All Rise
Justice for Vets

MENTAL HEALTH DISORDERS AND THE JUSTICE-INVOLVED VETERAN POPULATION

Dr. Meghan Geiss, PhD, LCP
Rehabilitation Neuropsychologist

Disclosure

- This project was supported by Grant No. 15PBJA-23-GK-02424-VTCX, awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the SMART Office. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Disclaimer

- The views expressed in this presentation are solely those of the presenter and do not represent those of the Veterans Health Administration, the Department of Defense, or the U.S. Government
- The presenter has no conflict of interest to disclose

Objectives

Describe	Describe the epidemiology and diagnostic features of Post Traumatic Stress Disorder (PTSD) and other mental health disorders prevalent in veterans
Identify	Identify risk factors unique to military personnel and veterans that may contribute to developing mental health disorders
Review	Review research driven treatment options in targeting mental health conditions in the veteran population

Why Should You Care about Mental Health?

The experience of trauma among people with substance abuse and mental health disorders, especially those involved with the justice system, is so high as to be considered *an almost universal experience*.

(SAMHSA, 2013)

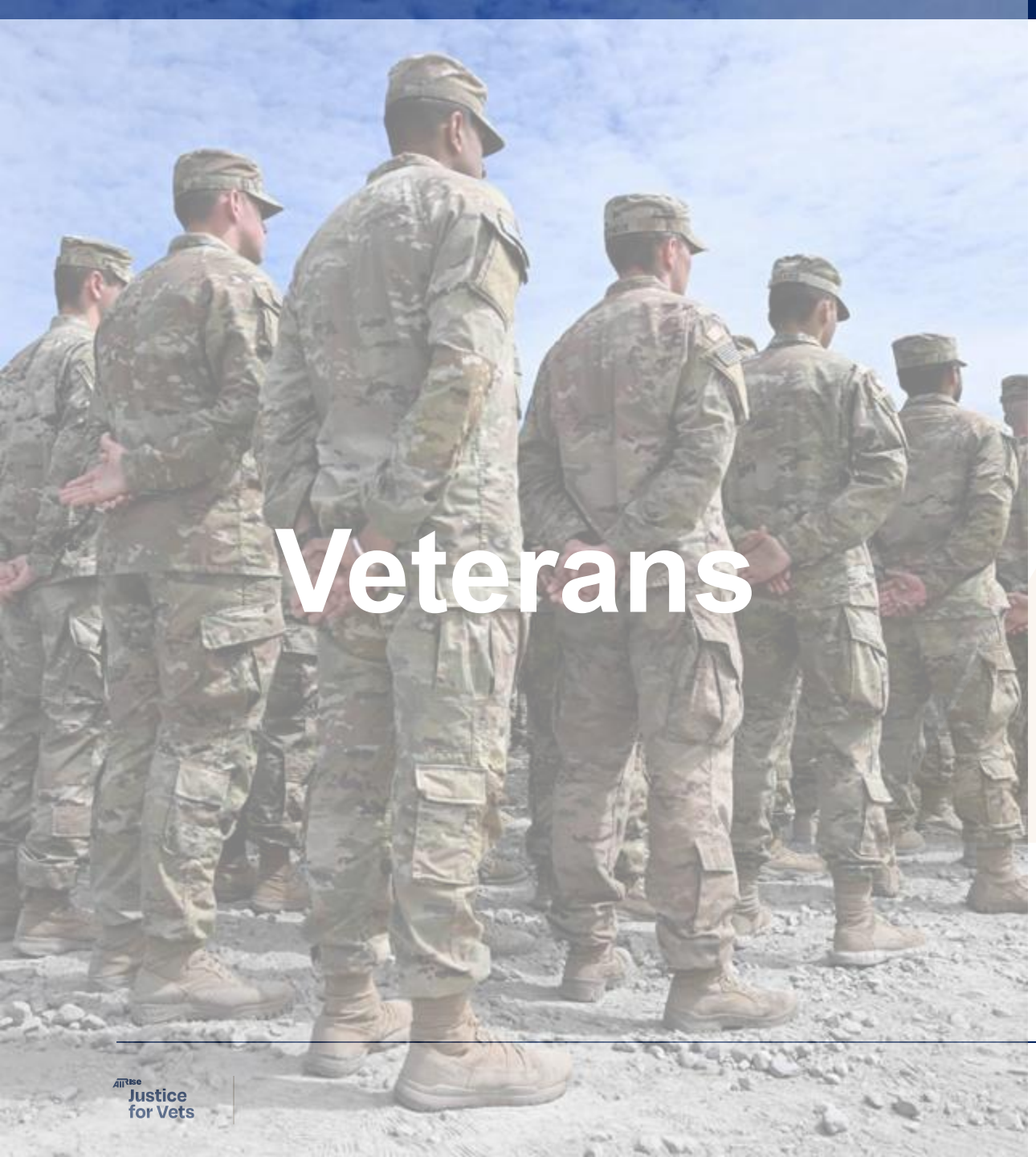
Prevalence of Mental Health Issues in the U.S.

1 in 5 U.S adults experience mental illness each year

1 in 20 U.S. adults experience serious mental illness each year

(NIH, 2022; SAMHSA, 2020)

50% of all lifetime mental illness begins by age 14, and 75% by 24. (Kessler, 2005)



Veterans

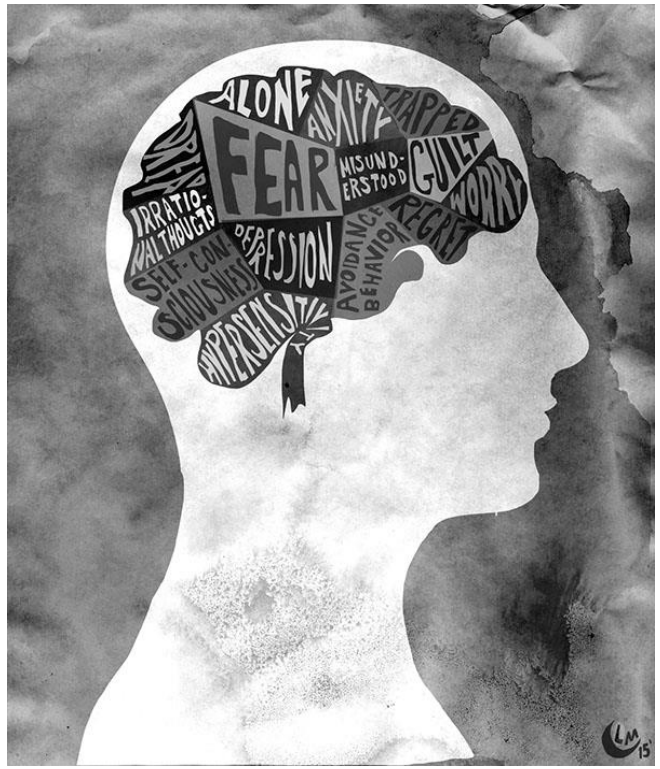
- There are around 18 million veterans and 2.1 million active-duty and reserve service members in the U.S. (US census 2020)
- Since September 11, 2001, the deployment of 2.8 million active-duty American military personnel to Iraq, Afghanistan, and other areas (DoD, 2018)
- Over 6% of the US population has served or is currently serving in the military (Dept of VA, 2020)

Prevalence of Mental Health Issues Among Veterans

- 1 in 10 veterans met criteria for more than one mental health condition
- More than 1.7 million veterans received treatment in a Veterans Affairs (VA) mental health specific program in fiscal year 2018

(Dept of VA, 2019)

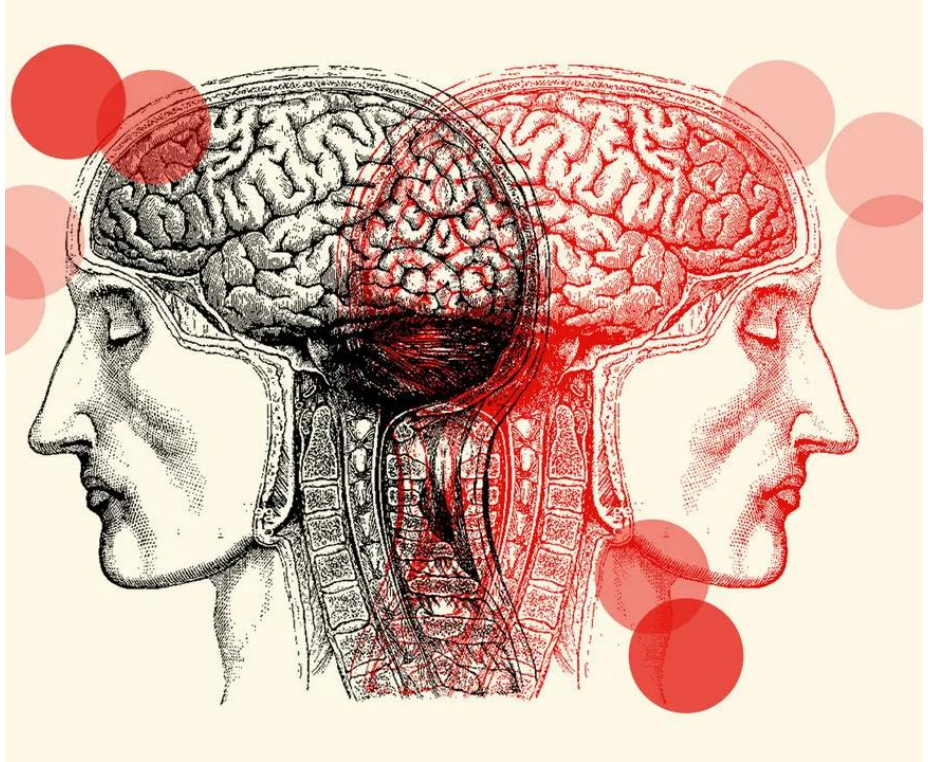
Prevalence of Mental Health Issues Among Veterans



- Very large prevalence study (4.4 million veterans)
- 1.15 million carried at least 1 mental health diagnosis
  - Depression was the most prevalent (13.5%)
  - PTSD (9.3%)
  - SUD (8.3%)

(Trivedi et al., 2015)

Prevalence of Mental Health Issues in the Justice-Involved



- Approximately 2 million times each year, people with serious mental illness are booked in jails. (NAMI, 2019)
- About 2 in 5 people who are incarcerated have a history of mental illness (37% in state and federal prisons and 44% held in local jails). (Bronson and Berzofsky, 2017)
- 66% of women in prison reported having a history of mental illness, almost twice the percentage of men in prison(James and Glaze, 2006)
- Nearly one in four people who died by lethal force employed by police officers between 2015 and 2020 had a mental health condition (The Washington Post, 2020)

