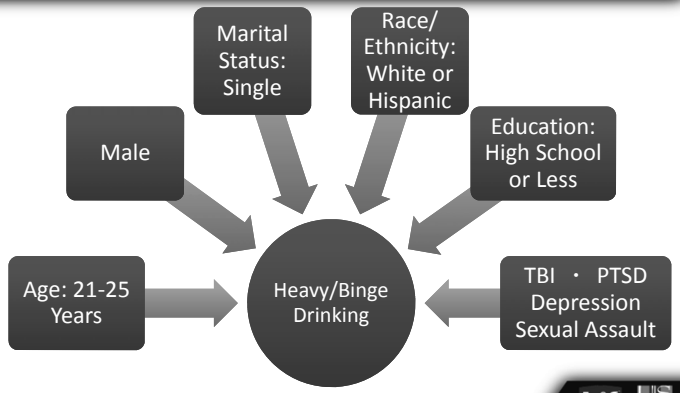
- Military alcohol use > civilian alcohol use

Drinking Behavior	Civilian	Military
Heavy Drinking (Past 12 Months)	5.1%	8.8%
Binge Drinking (Past 30 Days)	28.3%	33.3%

- 40% of current drinkers reported binge drinking
- Equal numbers of active duty M/F "heavy drinkers"
- <1% using/planning to seek treatment

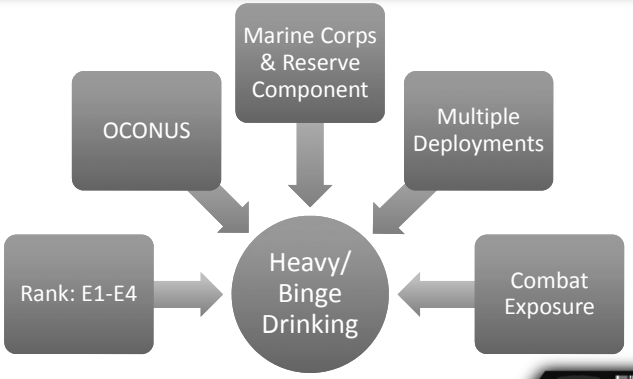
Barlas et al. (2013); Bray et al. (2009); Bray et al. (2010); IOM (2013); Jacobson et al. (2008); Mattiko et al. (2011); SAMHSA (2014)

General Risk Factors for Heavy/Binge Drinking Among AD



Barlas et al. (2013); Cucciare et al. (2011); Debell et al. (2014); Johnson et al. (2015); Marshall et al. (2012)

Military-Specific Risk Factors for Heavy/Binge Drinking



Barlas et al. (2013); Brancu et al. (2011); Bray et al. (2009); Cohen et al. (2015); References continue in handouts

Why Drink in the Military?

- Military culture
- Availability & low cost
- Top 5 reasons according to AD SMs:
  1. To celebrate
  2. Enjoyment of drinking
  3. To be sociable
  4. To cheer up
  5. To forget problems

Ames & Cunradi (2004); Ames et al. (2009); Barlas et al. (2013); IOM (2013); Jacobson et al. (2008); Thomas et al. (2010)

Tobacco Use in the Military

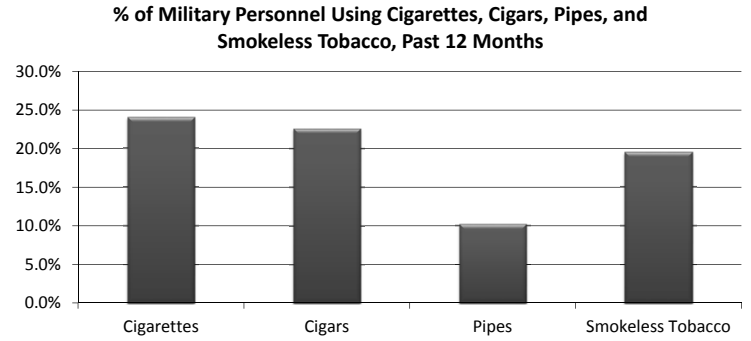
- Military tobacco use > civilian tobacco use

Smoking Behavior	Civilian	Military
Current Cigarette Smokers	21.2%	24.0%

- Higher rates of heavy smokers among:
  - Males
  - White, non-Hispanic
  - Individuals with HS education or less
  - Marine Corps
  - Deployed Service members

Bray et al. (2010); Hermes et al. (2012); IOM (2013); Larson et al. (2012); Little et al. (2015); Smith et al. (2008); Talcott et al. (2013)

Percent of Military Personnel Using Tobacco Products



Barlas et al. (2013)

Why Smoke in the Military?

- Military culture and history
- Cope with stress, boredom, sleep problems
- "Dangers of smoking are nothing compared to combat"
- Socially acceptable on deployment
- Something to do while drinking

Ames & Cundradi (2004); Ames et al. (2009); Barlas et al. (2013); Conway (1998); References continue in handouts

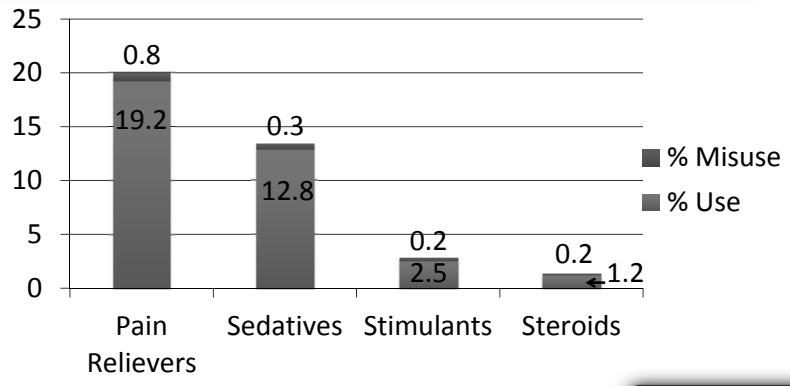
Prescription Drug Misuse Military vs. Civilian

Category of Misused Drug, Past 12 Months	Civilian*	Military**
Any Prescription Drug Misuse	7.3%	0.8%
Pain Relievers	-	0.8%
Sedative/Tranquilizer	-	0.6%
Stimulant	-	0.3%

*Civilian data are from the SAMHSA 2010 National Survey on Drug Use and Health
**Military data are from the 2011 Health Related Behaviors Survey of AD Military Personnel

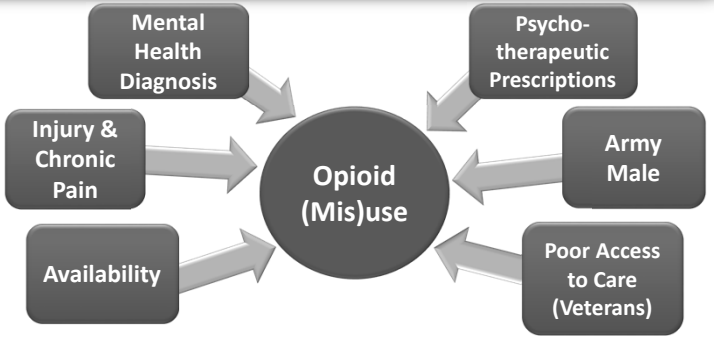
Barlas et al. (2013); SAMHSA (2011, 2014)

Prescription Drug Use and Misuse in the Military



Barlas et al. (2013)

Prescription Opioid Misuse in the Military



Barlas et al. (2013); Bray et al. (2009); Helmer et al. (2009); Sharpe Potter et al. (2014); SAMHSA (2014); Zoroya (2010)

Assessment and Diagnosis of Substance Use Disorders

DSM-5 Criteria for SUD Diagnosis

"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 Criteria

Impaired Control	Use of larger amounts/over longer time than intended
	Desire/unsuccessful efforts to cut down or control use
	Much time spent trying to obtain, using, recovering from effects
	Experience strong desires, urges, or cravings
Social Impairment	Results in failure to fulfill major obligations at work, school, or home
	Continued use despite causing or exacerbating persistent or recurrent social/interpersonal problems
	Important social, occupational, or recreational activities are given up/reduced
Risky Use	Recurrent use in physically hazardous situations
	Continued use despite knowing it likely causes or worsens physical or psychological problems
Pharmacological Criteria	Use greater amounts to achieve intoxication or desired effect, or affected less by same amount
	Experience withdrawal symptoms or use to relieve or avoid withdrawal symptoms

American Psychiatric Association (2013)

Screening for SUDs within a Military/Veteran Context

- Identify persons at-risk & currently using
- Brief, consistent, and evidence-based
- May include:
  - Self-report
  - Laboratory tests
- Population-based self-report screening:
  - Alcohol & Tobacco: strongly recommended
  - Other substances: not supported

Fiore et al. (2008); Hawkins et al. (2012); Management of Substance Use Disorders Working Group (2009)

Screening for Tobacco Use

- Assess frequently
- Evaluate current/past use
- Advise users to quit
- Assess willingness to quit

Fiore et al. (2008); Hawkins et al. (2012)

Screening for Alcohol Use Disorders

- Annual
- Use evidence-based tools
- Identify contraindications for alcohol use
- Include assessment of current consumption

Management of Substance Use Disorders Working Group (2009)

% Alcohol Content by Volume

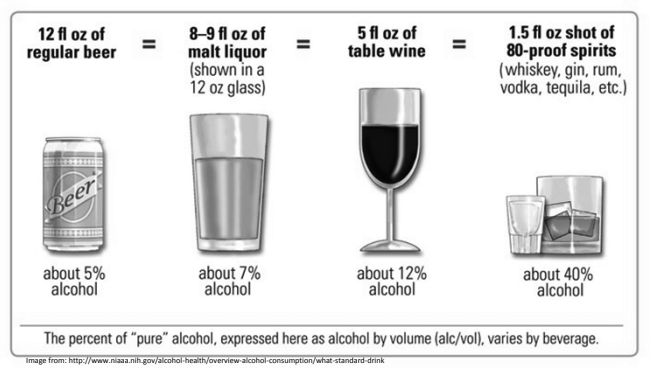


Image from: http://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/what-standard-drink

1 standard drink = 1 gm absolute ethanol

Recommended Alcohol Use Limits

For Men ≤ 65 Years of Age	For Women and Individuals >65 Years of Age
No More Than: • 4 standard drinks in a day • 14 standard drinks in a week	No More Than: • 3 standard drinks in a day • 7 standard drinks in a week

NIAAA (2015)

Alcohol-Related Screening Tools

- Alcohol Use Disorders Identification Test Consumption Questions (AUDIT-C)
- Single-Item Alcohol Screening Questionnaire (SASQ)
- Other Evidence-Based Screeners:
  - Alcohol Use Disorders Identification Test (AUDIT-10)
  - CAGE
  - Michigan Alcohol Screening Test (MAST)

Bradley et al. (2006, 2007); Management of Substance Use Disorders Working Group (2009); References continue in handout

AUDIT-C

How often do you have a drink containing alcohol?				
❑Never	❑Monthly or less	❑2-4 x per month	❑2-3 x per week	❑4+ x per week
How many standard drinks containing alcohol do you have on a typical day?				
❑1 or 2	❑3 or 4	❑5 or 6	❑7 to 9	❑10+
How often do you have 6 or more drinks on one occasion?				
❑Never	❑Less than monthly	❑Monthly	❑Weekly	❑Daily/ almost daily

Bradley et al. (2007)

Single-Item Alcohol Screening Questionnaire (SASQ)

Do you sometimes drink beer, wine, or other alcoholic beverages?

