Knowledge Gaps Among Behavioral Health Professionals at Center for Deployment Psychology Trainings

- David J. Reynolds, PhD

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Thanks!

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Disclosures

Presenter has no interest to disclose.

AMSUS and ACE/PESG staff have no interest to disclose.

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Disclaimer

The views expressed are those of the presenter 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

At the conclusion of this activity, the participant will be able to:

1. **Identify several areas where behavioral health professionals may have knowledge gaps**
2. **Discuss potential implications of such gaps**
3. **Describe ways to remedy these knowledge gaps**

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CE/CME Credit

If you would like to receive continuing education credit for this activity, please visit:

http://amsus.cds.pesgce.com

Hurry,

CE Certificates will only be

available for 30 DAYS

after this event!

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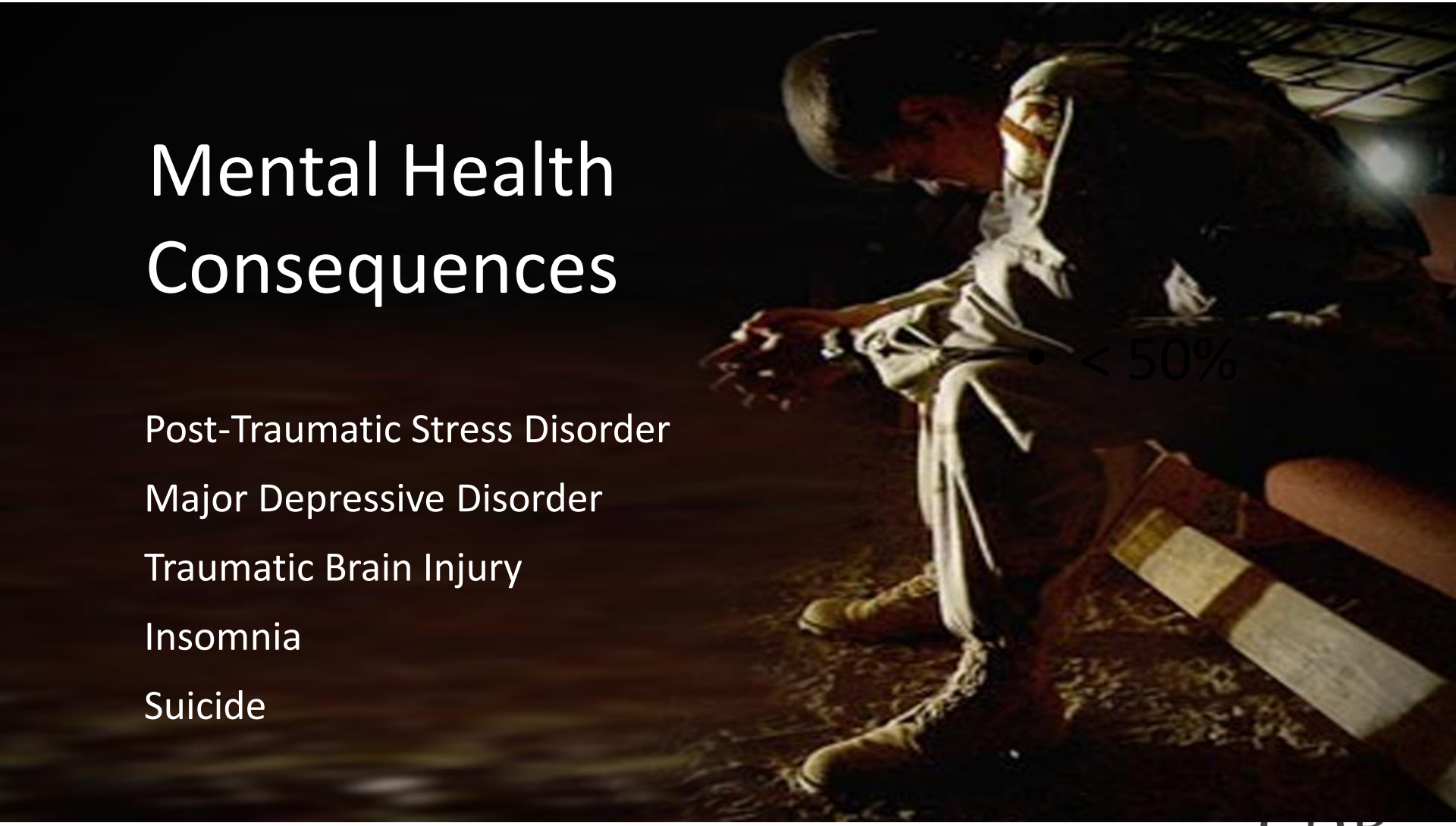
CDP

Uniformed Services University

Mental Health Consequences



- < 50%

Post-Traumatic Stress Disorder

Major Depressive Disorder

Traumatic Brain Injury

Insomnia

Suicide

CDP

Uniformed Services University

CDP Overview

- Established in 2006, CDP leads the development of a community of culturally mindful and clinically competent providers through high-quality training and education programs.

- ***Increase*** the number of MH providers prepared to treat military personnel and families
- ***Train*** providers to use evidence-based treatments
- ***Educate*** providers on the unique stress of deployment
- ***Prepare*** civilian providers to effectively treat military personnel
- ***Convene*** experts to exchange, integrate and consolidate knowledge

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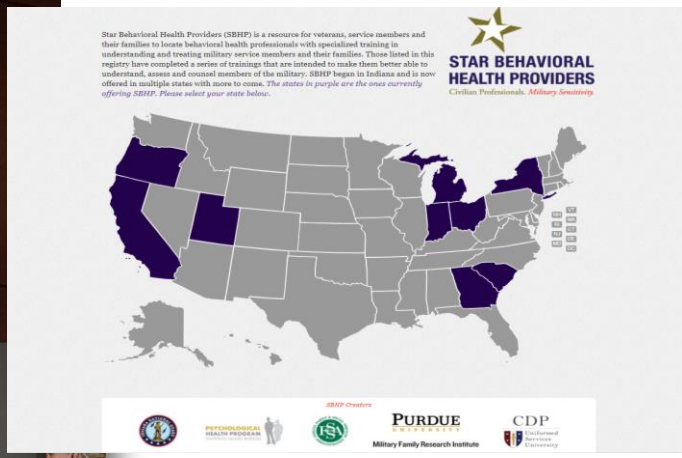
Evidence-Based Psychotherapies

CDP

Uniformed Services University

Traditional Workshops



CDP
Uniformed Services University

Online Workshops

Second Life Training Auditorium

Zoom Breakout room role plays

Online Training and Support

Self-paced online courses
Podcasts
Blog
Metaphor Bank
EBP videos
PE Session Notes
Consultation Calls and Message Board

CDP Presents - Monthly Webinar Series

CDP PRESENTS
MONTHLY WEBINAR SERIES

Welcome to CDP Presents, our monthly webinar series! This ongoing series will be hosted by CDP subject matter experts, as well as guest speakers, and will cover a variety of deployment and military psychology-related topics. Most of these events will also include 1 free CE for participants of the live versions. (For specific information about CE eligibility, please click on the event below.) These 1 to 1.5 hour webinars will include time for questions from the audience. For those unable to attend live, recordings will be available here afterwards. Please note, that CEs are not available for the recorded versions.

If you have a suggestion for a topic or a speaker you'd like to see as part of the CDP Presents webinar series, click here to let us know!