Justice-Involved Veterans

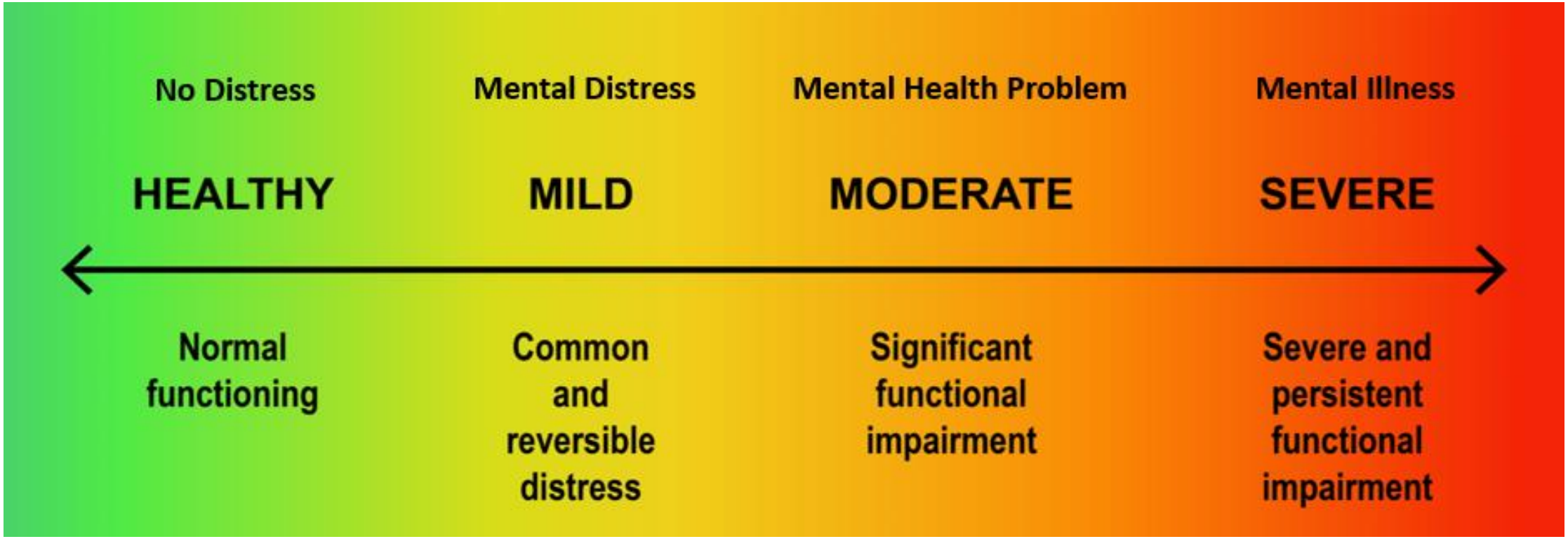
- Most recent United States Bureau of Justice Statistics (BJS) (2021) data from survey completed in 2016, indicates an estimated 107,400 veterans were incarcerated.
- 98% were male
- The majority of male veterans in state (56%) and federal (53%) prison served in the Army
- About 1 in 4 male veterans in state (28%) and 1 in 5 in federal (21%) prison were combat veterans
- An estimated 74% of male veterans in state prison and 77% of those in federal prison received an honorable discharge or a general discharge under honorable conditions

Justice-Involved Veterans

- Offenses ~43% non-violent (BJS, 2021)
- BJS (2006) 60% of all US jail inmates had mental health problem
- 5 in 6 of justice-involved veterans with a MH dx had received no previous treatment (Smith and Johnson, 2016)
- BJS (2002) found 65% had alcohol or drug dependency problem (Mumola, 2002)
- Historically, reports of Vietnam and Post-Vietnam era veterans with histories of civilian and military trauma suggest an association between trauma and subsequent contact with the legal system

Mental Health Conditions in the Veteran Population

Mental Health Continuum



Serious Mental Illness

- Serious Mental Illness (SMI) – SMI is a smaller and more severe subset of mental health conditions.
- Defined as one or more mental, behavioral, or emotional disorder(s) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities (NIMH).
- Psychotic spectrum and Bipolar Spectrum
- Approximately 3% to 5 % receiving healthcare in the VA meet criteria for SMI (Mcarthy et al., 2007; Trivedi et al., 2015)

Personality Disorders

Personality disorders are a class of mental disorders characterized by enduring maladaptive patterns of behavior, cognition, and inner experience, exhibited across many contexts and deviating from those accepted by the individual's culture.

- Meta Analysis (Edwards et al., 2022)
- Highest rates
  - 23% paranoid personality disorder
  - 21% borderline personality disorder
  - Lowest rates
  - Histrionic (.8%)
  - Rates were generally highest among veterans experiencing substance use or elevated suicide risk

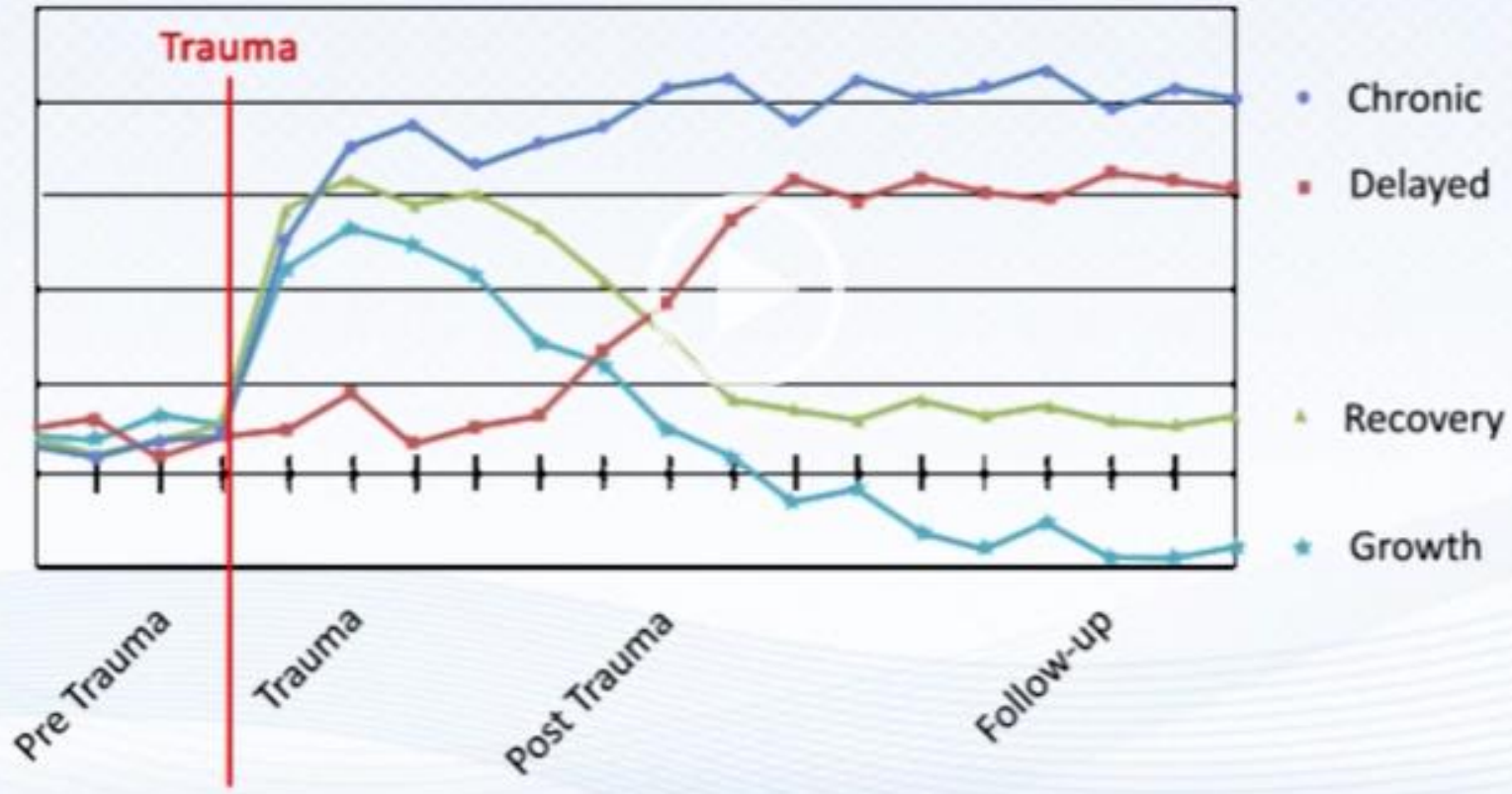
Post Traumatic Stress Disorder (PTSD)

Trauma ≠ PTSD

Not all trauma leads to PTSD

Depending on the study, the type of trauma, and the group studied, 3%-58% develop PTSD

Possible Trajectories of Emotional Responses to Trauma



Based on a slide from Foy (2009)

PTSD in Veterans: Epidemiology

- The prevalence of PTSD in the veteran population is between 2% and 23% in US veterans (Smith & Johnson, 2020)
- True prevalence rates are unknown
  - There are notable differences between studies, including variations in sampling methods and measurement strategies
  - Multifactorial, inherently subjective, and evolving nature of PTSD presents significant challenges in accurately defining its epidemiology.