How many times in the past year have you had…

5 or more drinks in a day (men)

4 or more drinks in a day (women)

Response of 1 or more → unhealthy drinking

Smith et al. (2009); US DHHS (2005, Updated Edition)

Identification of Service Members with Other SUDs

- Urine drug screening
- DUI or other substance-related incident
- Command- or incident-based referral
- Self-report/self-referral
- Regular screening in high-risk populations

IOM (2013); Management of Substance Use Disorders Working Group (2009)

Substance Use Screening Tools

- Alcohol, Smoking, & Substance Involvement Screening Test (ASSIST V3.0)
- Drug Abuse Screen Test-10 (DAST-10)
- CAGE-AID
- Screener and Opioid Assessment for Patients with Pain (SOAPP/SOAPP-R)
- Opioid Risk Tool (ORT)

Butler et al., (2004, 2008, 2009); Couwenbergh et al. (2009); Hinkin et al. (2001); References continue in handouts

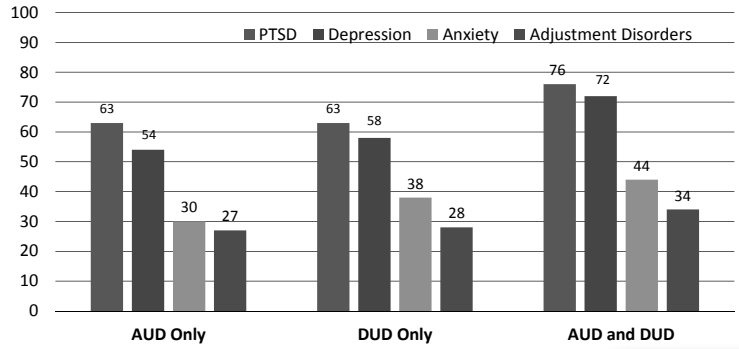
When to Refer to Specialty Care

- Unable to change alcohol/tobacco/other substance use
- Prior diagnosis/treatment & continued use
- AUDIT-C score ≥8
- Incident with possible substance involvement
- Medical stabilization is needed
- Ready to change

IOM (2013); Management of Substance Use Disorders Working Group (2009)

Co-Occurring Physical and Mental Health Conditions

SUDs & Co-Morbidities: Depression, Anxiety, & PTSD



Seal et al (2011)

SUDs & Sleep

- Alcohol use is <u>problematic</u> for sleep

	Sleep Onset Latency	Deep Sleep	REM Sleep	Other
Acute Use	Decreases	Increases	Fragments	
Chronic Use	Increases	Decreases 'power'	Decreases	Decreases sleep time
Withdrawal	Increases	Decreases	Increases ("Rebound")	

- Marijuana use <u>may be problematic</u> for sleep

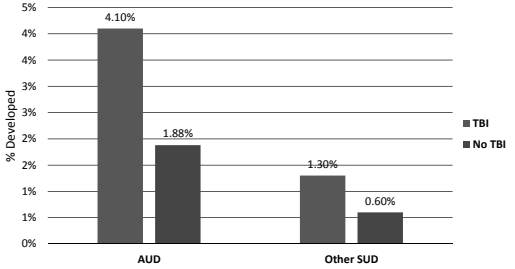
Subjective Perception
Decreased sleep onset latency

Objective Measurement
No change, or
Increased sleep onset latency / problems staying asleep

Conroy & Arnedt (2014)

SUDs & TBI

- Alcohol and other substances contribute to brain tissue atrophy, poorer cognitive performance



- Service members with TBI have a greater rate of SUD development within a year vs without TBI

Those who incurred TBI while deployed significantly less likely to develop a substance use disorder

West (2011); Johnson et al (2015)

SUDs & Chronic Pain

- Increasingly treated with long-term opioid therapy

Who is Prescribed Long Term Opioid Therapy?

MH History: 3-4x More Likely

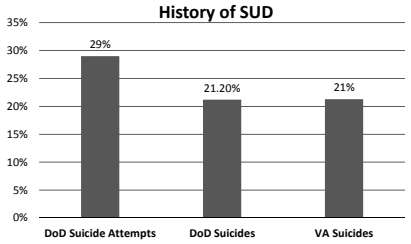
SUD History: 4-5x More Likely

- When opioids used as prescribed, physiological dependence will occur and must be distinguished from addiction/use disorder
- Discontinuing problematic substance use is more difficult when comorbid pain is present

Sullivan & Howe (2013); Zale et al (2015)

SUDs & Suicide

- Among VA-enrolled Veterans
  - –Males with any SUD history are 2.27 times more likely to die by suicide than those without
  - –Women with any SUD history are 6.62 times more likely to die by suicide than those without



Ilgen et al (2010); 2013 DoDSER Annual Report

Treating SUDs & Comorbidities

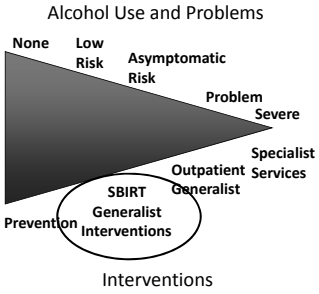
- Bottom Line
  - –Concurrent treatment recommended for:
    - PTSD
    - Sleep
    - Chronic Pain

Substance/Alcohol Use Disorders treatment ⟷ **Comorbidity treatment**

  - –Concurrent treatment needs further study for TBI

Trends and Guidelines for Treating SUDs: Brief Interventions & VA/DoD Guidelines

Trends in SUD Treatment



- Implement a stepped care approach
  - –Use less intensive settings first
  - –Provide brief SUD intervention in primary care
- Tackle smoking cessation as part of SUD treatment
- Use of web-based social networks, phone applications, and gaming approaches to facilitate engagement

Image adapted from IOM (1990); Citation: Sobell & Sobell (2000).

SBIRT: Screening, Brief Intervention, Referral to Treatment

S

1. If substance use suspected, provide screening

B

2. Express concern that the patient is drinking/using at unhealthy levels
3. Give feedback linking alcohol/substance use to medical, social, or mental health consequences
   - – Where relevant, personalize feedback to patient's specific medication conditions (e.g., depression, PTSD, insomnia, hypertension, diabetes)

I

R

4. Support the patient in choosing a drinking goal if he/she is ready to make a change

T

5. If appropriate, offer referral to specialty SUD care
6. Repeat as necessary

Hawkins et al (2012)

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

NIAAA (2005); VA/DoD Management of Substance Use Disorders CPG, (2009)

Web-based Social Media Interventions

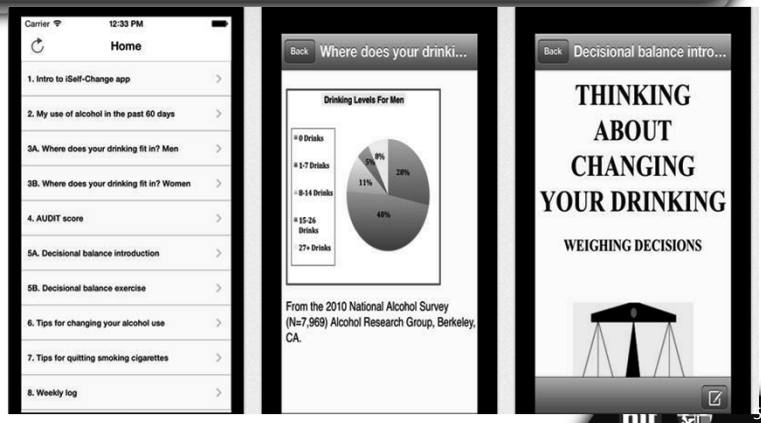
iSelfChange App

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

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

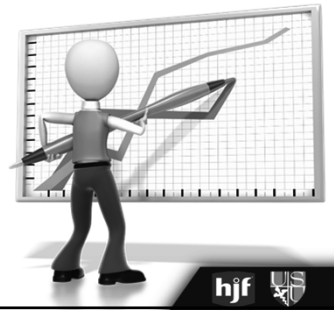
Mirtenbaum et al. (2013)

iSelfChange Screenshots and Menu



VA/DoD Clinical Practice Guideline: Psychotherapy

1. **Use EBPs:** Initiate addiction-focused psychosocial interventions with empirical support



VA/DoD Management of Substance Use Disorders CPG (2009)

VA/DoD Clinical Practice Guideline: Psychotherapy

2. Use Concurrent Treatment of Comorbidities:
Addiction-focused psychosocial interventions should be coordinated with evidence-based intervention(s) for other biopsychosocial problems to address identified concurrent problems

VA/DoD Clinical Practice Guideline: Psychotherapy

3. Consider the Setting:
Intervention should be provided in the least restrictive setting necessary for safety and effectiveness

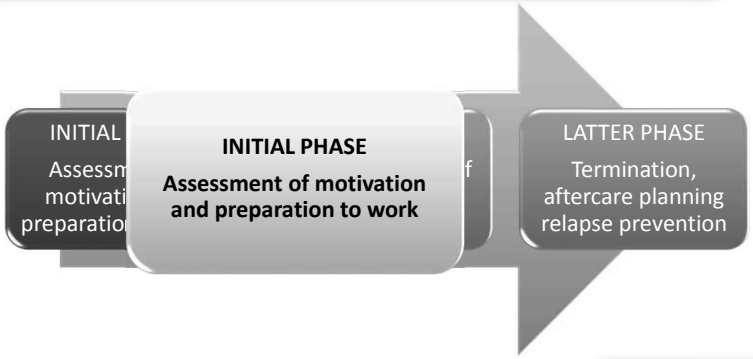
VA/DoD Clinical Practice Guideline: Psychotherapy

4. Use an MI Approach:
Motivational Interviewing (MI) techniques and style should be used in SUD treatment sessions. Confrontational counseling styles should generally be avoided.

VA/DoD Clinical Practice Guideline: Pharmacotherapy

- **Addiction-focused pharmacotherapy should be considered**, available and offered if indicated, for all patients with opioid and/or alcohol dependence.
- **Established pharmacologic treatments**, combined with addiction-focused counseling, **may reduce** the amount of drinking, the risk of relapse, the number of days of drinking, and craving in some alcohol-dependent individuals.

What a Standard Course of Treatment Might Look Like:



What is Motivational Interviewing?