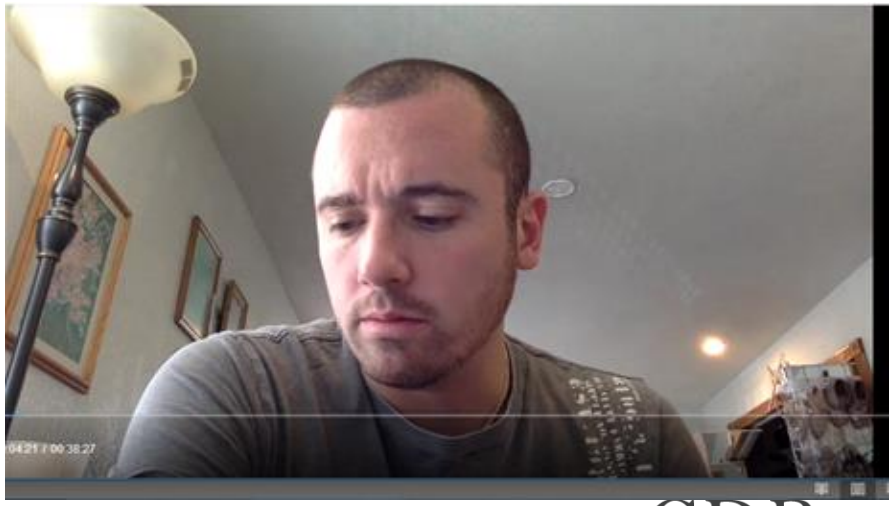
OPERATION AVATAR

A Virtual Allegory of Trauma, Assessment, & Recovery

"Snoozeum"

aka

Museum of Sleep Assessment and Treatment (MOSAT)



CDP

Uniformed Services University

CDP's Warfighter Impact

- CDP was developed to better prepare military behavioral health providers to deploy and to more effectively treat Service members with deployment related psychological health issues

CDP Future Directions

1. Dissemination and Implementation Research
2. Leverage training delivery expertise in collaboration with USU Centers

CDP (2006 – 2018)

Over 40,000 trained!

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EBP Knowledge Items

1. CDP trainings entail knowledge checks
   a. Pre-training survey items
   b. In-training polling questions
   c. Post-testing (10 items)
2. 2017; APA made post-tests mandatory
3. CDP reduced number of post-test items to 10 to accommodate PESI's other eval questions

Cognitive Therapy for Suicide Prevention

1. 2-day training covering ~13 hrs of content
   a. based on Dr. Aaron Beck's cognitive-behavioral model; breaks down "suicide mode"; trans-dx
   b. risk assessment, safety plan, means restriction
   c. relaxation, beh activation, inc. social resources
   d. cog restructuring
   e. relapse prevention; guided imagery & imaginal exposure to future stressors

Cognitive Therapy for Suicide Prevention

Of the following terms, which is currently recommended to describe the act of suicide?

a. Killed oneself
b. Died by suicide
c. Successful suicide
d. Completed suicide
e. Committed suicide

Cognitive Therapy for Suicide Prevention

Of the following terms, which is currently recommended to describe the act of suicide?

a. Killed oneself
b. Died by suicide
c. Successful suicide
d. Completed suicide
e. Committed suicide

Cognitive Therapy for Suicide Prevention

Of the following terms, which is currently recommended to describe the act of suicide?

a. Killed oneself – 0%
b. Died by suicide – 20%
c. Successful suicide – 0%
d. Completed suicide – 73%
e. Committed suicide – 7%

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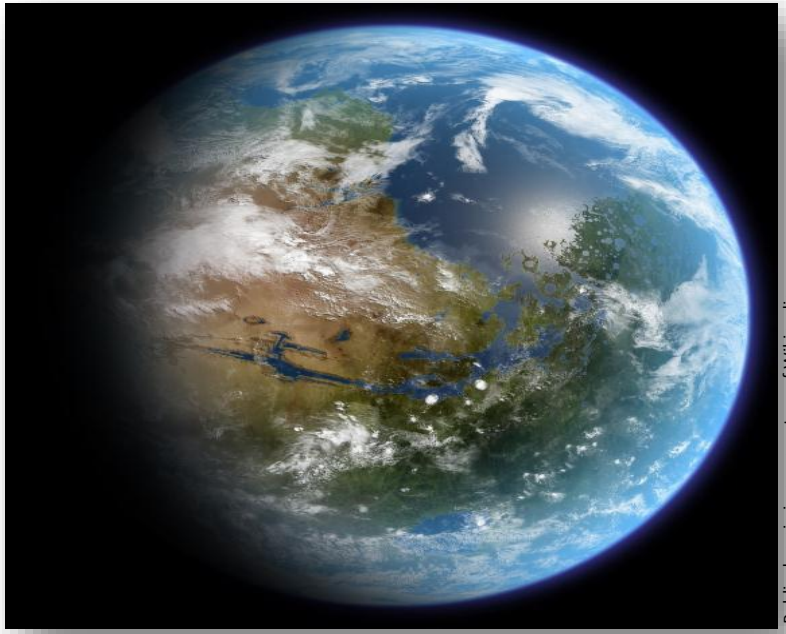
Cognitive Therapy for Suicide Prevention

73% of professionals picked “completed suicide"

So what?

1. Stigmatizing language (Beaton et al., 2013)
2. 2015 DoD Strategy for Suicide Prevention



Public domain image courtesy of Wikipedia

Every year…

Globally	Nationally
Over 800,000 deaths	Steady rise since 2000
11.4 per 100,000	13.4 per 100,000
1 every 40 sec	1 every 12.3 minutes

Curtin et al. (2016); Kochanek et al. (2016) ; World Health Organization (2014)

Cognitive Therapy for Suicide Prevention

On average, approximately how many active duty DoD suicide deaths (including activated National Guard and Reserve personnel) were reported each year between 2009 and 2012?

a. 60
b. 300
c. 600
d. 3000
e. 6000

DoD Suicides & Suicide Rates by Service: Active Component

	All Services	Air Force	Army	Marine Corps	Navy	General Population (CY 2014)
Total Count	266	64	120	39	43	42,826
Rate/ 100K	**20.2**	**20.5**	**24.4**	**21.2**	**13.1**	**13.4**

Pruitt et al. (2016); Centers for Disease Control and Prevention (2016)

Cognitive Therapy for Suicide Prevention

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Cognitive Therapy for Suicide Prevention

On average, approximately how many active duty DoD suicide deaths (including activated National Guard and Reserve personnel) were reported each year between 2009 and 2012?

a. 60
b. 300
c. 600
d. 3000
e. 6000

62% of professionals overestimated (picked c, d, or e)

Do therapists' perceived base rates impact hospitalization rates?

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Cognitive Therapy for Suicide Prevention

So what?

- BHPs who overestimate the annual rate of death by suicide may be more likely to assign higher risk ratings to patients
- Hospitalization rates?

Cognitive Therapy for Suicide Prevention

Of the following treatments, which has the strongest support for an intervention which leads to decreases in suicide attempts and suicidal ideation?

a. SAFEVet
b. Safety Planning
c. Dialectical Behavior Therapy (DBT)
d. Cognitive Behavioral Therapy (CBT)
e. Collaborative Assessment and Management of Suicidality (CAMS)

VA/DoD Clinical Practice Guidelines

- Suicide-focused psychotherapy to address suicide risk
  - Cognitive therapy is recommended for non-psychotic patients who survived a recent attempt
  - Problem-solving therapy is recommended for non-psychotic patients with more than one attempt
- Early evidence-based interventions to target specific symptoms
- Follow-up and monitoring

Department of Veterans Affairs/Department of Defense (2013)

Empirically-Supported Treatments

- Dialectical Behavior Therapy
  - Linehan (1993)
- Cognitive Therapy for Suicidal Patients
  - Wenzel, et al. (2009)

Cognitive Therapy for Suicide Prevention

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Cognitive Therapy for Suicide Prevention

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d. Cognitive Behavioral Therapy (CBT)
e. Collaborative Assessment and Management of Suicidality (CAMS)

72%

Cognitive Therapy for Suicide Prevention

So what?

- Might not pursue training in DBT
- Might not allow subordinates to get DBT training

Suicide

Approximately what percentage of military suicides occurs in a deployed location?

1. <5%
2. 5-10%
3. 11-15%
4. 16-20%
5. 21-25%

Suicide

Approximately what percentage of military suicides occurs in a deployed location?