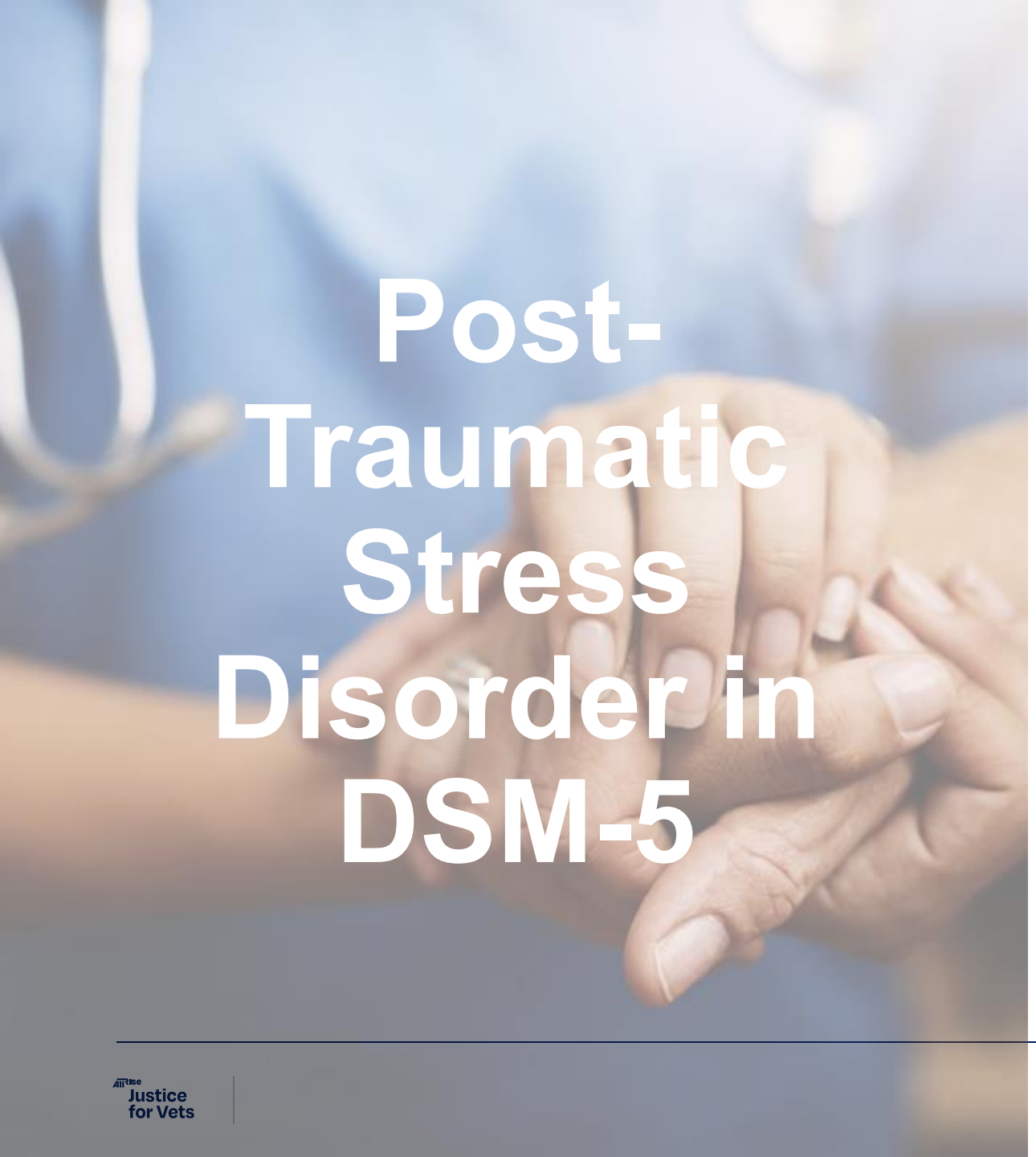
PTSD: Risk Factors for Veterans

- Childhood trauma places individuals at a higher risk of subsequently developing PTSD (Breslau et al., 1999; Seifert et al., 2011).
- Frequency and intensity of combat exposure
- Lower rank
- Being unmarried
- Having low level of education
- Being in close proximity to the enemy
- Experiencing low morale or poor unit social support
- Being unaware of common psychological reactions upon returning home

(Hoge et al., 2004)

PTSD: Risk Factors for Veterans, cont.

- Being female
- Being enlisted
- Serving in the Army
- Having a combat specialty
- Having undergone multiple deployments for longer periods
- Experiencing prior adverse life events
- Having pre-existing psychological problems (Xue et al., 2015; Richardson et al, 2010)
- Absence of post-deployment psychological and social support



Post-Traumatic Stress Disorder in DSM-5

PTSD is characterized by:

- Exposure to a severe life-threatening event
- Repetitive re-experiencing of the event
- Avoidance of stimuli associated with trauma
- Negative moods and cognitions
- Increased arousal

PTSD: Exposure to a Life-Threatening Event

A) Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s)
2. Witnessing, in person, the event(s) as it occurred to others
3. Learning that the traumatic event(s) occurred to a close family member or friend, the event(s) must have been violent or accidental
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse)

PTSD: Re-experiencing

B) Intrusion symptoms:

- Recurrent, involuntary and intrusive recollections
- Traumatic nightmares
- Dissociative reactions (e.g., flashbacks)
- Intense or prolonged distress after exposure to traumatic reminders
- Marked physiological reactivity to trauma-related stimuli

PTSD: Avoidance of Stimuli Associated with Traumatic Event

C) Persistent effortful avoidance of distressing trauma-related stimuli after the event:

- Trauma-related internal reminders (e.g., memories, thoughts, and feelings)
- Trauma-related external reminders (i.e., persons, places, conversations, objects, situations, aromas, activities, etc.)

PTSD: Negative Cognitions and Mood

D) Negative alterations in cognitions and mood that began or worsened after the traumatic event:

- Inability to recall key features of the traumatic event
- Persistent negative beliefs and expectations about self or world
- Persistent distorted blame of self or others for causing the event or the resulting consequences

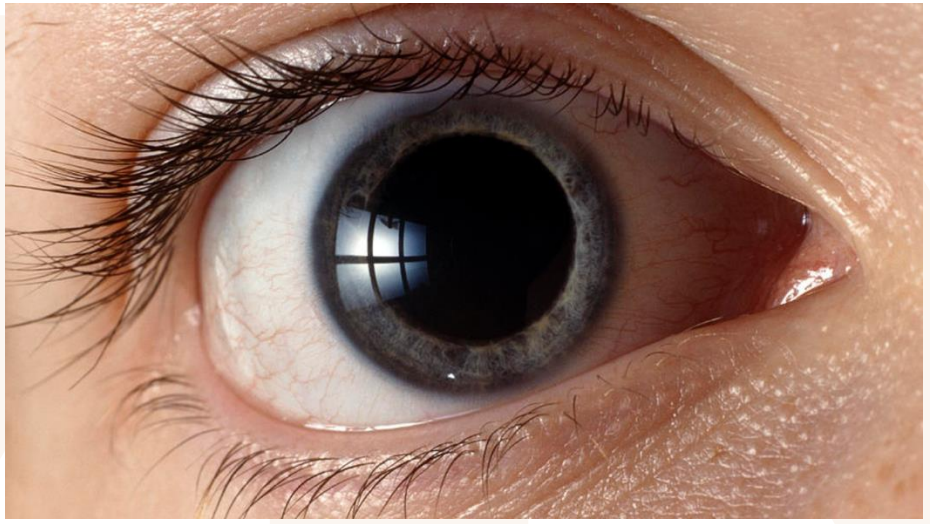
PTSD: Negative Cognitions and Mood, cont.

- Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame)
- Markedly diminished interest in significant activities
- Feeling alienated from others
- Constricted affect: persistent inability to experience positive emotions

PTSD: Increased Arousal and Reactivity

E) Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event:

- Irritable or aggressive behavior
- *Self-destructive or reckless behavior*
- Hypervigilance
- Exaggerated startle response
- Problems in concentration
- Sleep disturbance



PTSD: A New Subtype

Dissociative Subtype of PTSD:

- Meets criteria for a diagnosis of PTSD
- Experiences high levels of depersonalization or derealization
- Dissociative symptoms are not related to substance abuse or other medical condition

Other Trauma or Stressor-Related Disorder

- Some of the symptoms of PTSD but not all
- Formerly referenced as sub-clinical PTSD or partial PTSD
- Can be missing a criterion
  - Re-experiencing
  - Avoidance
- Can be partially-resolved PTSD
  - Due to time
  - Due to treatment

What is Complex Trauma?

- The psychological effects of chronic and cumulative traumas
- Results from interpersonal victimization, multiple traumatic events, and/or traumatic exposure of prolonged duration
  - Sexual and physical abuse
  - Intimate Partner Violence
  - Ethnic cleansing
  - Prisoners of war
  - Torture
  - Being held hostage

Complex PTSD

Complex psychological trauma results from "exposure to severe stressors that (1) are repetitive or prolonged, (2) involve harm or abandonment by caregivers or other ostensibly responsible adults, and (3) occur at developmentally vulnerable times in the victim's life.

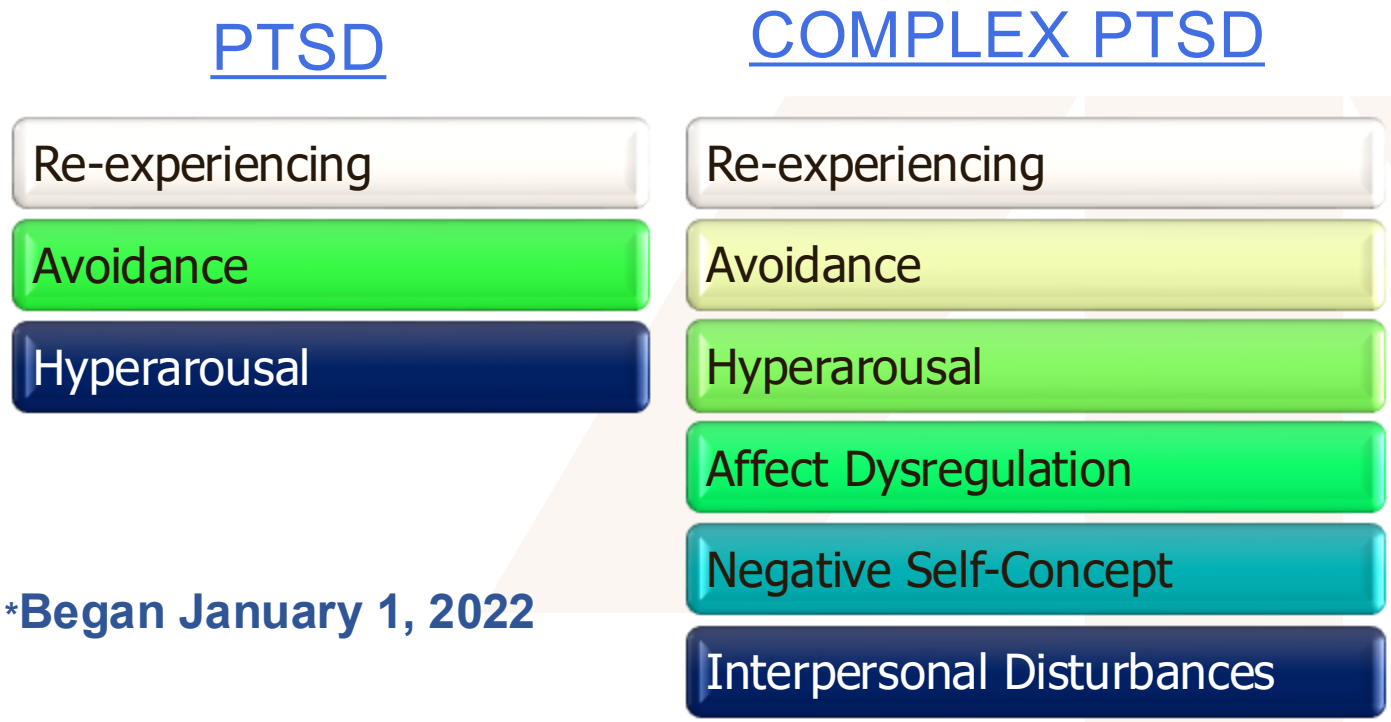
(Ford and Courtois, 2009)