- Often thought of as an intervention, but it is NOT a treatment
- 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

Tomlin and Richardson, 2004; Galanter and Kleber, 2008

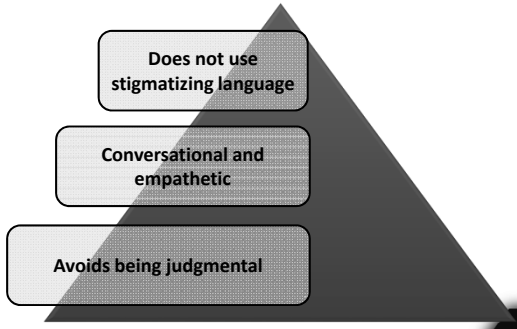
Benefits of Using a Motivational Interviewing Approach

- Significantly reduced health care costs
- Increased compliance with medication and treatment recommendations
- Improved outcomes
- Greater patient satisfaction

Lundahl, B.W., Kunz, C., Brownell, C., Tollefson, D. et. Al. (2010)

Motivational Interviewing

A Different Way of Talking with People that Uses a Specialized Set of Communication Skills



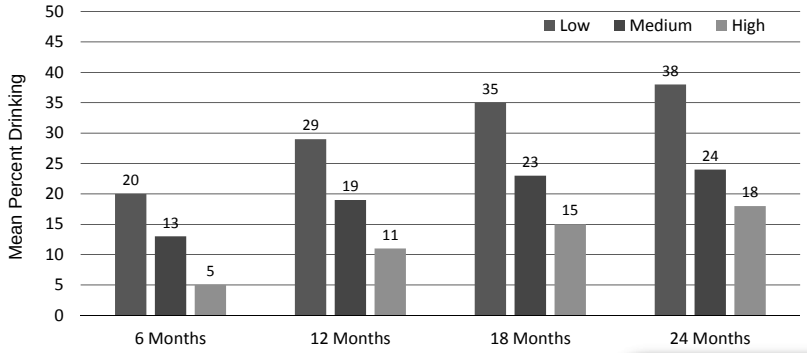
Motivational Interviewing in Action

Empathy: Key Feature In Motivational Approach

- **WHY?** High levels of empathy associated with positive outcomes
- Key to expressing empathy through **Reflective Listening**
- Listening in a reflective manner demonstrates an understanding of patients and validates their concerns

Miller and Rollnick, (2012); Moyers et al (2013); Tomlin and Richardson (2004)

Low Therapist Empathy is Toxic



Valle (1981); Moyers and Miller (2013); Miller and Rollnick (2012); Smith and Junquing (2014)

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)

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

Miller and Rollnick (2012)

What a Standard Course of Treatment Might Look Like:

INITIAL PHASE

Assessment of motivation and preparation to wor

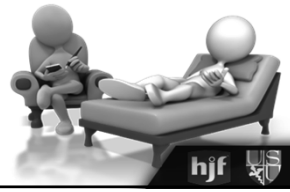
MIDDLE PHASE

Use of one or >1 of the listed interventions

LATTER PHASE

Termination, aftercare planning relapse prevention

Evidence-Based Treatments for SUDs



Evidence-Based Treatments for SUDs

- **Motivational Enhancement Therapy (MET)**
- **Cognitive Behavioral Therapy (CBT)**
- **Behavioral Couples Therapy (BCT)**
- **12-Step Facilitation Therapy(TST)**
- Contingency Management
- Community Reinforcement and Family Training (CRAFT)
- Family Systems Approach
- Methadone/Pharmacological Maintenance

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

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)

Motivational Enhancement Therapy (Continued)

Session 1	• Rapport building • Building the motivation to change
Session 2	• Strengthen the patient's desire to change • Create a plan or action for desired change
Session 3	• Review recovery progress • Renew motivation and commitment

Miller, W.R., Zweben, A., DiClimente, C.C. and Rychtarik, R.G.; Mattson, M. (ed.) (1995)

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

Galanter and Kleben (2008); Hawkins et al. (2012); Miller, Zweben and Johnson (2005)

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)

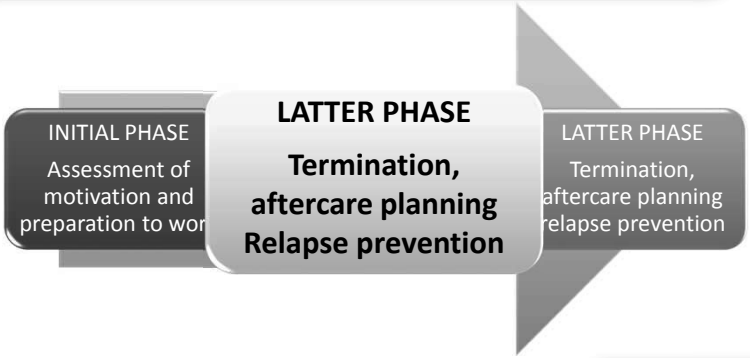
12-Step Facilitation Treatment

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)

What a Standard Course of Treatment Might Look Like:



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)

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)

DoD and VA Substance Abuse Programs

DoD Programs

- **Army:** Army Substance Abuse Program (ASAP)
- **Navy/Marine Corps:** Substance Abuse Rehabilitation Program (SARP)
- **Air Force:** Alcohol and Drug Abuse Prevention and Treatment (ADAPT)

VA Programs

- VA Substance Abuse Residential Rehabilitation Treatment Programs (SARRTP)
  - 28-Day Intensive Inpatient Program
  - 6-month Domiciliary Program
  - Intensive Outpatient Day Program
- Community Transitional Living Options (usually supported for up to 24-months):
  - Halfway House/Oxford House
  - Transitional Living Facility

Purpose of Treatment

- For Service members:
  - –To return the Service member to full operational duty
  - –To maintain the safety of the fleet, wing, battalion, unit
- For Veterans:
  - –To improve outcomes such as substance cessation or reduction, improve health and quality of life

Aspects of DoD Programs

- Command notification
- Limited protection for self-disclosure of alcohol disorder
- First alcohol-related incident does not typically result in separation
  - Multiple incidents or incidents during active treatment may
- Drug use disorder diagnoses result in initiation of separation proceedings and possible enrollment in treatment

DoD Prevention Campaigns

- Red Ribbon Week
  - –Annually in October
  - –Targets young military families
- 101 Critical Days of Summer
  - –Among multiple elements, includes alcohol and motor vehicle safety information
- That Guy

U.S. Navy photo by Trice Denny/Released

"That Guy" Video

www.thatguy.com

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

Online Resources

- Tricare Substance Use Disorder Coverage Information: http://www.tricare.mil/CoveredServices/IsItCovered/SubstanceUseDisorderTreatment.aspx
- Southeastern Consortium for Substance Abuse Treatment (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. http://sbirtonline.org/toolkit
- National Institute on Alcohol Abuse and Alcoholism (NIAAA): Resources and publications on alcohol use and alcohol-related problems http://www.niaaa.nih.gov/publications
- NIAAA Clinician's Guide http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm
- National Institute on Drug Abuse (NIDA): Resources and publications on drug use and drug-related-problems http://www.drugabuse.gov/publications/media-guide/nida-resources
- Substance Abuse & Mental Health Services Administration (SAMHSA): http://www.samhsa.gov
- SAMHSA publications http://store.samhsa.gov/facet/Substances
- 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
- National SBIRT ATTC Suite of Services http://ireta.org/toolkitforsbirt
- Rethinking Drinking: Alcohol and Your Health http://rethinkingdrinking.niaaa.nih.gov/
- 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

Links to Screeners

- Link to the NIDA QuickScreen questions and NIDA Modified ASSIST V2.0 (a modified version of the Alcohol, Smoking and Substance Involvement Screening Test developed by the World Health Organization) http://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf

- Link to NIDA version of the Drug Abuse Screening Test (DAST-10)
  https://www.drugabuse.gov/sites/default/files/files/DAST-10.pdf
- Link to the NIDA version of the Opioid Risk Tool (ORT)
  https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf
- The Screener and Opioid Assessment for Patients with Pain (original and revised versions: SOAPP and SOAPP-R are available)
  http://www.painedu.org

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Substance Abuse Medication Information

There are three main functions that can be served by medications to help treat substance use disorders.

1) Medications can help avoid or reduce the intensity of withdrawal symptoms when used to aid in detoxification from psychoactive substances that incur physiological dependence, such as alcohol and opiates.
2) Second, they can be used to help avoid or reduce the intensity of relapses that occur after a person has been drug free for a period of time.
3) Third, in some cases they can serve as part of a strategy to replace illicit psychoactive substance (e.g., heroin) use with a medically approved substitute that maintains the physically dependent state at a level that prevents the onset of withdrawal symptoms. When medications are used for relapse prevention or maintenance, it is recommended they be combined with psychosocial treatment.

Six medications have been approved by the Food and Drug Administration (FDA) for maintenance treatment or relapse prevention after withdrawal from dependence.

FDA Approved Medication	Substance Used to Treat	Method of Action	How It Works
Buprenorphine	Opioid	Partial Opioid Receptor Agonist	Reduces pleasurable effects of substance, reduces craving
Methadone	Opioid	Opioid Receptor Agonist	Reduces pleasurable effects of substance, reduces craving
Naltrexone	Opioid, Alcohol	Opioid Receptor Antagonist	Reduces pleasurable effects of substance
Extended Release Naltrexone	Opioid, Alcohol	Opioid Receptor Antagonist	Reduces pleasurable effects of substance, may reduce craving
Acomprosate	Alcohol	Unclear	Reduces craving
Disulfiram	Alcohol	Acetaldehyde dehydrogenase inhibitor	Negative reaction to consuming alcohol

For additional reading, see Renner, J.A. (2012). Drug substitution treatments and addiction pharmacotherapies: Integrating pharmacotherapy into the addiction syndrome treatment paradigm. In: H.J. Schaffer, ed. APA Addiction Syndrome Handbook, Volume 2. Washington, DC: American Psychological Association, 55-86.

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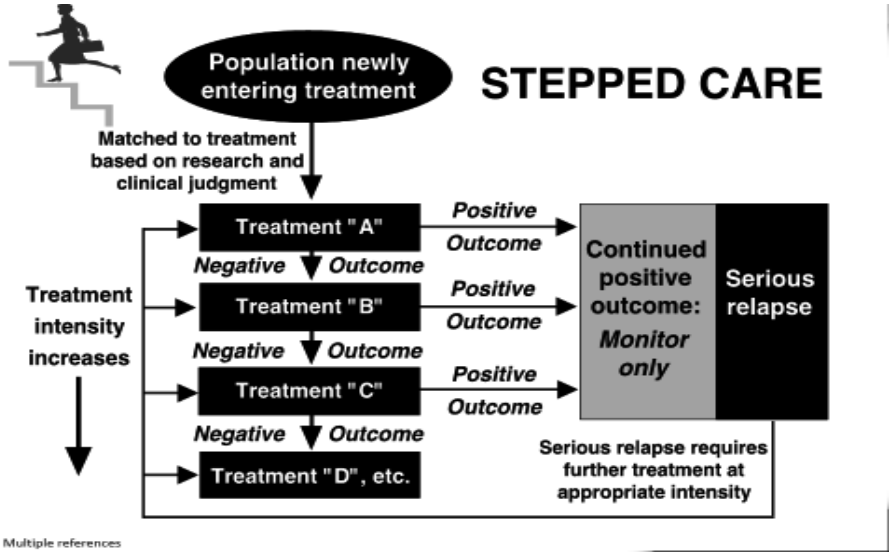
Stepped Care Model

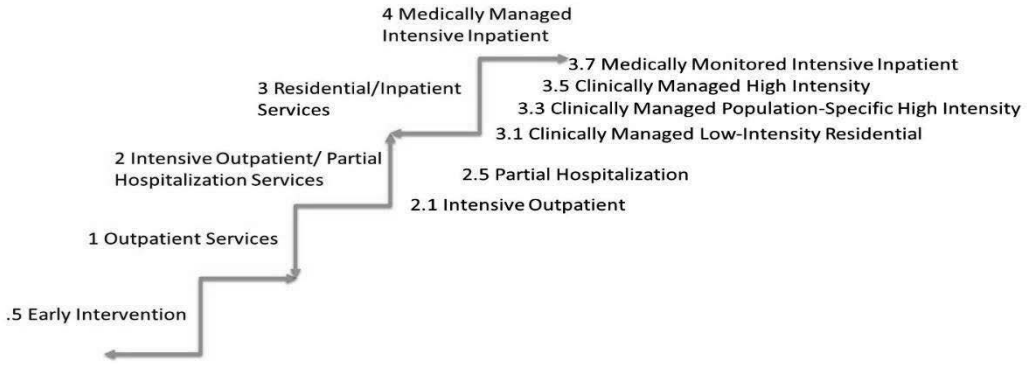


The stepped care model describes how many health services are delivered. The first approach used is the least intensive, least costly treatment that is acceptable to the patient, has research support, and that clinical experience suggests has a reasonable chance of being effective. Treatment progress is then monitored, and decisions about whether to "step up" treatment (either by more of the same treatment or switching to a different treatment) are based on how the person fares. Some have described stepped care as an adaptive approach to treatment. Services can work the same way for alcohol problems, with intensity increasing and/or the approach being modified based on how well the treatment is working.