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Military Risk Factors

- Relationship Problems*
- Hopelessness/Worthlessness
- Substance Misuse
- Feelings of Disgrace
- Stressful Military Life Events
- Separation from Service
- Easy Access to Firearms
- Moral Injury
- Unexplained Mood Change/Depression
- Financial, Legal or Job Performance Problems
- Medical or Administrative Discharge Processing
- Sleep Problems
- Previous Suicide Attempts**

Bryan et al. (2015); Jones et al. (2012); Khazem et al. (2016); LeardMann et al. (2013); Litz et al. (2009); Martin et al. (2009); Reger et al. (2015); Ribeiro et al. (2012); Shen et al. (2016)

Suicide

Approximately what percentage of military suicides occurs in a deployed location?

1. ~~<5%~~ 45% underestimated
2. 5-10% 32% got it right
3. 11-15% \
4. 16-20% --> 23% overestimated the rate
5. 21-25% /

Suicides While Deployed

So what?

- Underestimation may lead to lack of screening
- Overestimation may lead to early return to CONUS
- Perception of increased risk where there is none

Cognitive Behavioral Therapy for Depression (CBT-D)

2-day workshop covering ~13 hrs of content

- Explore prevalence rates of depression in military populations
- Point out treatment considerations specific to a military population when utilizing CBT-D
- Review the VA/DoD Depression CPG

Pick the correct statement about the VA/DoD CPG for Depression

a. The CPG recommends 3 first-line treatments for severe MDD and 6 first-line treatments for mild-to-moderate MDD.
b. The CPG does not distinguish between different severities of MDD when recommending first-line treatments.
c. CBT is the only therapy with a behavioral component that is recognized as a first-line treatment for MDD.
d. First line treatments have the most anecdotal/informal evidence in support of their effectiveness.
e. Only CBT & Acceptance and Commitment Therapy (ACT) are recognized in the CPG as effective treatments for mild to moderate MDD.

Pick the correct statement about the VA/DoD CPG for Depression

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VA/DoD CPG for Depression

So what?

- Providers might not know there are multiple options depending on severity level

Cognitive Behavioral Therapy for Depression (CBT-D)

Based upon surveys conducted by RAND and the DoD between 2008 and 2011, which range best describes the approximate percentage of active duty Service members and recently returned OIF/OEF Veterans who reported symptoms of depression?

a. 0 – 9%
b. 10 – 19%
c. 20 – 29%
d. 30 – 39%
e. 40 – 49%

Depression Among Returned OEF/OIF Service Members

Tanielian et al. (2008) - RAND Report "Invisible Wounds of War"

- An estimated 13.7% met study criteria for "probable depression"

Thomas et al. (2010)

12 Month Post-deployment	Depression Symptoms	Depression Symptoms/ Some Impairment	Depression Symptoms/ Functional Impairment
Active Component	15.7%	14.4%	8.5%
Reserve Component	15.9%	13.7%	7.3%

Cognitive Behavioral Therapy for Depression (CBT-D)

Based upon surveys conducted by RAND and the DoD between 2008 and 2011, which range best describes the approximate percentage of active duty Service members and recently returned OIF/OEF Veterans who reported symptoms of depression?

a. 0 – 9%

b. 10 – 19%

c. 20 – 29%

d. 30 – 39%

e. 40 – 49%

74% chose C, D, or E

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Cognitive Behavioral Therapy for Depression (CBT-D)

So what?

- Over diagnosis of depression
- Misdiagnosis

Cognitive Behavioral Therapy for Insomnia (CBT-I)

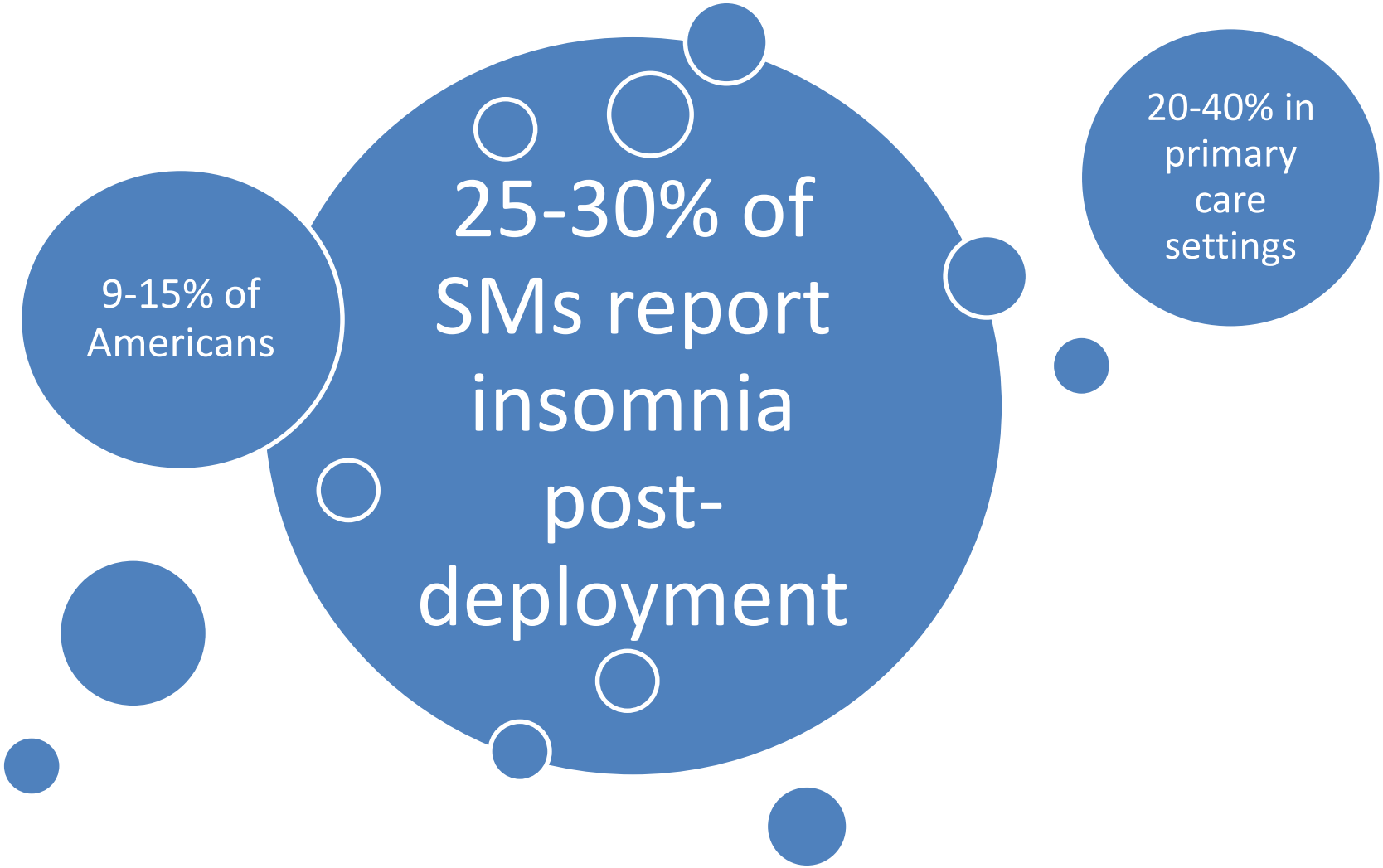
- Insomnia in the military & civilian populations
- Overview of ab/normal human sleep
- Insomnia assessment, diagnosis & treatment
- CBT for Insomnia
  - Session 1: Assessment, sleep log
  - Session 2+: Behavioral, cognitive interventions
  - Considerations, adaptations, and comorbidities

Cognitive Behavioral Therapy for Insomnia (CBT-I)

Which of the following represent the top 2 concerns or conditions among military personnel following a deployment?