Core Problems in Complex PTSD

- Affect dysregulation
- Dissociation
- Somatic dysregulation
- Impaired self-concept
- Disorganized attachment patterns
- In addition to symptoms of PTSD and other comorbid disorders

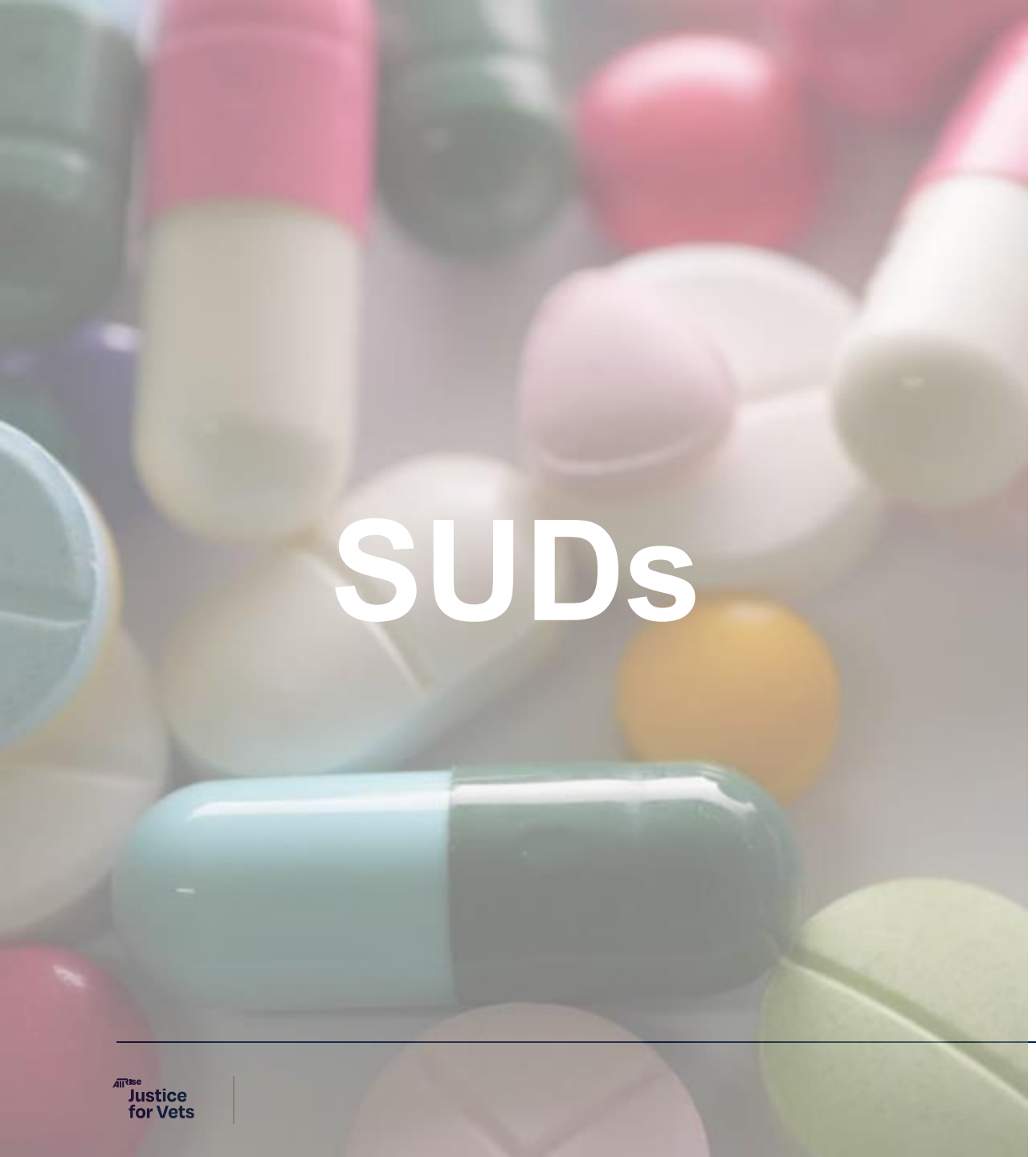
(Ford and Courtois, 2009)

Complex PTSD in International Classification of Diseases -11



*Began January 1, 2022

Substance Use Disorders (SUDs)



SUDs

- Characterized by a pattern of drug use leading to distress or impairment
- Diagnosis requires at least 2 of 11 symptoms, categorized under 4 groups
  - Impaired control
  - Social impairment
  - Risky use
  - Pharmacological effects
- Which occur over a year

Substance Use Disorders

Addiction is now recognized as a chronic relapsing disorder triggered by repeat drug exposure in individuals vulnerable to genetics, development, and psychosocial conditions

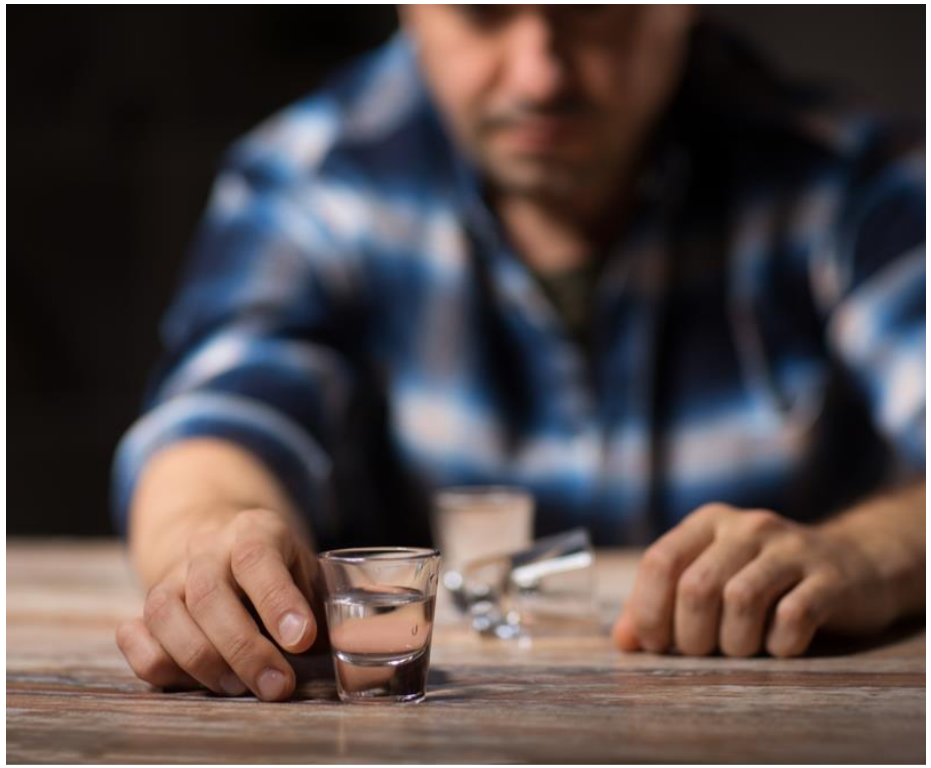
The reinforcing effects of drug use heavily rely on dopamine signaling at the nucleus accumbens in the brain

Chronic exposure leads to glutamate-mediated adaptations in the striato-thalamo-cortical pathway, particularly in the prefrontal cortex at the orbitofrontal and anterior cingulate cortices

Substance Use Disorders

- True prevalence of SUDs in veterans is unclear
- Changes to DSM criteria
- Not all veterans receive care through the VA
- More common in males than females (10.5% alcohol and 4.8% other drugs vs 4.8% and 2.4%, respectively)
- Unmarried
- Younger than 25
- Childhood trauma exposure

Substance Use Disorders: Alcohol



- Alcohol Use Disorders (AUDs) are the most prevalent SUDs
- Veterans are more likely to consuming alcohol than non-veterans (56% to 50.8%, respectively)
- Veterans more likely to engage in heavy alcohol use than non-veterans over 1 month period (7.5% to 6.5%, respectively)

(Teeters et al., 2017)

Substance Use Disorders: Alcohol

- Military personnel who experienced more combat had higher rates of problematic drinking than their peers
  - Heavy drinking rates
    - 26.8% (vs.17%)
  - Binge drinking
    - 54.8% (vs 45%)

(Teeters et al., 2017)

Substance Use Disorders: Opioids

- A diagnosis of PTSD (17.8%) or other mental health disorders (11.7%) significantly increased the likelihood of receiving an opioid prescription compared to those without such diagnoses (6.5%) (Teeters et al., 2017)
- Between 2001 and 2009 Opioid prescriptions increased from 17% to 24% (Bohnert et al., 2011)
- The Dept of VA reduced the number of opioid prescriptions by 67% since 2012, from 874,897 Veterans in 2012 to 288,820 in 2023 (Dept of VA, 2023)

Substance Use Disorders

- Illicit drugs use among veterans is comparable to civilians
- Among veterans, marijuana is the most commonly used *illicit drug
- Cannabis use disorders increased by 50% between 2002 and 2009 among VA patients

  (Teeters et al., 2017)

Substance Use: Suicide/Death

- A study conducted on military personnel revealed that approximately 30% of completed suicides and around 20% deaths resulting from high-risk behavior were attributed to alcohol or drug use (Smith et al., 2014)
- In the general US population, alcohol is the fourth leading cause of preventable death, contributing to 31% of driving-related fatalities involving alcohol intoxication (Teeters et al., 2017)