Source: Sobell, M. B., & Sobell, L. C. (2000). Stepped care as a heuristic approach to the treatment of alcohol problems. Journal of Consulting and Clinical Psychology, 573-579.

American Society of Addiction Medicine (ASAM) Patient Placement Criteria

The ASAM Patient Placement Criteria are guidelines for placement, treatment, and termination of care for patients with SUDs that allow for a common language between providers. They are required for use in the DoD and VA, and in over 30 states. Below are the identified levels of care in the Patient Placement Criteria, which function as a stepped care model in that lower levels reflect less intensive intervention and higher levels reflect increasingly more intensive care.



Screening, Brief Intervention, and Referral to Treatment (SBIRT) Model

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), SBIRT is "an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use."

It consists of three steps:

1. Screening — a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting
2. Brief Intervention — a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice
3. Referral to Treatment — a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services

Citation: http://www.integration.samhsa.gov/clinical-practice/SBIRT

SBIRT is a time-limited intervention (generally 5-15 minutes) that can be provided in a mental health provider or other health care provider's office. CPT codes 99408 and 99409 were developed to capture this intervention.

Additional Recommended Readings/Key Books:

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

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

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DSM-5 Criteria for Substance Use Disorders

According to the DSM-5, a substance use disorder (SUD) involves "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems" (p. 483).

Classes of substances for which a diagnosis of SUD can be applied:

- Alcohol
- Cannabis
- Hallucinogens
- Inhalants
- Opioids
- Sedatives, hypnotics, anxiolytics
- Stimulants
- Tobacco
- Other (or unknown) substances

Diagnostic Criteria:

A problematic pattern of substance use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

- Substance is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control substance use.
- A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
- Craving, or a strong desire or urge to use substance.
- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.
- Important social, occupational, or recreational activities are given up or reduced because of substance use.
- Recurrent substance use in situations in which it is physically hazardous.
- Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- Tolerance, as defined by either of the following:
  - A need for markedly increased amounts of the substance to achieve intoxication or desired effect
  - A markedly diminished effect with continued use of the same amount of the substance.
- Withdrawal, as manifested by either of the following:
  - The characteristic withdrawal syndrome for the substance
  - Substance is taken to relieve or avoid withdrawal symptoms

Specify if:

- **In early remission**: None of criteria for SUD have been met for >3 but <12 months
- **In sustained remission**: None of criteria for SUD have been met for >12 months
- **In controlled environment**: If individual is in an environment where access to the substance is restricted

Code based on current severity:

- **Mild**: Presence of 2-3 symptoms
- **Moderate**: Presence of 4-5 symptoms
- **Severe**: Presence of 6 or more symptoms

Source: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

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-10 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-Item Alcohol Screening Questionnaire (SASQ)

Question: "How many times in the past year have you had __X__ or more drinks in a day?"
(X = 5 for men, X = 4 for women, a response of >1 is considered positive for unhealthy drinking)

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?"*_____

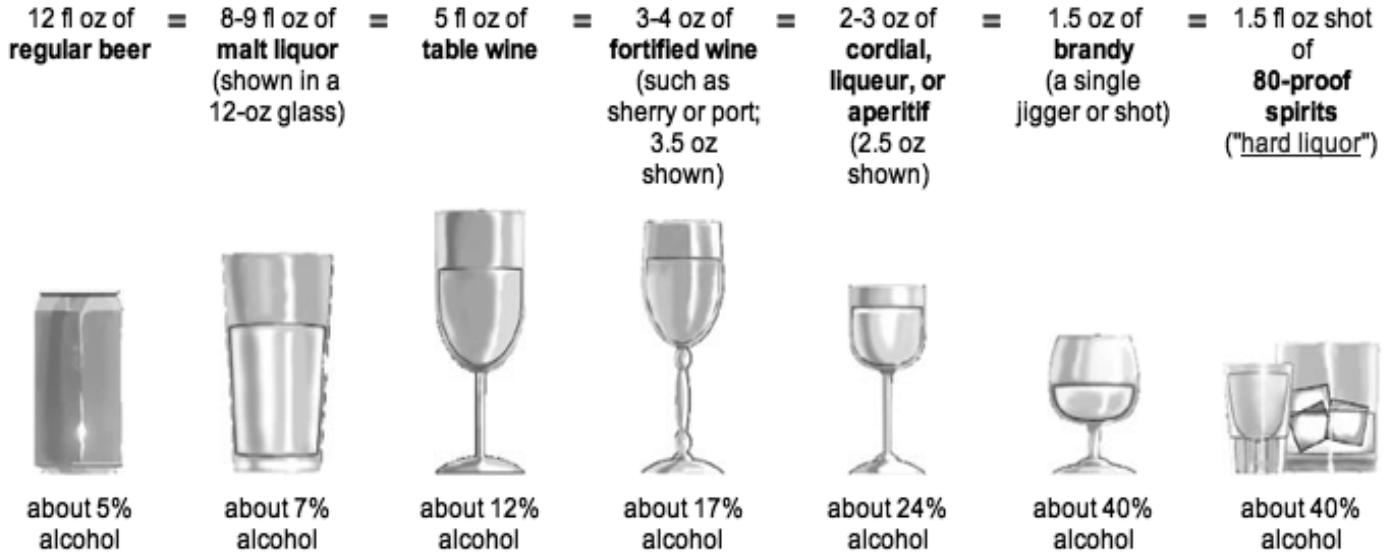
Question 4 (Single Binge Drinking question): Number of days drinking ≥ 5 SDs (for men) or ≥ 4 SDs (for women) "*How many times in the past ___month(s) have you had 5 or more (men) SDs or 4 or more SDs per day?"*

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.



CAGE Substance Abuse Screening Tool Directions:

Ask your patients these four questions and use the scoring method described below to determine if substance abuse exists and needs to be addressed.

CAGE Questions

Question 1. Have you ever felt you should **Cut down** on your drinking?

Question 2. Have people **Annoyed** you by criticizing your drinking?

Question 3. Have you ever felt bad or **Guilty** about your drinking?

Question 4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**Eye-opener**)?

CAGE Questions Adapted to Include Drug Use (CAGE-AID)

Question 1. Have you ever felt you ought to **Cut down** on your drinking or drug use?

Question 2. Have people **Annoyed** you by criticizing your drinking or drug use?

Question 3. Have you felt bad or **Guilty** about your drinking or drug use?

Question 4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (**Eye-opener**)?

Scoring:

Each affirmative response earns one point. One point indicates a possible problem. Two points indicate a probable problem.

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 assess risk for aberrant drug use behaviors among patients who may be prescribed opioids for treatment of chronic pain. **Scores ≥ 8 reflect very high risk for development of aberrant opioid use 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.

Motivational Techniques and Skills for Health and Mental Health Coaching/Counseling

AFFIRMATIONS

Examples of Affirmative Statements

- *"You showed a lot of [insert the person's trait e.g. strength, determination] by doing that."*
- *"It's clear that you're really trying to change your [insert risky/problem/behavior]."*
- *"In spite of what happened last week, you're coming back today reflects that you're concerned about changing your [insert risky/problem/unhealthy behavior]."*

Rationale: Affirmations are statements made by practitioners in response to what people have said. They are used to recognize people's strengths, successes, and efforts to change. They help to increase people's confidence in their ability to change. Avoid statements that sound overly ingratiating or insincere (e.g., "Wow, that's incredible," or "That's great, I knew you could do it!"). Use affirmations like salt, sparingly.

ADVICE/FEEDBACK

Examples of How to Provide Advice/Feedback

If appropriate, start by asking permission to talk about the person's behavior. Be prepared to provide them with relevant informational handouts.

- *"Do you mind if we spend a few minutes talking about…?"* ***[Followed by]***
- *"What do you know about…?" OR "What do you know about how your [insert a health behavior] affects your [insert health problem]?"*

[Followed by]

- *"Are you interested in learning more about…?"*
- *"What do you know about the benefits of quitting smoking?"*

[Follow-up with asking permission to talk about the person's concern]

- *"So you said you are concerned about gaining weight if you stop smoking; how much do you think the average person gains in the first year after quitting?"*

For People Who Do Not Want Information

- *"I get the sense that you are not ready to change at this time. We can discuss this at a later time if you change your mind."*

Rationale: People often have either little or incorrect information about their behaviors. Research has shown that telling people what to do does not work well. Most individuals prefer to be given choices in making decisions to change behaviors. By presenting information in a neutral and nonjudgmental manner empowers a person to make informed decisions about quitting or changing a risky/problem/unhealthy behavior.

Tips: When possible, focus on the positives of changing. (e.g., "Within 20 minutes of stopping smoking the body begins a series of changes. Immediately a person's blood pressure decreases. In 15 years after quitting, the risk of heart disease and death returns to nearly that of those who have never smoked.")

- Provide feedback that allows people to compare their behavior to national norms (e.g., % of people who have risky/problem/unhealthy behaviors). For example, "Where does your drinking fit in in relation to the national norms you see on the feedback page I just gave you?"
- Avoid using scare tactics, lectures, or dire warnings as some people might pretend to agree in order to not be further attacked.

ASKING PERMISSION

Examples of Asking Permission

- "*Can we talk a bit about your [insert risky/problem/unhealthy behavior]?"*
- *"I noticed that you have [insert conditions]? Do you mind if we talk about how different lifestyles affect [insert condition]?"*
  (Diet, exercise, smoking, and alcohol use can be substituted for the word "lifestyles.")

Rationale: People are more likely to discuss change when respected and asked, than when being told to change

NORMALIZING

Examples of Normalizing

- "*A lot of people are concerned about changing their [insert risky/problem/unhealthy behavior]."*
- "*Most people report both good and less good things about their [insert risky/problem/unhealthy behavior."*

Rationale: Normalizing is intended to communicate that having difficulties changing is not uncommon for many people.

OPEN-ENDED QUESTIONS

Examples of Open-Ended Questions

- "*What makes you think it might be time for a change?"*
- "*What brought you here today?"*
- "*What happens when you [insert risky/problem/unhealthy behavior]?"*
- "*What was that like for you?"*
- "*What's different about (quitting smoking, improving your exercise, diet, etc.) this time?"*

Rationale: Open-ended questions allow people to tell their stories and to do most of the talking. They give the practitioner opportunities to respond with reflections or summary statements that express empathy. Too many back-to-back close-ended questions can feel like an interrogation (e.g., "*How often do you overeat?"* "*How many years have you been smoking?"*)

REFLECTIVE LISTENING

Examples of Reflective Listening (generic stems)

- *"It sounds like…"*
- *"It seems as if…"*
- *"What I hear you saying…"*
- *"I get the sense that…"*
- *"I get the sense that this has been difficult…"*

Examples of Reflective Listening (specific reflections)

- *"It sounds like you are concerned about your [insert risky/problem/unhealthy behavior]."*
- *"I get the sense that you want to change, and you have concerns about your [insert risky/problem/unhealthy behavior or topic]."*
- *"What I hear you saying is that your [insert risky/problem/unhealthy behavior] is really not much of a problem right now."*
- *"What do you think it might take for you to change in the future?"*
- *"I get the feeling there is a lot of pressure on you to change, and you are not sure you can do it because of difficulties you had when you tried in the past."*

Rationale: Reflective listening allows practitioners to carefully listen and then to paraphrase the person's comments back (e.g., "*It sounds like you are concerned about gaining weight if you quit smoking*". **Goals of reflective listening include:** (a) Building empathy, (b) Encouraging people to state their own reasons for change, and (c) Affirming that the practitioner understands what a person is feeling and doing (i.e., "*It sounds like you are feeling upset at not meeting your goal."*). If the practitioner's guess is wrong, the person usually says so (e. g. "*No, I do want to quit, but I am concerned about withdrawal and weight gain."*).