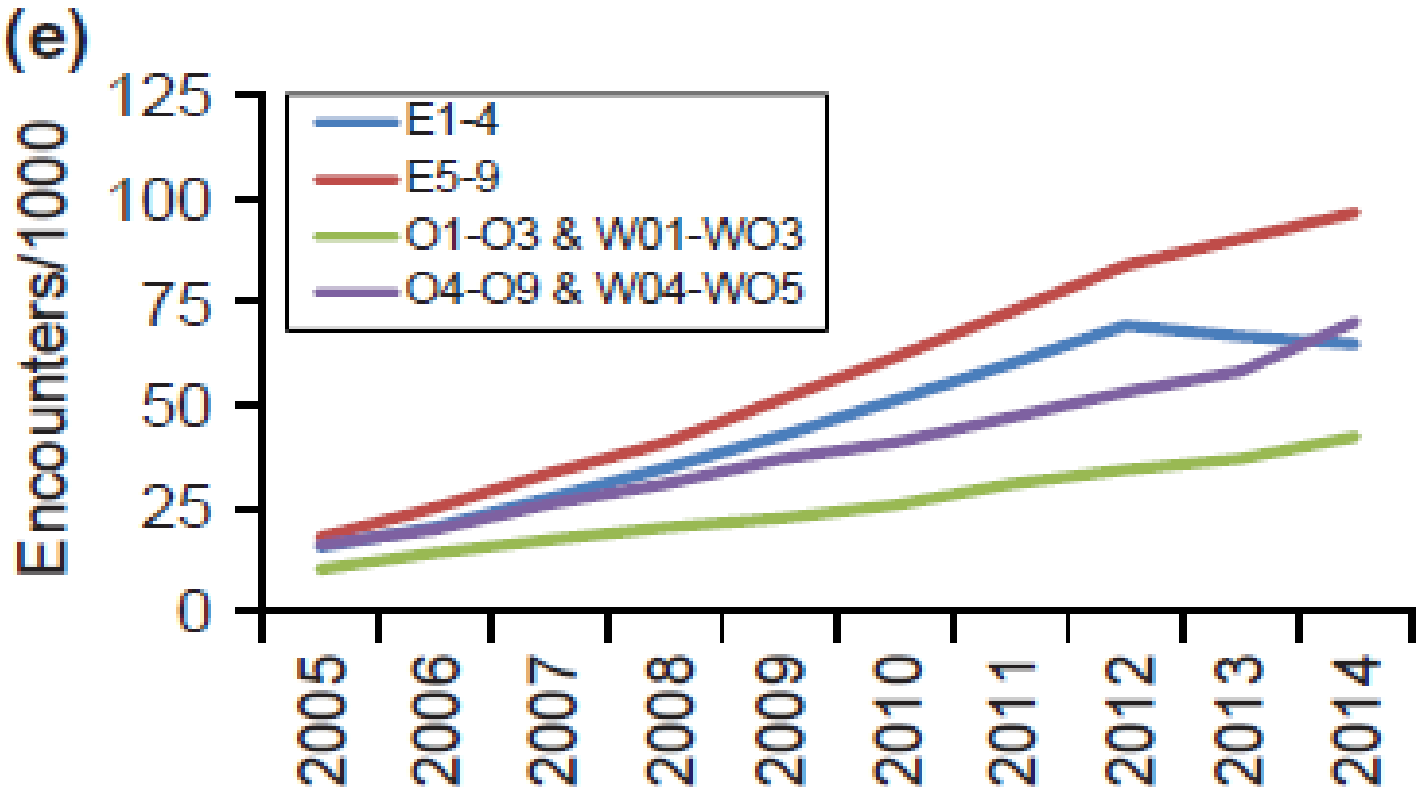
a. (1) PTSD, (2) Sleep problems
b. (1) Insomnia, (2) Sleep problems
c. (1) Relationship problems, (2) PTSD
d. (1) Sleep problems, (2) Back problems
e. (1) Insomnia, (2) Relationship problems

Insomnia Prevalence



Ellis et al, 2012; Roth et al, 2011; pdhra.mil; Seelig et al, 2010

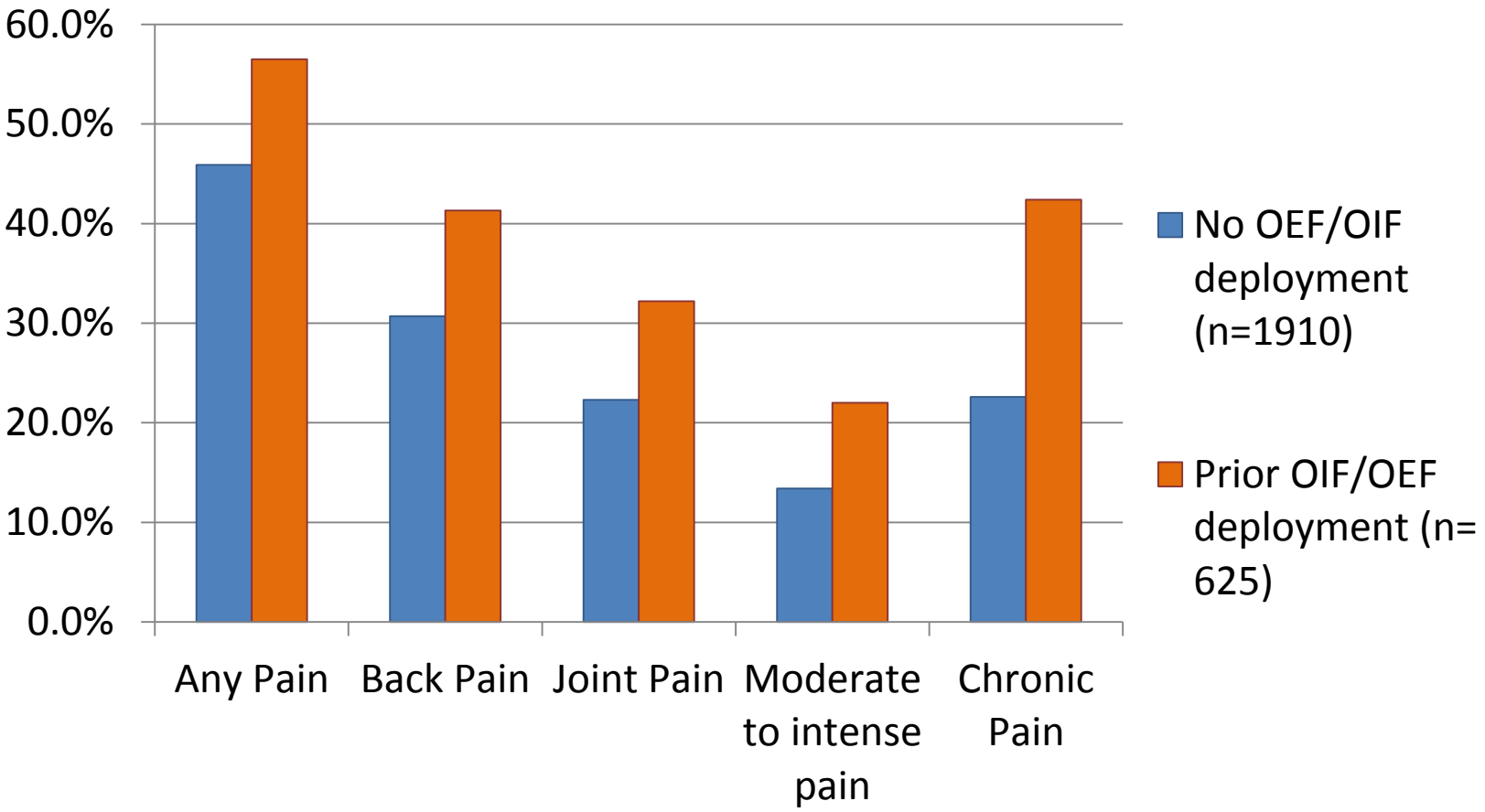
Insomnia



Caldwell et al, 2017

Chronic Pain & Deployment

Anonymous 2008 survey of 2,543 National Guard troops



Kline et al. (2010)

Cognitive Behavioral Therapy for Insomnia (CBT-I)

Which of the following represent the top 2 concerns or conditions among military personnel following a deployment?

a. (1) PTSD, (2) Sleep problems
b. (1) Insomnia, (2) Sleep problems
c. (1) Relationship problems, (2) PTSD
d. (1) Sleep problems, (2) Back problems **13%**
e. (1) Insomnia, (2) Relationship problems

Cognitive Behavioral Therapy for Insomnia (CBT-I)

So what?