Trauma, PTSD and SUD

Co-occurrence of PTSD and Substance Use Disorder

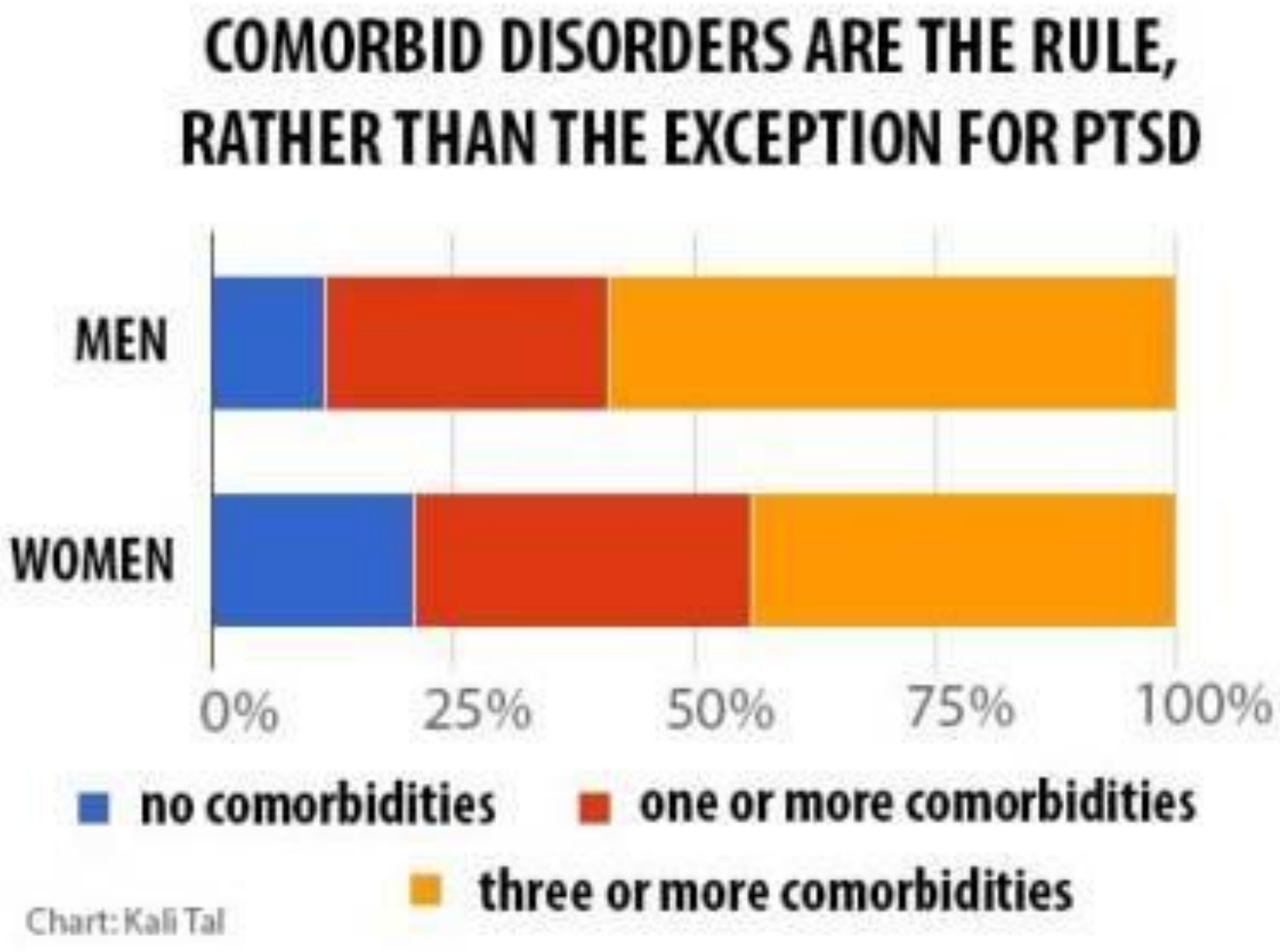
Co-occurring disorders are the rule rather than the exception.

(SAMHSA, 2002)

Co-occurrence of PTSD and Substance Abuse

Kessler et al., 1995

Figure 1



PTSD is Associated with Other Psychological Problems

PTSD and Substance Use Disorder

Substance use disorders are 3-4 times more prevalent in people with PTSD than those without PTSD (Khantzian & Albanese, 2008)
The presence of either disorder alone increases the risk for the development of the other
PTSD increases the risk of alcohol relapse (Heffner et al., 2011) and substance relapse (Norman et al., 2007)
The combination results in poorer treatment outcomes (Ouimette et al., 2003; Sonne et al., 2003)

PTSD & SUD: Justice-Involved Veterans

- A study of 15,000 veterans found that, in addition to more severe symptoms of PTSD and depression, **justice-involved veterans** were **nearly twice as likely** to report alcohol misuse and opioid misuse compared to veterans with no history of justice involvement (Holliday et al., 2021)
- Research suggests that the odds of justice system involvement are 61% greater among veterans with PTSD than veterans without PTSD (Taylor et al., 2020)

PTSD and Substance Use Disorder

1. PTSD does not go away with abstinence; in fact, it may get *worse*, at least initially
2. Improvement in PTSD symptoms does not bring about abstinence from substance use
3. Even if substance use began as self-medication, it takes on a life of its own
4. Separate treatment is usually uncoordinated and at worst counter-therapeutic
5. Integrated treatment leads to better outcomes

Integrated Treatment of Co-occurring Disorders

- Treating one disorder without treating the other is ineffective
- Sequential treatment (usually SUD first) is ineffective
- Fully integrated treatment is optimal
- Simultaneous treatment is next best

Depression

Depression

- Common condition in the general population, but it is often underdiagnosed
- According to the World Health Organization, depression is the 2nd leading cause of disability in the world and is projected to rank first by 2030 (WHO, 2004)
- Depression is associated with high rates of suicidal behavior and mortality
  - Suicide risk during a depressive episode equivalent to around 15% (WHO, 2017; Ponsoni et al., 2018)

Depression

- Major Depressive Disorder (MDD) can be diagnosed when a patient experienced 1 or more depressive episodes
- Depressive episode
  - Having 5 symptoms present during 2 weeks and a change in baseline functioning.
    - Depressed mood
    - Anhedonia
    - Weight loss or gain
    - Variable sleep
    - Psychomotor agitation or retardation
    - Fatigue
    - Feelings of worthlessness or excessive guilt
    - Decreased concentration
    - Morbid thinking

Depression- What is it?

Etiology/cause remains unclear

Definite connection between Major Depressive Disorder (MDD) and neurobiology

Heightened responses to cortisol (stress hormone) in the Hypothalamic-Pituitary-Adrenal (HPA) axis potentially explaining how stress becomes a significant risk factor

Neurocircuitry of emotions (dysfunction in the cortico-striato-pallido-thalamic circuitry) could contribute to the emotional experience of MDD which has been supported by neurophysiological imaging (Price and Drevets, 2010).

Depression: Risk factors

General Population

- Unemployment
- Financial stress
- Female gender
- Personal or parental history of mental health concerns

Depression: Risk factors

Military

- Uniform Code of Military Justice actions (legal concerns)
- Rank and promotion complications
- Deployments
- Combat exposure
- Physical fitness concerns
- Permanent changes of station (frequent relocations)
- Command or leadership discord

Depression: Epidemiology

General Population

- MDD is the most prevalent mood disorder in the general population with an estimated lifetime prevalence of up to 21%
- Females (as high as 25%)
  - Males (as high as 12%)
  - (Vilagut et al., 2016; Greenberg et al., 2012; Kessler et al., 2003)

Depression: Epidemiology

Veteran Population

- Gulf War veterans have a risk of suffering from depression that is more than twice that of the general population (Blore et al., 2015)
- According to a report in 2012, 15% of troops who returned from deployment had symptoms consistent with MDD (Greenberg et al., 2012)

Suicide

SUICIDE

- Suicide is a leading public health problem, being a leading cause of injury and death at a worldwide level, with **approximately one million people who die by suicide per year** and an estimate of around **one suicide death occurring every 40 seconds** (WHO, 2018)

- Suicide is ranked as the 2nd leading cause of death among people ages 10 to 34 and 10th among all age groups (WHO, 2018; Stone et al., 2017)

Suicide Rates: Veterans

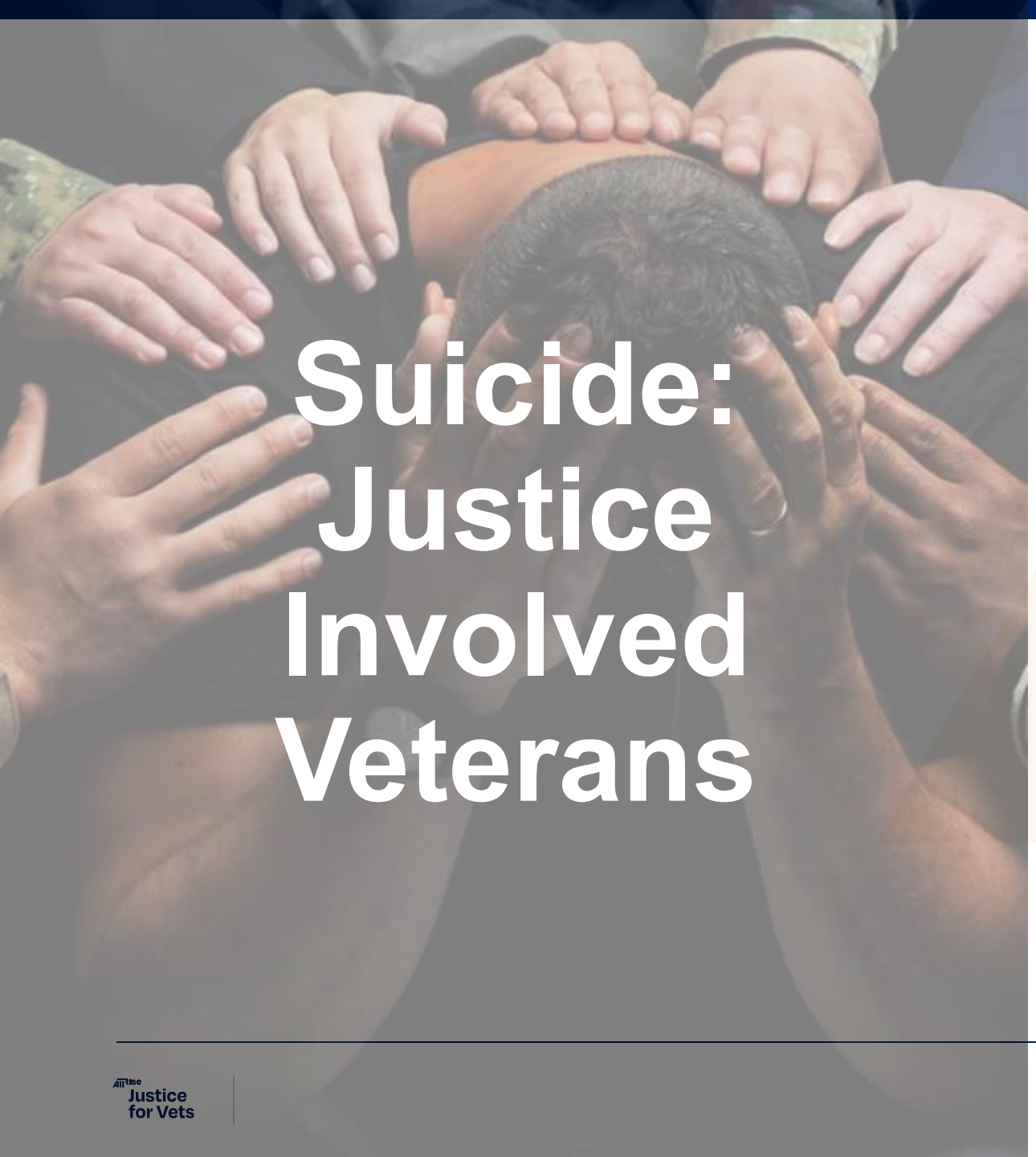
- Veteran suicide rates have reached their highest level in recorded history, with over **6000 veterans dying by suicide annually** (Nichter et al., 2020)
- Suicide rates within the United States have **increased by 30%** between 1999 and 2016.
- According to a study conducted in 27 US states, it was estimated that veterans committed 17.8% of reported suicide cases (Stone et al., 2015)
- Data published by the U.S. Department of Veterans Affairs (VA) in 2016 indicated that veteran suicide rates were **1.5 times higher than those of non-veterans** (Green et al., 2018)