SUMMARIES

Examples of Summaries

- *"It sounds like you are concerned about your [insert risky/problem/unhealthy behavior] because it is costing you many negative consequences. Where does that leave you?"*
- *"On the one hand you feel you need to quit smoking for your health, but on the other hand that will probably mean not associating with your friends anymore. That doesn't sound like an easy choice."*
- *"Over the past three months you have been talking about improving your diet and losing weight. It seems you have started to recognize the less good things about being overweight. And your girlfriend said she is leaving you if you don't do something about your weight. It's easy to understand why you are now committed to working on your weight."*

Rationale: Summaries require that practitioners listen very carefully to what a person has said. Summaries are a good way to end a session (i.e., offer a summary of the entire session) as well as to move a talkative person on to the next topic.

CHANGE TALK

Questions to Elicit Change Talk

- *"What makes you think you need to change?"*
- *"What will happen if you don't change?"*
- *"What will be different if you (insert desired change: lose weight, improve eating, exercise, take your medications, etc.?)"*
- *"What would be the good things about changing your [insert risky/problem/unhealthy behavior]?"*
- *"Why do you think others are concerned about your [insert risky/problem/unhealthy behavior]?"*

For People Having Difficulty Changing

Focus is on being supportive as the person is struggling to change.

- *"How can I help you get past some of the difficulties you are experiencing?"*
- *"If you were to decide to change, what would you have to do to make that happen?"*

For People Who Have Stated Little Desire For Change

Ask the person to describe a possible extreme consequence if they do or don't change.

- *"What is the BEST thing you could imagine that could result from changing?"*
- *"If you don't change, what is the WORST thing that might happen?"*
- *"If you do change, how would your life be different from what it is today?"*

Rationale: Rather than lecturing or telling people the reasons why they should change, the practitioner gets people to state reasons for change that are personally important to them. **Several studies show that change talk is associated with positive outcomes.**

PROS AND CONS OF CHANGE

(Decisional Balancing)

Examples of How to Use Pros and Cons of Change

- *"What are some of the good things about your [insert risky/problem/unhealthy behavior]?"* [The person answers]
- *"Okay, on the flipside, what are some of the less good things about your [insert risky/problem/unhealthy behavior]?"*

After the person discusses the good and less good things about their behavior, the practitioner can use a reflective, summary statement that allows people to talk about their ambivalence about changing.

Rationale: Asking people to evaluate both the good and less good things about their actions helps them understand their ambivalence by seeing that (a) they get some benefits (pros) from their *risky/problem/unhealthy* behavior, and (b) that there will be some costs (cons) if they decide not to change their behavior. Such discussions are intended to help move people further along the readiness to change continuum.

READINESS TO CHANGE RULER

Examples of How to Use a Readiness to Change Ruler

1___2___3___4___5___6___7___8___9___10
Not at all Ready Very Ready

Practitioner: "*On a scale from 1 to 10 where 1 is not at all ready to change and 10 is really ready to change where are you right now?"*
Person: "*Seven."*
Practitioner: "*And where were you six months ago?"*
Person: "*Two."*
Practitioner: "*So it sounds like you went from being not very ready to change your [insert risky/problem/unhealthy behavior] to being much more ready to change."*

- "*How did you go from a '2' 6 months ago to a '7' now?"*
- "*How do you feel about moving from a '2' to a '7' over the past 6 months?"*
- "*What would it take to move a bit higher on the scale?"*

People with Lower Readiness to Change (e.g., answers decreased from a '5' in the past to a '2' now)

- "*So, it sounds like you went from being ambivalent to changing your [insert risky/problem/unhealthy behavior] to no longer thinking you need to change your [insert risky/problem/unhealthy behavior]."*
- "*How did you go from a '5' to a '2'?"*
- "*What one thing do you think would have to happen to get you back to where you were before?"*

Rationale: Assessing readiness to change is critical. Readiness is not static; it can change from day to day. People are at different levels of motivation. If practitioners know where a person is on the readiness to change continuum they will be better prepared to work with them.

Depending on where the person is on the Readiness to Change Ruler, the conversation may take different directions. The Ruler can also be used to have people give voice to how their readiness changed, what they need to do to change further, and how they confident they feel about changing right now.

CONFIDENCE TO CHANGE

Examples of How to Explore Confidence Ratings

1___2___3___4___5___6___7___8___9___10
Not at all Confident Very Confident

- **Practitioner:** "*On a scale from 1 to 10 where 1 is not at all confident and 10 is very confident to change how CONFIDENT are you* ***right now*** *that you could make this change?"*
- "*What would it take to move from a [insert number] to a [higher number]?"*
- "*What do you think you might do to increase your confidence about changing your [insert risky/problem/unhealthy behavior]?"*

Rationale: Confidence ratings provide practitioners with information about how people view their ability

to make changes. The rating can be used to get people to give voice to what they need to do to increase their confidence. **Tip:** If a person reports a number of 7 or less, ask them "What will it take to raise your number?"

SUPPORTING CONFIDENCE TO CHANGE

Examples of Statements Supporting Self-Confidence

Ask People about changes they made:

- *"It seems you've been working hard to quit smoking. That is different than before. How have you been able to do that?"*
- *"So even though you haven't quit, you have managed to cut down on your smoking. How were you able to do that?"*

Follow up with a question about how People feel about the changes they made:

- *"How do you feel about the changes you made?"*
- *"How were you able to go from a [# 6 months ago] to a [# now]?"*

  [The Person answers]

  "How do you feel about those changes?"

Rationale: Making statements and asking questions about changes encourages people to recognize changes they have made. The objective is to increase their self- confidence that they can change. If a person's confidence goes from a lower number (past) to a higher number (now), practitioners may follow-up by asking how they were able to do that and how they feel about their change.

FOR PEOPLE WHO ARE MAKING LITTLE PROGRESS

Examples of How to Use a Paradoxical Statement

Practitioner: *"You have been trying to change [insert risky/problem/unhealthy behavior] for two months, but you are still doing [insert risky/problem/unhealthy behavior]. Maybe now is not the right time to change?"*

- *"It sounds like you have a lot going on, and these priorities are competing with your efforts to change at this time."*

For People Who Decide They Do Not Want to Change at This Time

The practitioner can discuss with people the reasons why it has been difficult for them to change. Then the practitioner might suggest that person might want to take a short "vacation" from therapy (i.e., a few weeks) and think about whether this is really the best time to commit to changing. The practitioner can tell the person that he/she will call the person in a month to see where they are in terms of readiness to change.

Rationale: Paradoxical statements about change are used to get people to argue for the importance of changing. It is hoped that the person would counter the practitioner statement with an argument that he/she wants to change (e.g., "No, I know I need to change, it's just tough putting it into practice."). Once a person states they do want to change, conversations can identify the reasons why progress has been slow up to now. If the person does not immediately argue for change, the practitioner can ask the person to think about this discussion between now and the next visit. Getting people to think about their behavior often serves to act as an eye-opener. Reserve these statements for people who may not be aware that they are not making changes within a reasonable period of time. When using this approach, the practitioner must sound genuine and not sarcastic.

"COLUMBO APPROACH" (Dealing with Discrepancies)

Using the Columbo Approach to Address Differences Between What People Say and Their Behavior

- *"On the one hand you're coughing and having trouble breathing, and on the other hand you are saying cigarettes are not causing you any problems. *****What do you think is contributing to your breathing difficulties?"*
- *"Help me to understand, on the one hand you say you want to live to see your 12-year old grow up and go to college, and yet you won't take the medication your doctor prescribed for your diabetes. * How will that help you live to see your daughter grow up?"*

Note: *When using discrepancies try to end the statement on the side of change talk as people are more likely to elaborate on the last part of the statement. This approach takes its name from the behavior demonstrated by Peter Falk who starred in the 1970s television series Columbo.

Rationale: The Colombo approach can be used to provide a curious inquiry without being judgmental or laying blame. This approach allows a practitioner to address discrepancies between what people say and their actual behavior without evoking defensiveness or resistance. By asking people to make sense of their discrepant information, they must give voice to, recognize, and resolve the discrepancies themselves. This approach evokes less resistance than a practitioner telling people that what they are doing does not make sense or is wrong. In addition, it eliminates the practitioner from sounding judgmental.

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**?

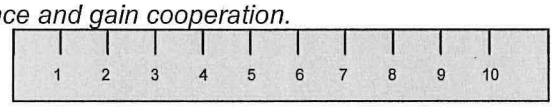
It sounds like there are some good things about **insert behavior** (insert specifics if you want). ***Reflection***

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**?

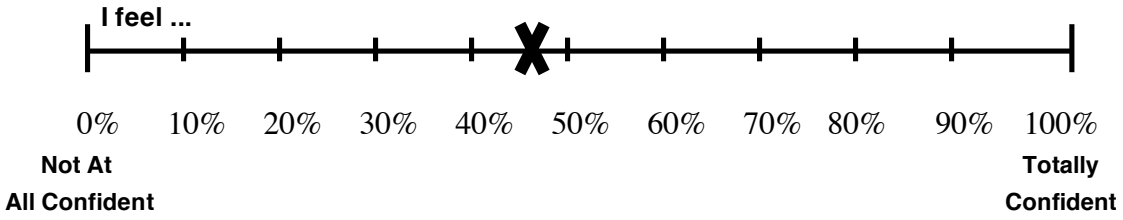
What would be the **best outcome** if you do change?

Name: _____ Date: _____

Brief Situational Confidence Questionnaire (SCQ)

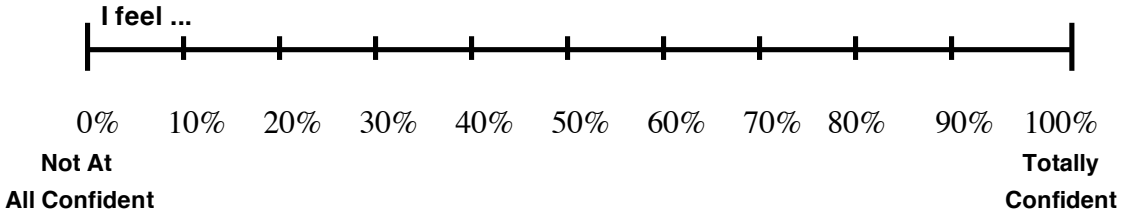
The behavior I would like to change is _____

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.

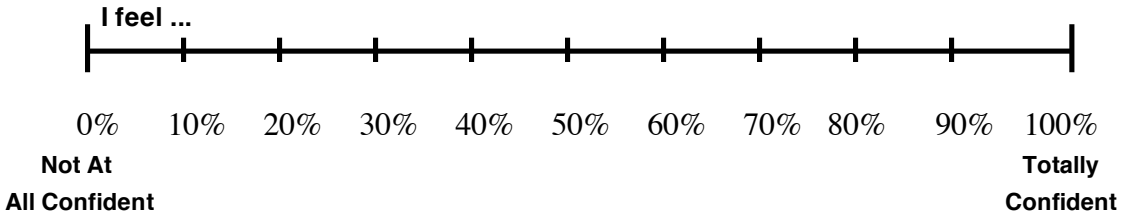


Right now I would be able to resist the urge to engage in the behavior I want to change when I experience…..