- Behavioral health providers may be prone to only assessing for PTSD post-deployment
- Missing acute back pain, which may develop into chronic pain

Which statement is accurate about PTSD and sleep disturbances?

a. Sleep disturbance & nightmares are normal & typical in an acute response to trauma & are usually transient.
b. Sleep disturbance (e.g., insomnia) is a direct consequence of PTSD, not a core symptom of the disorder.
c. Receiving effective treatment for PTSD nearly always serves to effectively treat/resolve comorbid insomnia as well.
d. Veterans with PTSD tend to report fewer sleep-related anxiety symptoms than Veterans with insomnia but no PTSD.
e. Symptoms of Insomnia Disorder tend to be more severe in Veterans with co-morbid PTSD than in those without co-morbid PTSD.

Sleep Problems in the Military

Complaint	Sample	Prevalence
Insufficient sleep	Navy and Marines SMs	39% (Navy) 42% (Marines)
Poor sleep quality	SMs and Vets (anonymous survey)	89%
Daytime fatigue	Army SMs 6 mos post-deployment	32.3%
Nightmares	OIF/OEF Vets warranting behavioral health assmt	51%

Plumb et al 2014; Toblin et al., 2012; Wallace et al, 2011 vs Hoge 2008??; Gellis et al., 2010

Which statement is accurate about PTSD and sleep disturbances?

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b. Sleep disturbance (e.g., insomnia) is a direct consequence of PTSD, not a core symptom of the disorder.

c. Receiving effective treatment for PTSD nearly always serves to effectively treat/resolve comorbid insomnia as well.

d. Veterans with PTSD tend to report fewer sleep-related anxiety symptoms than Veterans with insomnia but no PTSD.

e. **Symptoms of Insomnia Disorder tend to be more severe in Veterans with co-morbid PTSD than in those without co-morbid PTSD. 57%**

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PTSD & Sleep Disturbances

So what?

- Behavioral health professionals who believe vets with PTSD typically have more severe insomnia may misattribute the sleep problems to the PTSD, as opposed to being independent of PTSD
- Might only focus on the PTSD in the mistaken belief that insomnia will remit with PTSD treatment

Cognitive Behavioral Therapy for Insomnia (CBT-I)

Which of the major components of CBT-I has a goal of strengthening bed & bedtime as sleep cues?