Suicide: Veterans

Veterans are at significantly increased risk of suicide during their first year after leaving the military service (Shen et al., 2016)

The suicide rates in the US Armed Forces doubled between 2000 and 2012; however, since then, there has not been any significant change in the annual rates of suicides with approximately 19.74% deaths per 100,000 service members occurring each year (Pruitt et al., 2019)

Veterans are 57.3% more likely to die by suicide than non-veterans, with estimates ranging from 17 to 24 veterans dying by suicide in the U.S. each day (Dept of VA, 2024)



Suicide: Justice Involved Veterans

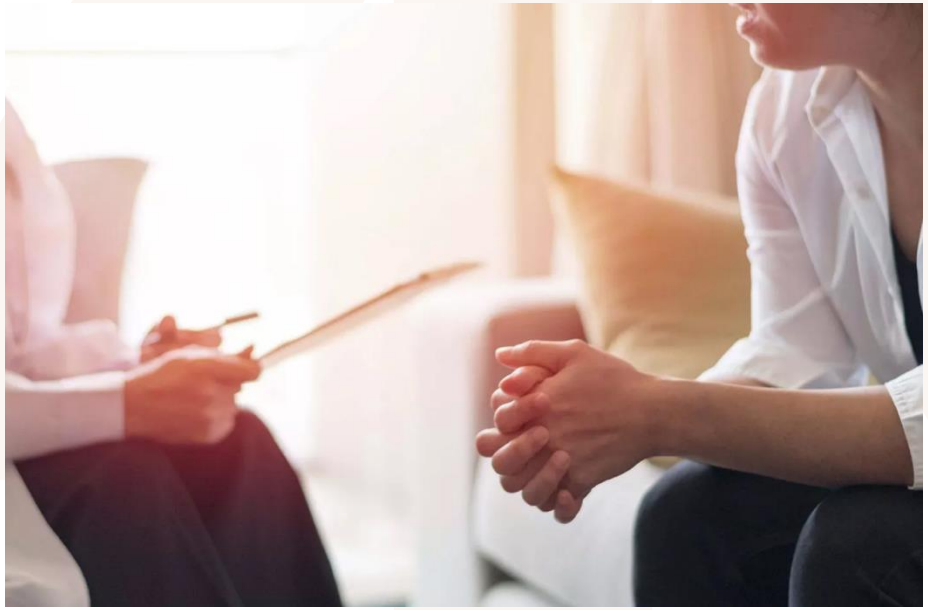
- Research suggests that justice-involved veterans are **almost twice as likely** to attempt suicide as veterans who do not encounter the criminal justice system (Holliday, 2021)

- The causal relationship between justice involvement and suicide risk is unclear. Difficulty to ascertain if it is a direct relationship vs reflecting other factors such as PTSD, MDD, etc.

Treatment: What works

The Therapeutic Relationship

- Build an alliance first
  - Respect
  - Caring
  - Unconditional positive regard
  - Be genuine
- Research shows that the therapeutic relationship is more important than the type of therapy provided (Wampold, 2015)



Research Driven Treatment for Depression

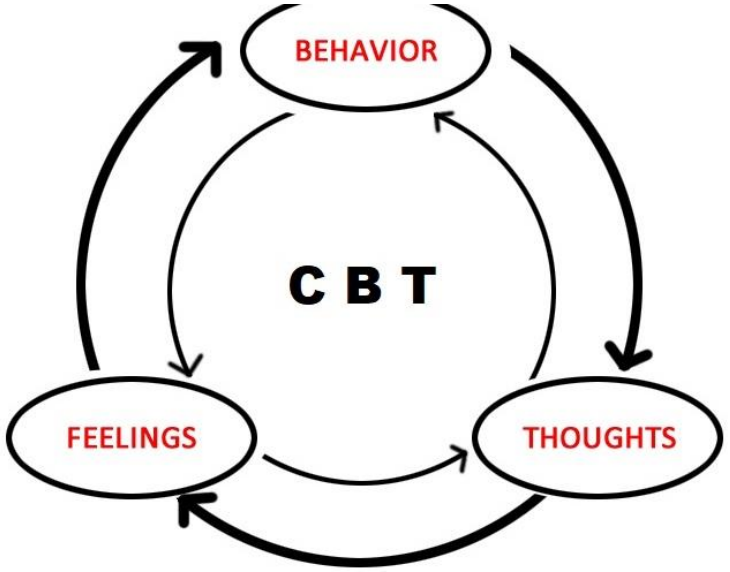
Pharmacotherapy

- Selective Serotonin Reuptake Inhibitors (SSRIs) are the medicinal Gold Standard
- Selective Neurotransmitter Reuptake Inhibitors (SNRI)
- Monoamine Oxidase Inhibitors (MAOI)- less commonly used given side effects, hepatotoxicity and other medical issues
- Tricyclic Antidepressants (TCAs) – Appears most effective for those requiring hospitalization for severe depressive symptoms. Comparable efficacy as SSRI/SNRI; however, more side effects make it less prescribed

Evidenced-Based Therapies for Depression

- Cognitive Behavioral Therapy (CBT)
- Interpersonal Psychotherapy (IPT)
- Mindfulness-Based cognitive Therapy (MBCT)
- Psychodynamic Therapy

Cognitive Behavioral Therapy



Targets current problems and symptoms and focuses on recognizing the relationship between behaviors, thoughts, and feelings and changing patterns that reduce pleasure and interfere with a person's ability to function at their best

CBT + SSRI –strong efficacy in treating MDD

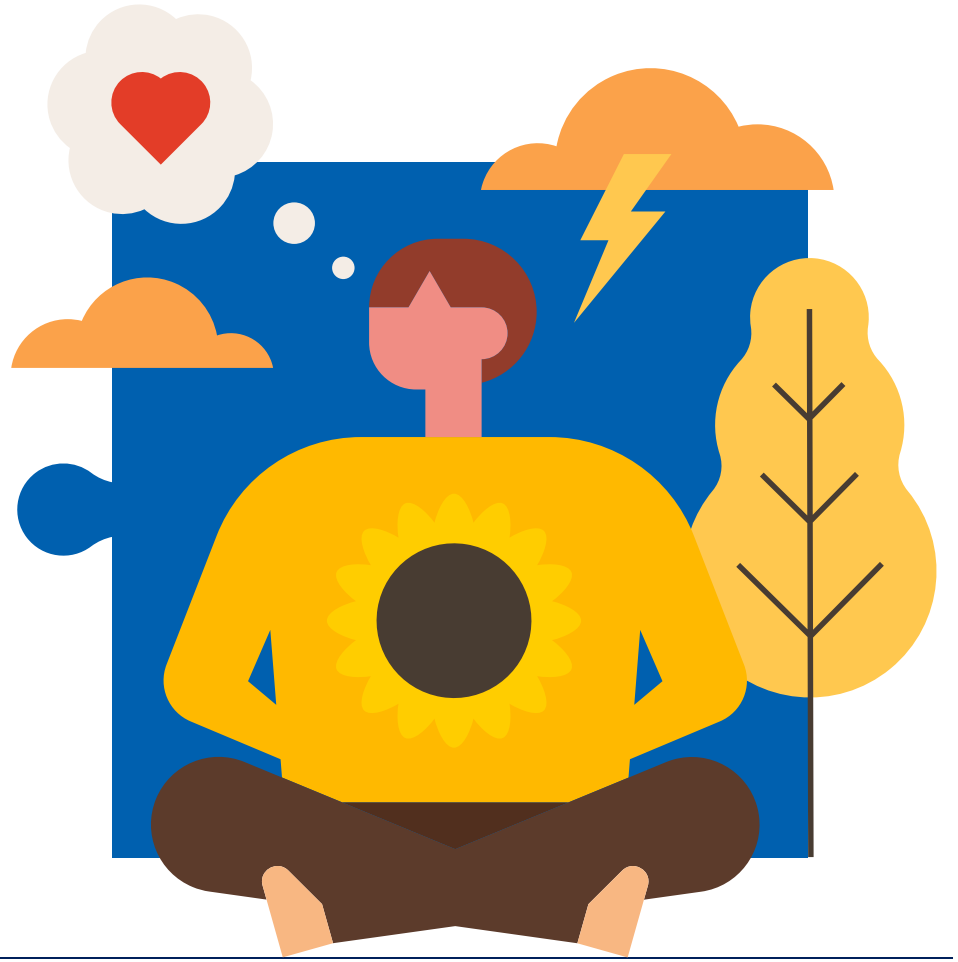
Adding CBT to SSRI associated with 27% additional improvement compared to simply providing an SSRI alone (Strawn et al., 2022)

Interpersonal Psychotherapy (IPT)

- Interpersonal psychotherapy focuses on improving problematic relationships and circumstances that are most closely linked to the current depressive episode

Mindfulness-Based Cognitive Therapy (MBCT)

- MBCT combines strategies of cognitive therapy with mindfulness meditation to modify unhelpful thoughts and compassionate self-view.



Psychodynamic Therapy

- Psychodynamic therapy focuses on unconscious thoughts, early experiences and the therapeutic relationship to understand current challenges, improve self-awareness and support the patient in developing more adaptive patterns of functioning.

Evidence-Based Treatments for SUDs

Evidence-based Medications for SUDs

- To help manage withdrawal symptoms, reduce cravings, prevent a return to use, and reduce risk of death related to SUD
- Opioid Use Disorder
  - Methadone, buprenorphine, Suboxone, extended-release naltrexone
- Alcohol Use Disorder
  - Acamprosate, disulfiram, naltrexone and topiramate
- Tobacco Use Disorder
  - Nicotine replacement therapy, bupropion and varenicline

Evidence-based therapies for SUDs

- Cognitive Behavioral Therapy (CBT)
- Motivational Interviewing (MI)
- Motivational Enhancement Therapy (MET)
- Contingency Management (CM)

Therapies for SUDs: Cognitive Behavioral Therapy

- Helps veterans with SUD develop more balanced and helpful thoughts about themselves, others, and the future.
- Can help veterans manage the urge to drink or use drugs, refuse opportunities to use substances
- Uses a problem-solving approach to deal with substance use disorder, and achieve personal goals

Therapies for SUDs: Motivational Interviewing

Involves conversations between the veteran and their provider to help identify and strengthen personal motivations for change.