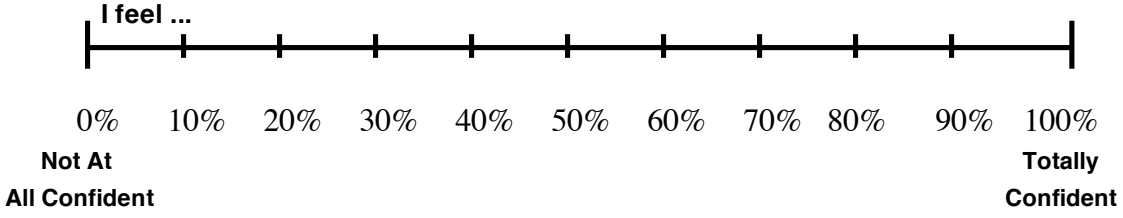
1. **UNPLEASANT EMOTIONS** (e.g., If I were depressed about things in general; If everything was going badly for me).



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

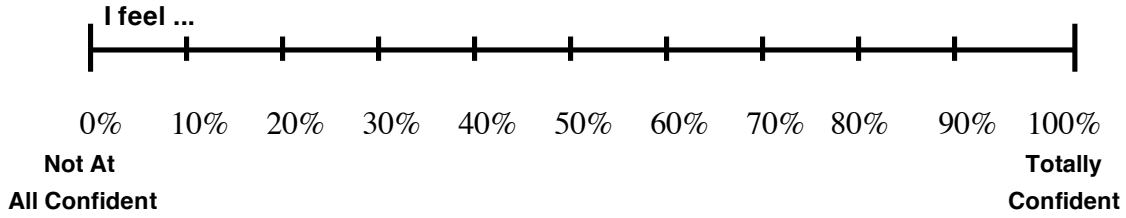


3. **PLEASANT EMOTIONS** (e.g., If something good would happen and I would feel like celebrating; If everything were going well).

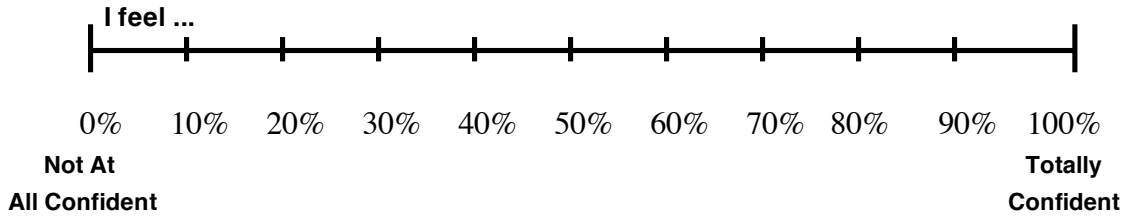


Right now I would be able to resist the urge to engage in the behavior I want to change when I experience…..

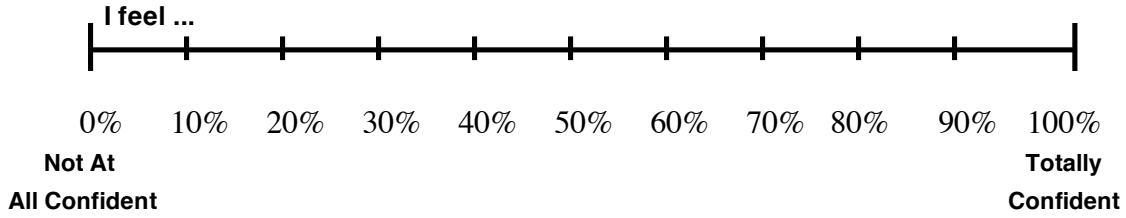
4. **TESTING CONTROL OVER THE BEHAVIOR I WANT TO CHANGE** e.g., If I would start to believe that the behavior is no longer a problem for me; If I would feel confident that I could engage in the behavior without problems).



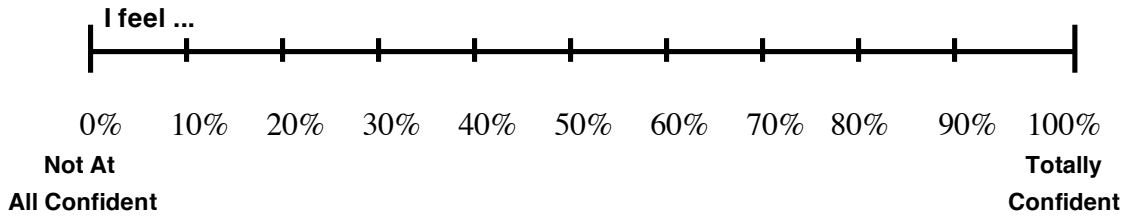
5. **URGES AND TEMPTATIONS** (e.g., If I suddenly had an urge to engage in the behavior I want to change or if I were in a situation where the behavior had occurred; If I began to think of how good it was to engage in the behavior I want to change).



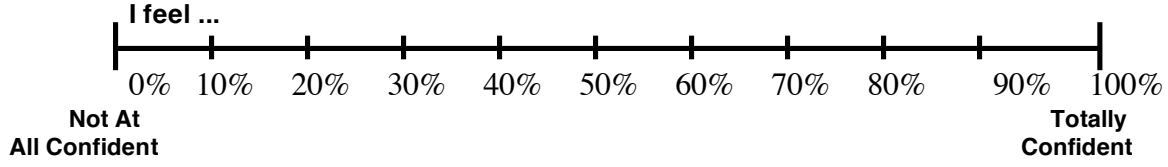
6. **CONFLICT WITH OTHERS** (e.g., If I had an argument with a friend; If I were not getting along well with others at work).



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).



CENTER FOR DEPLOYMENT PSYCHOLOGY

Preparing Professionals to Support Warriors and Families

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.

Content Awareness

The workshop may contain content related to sexual assault that some may find disturbing. Please be aware of your own needs and limitations, and plan accordingly.

Military Sexual Assault

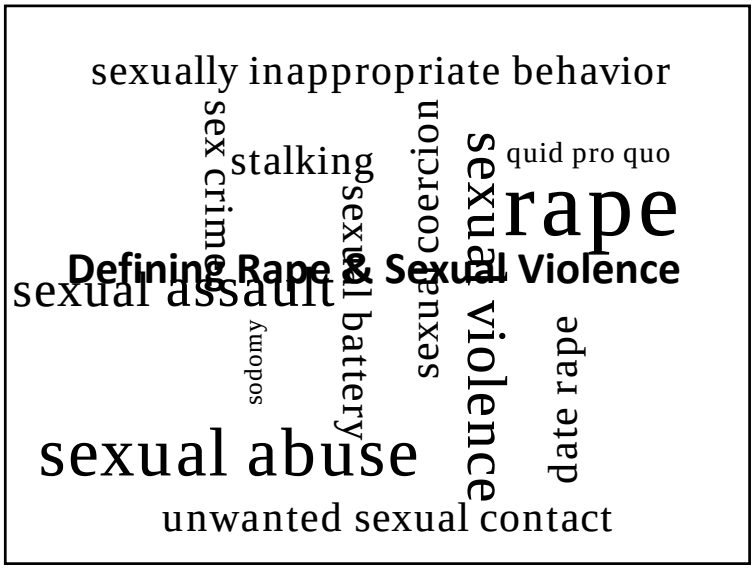
Understanding and Treating the Psychological Impact of Sexual Assault in the United States Military

Center for Deployment Psychology

Uniformed Services University of Health Sciences

Learning Objectives

- Compare the rates of sexual assault and unwanted sexual contact in military and civilian populations.
- Describe the impact of sexual trauma on the survivor's cognitions.
- List important life domains to assess before planning trauma focused treatment
- Identify the main treatment components of trauma-focused therapy.



Sexual Violence

"…**acts** of **rape** (forced penetration) and types of **sexual violence** other than rape." ….including being **made to penetrate** someone else, sexual **coercion, unwanted** sexual contact**,** and non-contact unwanted sexual experiences."

NISVS, 2010

Sexual Assault

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

- includes specific UCMJ defined offenses of **rape**, **sexual assault, aggravated sexual contact, abusive sexual contact, forcible sodomy** (forced oral or anal sex), or **attempts** to commit these offenses.

DoD 6495.01

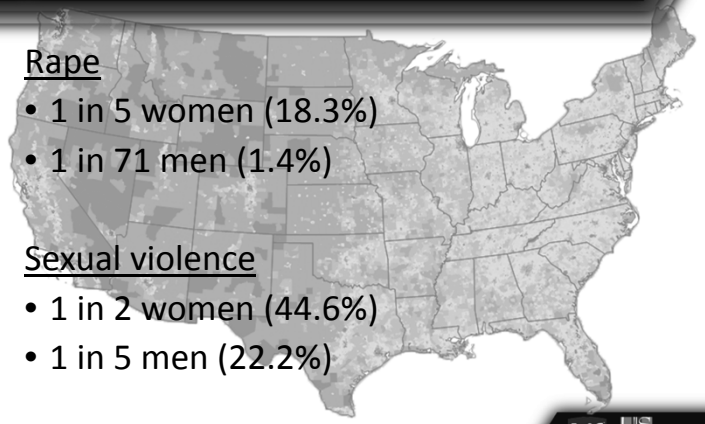
Military Sexual Trauma

"**Psychological trauma** which...resulted from **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

Incidence & Prevalence Rates

US Lifetime Prevalence



Rape
- 1 in 5 women (18.3%)
- 1 in 71 men (1.4%)

Sexual violence
- 1 in 2 women (44.6%)
- 1 in 5 men (22.2%)

NISVS, 2011

Prevalence of SA Among Active Duty Service Members

SA Prior to Enlistment
- Women (8.2%)
- Men (.9%)

Estimated Lifetime SA
- Women (17.9%)*
- Men (2.57%)*

U.S. Air Force photo by Jason Gutierrez. https://creativecommons.org/licenses/by-nc/2.0/

- Estimated by combining reported pre-military rates with rates during military service
- SA = Sexual Assault

Rand, 2015

12-Month Prevalence: U.S. vs. Active Duty Military

	Rape	Sexual Violence
US men	§%	5.1%
US women	1.6%	5.5%

	PSA	NPSA
AD men	.33%	.6%
AD women	2.1%	2.6%

§% too small to estimate
PSA=Penetrative Sexual Assault
NPSA=Nonpenetrative Sexual Assault
AD=Active Duty

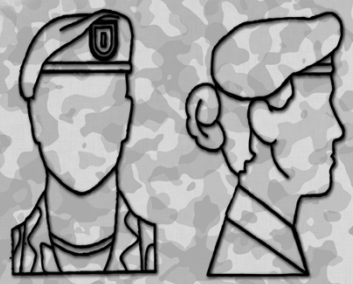
NISVS, 2010, Rand, 2014

MSA 12-Month Prevalence & Incidence

Men

Prevalence
1% (10,600)

Incidence
2.5 incidents per 100 men



Women

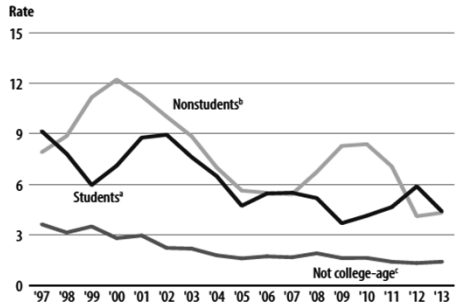
Prevalence
4.9% (9,600)

Incidence
9.6 incidents per 100 women

Rand, 2014

12-Month Incidence of Sexual Assault in Post-Secondary Women

FIGURE 2
Rate of rape or sexual assault for females, by age and post-secondary enrollment status, 1997–2013