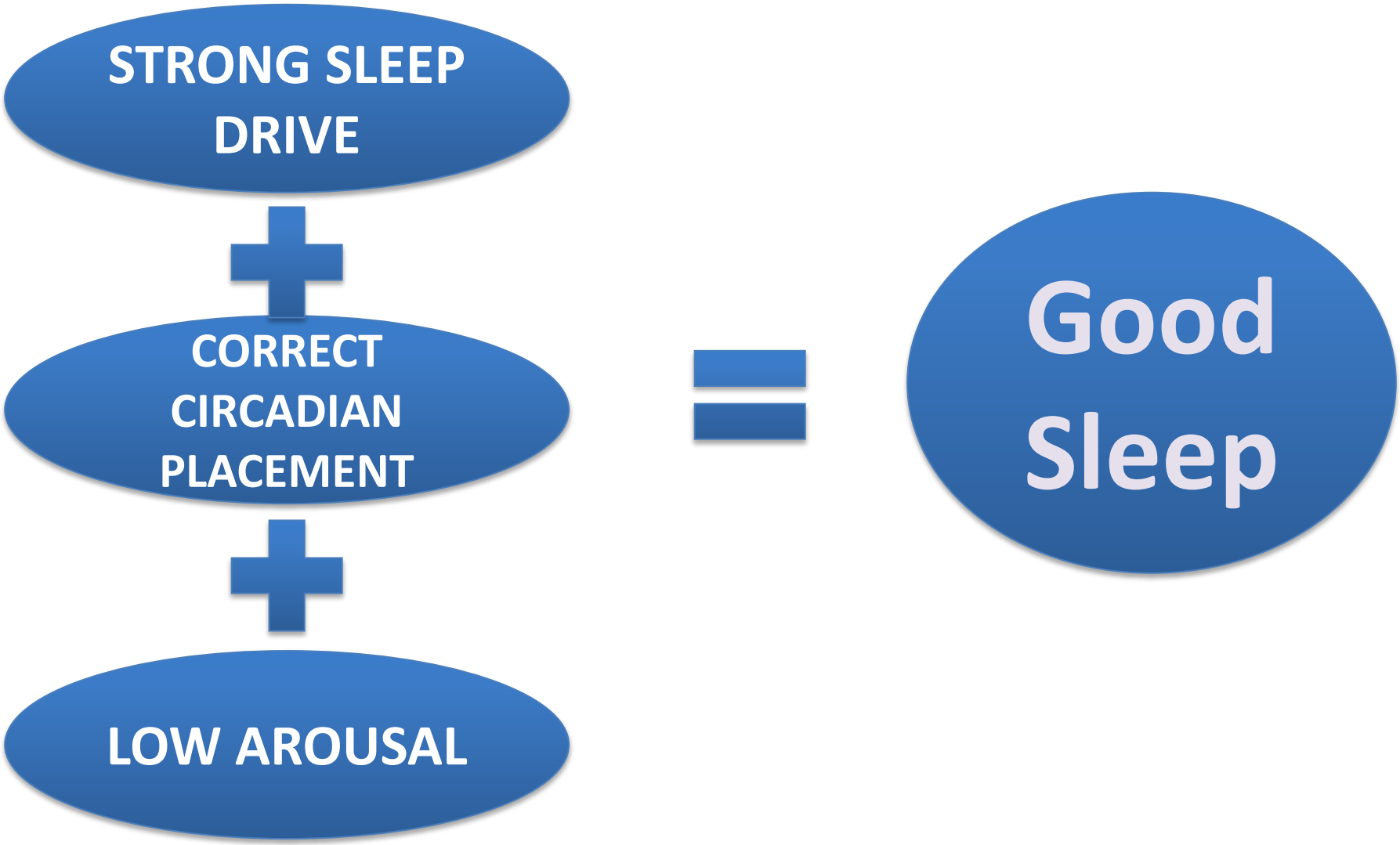
a. Sleep hygiene

b. Sleep restriction

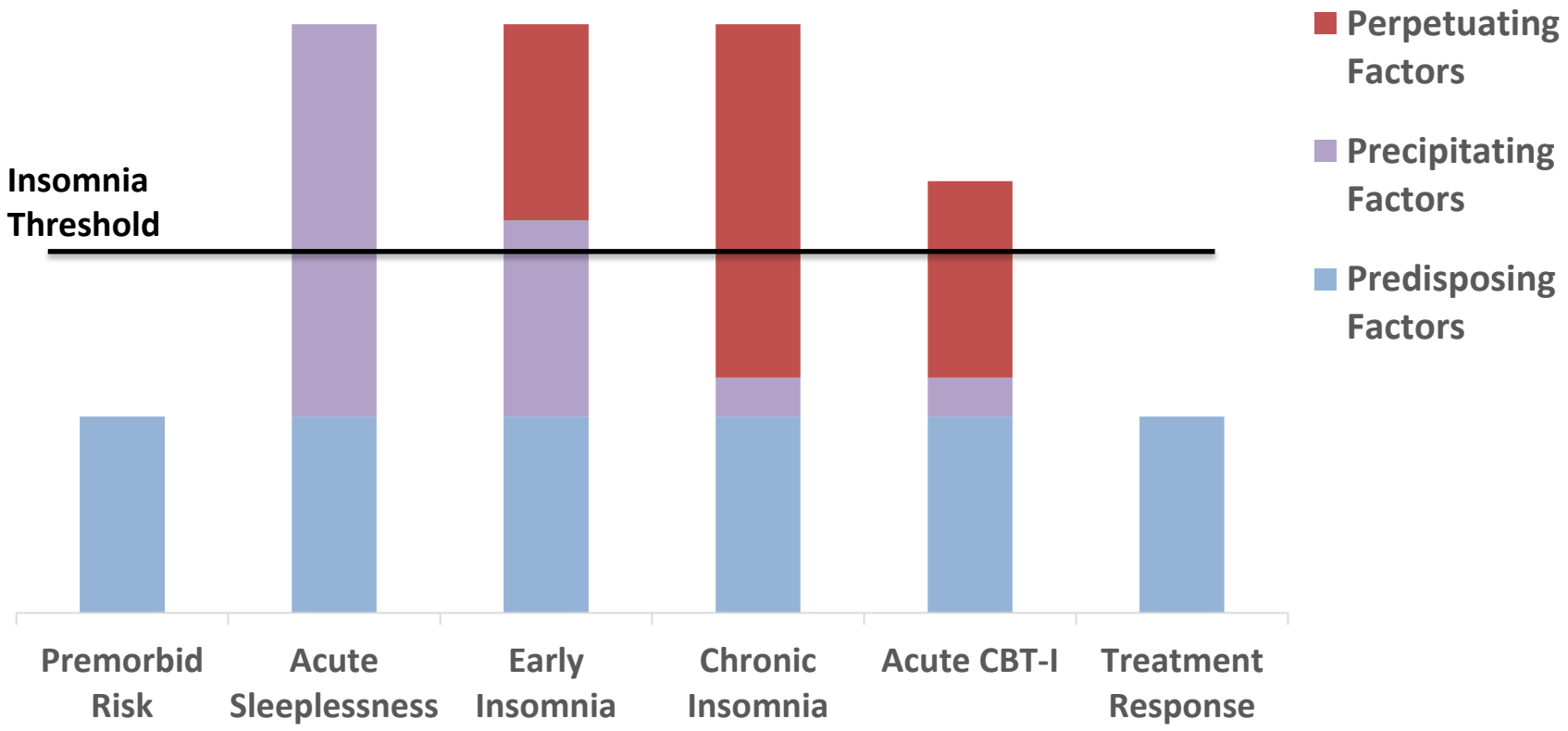
c. Stimulus control

d. Cognitive restructuring

e. Circadian rhythm entrainment


STRONG SLEEP DRIVE
CORRECT CIRCADIAN PLACEMENT
LOW AROUSAL
Good Sleep

Model of Response to CBT-I



Perlis, 2005

CBT-I Components

	Technique	Goal
Behavioral	Stimulus Control	Strengthen bed & bedtime as sleep cues Strengthen the signals from the circadian clock
	Sleep Restriction	Reduce time in bed to increase sleep drive and consolidate sleep
	Relaxation	Arousal reduction
Cognitive	Cognitive Restructuring/ Techniques	Address thoughts and beliefs that interfere with sleep and adherence Reduce sleep effort Reduce cognitive arousal
Relapse Prevention	Sleep Hygiene	Address substances, exercise, eating, environment

Cognitive Behavioral Therapy for Insomnia (CBT-I)

Which of the major components of CBT-I has a goal of strengthening bed & bedtime as sleep cues?

a. Sleep hygiene

b. Sleep restriction

c. Stimulus control **29%**

d. Cognitive restructuring

e. Circadian rhythm entrainment

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Cognitive Behavioral Therapy for Insomnia (CBT-I)

So what?

- Behavioral health professionals may not know to make stimulus control recommendations to help with sleep disturbances
- Sleep hygiene ≠ CBT-I

CBT-I Endorsements as Frontline Treatment

1. American College of Physicians - 2016
2. American Academy of Sleep Medicine - 2006
3. Society of Behavioral Sleep Medicine
4. National Institutes of Health – 2005

*With adequate training & supervision, mental health providers can work with insomnia beyond sleep hygiene

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Cognitive Processing Therapy (CPT)

- Intensive 2-day module
- Evidence-based treatment for PTSD
- Presents theory underlying CPT & brief overview of CPT's empirical support
- Step-by-step instructions in CPT protocol techniques
- Strategies for conceptualizing and dealing with co-morbidity
- Video clips of expert therapists demonstrate CPT skills
- Participants are asked to do role-plays and other assignments to learn concepts and practice skills.

Cognitive Processing Therapy (CPT)

Which of the following is a core principle in Socratic Dialogue?

a. Knowledge is a commodity to be acquired

b. Wisdom is to be imparted from teacher to student

c. Warmth is an important element of the approach***

d. The primary goal of the process is to have the correct answer

e. The patient is dependent upon the therapist for guidance and answers

Cognitive Processing Therapy (CPT)

What is Socratic Dialogue?

- Clarification of the thought
- Critical examination of the thought
- Exploration of the origin or source of the statement
- Examination of the implications and consequences of the statement
- Examination of alternative views

Cognitive Processing Therapy (CPT)

What Socratic Dialogue isn't…

- Disagreement with or discounting the client's answers
- Answering questions for the client
- Pre-identification of a specific replacement/alternative thought for the client
- Random questions
- Making suggestions or problem-solving for the client
- Judgment about the patient's views and experiences

Cognitive Processing Therapy (CPT)

Which of the following is a core principle in Socratic Dialogue?

a. Knowledge is a commodity to be acquired

b. Wisdom is to be imparted from teacher to student

c. Warmth is an important element 33%

d. The primary goal of the process is to have the correct answer

e. The patient is dependent upon the therapist for guidance and answers

Cognitive Processing Therapy (CPT)

So what?

- Without warmth, questions and paraphrasing may come across as condescension or judgment, adding to some patients sense of stigma and self-blame

Prolonged Exposure (PE)

- Intensive 2-day module
- Covers the theoretical underpinnings and research
- Reviews the main clinical techniques used in this structured protocol
- Step-by-step instructions for conducting PE therapy
- Includes in-vivo and imaginal exposure
- Strategies for working with over- and under-engaged patients and other difficult cases
- Videotaped examples of PE cases are used to demonstrate therapist skills

Prolonged Exposure (PE)

According to Hembree et al., 2003, approximately what percentage of patients drop out during exposure therapy (not in combination with other types of treatment)?