In this therapy, veterans look at their reasons they want to make a change and the potential benefits of that change.

Therapies for SUDs: Motivational Enhancement Therapy

- This treatment is a version of MI that focuses specifically on changing unhealthy alcohol or substance use.

Therapies for SUDs: Contingency Management

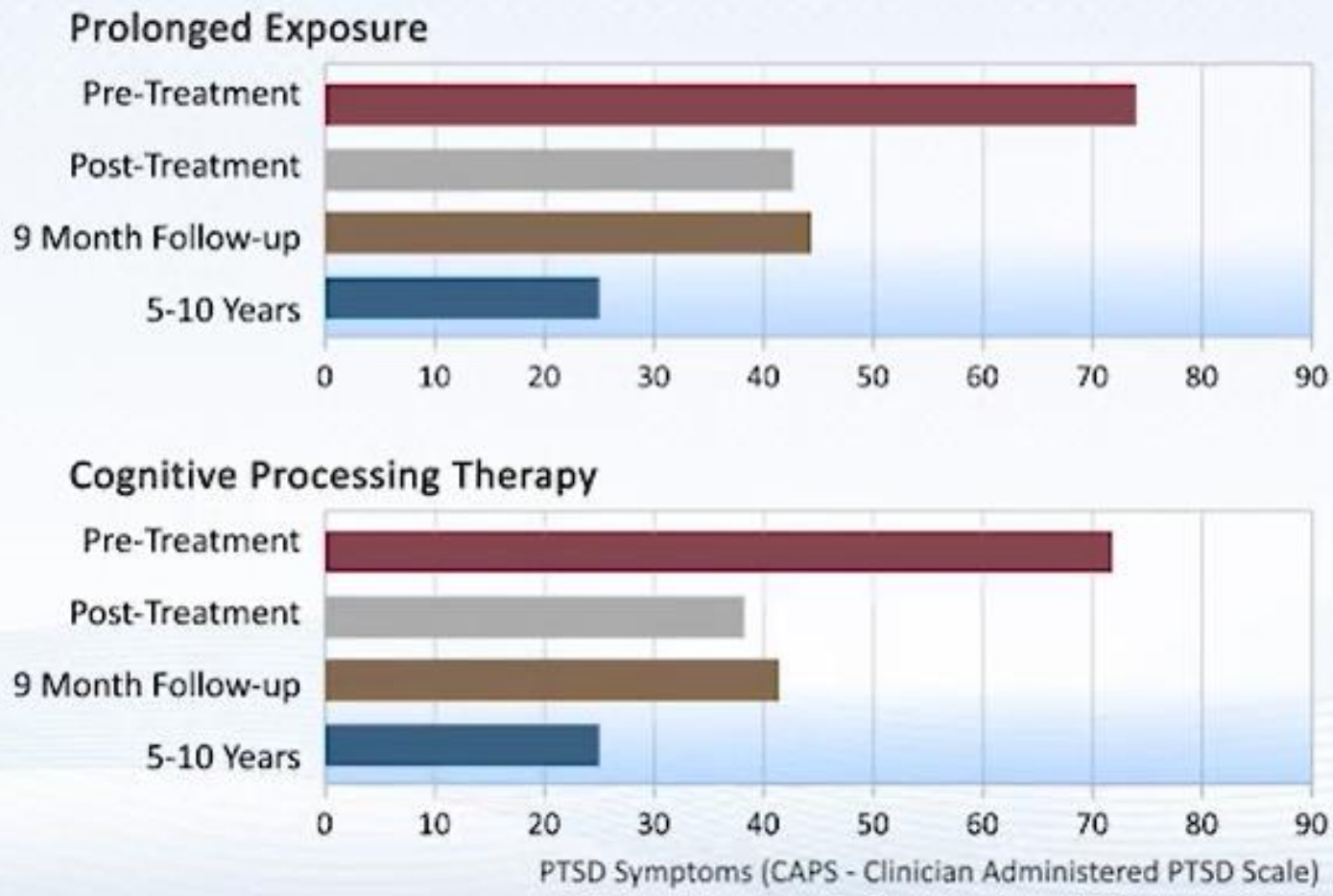
- This is a therapy in which the patient receives incentives for completing recovery behaviors such as abstinence verified by urine drug screens.
- The incentives increase in size with consistent performance of the recovery behavior.

Research Driven Treatments for PTSD

Treatment of PTSD: Medication

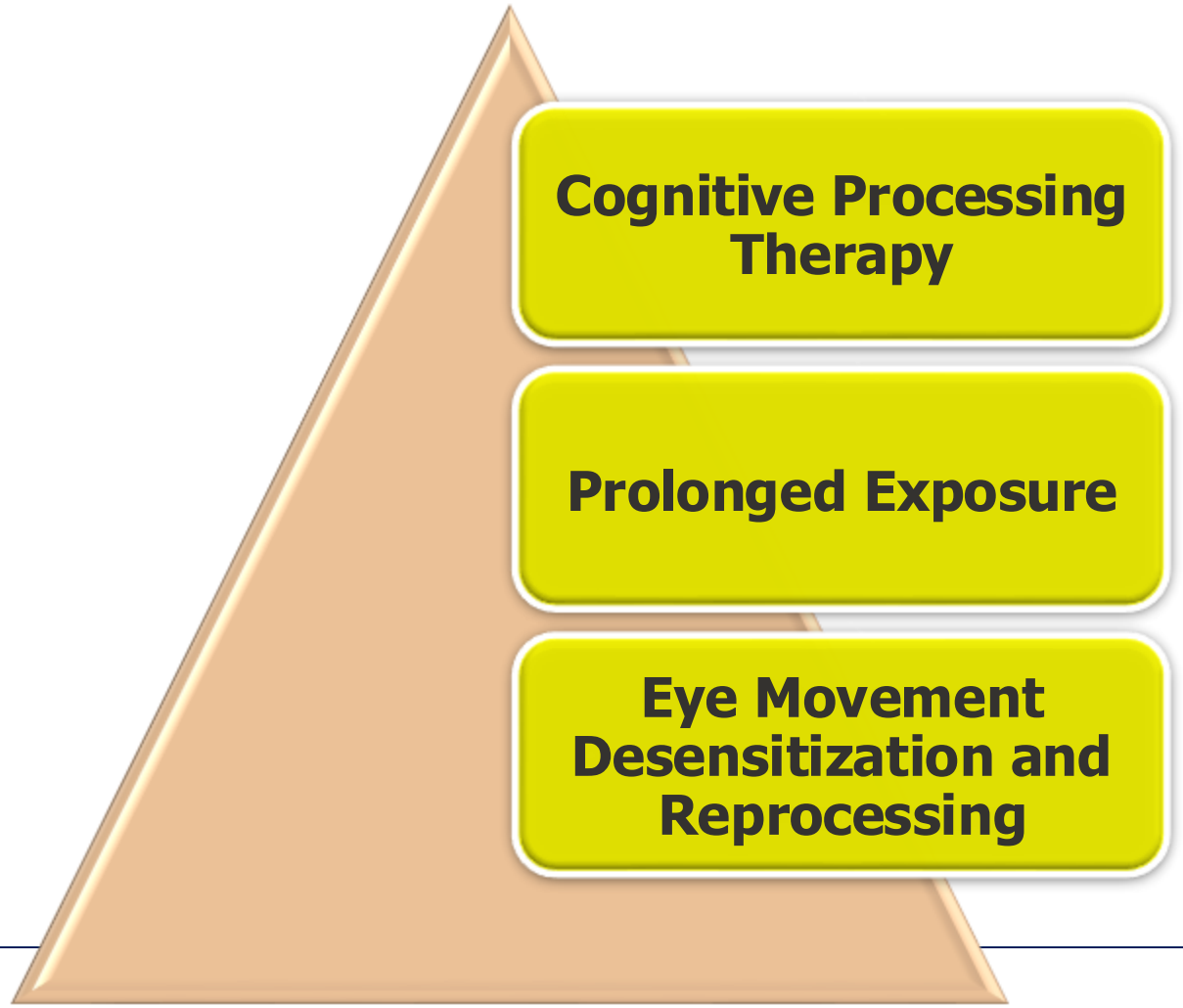
- There is no medication that specifically “treats” or “cures” PTSD
- Evidence is strongest for certain medications
  - SSRIs (Zoloft[Sertraline], Paxil[Paroxetine])
  - SNRI (Effexor[Venlafaxine])
- Currently, only Sertraline and Paroxetine have been approved by the FDA

Effects of Trauma Focused Cognitive Psychotherapy Last



(Resick et al., 2002)

Evidence-Based Treatments for PTSD



Cognitive Processing Therapy

- A cognitive based intervention to change the way a traumatized person thinks
- 12 weekly sessions delivered in a structured, manualized protocol
  - Number of sessions can be expanded
- Can be delivered individually and/or in groups
- Homework worksheets between sessions
- Central techniques:
  - Identifies stuck points
  - Examines evidence for thoughts and beliefs
  - Challenges beliefs

Prolonged Exposure

- A behavioral intervention that repeatedly exposes patients to distressing stimuli in order to decrease their anxiety in response to those stimuli
- **First part** involves *in vivo* exposure to places that increase anxiety (e.g., public places)
- **Second part** involves writing and dictating a trauma narrative focusing on one traumatic experience

Eye Movement Desensitization and Reprocessing (EMDR)

- Patient focuses on distressing image
  - States a belief that goes with it
  - Notices emotions that go with it
  - Identifies body sensations that go with it
- Therapist passes fingers back and forth, guiding the eyes
- As this occurs, the images, thoughts, feelings, and body sensations change
- Similar to how information is processed during rapid eye movement sleep

Promising Treatments

Written Exposure Therapy

Narrative Exposure Therapy

Conjoint Behavioral Couples Therapy for PTSD in veterans

Interpersonal Regulation (STAIR) Narrative Therapy uses coping skills from Stress Inoculation Training and

Mindfulness-Based Stress Reduction, a combination of Yoga and Meditation

Cognitive-Behavioral Therapy for Insomnia

Imagery Rehearsal Therapy (for nightmares)

Seeking Safety

25 lessons on topics that overlap between PTSD and Substance Misuse

- Safety Skills
- Grounding
- Anger
- Boundaries
- Self-care
- Honesty
- Compassion

Dialectical Behavioral Therapy (DBT) Skills Training

Four topics with multiple lessons

- Mindfulness
- Interpersonal Effectiveness
- Distress Tolerance
- Affect Regulation

18 Randomized Controlled Trials, results all positive

Clinical Considerations- What to do?