US Dept. of Justice, 2014

MSA Personal Risk Factors

- Female
- Gender
- Youth
- Alcohol Use
- Domestic Violence
- Prior Trauma
- Enlisted Rank
- Gender Discrimination/Harassment

Rand, 2014

The Context of MSA

	Males	Females
On an installation	64%	33%
TDY/field	23%	15%
While deployed	20%	9%
Socializing	24%	35%
At work	57%	30%
"Hazing"	34%	6%

Rand, 2015

MSA Perpetrator Characteristics

	Males	Females
Male offender	70%	98%
Single offender	51%	65%
Known individual	85%	93%
Friend/acquaintance	46%	67%
Military	81%	89%

Rand, 2015

The Intersection of Military Culture & Sexual Assault

Military Culture is Unique

- Military ethos
- Closed Community
- Hierarchical and rigid structure
- High risk, high stress occupation
- Potential for combat trauma is heightened
- Deployment intensifies separation & isolation

What is SAPRO

Restricted Reporting

Allows eligible sexual assault victims to do all of the following without triggering an investigation:

- confidentially disclose the assault to specified individuals
- receive medical treatment/emergency care
- receive counseling
- obtain a SARC and SAPR VA

Unrestricted Reporting

Allows eligible sexual assault victims to:

- make a non-confidential disclosure

Report of the disclosure is provided to:

- healthcare personnel
- SARC, & SAPR VA
- command authorities
- law enforcement

Changes in Reporting Over Time

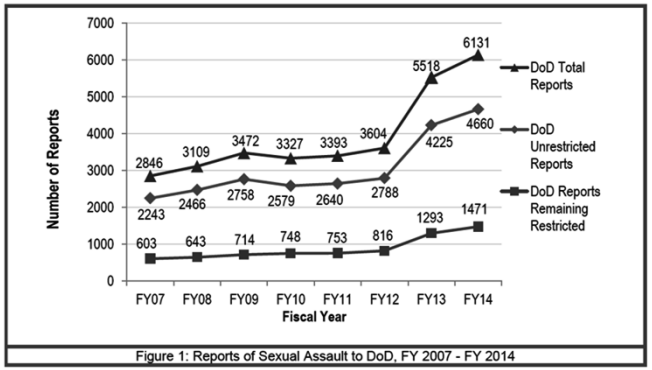
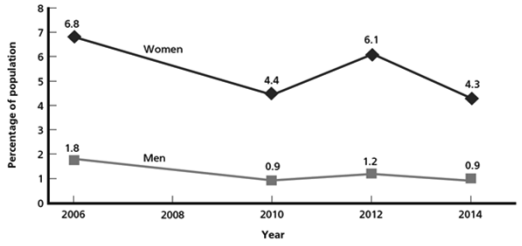


Figure 1: Reports of Sexual Assault to DoD, FY 2007 - FY 2014

Department of Defense Annual Report on Sexual Assault in the Military, 2014

Rates of MSA by Year

Figure 7.1
Estimated Percentage of Active-Component Men and Women Who Experienced Unwanted Sexual Contact in the Past Year, as Measured in the WGRA, 2006–2014



NOTE: 2006 estimates are for calendar year 2006. Estimates for 2010, 2012, and 2014 are for a time period closer to the fiscal year.

RAND RR870/2-7.1

Rand, 2015

Impact of Sexual Assault on Service Members

The Nature of Military Sexual Assault

- Occurs early in development
- May occur repeatedly
- Interpersonal
- Live, work & play in close proximity to perpetrator
- Risk of additional trauma
  - Training
  - Combat

The Impact of Sexual Assault

Trauma can disrupt or confirm previously held beliefs about:

Self	Safety
	Trust
Others	Power/Control
	Esteem
World	Intimacy

The Impact of MSA

Trauma can disrupt or confirm previously held beliefs about:

Self	Member
Others	Unit
World	Mission

Gender Issues in Sexual Assault

Men

- Higher risk of psychological consequences
  - Substance abuse
  - Depression
  - Suicide
- Fear of judgment
- Fear of disbelief
- Identity concerns

Gender Issues in Sexual Assault

Women

- Warrior role
- Intimacy

U.S. Marine Corps photo by Cpl. Alana Idarrola-Appleh. https://creativecommons.org/licenses/by/2.0/

DoD photo by Sgt. Michael J. MacLeod, U.S. Army. https://creativecommons.org/licenses/by/2.0/

Clinical Presentation

Fear/Anxiety	Depression	Anger & Irritability
Emotional Numbing	Substance Abuse	Relationship Difficulties
Sleep Problems	Attention, Concentration & Memory	Health Problems

U.S. Navy photo by MCSA Robert Winn/Released. Courtesy of Defenselmagery.mil

Assessment

Clinical approach

- Ask
- Be knowledgeable
  - Sexual assault
  - PTSD and other responses
  - Military culture
- Be direct
  - Avoid jargon
- Be empathic, nonjudgmental
  - Comfortable with explicit content
  - Comfortable with intense emotions
  - Unambiguously accepting of the client
  - Sensitive to barriers to disclosure

Goals for Assessment

- Differential diagnosis/Case conceptualization
- Inform treatment planning
- Establish baseline record
- Evaluate treatment response
- Validate, normalize, educate

Foa & Rothbaum, 1998

Documentation

Records are maintained to :

- provide good care
- assist collaborating professionals in delivery of care
- ensure continuity of professional services in case of injury, disability, death, or a change of provider
- provide for supervision or training if relevant
- provide documentation required for reimbursement or required administratively under contracts or laws
- document any decision-making, especially in high-risk situations
- allow the psychologist to effectively answer a legal or regulatory complaint

APA, 2007

Documentation of Details

Include:

- basic elements of what happened
- treatment the patient has received
- current level of social support
- assessment of sequelae
- treatment offered/accepted/declined
- nature and outcome of any intervention
- plan going forward

Use specific objective language:

- objective terms and quotes (e.g., “patient states/reports”)
- avoid judgmental terms, (e.g., “patient claims/alleges”)

Veterans Health Initiative, 2004

Assessment Domains

- Presenting problem
- Symptoms/diagnosis
- History
- Functional status
- Social support/resources
- Client goals

Trauma Exposure Measures

Self Report

- Life Events Checklist (LEC) 16 items
- Brief Trauma Questionnaire (BTQ) 10 items

Interview

- Evaluation of Lifetime Stressors (ELS) 56 items

LEC-5

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check all that apply in the column to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it (e.g., happened to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); or (e) you're not sure if it fits.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not Sure
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden violent death (for example, homicide, suicide)					
15. Sudden accidental death					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

PLEASE COMPLETE PART 2 ON THE FOLLOWING PAGE

http://www.ptsd.va.gov/professional/assessment/te-measures/index.asp

Diagnostic Interviews

- Structured Clinical Interview for DSM-5 (SCID)
- Mini International Neuropsychiatric Interview (MINI)
- Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)
- PTSD Symptom Scale - Interview (PSSI-5)

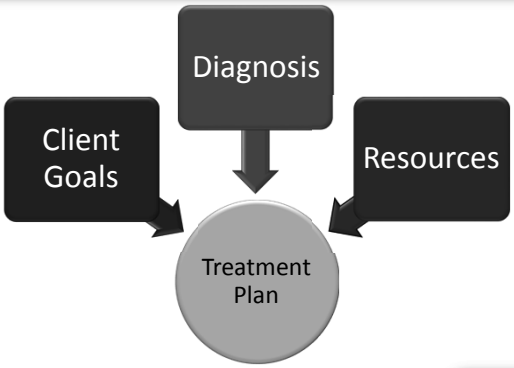
APA, 2015
http://www.medical-outcomes.com/index/mini
http://www.ptsd.va.gov/professional/assessment/te-measures/index.asp

Self Reports

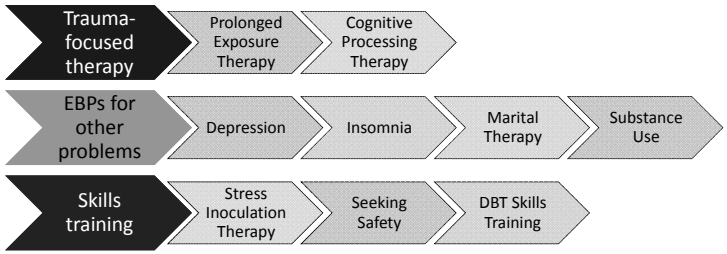
- **Primary Care PTSD Screen (PC-PTSD) = 4 items**
- **PTSD Check List for DSM-5 (PCL-5)- = 20 items**
- PTSD Diagnostic Scale (PDS-5) = 20 items
- PTSD Cognitions Inventory (PTCI) = 36 items
- Other Symptom Specific Measures based on the diagnostic interview (e.g., BDI, PHQ-9, BSS, AUDIT, DAST)

Treatment

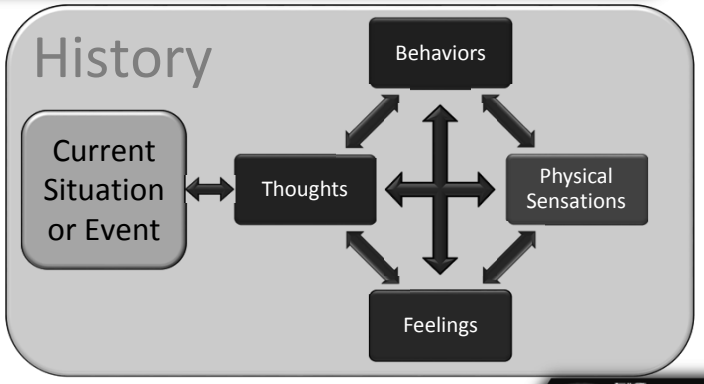
Treatment Planning



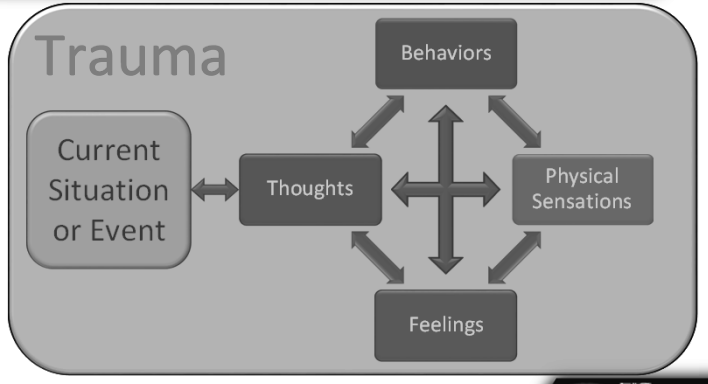
Treatment Options



Assumptions of CBT

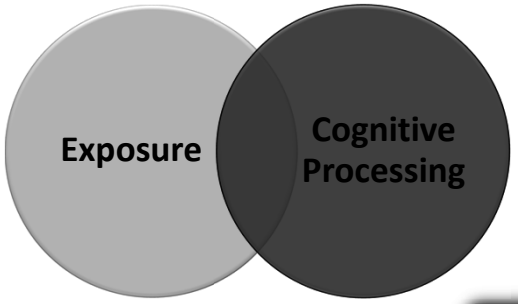


Assumptions of Trauma-Focused CBT



Recovery Processes

Trauma-focused CBT incorporates two essential techniques:



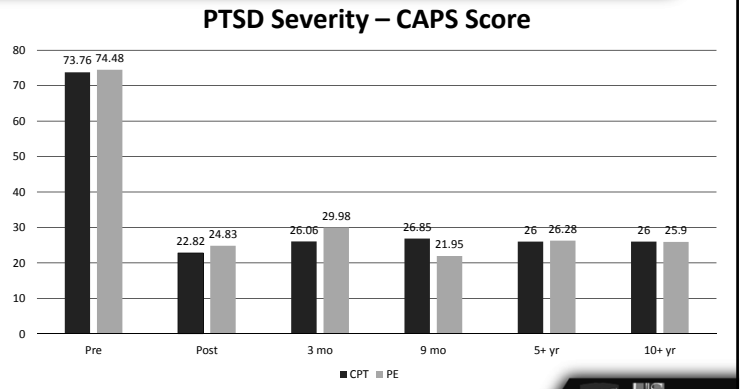
Recovery Processes

CPT	Procedures
Identify distorted beliefs	written exposure & spontaneous observation
Reconcile inconsistencies	formal cognitive processing
PE	**Procedures**
Activate trauma-related thoughts & emotions	exposure
Set up corrective experiences	exposure
Incorporate new information	processing

Components of Trauma-Focused CBT

Cognitive Processing Therapy	Prolonged Exposure Therapy
12 Sessions	10-12 Sessions
Psychoeducation	**Psychoeducation**
Exposure (limited, spontaneous)	Breathing Retraining
With or without Trauma Narrative	**Exposure** (specific, strategic)
Formal **Cognitive Restructuring**	Informal **Cognitive Processing**
Verbally Mediated	Experientially Mediated
Individual and/or Group	Individual Format

CPT and PE Follow-up



Resick et al (2012)

The Take Home…

- Sexual assault is a human problem not a military problem.
- Assessment of sexual assault-related problems should follow best practice guidelines.
- Treatment of sexual assault-related symptoms should follow best practice guidelines.
- Like members of any culture, Service Members need treatment that is culturally competent.

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**

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

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Facebook: http://www.facebook.com/DeploymentPsych
Twitter: @DeploymentPsych

TRMA260 Sexual Assault in the U.S. Military

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Guidance for interviewing patients about sexual assault in the military

The following is not intended as an exhaustive guide, nor is it a questionnaire that should be given in a structured way. Rather, this provides sample dialogue that will help you construct your own queries and responses as you work with patients who have experienced sexual assault.

Initial and subsequent disclosures

If you screen everyone for traumatic experiences, including sexual assault, you can let the patient know this. Your patient is less likely to feel stigmatized by the questions if they know they aren't being singled out. This is important because those who have experienced sexual assault often feel ashamed or singled out already.

"Many people have distressing or traumatic experiences that continue to bother them. I ask every patient about these kinds of experiences because it helps me understand better how to be of help."

"I see many patients who have problems like yours, and some have had distressing experiences in their lives, such as being hurt by a partner or being forced to have sex against their will. Has anything like that ever happened to you?" (VHA, 2004).

How much to ask depends on the goal of your interaction with the patient.

- Are you screening and referring?
- Are you completing a thorough assessment?
- Are you developing a treatment plan?

The LES is a short trauma screen that includes one question regarding sexual assault. If you wish more specific information, remember to describe behaviors and avoid terms that require some interpretation (such as rape or abuse).

Sexual assault screening (Less specific)

- Have you ever had an unwanted sexual experience?

Sexual assault screening (More specific)

- As a child, did anyone ever touch your private parts or have you touch their private parts?
- 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?
- As an adult, have you ever been forced to touch someone's private parts 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?"

Responding to disclosures

As important as how you ask is how you respond to the disclosure, how you guide the conversation to both meet the goals of the interaction and validate the patient's disclosure, and how you make sure clinical resources are in place. It is always appropriate to respond with empathy and compassion. At a minimum, disclosure should be followed by some expression empathy, normalization, and an assessment of current status and support.

Sample responses:

- Validate - e.g., "**I'm sorry that happened to you."**
- Educate/normalize - **e.g., "Many people have experienced sexual trauma during their military service.**"
- Assess current status - including health sequelae of trauma and current safety - **e.g., "Do you feel that you are currently having physical or emotional effects from the trauma?"**
- Assess level of support - **e.g., "Have you been able to discuss this with anyone else? Have you ever talked to a mental health provider about the sexual assault? Was it helpful?"**

Those who are attending the workshop are most likely intending to assess and treat, so the level of detail you may be asking is greater than a screener or a primary care doctor who may wish to find out only enough the make the patient feel heard, and to make appropriate referrals and treatment plans.

Assessing the effects of sexual assault

Sample question:

- **"How has the sexual assault affected you?" (Query symptoms, functional domains specifically -- e.g., "Has it affected your work, relationships with others?")**

Sample questions for service members and veterans

- How has the sexual assault affected your view of the military, your role, and your identity as a service member?
- If there has been a restricted report, has it met with your expectations? Has your desire for confidentiality been met? Were you satisfied with the process?
- If there has been an unrestricted report, what was the outcome? Has it met with your expectations? Has it changed your view of the military or of the justice system?

What symptoms does the client mention? What others become apparent as you explore differentials?

How is the client functioning in various life domains? How do their symptoms impact functioning?

- **How is the client managing his or her work life and military life vis a vis the~~ir~~ legal case (if there is one), the treatment, and the symptom management? Are co-workers/unit members/chain of command aware, supportive, etc. or not?**

- What are the client's resources (e.g., education, financial, SES, stability of living situation), and what are his or her sources of social support? How dependable are they?

- Are there unique aspects of military life that make this harder or easier -- for example, living on post, having access to a SAPR representative? Has he or she been reassigned as a result of the assault? Has the perpetrator been reassigned? Has there been fallout within the unit or the neighborhood/community?

What are they client's goals -- e.g., symptom relief, functioning in one or more domains, compensation?

- Does he or she want to stay in the military? Change his or her career trajectory in some way? Pursue legal options? Disability compensation? Medical discharge?

LEC-5

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it ***happened to you*** personally; (b) you ***witnessed it*** happen to someone else; (c) you ***learned about it*** happening to a close family member or close friend; (d) you were exposed to it as ***part of your job*** (for example, paramedic, police, military, or other first responder); or (e) you're ***not sure*** if it fits.

Be sure to consider your ***entire life*** (growing up as well as adulthood) as you go through the list of events.

Event	*Happened to me*	*Witnessed it*	*Learned about it*	*Part of my job*	*Not Sure*
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden violent death (for example, homicide, suicide)					
15. Sudden accidental death					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

PLEASE COMPLETE PART 2 ON THE FOLLOWING PAGE

PART 2:

A. If you checked anything for #17 in PART 1, briefly identify the event you were thinking of:

_____

B. If you have experienced more than one of the events in PART 1, think about the event you consider the *worst event*, which for this questionnaire means the event that currently bothers you the most. If you have experienced only one of the events in PART 1, use that one as the worst event. Please answer the following questions about the worst event *(check all options that apply)*:

1. Briefly describe the worst event *(for example, what happened, who was involved, etc.)*.

_____

_____

2. How long ago did it happen? _____ *(please estimate if you are not sure)*

3. How did you experience it?

____ *It happened to me directly*

____ *I witnessed it*

____ *I learned about it happening to a close family member or close friend*

____ *I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)*

____ *Other, please describe:*

4. Was someone's life in danger?

____ *Yes, my life*

____*Yes, someone else's life*

____*No*

5. Was someone seriously injured or killed?

____ *Yes, I was seriously injured*

____ *Yes, someone else was seriously injured or killed*

____ *No*

6. Did it involve sexual violence? ____*Yes* ____*No*

7. If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

____ *Accident or violence*

____ *Natural causes*

____ *Not applicable (The event did not involve the death of a close family member or close friend)*

8. How many times altogether have you experienced a similar event as stressful or nearly as stressful as the worst event?

____ *Just once*

____ *More than once (please specify or estimate the total # of times you have had this experience _____)*

PLEASE COMPLETE PART 3 ON THE FOLLOWING PAGE

Part 3: Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem <u>in the past month</u>.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “superalert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5

<u>Instructions</u>: This questionnaire asks about problems you may have had after a very stressful experience involving *actual or threatened death, serious injury, or sexual violence*. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a *serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.*

First, please answer a few questions about your *worst event*, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

Briefly identify the worst event (if you feel comfortable doing so): _____

How long ago did it happen? _____ ***(please estimate if you are not sure)***

Did it involve actual or threatened death, serious injury, or sexual violence?

_____Yes

_____No

How did you experience it?

_____ It happened to me directly

_____ I witnessed it

_____ I learned about it happening to a close family member or close friend

_____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)

_____ Other, please describe _____

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

_____Accident or violence

_____Natural causes

_____Not applicable (the event did not involve the death of a close family member or close friend)

Second, keeping this worst event in mind, read each of the problems on the next page and then circle one of the numbers to the right to indicate how much you have been bothered by that problem <u>in the past month</u>.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	**0**	**1**	**2**	**3**	**4**
2. Repeated, disturbing dreams of the stressful experience?	**0**	**1**	**2**	**3**	**4**
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	**0**	**1**	**2**	**3**	**4**
4. Feeling very upset when something reminded you of the stressful experience?	**0**	**1**	**2**	**3**	**4**
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	**0**	**1**	**2**	**3**	**4**
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	**0**	**1**	**2**	**3**	**4**
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	**0**	**1**	**2**	**3**	**4**
8. Trouble remembering important parts of the stressful experience?	**0**	**1**	**2**	**3**	**4**
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	**0**	**1**	**2**	**3**	**4**
10. Blaming yourself or someone else for the stressful experience or what happened after it?	**0**	**1**	**2**	**3**	**4**
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	**0**	**1**	**2**	**3**	**4**
12. Loss of interest in activities that you used to enjoy?	**0**	**1**	**2**	**3**	**4**
13. Feeling distant or cut off from other people?	**0**	**1**	**2**	**3**	**4**
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	**0**	**1**	**2**	**3**	**4**
15. Irritable behavior, angry outbursts, or acting aggressively?	**0**	**1**	**2**	**3**	**4**
16. Taking too many risks or doing things that could cause you harm?	**0**	**1**	**2**	**3**	**4**
17. Being "superalert" or watchful or on guard?	**0**	**1**	**2**	**3**	**4**
18. Feeling jumpy or easily startled?	**0**	**1**	**2**	**3**	**4**
19. Having difficulty concentrating?	**0**	**1**	**2**	**3**	**4**
20. Trouble falling or staying asleep?	**0**	**1**	**2**	**3**	**4**

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “superalert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Assessment Instruments

The following psychological instruments mentioned in the workshop can be obtained at the following links or contacts:

https://www.appi.org/products/structured-clinical-interview-for-dsm-5-scid-5

The Structured Clinical Interview for DSM-5 (SCID-5)

http://www.medical-outcomes.com/index/mini

The MINI-

http://www.ptsd.va.gov/professional/assessment/te-measures/index.asp

Life Events Checklist for DSM-5 (LEC-5)
Brief Trauma Questionnaire (BTQ)
Evaluation of Lifetime Stressors (ELS)
Clinician Administered PTSD Scale for DSM-5 (CAPS)
Primary Care PTSD Screen (PC-PTSD) = 4 items
PTSD Check List for DSM-5 (PCL-5)- = 20 items
and many more

Center for the Treatment and Study of Anxiety
University of Pennsylvania
3535 Market Street, 6th Floor
Philadelphia, PA 19104

Phone: (215) 746-3327

PTSD Symptom Scale Interview (PSSI-5) = 20 items
PTSD Symptom Scale Self Report (PDS-5) = 24 items
PTSD Cognitions Inventory (PTCI) = 36 items