a. 20%

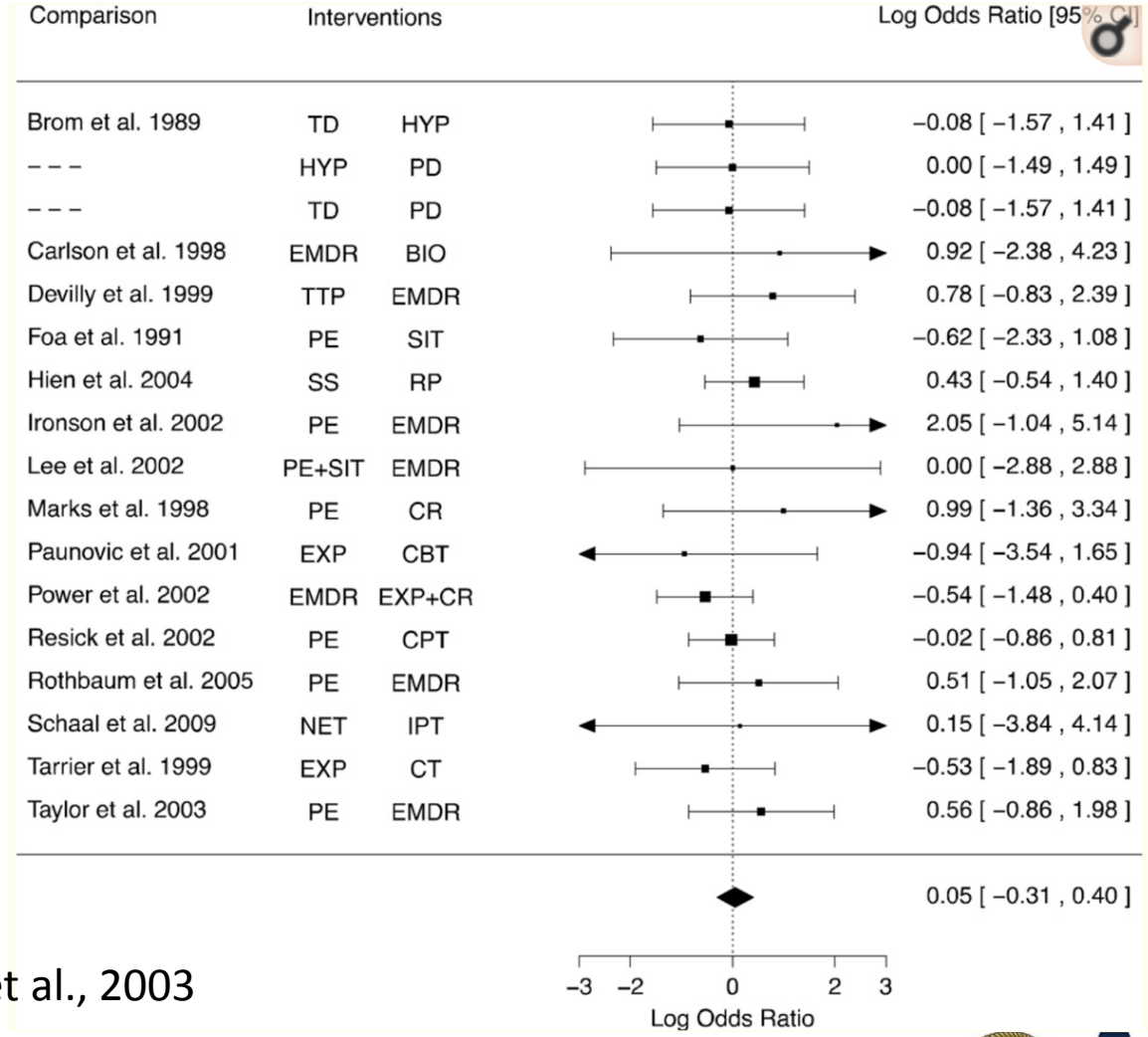
b. 30%

c. 40%

d. 50%

e. 60%

Prolonged Exposure (PE)



Hembree et al., 2003

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Prolonged Exposure (PE)

According to Hembree et al., 2003, approximately what percentage of patients drop out during exposure therapy (not in combination with other types of treatment)?

a. 20% **28% chose A**

b. 30%

c. 40%

d. 50%

e. 60%

Prolonged Exposure (PE)

So what?

- Behavioral health professionals who overestimate the withdrawal/dropout rate from PE may be reluctant to offer it along with other PTSD treatments

Repeated in vivo exposure facilitates which of the following outcomes?

a. Fosters realistic assessment of the situation as low risk

b. Promotes negative reinforcement of avoidance behaviors

c. Provides confirmation that anxiety in the feared situation does not have a clear end

d. Prevents habituation, making the target situation increasingly less distressing

e. Fosters the therapeutic alliance between provider and patient

Repeated in vivo exposure facilitates which of the following outcomes?

In vivo exposure involves repeatedly engaging in activities, situations, or behaviors that are avoided because of the trauma, but which are not actually dangerous. Over time, In vivo exposure reduces excessive fear, and other distressing emotions, and encourages the recognition that the avoided situations are not excessively dangerous, and that the client can cope effectively even when distressed.

Repeated in vivo exposure facilitates which of the following outcomes?

a. Fosters realistic assessment of the situation as low risk 42% chose A.

b. Promotes negative reinforcement of avoidance behaviors

c. Provides confirmation that anxiety in the feared situation does not have a clear end

d. Prevents habituation, making the target situation increasingly less distressing

e. Fosters the therapeutic alliance between provider and patient

Repeated in vivo exposure facilitates which of the following outcomes?

a. **Fosters realistic assessment of the situation as low risk** 42% chose A.

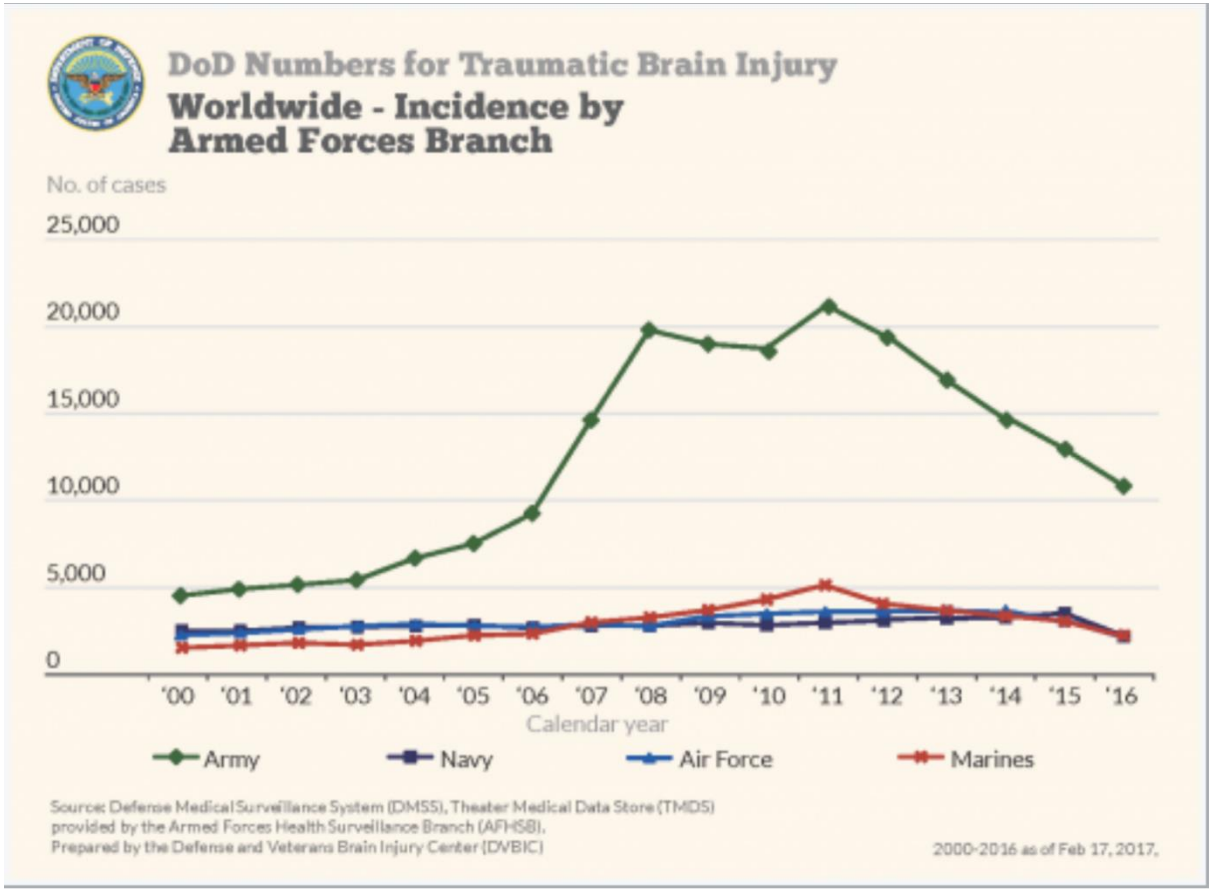
So what?