Screenings

Suicide

Anxiety

Depression

PTSD

Etoh/SA

Mental Health/Substance Abuse Treatment

- Individual
- Group (psychoeducation, support, MH condition specific, skills development processing)
- Couples/family
- Outpatient
- Residential

Resources

Assessment Resources for PTSD

- ACE questionnaire http://www.ncjfcj.org/sites/default/files/Finding_Your_ACE_Score.pdf
- Life Events Checklist 5 https://www.ptsd.va.gov/professional/assessment/documents/LEC-5_Standard_Self-report.pdf
- PCL 5 https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp
- International Trauma Questionnaire

  https://www.traumameasuresglobal.com/itq

PTSD and SUDs

- *Trauma and Substance Abuse (2nd ed.)* by Page Ouimette and Jennifer Read
- PTSD 101 course about treating PTSD and SUDs: www.ptsd.va.gov/professional/ptsd101/course-modules/SUD.asp
- Practice recommendations for treating co-occurring PTSD and SUDs: www.ptsd.va.gov/professional/pages/handouts-pdf/SUD_PTSD_Practice_Recommend.pdf

Seeking Safety

- *Seeking Safety* (2002), Lisa Najavits
- *Finding Your Best Self* (2019), Lisa Najavits
- http://www.treatment-innovations.org/seeking-safety.html

Dialectical Behavioral Therapy

- *Cognitive-Behavioral Treatment of Borderline Personality Disorder* (1993), Marsha Linehan
- *DBT Skills Training Manual, 2nd edition* (2014), Marsha Linehan
- *DBT Skills Training Handouts and Worksheets, 2nd edition* (2014), Marsha Linehan
- http://www.behavioraltech.com
- http://www.linehaninstitute.org/

Resources for PTSD

- *Handbook of PTSD, 2nd ed.* (2014), Matthew Friedman, Terence Keane, and Patricia Resick
- *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma* (2014), Bessel van der Kolk
- *The PTSD Workbook: Simple, Effective Techniques for Overcoming Traumatic Stress Symptoms, 2nd ed.* (2013), Mary Beth Williams and Soili Poijula

Resources for PTSD

- National Center for PTSD: www.ptsd.va.gov
- International Society for Traumatic Stress Studies: www.istss.org
- International Society for the Study of Trauma and Dissociation: www.isst-d.org
- World Health Organization, (2018). The ICD-11 for mortality and morbidity statistics. Retrieved from https://icd.who.int/browse11/l-m/e
- PTSD 101 courses: www.ptsd.va.gov/professional/ptsd101/course-modules.asp
- PTSD Decision Aid https://www.ptsd.va.gov/apps/decisionaid/

Prolonged Exposure

- *Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences Therapist Guide* (2007), Edna Foa, Elizabeth Hembree and Barbara Olaslov Rothbaum
- *Reclaiming Your Life from a Traumatic Experience: A Prolonged Exposure Treatment Program Workbook* (2007), Barbara Rothbaum, Edna Foa and Elizabeth Hembree
- Online courses: http://www.deploymentpsych.org/online-courses/pe

Cognitive Processing Therapy

- *Cognitive Processing Therapy for PTSD: A Comprehensive Manual* (2016), Patricia Resick, Candice Monson, and Kathleen Chard
- Online courses:

  https://cpt.musc.edu

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

EMDR

- *Eye Movement Desensitization and Reprocessing (EMDR): Basic Principles, Protocols, and Procedures, 2nd Ed.* (2001), Francine Shapiro
- *Light in the Heart of Darkness: EMDR and the Treatment of War and Terrorism Survivors* (2001), Steven Silver & Susan Rogers
- *Getting Past Your Past: Take Control of Your Life with Self-Help Techniques from EMDR Therapy* (2013), Francine Shapiro
- www.emdr.com
- www.emdria.org
- www.emdrhap.org

Self-Help Mobile Applications

http://www.t2health.org/mobile-apps

- PTSD Coach
- PTSD Family Coach
- Breathe 2 Relax
- Tactical Breather
- LifeArmor (includes family section)

Mobile Applications That Assist Psychotherapy

- PE Coach
- CPT Coach
- CBT-I Coach
- Mindfulness Coach

Resources for depression: CBT

- American Psychological Association, Div. 12: Society of Clinical Psychology. (n.d.). What is cognitive behavioral therapy? https://www.apa.org/ptsd-guideline/patients-and-families/cognitive-behavioral.pdf (PDF, 244KB)
- Beck, J.S. (2011). *Cognitive behavior therapy: Basics and beyond*. Guilford Press. https://beckinstitute.org/product/basics-and-beyond/
- Craske, M.G. (2017). *Cognitive-behavioral therapy* (2nd ed.). American Psychological Association. https://www.apa.org/pubs/books/4317445
- Muñoz, R.F., & Miranda, J. (1996). *Individual therapy manual for cognitive-behavioral treatment of depression.* https://www.rand.org/content/dam/rand/pubs/monograph_reports/2005/MR1198.6.pdf (PDF, 2.29MB)
- Persons, J.B., Davidson, J., & Tompkins, M.A. (2001). *Essential components of cognitive-behavior therapy for depression*. American Psychological Association. https://www.apa.org/pubs/books/431758A?tab=2

Resources for depression: IPT

- American Psychological Association, Div. 12: Society of Clinical Psychology. (n.d.). Treatment: Interpersonal psychotherapy for depression. https://www.div12.org/treatment/interpersonal-psychotherapy-for-depression/
- Bleiberg, K.L., & Markowitz, J.C. (2008). Interpersonal psychotherapy for depression. In D.H. Barlow (Ed.) *Clinical handbook of psychological disorders* (4th ed., pp. 306-327). Guilford Press. https://psycnet.apa.org/record/2008-00599-000
- Frank, E., & Levenson, J.C. (2011). *Interpersonal psychotherapy*. American Psychological Association. https://www.apa.org/pubs/books/4317234
- Ravitz, P., Watson, P., & Grigoriadis, S. (2013). *Psychotherapy essentials to go: Interpersonal psychotherapy for depression* (P. Ravitz, & R. Maunder, (Eds.)) W.W. Norton https://books.wwnorton.com/books/978-0-393-70829-5/
- Weissman, M.M. (1995). *Mastering depression through interpersonal psychotherapy: Patient workbook*. Oxford University Press. https://global.oup.com/academic/product/mastering-depression-through-interpersonal-psychotherapy-9780195188479?cc=us&lang=en&
- Weissman, M.M., Markowitz, J.C., & Klerman, G. L. (2017). *The guide to interpersonal psychotherapy: Updated and expanded edition*. Oxford University Press. https://www.oxfordclinicalpsych.com/view/10.1093/med-psych/9780190662592.001.0001/med-9780190662592

Resources for depression: MBCT

- American Psychological Association, Div. 12: Society of Clinical Psychology. (n.d.). Treatment: Mindfulness-based cognitive therapy. https://www.div12.org/treatment/mindfulness-based-cognitive-therapy/
- Kuyken, W., & Evans, A. (2014). Mindfulness-based cognitive therapy for recurrent depression. In R.A. Baer (Ed.) *Mindfulness-based treatment approaches* (2nd ed.). Academic Press. https://www.elsevier.com/books/mindfulness-based-treatment-approaches/baer/978-0-12-416031-6
- Segal, Z.V., Williams, M., & Teasdale, J. (2012). *Mindfulness-based cognitive therapy for depression* (2nd ed.). Guilford Press. https://www.guilford.com/books/Mindfulness-Based-Cognitive-Therapy-for-Depression/Segal-Williams-Teasdale/9781462537037
- Teasdale, J., Williams, M., & Segal, Z.V. (2014). *The mindful way workbook: An 8-week program to free yourself from depression and emotional distress*. Guilford Press. https://www.guilford.com/books/The-Mindful-Way-Workbook/Teasdale-Williams-Segal/9781462508143
- Williams, M., Teasdale, J., Segal, Z.V., & Kabat-Zinn, J. (2007). *The mindful way through depression: Freeing yourself from chronic unhappiness*. Guilford Press. https://www.guilford.com/books/The-Mindful-Way-through-Depression/Williams-Teasdale-Segal-Kabat-Zinn/9781593851286

Resources for depression: Psychodynamic therapy

- American Psychological Association, Div. 12: Society of Clinical Psychology. (n.d.). Short-term psychodynamic therapy for depression. https://www.div12.org/treatment/short-term-psychodynamic-therapy-for-depression/
- Barber, J. P., Muran, J. C., McCarthy, K. S., Keefe, J. R., & Zilcha-Mano, S. (2021). Research on dynamic therapies. In M. Barkham, W. Lutz, & L. G. Castonguay (Eds.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (7th ed., pp. 387-420). Wiley. https://www.wiley.com/en-af/Bergin+and+Garfield's+Handbook+of+Psychotherapy+and+Behavior+Change,+6th+Edition-p-9781118415924
- Busch, F.N., Rudden, M., & Shapiro, T. (2016). *Psychodynamic treatment of depression*(2nd ed.). American Psychiatric Publishing. https://www.appi.org/Psychodynamic_Treatment_of_Depression_Second_Edition
- Driessen, E., Hegelmaier, L.M., Abbass, A.A., Barber, J.P., Dekker, J.J.M., Van, H. L.,…Jansma, E. P. & Cuijpers, P. (2015). *The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis update. Clinical Psychology Review, 42*, 1–15. http://dx.doi.org/10.1016/j.cpr.2015.07.004

Resources for depression: Psychodynamic therapy cont.

- Eppel, A. (2018). A manual for short-term psychodynamic psychotherapy. In *Short-term psychodynamic psychotherapy* (pp. 133-168). Springer. https://www.springer.com/us/book/9783319749945
- Gabbard, G.O. (2017). *Long-term psychodynamic psychotherapy: A basic text* (3rd ed.). American Psychiatric Publishing. https://www.appi.org/Long-Term_Psychodynamic_Psychotherapy_Third_Edition
- Haggerty, J. (2018). Psychodynamic psychotherapy. https://psychcentral.com/lib/psychodynamic-therapy/
- Messer, S.B., & Warren, C.S. (1998). *Models of brief psychodynamic therapy: A comparative approach*. Guilford Press. https://psycnet.apa.org/record/1995-98730-000
- Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist 65*(2), 98-109. https://psycnet.apa.org/fulltext/2010-02208-012.pdf
- Summers, R.J. & Barber, J.P. (2009). *Psychodynamic psychotherapy: A guide to evidence-based practice*. Guilford Press. https://www.guilford.com/books/Psychodynamic-Therapy/Summers-Barber/9781462509706/reviews

QUESTIONS?

Evaluations

1. On your compatible phone or tablet, open the built-in camera app.
2. Point the camera at the QR code.
3. Tap the banner that appears on your phone or tablet.
4. Follow the instructions on the screen to complete the evaluation.
5. After completion, you will be provided with a certificate that can be saved and printed.

Justice for Vets

Thank You

Dr. Meghan Geiss, PhD, LCP

REHABILITATION NEUROPSYCHOLOGIST

Meghan.geiss1@gmail.com