- Behavioral health professionals who do not understand this rationale may not assess for a change in patient's beliefs, a key component of positive change, or the lack thereof

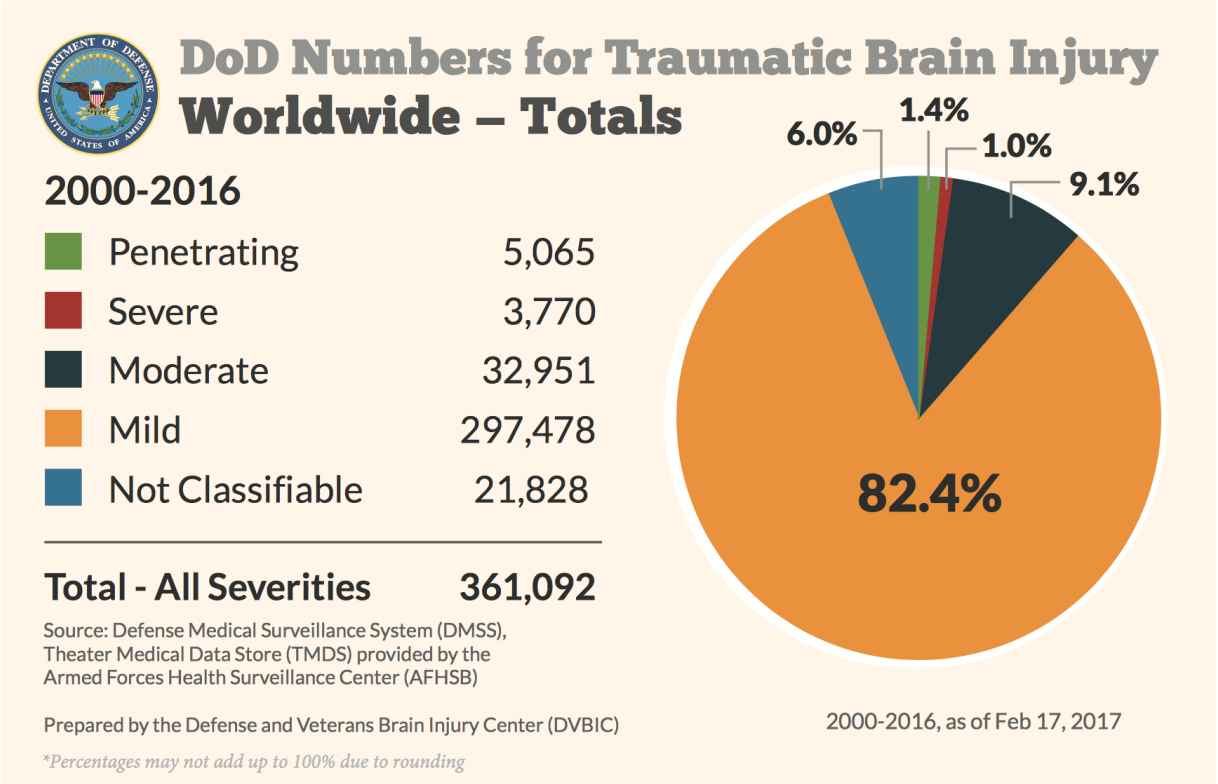
TBI

- Between 2000 - 2014, approximately what percentage of TBIs reported in the military were ‘mild’ (mTBI or concussions)?
  a. 9%
  b. 23%
  c. 51%
  d. 75%
  e. 83%

TBI Incidents by Branch of Service
2000 – 2015



All Armed Forces – TBI
2000 – 2016 Q1



TBI

- Between 2000 - 2014, approximately what percentage of TBIs reported in the military were ‘mild’ (mTBI or concussions)?
  a. 9%
  b. 23%
  c. 51%
  d. 75%
  e. 83% 25% answered correctly

TBI

75% of participants underestimated the prevalence of mild TBI in the military

TBI

75% of training participants underestimated the prevalence of mTBI in ADMs military

So what?

1. Underestimating the base rate within our population
2. May not screen for TBI
3. Misattribute sxs to something else (PTSD)

Caveats

1. Context: Training, in person or on-line
2. Convenience samples; surveys (not mandatory for those in training)
3. Mix of residents (new to military & BHS) as well as new to VA/DoD

So what?

Encourage continuing education (or train your staff) on:

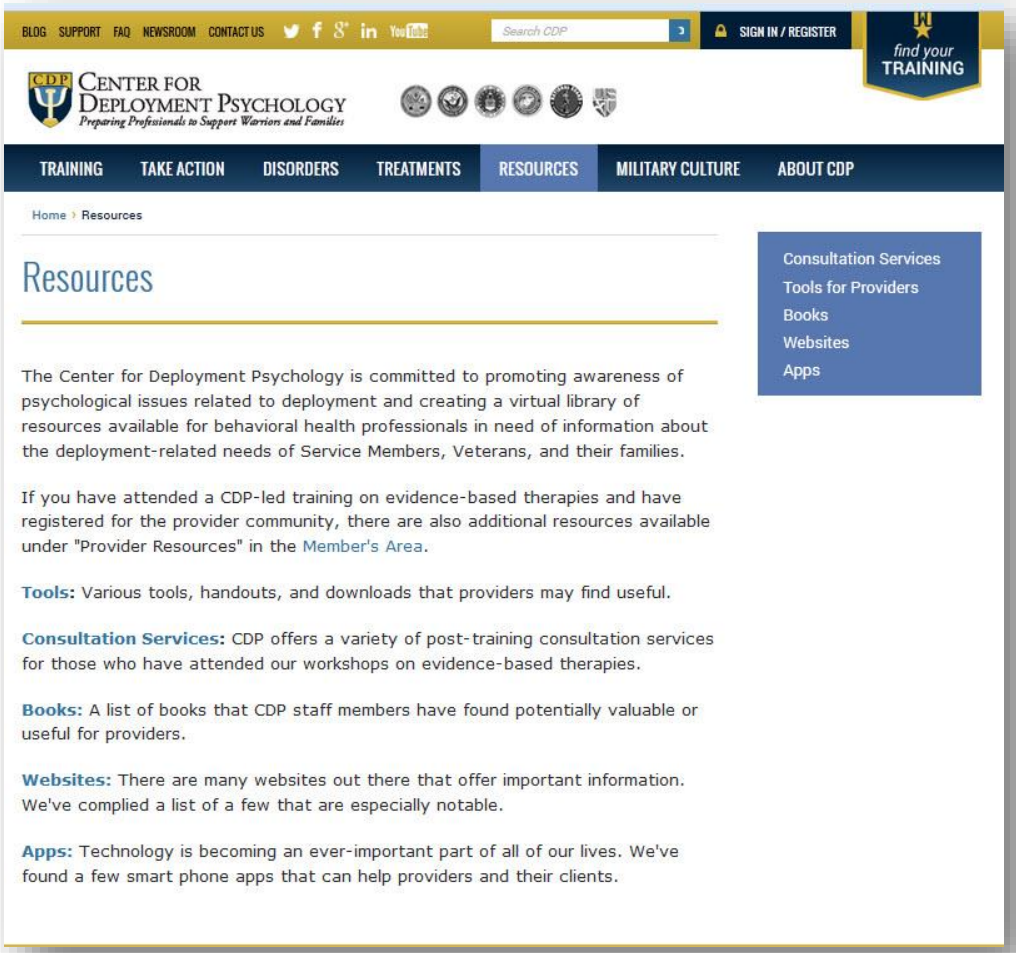
- Non-pejorative language to reduce stigma
- Accurate incidence & prevalence rates to reduce under/over/mis - diagnosis
- VA/DoD CPGs to identify appropriate EBPs
- Refresh training on EBPs to understand core components

CDP Website: Deploymentpsych.org

- Training descriptions & schedules
- Daily blog with relevant news
- SME articles on deployment psychology, PTSD, mTBI, etc.
- Other resources and information for behavioral health providers
- Links to CDP's Facebook page and Twitter feed

Provider Support

- 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, & multimedia training aids



How to Contact Us

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